Latvia

Health Care & Long-Term Care Systems

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Health care systems

1.16. LATVIA

General context: Expenditure, fiscal sustainability and demographic trends

General statistics: GDP, GDP per capita; population

In 2013, Latvia had a GDP per capita of 14.9 PPS (in thousands), below the EU average of 27.9.

Population was close to 2 million in 2014.

Total and public expenditure on health as % of GDP

Total expenditure ([166]) on health as a percentage of GDP (5.7% in 2013) is below the EU average ([167]) of 10.1%. Public expenditure is at 3.5% of GDP, far below the average of 7.8% in 2013.

When expressed in per capita terms, total spending on health at 1000 PPS in Latvia is below the EU average of 2988 in 2013. So is public spending on health care: 619 PPS vs. an average of 2208 PPS in 2013.

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 1.5 pps of GDP from now until 2060 (EU: 1.6). ([168])

Overall, for Latvia no significant short-term risks of fiscal stress appear at the horizon, though some macro-financial indicators point to possible short-term challenges.

Risks appear to be low in the medium term from a debt sustainability analysis perspective due to the low stock of debt at the end of projections (2026).

No sustainability risks appear over the long run thanks to the pension reforms implemented in the past.

Health status

Life expectancy at birth continues to increase gradually in Latvia (78.9 years for women and 69.3 years for men in 2013) but it is far below the respective EU averages (83.3 and 77.8 years of life expectancy). ([169]) Healthy life years, at 54.2 years for women and 51.7 for men are below the EU averages of 61.5 and 61.4 in 2013, but has increased gradually in last decade, although it should be noted 2013 has seen a sharp drop. The infant mortality rate of 4.4‰ (after a sharp drop from 6.3‰ in 2012) is higher than the EU average of 3.9‰ in 2011, having fallen over the last decade (from 11‰ in 2001). Future data should clarify whether this is a one-off occurrence or represents a change of trend.

As for the lifestyle of the Latvian population, there is a proportion of regular smokers of 27.9% above the EU average of 23.2% in 2009. Alcohol consumption is, at 10.2 litres per capita, higher than the EU average of 9.8.

System characteristics ([170])

Coverage

The Latvian health system is a tax-funded social insurance system. The services included in the statutory provision are determined annually in the Basic Care Programme.

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

([166]) 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.

([167]) 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.

([168]) The 2015 Ageing Report: http://europa.eu/epc/pdf/ageing_report_2015_en.pdf

([169]) 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.

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

through mandatory insurance contributions from employers and employees ([171]).

Despite full population coverage, the services available 100% free of charge are limited. The system suffers from low accessibility due to financial reasons. In 2013 12% 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 2.4%), while in the lowest income quintile the rate reported is close to 24%. This is the highest level of unmet need for health care in the EU and has been so for 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 (More than 35% for the 1st income quintile, i.e. the poorest, and 18.4% for the total population in 2013).

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 are not under contract to the Latvian heath system . 2013 data shows that Latvia has the fourth 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 EUR 171 per family member. Those with an income below EUR 213 euro were exempted from 50% of fees. From 2012 this was scaled back, with only those with an income below EUR 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 EUR 13.52 to 10 euro, as well as the patient's co-payment (for a surgical procedure in hospital) was reduced from EUR 42.69 to EUR 31.

The share of private expenditure on health in total health expenditure (38.1% in 2013) is far higher than the EU average of 22.6%. Out-of-pocket expenditure constitutes about 36.5% of total health expenditure, far above the EU average (14.1% in 2013). The authorities' effort to improve access to care is reflected in the observed reduction from 2003 (45.7%).

Statistical analysis of the expenditure of Latvian households has shown that the share devoted to health expenditure has increased by 3.3% in 2012 up to 6.1% of the income of households. Whereas in 2008 it represented the 9th highest expenditure group, by 2011 and 2012 it had gone up to the 5th highest, above items such as clothing and footwear ([172]).

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 ([173]).

Administrative organisation and revenue collection mechanism

Public funding, including transfers from general taxes (state or municipal budgets), together constitute 61.9% of total health expenditure funding (2013), compared with the EU average of 77.4%.

