

Latvia

Health system review

Daiga Behmane
Alina Dudele
Anita Villerusa
Janis Misins
Kristine Klavina
Dzintars Mozgis
Giada Scarpetti

Giada Scarpetti (Editor), and Ewout van Ginneken (Series editor)
were responsible for this HiT

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Health Systems in Transition

Latvia

Health System Review 2019

Daiga Behmane

Riga Stradins University

Alina Dudele

Riga Stradins University

Anita Villerusa

Riga Stradins University

Janis Misins

Centre for Disease Prevention and Control

Kristīne Kļaviņa

Ministry of Health of the Republic of Latvia

Dzintars Mozgis

Centre for Disease Prevention and Control

Giada Scarpetti

Berlin University of Technology and European
Observatory on Health Systems and Policies



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HEALTH SYSTEM PLANS – organization and administration

LATVIA

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PREFACE

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

HiTs seek to provide relevant information to support policymakers 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 policymakers and analysts in different countries; and
- to assist other researchers in more in-depth comparative health policy analysis.

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

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

A standardized review has certain disadvantages because the financing and delivery of health care differ across countries. However, it also offers advantages, because it raises similar issues and questions. HiTs can be used to inform policymakers 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 contact@obs.who.int.

HiTs and HiT summaries are available on the Observatory's website (<http://www.healthobservatory.eu>).

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The Health Systems in Transition (HiT) profile on Latvia was co-produced by the European Observatory on Health Systems and Policies and Latvia, which is a member of the Health Systems and Policy Monitor (HSPM) network. The HSPM is an international network that works with the Observatory on Country Monitoring. It is made up of national counterparts that are highly regarded at national and international level and have particular strengths in the areas of health systems, health services, public health and health management research. They draw on their own extensive networks in the health field and their track record of successful collaboration with the Observatory to develop and update the HiT. This edition was written by Daiga Behmane (Rīga Stradiņš University), Alina Dudele (Rīga Stradiņš University), Anita Villerusa (Rīga Stradiņš University), Janis Misins (Centre for Disease Prevention and Control of Latvia), Kristine Kļaviņa (Head of Human Resources Development Division at the Ministry of Health of the Republic of Latvia), and Dzintars Mozgis, (Centre for Disease Prevention and Control). It was edited by Giada Scarpetti. The basis for this edition was the previous HiT on Latvia, which was published in 2012, written by Uldis Mitenbergs, Maris Taube, Janis Misins, Eriks Mikitis, Atis Martinsons, Aiga Rurane and edited by Wilm Quentin. The European Observatory on Health Systems and Policies is grateful to Triin Habicht (International Consultant), Girts Brigis (Head of Department of Public Health and Epidemiology, Rīga Stradiņš University), Ruth Lopert (OECD) and Ewout van Ginneken (European Observatory on Health Systems and Policies) for reviewing the report. The authors are grateful to everyone at the Ministry of Health and Ministry of Welfare and its agencies (National Health Service, Centre for Disease Prevention and Control of Latvia), especially to Inga Milasevica (Director of the National Health Service of Latvia), Iveta Gavare (Director of the Centre for Disease Prevention and Control of Latvia) and Kristīne Šica (Senior expert, Policy Coordination Unit, Ministry of Health) for their assistance in providing information and for their invaluable comments on

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The HiT uses data available on July 2019, unless otherwise indicated. The HiT reflects the organization of the health system and the data availability, unless otherwise indicated, as it was in September 2019. The Observatory is a partnership that includes the Governments of Austria, Belgium, Finland, Ireland, Norway, Slovenia, Spain, Sweden, Switzerland and the United Kingdom; the Veneto Region of Italy; the French National Union of Health Insurance Funds (UNCAM); the Health Foundation; WHO; the European Commission; the World Bank; the London School of Economics and Political Science (LSE); and the London School of Hygiene & Tropical Medicine (LSHTM). The partnership is hosted by the WHO Regional Office for Europe. The Observatory is composed of a Steering Committee, core management team, research policy group and staff. Its Secretariat is based in Brussels and has offices in London at LSE, LSHTM and the Berlin University of Technology. The Observatory team working on HiTs is led by Josep Figueras, Director; Elias Mossialos, Martin McKee, Reinhard Busse (Co-directors); Richard Saltman, Ewout van Ginneken and Suszy Lessof. The Country Monitoring Programme of the Observatory and the HiT series are coordinated by Anna Maresso. The production and copy-editing process was coordinated by Jonathan North, with the support of Caroline White.

LIST OF ABBREVIATIONS

ALOS	Average length of stay
CDPC	Centre for Disease Prevention and Control
CEDM	Centre of Emergency and Disaster Medicine
CSB	Central Statistical Bureau
DALY	Disability-Adjusted Life years
DDD	Defined daily dose
DRG	Diagnosis-Related Group
EC	European Commission
EEA	European Economic Area
EHIC	European Health Insurance Card
EMA	emergency medical assistance
ERDF	European Regional Development Fund
ESF	European Social Fund
EU	European Union
EU27	The 27 EU Member States
EU12	EU Member States since 2004 or 2007
EU15	EU Member States before 2004
EUR	Euro (European Monetary Unit)
EU-SILC	European Union Statistics on Income and Living Conditions
FFS	fee for service
GDP	gross domestic product
GP	general practitioner
HI	Health Inspectorate
HIV/AIDS	human immunodeficiency virus/acquired immunodeficiency syndrome
HPC	Health Payment Centre
ICT	information and communication technology
IHME	Institute of Health Metrics and Evaluation

IHR	International Health Regulations
IMF	International Monetary Fund
INN	international nonproprietary name
LDA	Latvian Dental Association
Mol	Ministry of Interior
MoH	Ministry of Health
MoW	Ministry of Welfare
MRI	magnetic resonance imaging
NATO	North Atlantic Treaty Organization
NGO	nongovernmental organization
NHS	National Health Service
NORD-DRG	Common Nordic DRG system
NRS	National Revenue Service
OECD	Organisation for Economic Co-operation and Development
OHC	Oral Health Centres
OOP	out of pocket
OTC	over the counter
PD	Per Diem
PHC	primary health care
SAM	State Agency of Medicines
SCHIA	State Compulsory Health Insurance Agency
SDR	standardized death rate
SEMS	State Emergency Medical Service
SRS	State Revenue Service
STI	sexually transmitted infection
SUSTENTO	Latvian Umbrella Body for Disability Organizations
TB	tuberculosis
THE	total health expenditure
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
US\$PPP	US Dollar Purchasing Power Parities
VAT	value added tax

VHI	voluntary health insurance
VHIC	voluntary health insurance companies
WBG	World Bank Group
WHO	World Health Organization
WTO	World Trade Organization

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ABSTRACT

This analysis of the Latvian health system reviews recent developments in organization and governance, health financing, health care provision, health reforms and health system performance.

After regaining independence in 1991, Latvia experimented with a social health insurance type system. However, to overcome decentralization and fragmentation of the system, the National Health Service (NHS) was established in 2011 with universal population coverage. More recently, reforms in 2017 proposed the introduction of a Compulsory Health Insurance System, with the objective of increasing revenues for health, which links access to different health care services to the payment of social health insurance contributions. In June 2019 the implementation of this proposal was postponed to 2021.

Latvia has recovered from the severe economic recession of 2008, which resulted in the adoption of austerity measures that significantly affected the health care system. The recovery has created fiscal space to focus on policy challenges neglected in the past, especially regarding health. Despite recent increases in spending, the health system remains underfunded and resources have to be allocated wisely.

Latvia's health outcomes should be considered within this context of limited health system resources. While life expectancy at birth in Latvia has increased since 2000, reaching 74.9 years in 2017, it remains among the lowest in the EU. Recent reforms have focused on improving access to services in rural/remote areas, increasing funding for health care services, and tougher regulation of tobacco and alcohol. However, a number of long-standing unresolved problems still need to be addressed, including financial sustainability and low public funding, high levels of unmet need, high rates of preventable and treatable mortality, and challenges in both communicable and noncommunicable diseases.

EXECUTIVE SUMMARY

- **Latvia's economy is recovering well after the global financial crisis, but the health status of the population lags behind other EU countries**

The Republic of Latvia lies on the Baltic Sea and is bordered by Estonia, the Russian Federation, Belarus and Lithuania. In 2018 Latvia had a population of 1.93 million people. The country has reported a considerable decline in population since the mid-1990s, due to negative net international migration and negative population growth. While life expectancy at birth has increased from 70.2 years in 2000 to 74.9 years in 2017, there is a substantial gender gap, with women expected to live about 10 years longer than men. Diseases of the circulatory system have been the leading cause of death for a long time and rates for men and women are above the EU average. Malignant neoplasms (cancers) have been the second leading cause of death in the last couple of decades. Deaths attributable to external causes remain the third leading cause of death, and are much more frequent among males than females, with intentional self-harm in men ranking high among mortality in this category. The burden of mortality and morbidity in Latvia is heavily influenced by a high prevalence of behavioural risk factors. Smoking rates are a major public health issue, and obesity rates continue to rise. Alcohol consumption also remains high.

- **Latvia operates a national health system with strong government stewardship**

The Latvian National Health System is currently based on general tax-financed statutory health care provision, with a purchaser-provider split

and a mix of public and private providers. The parliament (Saeima) has a significant role in the development of national health policy. It approves both the national budget and the budget of the National Health Service (NHS). The Ministry of Health (MoH) is responsible for national health policy and the overall organization and functioning of the health system. The NHS institution implements state health policies, ensures the availability of health care services throughout the country, and is the main purchaser of publicly funded health services. Local governments are responsible for ensuring geographical accessibility, and, depending on budget and local priorities, maintain hospitals and long-term social care facilities. Local government is not involved in the direct payment of health care services, which is the responsibility of the NHS. Different ownership structures characterize health care provision in Latvia. Smaller hospitals and some larger regional hospitals are commonly owned by municipalities, while the larger hospitals (such as university hospitals) are owned by the state. Providers contracting with the NHS may be public or private; in the case of primary care they tend to be predominantly private; public or private in secondary care, and public in the case of tertiary care, with ownership concentrated at the state (national) or municipality (regional) level.

■ The share of public expenditure on health is low, and the proportion of out-of-pocket spending is among the highest in Europe

In 2017, total health expenditure (THE) as a share of GDP was 6.3%, and spending per capita was US\$PPP 1 722. Public expenditure as a share of current health expenditure was only 54.6% in 2016, and public expenditure on health as a share of general government expenditure is also low at 9.2%, and both are below the respective shares in Lithuania and Estonia and many other EU countries. State financing for health is approved annually by parliament as a part of the national budget. The Cabinet of Ministers outlines the allocation of the health budget according to the priorities set by the MoH.

The majority (around 85%) of the parliament-approved government health budget is allocated to the purchasing of health care services and is administered by the NHS, with the remaining share used by the MoH for

the provision of emergency medical care, health sector management and public health activities.

Despite near universal population coverage, the benefit package is rather limited in scope, and excludes, among others, dental care for adults and most rehabilitative and physiotherapy services. Furthermore, co-payments are required for a number of services. Out-of-pocket (OOP) spending amounted to 41.8% in 2017, one of the highest proportions in Europe. OOP payments are mainly linked to: 1) patients paying user charges for statutorily financed care provided by NHS-contracted providers and for care provided within MoH-financed health programmes; 2) patients paying directly for non-statutorily financed care (non-contracted care) provided by NHS-contracted providers; and 3) for care provided by non-contracted providers; and 4) pharmaceuticals.

General Practitioners (GPs) are paid using a mix of capitation, fee for service (FFS), fixed practice allowances and, since 2013, quality payments. Secondary ambulatory services are reimbursed through FFS, case payments and user charges. Hospitals receive fixed budgets for emergency care services and observational wards, calculated based on the number of specialists available in the hospital. Hospitals also receive payments for the treatment of patients based on predefined case payments, payments for bed-days (defined for every level of hospital and/or individual hospital) and payments based on DRGs.

■ **To boost efficiency of the sector, Latvia has taken steps to improve the distribution of health care workers, and has substantially decreased the number of acute hospital beds**

Health workers in Latvia are mainly concentrated in urban areas, leading to equity and accessibility issues, especially for rural populations (Villerusa et al., 2015). About 52% of the GP practices are based in the Greater Riga Area, with primary care accessibility gradually decreasing with increasing distance from Rīga, and with a similar pattern for specialist care. Although the number of doctors has stabilized in recent years, the system struggles to retain recent medical graduates (Villerusa et al., 2018). The number of physicians per 100 000 population in Latvia in 2017 was just below the EU28 average, while the number of nurses in Latvia is among the lowest in the EU.

Recently, the authorities have attempted to improve recruitment and retention of health workers by increasing salaries in 2018, with further annual increases of 20% committed between 2019–2021.

Of the Baltic states, Latvia has seen the largest decline in the number of acute hospital beds, with 330 beds for 100 000 population in 2017, a drop of almost 60% since 1992. At the end of 2017 there were 63 inpatient hospitals in Latvia. The government provides guarantees for loans of capital investments in state institutions and assumes the risk if providers fail to pay back. In general, the owners of all health care institutions are responsible for securing adequate investments for their facilities. In addition, international funding has been available through the European Regional Development Fund, the European Social Fund and other foreign financial assistance agencies. Between 2014 and 2020, the health system in Latvia has had access to 271.7 million euros from EU funds, of which 66% is for the development of health care infrastructure, 20% for health promotion programmes, 12% for health workforce development programmes, and 2% for the patient safety and health care quality systems.

Latvia is comparatively well equipped with diagnostic imaging equipment. It has 14 MRI units and 36 CT scanners per million population, with a substantial share of these devices owned by private institutions.

■ A partial gatekeeping system is in place

Almost all Latvians are registered with a GP who acts as a gatekeeper to secondary ambulatory and hospital care, with some exceptions (e.g. gynaecologists). Physician assistant/midwife “points” provide a considerable share of primary care in rural areas. A patient with a referral may choose any ambulatory or inpatient care provider/institution, depending on whether the patient wants a publicly funded service or is willing to use private insurance or pay for the service out of pocket. However, for publicly paid services, provider choice is limited since NHS-contracted institutions provide the services, and their availability depends on the contracted annual number of services for each provider. Specialized ambulatory care is provided in similar institutional settings and under similar ownership structures as primary care. Some specialists may be accessed directly under certain conditions without a referral from a GP. Hospitals in Latvia are classified according to ownership

structure and legal status: state hospitals (owned by the central government and accountable to the MoH); municipal hospitals; and private hospitals. State hospitals have the status of public limited (stock) companies. Hospitals have undergone a re-profiling in order to optimize resources, which has resulted in a 5-tier system based on the mandatory services provided at each level.

Three main institutions deal with pharmaceutical policy: the SAM (the national drug regulatory agency), the NHS (responsible for reimbursement and pricing decisions) and the HI (responsible for monitoring of market and professional activities). Pharmaceutical products are supplied to the public via a regulated distribution system consisting of licensed manufacturers, wholesalers and retail and hospital pharmacies.

Mental health is an important focus area of the Public Health Strategy 2014–2020 (Ministry of Health, 2014). Mental health promotion, disease prevention, analysis of statistics, conducting surveys and writing reports is under the responsibility of the Centre for Disease Prevention and Control (CDPC).

There are two types of long-term social care facilities in Latvia, with different areas of specialization and sources of financing: 1) specialized state social care institutions, financed by the state budget through the Ministry of Welfare for people with mental health disorders and serious disabilities, the blind, and orphaned children; and 2) general social care institutions, financed by local governments, for older people and people with health problems of a physical nature, as well as orphaned children from 2 to 18 years of age.

Dental services, including dental hygiene, are paid from the state budget only for children up to 18 years of age.

■ Key health reforms focus on increasing the number of healthy life years of Latvians, and improving the financial sustainability of the system

The period immediately prior to the economic crisis (2007–2008) was characterized by a process of institutional centralization and a slow shift away from hospital towards outpatient care. From 2009–2012 a shock-type reform led to a dramatic reduction in the number of hospitals, and far-reaching changes

in health care administrative institutions. Since 2013 there has been a focus on the financial sustainability of the system. In 2017, parliament passed a law for the introduction of a Compulsory Health Insurance System, with the aim of increasing revenues for health. Under the new system, entitlement to the full benefit basket would be linked to the payment of social health insurance contributions. However, the reform has been postponed to 2021. Since 2018, the government has increased the compulsory state social insurance contribution from payroll by 1 percentage point, which is currently implemented and is used specifically for funding health care.

Strengthening primary health care has been a priority in pursuing a more affordable, effective and comprehensive health care system. Strategies to improve retention of health workers have been implemented, including financial incentives and giving priority to medical students who apply for a residency in a rural area.

Latvia's Public Health Strategy 2014–2020 is among its most important health policy documents. It identifies priority areas to increase the number of healthy life years of the country's inhabitants, prevent premature deaths, as well as preserving, improving and restoring health. A mid-term evaluation of the Strategy found that the problems identified in the Strategy are still relevant, and the proposed strategic directions need to be reinforced. Target actions continue to include the promotion of healthy and active lifestyles, enhancing the quality and efficiency of health care services, emphasizing a person-centred health care approach, and developing integrated health care, as well as improving accessibility and reducing health inequalities.

■ Preventable and treatable mortality could be improved by channelling more resources into prevention and increasing efficiency and quality of care

Information available to the public on the performance monitoring of the health system is quite limited, but the Ministry of Health is taking steps both to improve monitoring and to identify health-related population needs and problems through the development of a set of indicators specific to the health system (in particular for structural resources, processes and outcomes).

Financial protection for the Latvian population remains insufficient due to the high share of out-of-pocket payments. In 2018, 6.2% of Latvians reported forgoing medical examinations due to costs, travel distance or waiting times. This proportion is among the highest in Europe. Furthermore, financial barriers to access disproportionately affect lower income groups.

The health system is confronted with a double burden of high rates of infectious diseases and the growing challenge of noncommunicable diseases. Latvia also reported the third highest mortality rate from treatable causes in the EU in 2017. A major challenge is the comparably low level of resources available for health care services, which hampers efforts to improve health outcomes.

The technical efficiency of the system is affected by issues of quality of care, the unbalanced skill mix of the health workforce, and overuse of certain medical procedures and equipment. Quality of care needs to be strengthened, and the introduction of quality monitoring of inpatient care services, together with quality payments for GP, are steps in the right direction. Other efficiency-oriented policies include the promotion of generic medicines, with generics now constituting a high share of the market, in terms of both value and volume. Furthermore, Latvia has managed to decrease the average length of stay in acute care hospitals, and the overall number of hospitals of all sizes has been reduced substantially. Between 2005 and 2016, the number of beds declined more rapidly in Latvia than in the EU, but remains above the EU average. Overall, Latvia has made progress in shifting care from the costly hospital setting to the community setting. Further diffusion of health technology assessments could contribute to greater efficiency in many crucial areas of expenditure.

■ Despite recent progress, comparably unfavourable population health outcomes reflect an underfunded system

The achievements of the Latvian health system over the past decade include increased life expectancy at birth, a shift in focus from inpatient care to outpatient care, progress in cancer care and some improvement in the burden of disease related to behavioural risk factors.

Nevertheless, as in many other countries, the Latvian health system faces compelling challenges that need to be addressed. Chief among them are the

need to reduce the substantial reliance on out-of-pocket payments, address inequity in access to care, improve prevention and monitoring, strengthen quality of care and overcome significant shortages in the health care workforce, especially among nurses. An important precondition for addressing these challenges, however, is generating sufficient and sustainable funding for the system.

Introduction

■ Chapter summary

- The Republic of Latvia has a population of about 1.93 million people in 2018. Riga – the capital – is the largest city, with about 641 400 inhabitants. Latvia has an ageing and declining population.
- Since regaining independence in 1991, Latvia has been a democratic, parliamentary republic. Legislative power is in the hands of the unicameral parliament (Saeima). Parliament is elected for a period of 4 years.
- Latvia joined the EU in 2004. During the economic crisis that began in 2008, GDP contracted by one quarter, more than in any other EU Member State.
- Life expectancy at birth has increased by almost 5 years since 2000 and reached 74.8 years in 2017, with a substantial gender gap (69.8 years for males and 79.6 years for females).
- Latvia faces a growing burden of noncommunicable disease, while challenges in communicable disease control remain. The main causes of death in Latvia are diseases of the circulatory system, malignant neoplasms and external causes.

1.1 Geography and socio-demography

The Republic of Latvia is one of the Baltic countries (Estonia, Latvia and Lithuania). Situated in north-eastern Europe on the east coast of the Baltic Sea, Latvia forms part of the eastern border of the European Union. It borders Estonia to the north, the Russian Federation to the east, Belarus to the south-east and Lithuania to the south. To the west lies the Baltic Sea and the Gulf of Riga. Riga – the capital of Latvia – is centrally located and is situated on the Daugava River estuary on the Gulf of Riga (Fig. 1.1).

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

FIG. 1.1 Map of Latvia



Source: United Nations

The Baltic Sea and the Gulf of Rīga strongly influence the regional climate, which is temperate, with average temperatures of 20°C in summer and –5°C in winter.

In 2018, Latvia had a population of 1.93 million people (Table 1.1). Since 1990, the population has declined by approximately 700 000 (or 26%) and since 2000 by approximately 400 000 (17%). The two immediate causes of the population decline are the negative net international migration and negative population growth. In 2017, the number of deaths exceeded the number of births by 7 900, the largest difference recorded over the preceding 4 years (6 600 in 2016). Although the crude birth rate has increased consistently since 1997 and the death rate has fallen steadily since 1995, the combined effect has been insufficient for positive population growth.

TABLE 1.1 Trends in population/demographic indicators, 1995–2018

	1995	2000	2005	2010	2015	LATEST AVAILABLE YEAR
Population, total (millions)	2.5	2.4	2.3	2.1	2.0	1.9 ^a
Population, ages 0–4 (% of total)	5.9	4.0	4.5	5.3	5.1	5.5
Population, ages 65 and above (% of total)	13.4	14.8	16.6	18.1	19.4	19.9
Population density (people per km²)	40.0	38.1	36.0	33.7	31.8	31.2 ^b
Population growth (average annual growth rate)	–1.4	–1.0	–1.1	–2.1	–0.8	–1.0 ^b
Fertility rate, total (births per woman)	n.a.	1.3	1.4	1.4	1.7	1.7 ^c
Distribution of population (urban/rural)	68.8 / 31.2	68.1 / 31.9	68.0 / 32.0	67.8 / 32.2	68.0 / 32.0	68.1 / 31.9 ^b

^a2018, ^b2017, ^c2016

Sources: Eurostat (2018); World Bank (2018).

Similar to the rest of the European Union (EU) the population of Latvia is ageing. Following a steady decline, since 2009 the percentage of children and young people (below 15 years) in the population slightly increased 15% (2016). However, the proportion of the population aged 65 years and over is steadily increasing, well exceeding the proportion of young people (19.5%

in 2016). The shrinking of the working age population is particularly pronounced and is expected to continue; hence, the age dependency ratio and the burden of an ageing population are also expected to increase in the coming years. This decline in the population of working age is notably affected by migration: in 2015 twice the number of people of working age left Latvia (16 800) than immigrated to the country (7 200).

The representation of Latvians in the total population was 62.2% in 2018. Notable differences in the population's ethnic composition may be observed between regions and cities, with the proportion of Latvians ranging from 45.7% in the eastern region (Latgale region) to 86.7% in the northern and western regions. The three largest religious groups in Latvia are Catholic, Lutheran and Orthodox Christians, although it is assumed that a large proportion of the population is atheist.

The country is sparsely populated, especially in rural areas. The population density has continuously declined since 1990 (reaching 31.5 persons per square kilometre in 2016). In 2016, more than two thirds of the population (68%) lived in urban areas. Rīga accounts for almost a third of the total population and reports the highest population density, followed by cities under state jurisdiction and counties close to Rīga.

Latvia has a very high literacy rate, at 99.9% in 2015, and educational levels are rising. In 2015, 40% of 25–34-year-olds had acquired a tertiary education (close to the OECD average of 42%). Labour market forecasts have emphasized skills shortages in the fields of science, technology, engineering, mathematics and in health.

■ 1.2 Economic context

The current economic situation in Latvia needs to be understood in the context of the deep transformation after the demise of communism, the strong economic growth in the early 2000s and the global financial and economic crisis, which hit Latvia particularly hard after 2008.

The transformation of the economy after 1991 resulted in the rapid expansion of the services sector, at the expense of both agriculture and industry. The successful economic development (low inflation and balanced state budget), as well as fundamental reforms contributed to increases in domestic demand, exports and foreign direct investments. As a result, Latvia

has seen one of the most impressive economic growths in the EU between 1997 and 2007, before the financial crisis.

The global financial crisis resulted in a deep recession in Latvia and led to very strong output losses. The GDP dropped more strongly than in any other EU member state, which had severe effects on both the labour market and fiscal stability of the government. During 2009, the worst year of the crisis, unemployment grew by 9.5 percentage points, reaching 19.5% in 2010 (Table 1.2). To restore stability, Latvia had to implement fiscal consolidation measures in collaboration with the EU, the World Bank and the International Monetary Fund. The planned entry of Latvia to the Eurozone for 2008 was postponed several times. In January 2014, Latvia finally adopted the Euro, signalling a high degree of convergence in inflation, interest rates, budget balance and public debt.

TABLE 1.2 Macroeconomic indicators, 1995–2018 or latest available year

	1995	2000	2005	2010	2015	2018 OR LATEST AVAILABLE YEAR
GDP per capita (current US\$)^a	2 082	3 302	6 973	10 705	13 647	16 405
GDP per capita (current PPP US\$)^a	5 330	8 041	13 053	16 312	24 723	28 362
GDP annual growth rate (%)^a	2.4 ^a	5.4	10.7	–3.9	3.0	4.6
Government expenditure as % of GDP^d	35.6	37.3	34.2	45.5	38.4	37.3 ^b
Government deficit/surplus (% of GDP)^d	–1.4	–2.7	–0.4	–8.7	–1.4	–0.6
General government gross debt (% of GDP)^d	13.9	12.1	11.4	46.8	36.8	40.0
Unemployment, total (% of labour force)^d	n/a	14.2	10.0 ^c	19.5	9.9	8.7
At-risk-of-poverty rate^d	n/a	n/a	n/a	20.9	22.5	23.3
Income inequality (GINI coefficient of disposable income)	n/a	34.0	36.2 ^c	35.9	35.4	35.6

^aFigure from 2006, ^b2016, ^cBreak in time series. n/a; data not available

Sources: ^dEurostat, 2019; ^eWorld Bank, 2018

Since 2010, economic growth slowly resumed and GDP grew by 4.6% in 2017, mainly driven by a rise in exports and private consumption (Ministry of Economics, 2018). Latvia recorded an increase in government

debt equivalent to 40.1% of the country's GDP in 2017 (compared with 36.7% of GDP at the end of 2016). Since then, the government's budgetary situation has stabilized and is well under control, and in 2016 the government requested a temporary deviation (0.5% of GDP) from the required adjustment path towards the medium-term budgetary objective 2017 set in the Stability and Growth Pact (SGP) with the European Commission. This adjustment is limited to the allowance of major structural reforms, notably the pension reform and the ongoing health sector reform (Public Health Strategy 2014–2020).

With economic recovery, employment levels and labour participation rates increased. The unemployment rate fell to 8.7% in 2017 but remains above the EU28 average. On a positive note, job opportunities continue to increase, and both youth unemployment and the proportion of young people not in education, employment or training (age group 15–24 years) are well below the EU average (European Commission, 2017). The labour market situation is expected to improve gradually in the forthcoming years. However, the working age population continues to fall, putting upward pressure on activity and employment rates. Sectors such as information and communication technology, textile manufacturing, construction and health care already experience shortages of qualified employees. Considerable local differences in unemployment and vacancies contribute to structural unemployment and poverty being much higher in the east of Latvia, particularly in the Latgale region, than in the Rīga area; 72% of vacancies notified to the public employment service are in Rīga. In 2015, 45% of the unemployed, mostly in the eastern rural areas, were unemployed for a year or longer. The unemployment rate is almost five times higher for workers with low education attainment than for those with high attainment.

Compared with some of the other transition countries among the new EU Member States, Latvia has made less progress in terms of convergence to EU living standards. In 2017 its GDP per capita was still among the lowest in the EU and largely behind EU average (EUR 13 800 at current prices compared with the EU-28 average of EUR 27 700). The Latvian economy developed considerably faster in 2017 than in the previous years, and GDP and is projected to grow at a rate of about 3% in both 2019 and 2020. Solid wage increases and continued consumer optimism are set to encourage private consumption.

Productivity is not sufficiently broad-based, and regional differences are high, with Rīga being almost twice as productive as the least performing region. The productivity gap between large firms and smaller firms is also substantial, as small and medium-sized enterprises are about 70% less productive than large firms.

Inequality in Latvia is among the highest in the EU. The main income inequality indicator – the ratio of the highest to the lowest income quintile or S20 /S80 ratio – stands at 6.5. This is above the EU average (where the top 20% earn 5.2 times the income of the bottom 20%), and this ratio has stagnated since 2011. In addition, inequalities are also reflected in non-financial aspects such as access to health care and quality learning opportunities between rural and urban schools.

A high proportion of Latvians report unmet health care needs, notably due to financial barriers (see Chapter 7). The inadequacy of social assistance benefits and pensions results in a lack of effective protection.

■ 1.3 Political context

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

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

The President of Latvia is elected for a 4-year term by the Saeima and may remain in office for a maximum of two consecutive terms. The current President is Mr Egils Levits. Although the President's position is mainly ceremonial, he is head of the armed forces, can veto some parliamentary decisions and he exercises substantial authority in both domestic and foreign affairs. The Prime Minister is appointed by the President and is the head of the executive branch of government. The Cabinet of Ministers is nominated by the Prime Minister and appointed by the parliament.

All major laws are enacted by parliament and come into force after being officially announced by the President. The President has veto rights that allow him to send the law back to parliament for further debate. 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 specify the legal basis of developments in the areas of health and health care.

The current five-party coalition government is headed by Prime Minister Krišjānis Kariņš, who took office on January 2019. Government priorities include improvement of competitiveness of the national economy, its productivity and investment volumes, as well as improvement of the country's demographic situation.

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 Latvian Centre for Human Rights, is responsible for monitoring human rights issues.

Administrative territorial division of Latvia has undergone several revisions. Since 2011 Latvia has been administratively divided into two levels: the central level (the state) and the 119 counties comprising 110 counties (or *novadi*) and nine cities under state jurisdiction.

Latvia joined the United Nations in December 1991, the World Trade Organization (WTO) in October 1998, the North Atlantic Treaty Organization (NATO) in March 2004, and the EU in May 2004, together with Estonia, Lithuania and seven other countries. In 2016, Latvia joined the Organisation for Economic Co-operation and Development (OECD) as its 35th member country.

Latvia has made good progress on the World Bank's Worldwide Governance Indicators since 2012. In 2017, Latvia scored well on Regulatory Quality, obtaining 83 (out of 100), while Control of Corruption remained problematic with a score of 70 (out of 100).

In competitiveness rankings Latvia scores far behind other new EU Member States. According to the Global Competitiveness Index 2017–2018 of the World Economic Forum's Global Competitiveness Report, Latvia scores at place 54 (out of 137) (World Economic Forum, 2017). It identifies the instability and complexity of tax regulations, inefficiency of government bureaucracy and corruption as the most problematic factors for doing business.

1.4 Health status

Trends in health status in Latvia are similar to those in the other Baltic countries. Between 2000 and 2017, life expectancy at birth increased by almost 5 years, (Table 1.3) albeit with a substantial discrepancy between genders (69.8 years for men versus 79.7 years for women).

TABLE 1.3 Mortality and health indicators, 1995–latest available year

	1995	2000	2005	2010	2015	LATEST AVAILABLE YEAR
Life expectancy (years)						
Life expectancy at birth, total (years)	66.4 ^d	70.3 ^d	70.6 ^c	73.1 ^c	74.8 ^c	74.9 ^c
Life expectancy at birth, male (years)	60.0 ^d	64.9 ^d	64.9 ^c	67.9 ^c	69.7 ^c	69.8 ^c
Life expectancy at birth, female (years)	73.1 ^d	76.0 ^d	76.3 ^c	78.0 ^c	79.5 ^c	79.7 ^c
Life expectancy at 65, male (years) ^c	n/a	n/a	12.3	13.1	14.2	14.1
Life expectancy at 65, female (years) ^c	n/a	n/a	17.0	18.1	18.9	19.0
Mortality (SDR per 100 000 population)						
Circulatory diseases	750.0	1 117.0	1 087.0	899.5	875.8 ^c	848.5 ^{c,e}
Malignant neoplasms	195.0	290.0	299.6	305.7	293.7 ^c	294.6 ^{c,e}
Communicable diseases	21.0	18.1	13.9	12.0	15.3 ^c	15.7 ^{c,e}
External causes of death	204.0	172.4	150.3	101.7	89.1 ^c	86.5 ^{c,e}
All causes	1 398.0	1 866.4	1 877.5	1 622.3	1 489.4 ^c	1 476.4 ^{c,e}
Infant mortality rate	18.8	10.3	7.7	5.6	4.1	n/a
Maternal mortality rate	54.0	24.8	4.6	26.1	55.2	4.9

^aThe adult mortality rate is the probability of dying between the ages of 15 and 60 years; ^b2013 figures; ^cEurostat, 2019; ^dWorld Bank, 2018; ^e2016 figures

Source: Eurostat, 2019; World Bank, 2018

As in several other countries in the former Eastern bloc, mortality indicators worsened during the 1990s, but much more substantially for men. Since 1995, the average life expectancy has increased by more than 8 years. Although the gap with the EU28 average is narrowing, the gap is still about 6 years, and in 2017 Latvia had the second lowest life expectancy among all EU countries after Bulgaria.

Socioeconomic status and educational background also affect life expectancy, which at age 25 is nearly 12 years less for men who have not completed secondary education than for those with higher education. For women at age

25, the difference is nearly 6 years. This is mainly due to a higher prevalence of risk factors (smoking, alcohol and obesity) among low-income households and people who have not completed secondary education (Murtin et al., 2017).

While the total mortality rate in Latvia has been declining in recent years it is still considerably higher than in the EU (SDR of 1 476.37 per 100 000 inhabitants in Latvia in 2016 compared with 1 002.25 in the EU). The main causes of death in Latvia are diseases of the circulatory system, malignant neoplasms, external causes, and diseases of the digestive and respiratory systems. The top two causes are the same for both men and women.

Diseases of the circulatory system have been the leading cause of death for a long time. Although the SDR for circulatory system diseases in Latvia has declined since 2012, it was still more than twice the EU28 average in 2016. Mortality rates are higher for both men and women; in 2016 the SDR for circulatory system diseases in Latvia for males was 1 114.5 (427.8 in EU28) and 696.1 for females (303.1 in EU28).

Malignant neoplasms (cancers) have been the second leading cause of death over the last couple of decades. The SDR for cancer in Latvia (294.6 per 100 000 population) was above the EU28 average (259.47) in 2016. In contrast to the falling malignant neoplasms SDR in the EU, Latvia's SDR has been fairly constant for both sexes since the 1990s. Cancers of the trachea, bronchus and lung and cancers of prostate are the main causes of cancer deaths among men. For women, breast cancer and colorectal cancer are the leading causes of cancer deaths.

Deaths attributable to external causes remain the third leading cause of death, and are much more frequent in males than females. In 2016, the SDR for external causes in Latvia was 86.05 (one of the highest in all EU28 countries). Yet, external cause mortality in Latvia has sharply declined since 1994, when the SDR was about three times as high as it is today. Latvia recorded one of the highest fatality rates due to traffic accidents in the EU in 2018 (78 million), and four times more men than women died in traffic accidents (European Commission, 2019c). Intentional self-harm in men was the second most common cause of death within external causes in 2016 (34.2 deaths per 100 000).

Diseases of the digestive system are the fourth leading cause of death, with no significant change in recent years. The SDR for digestive system diseases in Latvia was 52.47 in 2016, higher than 43.07 EU average, of which

chronic liver disease was the most frequent cause of death. Mortality is more frequent among males (73.05) than females (38.74).

Diseases of the respiratory system are the fifth leading cause of death. While the mortality rate is considerably higher in males (77.1) than females (23.3), it is among the lowest in the EU as a whole.

Maternal mortality has remained comparatively high, although with considerable variation resulting from the small population, where every death has a strong influence on the mortality rate: it was 26.1 per 100 000 live births in 2010, dropped to 14.0 in 2014, rose again to 55.2 deaths per 100 000 live births in 2015, before dropping again to 4.9 in 2016. In the EU28, average maternal mortality is 4.5 deaths per 100 000 live births. Given the high maternal mortality ratio, a confidential audit of maternal deaths was instituted in Latvia (Government of Latvia, n.d.).

