Latvia

Health Care & Long-Term Care Systems

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Health care systems

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2.16. LATVIA

General context: Expenditure, fiscal sustainability and demographic trends

General statistics: GDP, GDP per capita; population

With a GDP of around €24 bn or 16,200 PPS per capita in 2015, Latvia is below the EU average GDP per capita of €29,600.

During the coming decennia the population of Latvia will gradually decline, from 2.0 million inhabitants in 2016 to 1.3 million inhabitants in 2070. This 32% fall contrasts sharply with the EU average increase of 2%.

Total and public expenditure on health as % of GDP

Total expenditure ([224]) on health as a percentage of GDP (5.7% in 2015) is below the EU average ([225]) of 10.2%. Public expenditure is at 3.3% (2015) of GDP, far below the average of 7.8% in 2015. Looking at health care expenditure without long-term care ([226]) reveals a similar picture with public spending being below but slightly closer to the EU average (2.8% vs 6.8% in 2015).

When expressed in per capita terms, total spending on health at 1185 PPS in Latvia is below the EU average of 3305 in 2015. So is public spending on health care: 709 PPS vs. an average of 2609 PPS in 2015.

Expenditure projections and fiscal sustainability

As a consequence of population ageing, health care expenditure is projected to increase by 0.6 pps of GDP, below the average growth expected for the EU of 0.9 pps of GDP according to the AWG reference scenario. When taking into account the impact of non-demographic drivers on future spending growth (AWG risk scenario), health care expenditure is expected to increase by 1.8 pps of GDP from now until 2070 (EU: 1.6) ([227]).

Latvia faces only low fiscal sustainability risks in the short, medium and long-term. Nonetheless, addressing the underfinancing of the healthcare services might lead to higher public spending in the medium to long term ([228]).

Health status

Life expectancy at birth continues to increase gradually in Latvia (79.6 years for women and 69.8 years for men in 2016) but it is far below the respective EU averages (83.6 and 78.2 years of life expectancy)([229]). Healthy life years, at 54.9 years for women and 52.3 for men are below the EU averages of 64.2 and 63.5 in 2016. The infant mortality rate of 3.7‰ is around EU average of 3.6‰ in 2016.

As for the lifestyle of the Latvian population, there is a proportion of regular smokers of 24.1 % above the EU average of 20.9% in 2014([230]). Alcohol consumption is, at 10.4 litres per capita, slightly higher than the EU average of 10.2 ([231]).

System characteristics ([232])

Coverage

The Latvian health system is a tax-funded social insurance system. The services included in the statutory provision are determined by law.

([224]) Data on health expenditure is taken from OECD health data and Eurostat database. The variables total and public expenditure used here follow the OECD definition under the System of Health Accounts and include HC.1-HC.9 + HC.R.1.

([225]) The EU averages are weighted averages using GDP, population, expenditure or current expenditure on health in millions of units and units of staff where relevant. The EU average for each year is based on all the available information in each year.

([226]) To derive this figure, the aggregate HC.3 is subtracted from total health spending.

([227]) The 2018 Ageing Report https://ec.europa.eu/info/sites/info/files/economy-finance/ip065_en.pdf.

([228]) Fiscal sustainability Report (2018), Institutional Paper 094, January 2019, European Commission.

([229]) Data on health status including life expectancy, healthy life years and infant mortality is from the Eurostat database. Data on life-styles is taken from OECD health data and Eurostat database.

([230]) European health interview survey https://ec.europa.eu/eurostat/statistics-explained/index.php/Tobacco_consumption_statistics.
A third wave of the European health interview survey (the source of these data) is being conducted in 2019.

([231]) OECD Health at a glance (2018) and World Health Organisation, Pure alcohol consumption, (2014) https://gateway.euro.who.int/en/indicators/hfa_426-3050-pure-alcohol-consumption-litres-per-capita-age-15plus/visualizations/#id=19443&tab=table.

([232]) This section draws on ASISP (2014)

Public health care benefits provided in kind include a wide range of services provided by GPs, specialists, hospitals and emergency care units, as well as pharmaceutical care. Cash health care benefits (including maternity and sickness) are provided through social insurance, financed through mandatory insurance contributions from employers and employees ([233]).

Despite full population coverage, the services available 100% free of charge are limited. The system suffers from low accessibility due to financial reasons. In 2016, 5.3% of the population reported unmet needs for health care (according to EUROSTAT) because they could not afford it financially (in contrast with the EU average of 1.6%), while in the lowest income quintile the rate reported is close to 13.1%. This is one of the highest levels of unmet need for health care in the EU and has been so for a decade, being significantly different from its Baltic neighbours (Lithuania and Estonia). Self-reported unmet need for dental examination due to affordability concerns are also the highest in the EU (26.8% for the 1st income quintile, i.e. the poorest, and 13.2% for the total population in 2016, in comparison with the EU average of 3.6%).

Patients pay directly for those services that are not financed by the state, for example, dental care for adults, psychotherapy, most available rehabilitation and physiotherapy services as well as a significant proportion of medicines. Patients also pay the full cost if they do not follow the standard procedure for accessing publicly financed care (for example, directly visiting a specialist without first obtaining a primary care referral when required). This is most often the case when patients wish to avoid waiting lists for publicly funded care. Additionally, patients also pay in full the cost of all services provided by health care providers who have not contractual agreements with the National Health Service (NHS). However, there are numerous direct access specialists to whom no referral is required (detailed information in next section). The patient contribution (for adult patients) if of €1.42 for a visit to the general practitioner and €4.27 for a visit to the specialist with referral and out-patient visit to direct access specialist:.2015 data shows that Latvia has the fifth highest incidence of "under-the-table payments" to doctors on the part of patients (Health Powerhouse (2015)).

During the economic crisis until 2012 some new measures were introduced as an additional social safety net. An exemption from patient charges was introduced for those households with a monthly income below €171 per family member. Those with an income below €213 euro were exempted from 50% of fees. From 2012 this was scaled back, with only those with an income below €128 being exempted. This threshold appears to be too low to ensure good health care access for those from vulnerable groups. As obtaining this status requires several administrative procedures such as means-testing, and the latter may act as barriers to access for the elderly and infirm.

Nevertheless from 2015 payment of daily treatment in hospital was reduced from €13.52 to 10 euro, as well as the patient's co-payment (for a surgical procedure in hospital) was reduced from €42.69 to €31. Since 2015 in order to improve the availability of pharmaceuticals and medical devices for children under the age of 18, the reimbursable pharmaceuticals and medical devices in accordance with positive list are reimbursed at 100 %.

Since January 2016, amount of State compensated medicines for treatment hepatitis C increase from 75% to 100%. Also, since 2018 the amount of State compensated medicines for treating Crohn's disease, Psoriasis and ulcerative colitis has increased from 75% to 100%.

The share of private expenditure on health in total health expenditure (40.2% in 2015) is far higher than the EU average of 21.6%. Out-of-pocket expenditure constitutes about 42.07% of total health expenditure, far above the EU average (21.8% in 2015).

Beyond affordability, low accessibility is also influenced by long waiting lists for diagnostics and treatments. As of 2014, cancer patients with cancer had to wait on average 25 working days after diagnosis for treatment. the waiting time for an appointment with a rheumatologist was 86 working days ([234]).

([233]) ASISP (2014).

([234]) ASISP (2014).

Since October, 2016 patients where there is suspicion of malignancy are able to receive the necessary examinations and investigations (primary diagnostics) within 10 working days from the date of signing up for the examination. This referral can be made by general practitioners, gynaecologists or prison doctors and, after diagnosis can lead to specialist referral at a specialised hospital. The hospital then has to provide a consultation for the patient within 10 working days from the date of signing. The specialist decides about the necessary additional examinations (secondary diagnostics) in specialised hospitals and gives a referral to the patient. Secondary diagnostic examinations should be provided in tiem to ensure that the decision about the treatment is taken within a month of the first specialist consultation. It encourages priority of health care service receipt, shifting these patients from the total patient flow and allowing to plan the necessary resources for early diagnosis of oncological patients.

However, according to the law passed on December 2017, from 2019 the basket of publicly available services will however be divided into a minimum and a maximum basket.

The minimum basket of services includes: 1) full access to the GP (incl. diagnostic examinations for the treatment according to the competence of the GP); as well as medicines and medical devices prescribed by the GP for outpatient treatment of diseases which have a significant impact on public health or endanger public health. 2) maternity care; 3) emergency services; 4) health services related to the treatment of diseases that have a significant effect on public health indicators or which threaten public health (including mental illness, tuberculosis), as well as medicines and medical devices for ambulatory treatment of these diseases. However, it does not include access to public specialised care beyond the cases considered above.

Minimum basket is granted for all citizens and non-citizens of Latvia, third-country nationals who have a permanent residence permit in Latvia and stateless persons to whom the status of a stateless person has been granted in Latvia as well as refugees, asylum seekers or persons who have been granted an alternative status.