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 surce for the system.

([171]) ASISP (2014).

([172]) ASISP, (2014).
([173]) ASISP (2014).

There are plans to levy compulsory health insurance contributions to supplement the funding of health care. The Ministry of Health is working on the new health care funding model.

Types of providers, referral systems and patient choice

The total number of practising physicians per 100 000 inhabitants (319 in 2013) is below the EU average (344) and has increased since 2003 (279) . Data on the physician skill-mix indicates that the number of GPs per 100 000 inhabitants (59 in 2009) is below the EU average (78) although it registered a steady increase since 2003 (45) as part of the authorities' effort to improve primary care provision. The number of nurses (488 in 2013) per 100 000 inhabitants is far below the EU average (837 in 2013).

Latvia has 350 acute care hospital beds per 100 000 inhabitants (down from 543 in 2003), close to the EU (EU average of 356 in 2013).

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, narcologists, ophthalmologists, paediatricians, child surgeons, dentists and sports doctors). 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 in case of oncological disease, pneunomologist in case of tuberculosis, dermatologist in case of sexually transmitted disease, infectologist in case of HIV. 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 Latvian health system.

Price of healthcare services, purchasing, contracting and remuneration mechanisms

The Latvian public health system acts as the main purchaser of health care for the population, directly commissioning both public and private providers (including GPs, dentists and hospitals). In 2012,it held contracts with 2,139 health care providers ([174]).

Large tertiary and specialised hospitals are owned by the stated, 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.

The market for pharmaceutical products

Total pharmaceutical expenditure, at 1.56% of GDP, above the EU average of 1.44%. However, public pharmaceutical expenditure at 0.6% of GDP is far below the 0.96% 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), reorganised in 2009 and the NHS (National Health Service), 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,

([174]) ASISP (2014)

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 EUR 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 EUR 128 per family member per month are exempted from user charges.

In 2012, the existing reference price system for pharmaceuticals from List A was modified. Since the reform, only one pharmaceutical product per reference group has the status of reference medicine and is reimbursed by the NHS.

Pharmaceutical products are supplied to the public by a regulated distribution system consisting of licensed enterprises that manufacture and/or distribute them. In 2013, there were 64 licensed wholesalers and 7 licensed manufacturers of active pharmaceutical substances in Latvia (State Agency of Medicines of Latvia, 2013).

Wholesalers are private enterprises. The total wholesale turnover of pharmaceuticals (excluding sales among wholesalers) is EUR 295 million. Domestic production accounts for about 5% 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.

Most 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 owned most of the top 10 general pharmacies with the largest turnover in last five years. A small number of pharmacies exist at health care institutions and, in rural areas, under certain conditions determined by Pharmacy law, pharmacies can also be owned by pharmacy assistants.

eHealth, Electronic Health Record

The NHS is responsible for the implementation of the eHealth 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 eHealth projects which were finalised accordingly in the end of 2014 and the following eHealth information systems are developed – eHealth integration platform information system (IS), e-booking IS, e-referral IS, electronic health record IS, e-prescription IS, as well an eHealth portal. The publicly available part of the eHealth portal will provide the actual information about health care in Latvia, as well information about health prevention and other related topics. The authorised part of the eHealth portal will provide the easy access for inhabitants to their health data but for health care professionals - a virtual workplace. The publicly available part of the eHealth portal is open since June 2016. Currently NHS is working to provide the access to the authorised part of the eHealth portal in the nearest future.

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 electronic health information system, the data stored in the health information 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 and pharmacies are obliged to start using e-prescription and e- sick lists by December 31, 2016 and rest of IS functionalities by 2017 July 1.. In accordance with the regulations No.134 the eHealth IS will provide 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.

Since 2010 patients can access to certain health care records collected in some state information systems, ie. the patients have a right to access the information about the health care services received and paid by the state budget (information sent by health care institutions to NHS for payment purposes), about the GP to whom the patient is registered, the patient's newborn health data and the patient's data within the diabetes mellitus patients' register. The information can be accessed by using state's e-services' portal www.latvija.lv (authenticated with internet bank, electronic signature).