With Latvia's transition from a developing post-Soviet country to a high-income European country, chronic diseases have moved gradually to the forefront. Health behaviour strongly influences the health status of the Latvian population and in particular the rise of chronic diseases. Based on the Institute of Health Metrics and Evaluation (IHME) estimations, about 40% of the overall burden of disease in Latvia in 2015, measured in terms of DALYs, was attributable to behavioural and metabolic risks, with smoking (11.5%), alcohol (5.7%) and high body mass index (11.0%) contributing to most of this burden (IHME, 2018) (Fig. 1.2).

FIG. 1.2 Major risk factors influencing health status, latest available year



Note: The overall number of deaths related to these risk factors (14 000) is lower than the sum of each one taken individually (17 000), because the same death can be attributed to more than one risk factor. Dietary risks include 14 components such as low fruit and vegetable consumption, and high sugar-sweetened beverages and salt consumption.

Sources: IHME (2018), Global Health Data Exchange (estimates refer to 2017), in OECD/European Observatory on Health Systems and Policies (2019).

Vaccination coverage in Latvia has traditionally been very high for routine childhood vaccinations, and in 2017 immunization rates were above 95% (OECD Health Statistics database, 2018). However, influenza vaccination coverage for people above 65 remains very low, with only 6.9% of people in that age group vaccinated in 2017, possibly reflecting a lack of awareness of the seriousness of the health threat posed by influenza, as well as misconceptions about vaccine safety. Public coverage for selected groups only may play a role too.

Organization and governance

■ Chapter summary

- After regaining independence in 1991, Latvia experimented with introducing Social Health Insurance (SHI) but later moved to a National Health Service (NHS)-type system, with a purchaser-provider split and a mix of public and private providers.
- The NHS is the central national institution for administering the public budgetary funds of the health sector, and contracting services from health service providers. In general, public and private health care providers operate on a competition basis. Theoretically, any health care providers can participate in NHS procurement, but a set of criteria has to be met.
- Municipalities have a limited role but are responsible for ensuring access to health care services for their populations, implementing health promotion and prevention activities and organizing and providing long-term care services.
- Regulatory functions are concentrated mainly in the central government, i.e. the parliament, the Cabinet of Ministers, the MoH and its agencies.

■ 2.1 Historical background

After regaining independence in 1991, Latvia's attempts in the mid-1990s to transform its centrally planned health care system were characterized by the privatization of outpatient health care institutions (specifically polyclinics), which were either fully privatized or became non-profit-making state and municipal limited liability companies, and by efforts to decentralize the inherited Soviet health care system.

Most responsibilities for providing primary and secondary care were devolved to local governments (municipalities) and their local "sickness funds". Decisions on resource allocation, payment mechanisms, service provision and closing or privatization of facilities were made by local health care boards, which were often responsible for only very small populations (i.e. less than 50 000).

Decentralization led to a lack of coordination, duplication, and gaps in service provision, inefficient investments and use of health care infrastructure and services. The number of health care facilities and beds remained high. Decentralization of health care provision affected population access to services as well as the quality of care, which became highly variable across Latvia, with richer areas enjoying better coverage and more services than the minimum service package. Inequalities in access and Latvia's small territory and population (about 2.5 million inhabitants in the late 1990s) justified the return to the centralization of health care regulation, planning and financing.

The MoH was established in 2003 by separating health policy functions from the Ministry of Welfare. Until then, the Ministry of Welfare was the leading authority in the health sector. Local health boards were disbanded and the 35 local sickness funds were consolidated into eight regional sickness funds. Later, in 2002, the eight regional sickness funds were merged into one State Compulsory Health Insurance Agency (SCHIA). To facilitate central planning, the Development Programme for Outpatient and Inpatient Health Care Services Providers 2005–2010, the so-called "Master Plan", was developed (Taube et al., 2015).

Primary care physicians were encouraged to work in independent practices. Hospitals became either non-profit-making state or municipal limited liability companies, later also partially subject to privatization. Almost all dental practices, pharmacies and several sanatoria (spas) were privatized.

For the financing of the health care system, the Central Account Fund was originally established in 1993 to supervise and lead the reform, and was

then named the State Sickness Fund, the State Compulsory Health Insurance Agency, the State Payment Centre, before finally becoming the NHS in 2011.

Between 1997 and 2004 the compulsory health insurance revenue base was defined as an earmarked portion (28.4%) of the collected income tax revenue, plus a state subsidy financed from general tax revenue. However, this system was abandoned in 2005 in favour of general tax financing, which allowed the Ministry of Finance more flexibility in the use of public resources. The resulting “mixed” system in place in 2007/2008 was described by Tragakes et al. (2008) as “a unique combination of general tax-financed statutory health care provision, within a social insurance institutional structure”.

In response to the economic crisis and severely constrained budgets, multiple administrative reforms took place affecting the reorganization of several public institutions (see Chapter 6). The reforms in the period between 2007 and 2012 (see Chapter 6) focused on: (1) the development of a more centralized system; (2) the establishment of one central institution for purchasing health care (the NHS); and (3) a health care delivery system with a strong focus on primary care and ambulatory care (and substantially fewer hospitals). Virtually every aspect of the health care system has been affected by the ongoing process of reforms (see Chapter 6). In 2017, the mandatory social insurance contribution was increased by 1 percentage point to provide more funds for health care (see Chapter 3).

■ 2.2 Organization

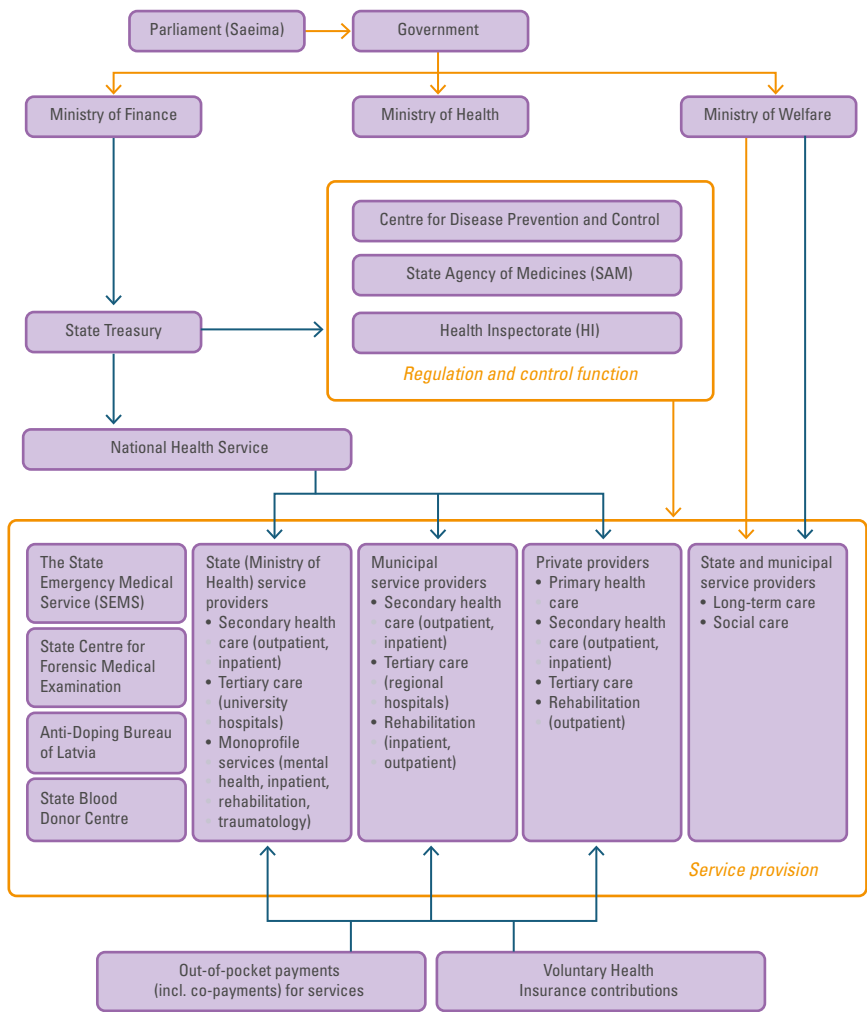
Latvia is a parliamentary republic and, consequently, the parliament and the Cabinet of Ministers issue the principal normative acts and regulations for the health sector. Health policy priorities are determined by the MoH. Figure 2.1 shows the organizational chart of the health system.

The main features of the system are:

1. The central government raises resources for the statutory health care system, mainly through general taxation and a small part through social tax (see Chapter 3).
2. Parliament approves the NHS budget and money is transferred from the Ministry of Finance via the State Treasury of Latvia to the NHS.

- 3. The NHS is a state-run organization under the control of the MoH, which allocates public health care funds and contracts health care providers.
- 4. Providers contracting with the NHS may be public or private: they tend to be predominantly private in the case of primary care; public or private in the case of secondary care, and public in the case of tertiary care, with ownership concentrated at the state (national) or municipality (regional) level.
- 5. Social care and long-term care are predominantly under the supervision of Ministry of Welfare and municipalities.

FIG. 2.1 Organization of the health system in Latvia, 2019



The most important actors in the system are the parliament, the government (Cabinet of Ministers), the MoH and the NHS.

The parliament (Saeima) has a significant role in the development of national health policy. It approves both the national budget and the budget of the NHS (see Chapter 3). The work of the parliament is organized into several committees. The Health Subcommittee within the Social and Employment Committee possesses legislative initiative and reviews all pressing health-related issues put forth by its members as well as issues brought to its attention by other members of parliament and the MoH. Proposals to this committee can be submitted by professionals, professional associations and non-government organizations. The committee initiates and organizes public discussions and public debates.

The parliamentary secretary of the MoH ensures a link between parliament and the ministry and is a representative of the Minister of Health in parliament. The MoH is the central government institution responsible for planning and regulation of the health system. It elaborates health policy, organizes and supervises its implementation. It is in charge of public health and it coordinates the health promotion and disease prevention activities of local governments. The MoH creates the preconditions for cost-effective health care and ensures accessibility and quality of services. In addition, it oversees medical education at the Rīga Stradiņš University postgraduate and professional medical education centres.

In response to the financial and economic crisis, the MoH cut administrative expenditure and employment and reorganized itself in 2009 to adjust to a smaller budget. In real terms, the direct administrative budget of the MoH in 2010 was 51% below the 2008 level. The current structure of the MoH consists of eight departments: (1) Department for European Affairs and International Cooperation; (2) Department of Document Management and Personnel; (3) Department of Public Health; (4) Department of Health Care; (5) the Department of Pharmaceuticals; (6) Department of Projects Management; (7) Department of Budget Planning; and (8) Department of Investments and Monitoring of the European Union Funds. The MoH also has 10 permanent divisions: Accounting Division, Audit Division, Information Technology Division, Human Resources Development Division, Legal Division, Division of Capital Enterprises and Monitoring of Sectoral Finance and Investment, Communication Division, Procurement Division, Property and Technical Security Division and the Policy Coordination

Division. In addition, there are subordinate institutions in which the MoH has a supervisory and governing role. These include the National Health Service (NHS), the Centre for Disease Prevention and Control, the Health Inspectorate, the State Agency of Medicines, the State Emergency Medical Service, the State Blood Donor Centre, the State Centre for Forensic Medical Examination, the Anti-Doping Bureau of Latvia, Pauls Stradiņš Museum of Medical History, and Rīga Stradiņš University.

The National Health Service (NHS) is under the MoH and responds directly to the Minister. It is the main institution responsible for the implementation of state health policies and for ensuring the availability of health care services in the country. The institution has changed names several times in its history (see section 2.1 and Chapter 6). Today, the main tasks of the NHS include: administering public financial resources for the health sector; concluding contracts with health care providers; calculating health care tariffs; determining the positive list of pharmaceuticals; and implementing e-Health. In addition, the NHS performs the function of contact point and information centre for the cross-border health care provision, and runs the Medical Treatment Risk Fund. The Centre for Disease Prevention and Control registers clinical guidelines and the State Agency of Medicines registers medical technologies, among other functions.

The NHS consists of a Central Office and five territorial branches. The Central Office contracts directly with all hospitals for inpatient services. The territorial branches are subordinated units responsible for contracting with primary care practitioners (mostly GPs), secondary-level outpatient service providers, and pharmacies for pharmaceuticals from the positive list of approved pharmaceuticals (see section 2.7.4). However, they do not have their own budgets and pharmaceuticals are reimbursed directly by the Central Office of the NHS.

In addition to the MoH, a number of other ministries are involved in the health care system in Latvia:

- The Ministry of Finance, through the State Treasury of Latvia, 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 social security of Latvia, including social rehabilitation and nursing care of disabled and impaired individuals, and all other social care services, although services (e.g.

for the elderly) are generally organized and provided by the local governments.

- The Ministry of Agriculture, through its Food and Veterinary Service, controls food safety.
- The Ministry of Education and Science deals with health promotion as well as several educational facilities in the health sector in Latvia, including the medical schools at the University of Latvia.
- The Ministries of Defence, Interior and Justice have their own budgets to finance health services for specific population groups (e.g. armed forces, inmates).

Local governments are responsible for ensuring geographical accessibility, and depending on budget and local priorities, they maintain hospitals and long-term social care facilities (e.g. for the elderly), and engage in promoting healthy lifestyles, controlling alcoholism and protecting vulnerable groups. Local governments are not involved in direct payments for health care services, which is the responsibility of the NHS.

The inequities between regions and local authorities in terms of both income and economic activity result in vast differences in access to health care services, especially in municipalities located far from Rīga. As a result, local governments, who are responsible for finding health professionals, raise funds to attract health care practitioners or to support the infrastructure for primary and secondary care specialists.

Inpatient and outpatient care in Latvia is provided by state and local government-owned institutions, private clinics and hospitals, and individuals (see Chapter 5). Independent of the type of property, all providers within the statutory system have to comply with regulations defined by the MoH and can be contracted by the NHS. In 2017, the hospital sector was reorganized into a five-tier hospital system, with clearly defined structures and designated responsibilities for each level.

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

an important share of secondary outpatient care. Almost all dental practices and pharmacies are private. Rehabilitation is provided by general hospital care or selected institutions (see Chapter 5).

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

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

Since the 1990s various patient groups have been founded, for example, for psoriasis, lymphoma, diabetes etc. Most of these organizations are members of the Latvian Umbrella Body for Disability Organizations (SUSTENTO), established in 2002. SUSTENTO actively participates in the European Disability Forum. The Association of Oncology Patients “Living Tree”, founded in 2004, is the leading nongovernmental organization in Latvia supporting oncologic patients and their relatives. The NGO Apeirons, founded in 1997, aims to integrate people with disabilities into society.

The largest medical professional organization is the Latvian Medical Association. This is an umbrella organization for more than 110 associations organized according to medical specialties, including dentists. The Latvian government delegated the function of professional certification to this organization. It is the only institution that can withdraw a doctor's certificate, abolishing the right to practice. The nursing profession has a similar organization, the Latvian Association of Nurses. The Pharmacists' Society of Latvia is a professional organization that represents economic and legal interests of pharmacists, and is also involved in the certification of the professional qualification of pharmacists and pharmacists' assistants in Latvia.

A number of international organizations have a presence in Latvia. (See section 3.6.2 for more details about the role of the EU and the World Bank in providing financial resources for health care). The World Health Organization (WHO) has been active in Latvia since 1991, when Latvia regained independence. WHO's two main priorities over the years have been (1) health promotion with emphasis on control of tobacco, alcohol and drugs; cancer prevention; mental health; and promoting healthy life styles and nutrition; and (2) health system strengthening, especially with regard to public health services, primary health care, health financing and human

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

■ 2.3 Decentralization and centralization

In 1997 a reform of the financing system introduced central planning and unified supervision of the health care system, with the aim of ensuring equal access to health care services and increasing the efficiency of the system. Several agencies under the MoH, such as the State Agency of Medicines (SAM), were established, gradually taking over responsibilities and functions from the MoH.

In 2011, as the result of a further process of consolidation of state functions, one central institution, the NHS, was established for the financing of the health care system and the implementation of national health policies (see section 2.1).

Decentralization has taken place in the supervision and compliance monitoring of professional standards and quality requirements. Certification, as well as monitoring of compliance with ethical professional standards of physicians, nurses and pharmacists, has been delegated to professional associations.

■ 2.4 Planning

The NHS and the MoH are the two most important institutions for health system planning in Latvia. The NHS works under the supervision and political guidance of the MoH, which is responsible for policy implementation. The NHS oversees planning of health care services and health care resources (except for human resources, which are the responsibility of the MoH). The overall planning of the system is based on the contracted care data provided by the NHS and the general health sector statistical information provided by the CDPC.

The MoH collaborates with international institutions (EC, World Bank, IMF, WHO) that provide technical assistance for planning in the Latvian health sector.

The main strategic medium-term planning document in Latvia is the Public Health Strategy 2014–2020, which is based on the WHO Regional Office for Europe’s Health 2020 policy (Cabinet Order, 2014a).

The overarching objectives of the public health policy are: (1) to increase the number of healthy life years of inhabitants of Latvia by 3 years (reaching 57 years for men and 60 years for women in 2020); and (2) to prevent premature death; preserve, improve and restore health, by reducing the number of potential years of life lost by 11% (up to 64 years of age).

To achieve these objectives, strategies focus on the elimination of inequities in health, reducing premature mortality from noncommunicable diseases, infant mortality, and mortality from external causes; promotion of a healthy work environment; and ensuring effective management of the health care system (Cabinet of Ministers, 2014b).

The World Bank Group (WBG), as part of a reimbursable advisory services agreement with the NHS, produced a number of health system planning documents intended to “develop a health system strategy for priority disease areas in Latvia” (World Bank, 2016b).

The Health Care Facilities Master Plan for 2016–2025 by the WBG (World Bank with Sanigest Internacional, 2016) suggests a new configuration

BOX 2.1 Is there sufficient capacity for policy development and implementation?

The health policy development and planning process in Latvia may be considered to be relatively immature due to frequent political changes and shifting priorities. The capacity to develop evidence-based policy options is limited and affected by limited resources and short time frames. Greater scientific substantiation of health policies and ongoing cooperation with research centres and universities in policy development are needed. In the past, there has not been a direct link between investment planning and health needs.

Frequent political and institutional changes and insufficient financial resources have had a negative impact on the capacity for policy implementation. General public administrative capacity affects the policy implementation and administrative capacity of health sector.

for Latvia's health facility network, hospital categorization and distribution of services across the network. It provides a tool for long-term facility planning, based on estimated demand for inpatient, outpatient, diagnostic and treatment services up to 2025. The plan outlines a strengthened regional health care model through which the regional hospitals would have the capacity to provide many more of the specialized health services that are presently available only in Rīga, as well as the investment required for the expansion of the emergency medical services under the preferred reconfiguration scenario.

The *Capital investment planning review* (World Bank, 2016a) suggests that routine capital planning and investments are not population or needs-based. Rather, they appear driven by targets related to the number of beds or the availability of investment budgets. The WBG recommends specific policy solutions aimed at improving the value-for-money of future investments.

Based on the WBG Master Plan and other reports, the Cabinet of Ministers approved the Concept Report on Future Health Reforms in July 2017 (Cabinet of Ministers, 2017a). The report outlines ideas for planned reforms including: reconfiguration of hospital inpatient provision structures according to a four-tier hospital system; substantial wage increases for health professionals by 2023 (2.8 fold increase for doctors and 2.7 fold increase for nurses, midwives etc.); introduction of a strategic purchasing concept for health care services; transformation of primary care practices into larger health care teams and centres; clarification of the role of municipalities in ensuring access to health care; implementation of the e-Health system, and a review of the functions of the subordinate institutions of the MoH.

■ 2.5 Intersectorality

The Public Health Strategy 2014–2020 are based on a strong intersectoral approach and clearly define the respective responsibilities of the Ministry of Economics, the Ministry of Finance, the Ministry of the Interior, the Ministry of Education and Science, the Ministry of Welfare, the Ministry of Transport, the MoH, the Ministry of Environmental Protection and Regional Development and the Ministry of Agriculture. For example, the Ministry of the Interior is responsible for strengthening point of sale controls to reduce the scope for minors to buy tobacco and alcoholic beverages, and for improving road safety; the Ministry of Education and Science is

responsible for the development and coordination of the programme “Health Promoting Schools” and for providing publicly funded school lunches for pupils up to Grade 6 in general education institutions. In addition, health has a prominent place in the Sustainable Development Strategy of Latvia until 2030 (UNESCO, 2012).

To promote the implementation of the health promotion goals set out in the Public Health Strategy 2014–2020 and to support the involvement of local governments in improving population health, the MoH has established a National Co-ordination Committee for Healthy Municipalities in cooperation with the Centre for Disease Prevention and Control, the Latvian Association of Local and Regional Governments, the WHO Representation in Latvia, and Riga Stradiņš University.

Other interdisciplinary commissions within the MoH are, for example, the Antimicrobial Resistance Limitation Commission, and the National Antismoking Committee.

Intersectoral policies affecting the health sector are usually dealt with in ad-hoc interministerial working groups.

The Health Care Sub-Council was established in 2001 as part of the institutional system of the National Tripartite Co-operation Council, which includes representatives of the government, the Employers’ Confederation of Latvia and the Latvian Free Trade Union Confederation. Its main aim is health policy coordination and it has an advisory capacity.

The MoH is open to cooperation with NGOs and various institutions and groups and it has established several consultative councils, such as the Health Sector Strategic Council, Chief Specialist institution and others.

Several policies deal with aspects of health in other policy portfolios: the Information Society Development Guidelines for 2014–2020 deal with e-Health system development; the Strategy for Active Ageing for Longer and Better Work Life in Latvia, the Inclusive Employment Guidelines for 2015–2020, and the Work Protection Policy Guidelines 2016–2020 consider employment and social policy; the Sports Policy Guidelines for 2014–2020 were developed to promote physical activity, to reduce the prevalence of risk factors for chronic noncommunicable diseases in Latvian society; the Youth Policy Implementation Plan for 2016–2020 aims to improve the quality of life of young people through the application of a coherent youth policy; and the Environmental Policy Guidelines 2014–2020 are intended to ensure that people live in healthy environments.

■ 2.6 Health information systems

Latvia's official statistical system, the competence of the statistical authorities, and the organization of statistical provision, including rights of data protection and access to data, are clearly defined in the Statistics Law (2016) and the Programme of Official Statistics, 2018–2020.

According to the National Information Systems Law (2002) the Ministry of Environmental Protection and Regional Development maintains the State Information System, a structured set of information technologies and databases, which provide the creation, compilation, accumulation, processing and use of information necessary for the performance of state functions. There are 20 different health sector-related state information systems, in which the information is generally available. These systems are administrated by the CDPC, the NHS, the SAM, the HI, the National Blood Donor Center and the Emergency Medical Service.

Quick and easy access to the information and services provided by state and local government institutions can be had via the official web portal (www.latvija.lv). The portal provides information on health care services contracted by the NHS, recommended actions in case of illness, reporting options for violations in health service provision, and other health system-related information. The portal also offers a range of health care e-services, which allows citizens to access their health-related information, such as basic medical data, e-prescriptions, etc., quickly and easily.

The planned e-Health portal (www.eveselib.gov.lv), maintained by the NHS, will be the entry point, and is planned to be used by medical practitioners to record and review patient medical data, prescribe medications and issue disability certificates. Pharmacists can access patients' prescriptions and record their dispensing at the pharmacy, and residents can now view information about their GP, provide their contact information and contact person for communication, to allow other e-Health users access to their medical information, as well as view and print e-prescriptions, etc. for themselves or their dependents.

The principal institutions responsible for health data collection are the CDPC, the NHS, and the Central Statistical Bureau (CSB). The CDPC is responsible for collecting and summarizing all health-related statistical data in Latvia, including data collected by the NHS and the CSB. The CDPC is also responsible for complying with international obligations by submitting

data to WHO and Eurostat. All health care providers, irrespective of their ownership, have a legal obligation to prepare register cards for a number of disease-based registers kept at the CDPC branch offices, and to submit data electronically about notifiable diseases directly to the CDPC Central Office (see also section 5.1). All statistical reports consist of aggregated data and do not include personal identifiers.

The CDPC collects cause of death statistics, which are produced from data submitted by health care providers.

The NHS collects all data related to state-paid health services, processing the service provision and payment information received from all contracted providers (hospitals, health centres, GPs). The NHS data system contains information on all services provided for individual patients, including patient personal data, diagnoses (primary and secondary coded according to the *International Classification of Diseases, 10th revision*), procedure codes (according to a national coding system), and a provider identifier. As every patient is identified in the database with a personal ID number, it is possible to link patient data across different providers and over time, including information from other sectors (e.g. social services). However, data about non-contracted care, for which patients have to pay OOP, is not collected by the NHS.

CSB collects statistical information on key health indicators, for example, the use of emergency medical services, and population morbidity, and reports directly to Eurostat and OECD.

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

■ 2.7 Regulation

The Latvian health system is regulated through a mix of legislative (laws, regulations), administrative (licences, permissions) and market (contractual relationships) mechanisms. In general, the basic rules of state administration and public system governance, as well as institutional and functional subordination of administrative bodies are set by the State Administration Structure Law (2002).

The health sector regulatory framework is determined by the laws passed by the parliament, such as the Medical Treatment Law (1997), the Pharmacy Law (1997) and the Health Care Financing Law (2017). They set the framework for regulation of health care provision, professional activities, provision of pharmaceuticals and medical devices, while more specific regulations for each of these fields are defined by the MoH and approved by the Cabinet of Ministers.

Regulatory functions (standard setting, monitoring, enforcement) are concentrated mainly in the central government, i.e. the parliament, the Cabinet of Ministers and the MoH and its agencies: the NHS with its five territorial branches, the Health Inspectorate, the State Agency of Medicines, the Centre for Disease Prevention and Control, the State Emergency Medical Service, the State Centre for Forensic Medical Examination, the State Blood Donor Centre and the Anti-Doping Bureau of Latvia. In addition, some regulatory functions in the area of continuing education and accreditation of health professionals have been delegated to professional associations, such as the Latvian Medical Association.

Municipalities no longer have a regulatory function in the health system.

■ 2.7.1 *Regulation and governance of third-party payers*

The NHS is the only third-party payer in the health care system in Latvia, reporting directly to the Minister of Health. With its five territorial branches, it is responsible for contracting health care providers to secure health services for the entire population within the annual health budget approved by the parliament. The NHS regulatory function is closely bound by instructions from the MoH regarding functional, methodological and organizational aspects. The director of the NHS is a civil servant and is formally employed by the MoH.

The principal documents regulating the activities of the NHS are the Health Care Financing Law (2017), the Regulations on Organization and Financing of Health Care (No. 1529) (Cabinet of Ministers, 2013a) and the Regulation of the NHS (No. 850 from 2011).

The responsibilities of the NHS include: determining the appropriate volume of statutory health services in accordance with the available financial resources, priorities and capacity of service providers; selecting providers

and planning, concluding and monitoring the contracts; and informing the public about publicly funded health services and terms and conditions of accessibility.

The administrative acts and calls to action issued by the director of the NHS can be challenged at the MoH.

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

■ 2.7.2 *Regulation and governance of service provision*

The Medical Treatment Law (1997) sets out the framework for the regulation of professional activities of health care practitioners and health care providers, the duties and rights of medical practitioners in medical treatment, the order of establishing a health care institution, as well as the structure of health care services and health care providers. It provides that a medical institution can be established by state, local governments, individuals or legal persons.

According to the law, all health service providers, regardless of their type and legal status, must meet compulsory requirements determined by the Cabinet Regulation Regarding Mandatory Requirements for Medical Treatment Institutions and Their Structural (No. 60; Cabinet of Ministers, 2009). These regulations determine structural (size, equipment, etc.) and staffing requirements (number and type of specialists) for the provision of specific services, as well as quality of services and patient safety standards and requirements. However, since 2009, accreditation of health care institutions according to these requirements is no longer mandatory. Instead, conformity with the standards is based on self-report as well as planned and random audits carried out by the Health Inspectorate (HI). The HI is the most important institution in ensuring compliance of health care providers with the conditions of service provision determined in NHS contracts, as well as adherence of providers to the mandatory requirements of health care institutions.

The legal action of medical institutions (hospitals and health centres) is specified by the Law of Commerce (2000), which determines the activities and governance of capital companies (stock companies or companies with limited liability). Smaller hospitals and regional hospitals are usually owned by municipalities, while larger tertiary hospitals (university hospitals) and specialized (monoprofile) hospitals (e.g. psychiatric hospitals) are owned by the MoH. All hospitals are limited liability companies and are governed by a management board, which is directly responsible to the local municipalities (municipal hospitals) or the State Secretary of the MoH (state hospitals).

Some institutions are organized as public–private partnerships (municipalities along with private owners).

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

Service provision is mostly regulated by contracts signed between health care providers and the NHS or its territorial branch offices. The NHS negotiates contracts as specified in the Regulations on Organization and Financing of Health Care (Cabinet of Ministers, 2018b). Contracts with outpatient facilities are based on competitive tendering if additional services are needed.

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

If an institution has reached its quota for the year (for example, it has performed the number of elective surgeries indicated in its contract with the NHS), it may offer patients services at full cost to avoid patients having to wait until the following year.

The mechanisms in place to ensure and monitor quality of care provided tend to be rather limited, although some quality control provisions are included in contracts with the NHS. Primary care is the only area in which quality plays an important role in the contracts between the NHS

TABLE 2.1 Overview of the regulation of providers

	LEGISLATION	PLANNING	LICENSING-ACCREDITATION	PRICING/TARIFF SETTING	QUALITY ASSURANCE	PURCHASING /FINANCING
Public health services	Public Health Strategy for 2014–2020 Cardiovascular Health Improvement Action Plan 2013–2015	MoH, CDCP		Government, NHS	Health Inspectorate	NHS, Municipalities
Ambulatory care (primary and secondary care)	Medical Treatment Law (1997) Health Care Financing Law (2017) Primary Health Care Development Plan 2014–2016	NHS	Professional certification by professional organizations	Government, NHS	Health Inspectorate	NHS, Households, VHI
Inpatient care	Plan for Improving Health Care Oncology Services for 2017–2020, Regulation No. 555 Procedures for Organizing and Paying for Health Care Services (2018)	NHS	Professional certification by professional organizations	Government, NHS	Health Inspectorate	NHS Households, VHI
Dental care	Medical Treatment Law (1997) Health Care Financing Law (2017) Regulation No. 555 Procedures for Organizing and Paying for Health Care Services (2018)	NHS	Professional certification by professional organizations	Government, NHS	Health Inspectorate	NHS (only for children), Households, VHI
Pharmaceuticals (ambulatory)	Pharmaceutical Law (1997) (Regulation No. 803 (2005) Rules on Pricing Principles for Medicinal Products Plan for Improving Health Care Oncology Services for 2017–2020) Regulation No. 899 Procedures for the Reimbursement of Expenditures for the Acquisition of Medicinal Products and Medical Devices Intended for the Outpatient Medical Treatment (2006)	NHS	SAM	Prices are negotiated by the NHS for pharmaceuticals included in the positive list; for those not included in the reimbursement system, prices are based on unregulated manufacturer's price with limited mark-ups	Health Inspectorate SAM	NHS, households/ VHI
Long-term care	Medical Treatment Law (1997) Social Services and Social Assistance Law (2002) Order No. 589 Guidelines for the Development of Social Services 2014–2020 (2013) Regulation No. 385 Provisions on the Registration of Social Service Providers (Cabinet of Ministers, 2017c) Regulation No. 138 Rules for Receiving Social Services and Social Assistance (2019)	MoW, municipalities	MoW maintains register of social service providers	Government, municipalities	Health Inspectorate MoW	MoW Municipalities
University education of personnel	Medical Treatment Law (1997)	MoH	Professional organizations			MoH, Ministry of Education

and providers, as both voluntary and mandatory quality incentive schemes exist (see section 3.7.1).

The HI audits service provision and informs the NHS about deviations from agreements, these can lead the NHS to refuse or reduce payments to providers. The HI is entitled to impose penalties for inappropriate service provision or misreporting.

The CDPC has responsibility, overtaken from the NHS in 2018, for the registration and implementation of clinical guidelines according to the Regulation Procedures for the Development, Evaluation, Registration and Implementation of Clinical Guidelines (No. 469) (Cabinet of Ministers, 2010a; approved, amended by No. 586 from 2018). Approved guidelines are published on the webpage of the NHS. Treatment guidelines are recommendations and are not necessarily entirely covered by NHS contracts.

■ 2.7.3 *Regulation of services and goods*

BASIC BENEFIT PACKAGE

The publicly funded health benefit package is limited in scope and only covers services provided by NHS-contracted physicians and institutions. No specific criteria are used in the decision-making process. More details are presented in section 3.3.1

HEALTH TECHNOLOGY ASSESSMENT

A formal process of health technology assessment for resource allocation was established in Latvia in 2002 with the introduction of pharmacoeconomic assessments of medicines. The Baltic Guidelines on Economic Evaluation of Pharmaceuticals were developed by a joint working group, adapted in national legislation for each country, and are used as the methodological basis for the assessments (Behmane et al., 2002). Pharmacoeconomic evaluation is applied only to medicines eligible for outpatient reimbursement, not for medicinal products used in hospitals. The SAM took over the function from the NHS in July 2019 and is responsible for carrying out the assessments and deciding on the inclusion of pharmaceuticals in the reimbursement list according to

criteria and procedures set by the Cabinet of Ministers' Procedure for the Reimbursement of Expenses for the Purchase of Medicines and Medical Devices for Outpatient Treatment (Cabinet of Ministers, 2006).

The SAM maintains the database of medical technologies authorized in Latvia according to the Regulation of the Cabinet of Ministers on "The Approval of Medical Technologies for Medical Treatment and Implementation of New Medical Technologies" (Cabinet of Ministers, 2005a). The NHS has been responsible for assessing and approving medical technologies since 2011, when it took over the function from the Centre of Health Economics. In order to utilize a new medical technology, a health care institution is required to apply to the SAM.

■ 2.7.4 *Regulation and governance of pharmaceuticals*

The Pharmacy Law (1997) sets out the framework for the regulation and governance of pharmaceuticals. The Department of Pharmacy of the MoH is responsible for developing pharmaceutical policy. Besides the MoH, the main institutions for regulation of the pharmaceutical sector are the State Agency of Medicines (SAM), the NHS, and the Health Inspectorate (HI).

The SAM, founded in 1996, is the national competent authority for pharmaceuticals, and assesses quality, safety and efficacy of (human and veterinary) medicines, issues marketing authorizations and maintains the Register of Human Medicines. It operates based on Cabinet Regulation No. 537 (2012), the Law on Public Agencies (2010) and other normative acts. It is financed from fees for the services it provides, without any contribution from the state budget. Since July 2019, SAM is also evaluating the cost-effectiveness of medicines. The SAM operates in the European medicines network by participating in work-sharing and complying with the collective standards and procedures of the EU. It also provides up to date scientifically grounded information and recommendations on the safety of medicines received from the State Agency of Medicines, the European Commission, the European Medicines Agency, WHO, and other Regulatory Authorities by issuing "Cito!" – a bulletin which is part of a worldwide network of bulletins and journals on drugs and therapeutics that are financially and intellectually independent of pharmaceutical industry.

PRICING DECISIONS

The pricing of pharmaceuticals in Latvia is controlled by the Rules on Pricing Principles for Medicinal Products (Cabinet of Ministers, 2005b). For pharmaceuticals not included in the reimbursement system, prices are based on the unregulated manufacturer's price with limited mark-ups for wholesalers and pharmacies.

To commence the distribution of medicinal products in Latvia, the holders of marketing authorizations must declare to the SAM ex-factory prices twice a year and each time the prices are updated. The maximum retail prices are then calculated and published on the SAM website for consumers and other interested parties.

The standard rate of value added tax (VAT) in Latvia is 21%, but a reduced rate of 12% is applied to medicines. The VAT on medicines in Latvia increased from 5% to 10% in 2010 and then to 12% in 2011.

For pharmaceuticals included in the positive list, prices are negotiated between the NHS and the marketing authorization holders, based on the economic assessment and budget impact analysis. The prices must not exceed those in the other Baltic countries or the second lowest price in certain EU Member States.

The NHS monitors physician prescribing practices each quarter. It sends out reports to service providers (outpatient clinics, GPs, etc.) if the prescriptions of a physician working at the institution are on average 30% more expensive (for a group of similar diagnoses) than the average across the country. In addition, this information is also forwarded to the HI, which then closely monitors prescribing practices at the health care institution concerned, and can verify the appropriateness of prescriptions by accessing patients' medical information.

In 2012 the MoH of Latvia, the Ministry of Social Affairs of Estonia and the MoH of Lithuania signed a Partnership Agreement on unified procurement and lending of medicines and medical devices, aiming to reduce public expenditure and ensure continuity of access in both states.

When necessary, countries have often borrowed medicinal products from each other. In 2017 Latvia and Estonia concluded the first successful procurement competition by purchasing rotavirus vaccines. The tender was run by Estonia.

REIMBURSEMENT DECISIONS

The NHS is responsible for reimbursement decisions for pharmaceuticals, and for maintaining the List of Reimbursable Medicinal Products (positive list). To include a pharmaceutical product in the positive list, a pharmaceutical company must apply to the NHS. SAM is responsible for a pharmacoeconomic analysis. The NHS evaluates the application on the basis of the provided information and its own research.