The list of the health care services in the minimum basket will be stipulated in the Regulation of Cabinet of Ministers by 1 September 2018.

The Healthcare Financing Law states also the full basket of services which includes: 1) all services provided in the minimum basket; 2) secondary and tertiary health care services, as well as medicines and medical devices intended for outpatient treatment in accordance with the regulatory acts regarding the procedure for the reimbursement of expenses for the purchase of medicines and medical devices for ambulatory treatment.

Full basket of the health care services provided by the state is granted for socially insured persons or those persons who have made health insurance contributions. In addition, there is a list of other groups qualifying for the full basket guaranteed by state, meaning they do not have to pay any contribution (except patient contributions if they are not exempted from those as well). In the list inter alia is included children up to 18 years, persons with I and II disability group (from 01.01.2021. also, persons with III disability group), persons receiving services of long-term social care institutions, persons studying in the educational institutions, unemployed persons, persons who have reached the age of old-age pension etc.

Those groups, which are not paying social contributions (for example those working under micro-enterprise tax regime) to state budget, to receive the full basket are expected to pay a contribution set at 1% of minimum remuneration in 2018 (€51.6 annually), rising to 3% of minimum remuneration amount in 2019 and 5% of minimum remuneration amount from 2020 onwards.

While this new reform aims at improving the incentives for citizens to make health care contributions so as to receive the maximum basket, it effectively limits the universality of access to health care by curtailing the access to specialised care for those who receive only the minimum basket. As such it is likely to worsen the accessibility of health care in Latvia([235]).

([235]) See LV Country Report 2018 https://ec.europa.eu/info/sites/info/files/2018-european-semester-country-report-latvia-en_1.pdf.

Administrative organisation and revenue collection mechanism

Public funding, including transfers from general taxes (state or municipal budgets), together constitute 59.8% of total health expenditure funding (2015), compared with the EU average of 78.4%.

Financial resources for the public health system come from central government general taxation. As explained above, out-of-pocket payments are also a very important financial source for the system.

The Saeima in 27.07.2017 adopted amendments to the Law "On State Social Insurance", which determines that the part of mandatory social contributions corresponding to 1 percentage point of mandatory contribution rates (0.5% paid by employers and 0.5% by employees) is foreseen to finance health care services. In the state budget planning process the annual fund collection is estimated and allocated to the Ministry of Health. In 2018, these funds are allocated to increase the remuneration for health care specialists. In December 2017, the Saeima adopted a Health Care Financing Law which introduces state health insurance system with two service baskets linking the right to receive a basket of full health care services with the payment of social contributions. State health insurance system with two service baskets (a full and a minimum) will be in force starting with January 1, 2019 (see further).

Types of providers, referral systems and patient choice

The total number of practising physicians per 100 000 inhabitants (321 in 2016) is below the EU average (344) and has increased since 2005 (288). Data on the physician skill-mix indicates that the number of GPs per 100 000 inhabitants (72 in 2016) is below the EU average (78.3) although it registered a steady increase since 2003 (45) as part of the authorities' effort to improve primary care provision. The number of nurses (463.6 in 2016) per 100 000 inhabitants is far below the EU average (833 in 2015).

Latvia has 340 hospital beds (2016) per 100 000 inhabitants (down from 543 in 2003), below to the EU (EU average of 402 in 2015).

The General Practitioner (GP) acts as a main point of entry into the health care system and as a gatekeeper to secondary ambulatory and hospital care. In order to receive the state financed secondary ambulatory or hospital care the referral from GP or other doctor is required. The referral to receive state financed health care services can be issued by doctors who are contracted with NHS. However, there are numerous direct access specialists to whom no referral is required (gynaecologists, ophthalmologists, paediatricians, child surgeons, dentists). Also patients with certain disease may go directly to the relevant specialists. No referral is needed to attend the endocrinologist in case of diabetes, psychiatrist in case of psychiatric disease, oncologist and oncologist-chemotherapist in case of oncological disease, pneunomologist in case of tuberculosis, dermatologist in case of sexually transmitted disease, infectologist in case of HIV, narcologist in case of an alcohol, narcotic or psychotropic substance addiction. No referral is required also in case of emergency medical assistance.

The patient has the right to choose a physician and health care institution. The patient has a right to freely register with a chosen GP and may freely change and register with a new GP.

Treatment options, covered health services

Services included in the statutory provision are defined by law. The statutory health care system covers only services provided by physicians and institutions that have contractual agreements with the NHS.

Price of healthcare services, purchasing, contracting and remuneration mechanisms

The NHS acts as the main purchaser of health care for the population, directly commissioning both public and private providers (including GPs, dentists and hospitals). In 2016, it held contracts with 1322 GPs and 41 hospitals.

Large tertiary and specialised hospitals are owned by the state, whereas smaller and regional hospitals tend to be owned by municipalities. GPs and those medical specialists not working for hospitals or health centres tend to work as self-employed private providers.

To increase the efficiency of the use of funding allocated to health care, improve the quality of services and increase competition between health care service providers, since 2017 service providers in certain service areas are selected using a strategic procurement procedure according to set criteria. This selection process is implemented for the following groups of services: planned in-patient cancer treatment (surgery, radiation, chemotherapy); out-patient mammography; medical fertilisation; and rehabilitation. To strengthen the competencies of the personnel of the Ministry of Health and NHS in the field of strategic procurement a training seminar supported by EC Structural Reform Support Service (SRSS) was held in 2017.

The market for pharmaceutical products

Total pharmaceutical expenditure, at 1.6% of GDP, above the EU average of 1. 4%. However, public pharmaceutical expenditure at 0.5% of GDP is far below the 1% EU average. This difference reflects partly the level of co-payments in the pharmaceutical sector.

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 two main institutions concerned with regulation of pharmaceuticals: the SAM (State agency of Medicines) and the NHS, which is responsible for reimbursement and pricing decisions.

There is a positive list in accordance with the Regulations of the Cabinet of Ministers Nr.899 “Procedures for the Reimbursement of Expenditures for the Acquisition of Medicinal Products and Medicinal Devices Intended for Out-patient Medical Treatment” (31.10.2006), designating a range of conditions (for example, diabetes, cancer, mental disorders) for which drugs are reimbursed according to the degree of severity. The objective is to keep expanding the positive list as well as to reduce the level of co-insurance required from patients. Patients pay the full price for a significant share of prescribed pharmaceuticals and the full price of all non-prescription drugs in the outpatient sector. In fact, about more than 60% of out of pocket (OOP) payments in Latvia are spent on pharmaceuticals and about 50% of these are related to payments for non-reimbursable prescription drugs or OTC drugs. Inpatient pharmaceutical care is provided free of charge as the costs are included in the cost of inpatient services.

There is a co-payment of €0.71 per prescription for outpatient pharmaceuticals on the positive list (if the pharmaceutical has 100% reimbursement level) and co-insurance of 25% (if the pharmaceutical has 75% reimbursement level) or 50% (if the pharmaceutical has 50% reimbursement level). However, households with an income below €128 per family member per month, as well children (up to the age of 18) and asylum seekers are exempted from user charges.

Reference price system is in place in Latvia. The pharmaceuticals with the same therapeutic efficacy are grouped in clusters taking into account the presentation form and dosage. The reference price is the price of the cheapest medicine in the cluster. If more expensive medicine is prescribed, the patient has to pay the difference between the actual price of a pharmaceutical and the reference price. To promote generic competition and the use of cheapest products, for newly diagnosed patients only International Nonproprietary Name (not a specific product) can be prescribed by a doctor and the pharmacy has a duty to dispense the cheapest reimbursable medicinal products, which conform to this name, the prescribed pharmaceutical form and strength.

Pharmaceutical products are supplied to the public by a regulated distribution system consisting of licensed enterprises that manufacture and/or distribute them. In 2018, there were 86 licensed wholesalers and 32 licensed manufacturers of medicines and 7 registered manufacturers of active pharmaceutical substances in Latvia (State Agency of Medicines of Latvia, 2018).

Wholesalers are private enterprises. The total wholesale turnover of pharmaceuticals (excluding sales among wholesalers) is €398.12 million. Domestic production accounts for about 4.3% of the pharmaceutical market. However, Latvian manufacturers export most of their pharmaceutical products. Foreign manufacturers operate through representative offices, subsidiaries or limited liability companies. Some of them perform only promotion and marketing activities, while others

have established companies and are licensed as wholesalers.

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

Nearly all community pharmacies are privately owned, pharmacies can be run by a pharmacist as a pharmaceutical practice, by a company or a local community government. If it is registered as a company, at least 50% of the shares have to be owned by a pharmacist or at least half the board must consist of certified pharmacists. In fact, the pharmacy market is dominated by five chains, with the most important chain being “AS Sentor Farm Aptiekas”, which draws up 33% from common pharmacies turnover. A small number of pharmacies exist at health care institutions (hospital pharmacies) and, in rural areas, under certain conditions determined by Pharmacy law, pharmacies can also be owned by pharmacy assistants.