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 CSBis 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, 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. All health care institutions in Latvia have a legal obligation to submit the relevant patient health data to CDPC. In accordance with the Regulations of the Cabinet of Ministers No.10 (01.06.2009) „Regulations on the state statistical overviews of health care" 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; the costs of the new technology; and a justification of the use of resources to purchase it.

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, as well as the economic justification of its use. About 50 to 60 evaluations of new technologies are conducted each year according to a methodology that is specified in the above-mentioned regulations. A positive assessment is a prerequisite for the introduction of a new technology in Latvia.

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 (0.04%) and public (0.04%) expenditure on prevention and public health as a % of GDP is far lower than the EU average (respectively 0.24% and 0.19% in 2013). The sharp drop with respect to earlier figures means that it will be necessary to monitor closely the future evolution of these variables to ascertain whether this really represents a change of trend rather or just a one-off impact.

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

Recently legislated and/or planned policy reform

Recent policy response

The implementation of The Maternal and Child Health Improvement Plan for 2012 – 2014, was approved in 2012. The main objective of the plan is to improve the health of mother and child through measures such as: statutory provision of fertility treatment and in vitro fertilisation procedures, reimbursement of pharmaceuticals for infertility treatment; introduction of the principle "money follows the pregnant woman"in order to involve gynaecologists and other specialists from private sector into the state-funded maternity care; to reduce the risk of hereditary pathology an additional preventive procedures for pregnant women included in the statutory provision; 50% reimbursement of the flu vaccine for pregnant women and 25% prescription drug cost reimbursement for pregnant women and women in the period following childbirth up to 42 days (except, when the diagnosis is eligible for other reimbursement categories (100%, 75% or 50%); 50% prescription drug cost reimbursement for children under the age of 24 months (except, when the diagnosis is eligible for other reimbursement categories (100% or 75%); establishment of The Committee of Experts on Confidential Analysis of MaternalMortality to investigate the death causes of pregnant women or women in postnatal period (until the 42nd day) and to develop recommendations for the medical treatment institutions, medical staff associations and policy makers in order to avoid the identified mistakes and nonconformities in the future. It is planned to introduce a perinatal deaths audit system in Latvia, as well.

The implementation of mental health care policy action plan for 2013- 2014, adopted in 2013,, which includes the measures to improve the quality and availability of mental health care services, the skills and knowledge of professionals who are involved in the care of persons with mental disorders, to reduce the stigma in the society, to improve the legal framework to protect the rights of persons receiving mental health care services, as well to improve the monitoring of mental disorders in the population.

Cardiovascular Health Improvement Action Plan for 2013- 2015, adopted in 2013, which aims to improve the cardiovascular health of the population. The Plan includes measures to promote healthy lifestyle habits in the population and early diagnosis and quality of cardiovascular health care services in the out-patient and in-patient health care settings, as well the monitoring of cardiovascular diseases. Implementation is pending additional financial resources.

In 2014 was adopted The Public Health Strategy for 2014-2020 to improve the healthy life years of the population, reduce risk factors for non-infectious diseases improve the health of both pregnant women and children, decrease the impact of traumatism and environmental risks upon public health, prevent infectious diseases, and to increase the accessibility of health care services.

The implementation of Primary Health Care Action Plan for 2014.-2016, adopted in 2014. The aim is to improve the access, quality and safety of the primary health care. The Plan includes the measures to improve the territorial and organisational accessibility of primary health care providers, the requirements for primary health care providers and services, the provision of primary health care services, the further development of primary health care quality assurance system, to promote the primary health care specialists' cooperation with other health care specialists and specialists from other sectors (e.g. social workers, school nurses), to improve financing mechanisms of primary health care, and to strengthen the collaboration between the pharmaceutical and primary health care sectors.

Addressing problems with medical personnel accessibility for citizens living in the regions outside the capital, in April 2015, the Ministry of Health required medical universities to give priority residency positions to those applicants who have concluded an agreement with a regional municipality and/or state medical institution outside the capital for work relations in rural area after the completion of the residency program. Accordingly, the residential program 2015-2016 accommodates 34 residents with a "regional arrangement".