The positive list is updated not less than four times a year, and consists of List A, List B and List C and a special category – List M – according to the following:

- List A includes pharmaceuticals for which there are several preparations of similar therapeutic effectiveness with the same INN or within the therapeutic class, and medical devices of the same type. Products are clustered according to the pharmaceutical form and dosage and a reference price is determined for each group, which is the price of the cheapest product in the respective group. There are 1 310 products on the A list (2017);
- List B includes pharmaceuticals and medical devices without an authorized alternative (319 products, 2017);
- List C includes pharmaceuticals, for which costs exceed EUR 4 270 per patient per year and special medical restrictions cannot be applied to reduce the expenditure (29 products, 2017).
- List M was introduced in 2012 and contains prescription-only medicines that are not included in the positive List (A, B or C categories), are eligible for children up to 24 months of age (reimbursement rate 50%) and for pregnant women and women within 42 days of postnatal period (reimbursement rate 25%).

Since 2014 the pharmaceuticals in the positive list have been reimbursed at 100% for children up to 18 years (except for non-reference products within list A). Regulation No. 899 Procedures for the Reimbursement of Expenditures for the Acquisition of Medicinal Products and Medical Devices Intended for the Outpatient Medical Treatment (Cabinet of Ministers, 2006) determines the conditions and criteria for reimbursement. The reimbursement

categories (100%, 75% or 50%) are based on the severity and chronic nature of the disease:

- **100% reimbursement** – for pharmaceuticals which ensure and maintain the patient's life functions in case of chronic, life-threatening diseases, or diseases causing irreversible disability, (eg. diabetes, cancer);
- **75% reimbursement** – for pharmaceuticals without which the maintenance of the patient's life functions are aggravated (eg. hypertension, cerebrovascular diseases, asthma, rheumatic diseases);
- **50% reimbursement** – for pharmaceuticals which maintain or improve patients' health and for vaccines (eg. COPD, digestive and endocrine system diseases).

Only prescription-only medicines are eligible for reimbursement and must have an approved indication relevant to the diseases listed in the Appendix of the Regulation. Patients must pay the co-payment in the case of the 75% or 50% reimbursement levels, or a flat prescription fee of EUR 0.7 at the 100% reimbursement level.

In certain cases, the NHS may also provide reimbursement for medicines that are not included in the positive list if it has been determined by a physician's case conference that the medicine is necessary for saving the patient's life (EUR 14 229 is the maximum amount payable by the State per patient and per year in the case of individual reimbursement, but the cost of the drug may also be higher).

Reimbursable pharmaceuticals are prescribed by GPs and specialists who have an agreement with the NHS of Latvia. Reimbursement is provided through pharmacies via special prescriptions.

The NHS pays the reference price, regardless of what medicine (reference or non-reference) is given to the patient. On 16 July 2019 an amendment to the regulations of reimbursement was passed. Beginning from 1 April 2020, international nonproprietary names of medicines will be allowed in prescriptions only. Other names will be reimbursed with additional clinical justification, but not exceeding 30% of prescriptions. Pharmacies will be obliged to hand out reference or lowest price medicines with the same effectiveness.

■ 2.7.5 *Regulation of medical devices and aids*

Medical devices and aids in Latvia are controlled by the Regulation Procedures for the Registration, Conformity Assessment, Distribution, Operation and Maintenance of Medical Devices, No. 689, which came into effect in 2017 (Cabinet of Ministers, 2017b). The SAM is the sole body responsible for registration and surveillance of medical devices.

The HI controls the manufacturing, distribution and technical supervision of medical devices.

Medical devices may be placed on the market if: (1) the EC declaration of conformity is drawn up and the devices are CE-marked; and (2) the information on the device label is provided in Latvian and contains indications of the device manufacturer and its authorized representative in Latvia with the contact information.

The purchase of most medical devices and goods is undertaken by health care providers in accordance with the Law on Public Procurement (2016).

The Procurement Division of the NHS provides centralized procurement of medical products and medical devices (vaccines, products for phenylketonuria, supplies for peritoneal dialysis and other genetic disorders, vision correction products for children and others) as defined by Regulations on Organization and Financing of Health Care (Cabinet of Ministers, 2013a). These purchases are undertaken on behalf of contracted institutions and statutory health care providers.

■ 2.8 **Person-centred care**

■ 2.8.1 *Patient information*

Access to information is guaranteed by the Information Transparency Law (1998) which ensures that citizens have access to information that is at the disposal of the institutions and establishes a common procedure for the right of private individuals to obtain and use information. The authorities shall provide information on their own initiative or at the request of an individual. Any person can ask for state-held information and public bodies must respond within 15 days.

TABLE 2.2 Patient information

TYPE OF INFORMATION	IS IT EASILY AVAILABLE?	COMMENTS
Information about statutory benefits	Yes	Information about the NHS-contracted services and the waiting times is available by calling a toll-free number or via www.rindapiearsta.lv .
Information on hospital waiting times	Yes	
Information on hospital clinical outcomes	No	
Comparative information about the quality of other providers (for example, GPs)	No	
Patient access to own medical record	Yes	
Interactive web or 24/7 telephone information	Yes	
Information on patient satisfaction collected (systematically or occasionally)	No	
Information on medical errors	No	

In accordance with the principle of good administration, the institution shall, on its own initiative, provide access to certain types of available information.

The portal www.latvija.lv provides information about public services provided by state and local government institutions, ways of requesting and receiving them, service-related payments and service descriptions, and electronic services including a link to the service receipt resource.

The information available to citizens has increased considerably in recent years. In particular, the MoH developed a portal called “Your Health”, where citizens may obtain information on their rights and responsibilities, health care organization, how to apply for health care services, health prevention, healthy lifestyle, special recommendations for specific patient groups etc. The MoH also informs patients about regulatory issues, planned reforms and provides links to other national and international institutions.

Public institutions subordinated to the MoH share information within their functions and competences. For example, the NHS provides information on the financing of health services, tariffs and access to contracted health

care providers. This information is available on its website and on posters and booklets in territorial branches and health care facilities.

The CDPC provides information on health promotion, infectious disease control, epidemiological data and health statistics. The SAM reports on the pharmaceutical sector regulation, rational pharmacotherapy, and pharmacovigilance and provides statistical information regarding the pharmaceutical market. The HI informs citizens of the compliance requirements for service providers, on reporting of violations, and issues alerts and notifications. Local governments provide information on health care provision and access to health services in the regions.

The Law on the Rights of Patients (2010) stipulates that patients have the right to receive clear information about their diagnosis and a plan of examination and treatment. The same law also guarantees a patient's right to information about quality of care. The GP usually serves as a health counselor, advising on planned treatment and health care institutions appropriate for the patient's needs.

■ 2.8.2 *Patient choice*

Article 8 of the 2010 Law on the Rights of Patients guarantees the right to choose a physician or medical treatment institution.

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

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

For privately paid services, choice is completely free. The price list of fees is determined by each medical institution, and prices may vary among medical institutions. The pricelist for the fees required by the institution should be clearly visible to patients.

TABLE 2.3 Patient choice

TYPE OF CHOICE	IS IT EASILY AVAILABLE?	DO PEOPLE EXERCISE CHOICE? ARE THERE ANY CONSTRAINTS (E.G. CHOICE IN THE REGION BUT NOT COUNTRYWIDE)? OTHER COMMENTS?
CHOICES AROUND COVERAGE		
Choice of being covered or not	Yes	Free choice to use or not to use publicly covered services. The same services can be obtained through private voluntary insurance or paid out of pocket.
Choice of public or private coverage	Yes	There is choice, but can be restricted by waiting times and geographical availability.
Choice of purchasing organization	No	For publicly covered services NHS is the only purchasing organization. People can freely choose voluntary private HI companies.
CHOICES OF PROVIDER		
Choice of primary care practitioner	Yes	Due to geographical distribution, rural areas do not have as much choice as urban areas.
Direct access to specialists	Yes	As long as the institution or specialist has a contract with the NHS and the patient has a referral from a family physician.
Choice of hospital	Yes	
Choice to have treatment abroad	Yes	Patients have to prove the need for seeking treatment abroad; e.g. due to urgency, and reimbursement may be limited to Latvian costs.
CHOICES OF TREATMENT		
Participation in treatment decisions	Yes	
Right to informed consent	Yes	
Right to request a second opinion	Yes	
Right to information about alternative treatment options	See comment	There is a choice to receive information on drug treatment instead of surgery or another type of surgery. But there is no choice for information on homeopathy or other alternatives of evidence-based (scientific) treatments.

■ 2.8.3 Patient rights

The rights of patients in Latvia are regulated by the Law on the Rights of Patients (2010), which sets the regulatory framework for patients' right to information, medical treatment or waiver, the right to choose a doctor or medical institution, and the right to data protection and quality health care.

The purpose of the law is to promote favourable relationships between a

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

TABLE 2.4 Patient rights

	Y/N	COMMENTS
PROTECTION OF PATIENT RIGHTS		
Does a formal definition of patient rights exist at national level?	Y	Law on the Rights of Patients (2010)
Are patient rights included in legislation?	Y	
Does the legislation conform with WHO's patient rights framework?	Y	
PATIENT COMPLAINTS AVENUES		The NHS proceeds patient complaints and HI carries out expert examination regarding inappropriate provision of services and determines the amount of remuneration to be paid, which may include also compensation for non-pecuniary damage.
Are hospitals required to have a designated desk responsible for collecting and resolving patient complaints?	Y	
Is a health-specific Ombudsman responsible for investigating and resolving patient complaints?	N	The health-specific Ombudsman operated till 2014, now the central functions are suspended, but delegated to health care providers.
Other complaints avenues?		The Treatment Risk Fund regulated by the Rules for the Operation of the Treatment Risk Fund (No. 1268, Cabinet of Ministers, 2013b) provides the patient with the opportunity to assert his or her rights and, in a simplified manner, without going to court, receive compensation for damage to health during the treatment process, which would compensate for the loss or improvement of health.
LIABILITY / COMPENSATION		The right to remuneration does not depend on whether it is a state, municipality or private medical institution, nor whether the patient has received state-paid or privately paid health care services.
Is liability insurance required for physicians and/or other medical professionals?	Y	
Can legal redress be sought through the courts in the case of medical error?	Y	
Is there a basis for no-fault compensation?	N	
If a tort system exists, can patients obtain damage awards for economic and non-economic losses?	Y	
Can class action suites be taken against health care providers, pharmaceutical companies, etc.?	Y	

■ 2.8.4 *Patients and cross-border health care*

The NHS is the competent institution and contact point in Latvia responsible for the coordination of EU cross-border health care as foreseen by the the Cross-border Directive (2011/24/EU) On the Application of Patients' Rights in Cross-Border Health Care.

Individuals can obtain pre-authorization from the NHS to seek treatment abroad if waiting time for a service covered by the Latvian basic service package exceeds medically justifiable time-limit. The scale of reimbursement may be limited to the cost of service in Latvia. Pharmaceuticals are covered for the amount reimbursable in Latvia.

Based on EC Regulation 883/2004, Latvian citizens use the EHIC to receive acute health services within the statutory system abroad, when on a temporary stay (for example, as tourists) and the statutory system of the foreign country will subsequently be reimbursed by the Latvian NHS. In 2016, the NHS paid 9 445 million euros for health care services provided in other Member States to individuals entitled to statutory health in Latvia (NHS, 2018).

Financing

■ Chapter summary

- The health care system in Latvia is financed mainly through general taxation. In 2018 the revenue base for the health system was expanded by adding an additional payment of 1 percentage point from social tax.
- As of 2011, the National Health Service (NHS) procures health care services for the population of Latvia on behalf of the state. The NHS benefit package is defined by a set of explicit inclusions and exclusions, and is less broad than in most other EU countries.
- Total current expenditure on health remains among the lowest in Europe. State financing comprises only 54% of total health expenditure, while the rest is financed by out-of-pocket payments. User charges and OOP payments still comprise a large part of the total health expenditure. OOP spending is mainly driven by pharmaceuticals and medical devices. Voluntary health insurance does not play a major role and accounts for about 5% of total health expenditure.
- Despite a growing economy, there was no substantial increase in state health care financing until 2018, when state financing for health care grew by more than 200 million euros, or by 29% in comparison with 2017. This increase was directed to raising the salaries of medical personnel and improving accessibility of services.

- Primary care providers are paid using a mix of capitation, FFS, fixed practice allowances and quality payments (since 2013). Secondary ambulatory providers are mostly paid by flat-rate fees for defined episodes of illness, with additional FFS payments for preventive, diagnostic and therapeutical interventions. Hospitals receive a fixed budget for emergency care services and observational wards, plus payments for treatment of patients based on predefined case payments, payments for bed-days (defined for every level of hospital and/or individual hospital) and payments based on DRG.
- For 2014–2020, Latvia has allocated around 272 million euros of cohesion policy funding for investments in the health sector.

■ 3.1 Health expenditure

TABLE 3.1 Trends in health expenditure, 2000 to latest available year

EXPENDITURE	2000	2005	2010	2015	2016	2017
Current health expenditure per capita in International US\$ PPP	434	808	1 069	1 394	1 590	1 722
Current health expenditure as % of GDP	5.4	5.9	6.1	5.7	6.2	6.3
Public expenditure on health as % of total expenditure on health	50.8	55.7	60.2	59.0	54.6	54.6
Public expenditure on health per capita in International US\$ PPP	220.4	449.8	643.3	794.9	868.5	941.0
Private expenditure on health as % of total expenditure on health	49.2	44.0	39.8	43.0	45.4	n/a
Public expenditure on health as % of general government expenditure	7.4	9.6	8.1	8.5	9.2	n/a
Government health spending as % of GDP	2.8	3.3	3.7	3.3	3.4	3.4
OOP payments as % of total expenditure on health	44.1	41.7	37.2	42.1	44.6	41.8
OOP payments as % of private expenditure on health	96.8	94.8	93.6	95.4 ^a	n/a	n/a
Private insurance as % of private expenditure on health	3.2	5.2	6.1	4.4	n/a	n/a

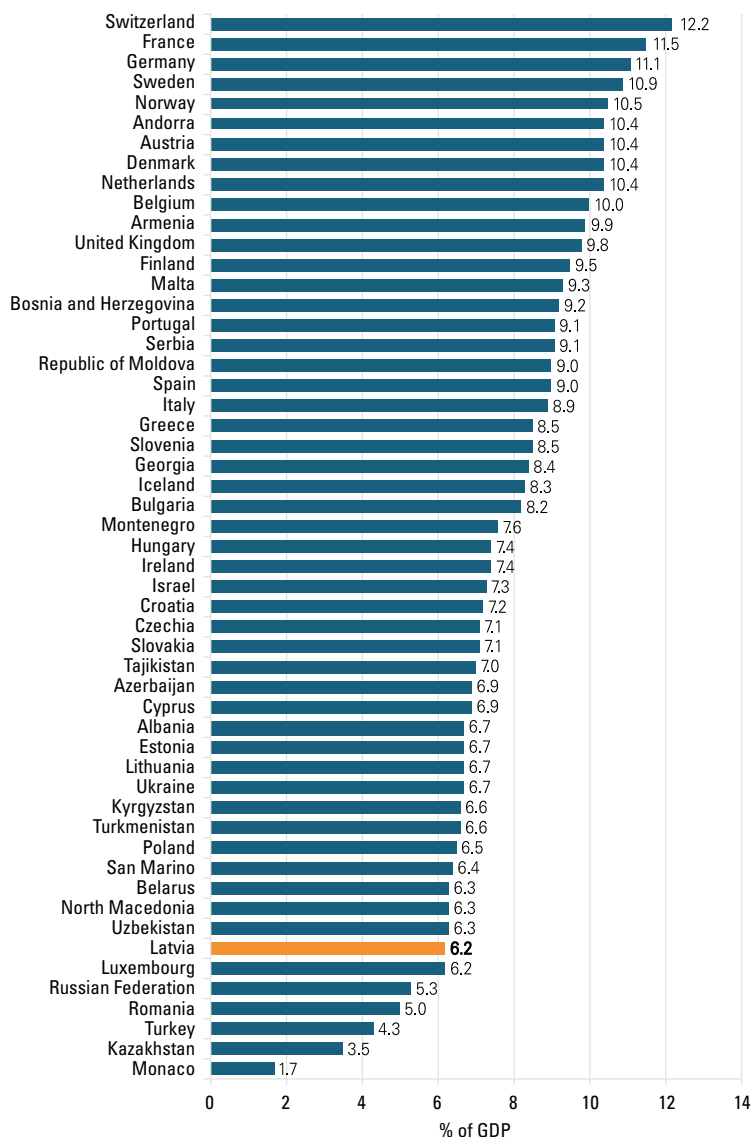
PPP, purchasing power parity; OOP, out of pocket; n/a, not available

^aWHO European Health Information data from 2014.

Source: OECD Health Statistics database, WHO Global Expenditure Database (updated December 2018)

In 2017, total health expenditure (THE) as a share of GDP was 6.3% (see Table 3.1). As a result of the economic crisis in 2008, THE as a share of GDP fell between 2009 and 2013 (Fig. 3.2). The levels of out-of-pocket (OOP) payments are high in Latvia, reaching 41.8% in 2017, one of the highest private expenditures on health in Europe.

FIG. 3.1 Current health expenditure as a share (%) of GDP in the WHO European Region, 2016

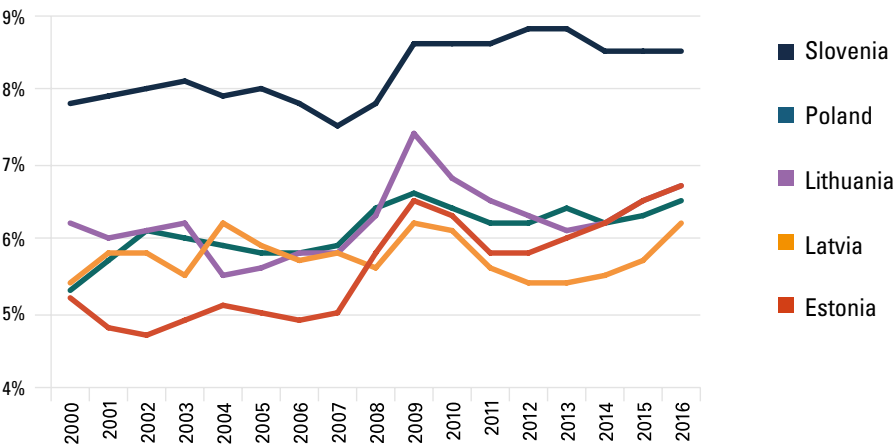


Source: WHO Global Expenditure Database (updated December 2018)

From an international perspective, Latvia is a low spender on health. Figure 3.1 highlights the health expenditure as share of GDP, showing Latvia at around 6%, lower than most countries in the WHO European Region. Figure 3.2 shows that the proportion of GDP spent on health has increased since 2012, but it remains low in comparison with other countries. The trend in current health expenditure as a percentage of GDP in Latvia mirrors developments in the other Baltic countries, as all three were hit harder by the financial crisis.

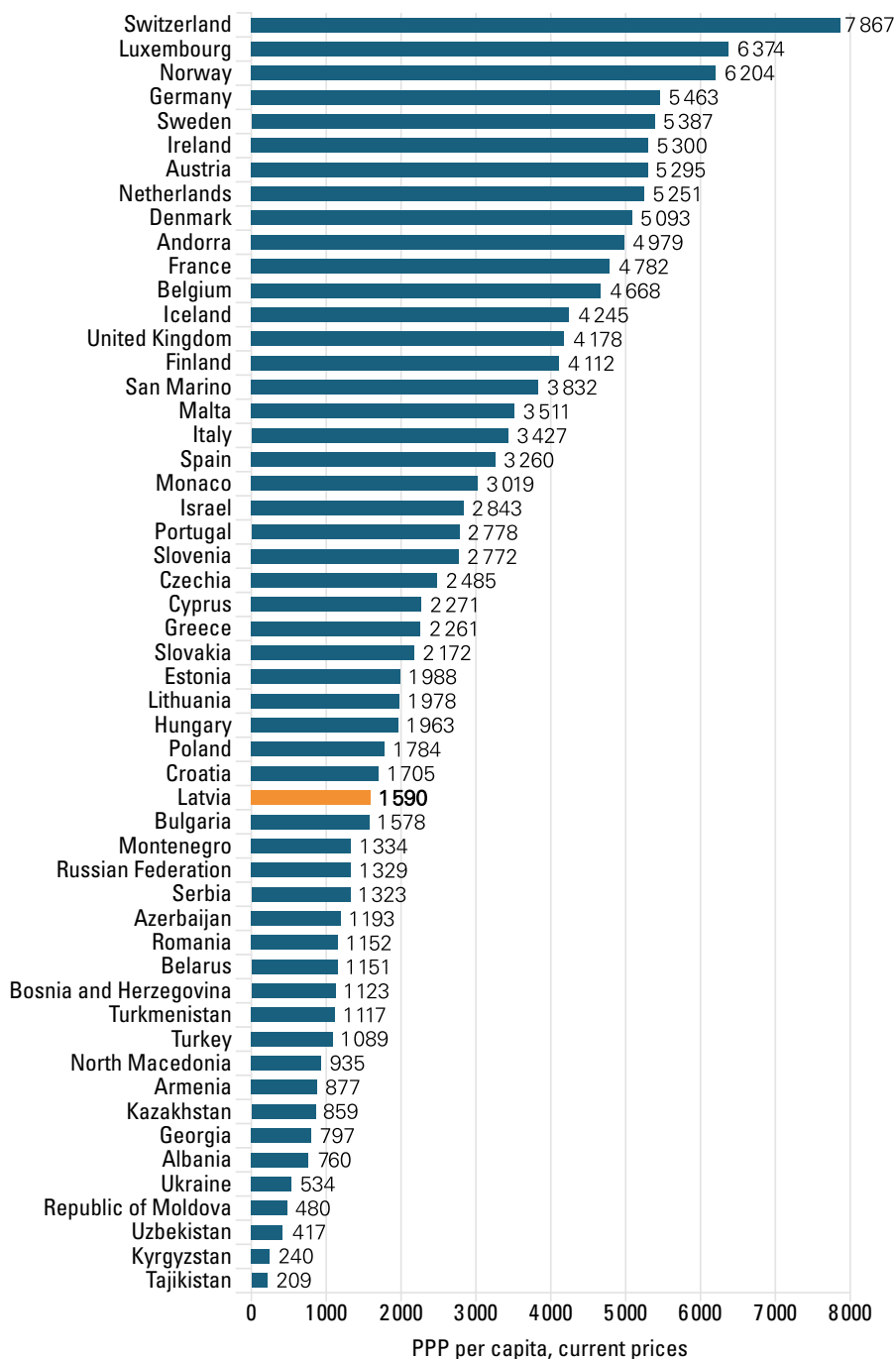
Figure 3.3 shows a comparison of per capita expenditure on health between countries in the WHO European Region, with Latvia reporting an expenditure of US\$ 1 589.7 PPP per capita, compared with US\$ 1 978.3 in Lithuania and US\$ 1 987.7 in Estonia. Also, the share of public spending as share of THE is comparatively low. Latvia’s public share was only 54.6% in 2016, compared with 65.5% in Lithuania and 75.4% in Estonia (Fig. 3.4). Latvia’s relatively low public expenditure on health as a share of general government expenditure (Fig. 3.5), amounting to 9.2% (compared with Lithuania’s 12.8% and Estonia’s 12.4%), points at the low priority of health within government expenditure compared with other budget items.

FIG. 3.2 Trends in current health expenditure as a percentage of GDP in Latvia and selected countries, 2000–2016



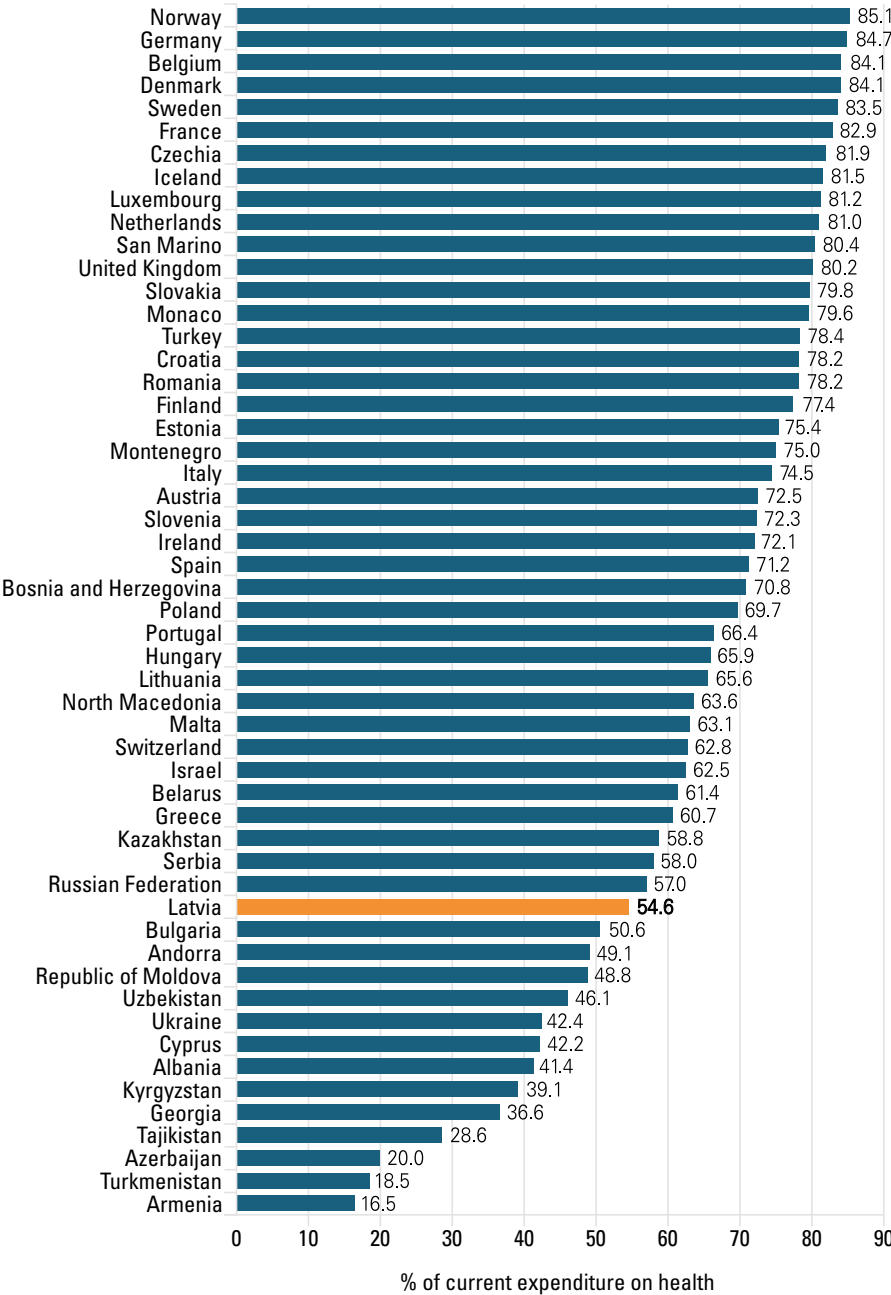
Source: WHO Regional Office for Europe

FIG. 3.3 Current health expenditure in US\$ PPP per capita in the WHO European Region, 2016



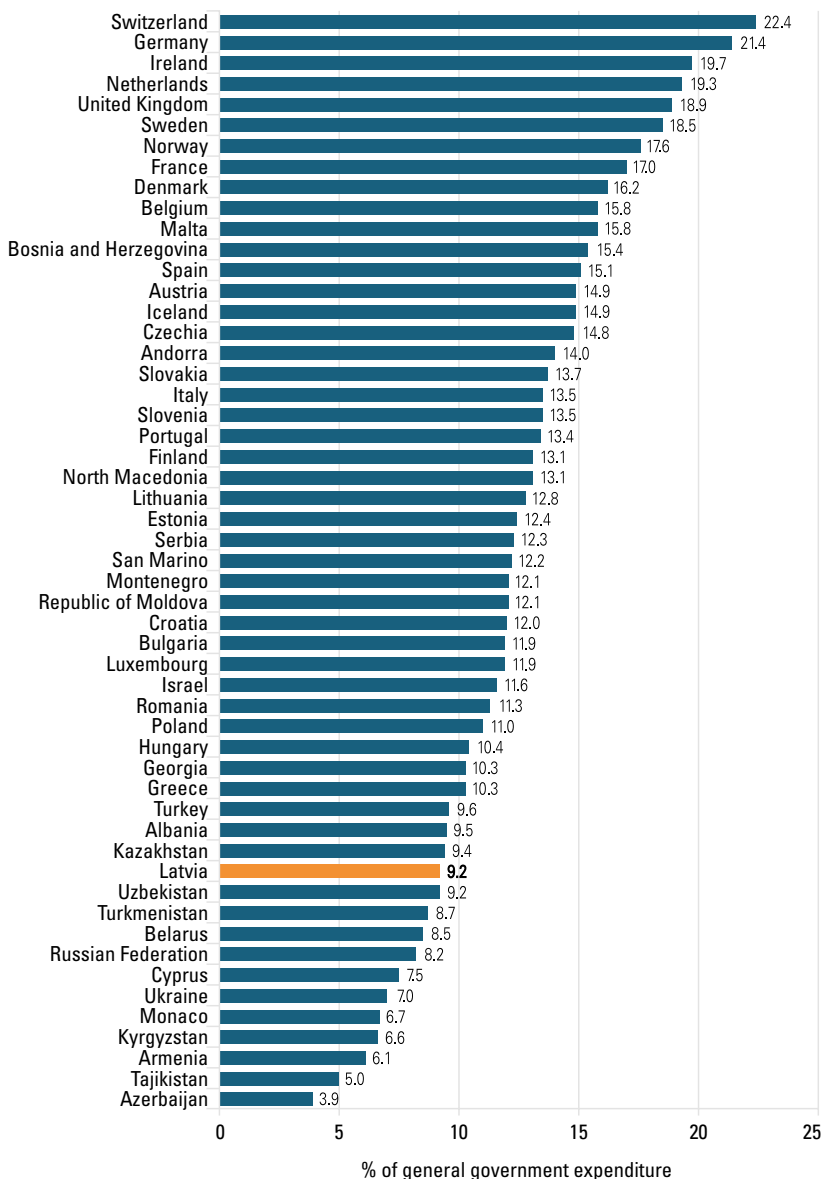
Source: WHO Global Expenditure Database (updated December 2018)

FIG. 3.4 Public expenditure on health as a share (%) of current health expenditure in the WHO European Region, 2016



Source: WHO Global Expenditure Database (updated December 2018)

FIG. 3.5 Public expenditure on health as a share (%) of general government expenditure in the WHO European Region, latest available year



Source: WHO Global Expenditure Database (updated December 2018)

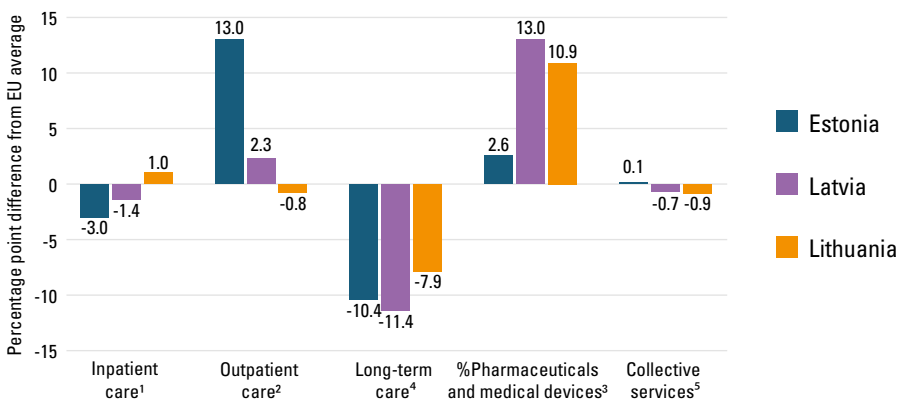
State financing for health is approved annually by the Saeima (parliament) as a part of the national budget. The Cabinet of Ministers defines the allocation of budget for purchasing of health care services and provision of other services.

The majority of the parliament-approved government health budget is allocated to purchasing of health care services and is administered by the NHS (84% in 2014, slightly increasing in 2015 to 85% and in 2016 to 85.2%), with the remaining share (approximately 15–16%) used by the Ministry of Health for provision of emergency medical care, health sector management, public health activities, medical education and cultural activities (such as maintenance of the Museum of Medical History). The division of the allocated budget between health care services administered by the NHS is determined by the Regulation of the Cabinet of Ministers No. 555 (Cabinet of Ministers, 2018b):

- for outpatient health care services not less than 45%;
- for inpatient health care services not more than 53%;
- for payments for cross-border settlements not more than 2%.

In 2017, about 31% of Latvia’s health care budget was used on the cost of medicines and medical devices – a high value compared with the EU average of 18% (Fig. 3.6). However, in absolute terms, pharmaceutical spending in Latvia was about one third below the EU average. While the shares of the health expenditure spent on inpatient and outpatient care were similar to EU averages (about 30% each in 2017), the proportion spent on long-term care was considerably lower (5% versus 16% in the EU).

FIG. 3.6 Expenditure on health according to function compared with the EU average for the Baltic countries, 2017



¹Includes curative-rehabilitative care in hospital and other settings; ²Includes home care; ³Includes only the outpatient market; ⁴Includes only the health component.

Note: Administration costs are not included.

Sources: OECD Health Statistics database 2019, Eurostat database (data from 2017) in OECD/European Observatory on Health Systems and Policies, 2019.

It should be noted that the current financing system does not present a clear flow of different financial sources to separate service lines. Although division of state financing between functions is fixed in the Regulation of Cabinet of Ministers, the division of OOPs and VHI is not defined. Moreover, as there are no definite reporting requirements for privately paid services, there are no reliable data about actual financing flow by functions. This overlapping of financing restricts analysis of financing division according to functions, and leads to potential loss of efficiency.

■ 3.2 Sources of revenue and financial flows

The most important financial flows within the health system are shown in Figure 3.7. About 60% of revenues for the health system come from general (non-earmarked) taxation at the central (national) level (see Table 3.1). Tax collection is centralized and carried out by the National Revenue Service (NRS), which is subordinated to the Ministry of Finance and distributes the revenue directly to the State Treasury of Latvia.

To improve the sustainability and solidarity of the health care financing system, a new Health Care Financing Law was adopted by parliament in December 2017 (see Box 6.1). Although the proposal within the law of splitting the benefit basket according to the payment of a social health insurance contribution was postponed, the government increased the compulsory state social insurance contribution from payroll by 1 percentage point, half paid by employers and half by employees, which is currently implemented and is used specifically for funding health care.

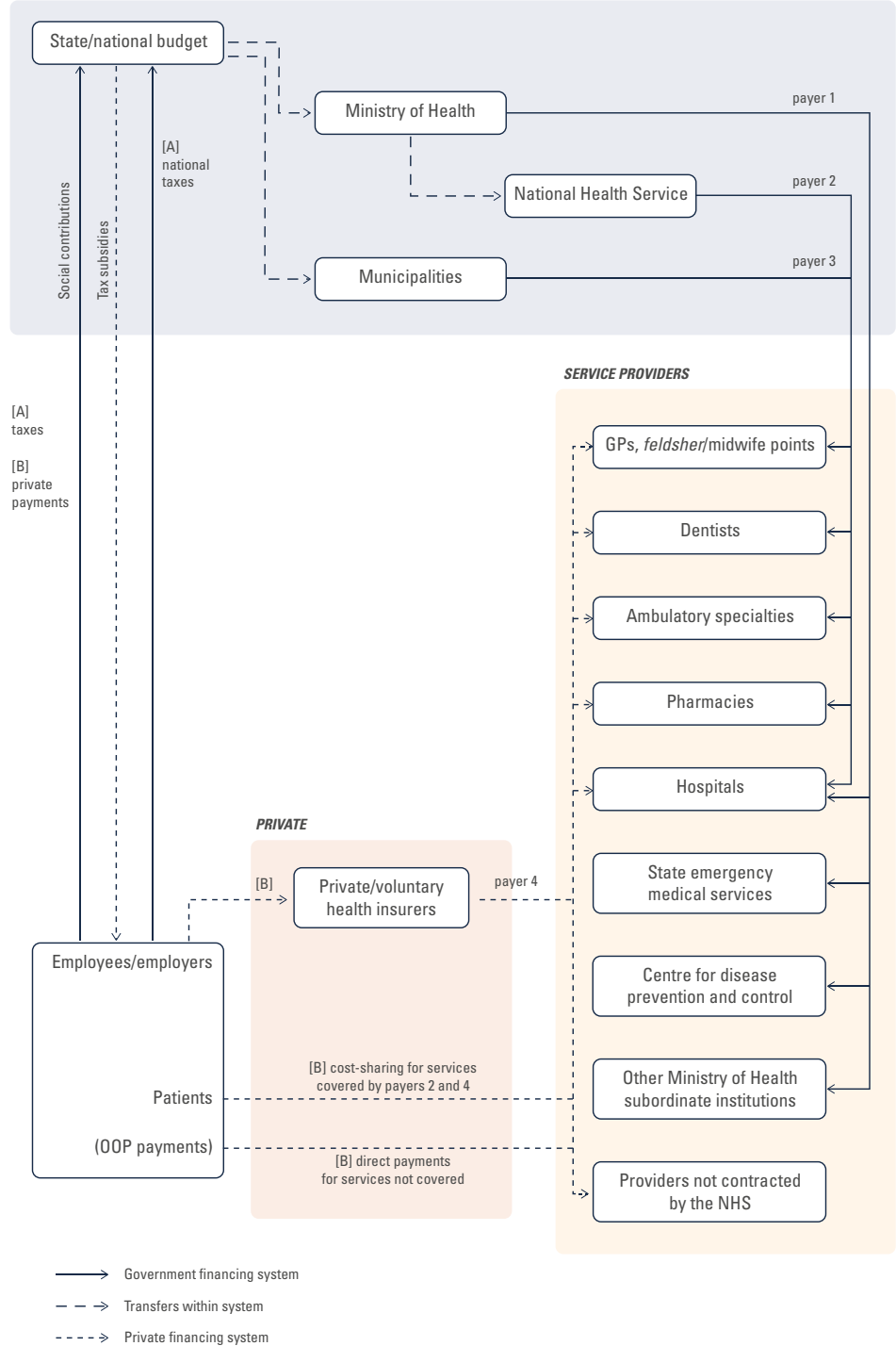
There are several tax subsidies for health care services. All health care services are exempt from VAT. In addition, inhabitants can apply for return of part of paid individual income tax by declaring private payments for medical services. The maximum for eligible expenses for medical services and education is EUR 600 per household member, but not more than 50% of total taxable income.