E-Health, Electronic Health Record

The NHS is responsible for the implementation of the e-health policy and the establishment of the necessary infrastructure. Financial resources for these tasks are provided by the Ministry of Health, but certain specific projects are financed by the EU.

In the framework of the first and second round e-health projects which were finalised accordingly in the end of 2015 the following e-health information systems are developed – e-health integration platform information system (IS), e-booking IS, e-referral IS, electronic health record IS, e-prescription IS, as well an e-health portal (www.eveseliba.gov.lv). The publicly available part of the e-health portal provides the actual information about health care in Latvia, as well information about health prevention and other related topics. The authorised part of the e-health portal provides the easy access for inhabitants to their health data but for health care professionals - a virtual workplace. The publicly available part of the e-health portal is open since June 2016. Since September 12, 2016 the authorised part of the e-health portal is available.

On 11 March 2014 Cabinet of Ministers accepted the Regulations No. 134 "Regulations Regarding Unified Electronic Information System of the Health Sector", which determine the manager of the unified electronic health information system (hereinafter – E-health system), the data stored in the E-health system and the data processing procedures as well as the procedures for the issuing of data. As it is stated in the Regulations No. 134 all health care institutions are obliged to use e- prescription (for pharmaceutical products fully or partly compensated / reimbursed by state) and e- sick lists since 1 January 2018, but pharmacies are obliged to accept e-prescription already since December 2016. In accordance with the regulations No.134 the e-health system is providing the centralised processing of person’s health-related data necessary for medical treatment, the preparation of e-prescriptions, the preparation of sick lists, e-booking and e-referrals etc. E-health system collects and stores the medical data of the patients regarding diagnoses, prescribed medications, carried out examinations and operations, sick-leave, disability and vaccination. All mentioned data is collected during doctor visits and stored in national data base, it will provide potentially valuable information for the health care professionals about their patients, allowing seeing the patients’ health status and history results, which is important for making decision for future health treatment plan, thus improving quality of care.

Health professionals (doctors) can view and add the patient's health data (diagnoses, allergies, administered medicines, etc.); prescribe e-precription and e- sick leave; create an e-referral to the specialist or diagnostic test; create results after consultation; describe the diagnostic tests; see another doctor created e-referrals and the results (findings); look at the results of diagnostic tests; see the vaccination data; deny patients right to view certain medical data; make several reports etc.

Health professionals (pharmacists) can issue prescribed medicaments, as well as make several reports.

The following information are available to the patients after authorising in E-health system: personal data (address, phone no., E-mail); GPs data; data on the EHIC (European Health

Insurance Card); basic health data (diagnoses and allergies, the most commonly used drugs etc.); prescribed and issued e-prescriptions; issued and closed e-sick-leave; referrals for consultations and examinations; medical findings (results); diagnostic test results; vaccination data etc.

The patients can access this medical documentation and also manage (grant/refuse) access to all/part of their health data to health professionals; mandate other (non-health professional) people (relatives etc.) enabling to act on behalf of the patient; check the audit logs (every step and access is recorded); request E-consultation from the health professional; add personal contact information, insurance data etc.

All functionality developed during first and second round of e-health projects is available for health care institutions, pharmacies and inhabitants, and NHS is continuing the development of E-health system offering wider range of services/ functionalities / documents. Some of E-health system services are available also through state's e-services portal ([236]).

E-health user support service is available every day from 8:00 to 20:00 which helps to solve relevant issues related to e-health portal and the use of available functionalities. There are two support phone lines - one for citizens and other for professionals.

In August 2017, the Cabinet of Ministers approved the objectives and activities of the next two e-health system development projects: (1) modernisation, development and integration of the health information systems (registers) with the e-health information system; (2) further Development of the E-health Information System, linking it with personal identification. Projects will be co-financed by EU funds.

([236]) www.latvija.lv.

Health and health-system information and reporting mechanisms/ Use of Health Technology Assessments and cost-benefit analysis

The main performer and coordinator of the official statistical work in Latvia is the Central Statistical Bureau (CSB). The CSB is a direct administration body subordinated to the Ministry of Economics and is responsible for organisation of the statistical work and authenticity of the data it has produced by summarising the information obtained from respondents.

There are two main institutions responsible for the collection of health-related information in Latvia: the Centre for Disease Prevention and Control (CDPC) and the NHS.

CDPC is the central institution responsible for collecting and summarising health related data in Latvia. CDPC is responsible for numerous information systems and databases where health data are collected (for example, HIV/AIDS Case Register, The Newborn Register, The Register of Patients Suffering from Diabetes, Malignant Neoplasms, Occupational Diseases, Congenital Anomalies, Injuries, Psychiatric Disorders, Tuberculosis, Multiple Sclerosis and Addiction, Hepatitis C, Death Cause Database of Latvian Inhabitants, National Infectious Disease Surveillance and Monitoring System etc.). The data which is collected in the named information systems is defined by law and is submitted to CDPC by health care institutions or reported by health care practitioners and microbiology laboratories (cases of infectious diseases). All health care institutions in Latvia have a legal obligation to submit the relevant patient health data to CDPC. Data from the register of Patients Suffering from Diabetes, Malignant Neoplasms, Occupational Diseases, Congenital Anomalies, Injuries, Psychiatric Disorders, Tuberculosis, Multiple Sclerosis and Addiction, are available in E-health system as well. In accordance with the regulatory framework in the field of health statistics all health care institutions in Latvia are also obliged to prepare and submit to CDPC the annual statistical overviews about delivered health care services.

The NHS collects the data related to the use of NHS paid health services. All contracted providers

irrespective of their ownership status have to electronically submit patient information about NHS paid services for payment purposes.

Data on occupational accidents is collected by the State Labour Inspectorate. In accordance with the Regulation of the Cabinet of Ministers No. 468 "The Approval of Medical Technologies and the Implementation of New Technologies" (28.06.2005) the NHS is responsible for assessing and approving medical technologies. NHS is also responsible for registering the approved medical technologies and maintaining the database of approved medical technologies.

In order to utilise a new medical technology, a health care institution, medical practitioner or medical personnel professional organisation is required to provide a package of documents including: a technical description of the new technology; a summary of published studies documenting the effectiveness of the technology; the justification of the need for the new medical technology (aims and the provisional results), the necessary qualifications of the medical practitioners who will use the technology; a description of the space within the treatment institution in which the technology will be used.

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

Since 2002, every new medicine is evaluated according to the Guidelines on Economic Evaluation of Pharmaceuticals (approved by regulations of the Cabinet of Ministers No.899) prior to being entered into the positive list of NHS paid medicines.

Health promotion and disease prevention policies

Total (0.12%) and public (0.11%) expenditure on prevention and public health as a % of GDP is far lower than the EU average (respectively 0.31% and 0.25% in 2015).

Public health is coordinated by the Ministry of Health. Activities are planned and monitored mostly by CDPC, which is the main institution for infectious and non-infectious disease surveillance, control and prevention and which coordinates collection of all health-related information. The CDPC engages in health promotion and implementation of the State Immunisation Policy. State paid immunisation is provided by GPs, paediatricians and hospitals and financed through the NHS.

The implementation of health promotion and disease prevention measures funded by the EU funds (of a total amount of 55,4 million euros) has been launched. National level health promotion and prevention measures are implementing by the Ministry of Health in cooperation with subordinate institutions. 96 project applications for local level health promotion and prevention measures have been approved and gradually are launching in local community.

Recently legislated and/or planned policy reform

Recent policy response

In order to reduce inequalities in health and health care by ensuring the sustainability of health care system financing, accessibility, quality and effectiveness of health care services, the health reform has been determined as a health priority in Government Action Plan. Health reform includes a change of model of financing, strategic procurement (incl. service basket), agreement control (quality, standards), review of functions of sectoral governmental bodies. Implementation of health reform will promote the increase of health sector budget.

The Ministry of Health on the basis of World Bank recommendations developed the conceptual report "On the Health System Reform" (adopted on 25 July, 2017), which determined the distribution of state funded inpatient health care providers (hospitals) by service levels (I, II, III and IV hospitals), providers of emergency medical treatment services, setting the ground for development of primary health care and also

highlighted the need for the development of cooperation areas for providers of inpatient health care services. It also included plans to improve remuneration of the medical staff and further development of the human resources, as well as defining the role of municipalities in the health care system, improve purchasing process of state funded health care services and the reorganisation of the subordinate institutions of the Ministry of Health. The reform will also introduce a quality improvement and patient safety system, and ensure linking the register of healthcare recipients with tax payment information on contributions made in Latvia through e-health solutions.

In 2017 €34.3 million were granted for the health care system reform from the budget deficit deviation allowed by the European Commission. This funding was used: 1) to decrease the waiting times to out-patient health care services, including out-patient rehabilitation services, and day hospital services; 2) to improve the accessibility to the diagnostics and treatment of the malignant tumours; 3) to provide the reimbursable drugs for the treatment of hepatitis C (for patients having F3-F4 stage of the illness).