A number of measures have been taken within the scope of the eHealth project in order to provide patients with access to the eHealth portal and thus gradually ensuring that patients have access to all the data that is stored in the system.

To change public attitude towards health and improve public health indicators, number of changes in laws and regulations have been made in order to limit unhealthy products and habits, such as the regulations on restriction of trans-fatty acid amounts in food products, as well as the regulations ensuring availability of healthy food in educational institutions, hospitals and nursing homes. As a result of the Ministry's initiative, Parliament has adopted the law on restriction of availability of energy drinks to children, as well as amendments to the Law "On Excise Tax" to increase rates of excise tax on alcoholic beverages from 1 August 2015. Currently, the Parliament is evaluating a new law on stronger restrictions on smoking.

The development of the National Network of Healthy Cities. The aim of the Network is 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 43 municipalities participating in the Network (36% of municipalities in Latvia) (data from 17.03.2016).

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 are reimbursed at 100 % for several group of diagnosis, for example pharmaceuticals in the case of conjunctivitis, atopic dermatitis, acute bronchitis, etc. As well in 2015 measures were also taken to reduce the amount of the patient's co-payment from 50% to 25% to patients diagnosed with diseases such as Crohn's disease, ulcerative colitis and psoriasis.

Taking into account the epidemiological risks and in order to improve the availability of medicines for hepatitis C and HIV/AIDS patients, the health sector in 2016 budget provided additional 4.2 million euro. This gave the opportunity to increase compensation for the expenses of the treatment of hepatitis C from 75% to 100% starting from 1 January 2016. In the first month, state-covered therapy of hepatitis C was provided to 172 patients, from which in 32 cases the newest therapies (interferon free therapy) were used.

Starting from January 2017, the state will cover the expenses related to liver transplantation for adults.

Policy changes under preparation/adoption

The NHS is working on the introduction of the Nord-DRG activity-based accounting system in hospitals. The use of DRGs is expected 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). This is seen to be a considerable advantage when compared to the current payment system, where resource allocation does not always follow rational criteria. The Ministry of Health with the technical assistance of the WHO Regional Office for Europe elaborated and in 2016 was adopted Diagnosis related groups (DRG) Implementation Plan for the next 3 years. DRG Implementation Plan is the roadmap for Latvia and will guide all stakeholders through the DRG implementation process during this period. It provides and defines the main goals, actions, responsible stakeholders, involved parties and timelines.

In the new programming period of the EU funds the Ministry of Health has succeeded to attract funding for health promotion from the European Social Fund of a total amount of 55,4 million euros.

In order to achieve significant improvements in health care quality, efficiency and availability the collaboration initiated at the end of 2014 with the World Bank for the priority health areas (cardiovascular, oncology, perinatal and neonatal period care and mental health) for the development and implementation of the health network guidelines especially for the health improvement of people at risk of social exclusion and poverty will be continued. Based on the research conducted by the World Bank the national health sector reform plan will be elaborated. It is also planned to launch a uniform health care quality assurance concept elaboration and implementation using EU funds in 2014-2020th the programming period investments.

To continue modernisation of the united health information system it is planned to develop and launch the implementation of eHealth projects,with the aim to centralise management of health data (including finances), as well as to develop an electronic patient identification system.

Possible future policy changes

In February 2015, the government approved the Action Plan aimed to develop a sustainable health system by providing a stable and predictable funding for health care, including the assessment of possible development of new health care financing (health insurance) model. Taking into account the fact that health sector is still under-funded and many needs are still uncovered, this task of new health care financing model and increasing the proportion of health sector funding to the GDP, is highlighted as a priority of the declaration of the Intended Activities of the Cabinet of Ministers Headed by Māris Kučinskis as well.