Voluntary health insurance does not play a major role and accounts for about 5% of THE (see section 3.5).

Municipalities also contribute to health care system financing. According to the Law on Municipalities, one of their functions is to ensure accessibility of health care services for their populations. However,

FIG. 3.7 Financial flows

NATIONAL REGIONAL AND LOCAL GOVERNMENT



every municipality can decide on measures to ensure accessibility. Some municipalities provide premises for GP practices free of charge or with reduced payments, some municipalities have programmes to attract specialists, etc. Municipalities often participate in financing long-term development investments for regional hospitals. Investment decisions are taken by the hospital management together with the municipality, often without coordination with the MoH. Some municipalities also have a programme of compensation for inhabitant's expenditure for health care services for those in need. The amount of money available for such payments as well as eligibility criteria are different in every municipality. As financial decisions are taken by every municipality individually, there are no aggregated data about their total participation in the financing of the system.

■ 3.3 Overview of the statutory financing system

■ 3.3.1 *Coverage*

BREADTH: WHO IS COVERED?

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

- Latvian citizens;
- Latvian non-citizens (permanent inhabitants of Latvia without citizenship – mainly citizens of the ex-USSR who have not applied for Latvian citizenship);
- citizens of Member States of the EU, of European Economic Area states, Ukraine and Swiss Confederation who reside in Latvia in relation to employment or as self-employed persons, as well as the family members thereof;

- third-country nationals who have a permanent residence permit in Latvia;
- refugees and persons who have been granted alternative status;
- persons detained, arrested and sentenced with deprivation of liberty.

SCOPE: WHAT IS COVERED?

As stipulated by the law, a detailed range of services as well as regulations for the provision of services and tariffs for state-paid health care interventions are defined by the Cabinet of Ministers in Regulation No. 555. The scope of services included in the state-paid services is determined by a number of explicit inclusion and exclusion lists as well as by certain implicit criteria.

Regulation No. 555 explicitly excludes certain services, such as dental care for adults, rehabilitation (with a long list of exceptions), medical check-ups required for occupational reasons, sight correction and hearing aids (except for children), spa treatment, abortions (if there are no medical or social indications) and others. Furthermore, the terms of the contracts between the NHS and providers determine that children, pregnant women and people in need of urgent medical care are priorities for resource allocation, exposing other patients to substantial waiting lists for non-prioritized services, up to the point where they are implicitly excluded. However, this does not mean that children receive all necessary health care, and charities often collect money for children if the government does not have sufficient resources.

Given the broadly defined state services basket together with very limited state financing for health care, access to services is limited. Waiting lists for some services can reach several years, forcing patients to seek services covered by VHI or pay OOP. Limited state financing is one of the key reasons for the flourishing privately financed health care services in Latvia. All services excluded from state coverage can be purchased by patients or their voluntary insurance plans either from providers with NHS contracts or from non-contracted providers (see also section 3.3.4). Patients are exposed to substantial direct payments, implying that the breadth of coverage is somewhat limited, especially since a considerable proportion of pharmaceuticals expenditure is not covered by the NHS.

DEPTH: HOW MUCH OF THE BENEFIT COST IS COVERED?

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

BOX 3.1 What are the key gaps in coverage?

- Pharmaceuticals are responsible for the main share of OOPs.
- A high burden of OOPs hinder accessibility of services for persons with low income.
- Limited state financing leads to long waiting lists and an increasing demand for privately financed health services.
- Due to limited financing, but also fragmentation in planning and purchasing, patient pathways are fragmented. This negatively affects the continuum of care (e.g. timely availability of rehabilitation is not ensured based on medical indications, and is undermined by long waiting lists).

■ 3.3.2 Collection

GENERAL GOVERNMENT BUDGET

Tax collection is centralized in Latvia and is mainly overseen by the State Revenue Service (SRS), subordinated to the Ministry of Finance. It operates territorial branches and incorporates several institutions, such as the Financial Police. Tax payments flow to the State Treasury of Latvia from the Ministry of Finance. The tax rates are set by laws passed by parliament.

In 2017, the Saeima approved a number of laws in the framework of tax reform, introducing significant tax changes for enterprises and individuals (in particular, a progressive individual income tax: annual income up to EUR 20 004 is taxed at 20%; from EUR 20 004 to 55 000 at 23%; and above EUR 55 000 at 31.4%). To compensate for a decrease in tax income, excise tax increase and several anti-shadow measures were also introduced.

To raise additional funding for health care, from 2018 the Social Security Contributions (SSC) rate increased by 1 percentage point, split between 0.5 percentage point for the employer and 0.5 percentage point for the employee. These revenues are earmarked in the law and transferred to the health care budget.

Personal income tax is collected by the SRS and the majority (80%) is passed directly to municipalities, representing one of the major sources of municipalities' budget. In order to ensure that every municipality, independent of size and number of inhabitants, can provide mandatory services to their inhabitants, an income equalization fund redistributes funds across municipalities. Municipalities have full autonomy on how to use their budgets for the financing of health care services.

BOX 3.2 Is health financing fair?

- OOP financing is extremely regressive, limiting access to necessary health care for those in need not only for privately paid care, but also for state financed care due to substantial user charges.
- The health system is based on solidarity, but the limited resources in the system cannot ensure the provision of services according to patients' needs.

■ **3.3.3** *Pooling and allocation of funds*

ALLOCATION FROM COLLECTION AGENCIES TO POOLING AGENCIES

The SRS is responsible for pooling tax revenue. It distributes the revenue directly to the State Treasury of Latvia and then to the corresponding agencies, including the MoH. The amount of funds distributed to each ministry

or sector is set annually by the approved budgets. During the year, there could be additional allocations of funds, depending on actual economic performance. The amount of additionally allocated funds is decided by the parliament, this may occur once or twice per year. The MoH allocates funds to the NHS for the provision of curative services, emergency care services, public health services and other functions (administration, health reform, education etc.).

OOP payments, voluntary health insurance and municipalities' funds for health care financing are not pooled by any agency and go directly to service providers. Fragmented sources of funds remain a major challenge for financing of the health care system in Latvia. The new Health Care Financing Law does not foresee any mechanism for pooling of resources. There is no provision for state regulations for investments in major medical technologies or investments for the development of health care infrastructure.

ALLOCATING RESOURCES TO PURCHASERS

NHS acts as a single purchaser of curative health care services on behalf of the state for the entire population. Residents can choose a voluntary health insurer, and are free to choose health care providers both for state financed care and for privately paid care.

BOX 3.3 Are resources put where they are most effective?

- There is an intention, reflected in the allocation of resources, to invest more in primary and ambulatory care. Latvia has increased the proportion of spending on outpatient care – by almost 20% since 2010 – from 27% to 32% of total spending. Still, the Latvian health system remains rather hospital-centric.
- The regional distribution of budgets as well as individual agreements with health care providers are set according to historical budgets and often do not correspond to the actual needs of the population.
- Health technology assessment (HTA) is applied only to pharmaceuticals and there is no investment policy for expensive medical equipment (e.g. MRI) (see Chapter 7).

■ 3.3.4 *Purchasing and purchaser–provider relations*

The NHS is the only purchaser of state-paid health care services in Latvia for primary, secondary, tertiary and emergency care, as well as for pharmaceuticals. It should be noted that the NHS administers only about 55% of THE, while the remainder is paid by patients at the place of delivery. The organizational relations between the NHS, as purchaser, and providers are structured in Regulation No. 555 (see also sections 2.8.1 and 2.8.2 for regulation of third-party payers and providers) and through annual agreements between the NHS and service providers. The NHS can contract selectively with individual providers. The NHS Central Office contracts with inpatient care providers. Territorial branch offices contract with GP practices, dentists and secondary outpatient services providers as well as with pharmacies for the provision of reimbursed pharmaceuticals. Individual contracts include the range of services, number of patients as well as total annual financing. Contracts contain health sector regulatory documents, define the responsibilities of the contract parties and specify reporting requirements, while the annexes, which are subject to annual agreements, specify the payment conditions, list the statutory services to be provided, eligible patient groups and a cap on the budget. Standard contracts exist for the main service provision levels (e.g. inpatient care, secondary outpatient care, primary care) and the same tariffs are applied to all providers (of the same category) across the country. Tariffs for all services include salaries for medical personnel, depreciation of capital investments, medication costs, administrative expenses etc. Tariffs are meant to cover both the running costs of services and the depreciation of capital investments. Agreements are signed for 5 years with a separate financial offer for every single year. For every calendar year, the NHS drafts a financial proposal for every contracted provider based on the previous 12 months (from 1 September to the 31 August). Volume and financial limits are based on performance of the provider, performance of other providers in the specific line of services, available total funds and strategic decisions to reduce waiting list in the specific service line. The NHS analyses the performance of every provider on a monthly basis. Deviation from the agreement can result in a revision of the total amount of services during a year.

However, in 2011, the State Audit Office claimed that the MoH and the NHS do not have a factual justification for the cost elements of tariffs, and those do not correspond to the actual costs of health care services at the

providers' level. No major changes were made by the MoH to bring actual costs information to the tariffs calculation since the report, until 2017, when the MoH started to re-calculate tariffs for services in order to adjust them to actual costs. Tariffs were updated for all services in 2018, taking into account agreed increases in salaries for health care professionals. For dentistry services, new tariffs include increases in salaries and in other elements, such as medical equipment etc.

State-paid inpatient care could be provided only by selected hospitals, which are listed in Annex 6 of Regulation No. 555. All hospitals providing inpatient care are allocated onto one of the five tiers of the five-tier hospital system (see section 2.2). Inpatient care programmes are allocated to hospital according to its defined level. Hence, competition between inpatient care providers for contracts is rather limited.

For secondary outpatient care, Regulation No. 555 (Annex No. 12) defines the outpatient services, diagnostic examinations, rehabilitation services and day care services to be provided in each administrative unit according to number of inhabitants. Volume of services for individual provider is defined based on a total volume of services for this administrative unit and previous performance of provider.

To introduce a new service, the NHS runs providers' selection procedures, assessing conformity of every secondary care outpatient institution to certain criteria, which include: providers' compliance with legal requirements, financial, technical and management capacity, personnel availability and qualifications. The procedure is considered an attempt to engage in selective contracting so as to avoid paying for inappropriate service provision. The reform of 2017 foresees the introduction of strategic purchasing and the establishment of selection criteria that favour cost-effective and patient-oriented providers (Cabinet of Ministers, 2017a). Contracts determine a cap on the numbers of services to be provided by secondary outpatient care providers. However, it appears that caps are often exceeded as this improves the ability to negotiate a higher cap for the next year, and if the total budget is increased this allows providers to obtain a larger share of the budget.

Primary care is provided by a network of GP practices, mostly private entrepreneurs, and few employed by health centres. NHS signs contracts either with single GP practices or, if GPs provide services as employees of health centres or hospital outpatient departments, with the administration of the respective provider institution. The NHS has a selection process for

GPs and the option to cancel agreements if certain requirements are not met. However, competition seems to take place only in Rīga and other larger cities where there are waiting lists of GPs willing to open their practices. At the same time, there is a shortage of GPs in remote and rural areas, where the population density is low and it is difficult to have sufficient numbers of patients to ensure a financially sustainable practice. Newly certified GPs are put on a waiting list for contracting or can apply to vacancies posted at the NHS website. The size of a GP budget for the provision of primary outpatient services is mainly determined by a capitation payment (see section 3.7).

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

According to recommendations by the World Bank in 2016 (Holla et al., 2016), the Latvian health care system requires significant improvements in its existing health information infrastructure and analytical capabilities. To allow tracking of a patient's path through the entire health care system, monitoring of services provided by state and private providers is needed.

■ 3.4 Out-of-pocket payments

Out-of-pocket (OOP) payments are the second most important source of revenue for the Latvian health system. Since the recession in 2008, when the government cut spending and increased user charges, the share of OOP payments as a percentage of THE has been constantly increasing, reaching 41.8% in 2017, according to OECD data (see Table 3.1).

Two main categories of OOPs exist in Latvia. In the first, patients pay user charges for statutorily financed care provided by NHS-contracted providers and for care provided within MoH-financed health programmes (see section 3.4.1 for details). In the second, patients make direct payments for non-statutorily financed care (non-contracted care) provided by NHS-contracted providers and for all care provided by non-contracted providers (see section 3.4.2); for example, private practitioners.

In 2010, the average monthly OOP spending per household member was

EUR 14.7, contributing to 5.9% of total household expenditure. Since 2010, OOP per household member has increased steadily both in absolute numbers and as percentage of total expenditure, reaching almost EUR 22 in 2016, accounting for 6.6% of total household expenditure. About 60% of OOP spending paid for medical goods (mostly pharmaceuticals, including OTC drugs), while outpatient care services accounted for another 30%, according to CSB information. Higher income groups spend higher amounts in absolute terms but these constitute a lower share of their income. According to data reported to the NHS by contracted providers, total revenue earned from user charges for state financed outpatient and inpatient services totalled 55 million euros in 2017. Of this total, 32 million euros was paid by patients while 23 million euros was paid by the state for patients exempted from payment. However, these figures reflect only part of all OOP payments since they do not include OOP for pharmaceuticals and direct payments for services.

■ 3.4.1 *Cost-sharing (user charges)*

Several types of user charges exist in Latvia. One is co-payments – a fixed amount (flat rate) to be paid, for example, per GP visit, hospital stay, inpatient surgical intervention or prescription drug with 100% reimbursement level. Another is co-insurance – a fixed proportion of the cost of a prescription drug or medical device (25% or 50%). All user charges are regulated by Regulation No. 555 and No. 899, Procedures for the Reimbursement of Expenditures for the Acquisition of Medicinal Products and Medical Devices Intended for the Outpatient Medical Treatment. However, it is important to note some ambiguity in the Latvian cost-sharing terminology. The co-payments for outpatient and inpatient services are locally referred to as “patient fees” (*pacienta iemaksa* in Latvian). However, when the co-payment is charged for an inpatient surgical intervention, it is locally referred to as a “co-payment” (*pacienta līdzmaksājums* in Latvian).

When first introduced in 1996, user charges were formally declared as a means of encouraging consumer responsibility over personal health, reducing inappropriate demand and increasing resources for health care. However, the government recognizes the need to reduce the burden of user charges on the population while maintaining their role in reducing excessive use of health care services.

Co-payments apply to almost all types and levels of statutorily financed health services, as well as outpatient prescription pharmaceuticals (Table 3.2). The current fee catalogue was introduced in 2009 and was only modified slightly in 2010.

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

Several mechanisms exist to protect the population from catastrophic health expenditures or underuse of services, which could result from user charges. These include exemption mechanisms for certain groups and low-income households, and a cap on user charges (Table 3.2).

The cap on user charges applies to the entire population. All co-payments for outpatient and inpatient health care services per person per year must not exceed EUR 570 in the year 2019. In addition, they must not exceed EUR 355 per one hospitalization episode. If a patient can prove to their NHS branch office that they have reached the cap, the NHS will issue a certificate and reimburse providers directly for all patient user charges exceeding the cap. However, the cap does not apply to co-payments and co-insurance for pharmaceuticals or medical devices. The cap also does not apply to privately paid services, pharmaceuticals or medical devices.

Children under the age of 18 are exempted by law from payment of any fees for all services included in the statutory list of services. But in reality, due to long waiting lists for some services parents often choose to pay out of pocket for services for their kids, to ensure timely service provision. Other exempt groups include pregnant women and women up to 42 days after childbirth, disabled people, mentally ill patients under treatment, and others.

In addition, persons below the poverty threshold, according to the Regulation of the Cabinet of Ministers No. 299, with average income below EUR 128.06 per month per family (in 2019) member and some other conditions (absence of real estate or cash savings etc.) are exempted from user charges.

For all patients exempted from user charges, the NHS (or the Ministry of Health for ministry-financed programmes) reimburses providers for the

TABLE 3.2 User charges for health services and protection mechanisms, 2019

	TYPE OF USER CHARGE IN PLACE	EXEMPTIONS AND/OR REDUCED RATES	CAP ON OOP SPENDING	OTHER PROTECTION MECHANISMS
Primary care	Co-payment of EUR 1.42	Children under 18, pregnant women and women up to 70 days after childbirth, victims of political repression and participants of the national resistance movement and other groups set by the Health Care Financing Law, p. 6	All co-payments for outpatient and inpatient health care services per person per year capped at EUR 570; co-payments per hospitalization episode are capped at EUR 355	
Outpatient specialist visit	Co-payment) of EUR 4.27	Children under 18, pregnant women and women up to 70 days after childbirth, victims of political repression and participants of the national resistance movement and other groups set by the Health Care Financing Law, p. 6		Households with low income, recognized as poor under current legislation
Outpatient prescription drugs	Co-payment EUR 0.71 per prescription (for drugs with 100% reimbursement), co-insurance of 25% or 50%	Children under 18, medicines or devices with a price below EUR 4.27	No cap	Households with low income, recognized as poor under current legislation
Inpatient stay	Co-payment of EUR 10.00 per day in hospital, EUR 5.00 for inpatient rehabilitation and EUR 7.11 in nursing care facilities, starting from the second day; co-payment up to EUR 31.00 for inpatient surgical intervention; patient fee for CT examination up to EUR 21.34 and MRI examinations up to EUR 35.57	Children under 18, pregnant women and women up to 42 days after childbirth, victims of political repression and participants of the national resistance movement and other groups set by the Health Care Financing Law, p. 6	All co-payments for outpatient and inpatient health care services per person per year capped at EUR 570; co-payments per hospitalization episode are capped at EUR 355	Households with low income, recognized as poor under current legislation
Dental care	Direct payment	Full reimbursement for children under 18 (under 22 for face/jaw cleft patients); 50% reimbursement for dental care and full reimbursement of dental plastic prostheses for Chernobyl victims	No cap	
Medical devices	Co-payment EUR 0.71 per prescription (for medical devices with 100% reimbursement), co-insurance of 25% or 50%			
Day care	Co-payment of EUR 7.11 per day	Children under 18, pregnant women and women up to 42 days after childbirth, victims of political repression and participants of the national resistance movement and other groups set by the Health Care Financing Law, p. 6		

co-payments and co-insurance that would otherwise have to be covered by patients. User charges can be covered by VHI for insured persons.

■ 3.4.2 *Direct payments*

Direct payments are frequent in Latvia and tariffs are freely determined by providers. Direct payments occur in three instances. 1) Patients have to pay for services or goods that are not included in the statutorily financed benefit basket. This includes, for example, dental care for adults, psychotherapy, most of the available rehabilitation and physiotherapy services and an important section of pharmaceuticals, which are excluded from NHS coverage. 2) Patients have to make direct payments for NHS-covered services or goods if they prefer to receive these services outside the standard patient pathway. For example, if a patient goes to a gastroenterologist for a regular check-up (a service which is included in the basic benefit package) without a GP's referral, it requires OOPs. Similarly, patients have to make direct payments if they want to jump waiting lists for non-prioritized NHS-covered services. The NHS monitors direct payments made to contracted providers and may terminate a contract if it finds that the provider deliberately defers treatment in order to be able to charge direct payments. 3) Patients have to pay directly for all services received from providers outside of the NHS, regardless of whether the services are included in the benefits basket.

■ 3.4.3 *Informal payments*

Informal payments include all unofficial payments for goods and services that are supposed to be free and funded from pooled revenue, as well as all official payments for which providers do not give a receipt. There is no reliable source of information on informal payments in Latvia. In 2017, the Special Eurobarometer Report on Corruption indicated that 8% of respondents in Latvia who had visited a public health care provider in the previous 12 months reported they had to make an extra payment or give a valuable gift to a nurse or doctor, or donate to the hospital (in comparison with an EU28 average of 4% and an EU13 average of 9%) (European Commission, 2017).

■ 3.5 Voluntary health insurance

The opportunity to provide complementary and supplementary VHI was introduced in 1996. VHI covers supplementary services (those not covered by the NHS, including faster access) as well as complementary services (user charges). Despite a high level of OOPs, the financial impact of VHI remains relatively low. According to the Financial and Capital Market Commission, in 2017 only four insurance companies were offering VHI. Most VHI companies (VHICs) work with employers, and only limited insurance packages are available for individual persons. Before the financial crisis, 35% of the total number of employed persons were covered by VHI. Due to the severe impact of crisis, there was substantial decrease in VHI coverage reaching as low as 19% in 2012. In 2018, total coverage was back to the pre-crisis level at 35% of the total number of employed individuals.

The main factor driving demand for VHI is that employers can make jobs more attractive with insurance bonuses while saving on corporate tax, as insurance premiums paid for employees can be deducted from profits. According to the data provided by the Financial and Capital Market Commission, total claims made to VHICs account for about 5% of THE in 2017. As VHI is purchased by the employer, premiums paid are classified as production costs and are exempt from corporate, individual and compulsory social contribution tax payments, unless the total premium per employee does not exceed 10% of annual salary of employee and does not exceed EUR 426.86.

Each commercial insurance company defines its own insurance schemes without any external regulation of prices and benefits packages. Insurance schemes provide a mix of complementary and supplementary coverage. They usually cover user charges and those health care services and/or prescription drugs that are not statutorily financed. Some benefits may be offered in kind (if providers have contracts with the insurer), others are offered in cash (reimbursement of claims). There is usually a cap on total expenses per insured per year and patients may be required to pay user charges for complementary services covered by the VHI scheme.

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

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

VHICs are generally quite profitable, with premiums frequently exceeding claims by more than 40%. However, VHICs can negotiate prices with health care providers only in limited volumes and do not have a real tool to control increase of fees for services by providers. In some cases, when VHI covers only part of providers' defined fees for services, the patient is asked to pay the difference.

There are no legal regulations specifically for VHICs; they conform to those of the commercial enterprises, including solvency controls. All insurance companies are supervised by the Financial and Capital Market Commission, which is an autonomous public institution. It is mostly concerned with ensuring stability, competitiveness and development of the financial and capital markets, as well as protection of the interests of investors, depositors and insured persons.

There have been discussions on expanding the role of VHI in health care. However, private insurers face lack of stability and predictability because the benefits package of the statutory system is not explicitly defined and is subject to changes depending on the budget, which makes designing benefits packages that fill the gaps of the statutory system a challenge.

■ 3.6 Other financing

■ 3.6.1 *Parallel health systems*

The ministries of Defence, Interior and Justice have their own health care budgets to finance health services for specific population groups. The Ministry of Defence receives budget funds to cover services provided for soldiers as well as the entire armed forces and their employees. The Ministry may tender necessary service providers in the vicinities of troops. The Ministry also operates a Medical Centre where a limited range of services is provided. The Ministry

of the Interior (MoI) also operates its own outpatient clinic, although its employees mostly use the mainstream statutory system. Medical services for prisoners and refugees are run by the Ministry of Justice. However, as the mainstream statutory system is available to all citizens and nearly all permanent residents, members of the armed forces, employees of the MoI, as well as prisoners and refugees generally use the mainstream system Regulation No. 555, which determines that the ministries cover user charges and service costs for the population groups under their responsibility (Art.166).

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

■ **3.6.2** *External sources of funds*

For the period 2014–2020, the Latvian health care system has access to EU funds of about 287 million euros for development projects to improve services in four priority areas responsible for the majority of the disease burden: cardiovascular diseases; oncology; perinatal and neonatal care; and mental health conditions.

■ **3.6.3** *Other sources of financing*

Another source of financing related to the provision of health services in Latvia is the Ministry of Welfare (MoW), which is responsible for social care in Latvia and covers most areas of long-term care. Social care is administratively and financially entirely separate from health services. Financing of long-term care facilities is undertaken partly with funds from the state budget (mainly specialized long-term care institutions) and partly by local governments (“general” long-term care institutions, such as care for the elderly). Currently, the MoW implements deinstitutionalization projects, with the main aim of decreasing service provision in institutions and to provide community-based services instead.

Further, occupational health services are by law the responsibility of the employers who cover all costs connected with regular check-ups.

An important source of additional revenues for health care comes from

donations. Several NGOs are active in the field of collecting funds for health care and rehabilitation services. One of the biggest organizations is Ziedodt.lv (<https://www.ziedot.lv/>). Every year Ziedodt provides financial assistance of around 1 million euros. Another organization working actively in this field is the Children’s Hospital Foundation, which in 2017 raised around 1 million euros. Nevertheless, unmet demand for health care services remains high.

■ 3.7 Payment mechanisms

■ 3.7.1 *Paying for health services*

Payment mechanisms for health care services are determined by government regulations (Regulation No. 555). The NHS concludes contracts with service providers according to these regulations. Payments are a mix of prospective and retrospective payments and are based on predefined tariffs.

The main service groups and corresponding payment methods are summarized in Table 3.3. Since 2016, diagnosis-related group (DRG) was used to analyse data and to inform the purchasing decisions of the NHS. Now DRG is used for reimbursement for selected inpatient services.

TABLE 3.3 Provider–payment mechanisms

PAYERS/PROVIDERS	MINISTRY OF HEALTH	OTHER MINISTRIES	MUNICIPALITIES	PRIVATE/ VOLUNTARY HEALTH INSURERS
GPs	C, P4Q	User charges, FFS		FFS
Ambulatory specialists	FFS, Case payment	User charges, FFS		FFS
Other ambulatory provision	FFS	User charges, FFS		FFS
Acute hospitals	FFS, PD, DRG, Case payment, Fixed budget	User charges, FFS		FFS
Other hospitals	Case payment	FFS		FFS
Hospital outpatient	FFS, case payment	User charges, FFS		FFS
Dentists	FFS	FFS		FFS
Pharmacies	FFS	FFS		
Public health services	Fixed budget			
Social care			Salary, fixed budget	

C, capitation; DRG, diagnosis-related group; FFS, fee for service; P4Q, pay for quality; PD, per diem

The current payment system features different methods of payment to providers, but there is no link between payment and national policy objectives, between payment and clinical outcomes, and absence of differentiation of payment for different severity and acuity patients, etc. Payment mechanisms in Latvia do not provide incentives for providers' efficiency and service quality. Different payment methods are used for payment of different services group. Currently, only the payment system for GP services has some elements of quality payments (see section 3.7.1 for more details).

The purchase of health care services paid by the state is characterized as passive; i.e., a predetermined budget is divided among existing service providers. This allocation is based on the compliance of service providers with qualifications and technical support requirements, and on the amount of services provided in the previous year. In order to increase the efficient use of funding for health care, improve the quality of services and increase competition between health care providers, health sector-specific strategic procurement was implemented for several services. In 2018 strategic procurement was implemented for purchasing mammography services and rehabilitation services.

PRIMARY CARE

GPs are paid using a mix of capitation, FFS, fixed practice allowances and quality payments (since 2013). The capitation fee is calculated based on a number of registered patients, amount of chronically ill patients, age structure of patients, and density of population at the area of practice. Fixed payments are made depending on the number of nurses per GPs practice, the number of places where GPs provide services for patients, etc. In addition to capitation payments and fixed payments, GPs also receive FFS payment for additional services provided. All the details on the calculation of fees are included in Regulation No. 555. In addition, GPs are paid a bonus for the fulfilment of a set of quality indicators, including preventive activities, children's care, care for chronically ill patients, response rate to state screening programmes, number of emergency care visits, etc. (see Chapter 6.1).

SECONDARY AMBULATORY CARE SERVICES

The reimbursement of outpatient specialists also consists of three components. First, outpatient specialists are reimbursed by a flat rate per episode of illness. There are seven types of episodes; for example, related to acute disease or trauma, episodes with a first diagnosis of a chronic disease, or prevention episodes. Every outpatient specialty group has its own episode rates (Annex 3, Regulation No. 555) calculated by the NHS. One episode-based payment covers all visits/services performed by a specialist within 30 days. For longer episodes (e.g. chronic illnesses), every month is considered a new episode. Then, FFS payments exist for a list of certain preventive, diagnostic, treatment and rehabilitation interventions/manipulations, with fixed prices per intervention. However, total payment is capped, limiting both number of services to be provided and total amount of money.

Preventive, diagnostic, treatment and rehabilitation interventions in day-hospitals are paid according to a FFS schedule for each intervention, within a budget determined by the contract with the NHS. Diagnostic services (e.g. laboratories, radiology services) are paid for according to FFS and specified tariffs. There is no difference in the form of the agreement or level of fee between state, municipal or private health care providers.

The current system of allocation of resources for purchasing services was criticized by the World Bank experts' team in 2015–2016 (Holla et al., 2016). Specifically, it mentioned that the “current services’ purchasing system has no incentives to deliver a responsive health system and there are little to no quality or efficiency incentives for physicians or hospitals available” (Holla et al., 2016). The deficiencies in the financing system has led to a shortage of health care professionals in certain regions, and difficulties with staff retention outside major metropolitan centres. The current payment system does not have a mechanism for rationalizing provision of services, thus leading to excess demand (overuse of outpatient services and some examination services), not connected with improved outcome. As the distribution of available financing between service providers is based on the previous year, this also leads to different access to services in regions, which is not based on different service need, but often on the availability of specialists in a region in the previous year.

INPATIENT SERVICES

Inpatient services can only be provided by hospitals, listed in Annex 6 of Regulation No. 555. Services to be provided by every hospital and payment mechanisms for every line of services are also defined in that Annex. Every hospital receives a fixed budget for emergency care services and observational wards, calculated based on a number of specialists to be available in the hospital day and night (24/7). Hospitals also receive payments for treatment of patients based on predefined case payments, payments for bed-days (defined for every level of hospital and/or individual hospital) and payments based on DRG. The total annual budget is equally divided between 12 months, and paid to hospitals prospectively once a month by the NHS.

■ 3.7.2 *Paying health care workers*

The state defines the minimum remuneration for health care workers according to the Cabinet of Ministers' regulations (Cabinet of Ministers, 2018a). The average salary for doctors in 2018 was EUR 1 547, and for nurses EUR 929. There are plans to increase average salaries in 2019 to EUR 1 856 for doctors and EUR 1 114 for nurses. The MoH has made increasing remuneration for health care workers the highest priority within the health care reform plan.

Physical and human resources

■ Chapter summary

- In the aftermath of the global financial crisis, there was a major effort in Latvia to decrease the total number of hospital beds, which is now below the levels of neighbouring countries. There was also a strong decline in the number of hospitals, from 88 in 2008 to 63 in 2017.
- In general, the owners of health care institutions (hospitals as well as primary care institutions or practices) have the responsibility for financing investments and there is no centralized planning of capital investments.
- Health workforce challenges are a major concern for the Latvian health system. Although the number of doctors has stabilized in recent years, the number of nurses in Latvia is among the lowest in the EU.
- The number of dentists and pharmacists has remained stable and is similar to the averages for these professions in the EU as a whole. Further, the number of physicians' assistants is increasing, from 1 653 in 2005 to 2 216 in 2017.
- Latvia has a high number of MRI units and CT scanners per 100 000 population, although there are differences in distribution of equipment among state, municipalities, and private institutions.

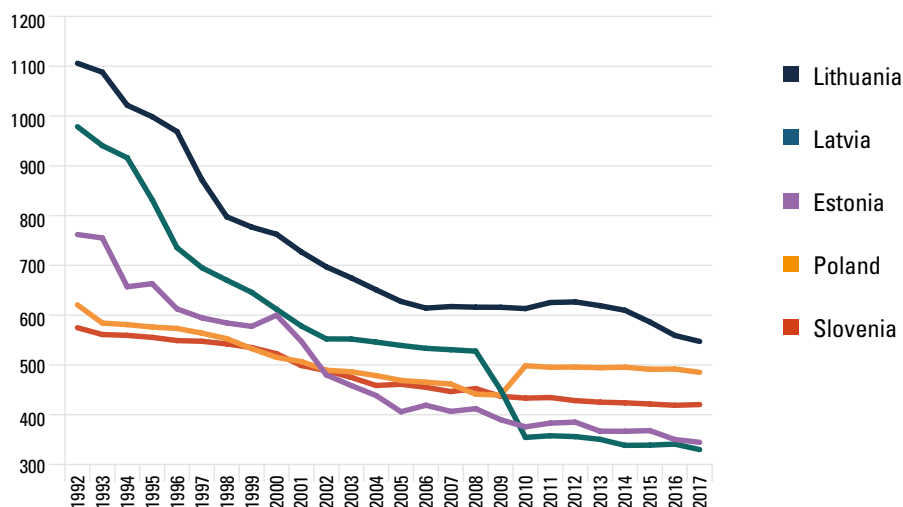
■ 4.1 Physical resources

■ 4.1.1 Infrastructure, capital stock and investments

INFRASTRUCTURE

A main priority in Latvia's health policy agenda is to increase the efficiency of the limited resources available to the health care system. Capital and investment planning has been driven by targets related to the number of beds or other productivity indicators subjected to outpatient health care services. Optimization of health care provider structure has resulted in closure or transformation of inpatient health care providers. Compared with the other Baltic countries, the decrease in the number of acute hospital beds was the largest in Latvia, with 330 beds for 100 000 population in 2017 and a drop of almost 60% since 1992 (Fig. 4.1). At the end of 2017 there were 63 inpatient hospitals in Latvia all together providing 10 812 beds.

FIG. 4.1 Beds in acute hospitals per 100 000 population in Latvia and selected countries, 1992–2017



Note: Different methodology used for Slovenia.

Source: Eurostat, 2018

BOX 4.1 Are health facilities appropriately distributed?

- Health facilities are mainly concentrated in urban areas, leading to geographical barriers to accessing care especially for rural populations. Furthermore, the rural population faces access problems to facilities with the necessary medical equipment as these are mostly located in urban areas.
- Regional hospital networks with centralization and specialization of services, consulting and development of telemedicine are being created to overcome the unequal distribution.

CURRENT CAPITAL STOCK

All hospitals in Latvia operate under the legal status of capital companies (see section 2.7.2). The largest hospitals (over 400 beds) and more than half of all beds are owned by the state. Furthermore, local governments own almost half (46%) of all hospitals. Interestingly, private owners operate more hospitals in total than the state but account for less than 10% of all beds. More than half of all hospitals have fewer than 100 beds.

As a result of budget cuts in 2009 and 2010, the status of several hospitals, which had been renovated and equipped with new technologies (including those equipped using EU funding), was transformed from acute care to long-term care/nursing and rehabilitation facilities.

Among the technical and analytical reports produced by the WBG Reimbursable Advisory Services in 2016, the *Capital investment planning review* recommended that Latvia should change the capital investment strategy from one driven by hospital infrastructure to one driven by service planning to respond to real population needs (World Bank, 2016a). The report revealed that there were only basic mechanisms in place to identify, monitor, and evaluate investments. It found that investments do not necessarily result in improvement of health outcomes, financial protection or responsiveness.

Another report by the WBG Reimbursable Advisory Services in 2016, the *Prospects for Health Sector Reform in Latvia* (Holla et al., 2016) made the following recommendations:

- immediate investment in tertiary and regional hospitals, including trauma and maternity services;
- implementation of strategic purchasing among local hospitals to determine future investments needed in these facilities;
- further investigation of the needs for psychiatric services at the primary, ambulatory specialist, and acute care levels, as well as patients who are currently severely underdiagnosed (for example, patients diagnosed with cancer, diabetes or hypertension).

This report also recommended incorporating more elements of strategic purchasing into NHS contracts. In addition, the report advised the establishment of a health technology assessment (HTA) facility to conduct comprehensive, systematic evaluations of the benefit and impact of the utilization of health technologies.