To continue these measures and improve access to healthcare services, at the end of 2017 an Informative report ([237]) was adopted. It foresees further measures in amount of €113.4 million in 2018: 1) to improve accessibility of health care services; 2) to improve accessibility of oncological diseases diagnosis and treatment; 3) to reduce the spread of infectious diseases, including Hepatitis C and HIV infection treatment; 4) to improve the accessibility and quality of primary health care system; 5) to decrease the morbidity rates with cardiovascular diseases and to improve the effectiveness of the treatment.

From January 2018, new health care services are covered by the state budget: transcatheal aortic valve implantation and liver transplantation for adults, positron emission tomography services for patient with certain oncological diagnosis (PET services from 01.07.2018). As well the provision of diagnostics and consultation for patients with rare disease was improved by introducing the specialised Rare Disease Coordination Center, at the Children's Clinical University Hospital. Diabetes patients' care was improved by introducing services of training cabinet.

One of the priorities of the Ministry of Health is to tackle difficulties in recruitment and retention of staff due to low remuneration, particularly for the middle and lower level personnel. Increases in pay will continue to be considered relative to the available space in the health sector budget.

From January 2017 the minimal monthly wage was increased, and the lowest wages were equalised, as well there as ensuring that overtime working is limited to a maximum average of 16 hours in a seven-day period for medical personnel and emergency medical care assistance staff, which is not medical personnel, by allocating additional funding.

In 2018, additional financing of €85.3 million was attracted to increase remuneration of medical personnel and other workers in health care sector, as a result percentage increase in wages for doctors and functional specialists is foreseen by 44%, for medical and patient care persons and functional specialists' assistants by 38%, but for medical and patient care support persons by 24%. The wages of medical personnel working in inpatient institutions will increase more significantly due to the mandatory premium when working twenty-four hour periods and the gradual refusal from extended normal working time.

In order to tackle the lack of medical personnel in regions outside Riga, measures have been funded from the EU funds 2014-2020 planning period. There are other measures financed by EU funds such as providing medical personnel with the opportunity to increase their qualifications and opportunities for non-practitioners in their speciality to return to the labour market.

EU funds for the 2014-2020 planning period also provide support for the development of GP practice, including both the renovation of premises and the purchase of equipment. Support will be provided for around 600 GPs' practices with a budget of €4.5 million. It is intended to provide support not only to individual practices but also to promote the development of cooperation practices to ensure more effective use of resources and improve access to primary health care. The process

([237]) Informative report "On implementation of health reform measures in 2018", 19.12.2017.

of development and harmonisation of the support conditions is currently under way, while the implementation of the projects is envisaged to start in early 2019.

There are also projects financed by EU funds to invest in infrastructure for tertiary health care and regional hospitals, as well as for mono-profile hospitals providing rehabilitation, maternity care and traumatology services. In 2018, the Cabinet regulations on implementation conditions for investments of EU funds in infrastructure for local hospitals (I, II, III level hospitals) were approved and project implementation will begin by the end of 2018.

A large number measures have been launched to improve patient safety. Accordingly, since October 2017 each medical institution must follow guidelines including: 1) improve patient identification (throughout the treatment process using at least two identifiers); 2) facilitate effective communication between patient and health care professionals, 3) provide risk-reduction measures for surgery, anaesthesiologic procedures, as well as for high risk patients or groups of patients related to the age, medical condition and need for special care; 4) establish and maintain the blame-free reporting and learning system on adverse events; 5) introduce and maintain a safe drug circulation system in accordance with the regulatory enactments regarding the procedure for the acquisition, storage, use, recording and destruction of medicinal products in medical institutions and social care institutions and 6) introduce and maintain a system for patient complaints and suggestions analysis.

There was also an update of the requirements for the care during pregnancy, delivery and postnatal period, as well as the procedures for new-borns, in order to ensure the quality of service.

Simultaneously, the Ministry of Health developed and approved in January 2017 the Concept for the Health Care system's quality improvement and patient safety to improve these aspects, as well as to create a common understanding of them. Within the framework of the Concept are activities co-financed by the EU Social Fund, such as targeted medical staff training for patient safety. Significant work has begun to develop clinical algorithms and patient pathways, which is critical for providing high-quality and efficient health care services. Starting from 2018, clinical guidelines and medical technologies in use are evaluated and updated using available international comparisons as well as performance indicators for the priority health areas (cardiovascular, oncological diseases, mental health, perinatal care, children (from the neonatal period) care).

The Patient Safety and Healthcare Quality Improvement Unit has been set up at the CDPC to provide supporting functions for medical institutions in patient safety and quality of health care area.

The NHS is working on the development of the Nord-DRG activity-based accounting system in hospitals. The use of DRGs has the potential to increase transparency in the inpatient sector, both concerning performance (as it will allow evaluating the complexity of patients treated in different institutions) and resource allocation (as resources will be allocated according to the number and type of patients treated).

In order to change public attitude towards health and improve their health behaviours and status, a number of changes in laws and regulations have been implemented. The aim is to limit consumption of unhealthy products and habits, through regulations on restriction of trans-fatty acid amounts in food products, as well as the regulations ensuring availability of healthy food in educational institutions, treatment institutions and social care and social rehabilitation institutions. In August 2018, amendments to the regulation were approved and new nutritional norms were defined, with the addition of more vegetables, fruits and milk products. In 2016 parliament adopted the law on the Handling of Energy drinks, which prohibits to sell energy drinks to persons under the age of 18. Since 2000 Latvia has an excise tax on non-alcoholic beverages and the tax rate has been increased two times.

The National Network of Healthy Cities. The aim of the Network aims to improve the municipal employees' knowledge on public health and health promotion, to promote the local governments' involvement in the health promotion, to promote the exchange of the knowledge and good practice among local municipalities and to provide the

methodological support for local governments on public health and health prevention issues. Currently there are 112 municipalities participating in the Network (94% of municipalities in Latvia) (data from 2018).

The Plan for improving health care services in oncology for years 2017-2020 was adopted in 2017 and aims is to improve primary diagnostic and treatment of the most frequent oncologic diseases, quality and responsiveness of cancer screening and access of palliative care. The Plan includes the measures to decrease risk factors of oncologic diseases, coordination and surveillance of cancer screening, to improve early diagnostic, treatment and post–treatment observation as well as to improve services of medical rehabilitation and palliative care.

In October 2017, the Action Plan for the Elimination of HIV Infection, Sexually Transmitted Infections and Hepatitis B and C for 2018-2020 was adopted with the aim of limiting the spread of these conditions.

In October 2017, the Plan of Rare diseases for years 2017-2020 was adopted. It includes priority tasks and measures to improve early and timely diagnosis of rare diseases and their treatment as well as information of rare diseases.

In June 2018, The Maternal and Child Health Improvement Plan for years 2018 – 2020 was adopted. The aim is to do this through activities of health promotion and disease prevention as well as promote early diagnosis, timely treatment and medical rehabilitation.

A new order to improve cardiovascular disease (CVD) prevention is introduced since July 2018, providing additional prophylactic examinations for adults at a certain age (at 40, 45, 50, 55, 60 or 65 years age). CVD prevention includes cardiovascular risk assessment at GP practice, using SCORE method and necessary diagnostic tests, and certain measures according to the identified risk.

In December 2017, The Healthcare Financing Law was adopted. It states the introduction of state health insurance and two health care services' baskets: (minimum basket and full basket) from 2019. See above for a more detailed description of this policy.

Policy changes under preparation/adoption.

According to conceptual report "On the Health System Reform" there is ongoing implementation of the reform.

The Ministry of Health is developing an Action plan for the improvement of mental health for years 2019-2020. It will include issues related to the development of integrated mental health care; improvement of the knowledge, skills and competences of GPs; to promote the further education of nurses working in GPs' practice; the improvement of efficiency and quality of in-patient treatment; improvement of accessibility and quality of outpatient psychiatric health care by strengthening the practices of psychiatrists and by the creation of regional centers, where the services are provided by a multi-professional team.

To continue modernisation of the e-health system two e-health system development projects (see above) are submitted for the approval to the responsible institution.

In 2017, a project on Development of the Health System Performance Assessment (HSPA) for Slovenia and Latvia was launched with support from the EC Structural Reform Support Service and in collaboration with Sant'Anna School of Advanced Studies. This is a key part of substantial reform to improve the fiscal sustainability and the efficiency of Latvia`s health system, enabling the authorities to monitor progress towards defined health system goals.

New amendments to the "Law On Handling of Tobacco Products, Herbal Products for Smoking, Electronic Smoking Devices and Their Liquids" have been prepared including display ban of tobacco products, herbal products for smoking, electronic smoking devices and their liquids (this draft has been approved by the Parliament in the 2nd reading and has been notified to the European Commission and member states).

Currently under preparation is a new national Action plan for reduction of consumption of alcoholic beverages and limitation of alcoholism for next planning period. The plan includes a

variety of activities regarding the restriction of marketing and supply of alcoholic beverages, the reduction of harmful alcohol use, treatment and rehabilitation services.