Ministry of Health has prepared the estimates on the necessary extra funds for the health sector:

6. to gradually increase of the average wage of medical professionals;

7. to decrease the patient contributions and copayments for the health care services;

8. to decrease the patient payments for pharmaceuticals by decreasing the copayments for reimbursable pharmaceuticals, expanding the list of pharmaceuticals eligible for reimbursement, expanding the list of conditions for which drugs are reimbursed;

9. to decrease the waiting times to out-patient and in-patient health care services by allocation additional funds for diagnostic and treatment procedures;

10. to increase the availability of rehabilitation services;

The above policy changes are still being considered taking into account whether additional funds are allocated.

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.

- 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 1.16.1: **Statistical Annex – Latvia**

General context												EU- latest national data		
GDP	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
GDP, in billion Euro, current prices	10	12	14	17	23	24	19	18	20	22	23	9289	9800	9934
GDP per capita PPS (thousands)	15.3	15.8	15.9	16.2	15.4	13.9	12.7	13.3	13.8	14.5	14.9	26.8	28.0	27.9
Real GDP growth (% year-on-year) per capita	8.7	10.0	11.3	12.0	10.9	-1.7	-16.3	0.8	7.3	6.5	5.1	-4.8	1.4	-0.1
Real total health expenditure growth (% year-on-year) per capita	7.8	17.0	8.7	19.2	14.3	-7.0	-13.6	-4.8	1.3	3.0	1.9	3.2	-0.2	-0.4

Expenditure on health*												**2009**	**2011**	**2013**
Total as % of GDP	6.2	6.5	6.4	6.8	7.0	6.6	6.8	6.5	6.1	5.9	5.7	10.4	10.1	10.1
Total current as % of GDP	:	6.5	6.2	6.2	6.2	6.0	6.2	6.0	:	:	:	9.8	9.6	9.7
Total capital investment as % of GDP	:	0.0	0.2	0.6	0.8	0.6	0.6	0.5	:	:	:	0.6	0.5	0.5
Total per capita PPS	401	493	599	810	1112	1143	924	848	925	978	1000	2828	2911	2995
Public as % of GDP	3.2	3.7	3.6	4.4	4.3	4.1	4.1	3.9	3.9	3.6	3.5	8.1	7.8	7.8
Public current as % of GDP	:	3.7	3.5	3.8	3.6	3.6	3.7	3.6	3.5	3.2	3.2	7.9	7.7	7.7
Public per capita PPS	212	264	307	421	536	586	497	:	587	593	619	2079	2218	2208
Public capital investment as % of GDP	:	0.0	0.2	0.6	0.6	0.5	0.4	0.3	0.3	0.3	0.4	0.2	0.2	0.1
Public as % total expenditure on health	52.8	56.3	57.0	64.1	60.8	62.1	59.5	59.6	63.5	60.6	61.9	77.6	77.2	77.4
Public expenditure on health in % of total government expenditure	9.7	9.7	12.0	12.8	11.9	11.8	10.8	9.7	10.7	10.7	:	14.8	14.9	:
Proportion of the population covered by public or primary private health insurance	:	:	:	:	:	:	:	:	100.0	100.0	:	99.7	99.7	98.7
Out-of-pocket expenditure on health as % of total expenditure on health	45.7	40.6	41.7	35.6	39.3	37.3	38.8	37.8	32.1	35.1	36.5	14.1	14.4	14.1

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												**2009**	**2011**	**2013**
Population, current (millions)	2.3	2.3	2.2	2.2	2.2	2.2	2.2	2.1	2.1	2.0	2.0	502.1	504.5	506.6
Life expectancy at birth for females	75.7	76.0	76.3	76.1	76.2	77.5	77.7	78.0	78.8	78.9	78.9	82.6	83.1	83.3
Life expectancy at birth for males	65.3	65.6	64.9	65.0	65.3	66.5	67.5	67.9	68.6	68.9	69.3	76.6	77.3	77.8
Healthy life years at birth females	:	:	53.2	52.5	54.8	54.3	56.0	56.4	56.6	59.0	54.2	:	62.1	61.5
Healthy life years at birth males	:	:	50.8	50.8	51.4	51.6	52.6	53.1	53.6	54.6	51.7	:	61.7	61.4
Amenable mortality rates per 100 000 inhabitants*	219	201	199	185	168	154	144	145	290	318	:	64.4	128.4	:
Infant mortality rate per 1 000 life births	9.4	9.3	7.7	7.4	8.5	6.6	7.6	5.6	6.6	6.3	4.4	4.2	3.9	3.9

Notes: Amenable mortality rates break in series in 2011.