REGULATION OF CAPITAL INVESTMENT

The approach to capital investment planning in Latvia is rooted in the previous decentralization of health care provision and different forms of ownership of health care institutions. In general, the owners of health care institutions (hospitals as well as primary care institutions or practices) have been responsible for financing investments and there is no centralized planning of capital investments. As a result, capital investments decisions are driven by competition between service providers based on the purchased equipment and services offered rather than actual population health needs. Furthermore, the government guarantees credit for capital investments in state institutions and assumes the risk if providers fail to pay back this credit. The government usually covers debts for state institutions at the end of the year, a phenomenon that providers know to rely on. The need for introducing centralized planning of capital investments is recognized, but the organization of health care provision challenges the process.

INVESTMENT FUNDING

In general, the owners of all health care institutions are responsible for providing investments. The state provides funding for the majority of tertiary and specialized health care services. Local governments (municipalities)

provide investment funding for their municipal hospitals and PHC centres. Investments in private hospitals or other private health care institutions (e.g. private practices) are financed solely by the private owners. In addition, international funding has been available through the European Regional Development Fund (ERDF), the ESF and other foreign financial assistance agencies, based on the recommendations from the Master Plan (World Bank with Sanigest Internacional, 2016) (see section 2.4).

Between 2007 and 2013, the health care system in Latvia had access to EU funds mainly for infrastructure development: EUR 207.7 million from the ERDF and EUR 14.4 million from the ESF. In addition to EU funds, Latvia had to ensure at least 15% co-financing, from either national or municipality budgets or from the recipient's own private financing. Between 2014 and 2020, the Latvian health care system has access to EUR 271.7 million from EU funds, of which 66% goes towards development of health care infrastructure; 20% for health care promotion programmes; 12% for health workforce development programmes and 2% for patients' safety and health care quality system (see section 3.6.2).

■ 4.1.2 *Medical equipment*

EQUIPMENT INFRASTRUCTURE

Latvia is comparatively well equipped with diagnostic imaging technologies (Table 4.1). It has 14 MRI units per million population (compared with 17 in EU27), especially CT scanners (36 per million population compared with 22 in EU28). It is interesting to note the distribution of this equipment, which indicates unbalanced access and potential waste of resources: in 2017, state-owned institutions reported a total of 4 MRI units and 12 CT scanners; municipalities had 6 MRI units and 30 CT scanners, while private institutions owned 17 MRI units and 31 CT scanners in total.

TABLE 4.1 Items of functioning diagnostic imaging technologies per million population

	LATVIA	EU AVERAGE
MRI units	14	17
CT scanners	36	22

■ 4.1.3 *Information technology and e-Health*

The development of an e-Health system has been a long process since the Guidelines on e-Health strategy was adopted in 2005. Since then, the responsible institutions for the implementation of e-Health have changed several times, which simultaneously contributed to changes in project management, strategic and technological solutions.

The current e-Health system serves as an electronic public health care information system for secure, easy and quick record and exchange of medical and patient information. The use of the central e-Health system is voluntary for medical institutions; however, from January 2018 electronic sick leave certificates and prescriptions for state reimbursed pharmaceuticals have been mandatory. Health care institutions are obliged to provide online information regarding referrals for receiving inpatient or hospital services, radiological examinations, overview of outpatient examination, information on vaccinations etc.

The e-Health system consists of two sections: one for the public and one for authorized health care professionals. The public section, accessible through the e-Health portal, provides information on the health care system, healthy lifestyles, databases, etc. After authentication, residents can view their basic health data, check current prescriptions or sick leave certificates. Health care professionals are able to enter and process patient data and prescribe medications and sick leave certificates, while pharmacists can access prescriptions for the patient and mark their delivery to the pharmacy.

The NHS is responsible for the implementation of the national e-Health strategy, establishment of the necessary infrastructure and running of the e-Health support service. Health care providers are responsible for ICT solutions in their institutions. The national e-Health system does not provide technological solutions for data processing in health care institutions. Lacking stakeholder involvement in the development of the national e-Health system caused disagreements in the implementation of the system and signalled a need to invest in making provider systems compatible with the central system. There are still considerable discrepancies concerning the availability of e-Health infrastructure between institutions, with some having established electronic patient records whereas others are lagging far behind. Most health care providers have websites, where they present information to patients; for example, about available services, prices for non-contracted services, and answers to frequently asked questions.

■ 4.2 Human resources

■ 4.2.1 *Planning and registration of human resources*

All health professionals must be certified under the pertinent professional association, which are the Latvian Medical Association, the Latvian Nursing Association or the Latvian Confederation of Professional Organizations of Health Care Personnel (responsible for allied sciences, such as speech therapists, dental technicians, etc.). Certification requirements are regulated by Article 26 of the Medical Treatment Law (1997) and specified in the Cabinet Regulation Procedures for the Certification of Medical Persons No. 943 (Cabinet of Ministers, 2012a). The organizations determine examination programmes and establish examination committees for each specialty, sub-specialty or subsidiary specialty. Certification and recertification is defined in the regulatory enactments for regulated professions. Certification can be performed if a medical practitioner is registered in the state register of medical practitioners and medical support persons. All health care practitioners are listed in a nationwide information system, the Register of Medical Persons, maintained by the HI in accordance with the Cabinet regulation on the Procedure for Establishing, Supplementing and Maintaining the Register of Medical Persons and Medical Support Persons (No. 317, Cabinet of Ministers, 2016a). Registered professionals receive the certificate of a “Medical Person”. The certificate has to be renewed once every 5 years and contains information regarding the right to practice a specific profession. Every health care practitioner has a personal registration number.

Medical practitioners wishing to undergo a recertification must apply to the Certification Authority or the Certification Commission no later than 3 months before the end of the certification period. The application includes a report on the professional activity approved by the head of the medical treatment institution, which reflects the volume, intensity and quality of the work performed during the period of validity of the certificate. Doctors, dentists and physiotherapists during the period of validity of the certificate should collect 250 further education points by attending different professional and scientific activities. Other medical practitioners require 150 education points, and specialists in medical or diagnostic methods need 100 further education points. The Cabinet Regulation No. 943 (Cabinet of Ministers, 2012a) determines the description and amount of further education points.

The Certification Councils for the Latvian Medical Association, the Latvian Nursing Association, or the Latvian Association of Medical Professionals can decide to suspend or revoke the issued certificate.

Training of health professionals in Latvia conforms to EU standards for mutual recognition. Study programmes are developed by professors, associate professors, assistant professors, study programme councils, as well as academic structural units involving student representatives and employers, in accordance with standards for the profession of health care professionals concerned and the requirements of the Law on Higher Education Institutions, the Law on Vocational Education, the State Standards of Higher Education, the Study Programme Licensing Regulations and the Regulations of Study Institutions Study Programmes. New study programmes need to be licensed by the Higher Education Center in accordance with the Cabinet of Ministers Regulations for Licensing Study Programmes. The MoH determines the number of training places at universities and for residencies (specialist training). The Latvian Medical Association monitors specialists moving to other countries and provides the Certificate of Conformity to physicians who are interested in working abroad.

For the period 2006–2015, the Basic Statement on Development of Human Resources for Health Care (Cabinet of Ministers, 2005c) was adopted for the coordination and adjustment of health care personnel remuneration to promote recruitment of new doctors and retain existing staff. However, due to the economic crisis, the document was abandoned in 2010 and salaries of health professionals were generally reduced rather than increased.

The most recent planning document is the conceptual report On the Health System Reform (Cabinet of Ministers, 2017a). It envisages an increase in wages for medical staff, and the adoption of personnel requirements by number of beds and specialties.

As part of the WBG Reimbursable Advisory Services agreement with the Latvian NHS, the Health Care Facilities Master Plan for 2016–2025 by the World Bank (World Bank with Sanigest Internacional, 2016) aims at restructuring Latvia's health facility network, and provides standards for the planning of medical personnel based on the estimate of future demand for health care services in primary, secondary, tertiary and long-term care. The Master Plan recommended strengthening the primary care level and the expansion of coverage of outpatient services nationwide. It suggested replacing individual GP offices by health centres or team oriented, multi-GP practices that could

provide a variety of services. Using risk-adjusted population projections, the plan suggested recruiting an additional 568 primary care physicians to ensure their equal distribution by 2020. This reconfiguration however entails adequate human resources, training programmes and continuous education in place.

A full GP practice starts from 1 800 patients (or 800 children, as there are GPs who take only children). If the number of patients registered by the GP exceeds the number of patients who constitute full practice, GPs have to ensure that at least two other medical practitioners are employed (nurse, assistant doctor or midwife) (Regulation No. 555).

■ 4.2.2 *Trends in the health workforce*

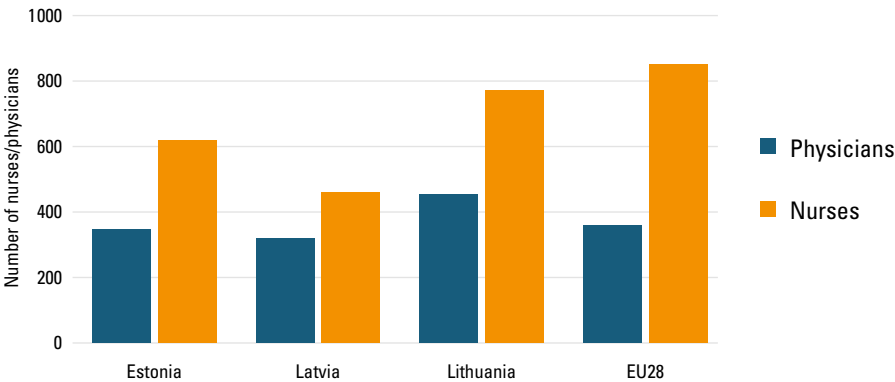
Over the past two decades the health workforce in Latvia has undergone considerable changes.

Family medicine was only introduced as a new specialty in Latvia in 1990 and considerable efforts were undertaken to retrain doctors to become GPs in order to build a stronger primary care.

About 52% of the GP practices are based in the Greater Rīga Area, and are also linked to the higher distribution of population in urban areas and around the capital, with primary care accessibility gradually decreasing with increasing distance from Rīga (see Box 4.2). In 2018, the density of practising medical doctors was more than three times higher in the Rīga area than in Zemgale or Kurzeme. These regional differences persist for medical staff with secondary medical education (i.e. physician assistants, nurses, midwives): 109.9/10 000 inhabitants in Rīga; 48.7 in Zemgale and 48.5 in Kurzeme. However, the overall ratio of medical staff with secondary medical education per medical doctor remains very low and decreased from 2.1 in 2010 to even less than 1.7 in 2016. This could suggest that physicians assume some of the nurses' duties, which could influence both the quality of physicians' work and the care for patients.

In absolute numbers, there were about 9 440 physicians in Latvia in 1990 declining to 6 472 in 2018. Further, many GPs are reaching retirement without being replaced, an issue that is especially present in rural areas (see Box 4.2). In international comparison, the number of physicians per 100 000 population in Latvia in 2017 was just below the EU28 average (Fig. 4.2), while the number of nurses is low in comparison to the other Baltic countries and the EU as a whole.

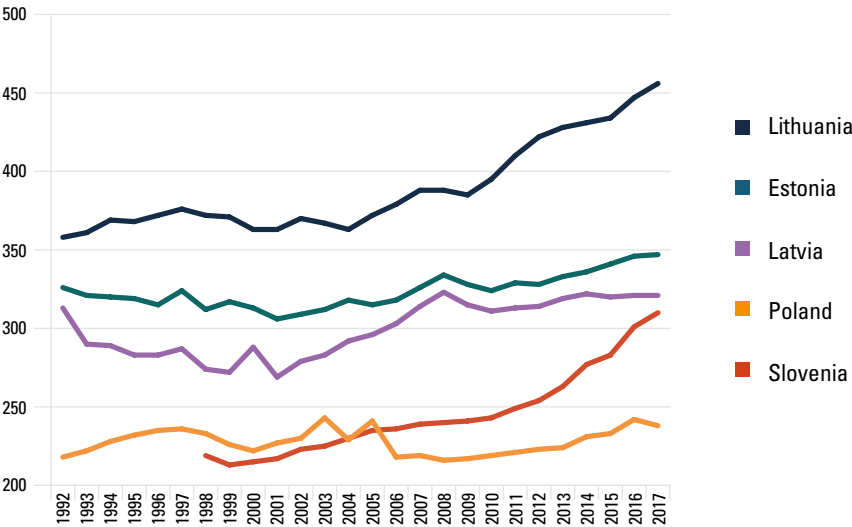
FIG. 4.2 Practising nurses and physicians for 100 000 population, 2017



Source: OECD Health Statistics database, 2019

There has been a relatively continuous increase in the number of doctors since 2001 (Fig. 4.3), and in the period from 2009 to 2014, the proportion of doctor-trainees (including residents) in Latvia increased threefold, from 0.2 to 0.6 per 100 000 inhabitants. However, the number of nurses per population has been decreasing since 2010 and the nurse-to-population ratio is one of the lowest among EU countries.

FIG. 4.3 Number of physicians per 100 000 population in Latvia and selected countries, 1992–2017

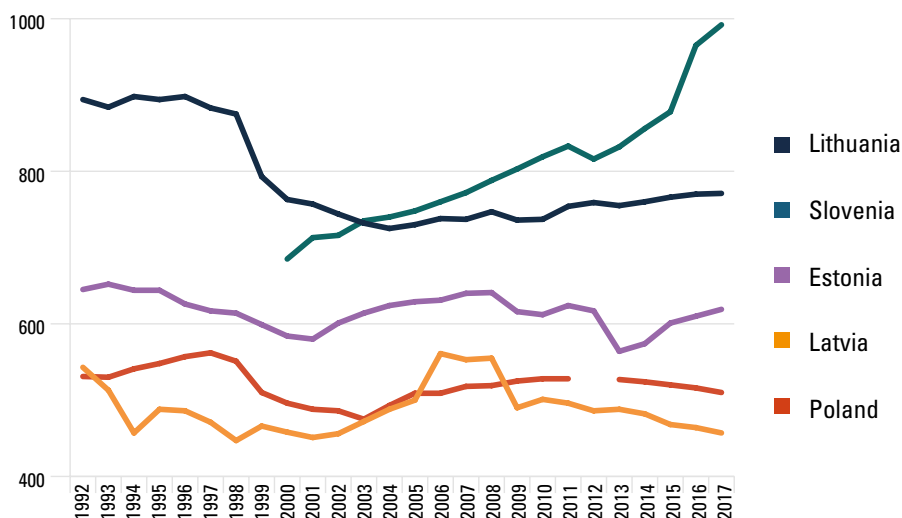


Source: OECD Health Statistics database, 2019

To increase their incomes, doctors often work in multiple workplaces or perform several positions. From 2011 to 2016, the average number of positions per doctor increased from 1.9 to 2.0. This also leads to inequalities between institutions and specialties as, for example, doctors reduce the working hours in inpatient settings and increasingly work in ambulatory secondary care (including private health care). Recent improvements in remuneration for nurses in the primary care sector led to increasing numbers of nurses leaving hospitals. Both developments further exacerbate shortages in the hospital sector (OECD, 2016; World Bank, 2016b).

As indicated in Figure 4.4, Latvia has very low numbers of practising nurses per population. The numbers of nurses increased slightly until 2006 before starting to decline again. In particular, there was a strong decline in 2009, when important budget cuts were implemented in the health sector, including reductions in salary levels and closing down of institutions. In 2017, there were 457 nurses per 100 000 inhabitants (484 per 100 000 if considering nurses and midwives). The absolute number of nurses practising in Latvia in 2018 was 8 332.

FIG. 4.4 Number of nurses per 100 000 population in Latvia and selected countries, 1992–2017



Source: OECD Health Statistics database, 2019

In contrast, the number of physicians' assistants is increasing, going from 1 653 in 2005 to 2 216 in 2017. Physician assistants are a particular feature of Latvia's health care workforce as they relieve the shortages of nurses and family doctors especially in rural areas as they are trained in emergency care and outpatient care for diagnosis and prescribing (OECD, 2016).

The number of dentists began to increase steadily as of 1995 due to the privatization of nearly all dental practices, which raised the attractiveness of this profession. In 2017, there were 0.7 dentists per 1 000 population, which was similar to the number of dentists in the EU28. The total number of practising dentists has decreased from 1 456 in 2008 to 1 361 in 2018. However, this decrease occurred simultaneously with the decrease of the population and thus does not affect the ratio per 1 000 inhabitants, which remains stable at around 0.7.

The number of pharmacists has increased considerably over the past few years for which data are available and is considered to be sufficient to meet the country's needs. In 2014 the number of pharmacists in Latvia (0.8 per 1 000 population) was slightly below the European average (0.86) but far above the EU13 average (0.66).

Since 2000, Latvia has witnessed an increase in the overall number of graduates of health-related study and training. In particular the number of medical graduates increased more than four times between 2000 and 2015 and is above the EU28 average. Despite the continuous growth in numbers of medical graduates, Latvia faces important shortages of health professionals as many graduates choose to work in different professions or move abroad.

BOX 4.2 Are health workers appropriately distributed?

Geographical distribution of health workers represents a major equity and health system challenge, especially for rural populations. Health workers are mainly concentrated in urban areas. In order to attract health personnel to work in rural areas, the Ministry of Health has used an ESF-funded programme "Growth and Employment" to *Improve access to medical and medical support persons providing services to priority health areas living outside Rīga* (Regulation of the Cabinet of Ministers No. 158, 21 March 2017).

■ 4.2.3 *Professional mobility of health workers*

Health professional mobility can contribute to human resource shortages if countries lose significant numbers of well-trained professionals who decide to work abroad in search of better working conditions or salaries. Since the accession of Latvia to the European Union, health professional mobility is thought to have increased considerably, although reliable data is limited. In 2005, when Latvia planned to increase the wages of health workers, one motivation was to prevent the potential emigration of health workers as a result of EU accession (WHO, 2006). However, the planned wage increase was delayed and only recently implemented. Yet, a large proportion of well-trained and experienced specialists leave the public sector to work in the private sector, where incomes are much higher.

A higher number of doctors also decide to migrate to other EU countries requesting certificates of conformity of study from the Latvian Society of Physicians every year. Every year around 100 Latvian doctors hand in the necessary documents to go to work in other countries; for example, Germany and Sweden. In 2017, 85 doctors submitted the documents to the Latvian Medical Association. However, these certificates indicate only the intention to leave the country rather than actual migration, and they do not capture health workers who decide to work in countries outside the EU or Norway. There are no official statistics on the number of graduates that leave Latvia for good or the number of doctors that leave to work in other countries, as this information is not included in the registers of medical persons in Latvia. Also, a significant proportion of medical graduates pursue their residencies in other EU countries and pose a problem for the retention of medical graduates in Latvia.

Migration of nurses also presents an important challenge, given the already low numbers of nurses in Latvia. Low salaries and difficult working conditions have led many nurses to move to other EU countries with better work opportunities where the demand for specialized nurses is high (OECD, 2016). Acknowledging the need to restrain outward migration and increase the supply of health workforce, the Government of Latvia has taken steps to develop a human resources strategy and amended the remuneration system for health professionals (see sections 6.1 and 3.7.2).

There are also some health workers from other countries, such as the Ukraine, who migrate to Latvia.

■ 4.2.4 *Training of health care personnel*

The medical training system in Latvia provides a good basis for professional medical education. Currently, physicians are trained at two universities in Latvia, both located in Rīga: the University of Latvia (under the responsibility of the Ministry of Education) and Rīga Stradiņš University (RSU; under the responsibility of the MoH). In particular, RSU offers a simulation-based approach using virtual environments to train medical students.

Undergraduate medical education lasts 6 years. The first 2 years are exclusively theoretical, while the practical training increases progressively starting in year 3. Medical students have to pass a state exam divided into medical and surgical parts and obtain the Diploma at the Highest Level of Medical Education. Subsequently, physicians must complete a 3- to 6-year postgraduate residency programme to obtain a specialty. Dentistry training lasts 5 years. Medical professional associations carry out certification of specialists. Continuous medical education is offered and organized by universities and medical professional associations. There are different forms of training: courses, seminars etc. Physicians can choose the courses they wish to take. Proof of having participated and passed a certain number of continuous medical courses is required for recertification every 5 years, independent of the type of health care institution in which physicians work.

There are two separate nurse education tracks in Latvia. Firstly, a 3-year vocational training programme at one of five colleges of medicine (former nursing schools) qualifies students to work as nurses. The programme entails at least 1 year of theoretical studies and at least 1.5 years of practical studies. Secondly, since 1990, nurses can train through a 4-year Bachelor study programme at Rīga Stradiņš University or, since 2010, at the University of Latvia. These university programmes are intended to train nurses who wish to pursue supervisory roles or managerial tasks on specialized wards. Nursing students train in several specialties: anaesthesia, intensive and emergency care, child care, internal medicine, outpatient nursing, mental health care nursing, surgical nursing, as well as basic nursing training. All nurses have to be registered in the Register of Medical Persons and Medical Support Persons maintained by the Health Inspectorate. After finishing nursing school, nurses usually start working under the supervision of a specialized (certified) nurse or a certified physician (e.g. in a GP practice), and have to

be certified by the Latvian Nurses Association, which is also responsible for recertification after 5 years.

For midwives, the same two training options exist and the duration of studies is the same as for nurses. Most midwives study at one of the colleges of medicine. If the midwives' programme of education begins after finishing the nursing educational programme, the minimum duration of study is 18 months. Since 2007, RSU has also offered a first level higher professional education study programme "Midwife" and, from 2010, a 4-year Professional Bachelor programme for midwives.

Pharmacists receive their education in the Faculties of Pharmacy within Rīga Stradiņš University and the University of Latvia. Following 5 years of professional education, students receive a Master's Degree in pharmacy. In the University of Latvia students receive a Bachelor's Degree after 3 years of academic study and a Master's Degree after 2 additional years. Pharmacist's assistants are educated within the Rīga 1st Medical College and Stradiņš University Red Cross Medical College in cooperation with RSU. Since 2004, pharmacists and their assistants have had to register with the Latvian Pharmacists Association in order to be allowed to work in a pharmacy. For recertification, which is carried out by the Latvian Pharmacists Association, pharmacists have to submit proof of having obtained 60 credit points of postgraduate training every 3 years.

A Physician Assistant Professional Standard has been developed and approved since 2011. The qualification of physician assistant can be acquired in several medical colleges, RSU, and University of Latvia. This is a 3-year programme. It is possible to work as a physician assistant in various health care institutions.

The Faculty of Rehabilitation at RSU was established in 1993. Around 100 different specialists like physiotherapist, logopedists, ergotherapists, and nutrition specialists graduate each year. Since 1997, RSU has offered a 4-year Bachelor programme in public health. Every year, approximately 20 students graduate. After their Bachelor's Degree, graduates as well as other health professionals (physicians, nurses, etc.) may continue with a 2-year Masters' programme in Public Health, after which they may pursue a doctoral degree.

In 2014, RSU and Rīga International School of Economics and Business Administration (RISEBA) established a joint full-time Professional Masters degree in Health Management and a professional Business Establishment Executive, which lasts 1.5–2 years.

All study programmes in health care at RSU and at the Faculty of Medicine of the University of Latvia are accredited by the Ministry of Education and Science until the year 2022. Cabinet of Ministers Regulation No. 626, adopted on 9 October 2018 (prot. No. 46, § 15) Regulations on the List of Mandatory Occupational Standards and Professional Qualification Requirements and the Procedure for Publishing the Professional Standards and Professional Qualification Requirements Contained Therein determines the professions that need to develop professional standards, including all health care specialties.

The minimum professional qualification requirements for physicians have been defined in line with EU standards by the regulations of the Cabinet of Ministers No. 315 on the Minimum Requirements of the Educational Programme to Receive the Doctor's Professional Qualification (in force since July 2002). The minimum requirements for dentists, pharmacists, nurses and midwives are defined by the regulations of the Cabinet of Ministers on the Minimum Requirements of Educational Programmes for the Acquisition of the Professional Qualification of Dentist, Pharmacist, Nurse and Midwife (in force since February 2002).

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

■ 4.2.5 *Physicians' career paths*

Doctors' career paths depend very much on individual initiative, capabilities and choices. There is no standard procedure in Latvia regarding career development. After completing their basic studies and receiving a doctor's diploma, graduates continue their education in the residency programme of the chosen speciality.

Each year, the Ministry of Health approves the number of resident places by speciality. After completion of postgraduate education, most physicians begin work as a specialist within different health care institution or privately. For sub-specialization, it is necessary to attend further training courses. After several years, it is possible to rise to positions of chief doctor or director,

depending on professional knowledge and management skills. Decisions regarding promotions within the institution are made by the board of the institution, which is nominated by the owners, such as the MoH in the case of state institutions, municipalities or private institutions.

Physicians who choose to work in the public sector can also teach in university hospitals. Doctors are encouraged to pursue a PhD in medicine in order to strengthen research capacity and can pursue a career in academia.

The NHS regulates the countrywide distribution of GPs through contracts with individual practices and the administrations of hospital outpatient institutions or health centres. The restricted public funding influences the number of vacancies available through contracts with the NHS.

■ 4.2.6 *Other health workers' career paths*

Other health workers' career paths also depend on their individual initiatives, capabilities and choices, with no standard procedure in place regarding career development. Every health worker begins work within an institution or privately. There are opportunities to rise in any health career. Nurses and other specialties can pursue master degrees and apply for managerial positions, or within academia.

Provision of services

■ Chapter summary

- The NHS is the main institution responsible for the implementation of state health policies and for ensuring the availability of health care services in the country. The CDPC is the main institution for coordination of public health activities, and infectious and non-infectious disease control.
- Almost all Latvians are registered with a GP, who acts as the main point of entry into the health care system and as the gatekeeper to secondary ambulatory and hospital care, with some exceptions so patients can access a specialist without a referral from the GP. In rural areas, physician's assistants and midwives still provide a considerable share of primary care. A patient with a referral from a GP can freely choose any ambulatory or inpatient care provider (institution) that has a contract with the NHS. Secondary ambulatory care is provided in a range of institutional settings, including self-employed specialists, health centres and hospital outpatient departments.
- Following budget cuts and the restructuring of the hospital sector since 2009, there have been efforts to promote a shift in use from inpatient to outpatient or day care settings. However, the system remains rather hospital-centric.
- Provider choice in the statutory system is often limited, in particular in rural areas, because of waiting lists and limited

providers' alternative. If waiting lists are substantial, and if providers have exceeded the number of treated patients according to their contracts with the NHS, patients have the option to pay directly (100% of costs) for the treatment at contracted or non-contracted providers.

- The pharmaceutical market is growing steadily and pharmaceutical consumption has reached 430 million euros in 2018. The NHS covers pharmaceuticals with varying degrees of co-insurance (100%, 75% or 50% coverage) amounting to 149 million euros in 2018. 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.
- Long-term care in Latvia falls within the scope of social care, which is administratively and financially entirely separate from the health system. Long-term care and other social care are the responsibility of the Ministry of Welfare.

■ 5.1 Public health

Under the governance and supervision of the MoH, the CDPC (a state authority established in 2012 and financed by the national budget) plans, performs and monitors most public health activities. The CDPC took over the functions and tasks of nine different institutions and is responsible for prevention of communicable and noncommunicable diseases, health statistics and monitoring, health promotion, methodological support to health care institutions for patient safety and health care quality. The CDPC operates at two levels – national and regional – with nine structural units in Riga, Daugavpils, Rēzekne, Valmiera, Gulbene, Jelgava, Jēkabpils, Liepāja, Ventspils. These units are responsible for epidemiological surveillance and monitoring, outbreak investigation of infectious diseases and antimicrobial resistance, surveillance of the immunization programme, emergency management and epidemic threat prevention. The Epidemiological Safety Act (1997), Procedures of Registrations of Infectious Diseases; Regulation No. 7 (Cabinet of Ministers, 1999) and other regulations define epidemiological surveillance. Communicable disease surveillance follows the requirements of the EU. PHC services and laboratories play an important role in

the notification of communicable diseases. Legislation requires immediate notification of a single suspected case of a dangerous infectious disease, of three or five cases of some other particular infectious diseases or reasonable suspicions, as well as suspicion of quarantine diseases at state borders, and two or more cases of adverse events following immunization. Individuals living with HIV and AIDS patients, as well as patients with TB and STIs, are also reported to the CDPC (Cabinet of Ministers, 1999, 2008).

Originally within the competencies of the CDPC, the MoH took over health promotion in 2012 after the centralization of health promotion activities due to the economic crisis. The MoH continued to lead health promotion projects financed by the European Social Fund, delegating the work to local municipalities. The CDPC is involved in planning health promotion projects particularly in municipalities lacking health promotion capacity. The CDPC also runs an HIV/AIDS prevention office and supports NGOs in other regions with community-based, low-threshold programme (see Box 5.1). Furthermore, the CDPC regularly disseminates an epidemiological bulletin and provides main health statistical information on its official webpage (www.spkc.gov.lv).

BOX 5.1 Are public health interventions making a difference?

Latvia has one of the highest preventable mortality rates in the EU, and the country is attempting to tackle the disease burden related to behavioural risk factors. A wide range of activities (public awareness campaigns, educational events, seminars etc.) is organized annually for different target groups to promote healthy, physically active lifestyles and healthy, diversified nutrition, and to provide information and practical advice for maintaining health and wellness. Public awareness campaigns are organized to improve knowledge about STIs, HIV prevention and testing, as well as to reduce the stigma about HIV. Low-threshold, harm-reduction services have been operative since 1997 and offer rapid testing, syringe exchange, counselling and the provision of condoms, and information on health risks related to drug injection. Latvia has some of the most restrictive public health policy measures in place. Smoking was classified as violence towards minors, and selling alcohol and energy drinks to minors is forbidden. Alcohol sale is prohibited in shops between 22:00 hours and 8:00 hours. Given the rate of preventable mortality that could be avoided, continuous focus on public health and primary prevention interventions could greatly improve the health of the population.

The CDPC collaborates with the European Centre of Disease Control (ECDC), Early Warning and Response System (EWRS), European Monitoring Centre for Drugs and Drug Addictions (EMCDDA), and WHO. Key partners of the CDPC are NGOs (e.g. The Latvian Red Cross, Association HIV.LV, Dia+logs, Papardes zieds etc.) and state and local government organizations outside the traditional health system (see section 2.5).

Public health laboratories provide essential services including disease and outbreak detection, emergency response, environmental monitoring, and disease surveillance. State and local public health laboratories serve as a focal point for the national system, through their core functions for human, veterinary and food safety, including disease prevention, control, and surveillance; integrated data management; reference and specialized testing; laboratory oversight; emergency response; public health research; training and education; and partnerships and communication. The national reference laboratory (NRL) covers all registered (communicable) infectious diseases.

The National Immunization Council determines the State Immunization Programme, based on WHO guidelines, including the vaccination calendar for child immunizations. The up to date national immunization schedule is in line with the Global (European) Vaccine Action Plan. Vaccination is comprehensive and mandatory, and is provided free of charge at the PHC level by family doctors, paediatricians and doctors' assistants (Cabinet of Ministers, 2000). Adults receive vaccination against diphtheria, tetanus (with specific indications), and influenza (specific age and high-risk groups). In general, vaccination coverage in Latvia is relatively high (>90%) and morbidity from vaccine-preventable diseases is low. Immunization data show increased coverage since 2012, which is now at the EU average for a number of vaccines and for routine childhood vaccinations even higher than WHO's general target of 95%.

The Health Inspectorate (HI) is also involved in public health activities. It carries out evaluations of health care premises, equipment, personnel and documentation to assess compliance with government regulations. The HI controls the compliance the observance of permissible noise limits and levels of vibration in the premises of residential and public buildings and some other standards for environmental safety. It disseminates findings to the public, considers complaints, applications and proposals. It also creates and maintains a cosmetic ingredients database, organizes and performs monitoring of the quality of drinking-water and water in public swimming

places. In the cases specified in regulatory enactments or at the request of a natural or legal person, it assesses the conformity of a construction project and an object with hygiene requirements, and evaluates the risks of chemicals to human health. The HI, together with the MoH, CDPC and State Emergency Medical Service (SEMS) participates in the implementation of the International Health Regulations (IHR) and in the management of emergencies involving threats to public health. SEMS is the national focal point in assurance of the IHR, and is operational 24/7. The capability for timely and accurate disease reporting to international organizations, according to WHO requirements, is generally good in Latvia.

Other institutions, such as the Food and Veterinary Service (under the Ministry of Agriculture), the Road Traffic Safety Directorate (under the Ministry of Traffic), and the State Environmental Service (SES) (under the Ministry of Environmental Protection and Regional Development) are important for the successful implementation of the intersectoral approach for health improvement, which is included in the Public Health Strategy 2014–2020 (see section 6.1). In order to facilitate the development of human biomonitoring and intersectoral collaboration, a Human Biomonitoring Council was established in 2016, with participation of members from the MoH and its public health institutions, Rīga Stradiņš University, the Ministry of Environmental Protection and Regional Development, the Ministry of Agriculture, the Ministry of Education and Science, the Ministry of Welfare, the Latvian Medical Association and the Environmental Consultative Council.

The occupational health services in Latvia are not government financed but employers are obliged to establish an organizational structure for labour protection and provide financing for occupational health. There are several laws and more than 20 regulations related to occupational health and safety. The State Labour Inspectorate under the Ministry of Welfare monitors developments in this scope. Research on this issue exists at Rīga Stradiņš University in the Institute of Occupational and Environmental Health. There are three population-based screening programmes in Latvia: one is for neonates to detect congenital phenylketonuria and hypothyroidism; another for pregnant women; and the third is a breast, colorectal and cervical cancer-screening programme, launched in 2009. The NHS finances all three. Under the cancer-screening programme, women between 25 and 70 years of age are eligible to receive Pap smear screening for cervical

cancer once every 3 years, and mammography screening every other year between age 50 and age 69. The entire population above age 50 should receive faecal occult blood tests once a year. The NHS sends out invitation letters to eligible females for cervical and breast cancer screening. Colorectal cancer screening is the responsibility of GPs (opportunistic screening). In the first year of the programme, the population response was relatively low; according to NHS internal data only 6.95% of the eligible population received colorectal screening, 14.9% Pap smear screening and 21% breast cancer screening. In 2017, the eligible population response reached 13.4% for colorectal screening (from 2014 it has been limited to both women and men from age 50 to 74), 39% for Pap smear and 44% for breast cancer screening.

■ 5.2 Patient pathways

Almost every Latvian citizen (96%) is registered with a GP based on free choice, (children under the age of 18 years can be registered with paediatricians). A partial gatekeeping system exists, with patients requiring referrals from GPs to access most secondary ambulatory and hospital care services, with some exceptions (e.g. for gynaecology).

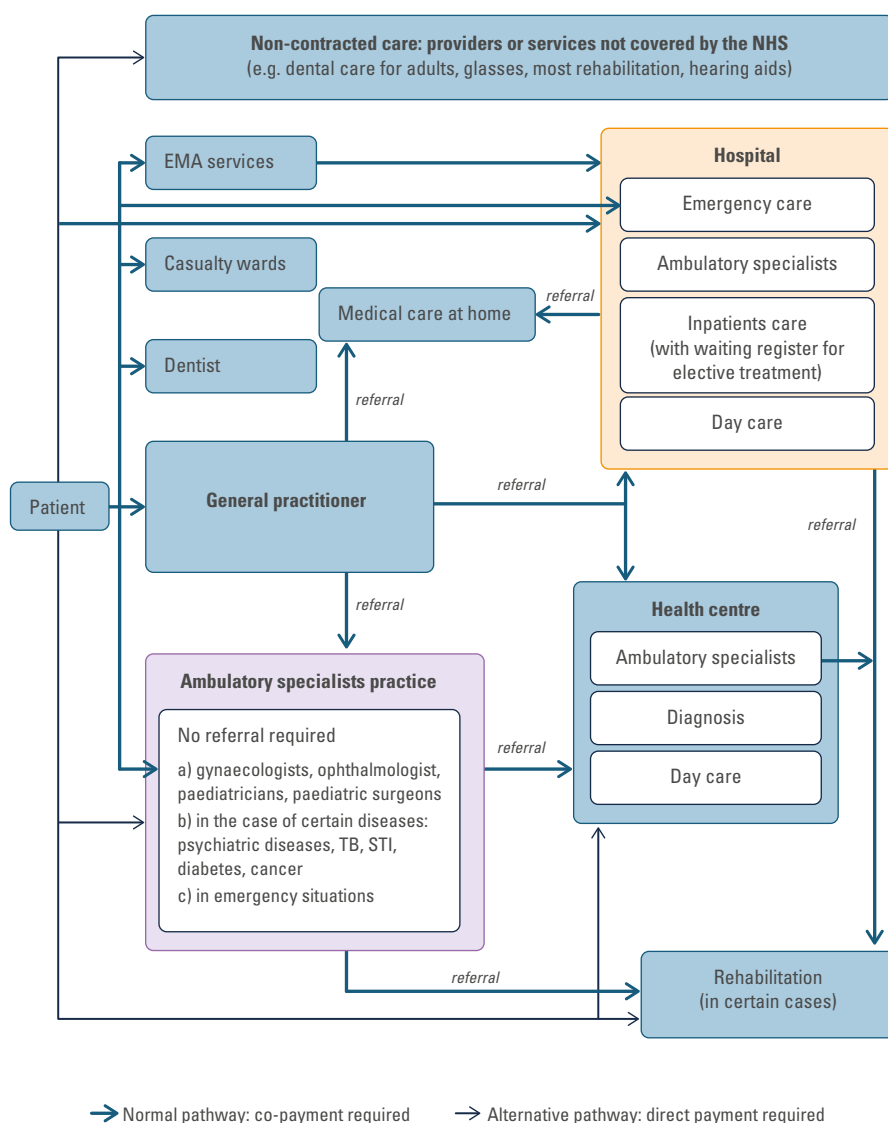
In case of illness the GP either treats the patient directly or issues a referral: 1) to a specialist; 2) for laboratory examinations or diagnostic evaluation; 3) to a day care centre; or 4) to a hospital; (Fig. 5.1). If the patient requires further evaluation or treatment, the specialist may refer the patient 1) to another specialist; 2) for laboratory examinations or diagnostic evaluation; 3) to a day care centre; (d) to a hospital.