Possible future policy changes

The Ministry of Health continues to implement the health care reform as described above.

Challenges

The analysis above shows that a wide range of reforms have been implemented over the years, to a large extent successfully (e.g. the development of a strong primary care system), and which Latvia should continue to pursue. However, some policies have met with a number of obstacles and there may be room for improvements in a number of areas. The main challenges for the Latvian health care system are as follows:

- To improve, as acknowledged by the authorities, the basis for more sustainable and larger financing of health care in the future (e.g. considering additional sources of general budget funds), with a better balance between resources and demand, between the number of contributors (including general, unmarked taxes etc. contributions) and the number of beneficiaries and which can improve access and quality of care and its distribution between population groups and regional areas. If more resources are brought into the sector it is important that they do not remain fragmented but are pooled together maintaining the strong pooling mechanisms in place today.

- To define a comprehensive human resources strategy – including higher education prospects – to ensure a balanced skill-mix, avoid staff shortages and motivate and retain staff to the sector.

- To continue to enhance and better distribute primary health care services and basic specialist services to improve equity of access and the effectiveness and efficiency of health care delivery as well as ensuring effective referral systems from primary to specialist care and improving care coordination between types of care. This can be helped through developing electronic patient records in the future and ensuring that the coverage of specialised care is extended to the whole of the population.

- To continue the efforts to make hospital budgets more prospective and costs more transparent.

- To continue to improve data collection and monitoring of inputs, processes, outputs and outcomes so that regular performance assessment can be conducted and used to improve access, quality and sustainability of care.

- To gradually increase the use of cost-effectiveness information in determining the basket of goods and the extent of cost-sharing.

- To enhance health promotion and disease prevention activities i.e. promoting healthy life styles and disease screening given the recent pattern of risk factors (diet, smoking, alcohol, lack of exercise, obesity). The introduction of a smoking ban accompanied by taxes on tobacco, alcohol and soft drinks, stricter regulation of tobacco advertisement and labelling as well as stricter road safety measures can contribute to improving population health status in the long run. Health education and healthy environments in various settings (school and workplaces) can also be a cheap complementary policy.

Table 2.16.1: **Statistical Annex - Latvia**

General context												EU- latest national data			
GDP	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
GDP, in billion Euro, current prices	14	17	23	24	19	18	20	22	23	24	24	12,451	13,213	13,559	14,447
GDP per capita PPS (thousands)	15.9	15.7	15.0	13.8	12.7	13.4	14.0	14.6	14.9	15.4	16.2	26.8	28.1	28.0	29.6
Real GDP growth (% year-on-year) per capita	11.9	12.9	10.9	-2.5	-13.0	-1.9	8.4	5.3	3.5	2.8	3.9	-4.7	1.5	0.1	2.0
Real total health expenditure growth (% year-on-year) per capita	:	14.5	18.9	-10.0	-5.7	-3.5	-0.5	13.4	-9.6	5.3	7.8	3.7	0.2	0.2	4.1

Expenditure on health*	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Total as % of GDP	6.2	6.3	6.8	6.2	6.8	6.6	6.1	6.6	5.7	5.9	6.1	10.2	10.1	10.1	10.2
Total current as % of GDP	5.8	5.5	6.2	5.9	5.7	5.8	5.6	6.2	5.4	5.5	5.7	9.3	9.4	9.9	9.9
Total capital investment as % of GDP	0.4	0.8	0.5	0.4	1.0	0.9	0.5	0.4	0.3	0.4	0.4	0.9	0.6	0.2	0.3
Total per capita PPS	600	773	1,098	1,097	928	883	942	1,124	1,028	1,102	1,185	2,745	2,895	2,975	3,305
Public total as % of GDP	3.9	4.3	4.2	3.9	4.2	3.9	3.8	3.7	3.6	3.7	3.7	8.0	7.8	7.8	8.0
Public current as % of GDP	3.5	3.8	3.6	3.6	3.7	3.6	3.5	3.3	3.2	3.3	3.3	7.7	7.6	7.6	7.8
Public total per capita PPS	378	527	677	687	571	523	585	631	641	685	709	2,153	2,263	2,324	2,609
Public capital investment as % of GDP	0.44	0.49	0.52	0.29	0.44	0.37	0.25	0.42	0.34	0.39	0.40	0.2	0.2	0.2	0.2
Public as % total expenditure on health	63.0	68.2	61.6	62.6	61.5	59.2	62.1	56.1	62.4	62.1	59.8	78.1	77.5	79.4	78.4
Public expenditure on health in % of total government expenditure	16.6	14.7	13.7	9.5	9.1	10.4	10.9	10.2	10.6	10.1	10.2	14.8	14.8	15.2	15.0
Proportion of the population covered by public or primary private health insurance	:	:	:	:	:	:	100.0	100.0	:	:	100.0	99.6	99.1	98.9	98.0
Out-of-pocket expenditure on health as % of total current expenditure on health	41.7	35.6	39.3	37.3	38.8	37.8	32.1	34.4	38.5	39.1	42.1	14.6	14.9	15.9	15.9

Note: *Including also expenditure on medical long-term care component, as reported in standard internation databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

Population and health status	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Population, current (millions)	2.2	2.2	2.2	2.2	2.2	2.1	2.1	2.0	2.0	2.0	2.0	502.1	503.0	505.2	508.5
Life expectancy at birth for females	76.3	76.1	76.2	77.5	77.7	78.0	78.8	78.9	78.9	79.4	79.5	82.6	83.1	83.3	83.3
Life expectancy at birth for males	64.9	65.0	65.3	66.5	67.5	67.9	68.6	68.9	69.3	69.1	69.7	76.6	77.3	77.7	77.9
Healthy life years at birth females	53.2	52.5	54.8	54.3	56.0	56.4	56.6	59.0	54.2	55.3	54.1	62.0	62.1	61.5	63.3
Healthy life years at birth males	50.8	50.8	51.4	51.6	52.6	53.1	53.6	54.6	51.7	51.5	51.8	61.3	61.7	61.4	62.6
Amenable mortality rates per 100 000 inhabitants*	199	185	168	154	144	145	371	357	353	332	326	64	138	131	127
Infant mortality rate per 1 000 live births	7.7	7.4	8.5	6.6	7.6	5.6	6.6	6.3	4.4	3.8	4.1	4.2	3.9	3.7	3.6

Notes: Amenable mortality rates break in series in 2011.

System characteristics												EU- latest national data			
Composition of total current expenditure as % of GDP	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Inpatient curative and rehabilitative care	1.9	1.8	2.0	1.7	2.0	1.7	1.4	1.3	1.3	1.2	1.2	2.7	2.6	2.7	2.7
Day cases curative and rehabilitative care	0.0	0.1	0.1	0.1	0.1	0.2	0.3	0.3	0.4	0.3	0.4	0.2	0.2	0.3	0.3
Out-patient curative and rehabilitative care	1.5	1.3	0.9	1.5	1.3	1.2	1.0	1.1	1.0	1.2	1.2	2.5	2.5	2.4	2.4
Pharmaceuticals and other medical non-durables	1.4	1.4	1.7	1.3	1.5	1.6	1.5	1.4	1.4	1.5	1.6	1.2	1.2	1.5	1.4
Therapeutic appliances and other medical durables	0.4	0.2	0.4	0.2	0.3	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.4	0.4
Prevention and public health services	0.0	0.2	0.1	0.1	0.2	0.1	0.2	0.2	0.0	0.1	0.12	0.27	0.23	0.30	0.31
Health administration and health insurance	0.2	0.2	0.3	0.2	0.2	0.2	:	:	:	0.1	0.1	0.4	0.4	0.4	0.4
Composition of public current expenditure as % of GDP															
Inpatient curative and rehabilitative care	1.3	1.3	1.6	1.4	1.6	1.3	1.1	1.0	1.0	1.0	1.0	2.6	2.5	2.5	2.5
Day cases curative and rehabilitative care	0.0	0.1	0.1	0.1	0.1	0.2	:	:	:	0.2	0.2	0.1	0.2	0.3	0.3
Out-patient curative and rehabilitative care	0.6	0.7	0.4	0.5	0.5	0.6	0.6	0.5	0.5	0.6	0.5	1.8	1.8	1.7	1.8
Pharmaceuticals and other medical non-durables	0.4	0.5	0.4	0.5	0.6	0.6	0.6	0.6	0.5	0.5	0.5	0.9	0.9	1.0	1.0
Therapeutic appliances and other medical durables	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.2	0.2
Prevention and public health services	0.0	0.17	0.10	0.09	0.19	0.14	0.18	0.16	0.04	0.11	0.11	0.23	0.19	0.25	0.25
Health administration and health insurance	0.4	0.4	0.2	0.3	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.3	0.3	0.3

Source: EUROSTAT, OECD and WHO.