System characteristics												EU- latest national data		
Composition of total current expenditure as % of GDP	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
Inpatient curative and rehabilitative care	:	2.07	1.85	1.81	1.96	1.74	1.96	1.71	:	:	:	3.13	2.99	3.01
Day cases curative and rehabilitative care	:	0.06	0.04	0.07	0.08	0.09	0.10	0.23	:	:	:	0.18	0.18	0.19
Out-patient curative and rehabilitative care	:	1.36	1.46	1.32	0.89	1.49	1.26	1.17	:	:	:	2.29	2.25	2.24
Pharmaceuticals and other medical non-durables	:	1.54	1.40	1.44	1.65	1.29	1.52	1.56	:	:	:	1.60	1.55	1.44
Therapeutic appliances and other medical durables	:	0.39	0.41	0.17	0.41	0.17	0.27	0.21	:	:	:	0.31	0.31	0.32
Prevention and public health services	:	0.06	0.02	0.19	0.10	0.09	0.19	0.14	:	:	0.04	0.25	0.25	0.24
Health administration and health insurance	:	0.19	0.17	0.20	0.25	0.17	0.21	0.19	0.17	0.14	0.13	0.42	0.41	0.47
Composition of public current expenditure as % of GDP														
Inpatient curative and rehabilitative care	:	1.55	1.34	1.33	1.62	1.42	1.60	1.29	:	:	:	2.73	2.61	2.62
Day cases curative and rehabilitative care	:	0.06	0.04	0.06	0.06	0.06	0.08	0.19	:	:	:	0.16	0.16	0.18
Out-patient curative and rehabilitative care	:	0.61	0.64	0.65	0.36	0.52	0.52	0.60	:	:	:	1.74	1.71	1.80
Pharmaceuticals and other medical non-durables	:	0.40	0.44	0.47	0.44	0.49	0.55	0.60	:	:	:	0.79	1.07	0.96
Therapeutic appliances and other medical durables	:	0.05	0.01	0.00	0.01	0.00	0.05	0.00	:	:	:	0.13	0.12	0.13
Prevention and public health services	:	0.06	0.01	0.17	0.10	0.09	0.19	0.14	0.18	0.15	0.04	0.25	0.20	0.19
Health administration and health insurance	:	0.17	0.50	0.48	0.31	0.42	0.18	0.21	0.18	0.14	0.14	0.11	0.27	0.27