A patient with a referral can freely choose any ambulatory or inpatient care provider (institution). The choice depends on whether the patient expects a publicly paid service or is willing to use private insurance or pay for the service out of pocket. In the case of publicly paid services, provider choice is limited since NHS-contracted institutions provide the services, and their availability depends on the annual contracted number of services for each provider. If waiting lists are substantial or if providers exceeded the number of patients to be treated according to their contracts with the NHS, patients have the option to pay directly (100% of costs) for the treatment at contracted or non-contracted providers. Public provider choice can be limited because

of waiting lists and limitations in infrastructure which leads to substantial distances to the closest provider, particularly in rural areas.

EMA services can also refer patients to hospitals (see section 5.5). After hospital discharge, patients may be referred for rehabilitation or home care. Figure 5.1 shows a typical patient pathway through the health care system in Latvia.

FIG. 5.1 Patient flow



■ 5.3 Primary care

Primary health care (PHC) is provided by PHC physicians with their team – physician’s assistants, nurses and midwives, as well as dentists, dental assistants, dental nurses and hygienists. PHC physicians are certified general practitioners (GPs), internists or paediatricians. The majority of PHC physicians are contracted by the NHS for the provision of state-covered PHC services.

GPs carry out basic examinations, diagnostics and treatment for acute and chronic diseases in children, adults and elderly people. They are responsible for prescribing medications from the positive list of drugs and they perform outpatient surgical procedures. They also provide family planning services, preventive activities (screening and immunization), health promotion and health education.

Patients can freely choose to register with any GP in Latvia and may change their doctor at any time. However, catchment areas are defined for every GP and patients from another doctor’s catchment area may be refused if GPs already have 1 800 adult patients or 800 children on their list (except if other family members are already registered with the same doctor). For children under age 18, paediatricians can also act as GPs.

In order to register with a GP, individuals can use the unified electronic health information system or public administration service portal (www.latvija.lv).

On average GPs have 1 500 registered patients. As the maximum amount of patients per practice is not regulated, there are practices with registered patients exceeding 3 000 (NHS, 2018).

If the number of registered persons in practice is less than 2 000, GPs are available at least 20 hours a week, and 25 hours if the number exceeds 2 000 registered persons. The working time of a practice cannot be less than 40 hours a week, to ensure the presence of a doctor or nurse at the place of practice. There should be specific timetables for both morning and evening hours, considering the fact that predetermined appointments should be served within 5 working days and at least 1 hour per day should be designated for patients with acute illness without a prior appointment. Provision of primary health care services have to be ensured within 5 working days.

At other times, the patient can receive care from out-of-hours family doctors, 24-hour hospital admission and emergency wards, urgent care wards in health centres, and emergency care teams (see section 5.5). However,

out-of-hours family doctors are usually available only in urban areas. Citizens can also dial a family doctor's advisory telephone line to receive a medical consultation on how to handle acute illness or exacerbation of chronic illness outside of the doctor's working hours.

GPs must provide home visits to patients who, due to their health conditions, cannot attend an outpatient medical institution. Home visit is a service paid out of pocket according to the price list approved by the GP. The patient groups exempted from the payment are children, disabled people, palliative care, home care patients and those subjected to artificial ventilation of the lungs and persons after the emergency medical team visit. There is a patient fee of EUR 2.85 for home visits for senior patients over 80 years of age, and during flu epidemics.

GPs function as gatekeepers and make referrals to ambulatory specialist and inpatient services. Children and pregnant women have direct access to paediatricians and gynaecologists respectively, and patients with certain diseases (e.g. cancer or diabetes) may go directly to the relevant specialists (see Fig. 5.1). Patients with a referral from the family doctor can freely choose any secondary ambulatory or inpatient care provider contracted by the NHS. Although there are no limits to the number of specialist referrals that a GP can make, the total (financial) volume of prescribed diagnostic investigations is limited. The limit is based on national average diagnostic expenditures per patient, adjusted for the age distribution of registered patients.

As well as GP practices, physician's assistant/midwife points, which are located mostly in rural areas, still provide a considerable share of primary care services, in particular preventive services and chronic care. Most physician's assistant/midwife points are owned and financed by municipalities, and the professionals work as independent providers (without NHS contracts). Some points are owned by municipalities but have contracts with the NHS, while still others are satellite offices of GP practices in rural areas, where GPs from the closest town spend 1 or 2 days per week. In addition, some physicians assistant and nurses are employed by GP practices and ensure that PHC services are available 8 hours a day, 5 days a week. They assist in treatment and preventive work, provide simple diagnostic tests (taking blood samples, etc.) and provide health promotion activities.

The voluntary primary care Quality Programme has been in place since 2013 and was revised in 2017 to include 23 quality indicators covering both the work organization of the doctor's practice and the results of care. The

Programme offers incentives to improve patient care by applying bonuses for the fulfilment of quality criteria. Performance evaluation includes assessment of prevention activities, care of patients with chronic diseases, improving the cost-effectiveness of health care services; and the diversity of provided health care manipulations.

In addition, the reform initiated in 2017 aimed to improve access to primary health care (supported by an additional EUR 9.7 million). To improve the capacity of family doctors and ensure patient access to primary health care, three performance indicators were used:

1. The GP must carry out a regular assessment of the health status of registered patients, ensuring that no less than half of all patients registered with the GP are subject to a standardized annual assessment;
2. Ensure access to family doctor consultation within 5 days;
3. Ensure availability of the GP practice in both early morning and evening hours, with a once-weekly patient reception time from 8:00 hours and a patient reception time extended until 19:00 hours once a week.

Another activity to improve access was the initiation of cooperation between primary care providers. Additional financial support from EU structural funds, a total of EUR 4.5 million, was provided to GP practices that concluded cooperation agreements, and was available for pilot projects to develop primary care centres. As a criterion to receive funding, a cooperation agreement has to be concluded between 2 to 5 GP practices in the location within 5 kilometres from each other. The joint practices are supposed to include a wider range of health care services and at least one of the following specialists – paediatrician, physiotherapist, midwife or gynaecologist – and extend the working hours. Primary care centres should have 3 to 5 GP practices and at least two specialists recruited – paediatrician, physiotherapist, midwife or gynaecologist – as well as a social worker. The working hours of primary care centres will be every working day from 8:00 to 19:00 hours. Municipalities are encouraged to develop these primary care centres, although discussions about the legal form of the cooperation between GPs are not solved (taking into account their private ownership).

Regulation No. 288 (Cabinet of Ministers, 2010b) facilitated the integration of pharmaceutical care into the primary health care, introducing

pharmacies' self-help support services that are allowed in pharmacies, as well as mandatory requirements for doing them (blood pressure measurement, body mass index determination, glucose measurement with a glycometer).

BOX 5.2 What are the key strengths and weaknesses of primary care?

- Avoidable hospital admissions, for asthma and chronic obstructive pulmonary disease, is an indicator of quality and access in primary care. Latvia is slightly above the EU average for avoidable admissions for these two conditions, which can be treated at primary care level, showing room for further improvement.
- **Strengths of primary care:** Comparatively easy and improved access even in rural areas due to recent reforms in 2017 (see Box 4.2); EMS provide information to GPs whose patients called for EMS but were not taken to hospital; quality bonus system for GPs that offers incentives to improve patient care awarding bonuses for the fulfilment of quality criteria.
- **Weaknesses of primary care:** Partial gatekeeping is in place so certain specialists (e.g. paediatricians and gynaecologists) can be accessed directly; a plan to develop joint practices exists but there is no clear legal framework, and there is a lack of integration between GPs and other specialties. There is limited professional role clarification among specialties in primary care, which affects the involvement of the GP within the patient pathways.

■ 5.4 Specialized care

■ 5.4.1 *Specialized ambulatory care*

Specialized ambulatory care is provided in similar institutional settings and under similar ownership structures as primary care (see Fig. 5.1). Some specialists can be accessed directly under certain conditions (for example, with a confirmed diagnosis) without a referral from the family doctor:

- gynaecologist;
- ophthalmologist;
- child surgeon;

- paediatrician;
- psychiatrist or a child psychiatrist;
- pneumonologist (in case of tuberculosis);
- dermato-venerologist;
- endocrinologist;
- oncologist;
- infectologist (in the case of HIV);
- narcologist.

For all other specialists, a referral from a family doctor is required. Patients are free to choose any specialist who has a contract with the NHS.

The dominant setting of secondary ambulatory care provision is independent practice, usually consisting of one specialist physician who works as a self-employed individual (a private sector agent). Most of these practices are located in rented facilities at health centres, which are owned by local governments or private owners. Employed specialists working at hospital outpatient clinics or health centres are the second most important type of ambulatory care provider. The number of specialists working in health centres can differ largely, with small health centres in rural areas having three to five specialists, while large health centres in Riga may employ up to 100 specialists. In addition, a large number of diagnostic centres exist, which provide visual diagnostics (radiologists), laboratory investigations, functional diagnostics (e.g. endoscopy), etc. Many specialists hold jobs in different clinics (hospitals and/or health centres).

All providers offer certain services for which patients must pay out of pocket (or through voluntary health insurance) in cases where publicly funded services are subject to waiting lists. In particular, towards the end of the month or at the end of the year, providers may have already exceeded the number of services contracted with the NHS and, in this case, patients have the option to access the service by paying full costs.

■ 5.4.2 *Day care*

Day care service is a medical or diagnostic service at a medical facility where the patient is provided with treatment and health care for less than 24 hours and no less than 3 hours of treatment or follow-up procedures.

Day care services in Latvia are considered as outpatient services and are paid for from the outpatient care budget of the NHS. About 45% of the state budget funds for the payment of health care services goes to outpatient treatment services (Cabinet of Ministers, 2018b). Patients are usually referred for day care treatment by their family doctors or other specialists.

The purpose of the latest reform of day care services (2018) was to facilitate a reduction in the provision of inpatient health care services with the development of outpatient health services. As a result, outpatient treatment institutions provide health services, which in essence are inpatient health care services without the need for day-to-day patient supervision by the treatment staff. The purpose of the reform was to ensure that day care services are performed during 1 day, while complex procedures requiring long-term postoperative care (2 or 3 days) are excluded from the scope of day care services and are part of the recently launched special hospital programme Scheduled Transient Surgery.

Day care has become an important part of hospital ambulatory activities, especially after the reform in 2009, when the scope and amount of planned care health services were significantly reduced.

The number of services provided in outpatient settings has been rising in recent years. The total number of NHS-contracted outpatient surgical operations increased by around 20% between 2014 and 2017. In the same period, surgical operations in day care hospitals increased even more – by around 36% – and the number of patients admitted in day-hospitals increased by 18.4%.

■ 5.4.3 *Inpatient care*

Inpatient health care services are provided by secondary/tertiary hospitals (university hospitals and multiprofile hospitals), specialized hospitals (e.g. for the treatment of psychiatric patients or trauma) and care hospitals (see section 5.4). Large hospitals are generally located in urban areas, while smaller hospitals often provide services in municipalities with a small number of inhabitants.

Hospitals in Latvia can be classified according to ownership structure and legal status: state hospitals (owned by the central government) and accountable to the MoH; municipal hospitals; and private hospitals. State

hospitals have the status of public limited (stock) companies. Municipal hospitals have the status of limited companies. Municipalities usually own smaller (local) hospitals and some bigger (regional) hospitals, while the MoH owns larger tertiary hospitals (university hospitals) and specialized (monoprofile) hospitals (e.g. psychiatric hospitals). In total, 63 hospitals provided inpatient services in 2017.

Another way to categorize hospitals is based on the services provided: 1) multiprofile hospitals (with at least two specialized wards) at national (university hospitals), regional and local level, with the difference between regional and local being determined by the number of specialties on duty around the clock (at least three specialties in local hospitals and at least seven specialties in regional hospitals); 2) specialized (psychiatry, narcology, maternity, traumatology and rehabilitation) hospitals; and 3) care hospitals, which provide low-intensity non-specialized inpatient care.

NHS-paid services are provided in 31 hospitals. Latvia runs a 5-tiered hospital system:

- 1st level hospitals provide two mandatory profiles – therapeutic and chronic patient care. One internist must be present 24 hours a day to provide emergency medical assistance (six hospitals);
- 2nd level hospitals provide three mandatory profiles – therapeutic, chronic patient care and surgery. 24-hour emergency medical care has to be provided by three specialists – surgeon and internist, anaesthetist or reanimatologist, gynaecologist or paediatrician. In addition 2nd level hospitals can provide gynaecology, pregnancy and childbirth, paediatrics and traumatology services (five hospitals);
- 3rd level hospitals provide activities in seven mandatory profiles: therapeutic, chronic care, surgery, neurology, gynaecology, pregnancy and childbirth, as well as paediatrics. Provision of emergency medical assistance 24 hours a day should be ensured by five specialists – surgeon, anaesthetist or reanimatologist, gynaecologist, paediatrician and internist. In addition, these hospitals can be provided with a traumatology profile (seven hospitals);
- 4th level hospitals (tertiary level) provide activities in 13 profiles and additional profiles according to the specialization of each hospital. This level of hospital is mainly attributed to the so-called

regional hospitals, which serve as hubs for health care networks in the regions (seven hospitals);

- 5th level hospitals (tertiary level) provide activities in 22 mandatory profiles and, according to the specialization, additional profiles (e.g. infection, pregnancy and childbirth) (seven hospitals).

BOX 5.3 Are the efforts to improve integration of care working?

Integration of care is one of the priorities mentioned in the reform plan, and a special unit for integration of care was created in the MoH. There are policies to increase integration in the health sector (for example, patient pathways in oncology), but very limited policies addressing integration between the health and social sectors. There is no specific policy for integrated care of multi-morbidity.

The Public Health Strategy 2014–2020 (Ministry of Health, 2014) foresees the following policy directions:

- planning and implementation of health networks has to take into account the peculiarities and interests of territorial development, as it is necessary to achieve mutual coordination between health policy and regional policy;
- the need to determine the role and functions of state, municipal and private medical institutions in the provision of health care services;
- in order to ensure the rational development of the hospital services in the planning region, it is necessary to evaluate the possibilities of local government cooperation at the level of planning regions;
- A family doctor should be the central person who guides patients within the health system and coordinates the treatment process both horizontally and vertically;
- It is necessary to develop a network of family doctor practices, to improve teamwork, as well as to expand the family doctor's competence and motivation to engage not only in disease diagnostics and treatment, but also in health promotion and disease prevention;
- the development of long-term care should be weighed up in a cooperation between the health and welfare sectors.

The recommendation for joint care practices, although lacking a legal framework for implementation, has potential to facilitate integration. Although the commitment at political level is encouraging, it is too early to assess whether these efforts will result in better integrated care.

The re-profiling of hospitals includes not only the concentration and expansion of services at the appropriate level of to optimize resources, but also aims to provide sufficient volume to maintain quality level and timely access to hospital services.

Due to the ongoing reforms, there is a stable decrease in the number of hospitalizations, from 383 816 in 2012 to 353 388 in 2017 (CDPC, 2018). As for the publicly paid inpatient services, the NHS has covered 88.3% of all hospitalizations in 2017. About 82% of hospitalizations were in emergency hospitals, 15% in specialized hospitals and 3% in care hospitals. Compared with 2016, the number of NHS-paid hospitalizations (323 003 cases) decreased by 10 965 in 2017.

A recently developed set of quality indicators for hospitals is being piloted and assessed by the NHS, but is not still publicly available.

The Placement Plan for Health Care Providers (2018) envisages the identification of a potential region of health care networks at regional level, based on factors such as demography, patient flow, hospitalization trends and operation of hospitals. Priorities within the framework of the reform are the rational use of human resources, infrastructure resources, financial resources, medical equipment and the avoidance of duplication of functions, and the possibility for health care providers to establish eight hospital cooperation areas, where 4th and 5th level hospitals form a single model of cooperation with 1st, 2nd and 3rd level hospitals.

It is critical to base the process of planning on more accurate evaluations of existing and projected resources to increase the financial soundness of the plans (State Audit Office, 2016).

BOX 5.4 What do patients think of the care they receive?

An evaluation survey of the Green Corridor oncology pathway highlighted that communication between patient and doctors is a weakness, as patients lack information about treatment options, side-effects, etc. Certain patient groups may also have difficulties in accessing information regarding their conditions.

In 2018, the MoH ran a patient satisfaction survey for services provided by the EMS, GPs and specialists. Half of the respondents said they were satisfied, and the highest satisfaction rates were linked with quality of communication provided by medical personnel.

■ 5.5 Urgent and emergency care

Emergency care in Latvia is provided by EMA teams or ambulances, emergency departments in hospitals, and urgent medical aid points. Since 1 July 2010, one centralized institution – the SEMS – has provided all EMA services. The SEMS consists of five call centres, which receive emergency calls from all over Latvia. The SEMS is a state agency under the direct control of the Ministry of Health and operates under a fixed budget. Medical personnel are employed and ambulances are owned by the SEMS.

The SEMS has 191 ambulance teams, consisting of at least two (para-) medical staff and one driver. The rest are physicians' teams (including six highly specialized ones, e.g. cardiology), consisting of one medical doctor and a nurse or doctor's assistant, and 167 teams with two paramedical staff. Ambulances are stationed at 103 locations across the country and transport patients to the nearest appropriate hospital according to the plan of hospitalization. In 2017, the SEMS ambulance teams have been on 440 501 calls, about 0.9% (n = 4 111) more than in 2016. Some 53.8% of total calls responded to patients in critical and life-threatening conditions, and the patients were taken to hospitals in 48.9% of cases (SEMS, 2018).

Emergency ambulance teams have to respond to calls within specified time limits. These are:

- responding to 75% of calls within 15 minutes in cities and towns;
- responding to 75% of calls within 25 minutes in rural areas.

A specific part of the SEMS is the Specialized Medical Centre (SMC), which:

- provides telephone consultations to hospitals, SEMS teams, ships;
- provides operations, procedures, on-site hospital counselling and critical medical transportation of sick patients to other hospitals;
- provides patient medical transportation to/from abroad;
- coordinates and provides medical assistance for public events of national importance.

Operational activities in 24-hour mode are provided by two SMC controllers, four specially equipped resuscitation teams (two adult patients, one

for children, one for neonates) and medical professionals of more than 18 different specialties, drivers and operational nurses in standby mode.

Telemedicine (Visual diagnostics, ECG) services are becoming increasingly widespread providing opportunities for timelier assessments of patients' needs, types of help and recognizing cases for advice by phone. Therefore, it is possible to avoid unnecessary SMC specialist visits, rationalize the workload and better assess situations that might need an SEM team. The technological potential of telemedicine is present in all hospitals who provide emergency assistance all over the country.

The SMC can also be called by patients, relatives or employers who are not satisfied by the care provided in the hospital in which the patient is being treated (even outside Latvian borders). However, in these cases, the services are not covered by the state budget but have to be paid directly by the service recipients.

Urgent medical aid points provide services for patients with trauma, sudden illness or an exacerbation of chronic illness requiring urgent intervention by medical practitioners and the need for help goes beyond the competence of primary health care physicians. These points are outpatient units located in either health centres or hospitals, and one is situated at the Children's Clinical University Hospital in Riga. Urgent medical aid points have three levels.

At Level 1, care is provided by one doctor and one nurse or a doctor's assistant – on holidays and on public holidays 24 hours; working days: 16.00 hours to 8.00 hours. At Level 2, two doctors (surgeon/traumatologist and internist or anaesthesiologist/reanimatologist) and one nurse provide care on weekdays, weekends and holidays: 8.00–24.00 hours; during night time – one doctor and one nurse or doctor's assistant. At Level 3, care is provided by two doctors (surgeon/traumatologist and internist or anaesthesiologist-reanimatologist) and one nurse – on weekdays, weekends and holidays: 8.00–24.00 hours; during night time – by two doctors and one nurse or doctor's assistant.

At the end of 2017, there were 15 urgent medical aid points (7 points – Level 1; 5 points – Level 2 and 3 points – Level 3).

One example of a patient pathway in an emergency situation is given below.

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

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

■ 5.6 Pharmaceutical care

Legislation and policies in the field of pharmaceuticals are the responsibility of the Department of Pharmacy of the Ministry of Health. In addition, there are three main institutions concerned with regulation of pharmaceuticals: the SAM (the national drug market authorization agency), the NHS (responsible for reimbursement and pricing decisions) and the HI (responsible for monitoring of market and professional activities). In the pharmaceutical sector, vertical integration with the growing concentration of individual market players is an issue of concern.

Pharmaceutical products are supplied to the public by a regulated distribution system consisting of licensed enterprises that manufacture and/or distribute them. At the end of 2018 there were licensed 31 manufacturers, 85 wholesalers and 816 (782 retail and 36 hospital) pharmacies in Latvia (SAM, 2019). Foreign manufacturers operate through representative offices, subsidiaries or limited liability companies. Some of them perform only promotion and marketing activities, while others have established companies and are licensed as wholesalers. Only a few Latvian pharmacies are authorized to distribute over-the-counter non-prescription medicines on the Internet. Distribution of prescription medicines via the Internet is prohibited.

When launching medicinal products in Latvia, the holder of marketing authorization shall declare the ex-factory price to the SAM. Ex-factory price is not regulated and serves as a basis to calculate the indicative maximum

retail prices. The price of the product is calculated by adding wholesale and retail mark-ups (digressive curve depending on the manufacturer's price) and value added tax to the manufacturer's selling price. The maximum allowable mark-ups are approved by the Cabinet of Ministers. Maximum wholesale and retail margins for pharmaceuticals marketed in general and in the reimbursement system differ. The wholesale mark-ups range from 10% to 18% for general market and from 1% to 10% for reimbursable products. The pharmacy mark-ups range from 10% to 40% for general market and from 5% to 30% and a fixed sum of EUR 6.05 for wholesale price over EUR 71.14 for reimbursable products. The VAT for pharmaceuticals is 12%, which is higher than in Estonia (9%) and Lithuania (5%). The list of medicines registered in Latvia and their retail (pharmacy) prices is available on the SAM website (<https://www.zva.gov.lv/lv/pacientiem-un-sabiedribai/zales>). In cases in which a person has doubts about the validity of the price of the medicine, it must be reported to the HI.

In 2018 the total turnover of pharmaceutical wholesalers in Latvia and abroad was EUR 931.54 million (excluding VAT), which increased by 10% compared with the previous year. Pharmaceutical wholesalers continue to increase the sales of medicines in Latvia and abroad. The volume of medicines sold in Latvia in 2018 amounts to EUR 591 million. Meanwhile, the pharmaceutical exports increased by 27% and reached EUR 259.03 million (excluding VAT). Domestic production on average accounts for about 5% of the pharmaceutical market (2010–2018). However, there was a rapid growth in 2018, when the share of local production comprised 11.6% of the internal consumption. The growth in turnover can be related to the growth of repackaging of products by the wholesale companies.

The pharmaceutical market steadily grows and pharmaceutical consumption has reached 430 million euros in 2018 (SAM, 2018a). The annual growth of the market (since 2011) is on average 6%. The retail pharmaceutical market comprises 359 million euros, sales to hospitals, 51 million euros and sales to doctors' practices, 19 million euros (in wholesale prices, excluding VAT). In 2018, there was a significant increase compared with 2017 in the sales of pharmaceuticals to doctors' practices (4.6 times) and a slight decrease to hospitals (by 5 million euros). Pharmacy chains (three or more pharmacies) account for 80% of total retail pharmaceutical sales. The share of general type pharmacy chains in the market continues to grow (in 2017, 76.57%; in 2016, 76.2%; in 2015, 74.71%; in 2014, 68%).

The turnover of extemporal medicines in general type pharmacies amounts to 2.15 million euros (excluding VAT) in 2018, which is 4% less than in 2017 (SAM, 2019).

Hospitals purchase medicines from wholesalers or pharmacies. The NHS provides centralized procurement of medicinal products and medical devices. These apply to vaccines, syringes, standard tuberculin, peritoneal dialysis products, phenylketonuria products and products for other genetically determined diseases, vision correction products for children, immunobiological preparations, and, since April 2017, artificial mixtures for infants and follow-on formulae for children under 1 year born to HIV-infected mothers. From 2019, parenteral treatments will also be centrally purchased for the treatment of oncological diseases.

In 2017, the cost of centralized purchase of medicines and materials was EUR 11.7 million. Compared with 2016, this cost increased by EUR 163 770 (14%) due to increase in purchases of vaccines and peritoneal dialysis products (NHS, 2018). For other medicines, each medical institution organizes annual purchases.

The NHS approves a list of medicinal products necessary for provision of inpatient health care services paid for from the state budget. In each medical institution, a responsible person with pharmaceutical education is appointed for the circulation of medicines. Multiprofile hospitals form a closed-type pharmacy (Regulation No. 222, 2007).

In 2017, the reimbursement of pharmaceuticals accounted for a total of EUR 149.43 million, an average increase of 31% in monetary terms and 29% in natural units (DDDs per 10 000 inhabitants) compared with 2012. Reimbursement was provided for 708 067 patients in 2016, an increase of 5.3% from 2015. On average reimbursable pharmaceuticals per patient was EUR 213.56. Individual reimbursement was provided for 833 (584 in 2016) patients amounting for EUR 4.47 million. In 2017, a total of 6.5 million reimbursable prescriptions (List A, B, C and M medicines) were issued, an increase of 3.2% (6 367 million prescriptions issued in 2016). The average price of one prescription for List A, B, C and M medicines is EUR 22.81 (2016). The average price for one prescription for children up to 2-year-olds, pregnant women or postpartum women (List M) is EUR 5.40.

Patients' co-payments comprise a considerable part of the reimbursement system (due to partial reimbursement at 50% or 75% level). The co-payments amounted to EUR 16.94 million in 2017 (EUR 16.48 million in 2016).

BOX 5.5 Is there waste in pharmaceutical spending?

About 31% of Latvia's health care budget was spent on medicines and medical devices in 2017— a proportion much higher than the EU average of 18%. However, in absolute terms, pharmaceutical spending in Latvia was one third below the EU average. The higher level of pharmaceutical expenditure in Latvia should also consider that pharmaceutical prices are to an extent inelastic across the EU, and therefore absorb a higher share of the budget in countries where health spending is overall low.

To secure cost-effectiveness of the system:

- reimbursement decisions are based on the economic evaluation of pharmaceuticals and the budget impact analysis;
- the reference price system is applied for interchangeable products (International Nonproprietary Names –INN – or pharmaco-therapeutic group level);
- doctors are obliged to prescribe the pharmaceuticals by INN for all patients beginning from 1 April 2020;
- pharmacists must provide the reference product, which is the cheapest alternative on the reference group;
- Marketing Authorization holders should provide information on product prices in other countries annually to allow the NHS to review the prices;
- the NHS sets the recommended prescribing budgets for doctors and controls the prescription volumes;
- doctors have to follow rational pharmacotherapy guidelines issued by the NHS.

Recent reforms in the pharmaceutical reimbursement system are aimed to increase access and affordability.

A significant change in the price setting procedure for the reimbursable pharmaceuticals came into force in 2018, with the introduction of a price corridor set at the level of 100% from the cheapest product in the reference group for identical active substance pharmaceuticals, with the aim to reduce patient co-payments. The price will be reduced gradually by 20% in 2018 and 2019. Before that, there were cases when prices differed up to 800%.

In addition, in 2018 the amount of reimbursement increased from 50% to 100% for several diagnoses, including rare diseases (interstitial lung

diseases, Sarcoidosis, motor neuron disease, Huntington disease, copper metabolism disorders). In 2019, the reimbursable diagnoses in the mental and behavioural disorders group were extended and the amount of reimbursement for a range of diagnosis increased from 50 to 75% and 100%.

■ 5.7 Rehabilitation/intermediate care

Individual professionals, at health centres and outpatient rehabilitation units in hospitals, provide ambulatory rehabilitation and physiotherapy. Inpatient rehabilitation is provided at the National Rehabilitation Centre and at several multiprofile hospitals.

Individual specialists provide ambulatory rehabilitation (mono-professional rehabilitation). They can be physical medicine and rehabilitation specialists, physical medicine physicians, rehabilitologists or functional specialists, who have to ensure that care is coordinated with other health professionals and medical support persons. Additionally, rehabilitation services are provided in day-hospital settings.

Inpatient rehabilitation consists of a range of services provided by multidisciplinary rehabilitation teams (multi-professional rehabilitation). For patients with chronic functional limitations, a long-term medical rehabilitation programme exists; this includes active case management of patients to ensure that patients' functional conditions are monitored at regular intervals (at least once a year) and that the different rehabilitation services which are needed are coordinated with other medical professionals, the family doctor and municipalities' social services.

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

The following medical rehabilitation services are covered by the NHS:

- acute rehabilitation services provided at the same time as the treatment of an acute illness or exacerbation of the disease for up to 3 months from the onset of the disease or the onset of the exacerbation of the disease;
- sub-acute rehabilitation services provided up to 6 months from

the onset of the disease or the onset of treatment for exacerbation of the disease;

- Long-term rehabilitation services in cases of chronic dysfunction, which are provided more than 6 months after the onset of the disease or exacerbation of the disease at the start of treatment, or in case of perinatal dysfunction, including the patient in the dynamic monitoring of medical rehabilitation.

For the provision of state financed services the medical institution shall provide outpatient medical rehabilitation services in the following order of priority:

- persons with acute and sub-acute dysfunction;
- persons with chronic functioning disorders at the intervals specified in the rehabilitation plan under dynamic observation;
- Other persons with functional disabilities.

After surgical operations, nurses or physician's assistants, under the supervision of family doctors, also provide rehabilitation care at home (home care). Medical care at home is also provided for chronic immobile patients to decrease the need for hospitalization.

Since April 2019, strategic purchasing was implemented, and acute rehabilitation services are provided by selected institutions. In addition, there are social rehabilitation providers, which are under the responsibility of the Ministry of Welfare (MoW). Social rehabilitation is provided for disabled persons; for example, visually impaired persons, for hearing-impaired persons and for persons with functional disabilities.

■ 5.8 Long-term care

There are two types of long-term social care facilities in Latvia, which differ by the degree of specialization and the source of financing:

- Specialized state social care institutions, financed by the state budget through the MoW for people with mental disorders and serious disabilities, blind people, and orphaned children. There are

five state social care centres with 27 branches (2018) with 4 054 patients (223 children and 3 831 adults, including 3 631 with mental health problems).

- General social care institutions, financed by local governments, for certain groups such as the elderly and orphaned children from 2 to 18 years of age. There are 135 municipal social care institutions with 8 129 clients (children and adults) (2018).

The level of care is determined by the social services in municipalities or social service providers based on a person's needs evaluation.

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).

The Guidelines for the Development of Social Services 2014–2020 (Government Order No. 589, 2013) outline the future development of the social service system with the aim of increasing its quality and ensuring effective management. Recent reforms are aimed at the development of alternative forms of social care and the reduction of institutional social care.

The measures included in the guidelines focus on: 1) deinstitutionalization; 2) socially based, continuous and personalized social services; and 3) effective management of social services.

Within the framework of deinstitutionalization, there are plans to study the needs of clients living in social care institutions and the development of infrastructure and services suited to individual needs in local governments. One aim is to limit the placement of adult persons in care institutions, if there are options for them to receive alternative services. The second aim is to reduce the number of clients placed in state-funded social care institutions by 1 000, and place 700 clients from the mentioned institutions in the community. Services to social care institutions for new clients will only be offered in extreme cases.

Community-based services (such as home care, day care centres, support staff) will consider the needs of different customer groups – people with mental disabilities, children, seniors, people with physical disabilities and others, as well as tighter cooperation with the health care system.

With regards to the effective management of social services, special attention will be paid to the development of multidisciplinary services,

including services for palliative care, rehabilitation of persons with addiction problems, provision of access to mental health outpatient services, development of community-based rehabilitation services, and cross-sectoral health promotion and prevention.

Residential care is a boarding house offering social care services for adults between home care and long-term social care and social rehabilitation institution. Patients of boarding houses have less challenging functional disorders than those in long-term social care institutions.

■ 5.9 Services for informal carers

There is no reliable information on the number of informal carers, but there are some support services for caregivers. For example, family financial support (EUR 213 per month in 2018) and transportation subsidies (EUR 79 for 6 months) are available for people caring for children with needs.

■ 5.10 Palliative care

Palliative care is provided at primary, secondary and tertiary levels.

Primary level services include general (non-specialized) palliative care at home provided by the GP, ambulatory nurse or social worker. Secondary-level services at ambulatory level are specialist consultations, services provided by the so-called Pain cabinets and day care services. Pain cabinets and day care services are additional secondary care services. Tertiary level palliative services are provided in the specialized palliative care units in the Latvian Oncology Center and Children's Clinical University Hospital.

The first palliative care unit in the Latvian Oncology Center was established in 1997, with 25 beds and an interdisciplinary team (doctors, nurses, social worker, psychotherapist, chaplain), which provides a model of bio-psycho-social and mental care. Specialists from other hospital departments are also involved, if necessary. On average, 700–800 patients are hospitalized annually.

Specialized palliative care for children was established in 1998 when the first palliative care unit opened at the Children's Clinical University Hospital. The service provides consultations for patients within various departments of the hospital, consultations with patients' relatives throughout

Latvia, and home care for patients who live in Rīga City and surrounding areas; 24-hour telephone consultancy on palliative care for a child and his/her relatives is available.

Palliative care has been set as one of the priorities highlighted by the Oncological Disease Control Programme (2009) recommending care to be provided by a multidisciplinary team consisting of specialized oncologists, nurses, nurse assistants, social workers, chaplains and voluntary care providers. However, the programme has not been fully implemented due to insufficient resources.

Several medical institutions offer temporary social care beds as a kind of municipal social service. In line with hospital reforms, several small hospitals transformed into social and palliative care centres (Bauska, Iecava, Irlava, Līvāni, Mazsalaca).

Palliative care beds are situated in the seven regional multiprofile hospitals (Daugavpils, Jēkabpils, 2 in Liepāja, Rēzekne, Valmiera, Ventspils). Financing for palliative inpatient treatment is the same as for other inpatients. As the demand for palliative care exceeds the provision covered by public funds, palliative care is also provided as an out-of-pocket service.

■ 5.11 Mental health care

Mental health is an important focus area of the Public Health Strategy 2014–2020. Mental health promotion, disease prevention, analysis of statistics, conducting surveys and writing reports come under the responsibility of CDPC.

The register of patients with psychiatric and behavioural disorders (hereinafter – the Register), maintained by 2018 by the CDPC is an important source of information for identifying the situation in the field of mental health. Prevalence of mental disorders has slightly increased from 3 753 persons per 100 000 inhabitants in 2011 to 4 635 in 2017 (CDPC, 2018). At the end of 2016, there were 88 319 patients with psychiatric and behavioural disorders, which is 4.5% of Latvian population.

The number of patients enrolled in the Register since 2011 gradually decreased until 2015, but in 2016 there was a slight increase. In absolute numbers in 2016, 5 810 patients were in the Registry, or 11.5% (599 patients) more than in 2015. The number of patients has grown fastest in the age group

of 70 years and over, which can be explained by the prevalence of mental and behavioural disorders associated with age.

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. Regarding the organization of psychiatric assistance, a greater emphasis should be placed on strengthening the outpatient care phase by creating a “psychiatric pyramid” where the patient at any stage of care could receive outpatient psychiatric services without waiting in a long queue. This would enable hospitals to deal with acute and complex situations. A main challenge is the restricted availability of rehabilitation services for psychiatric patients, due to insufficient funding for psychiatric rehabilitation programmes and psychotherapy.

NHS-paid psychiatric care is provided in specialized psychiatric hospitals, hospitals with psychiatric beds, psychiatric practices, ambulatory centres and social care institutions.

The different psychiatric care settings are described in more detail in the following subsections.

■ 5.11.1 *Inpatient care*

Inpatient care provides treatment for acute disorders and offers the Minnesota Psychotherapeutic 28-Day Treatment Programme, isolating the patient from the usual environment.