Table 2.16.2: **Statistical Annex - continued – Latvia**

												EU- latest national data			
Composition of total as % of total current health expenditure	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Inpatient curative and rehabilitative care	32.1%	33.0%	31.5%	29.7%	34.2%	29.6%	24.5%	21.0%	23.8%	21.4%	21.1%	29.1%	27.9%	27.1%	27.0%
Day cases curative and rehabilitative care	0.7%	1.3%	1.3%	1.5%	1.7%	4.0%	4.6%	4.7%	6.9%	6.2%	6.5%	1.7%	1.7%	3.0%	3.1%
Out-patient curative and rehabilitative care	25.3%	24.0%	14.3%	25.4%	22.0%	20.3%	17.8%	17.3%	18.5%	21.6%	21.4%	26.8%	26.3%	23.7%	24.0%
Pharmaceuticals and other medical non-durables	24.3%	26.2%	26.5%	22.0%	26.5%	27.0%	25.8%	22.5%	26.3%	26.9%	27.7%	13.1%	12.8%	14.7%	14.6%
Therapeutic appliances and other medical durables	7.1%	3.1%	6.6%	2.9%	4.7%	3.6%	3.7%	3.3%	3.6%	3.1%	2.8%	3.6%	3.6%	4.1%	4.1%
Prevention and public health services	0.3%	3.5%	1.6%	1.5%	3.3%	2.4%	3.3%	2.5%	0.7%	2.0%	2.1%	2.8%	2.5%	3.0%	3.1%
Health administration and health insurance	2.9%	3.6%	4.0%	2.9%	3.7%	3.3%	:	:	:	1.6%	1.9%	4.5%	4.3%	3.9%	3.8%
Composition of public as % of public current health expenditure															
Inpatient curative and rehabilitative care	38.6%	34.9%	44.5%	39.3%	43.0%	36.2%	30.3%	30.2%	32.0%	29.4%	30.5%	33.9%	33.6%	32.1%	31.9%
Day cases curative and rehabilitative care	1.2%	1.6%	1.6%	1.7%	2.2%	5.3%	:	:	:	5.8%	5.8%	1.9%	2.0%	3.4%	3.5%
Out-patient curative and rehabilitative care	18.4%	17.1%	9.9%	14.1%	14.0%	17.1%	16.1%	15.7%	16.0%	17.5%	15.4%	22.9%	23.5%	22.2%	22.5%
Pharmaceuticals and other medical non-durables	12.7%	12.3%	12.1%	13.6%	14.8%	16.9%	16.8%	16.9%	16.3%	16.0%	16.6%	11.8%	11.9%	12.6%	12.7%
Therapeutic appliances and other medical durables	0.3%	0.0%	0.3%	0.0%	1.3%	0.0%	0.5%	0.6%	0.5%	0.9%	0.6%	1.8%	1.9%	2.0%	2.1%
Prevention and public health services	0.3%	4.5%	2.7%	2.5%	5.1%	3.9%	5.1%	4.7%	1.2%	3.4%	3.4%	2.9%	2.5%	3.2%	3.2%
Health administration and health insurance	10.7%	9.7%	6.6%	8.9%	3.5%	3.9%	3.6%	3.1%	3.0%	1.8%	2.8%	4.1%	4.0%	3.6%	3.4%

												EU- latest national data			
Expenditure drivers (technology, life style)	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
MRI units per 100 000 inhabitants	0.26	0.26	0.48	0.66	0.71	0.79	0.92	0.98	1.04	1.25	1.26	1.0	1.4	1.5	1.9
Angiography units per 100 000 inhabitants	0.1	0.2	0.3	0.3	0.4	0.6	0.5	0.6	0.7	0.6	0.6	0.9	0.9	0.9	1.0
CTS per 100 000 inhabitants	1.8	1.8	2.1	2.3	2.4	2.8	3.1	3.2	3.5	3.6	3.7	2.1	1.9	2.1	2.3
PET scanners per 100 000 inhabitants	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.2	0.2
Proportion of the population that is obese	:	15.6	:	18.5	:	15.5	:	17.5	:	20.8	:	15.0	15.1	15.5	15.4
Proportion of the population that is a regular smoker	:	30.4	:	27.9	:	:	:	:	:	24.1	:	23.2	22.3	21.8	20.9
Alcohol consumption litres per capita	9.9	10.4	12.1	11.8	9.9	9.8	10.1	10.2	10.4	10.6	10.8	10.4	10.3	10.1	10.2

Providers	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Practising physicians per 100 000 inhabitants	288	294	304	311	299	302	314	314	319	322	320	324	330	338	344
Practising nurses per 100 000 inhabitants	487	544	535	534	465	486	496	486	488	482	468	837	835	825	833
General practitioners per 100 000 inhabitants	58	59	60	61	61	63	64	66	67	70	70	77	78	78	78
Acute hospital beds per 100 000 inhabitants	690	617	608	559	553	546	535	528	523	524	518	416	408	407	402

Outputs	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Doctors consultations per capita	5.3	5.6	6.0	6.2	5.9	5.9	6.3	7.0	6.2	5.8	5.9	6.2	6.2	6.2	6.3
Hospital inpatient discharges per 100 inhabitants	21	21	21	20	18	15	18	17	17	16	:	17	16	16	16
Day cases discharges per 100 000 inhabitants	:	:	:	528	:	:	6,791	7,198	7,341	7,185	:	6,362	6,584	7,143	7,635
Acute care bed occupancy rates	74.0	76.0	76.1	75.5	64.0	71.1	70.4	68.1	68.0	69.7	70.7	77.1	76.4	76.5	76.8
Hospital average length of stay	7.4	7.2	9.4	9.5	8.5	8.5	8.4	8.3	8.3	8.3	8.3	8.0	7.8	7.7	7.6
Day cases as % of all hospital discharges	10.6	:	:	2.5	:	:	27.9	29.3	29.9	31.1	:	28.0	29.1	30.9	32.3

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP*	**2016**	**2020**	**2025**	**2030**	**2035**	**2040**	**2045**	**2050**	**2055**	**2060**	**2065**	**2070**
AWG reference scenario	3.7	3.9	4.1	4.2	4.3	4.4	4.4	4.5	4.5	4.4	4.4	4.3
AWG risk scenario	3.7	4.1	4.5	4.8	5.1	5.3	5.5	5.6	5.6	5.6	5.6	5.5

Change 2016-2070, in pps.	
Latvia	**EU**
0.6	0.9
1.8	1.6

Note: *Excluding expenditure on medical long-term care component.

Population projections	**2016**	**2020**	**2025**	**2030**	**2035**	**2040**	**2045**	**2050**	**2055**	**2060**	**2065**	**2070**
Population projections until 2070 (millions)	2.0	1.9	1.8	1.7	1.7	1.6	1.5	1.5	1.5	1.4	1.4	1.3

Change 2016-2070, in %	
Latvia	**EU**
-31.8	2.0

Source: EUROSTAT, OECD, WHO and European Commission (DG ECFIN)-EPC (AWG) 2018 Ageing Report projections (2016-2070).

Latvia

Long-term care systems

3.16. LATVIA

General context: Expenditure, fiscal sustainability and demographic trends

With a GDP of around €24 bn or 16,200 PPS per capita in 2015, Latvia is below the EU average GDP per capita of €29,600.

During the coming decennia the population of Latvia will gradually decline, from 2.0 million inhabitants in 2016 to 1.3 million inhabitants in 2070. This 32% fall contrasts sharply with the EU average increase of 2%.

Health status

Life expectancy at birth for men and women was, in 2015, respectively 69.7 years and 79.5 years, below the EU average (77.9 and 83.3 years respectively). In 2015 the healthy life years at birth were 54.1 years (women) and 51.8 years (men) below the EU-average (63.3 and 62.6 respectively). At the same time, the percentage of the Latvian population having a long-standing illness or health problem is higher than in the Union as a whole (41.2% and 34.2% respectively in 2015). The percentage of the population indicating a self-perceived severe limitation in its daily activities was in 2015 10.1%, above the EU-average (8.1%).

Dependency trends

The share of dependents in Latvia is set to increase over this period from 8.5% in 2016 to 11.1% of the total population in 2070, an increase of 31%. This is slightly below the EU-average increase of 21%. From 0.17 million residents living with strong limitations due to health problems in 2016, a decrease of 11% is envisaged until 2070 to 0.15 million. This is in contrast to the increase in the EU as a whole (25%).

Expenditure projections and fiscal sustainability

With the demographic changes, the projected public expenditure on long-term care as a percentage of GDP is set to gradually increase. In the AWG reference scenario, public long-term expenditure is driven by the combination of changes in the population structure and a moderately positive evolution of the health (non-disability) status. The joint impact of those factors is a projected increase in spending of about 0.2 pps of GDP by 2070 ([526]). However, the "AWG risk scenario", which in comparison to the "AWG reference scenario" captures the impact of additional cost drivers to demography and health status, i.e. the possible effect of a cost and coverage convergence, projects an increase in spending of 2.6 pps of GDP by 2070. Latvia faces only low fiscal sustainability risks in the short, medium and long-term. Nonetheless, addressing the underfinancing of the healthcare services might lead to higher public spending in the medium to long term ([527]).

System Characteristics ([528])

Administrative organisation

LTC is organised in a relatively fragmented way: services provided for different target groups are organised in different ways and financed from different sources of public financing. Latvian legislation stipulates that in a situation when there is a need for care, municipalities need to organise the provision of services, either by the municipality itself, NGOs or private providers.

All types of long-term care for the elderly (institutional and residential – such as home care, day centres, etc.) are the responsibility of municipalities while long-term institutional social care for persons with mental disorders (children as well as adults) and long-term care (including both social and health) of chronic psychiatric patients are the responsibility of the Ministry of Welfare and the Ministry of Health.

Institutional care for children deprived of parental care up to age of 2 years is responsibility of the Ministry of Welfare and institutional care for children from age of 2 years up to age of 18 years is responsibility of municipalities. Institutional care is provided in cases when care in a family-like environment — foster family or with a guardian cannot be provided for respective child.

Public spending on long-term care([529]) reached 0.4% of GDP in 2016 in Latvia, below the average

([526]) The 2018 Ageing Report https://ec.europa.eu/info/sites/info/files/economy-finance/ip065_en.pdf.

([527]) Fiscal sustainability Report (2018), Institutional Paper 094, January 2019, European Commission.

([528]) This section draws on OECD (2011b) and ASISP (2014).

EU level of 1.6% of GDP. 84.7% of the benefits were in-kind, while 15.3% were cash-benefits (EU: 84.4 vs 15.6%).

In the EU, in 2016, the base year of the Ageing Report projections 50% of dependents are receiving formal in-kind long-term care services or cash-benefits for long-term care. This share is with 26% lower in Latvia. Overall, 2.2% of the population (aged 15+) receives formal long-term care in-kind and/or cash benefits (EU: 4.6%). On the one hand, low shares of coverage may indicate a situation of under-provision of long-term care services. On the other hand, higher coverage rates may imply an increased fiscal pressure on government budgets, possibly calling for greater needs of policy reform.

The expenditure for institutional services makes up 82.3% of public in-kind expenditure (EU: 66.3%), 17.7% being spent for long-term care services provided at home (EU: 33.7%). Thus, relative to other Member States Latvia seems might have some potential to focus more on home care, which may be cost-efficient. As institutional care is relatively costly, Member States with shares well above the EU levels may benefit from efficiency gains by shifting some coverage (and thus expenditure) from institutional to other types of care.

Types of care

In 2016 there were 85 municipal nursing homes for elderly (known as “social care centres” in the Latvian long-term care systems) providing care for 6344 recipients. As explained above, nursing homes for elderly are run by local municipalities. There are as well several institutional care homes for the elderly run by the private sector and NGOs. These are often contracted by municipalities to provide services for their recipients, subject to means-testing of clients and under a price negotiated with the provider. Additionally, in 2016 there were 28 state owned long-term care institutions and 12 long-term care institutions contracted by state provided care for 5194 adults and children with mental disorder and 66 children deprived of parental care up to age of 2 years..

Home care is provided formally by a range of providers, including the social services of municipalities, NGOs, charities, private sector agencies and individuals. The provision of home care encompasses as well other forms of support for the elderly, such as help with daily activities (laundry, delivery of warm meals), assistant service and security buttons that can be activated by the recipient if urgent help is needed. The number of recipients receiving home care has been increasing over the last few years, with a slight fall during the economic crisis, but from 2010 it has grown again. At the end of 2016 there were 14,022 elderly and disabled recipients of home care financed by the municipalities. The majority of the services were provided by carers from the municipal social services.

Alternative forms of long-term care include day care centres for pensioners and persons with psychosocial disabilities, social residential facilities as well as group houses. These services are however relatively underdeveloped.

Recipients of home care and institutional care for elderly persons normally cover the expenses of care . For recipients who live in a household with an average income below the defined "needy" threshold (128 euro per month per person) and who have no spouse or child who is legally obliged to support them financially, municipalities will fully cover expenses of care. Municipalities can however set a higher level income threshold for access free of charge services.

In parallel to formal home care, a great proportion of home care services are provided informally without payment by family members, relatives or neighbours. Municipalities are obliged to provide home care services in situations when the elderly or disabled person itself or persons’ family members are not able to take care of elderly or disabled person mentioned. Finally, the municipalities can decide to provide additional long-term care cash benefits to recipients or to those relatives with caring responsibilities, although they have no legal obligation to do so. Due to this, the amount of support can vary greatly between different municipalities. Care benefit is granted by local governments mostly in cases

([529]) Long-term care benefits in the system of Health Accounts classification can be disaggregated into health related long-term care (including both nursing care and personal care services) and social long-term care (relating primarily to assistance with IADL tasks).

where they cannot provide the service themselves or in cases where there are several service providers available in the municipality and the client can choose between them

Additionally, there is a universal state benefit for disabled people introduced in 2008.

Eligibility criteria

In principle there is no means-testing threshold for access to home care. According to the Law on Social Services and Social Assistance (LSSSA), social services shall be provided only on the basis of an evaluation of the individual needs and resources of a person carried out by a social work specialist.

There is a specific dependency threshold set for each different form of long-term care service.

For home care, dependents are eligible if they are unable to take care of themselves and perform everyday activities.

Recipients of state provided long-term care have to pay for long-term care up to 90% of their pension. The rest of the expenses are covered by the state budget. The amount of money paid by social care recipients for state institutional long-term care was 6,827,506 euro in 2016.

In case of long-term care services financed from the State budget, there is no duty of payment for in case of persons (both children and adults) with severe mental disability and in case of small children (between ages 0 and 2) deprived of parental care.

Municipalities have to provide services to everybody who needs them. If the recipient has no income or spouse or child who is legally obliged to support them financially, then the municipality will partially or fully share the costs of care. The state defines the amount of remaining income after the services received are paid for (the amount of monthly minimum wage for the first family member and half the minimum wage for each next family member). Municipalities can introduce provisions above that if they show wish. The threshold is set at a relatively low level, therefore access to long-term care for people with the income above this threshold can be limited either by low affordability (especially, if the service is provided by private service providers) or non-availability of home care services in the community.

In 2016 the amount of money paid by recipients and /or their financial supporters for municipal institutional long-term care for elderly persons was 17685,592 euro.

Role of the private sector

As long-term care recipients in Latvia mostly cannot afford to pay the full cost of care in nursing homes, there are some municipalities that commission services from private nursing homes. However, this area is still relatively underdeveloped.

Private home care services are available mostly in the cities; even then, costs of the services are too high to afford for the most of the families, depending on the municipality services can be co-financed. Depending on the municipality those can be available outside the cities as well, including in more remote areas, organised by service providers ([530]).

Formal/informal caregiving

As explained above, municipalities are also free to grant their own long-term care cash benefits. If the municipality does not have its own home care services, it will often grant the benefits in cash to the recipients or their relatives. As a consequence, depending on the municipality financial situation support is granted to care-takers or/and care-givers.

In 2016 only 19 municipalities out of 119 reported spending for financial support to carers; the amount of resources for this purpose has been growing in recent years: It was 539,000 euro in 2010, 786,000 euro in 2012, 848,543 euro in 2014 and 1404,181 euro in 2016. About 50% of municipalities have reported expenditures for financial support to care receivers or carers over the years. Depending on the municipality, support can be granted as a simple cash benefit to the

([530]) For example – http://www.samariesi.lv/lv/pakalpojumi/aprupe-majas-novados http://www.aprupemajas.lv/pakalpojumi.html

family member providing the informal care or can be formulated as a formal payment for care services on the basis of a contract, therefore formalising what was informal care. Most often these types of contracts are made between a neighbour or a relative and the municipality.

Prevention and rehabilitation policies/measures

Government funded social rehabilitation programme (14 or 21 days long) for persons with different functional disorders is available. For persons above the age 62 (old age pensioners) this service is available only if persons are still in employment.

Recently legislated and/or planned policy reforms

Ministry of Welfare is planning to support more community-based services (primarily for children and persons with mental disabilities), and thus to promote deinstitutionalisation by creating more affordable and more diverse services for the target groups.

Long-term care legislation provides some changes in the calculation of person's payments for long-term institutional care. Since year 2017 in addition to State pensions (including a supplement to the pension) in receiver's income, from which to pay for long-term care service, the following are also included: (i) a service pension, (ii) a special State pension, (iii) a compensation for the loss of capacity to work, (iv) a compensation for harm, (v) a survivor's compensation due to an accident at work or occupational disease, (vi) income from a life-long pension insurance contract regarding the receipt of the accrued funded pension capital as well as (vii) pensions granted in accordance with foreign laws and regulations. From year 2020 onwards, it is planned to decrease, the part of income paid for the institutional long-term care from 90 to 85%.