Hospital admission are provided according to referrals by a psychiatrist, a GP or an emergency medical service.

Inpatient care is provided by seven specialized psycho-neurological hospitals (located in Rīga, Jelgava, Daugavpils, Strenči, Akniste and Ainazi) and 35 general hospitals. In 2016, compared with 2011, the average number of inpatient beds decreased by 6.6% while the hospitalization rates remained on the same level. Patients are often hospitalized not for medical but for social-psychological indications that are not solved at the pre-hospital stage.

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

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

The Children's Psychiatric Clinic of the Children's Clinical University Hospital provides high-level differential diagnostics and treatment for various mental illnesses in collaboration with other clinics. In collaboration with the Medical Genetics and Prenatal Diagnostic Clinic, several scientific studies have been launched on hereditary metabolic diseases and mental disorders. Clinic develops work with children with autism spectrum disorders, improving their early diagnosis and correction methods.

Long-term care psychiatric services are classified under social care, which are under the responsibility of the MoW.

■ 5.11.2 *Day care*

Day care services include day care beds in psychiatric hospitals, ambulatory day care centres, social day care, residential care services (up to 10 hours per week covered from the budget of MoW), and temporary placement of a child in an institution.

Ambulatory day care centres' treatment usually lasts up to 1 month. If necessary, treatment may be extended or the patient is advised to be treated in a hospital unit. For a more successful treatment, a multidisciplinary team method is used in day care centres. Treatment days in hospital are free. In order to apply for state-funded day care treatment, a referral from a psychiatrist is required.

Day care services have become more available and there was a substantial increase in the number of patients treated in day care settings. In 2016, the number of day care patients increased by 70.5% compared with 2011.

■ 5.11.3 *Outpatient care*

Outpatient counselling departments provide psychiatric counselling and, if necessary, recommend a psychiatrist. Visits to specialists increased by 16.8% between 2016 and 2011, and GP visits due to mental disorders by 38%.

Outpatient psychiatric care is provided in a variety of settings:

- private psychiatric practices, some of which are contracted by the NHS;
- two psychiatric assistance centres in Rīga (including day care services);
- four outpatient departments at psychiatric and general hospitals, in Rīga, Jelgava, Liepāja and Daugavpils;
- outpatient department at the Children's Clinical University Hospital;
- municipal psychiatric consulting rooms in primary care centres.

■ 5.12 Dental care

Dental care services in Latvia are provided both by public and private providers. There were 1 429 practising dentists and 809 dental institutions in Latvia in 2018. About 62% of dental practitioners have contractual relations with the NHS for providing dental services covered by the state budget. No less than 11% of primary health care funding is redirected for dental care. Dental services, including dental hygiene, are fully paid from the state budget only until 18 years of age. Orthodontic treatment is paid from state budget to persons under 22 years of age only in cases of congenital facial–jaw splits. For Chernobyl Nuclear Power Plant victims, the state pays for 50% of dental care, while it fully covers dental prosthesis.

Currently, the CDPC provides prevention and organizational methodological activities for dental care for children and evaluation of the availability and accessibility of oral health through the network of Oral Health Centres (OHC) including five regional and 25 local centres located throughout Latvia. CDPC took over the function from Paul Stradiņš Clinical University hospital in 2017.

Children under the age of 18 are the main target group for oral health prevention activities providing suggestions to improve dental care, fluorine programmes and regular monitoring – once every 3 years – for 6-, 12- and 17-year-olds. In 2017, 180 233 children received state-funded dental services (at a cost of 8.5 million euros). About 73.7% of children used dentist services, which is 3.5% less than in 2016, while 53.8% of children used dental

hygienist services, 1.6% more than in the previous year (NHS, 2018). Recent prevention activities are justified by the results of the study Oral Health Study among schoolchildren (2015/2016) (CDPC, 2016), which revealed that caries prevalence among 12-year-old pupils is one of the highest in Europe.

To ensure access to dental health services to people in remote areas, with disabilities and residents of nursing homes and orphanages, a mobile dentistry project was launched. Three specialized mobile dental buses, with medical equipment including dental X-ray, provide preventive examinations and treatments of cavities. Services are provided by dental practitioners from the closest area to ensure continuity of service provision. In 2017, 6 903 mobile dental services were provided, 7.1% less than in the previous year. Mobile dentist visits account for approximately 1.4% of total dental attendance. The CDPC took over the mobile dental buses from Paul Stradiņš Clinical University hospitals to continue providing state-funded dental care to children under 18 years old in remote regions of Latvia. The OHC are planning more mobile dental bus outings. Planning involves expanding the list of educational institutions recommended by the NHS. Due to the continuous annual monitoring of children's cavities, the estimated duration of treatment decreases, and mobile buses have the opportunity to visit new educational institutions.

The Latvian Dental Association (LDA) is responsible for the development and implementation of policy in the field of dentistry, organizing members' professional training and further education activities, certification and recertification of dentists. LDA develops tariffs for medical services to be covered by the state budget and submits them to the NHS for approval. In the case of private dental services, there is a free market and providers can set their own tariffs.

Principal health reforms

■ Chapter summary

- The reforms that took place between 2007 and 2012 can be seen in the context of pre- and post-economic crisis. The period before the crisis (2007–2008) was characterized by a continuing institutional centralization process and a slow shift away from hospital to outpatient care. In the immediate post-crisis period (2009–2012), Latvia witnessed a shock-type reform with a dramatic reduction in the number of hospitals and far-reaching changes of health care administrative institutions.
- In the years from 2013 to today, the improvement of accessibility, quality and cost-effectiveness of the health care services, as well as a focus on certain diseases, have been a high priority on the Latvian political agenda.
- The Public Health Strategy 2014–2020, which updates the Public Health Strategy 2011–2017 is a key reform. It aims to help improve population health status and focuses on increasing healthy life years, as well as reducing the number of potential life years lost. A mid-term evaluation of the Strategy found that the problems identified in the Strategy are still relevant, and the proposed strategic directions need to be reinforced.
- Important priorities for the future include a plan to improve the availability of reimbursable medicines, as according to an NHS

- analysis, in 2017 patients overpaid 25 million euros for reimbursable medicines; the promotion of a healthy and active lifestyle; quality and efficiency of health care services; an emphasis on a person-centred health care approach and the development of integrated health care, as well as improving accessibility and reducing health inequalities; tackle the high prevalence of some infectious diseases.
- Plans for the future also envisage progress in the development of clinical algorithms, clinical pathways and performance indicators for the priority health conditions; the introduction of a national health care quality system, an approach towards outcomes-based payment system and the introduction of comprehensive health technology assessment system to encourage transparency and efficiency in the system.

■ 6.1 Analysis of recent reforms

Latvia was among the countries that were hit hardest by the economic crisis of 2008. In analysing the reforms that took place in Latvia from 2007 to today, it is useful to define the reforms according to pre- and post-crisis period, as these periods mark a very different pace and scope of reforms. Just before the crisis (2007–2008) Latvia underwent a period of relatively few changes in the health care system. As the magnitude of the economic crisis had not yet emerged, there was no urgent need for reform. At the same time, politics and personal relationships obstructed a number of necessary (but painful) reforms to the health system's institutional structures or hospitals. Nevertheless, several small agencies under the Ministry of Health were incorporated into the Public Health Agency and the availability of specialized ambulatory care and day-hospital services was improved.

The post-crisis period (2009–2012) was kicked off by the enormous financial constraints resulting from the financial and economic crisis in 2009, when the GDP contracted by almost 18% (see section 1.2). The subsequent reform process was very quick and was pushed through, almost without discussions and scientific analyses, within approximately 1 year: waiting times were extended; cost-sharing was expanded; and wages for health workers were cut (van Ginneken et al., 2012). The financial crisis provided the impetus to implement structural reforms that had been on the agenda for a long

time but had not been carried out because of local opposition, such as the downsizing of the hospital sector (Mitenbergs et al., 2012).

Below are the main reforms from the second stage, which still have implications today:

- **2009:** Cabinet Approval of the Safety Net Strategy – to avoid harming the most vulnerable populations during the economic crisis (in the health sector it entailed the exemption of people on low incomes from user charges).
- **2010:** Start of the e-Health project funded by EU Funds and continued until 2013.
- **2011:** Cabinet Approval of Public Health Strategy 2011–2017.
- **2011:** Creation of the NHS as the result of merging the Health Payment Centre (HPC) with the Centre of Health Economics.
- **2012:** Creation of the CDPC as the new National Institute of Public Health.
- **2012:** Political decision to introduce the Nord-DRG system for hospitals: preparatory work for implementation.

TABLE 6.1 Major health reforms

THIRD STAGE 2013–2019	
(ongoing)	Programme of Outpatient and Inpatient Health Care Providers using 1EU funds to improve infrastructure and purchase equipment.
2013	Approved Tuberculosis Prevention Restriction Plan 2013–2015, which also included the external evaluation report of the WHO Regional Office for European and European Centre for Disease Prevention and Control on tuberculosis monitoring proposals for control measures in Latvia.
2013	Introduction of monitoring of the quality of inpatient health care services which includes both qualitative and quantitative evaluation criteria.
2013	Establishment of the Medical Risk Fund with the aim of providing the patients with the opportunity to assert their rights and receive compensation through out-of-court procedures, which is significantly more accessible and faster. The Fund is administered by the National Health Service and the Health Inspectorate.
2013	Latvia joined the WHO Network of Healthy Municipalities and created the national network for healthy municipalities.
2014	Government approved the Public Health Strategy 2014–2020 which updates Public Health Strategy 2011–2017: priority areas were identified, with targeted actions planned and investment in available investments for 2014–2020, aiming to significantly improve Latvian public health indicators.
2014	Primary Health Care Development Plan 2014–2016.
2014	Gradual implementation of the DRG system (Government Action Plan; Public Health Strategy 2014–2020 which updates Public Health Strategy 2011–2017).

2014	Action Plan for Alcohol Abatement and Alcohol Limitation 2012–2014 and Alcoholic Beverages Circulation Act.
2014	Tobacco law introduces additional smoking restrictions in public places.
2014	First, the Regulations on the Unified Health Electronic Information System are adopted, which establishes the Health Information System Manager, data stored in the Health Information System and the processing procedure, as well as the procedure for issuing the data (Cabinet of Ministers, 2014b).
2016	Introduction of Green Corridors (patient pathways in oncology), highlighting the role of GPs in early diagnostics (over 1 year, more than 5 000 patients received the necessary examinations and medical advice if there was a reasonable suspicion of an oncological disease). In the following years, the measures were expanded with new tumour localizations and appropriate investigative algorithms.
2016	Ban on junk food in schools, social and health care institutions and introduction of nutrition norms (Cabinet of Ministers, 2012b).
2016	Prohibition of the sale of energy drinks to persons under the age of 18 years and these persons may not purchase them, as well as certain restrictions on the distribution and advertising of energy drinks.
2016	Law limiting the use of tobacco products, plant-based smoke products, electronic smoking equipment and their liquids.
2016	Strategies to improve the distribution of health professionals, in particular doctors, across the country (Cabinet of Ministers, 2011).
2016	The e-Health system is available to citizens, health care facilities and pharmacies, making e-prescriptions and e-sick leaves available to the residents.
2017	A new function was given to the Center for Disease Prevention and Control to provide methodological support to medical treatment institutions in terms of quality of treatment and patient safety (Government Action Plan; Public Health Strategy 2014–2020).
2017	Conceptual Report On Health System Reform highlights certain priorities, such as providing optimal funding for a sustainable health system and increasing salaries of health staff, reducing waiting times, reviewing the mapping of the hospitals, introducing strategic procurement, and introducing quality and patient safety measures (Government Action Plan) (Cabinet of Ministers, 2017a).
2017	The Saeima stipulates an increase of 1 percentage point of the mandatory social insurance contribution, which is intended to finance health care services. Subsequently, the Saeima adopted the Law on Health Care Financing, which determines the use of funds for the financing of health care services and the rights of socially insured persons to receive health care services (Government Action Plan). The financing reform was then postponed to 2021.
2017	Action Plan for the elimination of HIV infection, sexually transmitted infections and hepatitis B and C for 2018–2020.
2017	The National Health Service implemented a strategic selection of providers (strategic procurement) in three service groups: outpatient mammograms, medical insemination and inpatient oncological treatment. Plan for Rare Diseases for 2017–2020 approved.
2018	Government of Latvia has agreed for substantial increase (apart of the social tax raise or individual contribution) in financing which is expected from 2018 onwards.
2018	Plan for the Improvement of Mother's and Child Health approved.
2018	Government Action Plan; Public Health Strategy 2014–2020, Cabinet of Ministers Regulation No. 301 of 17 May 2016 Regulations on the Maximum Level of Trans-Fatty Acids in Foodstuffs.
2018	The Latvian Anti-Doping Organization establishes the Anti-Doping Bureau of Latvia, the Therapeutic Use Exception Commission, the Disciplinary Anti-Doping Committee and the Latvian National Anti-Doping Council.
2019	The Cabinet of Ministers approves a Plan for Improvement of Access to Mental Health Care for 2019–2020.
2019	A new division in the MoH was established for integrated care, which entails collaboration with the Ministry of Welfare.

For more details on the reforms between 2007 and 2012, please consult the previous Latvia HiT (Mitenbergs et al., 2012).

After the radical reforms of the immediate post-crisis period, the following years from 2013 until 2019 have been characterized by reforms that address priority areas linked to the burden of morbidity and mortality (Table 6.1). In particular, these reforms aim to address cardiovascular diseases, oncology, maternal, newborn and child health, mental health, as well as a broader focus on tackling behavioural risk factors to improve the health of the population.

One key document is the Public Health Strategy 2014–2020, a medium-term policy-planning document based on the WHO Regional Office for Europe Health 2020 Strategy (Ministry of Health, 2014). The main objective of the Strategy is: 1) to increase the number of healthy life years of inhabitants of Latvia (to reach 57 years for men and 60 years for women in 2020); and 2) to reduce the indicator of potential years of life lost by 11%. Steps in this direction are reflected in the overall view of the reforms that took place since 2013, and, overall, a few areas of focus can be identified:

■ *A substantial effort to address behavioural risk factors in the population*

In Latvia, lifestyle-related risk factors (smoking, alcohol consumption, poor nutrition) are implicated in over 50% of deaths. Resources have been allocated for health promotion activities and legislation has been enacted. For instance, for tobacco, the aim of the 2014 Law is to protect public health, including the right of people to live in clean and unpolluted environment. The law regulates the circulation and control of tobacco products, plant-based smoking products, electronic smoking equipment and their filling containers, as well as advertising, sponsorship and packaging conditions, smoking restrictions and other related issues. Also, since 2018, foods that exceed the prescribed maximum levels of trans-fatty acids cannot be distributed in Latvia. Further, Latvia enforced prohibition of alcoholic beverages in environmental advertisements, and enforced prohibition of the retail sale of alcoholic beverages at the premises and territory of social care institutions, educational institutions, service hotels, state and local government offices.

■ *Efforts to improve the financing of the health care system*

A major health financing reform was approved in 2018, aiming to address the chronic underfunding of the system and proposing a two-basket system. The purpose of the law was to define the general principles and structure of the health financing system and to regulate the financial and organizational structure of the state compulsory health insurance. This new law could affect universal coverage for all citizens, introducing limitations to the eligibility to receive state financed health care services depending on participation in payment of social insurance contributions. The law defined two baskets of services: minimum and full. To be eligible to receive the full basket of services, individuals should make social insurance contributions or be in one of several exemption groups (such as children, the unemployed, retired, etc.), or make voluntary payments to the NHS set at 1 percentage point of minimum salary in 2018 (totalling to EUR 51.6 per year) and 3 percentage points of minimum salary in 2019 (totalling to EUR 154.80 per year). Those who do not make social insurance payments and do not belong to an exemption group would have access to only limited state-paid health care services, the so-called minimum basket of services, including emergency care, GP services, care for pregnant women and care for some diseases having potential major influence on the health of the population (see section 3.3.1 for more details). The Law was highly criticized both internationally and domestically, and in 2019 the newly appointed Minister of Health suggested postponing the introduction of differential eligibility based on payment of social contributions. In June 2019, the Saeima approved the amendments to the Law proposed by the MoH, postponing the introduction of the two service baskets until 2021.

The Health Care Financing Law does not include any measures to decrease OOP payments. The estimated total increase in health care financing from the 1 percentage point of the social insurance tax was about 80 million euros in 2018, i.e., almost 10% of the state health care financing in 2017. According to the reform plan, the first priority is to increase salaries of health care professionals (physicians, nurses and support personnel). Therefore, it is foreseen that OOP payments through formal user charges and direct payments for services will continue to provide a substantial amount of total health care financing (see section 3.4).

While the new parliament postponed the health financing reform to 2021, one element has been implemented since 2018; i.e. additional revenues

from the increase of the social insurance contributions rate by 1 percentage point are allocated for the financing of the health system.

The increase in financing brought by the 1 percentage point rise of the social insurance tax will support the improvement of accessibility and quality of the health care services. Further, to implement new measures to improve access to health care services in line with health care reform, at the end of 2017 the government granted an additional EUR 113.4 million to the health sector for 2018. The budget of the Ministry of Health increased from EUR 820 million in 2017 to EUR 1.01 billion in 2018, the largest increase in the health care sector budget since Latvia regained its independence (European Commission, 2017).

■ *Efforts to improve access and quality of care*

Increasing access and quality of care has been a major area of focus. In particular, for mental health, there are plans to increase the competence of family doctors, nurses and doctors' assistants in psychiatric care, to establish cooperation between family doctors and the outpatient team of psychiatrists and child psychiatrists, as well as to involve psychologists and functional specialists in the team of psychiatrists, promoting non-pharmacological treatment. Further, there are plans to introduce preventive examinations for children aged 1.5 to 5 years at the practices of family doctors for the evaluation of mental development, etc. Efforts to improve quality in primary care also include the introduction of quality criteria in the reimbursement of GPs (see section 3.7). A set of performance assessment indicators is also being developed for hospitals. In order to address the unequal distribution of health care professionals, especially doctors and specialists, since 2016 priority is given to those applicants for a residency who have an agreement with the municipality outside Rīga for an employment relationship starting in a medical institution outside Rīga after the end of residency.

■ *Efforts to improve treatment of infectious diseases*

Several infectious diseases are still main contributors to the disease burden in Latvia, and steps have been taken to address this issue. For example, the

introduction of 100% reimbursement of hepatitis C medicinal products lead to a significant improvement in hepatitis C treatment, resulting in 80% virus-free patients, compared with 50–60% in previous years; early treatment of HIV-infected patients has started, and the proportion of HIV-infected persons who received treatment in 2016 has increased to 35–37% of the total number of HIV-infected persons.

■ *An ongoing effort to downsize hospital care and support primary care*

Strengthening primary health care is an ongoing priority to achieve a more affordable, effective and comprehensive health care system (see section 4.2.1, and section 5.3). The objective is increasing the role of primary care in prevention, diagnosis and treatment, and providing information and empowerment for patients. Between 2010 and 2016 the number of health care institutions providing outpatient services increased from 1 127 to 4 192, the number of primary care practices (GP, paediatricians, internists) went from 361 to 1 275, and the number of other outpatient health care institutions grew from 75 to 729. Revised quality criteria for the evaluation of the family doctor's annual activities were also introduced.

■ 6.2 Future developments

A mid-term evaluation (in 2017) of the implementation of the Public Health Strategy 2014–2020 found that the strategic directions regarding health promotion, disease prevention and access to health care services have to be reinforced. Consequently, the health sector priorities continue to be the promotion of healthy and active lifestyles, quality and efficiency of health care services, an emphasis on a person-centred health care approach and the development of integrated health care, as well as improving accessibility and reducing health inequalities. The health sector plays a key role in the National Development Plan 2021–2027 (NDP 2027), currently under development, which defines the national development goals, priorities and directions of action. The overall aim of the plan is to increase *the quality of life for all citizens*. The NDP 2027, approved by the National Development Council, the Cabinet of Ministers and the Saeima, prioritizes “Strong families, healthy

and active people”, and sets prerequisites for longer, more inclusive and active lives. The main areas of action are: birth and family support; healthy lifestyles; quality; access; effectiveness of health care services; social inclusion through social services; and social assistance for vulnerable groups. Several of these key areas are mirrored in the new government’s Declaration, a document on the implementation of the Cabinet’s intended activities throughout the government term, which states the following priorities for the health sector:

1. Improving access to health care services by developing a sustainable financing model, defining an evidence-based unified health services’ basket provided to all residents of Latvia, reducing waiting lists, ensuring free and fair competition in the pharmaceutical market, improving access and reducing prices of pharmaceuticals.
2. Targeting management and quality by strengthening the work of GPs, expanding the role of primary health care, improving the quality of primary health care and of the management of state and municipal health care institutions, introducing evidence-based selection of medical technologies, improving quality assessment, adjusting health tariffs to their real costs, ensuring the development and usability of the unified e-Health system.
3. Increasing support for specific target groups; for example, maternal and child care, and mental health. The Plan for the Improvement of Mother’s and Child Health aims to improve maternal and child care by health promotion and preventive measures, improvement of prenatal and postnatal care, care of premature babies and children with chronic diseases, improved outpatient services for children by enhanced screening services and additional examinations and medical rehabilitation possibilities. Within the realm of mental health, the aim of the Plan for Improvement of Access to Mental Health Care for 2019–2020 is to provide citizens with evidence-based, high-quality and responsive mental health care. The plan includes a series of initiatives with a focus on four main areas: prevention and early diagnosis, patient-centred care and care coordination, mental health promotion and ensuring sufficient human resources in psychiatry. The strengthening of outpatient treatment will be supported through new regional outpatient centres, multidisciplinary teams, mental development screening for children (1.5 to 5

years old), increase of pharmaceutical reimbursement levels, and the development of a depression and suicide reduction programme for young people. Mental health promotion is emphasized with the goal of reducing the stigma and awareness of mental health in the population. The plan also includes an increase in salaries for medical staff and recalculation of psychiatric care tariffs.

In addition, given the rather high prevalence of some infectious diseases, the Action Plan for the Elimination of HIV Infection, Sexually Transmitted Infections and Hepatitis B and C for 2018–2020 and the Public Health Strategy 2011–2020 propose a list of activities that will address early diagnosis and improvement of treatment for HIV, availability of antiretroviral drugs, promote access to hepatitis C treatment, prevention, improved diagnosis and treatment of tuberculosis, and a policy for the spread of antimicrobial resistance.

Significant work is being done in developing clinical algorithms, clinical pathways and performance indicators for the priority health areas (cardio-vascular, oncological diseases, mental health, perinatal care, paediatric (from the neonatal period) care). This process is carried out via procurements and is co-funded by the European Social Fund. In the development of clinical algorithms, clinical pathways and performance indicators, the clinical guidelines and medical technologies that are in force and approved by the NHS were evaluated to identify whether they required an update using the available international guidelines (Concept for Quality and Patient Safety, approved by the Ministry of Health Order No. 22 of 20 January 2017).

One important priority to be pursued concerns pharmaceuticals. According to an NHS analysis in 2017, only 35% of patients use the cheapest reference products, others use higher priced products within the same therapeutic or active substance group eligible to additional co-payment. Thereby, in 2017 patients overpaid 25 million euros for reimbursable medicines. They could have saved a large part of this amount by purchasing cheaper medicines of equivalent effectiveness. To improve the availability of reimbursable medicines, on 16 July 2019 the government approved the amendments to the Cabinet of Ministers' Regulations on the reimbursement of medicines and medical devices (Regulation of Cabinet of Ministers No. 899 31 October 2006, Procedures for the Reimbursement of Expenditures for the Acquisition of Medicinal Products and Medical Devices Intended

for the Outpatient Medical Treatment), initiated by the MoH. The amendments also aim to reduce the cost of medicines and patient co-payments for reimbursable medicines. From 1 April 2020, in accordance with the approved amendments to the Cabinet of Ministers' Regulations on the reimbursement of medicines and medical devices, the patients' co-payments for reimbursable medicines will be reduced through the following measures:

1. The price difference between the cheapest and the most expensive medicines with equivalent therapeutic efficacy when listed by the NHS, shall not exceed the 100% threshold.
2. In addition, the external price referencing will be further applied to the ex-factory price (or wholesale price) with the aim not to exceed the second lowest price in Czechia, Denmark, Poland, Romania, Slovakia and Hungary and not exceed the lowest price in Estonia and Lithuania.
3. Doctors are supposed to prescribe by active substance (INN). A physician may use the brand name only when there are medical conditions, such as justified occurrence of side-effects from the cheapest equivalent or, for example, when prescribing a narrow therapeutic index drug. The INN of the product shall be prescribed in at least 70% of the total amount of the reimbursable prescriptions over the year per doctor.
4. If there are two or more reimbursable medicinal products of equivalent therapeutic efficacy with the lowest price, the pharmacy is required to keep all the cheapest medicines in stock, thereby enhancing the patient's choice of the cheapest products.

Finally, future plans also envisage the introduction of a national health care quality system to enforce the quality criteria in the selection of health care providers, an approach towards outcomes-based payment system, and the introduction of comprehensive health technology assessment to stimulate transparency and efficiency in the system.

Assessment of the health system

■ Chapter summary

- Although average life expectancy at birth in Latvia has improved since 2000, at 74.9 years in 2017 it remains more than 6 years below the EU average.
- There is a need for a strong intersectoral approach to improve health system efficiency in Latvia, focusing on addressing the burden of disease and risk factors, increasing public expenditure on health, and reducing the share of OOPs.
- Access to health care is restricted due to high levels of out-of-pocket payments (mainly driven by pharmaceuticals and medical devices) and uneven distribution of services, although there are ongoing programmes to address uneven geographical distribution of specialists and health workforce shortage. Up to one in five Latvians report forgoing health care because of the financial burden; waiting times for key diagnostic and treatment services can be substantial, and the inclusion of key services in the state-funded benefits basket does not always mirror best practice.
- Financial protection remains insufficient due to the share of out-of-pocket payments and individuals/household forgoing care or being exposed to the risk of catastrophic health expenditure.
- The high amenable mortality rate points to shortcomings in health system efficiency; a major challenge is the limited amount of

- funding for health care services. However, Latvia's health outcomes need to be considered in the light of the limited financial resources.
- Several limitations affect technical efficiency, such as issues with quality of care, the unbalanced skill mix, and unnecessary overuse of certain medical procedures and equipment.

■ 7.1 Health system governance

Despite the frequent rate of political changes in the health policy process, Latvia has made good progress in improving transparency and accountability of the health system. Every citizen is by law entitled to express their view on policy-planning documents, which are publicly available on the MoH website. The MoH is responsible for developing and evaluating health policies (e.g. on mental health, e-Health, human resources). The CDPC provides annual statistics on health resources, services, and outcomes, which are also available to the public. Recently the CDPC in collaboration with the NHS created a database, only available for research purposes, with information on publicly funded health care, incorporating data from the mortality registry. This database links different registers and allows researchers to follow the patient through the system, protecting patients' identities through encryption. However, the information available to the public on performance monitoring is until now rather limited. Reports on a set of indicators on hospital performance are published on the NHS website, and the MoH is developing a set of indicators specific for the health system (in particular for structural resources, processes and outcomes) to improve monitoring and to identify health-related population needs and problems.

In recent years, Latvia has strengthened its health information system capacity and has gradually introduced an e-Health system since 2015. The ongoing implementation of the e-Health system plays an important role in providing transparency of health services and information, as well as traceability of data for the patients and different health care providers. Although still limited in scope, the e-Health portal is a central element of the e-Health system as it will enable citizens to access their basic health data, current drug prescriptions and their sick leave certificates. It will also allow medical practitioners to have an overview of their patients' health data and past tests and examinations, which helps avoid duplication of services.

Reliable and direct information on the size of informal payments in Latvia is limited (see Chapter 3).

In terms of overall governance indicators, in 2018 Latvia scored 58 on a corruption perception index, on a scale from 0 (highly corrupt) to 100 (very clean), and ranked 41st among 180 countries (Transparency International, 2018). In comparison, Lithuania scored 59 out of 100 and ranked 38th among 180 countries, while Estonia scored 73 out of 100 and ranked 18th among 180 countries. Overall, the Ombudsman of the Republic of Latvia supervises good public governance. The Ombudsman surveyed public opinion in 2017 asking whether the public administration respects the principle of good governance. The results of the survey concluded that around 30% of respondents believe that good governance is respected, about half pointed out that good governance is ensured in part and needs to be improved, while 20% believed that good governance is not respected. The transparency and involvement of the population in decision-making processes was also assessed.

Accountability is one of the pillars of WHO Regional Office for Europe's Health 2020 policy framework. Accountability in Latvia would greatly benefit from the development of specific key performance indicators (KPIs) to monitor access, quality, efficiency, and sustainability (European Commission, 2019b; OECD, 2016). The use of these indicators would also allow for more effective monitoring and regular reporting on long-term spending, which Latvia still needs to improve. The developed set of health system indicators will help increase accountability of the system.

Patient awareness about their health status and treatment options is increasing due to extensive information provided by different media and social networks. Public participation in professional and patient societies and associations related to specific diseases is also rising (see section 2.8.3). The aim is to protect the interests of the patients, as well as supporting and educating them. Physicians often take part in these organizations by supporting collaboration between patients and clinical centres and doctors' professional associations.

For some of their activities, patient organizations require funding. Some associations succeed in attracting EU structural funds. As an example, the NGO Latvian Children's Fund has successfully acquired funding from the EU structural funds to develop several projects in the area of social and medical support for children, such as the project Development of a Multifunctional Support Centre for Children with Special Needs with the

aim of providing medical and social rehabilitation services. However, some associations could be influenced by the market interests of pharmaceutical and other commercial companies as there may be a shared interest (e.g. faster access to innovative technologies and medicines or orphan drugs). The Ethics Code of the pharmaceutical industry serves to provide transparency regarding their support for doctors' and patients' organizations.

In recent years there has been an increase in public participation through charity donations for the treatment of persons who are not eligible for statutory health services or to support specific projects in cases in which other funding options are not available. In terms of capacity, as discussed in Chapter 2 (Box 2.1), frequent political and institutional changes and insufficient financial resources have had a negative impact on the capacity for policy implementation. There is room for improvement with regards to scientific evidence review, policy adoption, and monitoring and evaluation.

■ 7.2 Accessibility

Several accessibility bottlenecks remain in the Latvian health system, and are discussed in this section in the context of population coverage, benefits package, and availability of services.

The NHS provides coverage to the Latvian population through general taxation, contracting services from public and private providers. As seen in Chapter 6, there were attempts to introduce a compulsory health insurance and link entitlement to health services to the payment of social contributions. Most recently, in 2017, a proposal for a new Health Care Financing Law considered the introduction of two baskets of health care services that would be available to two groups, depending on their tax contribution status. A major critique of the new proposal was the potential to increase inequalities and threaten universal coverage, and the Saeima postponed the proposal to 2021 (see section 3.2).

The benefit package is rather limited compared with other EU countries and is amended based on priorities set by the MoH, as well as availability of funding. Among the services excluded are dental care for adults, some rehabilitation and physiotherapy, medical check-ups for occupational purposes, hearing aids for adults, sight correction, psychotherapy, spa treatments and pregnancy termination if there are no medical or social grounds (WHO, 2018).

A new Law on Funding of Health Care was passed in September 2017, introducing an additional source of funding by increasing the social contribution tax by 1 percentage point – half paid by employers and half by employees. The MoH has plans to develop rules for mandatory participation in the contributions for those who do not take part in social contribution payments (e.g. seasonal workers). Exemptions from contributions will apply to several vulnerable groups, such as the unemployed, pensioners, etc.

Concerning availability of services (as mentioned in section 2.7.2), publicly funded health services are limited to annual quotas, after which patients have to either wait until the following year or cover the costs privately. For example, the number of inpatient procedures for total knee replacement and hip replacement is lower than OECD average, which could be due to the quota system and different distribution of specialized centres. In the case of cataract surgery, waiting times used to be among the highest in the region; however, the NHS channelled money to improve access, which resulted in a decrease in waiting times. The draft of the new health financing law also proposes to decrease waiting times through increases in funding.

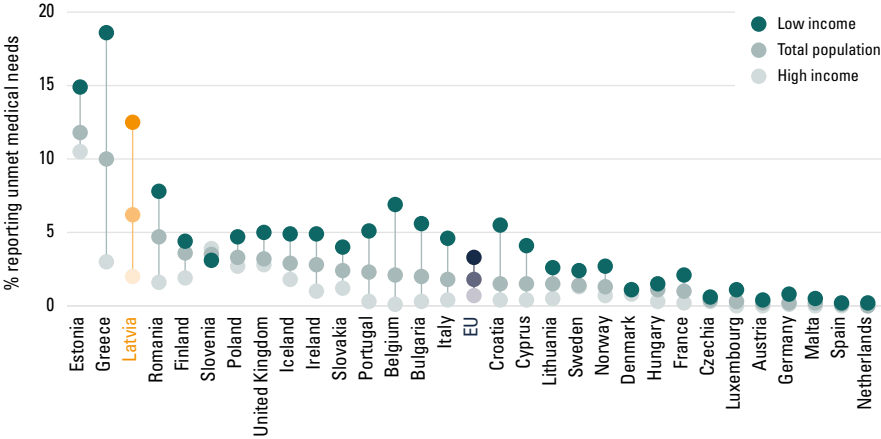
An overview of waiting times for a variety of services is provided on a website maintained by the NHS: http://www.rindapiearsta.lv/lv/rindu_garums.

Access to services in rural areas remains more limited than in urban areas, and the geographical distribution of doctors is a main challenge. However, new funding and programmes are targeting this gap in access (see Chapter 5). In addition, although the number of practising doctors in Latvia is close to the EU average, the emigration of young health workers, internal migration, and the expected retirement of a substantial share of the GP population in coming years poses challenges for ensuring an adequate supply of health professionals in rural areas. The authorities introduced measures in an effort to address the issue; for example, the capitation rate for primary health care is higher in rural areas than in urban areas. Further, since April 2015 medical universities are required to give priority to applicants who have committed to practice in a rural area. The government has raised salaries for all groups of health professionals and increased the number of student places in nursing schools (see Chapter 4).

Based on the EU Statistics on Income and Living Conditions (EU-SILC) survey, the proportion of the Latvian population reporting unmet needs for medical examinations is among the highest in the EU (Fig. 7.1). In 2018, 6.2% of Latvians reported forgoing medical examinations due to costs, travel

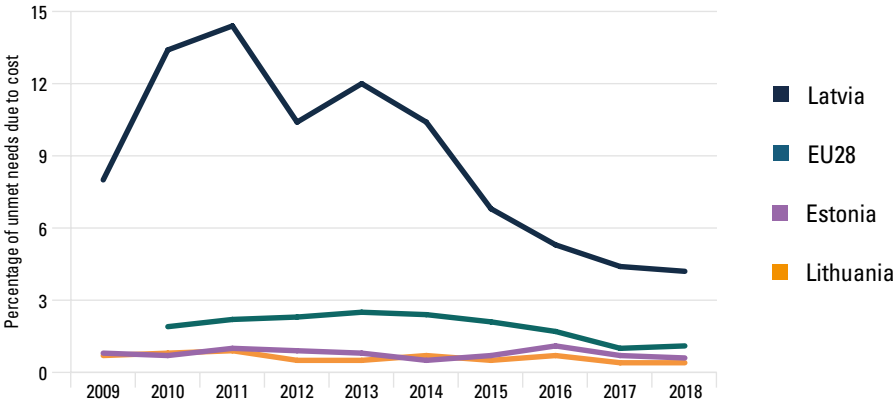
distances or waiting times. This proportion is the third highest in Europe, after Estonia and Greece. The largest share of unmet need was accounted for by cost (4.2%) (Fig. 7.2). More positively, this number has been falling after peaking in 2011 (Fig. 7.2). However, “too expensive” was reported by 12.5% of respondents among the lowest income quintile, compared with 2% in the richest quintile, which points to inequities in accessing services.