Challenges

The main challenges of the system appear to be:

- **Improving the governance framework:** To establish a coherent and integrated legal and governance framework for a clear delineation of responsibilities of state authorities wrt. the provision of long-term care services. To strategically integrate medical and social services via such a legal framework. To define a comprehensive approach covering both policies for informal (family and friends) carers, and policies on the formal provision of LTC services and its financing taking into account the fiscal constraints. To establish good information platforms for LTC users and providers. To set guidelines to steer decision-making at local level or by practising providers. To use care planning processes, based on individualised need assessments, involving health and care providers and linking need assessment to resource allocation. To share data within government administrations to facilitate the management of potential interactions between LTC financing, targeted personal-income tax measures and transfers (e.g. pensions), and existing social-assistance or housing subsidy programmes. To deal with cost-shifting incentives across health and care.

- **Improving financing arrangements:** To explore the potential of private LTC insurance as a supplementary financing tool. To consider adjusting the extent of user cost-sharing on LTC benefits.

- **Providing adequate levels of care to those in need of care:** To adapt and improve LTC coverage schemes, to assess the need-level triggering entitlement to coverage; the breadth of coverage, i.e. the extent of user cost-sharing on LTC benefits; and the depth of coverage, i.e. the types of services included into the coverage; To explore the potential of providing targeted benefits to those potential recipients of LTC care with highest LTC needs. To reduce the risk of impoverishment of recipients and informal carers.

- **Encouraging home care**: To develop alternatives to institutional care by e.g.

encouraging home care and assessing admissions to institutional care or the establishment of additional payments, cash benefits or financial incentives to encourage home care taking into account fiscal constraints; to monitor and evaluate alternative services, including incentives for use of alternative settings.

- **Encouraging independent living:** To encourage additional provision of effective home care, tele-care and information to recipients, as well as improving home and general living environment design.

- **Ensuring availability of formal carers:** To determine current and future needs for qualified human resources and facilities for long-term care.

- **Supporting family carers:** Assessing the possibility to introduce policies for supporting informal carers, such as through flexible working conditions, respite care, carer's allowances replacing lost wages or covering expenses incurred due to caring, cash benefits paid to the care recipients, while ensuring that incentives for employment of carers are not diminished and women are not encouraged to withdraw from the labour market for caring reasons.

- **Ensuring coordination and continuity of care:** To establish better co-ordination of care pathways and along the care continuum, such as through a single point of access to information, the allocation of care co-ordination responsibilities to providers or to care managers, via dedicated governance structures for care co-ordination and the integration of health and care to facilitate care co-ordination.

- **To facilitate appropriate utilisation across health and long-term care:** To create better rules, improving (and securing) safe care pathways and information delivered to chronically-ill people or circulated through the system. To steer LTC users towards appropriate settings.

- **Changing payment incentives for providers:** To consider a focused use of budgets negotiated ex-ante or based on a pre-fixed share of high-need users.

- **Improving value for money:** To invest in assistive devices, which for example, facilitate self-care, patient centeredness, and co-ordination between health and care services. To invest in ICT as an important source of information, care management and coordination.

- **Prevention:** To promote healthy ageing and preventing physical and mental deterioration of people with chronic care. To employ prevention and health-promotion policies and identify risk groups and detect morbidity patterns earlier.

Table 3.16.1: **Statistical Annex – Latvia**

GENERAL CONTEXT

GDP and Population	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	EU 2009	EU 2011	EU 2013	EU 2015
GDP, in billion euro, current prices	14	17	23	24	19	18	20	22	23	24	24	12,451	13,213	13,559	14,447
GDP per capita, PPS	15.9	15.7	15.0	13.8	12.7	13.4	14.0	14.6	14.9	15.4	16.2	26.8	28.1	28.0	29.6
Population, in millions	2.2	2.2	2.2	2.2	2.2	2.1	2.1	2.0	2.0	2.0	2.0	502	503	505	509
Public expenditure on long-term care (health)															
As % of GDP	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.2	0.2	0.3	0.3	1.1	1.2	1.2	1.2
Per capita PPS	:	:	:	:	:	:	:	:	42.8	46.1	50.1	264.1	283.2	352.1	373.6
As % of total government expenditure	0.6	0.6	0.6	0.6	0.5	0.5	0.7	0.7	0.7	0.7	0.7	1.6	1.8	2.5	2.5
Note: Based on OECD, Eurostat - System of Health Accounts															
Health status															
Life expectancy at birth for females	76.3	76.1	76.2	77.5	77.7	78.0	78.8	78.9	78.9	79.4	79.5	82.6	83.1	83.3	83.3
Life expectancy at birth for males	64.9	65.0	65.3	66.5	67.5	67.9	68.6	68.9	69.3	69.1	69.7	76.6	77.3	77.7	77.9
Healthy life years at birth for females	53.2	52.5	54.8	54.3	56.0	56.4	56.6	59.0	54.2	55.3	54.1	62.0	62.1	61.5	63.3
Healthy life years at birth for males	50.8	50.8	51.4	51.6	52.6	53.1	53.6	54.6	51.7	51.5	51.8	61.3	61.7	61.4	62.6
People having a long-standing illness or health problem, in % of pop.	:	36.1	33.6	34.4	34.3	35.6	36.4	36.0	39.7	40.6	41.2	31.3	31.7	32.5	34.2
People having self-perceived severe limitations in daily activities (% of pop.)	:	10.3	9.1	8.2	6.9	7.5	6.7	7.1	10.1	9.6	10.1	8.3	8.3	8.7	8.1

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	EU 2009	EU 2011	EU 2013	EU 2015
Number of people receiving care in an institution, in thousands	:	:	6	8	9	11	11	11	11	11	11	3,433	3,851	4,183	4,313
Number of people receiving care at home, in thousands	:	:	6	8	9	10	11	11	9	9	9	6,442	7,444	6,700	6,905
% of pop. receiving formal LTC in-kind	:	:	0.6	0.7	0.8	1.0	1.0	1.0	1.0	1.0	1.0	2.0	2.2	2.2	2.2
Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients															
Providers															
Number of informal carers, in thousands	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:
Number of formal carers, in thousands	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:

Source: EUROSTAT, OECD and WHO.

Table 3.16.2: **Statistical Annex - continued – Latvia**

PROJECTIONS

Population	**2016**	**2020**	**2030**	**2040**	**2050**	**2060**	**2070**	**MS Change 2016-2070**	**EU Change 2016-2070**
Population projection in millions	2.0	1.9	1.7	1.6	1.5	1.4	1.3	-32%	2%
Dependency									
Number of dependents in millions	0.17	0.17	0.17	0.17	0.17	0.16	0.15	-11%	25%
Share of dependents, in %	8.5	8.8	9.6	10.6	11.1	11.2	11.1	31%	21%
Projected public expenditure on LTC as % of GDP									
AWG reference scenario	0.4	0.4	0.5	0.5	0.6	0.6	0.6	34%	73%
AWG risk scenario	0.4	0.5	0.6	0.9	1.4	2.1	3.0	591%	170%
Coverage									
Number of people receiving care in an institution	13,003	13,160	13,108	12,951	12,862	12,427	11,766	-10%	72%
Number of people receiving care at home	14,573	14,743	14,792	15,008	15,070	14,434	13,831	-5%	86%
Number of people receiving cash benefits	15,935	16,150	16,566	16,909	17,551	17,411	16,841	6%	52%
% of pop. receiving formal LTC in-kind and/or cash benefits	2.2	2.3	2.6	2.8	3.0	3.1	3.2	43%	61%
% of dependents receiving formal LTC in-kind and/or cash benefits	26.0	26.3	26.6	26.6	27.2	27.8	28.5	9%	33%
Composition of public expenditure and unit costs									
Public spending on formal LTC in-kind (% of tot. publ. spending LTC)	84.7	83.9	83.3	82.5	82.0	81.8	80.7	-5%	5%
Public spending on LTC related cash benefits (% of tot. publ. spending LTC)	15.3	16.1	16.7	17.5	18.0	18.2	19.3	26%	-27%
Public spending on institutional care (% of tot. publ. spending LTC in-kind)	82.3	81.1	78.3	74.9	71.6	69.5	67.7	-18%	0%
Public spending on home care (% of tot. publ. spending LTC in-kind)	17.7	18.9	21.7	25.1	28.4	30.5	32.3	83%	-1%
Unit costs of institutional care per recipient, as % of GDP per capita	45.6	43.1	42.5	40.5	39.4	38.7	36.1	-21%	10%
Unit costs of home care per recipient, as % of GDP per capita	8.8	9.0	10.4	11.7	13.3	14.7	14.7	68%	1%
Unit costs of cash benefits per recipient, as % of GDP per capita	8.2	8.3	8.6	8.8	8.8	8.9	8.9	9%	-14%

Source: EUROSTAT, OECD, WHO and European Commission (DG ECFIN)-EPC (AWG) 2018 Ageing Report projections (2016-2070).