FIG. 7.1 Unmet needs for a medical examination (due to cost, waiting time, or travel distance), by income quintile, EU/EEA countries, latest available year



Source: Eurostat database, based on EU-SILC (data refer to 2017)

FIG. 7.2 Percentage of self-reported unmet needs due to cost, Latvia and selected countries



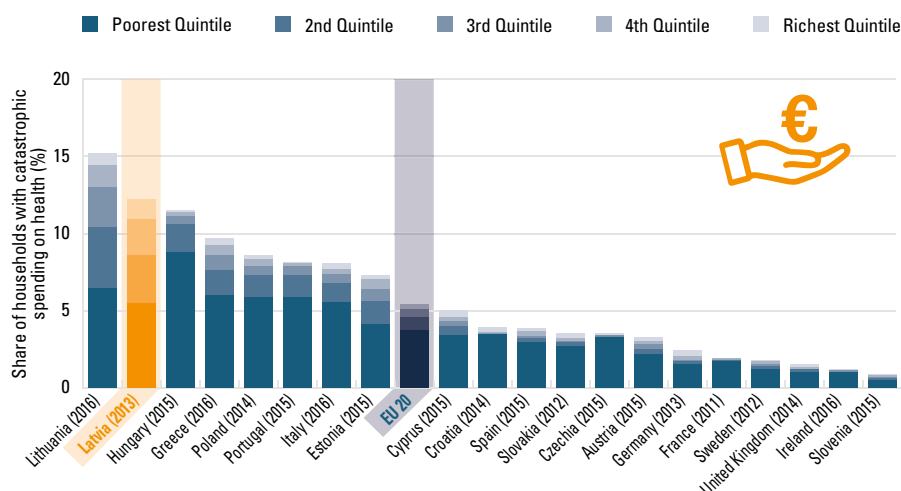
Source: Eurostat, 2019

7.3 Financial protection

The degree of financial protection provided by a health system is determined by the extent to which people are protected from the financial consequences of illness. High OOP payments in Latvia limit financial protection for individuals and households. The proportion of health expenditure paid out of pocket was around 35% in the mid-2000s but has risen to 41.8% in 2017, a level much higher than in other EU countries. Unsurprisingly, 72.8% of low-income Latvian households (and 61.9% of the whole Latvian population) reported using health care services but reported having some, moderate or great difficulty in affording them in 2016 (Eurostat, 2019).

In Latvia, the population – and especially the poorest income quintile – is at risk of catastrophic health expenditure and impoverishment due to high OOPs (catastrophic expenditure is defined as household out-of-pocket spending exceeding 40% of total household spending net of subsistence needs, i.e. food, housing and utilities). A substantial share of Latvian households reports catastrophic health expenditure, far above EU18 average and among the highest in the countries with data available (Fig. 7.3). Further, almost half of all households incurring catastrophic health expenditure are in the poorest quintile, with more than one in four low-income households facing catastrophic OOP spending. In particular, pensioners are most exposed to catastrophic OOP payments due to ill health (Taube et al., 2015).

FIG. 7.3 Share of households who experienced catastrophic health expenditure, latest year for all countries with data available



Source: WHO Regional Office for Europe (2018) in OECD/European Observatory on Health Systems and Policies, 2019

The largest share of OOP payments is absorbed by pharmaceuticals and medical devices. Better access to medicines and improving affordability is a policy priority.

There are a number of mechanisms in place to protect people from catastrophic spending or underutilization of required services. Very poor households have been exempted from all user charges since 2009. Other exempt groups include children under the age of 18 years, pregnant women, severely disabled people, etc. Yet, although there is an annual cap on user charges for all the population, this does not apply to outpatient medicines.

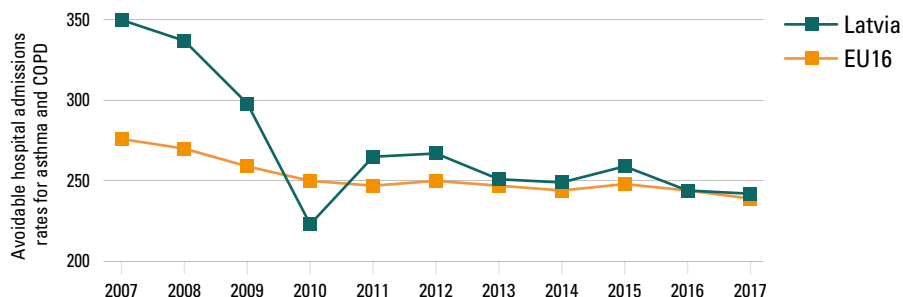
Addressing the high share of OOPs is a major priority towards ensuring financial protection for individuals and households. Previous research indicated that financial hardship is more likely to occur when public spending on health is low in relation to GDP and OOPs account for a considerable share of THE (Xu et al., 2007; WHO, 2010; 2018b). Recent reforms introduced additional sources of funding (social contributions) in order to diversify the funding stream. Nevertheless, these reforms need to tackle out-of-pocket payments first (see Chapter 6) if the inequality in the system is to be addressed.

■ 7.4 Health care quality

Quality is particularly important in the context of primary care, since it influences health outcomes and the efficiency of the health system (Lancet Global Health, 2018). In the context of primary care for chronic conditions, avoidable hospital admission rates for conditions that could be treated in primary care are indicative of the quality of primary care. Compared with other countries, rates in Latvia indicate that chronic disease management outside hospitals and the functioning of primary care has improved considerably since 2007 and could improve further, as it sits slightly above the EU average (Fig. 7.4). There have been several initiatives to strengthen primary care, in particular the development of quality indicators. However, progress in this area has been limited owing to disagreements between GPs and the NHS about the appropriateness of the indicators, with a new set introduced in 2018.

Antibiotic prescribing is controlled, and trends in the consumption of antibiotics for systemic use in the community remained rather stable between 2012 and 2016 (ECDC, 2017). Pharmacists do not dispense antibiotics without prescription.

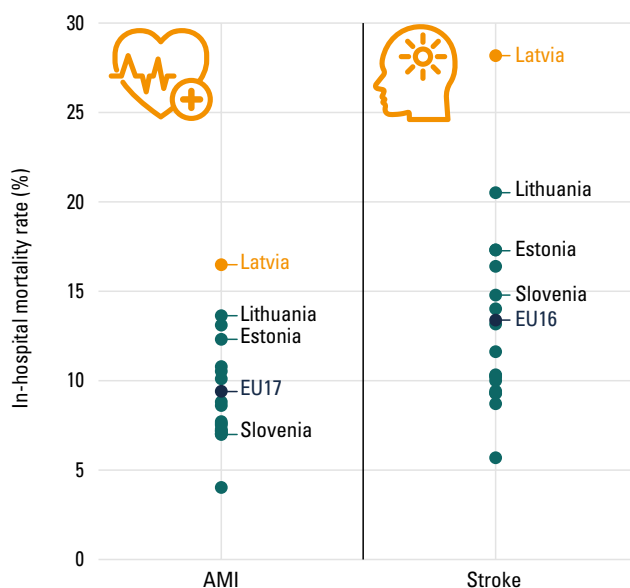
FIG. 7.4 Avoidable hospital admission rates for asthma and chronic obstructive pulmonary disease, 2006–2017



Source: OECD Health Statistics database, 2019

Having seen that there is room for improvement in terms of quality in primary care, there are more substantial concerns about hospital care quality. Latvia reports the highest rates of mortality within 30 days of hospital admission for acute myocardial infarction (AMI; or heart attack) and stroke in the EU (Fig. 7.5). Furthermore, case fatality after stroke is almost three times higher than the OECD average, although it should also be noted that mortality varies considerably across hospitals in different regions in Latvia. University hospitals in general are better equipped and provide timely access, especially important for stroke.

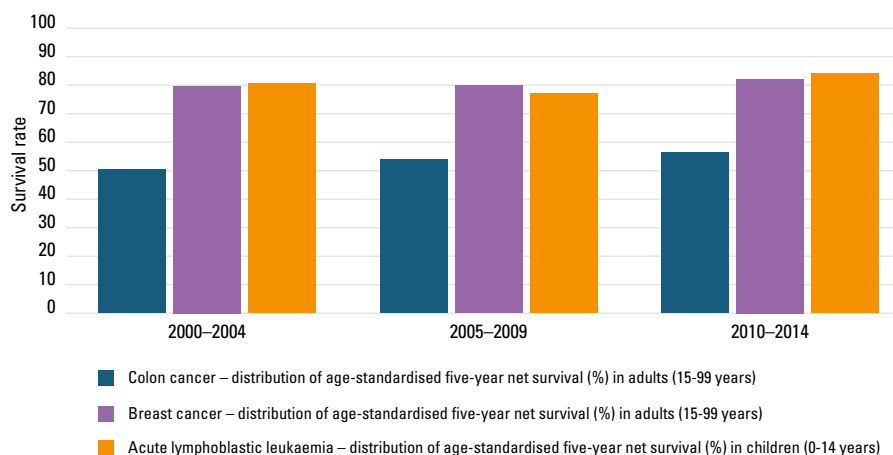
FIG. 7.5 In-hospital mortality rates (deaths within 30 days of admission) for admissions following acute myocardial infarction, haemorrhagic stroke and ischaemic stroke, Latvia and selected countries



Note: Figures are based on patient data and have been age–sex standardized to the 2010 OECD population aged 45+ admitted to hospital for heart attack (AMI) and ischaemic stroke.

Source: OECD Health Statistics database 2019 (data refer to 2017 or nearest year) in OECD/European Observatory on Health Systems and Policies (2019).

FIG. 7.6 Cancer survival rates for colon cancer, breast cancer (among women), and leukaemia (among children)



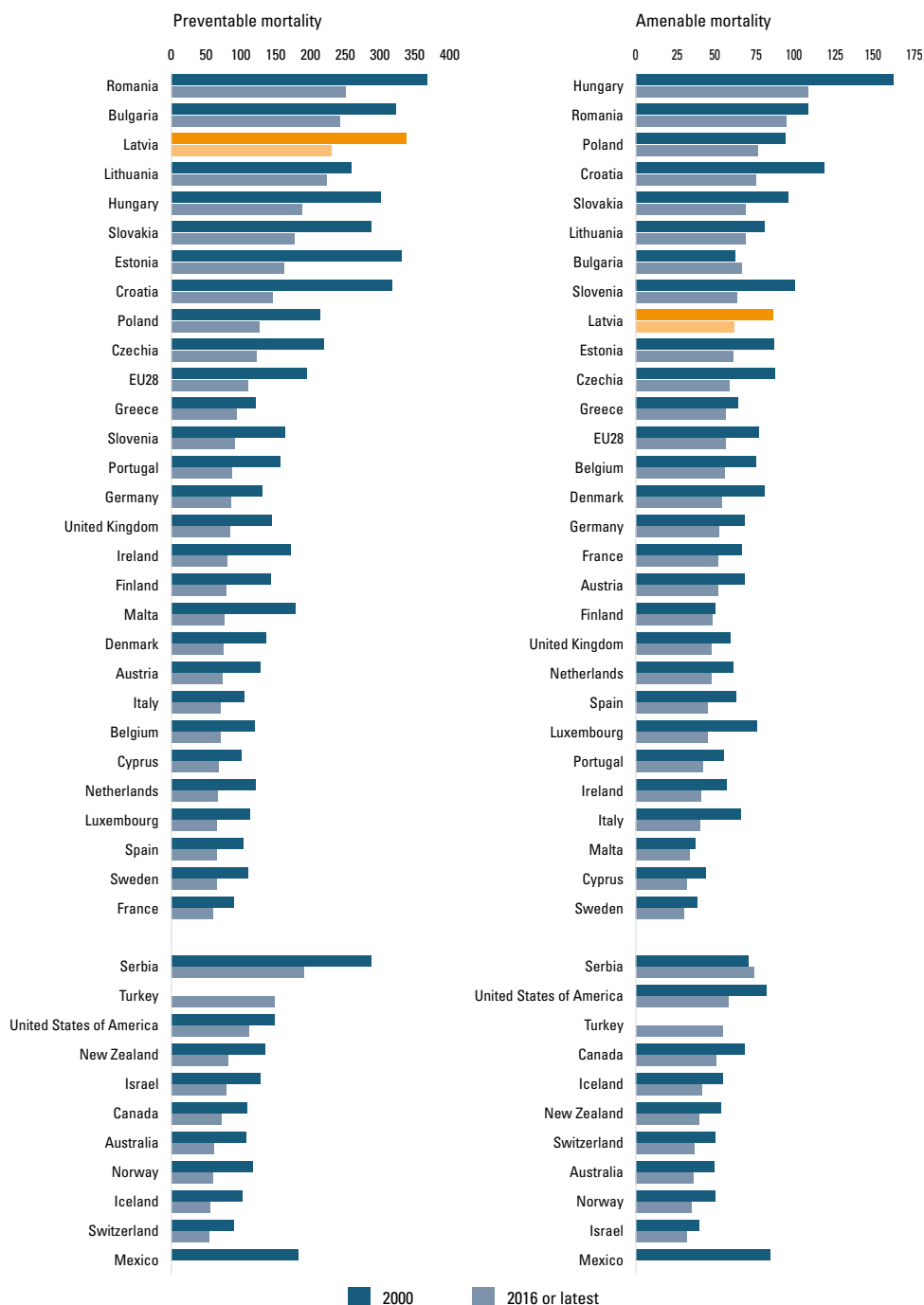
Source: OECD Health Statistics database, 2019

Cancer care quality is improving. Five-year survival rates for colon cancer, breast cancer, and leukaemia have slightly increased since 2010, and are now comparable to most EU countries. For example, colon cancer survival increased from 51% to 57% between 2000–2004 and 2010–2014 (Fig. 7.6).

Latvia has tried to improve cancer care by launching large-scale public screening programmes against breast cancer, cervical cancer and colorectal cancer in 2009. Although some cancer-screening rates in Latvia are improving, they remain low by EU standards. The NHS sends letters to eligible individuals; however it is reported from an ongoing pilot that the involvement of GPs, who can provide more information and directions, improves adherence to screening.

In 2016, only around one quarter of women aged 50–69 had been screened for breast cancer within the preceding 2 years and in 2016, only 25% had been screened for cervical cancer over the same period. Differences in geographical accessibility might be factors contributing to a delayed diagnosis. A lack of a multidisciplinary approach and coordination among doctors also influences disease outcome. The introduction of an improved patient pathway (the Green Corridor) in 2016 aimed to streamline and expedite diagnosis and treatment decision for suspected cancer cases, paid from state budget funds. There is still a need to include next treatment steps, rehabilitation and palliative care into the Green Corridor. Patients'

FIG. 7.7 Preventable and amenable mortality in Latvia and selected countries, 2000 and latest available year



Note: 2000–2016 unless stated otherwise (2000–2015 for BE, DE, DK, EL, FI, FR, IE, IT, LU, LV, MT, PL, SI, EU28; 2000–2014 for BG, SK; 2001–2015 for UK; 2004–2016 for CY). Age-standardized death rates for all persons; calculated by European Observatory for Health Systems and Policies (contact: marina.karanikolos@lshtm.ac.uk)

Source: Mortality data from WHO detailed mortality files (released Dec 2018); Population data from WHO detailed mortality files, except for Canada (UN population database), USA (Human Mortality Database). Amenable causes as per list by Nolte and McKee (2004)

surveys highlight the importance of clear communication with specialists (see Box 5.4).

With regards to immunization against measles, diphtheria, pertussis, tetanus and other infectious diseases, Latvia historically has relatively high rates. Vaccination coverage in Latvia is high for routine childhood vaccinations, with immunization rates above 95%. However, in 2016 immunization against influenza for people above 65 was very low, at only 4% of people in that age group, well below the EU average of 43% and WHO's recommended target of 75%. Reasons for poor vaccination coverage among the elderly may relate to the financial burden of vaccine costs and vaccine administration fees, but lacking awareness about the health threats posed by influenza and misperceptions about vaccine safety may play a role as well.

■ 7.5 Health system outcomes

The health system is confronted with a double burden of disease resulting from the unresolved challenge of infectious diseases and the increasing challenge of noncommunicable diseases. For example, Latvia reports one of the highest incidence and prevalence rates of HIV in Europe, and detection is one of the main bottlenecks. Testing for HIV is provided in clinical settings if a health care provider suspects a case, and there are public health programmes targeted to HIV-infected patients. In addition, in 2016 the Cabinet of Ministers updated the parameters of the CD4 cells level at which patients are eligible to start therapy as recommended by WHO. However, population-screening programmes for HIV are not offered.

Latvia is well above the EU average in terms of preventable mortality but fares better than Lithuania, Slovenia and Poland (Fig. 7.7). Preventable mortality refers to premature deaths that could have been averted through effective public health interventions. This points to missed opportunities related to broader public health interventions, particularly given the high burden caused by behavioural risk factors.

More recently, various pieces of legislation have been implemented to improve public health; for example, prohibiting the sale of energy drinks to people under 18, and setting the maximum permissible content of trans-fatty

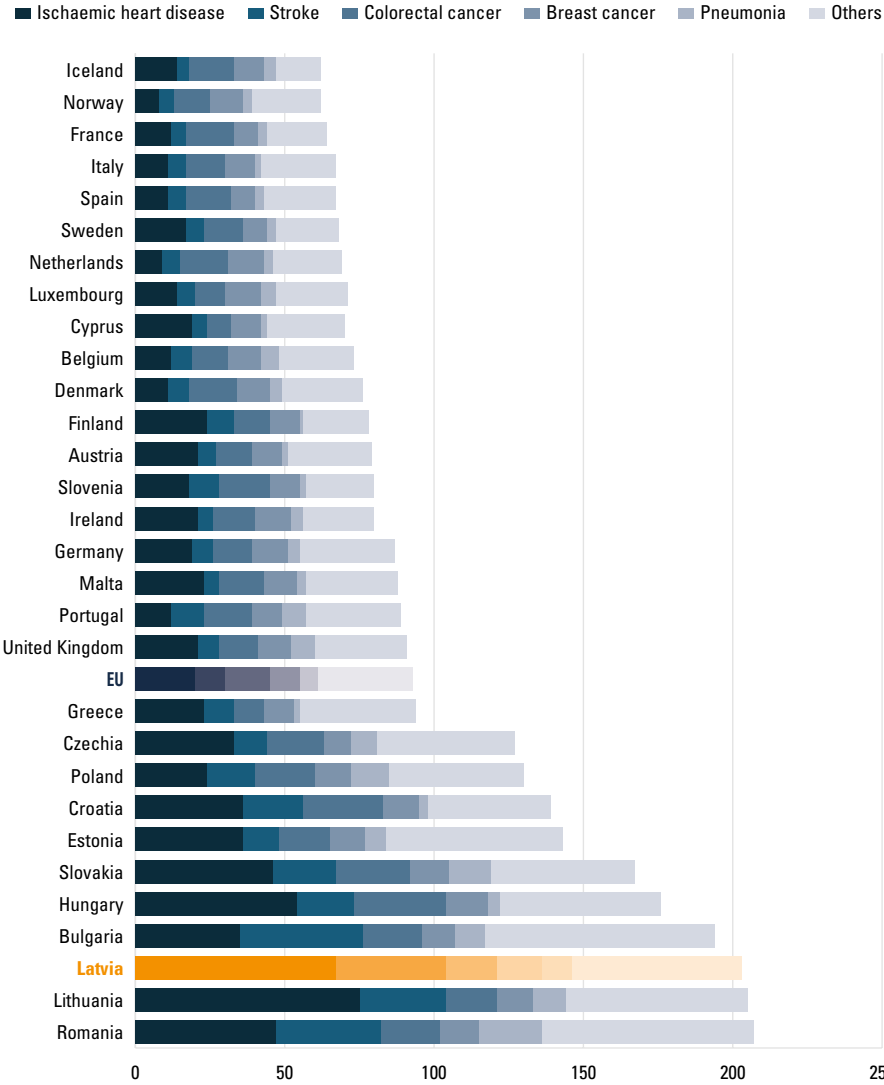
acids in foods (Cabinet of Ministers, 2016b) and maximum volume of alcohol in beverages. In 2014, tobacco control laws were revised, with an emphasis on promoting the rights of non-smokers to live in a smoke-free environment over smokers' rights to smoke. The law prohibits smoking in the presence of children or pregnant women, and – if anyone objects – in any other public place. In addition to the Law on Children Rights Protection, which considers smoking in the presence of a child as physical violence, the 2014 tobacco control law clearly states that smoking in the presence of a child is prohibited. The revised law applies also to electronic smoking devices, containing nicotine or not. In addition, the Tobacco Law regulates tobacco advertising and sales of tobacco, and sets out requirements for health warnings on tobacco packaging. Despite these measures, people continue to die because of smoking.

Treatable (or amenable) mortality is defined as death that can be mainly avoided through health care interventions, including screening and treatment. Treatable mortality in Latvia is also among the highest in the EU, and more than twice as high as the EU28 average (230 versus 110 per 100 000 population respectively). However, it has improved over time, from 338 per 100 000 population in 2000 to 230 in 2015. These data signal plenty of room for improvement in effectiveness and quality of care in Latvia.

Looking at the main causes of amenable mortality allows for a more detailed analysis. Ischaemic heart disease accounts for almost half of all amenable deaths, followed by stroke, colorectal cancer, breast cancer, and hypertensive diseases (Fig. 7.8). These results indicate ample scope for improving health care interventions.

Latvia has made some progress in reducing mortality from suicide, although it remains a major cause of death, particularly among men. Latvia records the third highest rate of mortality from suicide in the EU. The campaign “Don't turn away” was launched in 2014 by the Centre for Disease Prevention and Control, aiming to inform society about mental illnesses, and debunk the myths still associated with them. There are ongoing initiatives to address mental health and recently, a new mental health programme was introduced as part of the priorities for the coming years (see Chapter 6). Information is also available to the public on the website of the CDPC.

FIG. 7.8 Main causes of amenable mortality in Latvia and selected countries, latest available year



Source: Eurostat database (data refer to 2016).

7.5.1 Equity of outcomes

Between 2007 and 2017, the proportion of Latvians reporting that their health is “good” went up from 35% to 44%, but this percentage remains well below the OECD average in 2017 (69%). The Latvian rate was the second lowest in the EU, after Lithuania. Differences in self-reported health persist across income or educational levels. In 2017, 64% of Latvians in the highest

income quintile reported to be in good health, compared with only 26% in the lowest income quintile. These disparities are likely linked to differences in living and working conditions, as well as differences in lifestyles (e.g. smoking, harmful alcohol drinking, physical inactivity and obesity).

Similarly, data from the EU-SILC survey for 2018 show that lower income groups are also more likely to report having a longstanding illness or health problem. Almost 62% of people in the lowest income quintile reported having a longstanding illness or problem, compared with about 21% in the highest income quintile (Eurostat database, based on EU-SILC). Moreover, the difference between the income quintiles with the highest and lowest proportion of a longstanding illness in 2018 was the highest recorded for the period 2008–2018.

■ 7.6 Health system efficiency

■ 7.6.1 *Allocative efficiency*

Within the health sector context, allocative efficiency refers to whether the allocation of resources among the different levels and type of care is in line with society's best interests. In Latvia, allocative efficiency can be assessed at four different levels: 1) the allocation of resources to the health system; 2) the allocation of resources to different types of providers; 3) the allocation of resources to different types of services; and 4) the allocation of resources for public health.

Despite the recent increase in spending, the Latvian health system remains underfunded. In 2017, Latvia reported the second lowest total health expenditure per capita (EUR 1 213 PPP) in the EU28 after Romania. Furthermore, the proportion of GDP spent on health, although it increased since 2014, remains one of the lowest shares in the EU. The postponed proposal for the new Health Care Financing Law envisaged the health budget to reach at least 4% of GDP by 2020.

Comparatively poor population health outcomes in Latvia (see sections 1.4 and 7.5) should be interpreted in the context of this extremely tight health care budget.

Public spending on health is low and based on a quota system, which implies an uneven distribution of services. Since the allocation of funds is

based on the previous year's performance and volume of services provided, as soon as the threshold is reached, patients need to pay for the service out of pocket. There should be more clearly defined parameters for various funding sources (state budget, municipalities, private), which can lead to duplication of services and inefficient allocation of resources.

Concerning the allocation of resources to different providers, one central objective of health reforms in many European countries as well as in Latvia over the past decade has been to shift health care provision away from (expensive) hospital care and towards (less costly) ambulatory care. In the context of funding shortfalls resulting from the financial and economic crisis, the Latvian government was able to make considerable progress in this direction. It introduced measures that gave relative priority to primary care, coverage of essential medicines and outpatient specialist services while reducing funding for inpatient care and hospital capacity. While expenditures on inpatient care consumed about 32% of government expenditures on health in 2010, this share was reduced to about 27% in 2016. In addition, hospital bed capacity, which used to be far above the EU average (see section 4.1.1) has decreased more drastically in Latvia than on average in the EU, although it still remains above the EU average. Still, the occupancy rate of acute care beds is low (71% versus 77% across the EU), pointing to persistent hospital overcapacity.

Allocative efficiency is also negatively affected by the uneven distribution and lack of health workforce. Although the full spectrum of services has to be available in all regions, they may not always be available due to lacking practising health professionals. This, in turn, worsens efficiency and, for example, leads to underutilization of expensive medical technology.

In the context of medical technology, it is important to note that municipal hospitals have less stringent operating conditions compared with government-owned hospitals, and make autonomous procurement and capital investment decisions. This regulatory system creates incentives for municipal hospitals to buy expensive devices such as MRIs and CT scanners, since their use is financed by the NHS, and affects efficiency.

For the third point, the allocation of resources to different types of services in the health care system relies on a mix of implicit and explicit setting criteria. HTA is not used for allocation of resources, with the exception of pharmaceuticals, where cost-effectiveness of new products is assessed mainly for the purpose of reimbursement.

Finally, relatively limited resources go into public health and prevention activities, despite the high burden of mortality and morbidity associated with preventable lifestyle-related diseases. Latvia currently spends 2.4% of its health care budget on public health and prevention, a proportion that is lower than the EU average of 3.1%.

The Public Health Strategy 2014–2020 represented an update to the Public Health Policy Guidelines 2011–2017, which is based on the WHO Regional Office for Europe Health 2020 policy and was drawn up in order to update the formulation of the problems, objectives, policy results, and to align them with the National Development Plan of Latvia 2014–2020 and the financial planning period.

■ 7.6.2 *Technical efficiency*

This section illustrates some of the achievements and challenges in the context of technical efficiency through a number of indicators concerning hospital care, human resources, efficiency of pharmaceutical spending, and impact of reforms to increase technical efficiency. Due to the lack of recent studies analysing the technical efficiency of the health system in Latvia, average length of stay (ALOS) in hospital and use of generic drugs are used as indicators, although these are measures of efficiency and therefore provide only a partial picture.

ALOS in Latvian acute care hospitals has dropped considerably in recent years, possibly indicating improvements in efficiency. In the year 2000, ALOS was still comparatively high in Latvia at 8.5 days, compared with 7.5 days in the EU15 and 7.8 days in the EU12. In 2010 it had reduced to 6.2 days, and further to 5.9 days in 2016. In fact, ALOS in Latvia is shorter than that of Estonia (6.1 days in 2016), and Lithuania (7.1 in 2016).

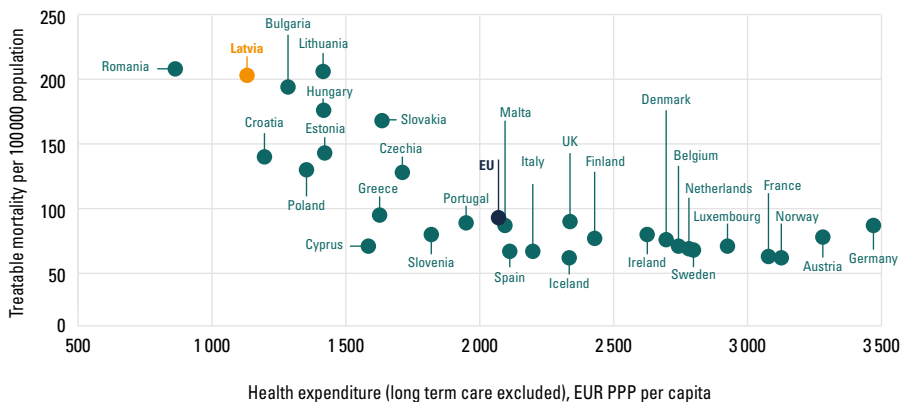
Similarly, in an effort to move care from costly hospital setting to community settings, the overall number of hospitals of all sizes has been reduced substantially (from 156 in 1997 to 63 in 2017), and recent reforms have been aimed at concentrating specialized care in fewer hospitals by creating a tiered system under which the NHS contracts fewer hospital services.

Latvia has promoted the use of generic drugs by requiring prescriptions by active ingredient, and pharmacists to offer the cheapest version of prescribed pharmaceutical products that are included in the publicly funded

benefit package. Generics now constitute a high share of the market, in terms of value and volume. According to 2016 data, the estimated generics market volume was at 75% and value at 43% (compared with 36% and 16% in Estonia, respectively) (OECD, 2018). In 2017 the sales volume of authorized medicines reached 392.78 million euros (SAM, 2018b).

Relating amenable mortality to health expenditure per capita (Fig. 7.9) indicates that there is significant room for improvement. The limited resources available need to be taken into consideration when analysing the efficiency of the health system, but other countries with similarly low levels of spending report better outcomes in terms of treatable mortality. However, the main message is that additional spending would be needed to substantially improve treatable mortality.

FIG. 7.9 Treatable mortality per 100 000 population versus health expenditure per capita, Latvia and selected other countries



Note: EU average is unweighted only for health expenditure data.

AT, Austria; BE, Belgium; BG, Bulgaria; HR, Croatia; CY, Cyprus; CZ, Czechia; DK, Denmark; EE, Estonia; FI, Finland; FR, France; DE, Germany; EL, Greece; HU, Hungary; IS, Iceland; IE, Ireland; IT, Italy; LV, Latvia; LT, Lithuania; LU, Luxembourg; MT, Malta; NL, Netherlands; NO, Norway; PL, Poland; PT, Portugal; RO, Romania; SK, Slovakia; SI, Slovenia; ES, Spain; SE, Sweden; UK, United Kingdom.

Source: Eurostat database; OECD Health Statistics database 2018 (Data refer to 2015).

Among the main challenges for the health system, as described in Chapter 4, is the unbalanced skills mix. In particular, Latvia has one of the lowest number of nurses in the EU. Regional differences in the distribution of family physicians and nurses are also a problem, especially in rural areas. The physician's assistant plays an important role in rural areas easing the burden related to the shortage of physicians and nurses. New strategies to

increase remuneration of the workforce have been proposed as a means to limit outward migration and increase supply of health personnel in Latvia (see Chapters 4 and 6). To improve the management of chronic conditions, Latvia is experimenting with skill mix innovations, notably the second practice nurses and the physician's assistants. For example, every GP practice with more than 1 200 registered patients is required to hire two nurses, with one nurse specifically focusing on chronic disease management.

Other sources of technical inefficiency include quality issues, as there is no standardized care apart from isolated cases. For the majority of health services, there is a lack of general approach to standardized care. Further, Latvia reports an overuse of certain procedures and equipment, such as CT scans or tomography (see section 4.1.2), while other diagnostic services are underused (for example, some oncology diagnostics such as PET scan).

Finally, greater diffusion of health technology assessments could contribute to greater efficiency in many crucial areas of expenditure.

Conclusions

The achievements of the Latvian health system over the past decade include an increase in life expectancy at birth, a shift from inpatient care to outpatient care, progress in cancer care, better availability of medical technology, and some improvement in the burden of morbidity and mortality related to behavioural risk factors. Nevertheless, the Latvian health system faces ongoing challenges that need to be addressed. For example, decreasing the reliance on out-of-pocket payments (one of the highest OOP rates in Europe); reducing inequities in access to health care, as the proportion of the Latvian population reporting unmet medical needs is among the highest in Europe, and low-income groups face barriers in accessing care; improving preventable and treatable causes of mortality, both substantially higher than the EU average; strengthening monitoring; and improving quality of care. Latvia also faces a shortage of health workers, especially nurses, and as an attempt to ensure an adequate supply of health professionals, the government has raised the salaries of health care personnel in 2018 and is planning additional increases.

The main strategic medium-term planning document, the Public Health Strategy 2014–2020 places a strong emphasis on increasing the number of healthy life years for the Latvian population by 3 years (to 57 years for men and 60 years for women in 2020) by preventing premature deaths, improving health, especially maternal and child health, and ensuring equitable access to care. In order to achieve these goals, and improve the overall performance of the health system, the government needs to address a number of challenges affecting quality, efficiency, and access.

A key challenge is ensuring sustainable and stable financing to the health care sector, while increasing the share of public expenditure on health and

reducing the substantial dependence on out-of-pocket payments. In 2017 a new Health Care Financing Law introduced major changes intended to go into effect in January 2019. Among them was the introduction of two different baskets of health care services, accessible according to the payment of social health insurance contributions. However, the new law was viewed as undermining universal coverage for the Latvian population, and its introduction has been postponed until 2021. Potential changes in the financing model should consider possible repercussions and be considered along with other options to improve access and quality of care. Further, in 2017 the mandatory social insurance contribution was increased by 1 percentage point to provide more funds for health care.

From an international perspective, Latvia is a low spender on health. Despite recent increases in spending, the share of GDP spent on health in 2017 is well below the EU average. Given the current level of resources channelled into the health system, improving accessibility to care and quality remain a challenge. In order to substantially narrow the existing health care gap between Latvia and the other EU countries, an increase in the share of the public budget to health will be needed. Finally, Latvia needs to plan to ensure fiscal sustainability in the face of demographic changes and increasing demand for care, to continue emphasizing prevention, to downsize the hospital sector, and advance the digitalization of the health system.

Appendices

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■ 9.2 HiT methodology and production process

HiTs are produced by country experts in collaboration with the Observatory's research directors and staff. They are based on a template that, revised periodically, provides detailed guidelines and specific questions, definitions, suggestions for data sources and examples needed to compile reviews. While the template offers a comprehensive set of questions, it is intended to be used in a flexible way to allow authors and editors to adapt it to their particular national context. This HiT has used a revised version of the template that is being piloted during 2016–2017 and will be available on the Observatory website once it has been finalized. The previous (2010) version of the template is available online at: <http://www.euro.who.int/en/home/projects/observatory/publications/health-system-profiles-hits/hit-template-2010>.

Authors draw on multiple data sources for the compilation of HiTs, ranging from national statistics, national and regional policy documents to published literature. Furthermore, international data sources may be incorporated, such as those of the OECD and the World Bank. The OECD Health Data contain over 1 200 indicators for the 34 OECD countries. Data are drawn from information collected by national statistical bureaux and health ministries. The World Bank provides World Development Indicators, which also rely on official sources.

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

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

A typical HiT consists of nine chapters.

1. Introduction: outlines the broader context of the health system, including geography and sociodemography, economic and political context, and population health.
2. Organization and governance: provides an overview of how the health system in the country is organized, governed, planned and regulated, as well as the historical background of the system; outlines the main actors and their decision-making powers; and describes the level of patient empowerment in the areas of information, choice, rights and cross-border health care.
3. Financing: provides information on the level of expenditure and the distribution of health spending across different service areas, sources of revenue, how resources are pooled and allocated, who is covered, what benefits are covered, the extent of user charges and other OOP payments, VHI and how providers and health workers are paid.
4. Physical and human resources: deals with the planning and distribution of capital stock and investments, infrastructure and medical equipment; the context in which IT systems operate; and human resource input into the health system, including information on workforce trends, professional mobility, training and career paths.

5. Provision of services: concentrates on the organization and delivery of services and patient flows, addressing public health, primary care, secondary and tertiary care, day care, emergency care, pharmaceutical care, rehabilitation, long-term care, services for informal carers, palliative care, mental health care and dental care.
6. Principal health reforms: reviews reforms, policies and organizational changes; and provides an overview of future developments.
7. Assessment of the health system: provides an assessment of systems for monitoring health system performance, the impact of the health system on population health, access to health services, financial protection, health system efficiency, health care quality and safety, and transparency and accountability.
8. Conclusions: identifies key findings, highlights the lessons learnt from health system changes; and summarizes remaining challenges and future prospects.
9. Appendices: includes references and useful websites.

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

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

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

■ 9.3 The review process

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

■ 9.4 About the authors

Daiga Behmane is a Vice-director and Researcher at the Institute of Public Health at Riga Stradins University. Her research areas are health policy and system analysis, health economics and health system competitiveness. She has a background in economics and holds a Master's degree in social sciences from the University of Latvia

Alina Dudele is a lecturer at Riga Stradins University and a Researcher at the Institute of Public Health at Riga Stradins University. Her research areas are health system management, health system financing and health outcome analysis. She holds a Master's degree in Public Health from the University of London.

Anita Villerusa is an Associate Professor in the Department of Public Health and Epidemiology at Riga Stradiņš University (RSU). Her research interests include epidemiology of health related behaviour, health of children and adolescents, human resources of healthcare. She is a medical doctor and holds a Doctoral degree from the Medical Academy of Latvia.

Janis Misins is head of the Health Statistics Unit at the Department of Research and Health Statistics, Centre for Disease Prevention and Control of Latvia. He is a Researcher and Assistant Professor in the Faculty of Medicine, University of Latvia. He is a medical doctor and holds a Doctoral Degree from the University of Latvia.

Kristīne Kļaviņa is head of Human Resources Development Division at the Ministry of Health Republic of Latvia. Previously, she has worked for a long time in the ministry with strategic planning issues. She holds a Master's Degree in Public Health from Riga Stradiņš University.

Dzintars Mozgis is Deputy Director of the Centre for Disease Prevention and Control in Latvia and also Associate Professor in the Department of Public Health and Epidemiology of the Riga Stradiņš University. He is a Medical Doctor, Paediatric Surgeon and Paediatrician and in the last years his interests are related to public health and health care management.

Giada Scarpetti is a Researcher in the Department of Health Care Management at the Berlin University of Technology and the Berlin hub of the European Observatory on Health Systems and Policies. She holds a Master's Degree in Public Health from New York University.

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(2012)

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