Sources: EUROSTAT, OECD and WHO

Table 1.16.2: **Statistical Annex - continued – Latvia**

Composition of total as % of total current health expenditure	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU- latest national data 2009	2011	2013
Inpatient curative and rehabilitative care	:	31.7%	29.7%	29.2%	31.5%	29.0%	31.5%	28.6%	:	:	:	31.8%	31.3%	31.1%
Day cases curative and rehabilitative care	:	0.9%	0.6%	1.1%	1.3%	1.5%	1.6%	3.9%	:	:	:	1.8%	1.9%	1.9%
Out-patient curative and rehabilitative care	:	20.9%	23.5%	21.3%	14.3%	24.9%	20.2%	19.6%	:	:	:	23.3%	23.5%	23.2%
Pharmaceuticals and other medical non-durables	:	23.6%	22.5%	23.2%	26.5%	21.5%	24.4%	26.1%	:	:	:	16.3%	16.2%	14.9%
Therapeutic appliances and other medical durables	:	6.0%	6.6%	2.7%	6.6%	2.8%	4.3%	3.5%	:	:	:	3.2%	3.3%	3.3%
Prevention and public health services	:	0.9%	0.3%	3.1%	1.6%	1.5%	3.0%	2.3%	:	:	:	2.6%	2.6%	2.5%
Health administration and health insurance	:	2.9%	2.7%	3.2%	4.0%	2.8%	3.4%	3.2%	:	:	:	4.2%	4.3%	4.9%
Composition of public as % of public current health expenditure														
Inpatient curative and rehabilitative care	:	42.3%	38.6%	34.9%	44.5%	39.3%	43.0%	36.2%	:	:	:	34.6%	34.1%	34.0%
Day cases curative and rehabilitative care	:	1.6%	1.2%	1.6%	1.6%	1.7%	2.2%	5.3%	:	:	:	2.0%	2.1%	2.3%
Out-patient curative and rehabilitative care	:	16.7%	18.4%	17.1%	9.9%	14.4%	14.0%	16.9%	:	:	:	22.0%	22.3%	23.4%
Pharmaceuticals and other medical non-durables	:	10.9%	12.7%	12.3%	12.1%	13.6%	14.8%	16.9%	:	:	:	10.0%	13.9%	12.5%
Therapeutic appliances and other medical durables	:	1.4%	0.3%	0.0%	0.3%	0.0%	1.3%	0.0%	:	:	:	1.6%	1.6%	1.6%
Prevention and public health services	:	1.6%	0.3%	4.5%	2.7%	2.5%	5.1%	3.9%	5.0%	4.7%	1.2%	3.2%	2.7%	2.5%
Health administration and health insurance	:	4.6%	14.3%	12.7%	8.6%	11.8%	4.8%	5.8%	5.2%	4.4%	4.3%	1.4%	3.5%	3.5%

Expenditure drivers (technology, life style)	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU- latest national data 2009	2011	2013
MRI units per 100 000 inhabitants	0.13	0.09	0.26	0.26	0.48	0.66	0.71	0.79	0.92	0.98	1.04	1.0	1.1	1.0
Angiography units per 100 000 inhabitants	0.1	0.1	0.1	0.2	0.3	0.3	0.4	0.6	0.5	0.6	0.7	0.9	0.9	0.8
CTS per 100 000 inhabitants	1.3	1.5	1.8	1.8	2.1	2.3	2.4	2.8	3.1	3.2	3.5	1.8	1.7	1.6
PET scanners per 100 000 inhabitants	:	:	:	:	:	:	:	:	:	:	0.0	0.1	0.1	0.1
Proportion of the population that is obese	15.5	:	:	:	:	16.9	:	:	:	:	:	14.9	15.4	15.5
Proportion of the population that is a regular smoker	:	30.1	:	30.4	:	27.9	:	:	:	:	:	23.2	22.4	22.0
Alcohol consumption litres per capita	8.2	8.8	9.9	10.4	12.1	11.8	9.9	9.8	10.2	10.2	:	10.3	10.0	9.8

Providers	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2009	2011	2013
Practising physicians per 100 000 inhabitants	279	285	288	294	304	311	299	302	314	314	319	329	335	344
Practising nurses per 100 000 inhabitants	464	477	487	544	535	534	465	486	496	486	488	840	812	837
General practitioners per 100 000 inhabitants	45	53	57	57	58	59	59	:	:	:	:	:	78	78.3
Acute hospital beds per 100 000 inhabitants	543	534	525	517	513	507	428	344	358	356	350	373	360	356

Outputs	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2009	2011	2013
Doctors consultations per capita	4.8	5.1	5.3	5.6	6.0	6.2	5.9	5.9	6.3	7.0	6.2	6.3	6.2	6.2
Hospital inpatient discharges per 100 inhabitants	:	19.7	21.3	20.6	21.1	20.3	17.9	14.9	17.6	17.4	17.2	16.6	16.4	16.5
Day cases discharges per 100 000 inhabitants	:	:	:	:	:	528	:	:	6,791	7,198	7,341	6368	6530	7031
Acute care bed occupancy rates	74.0	75.0	74.0	76.0	76.0	75.5	64.0	71.1	70.4	68.1	68.0	72.0	73.1	70.2
Hospital curative average length of stay	7.9	7.8	7.4	7.2	7.1	7.1	6.1	6.2	6.0	5.8	5.8	6.5	6.3	6.3
Day cases as % of all hospital discharges	:	:	10.6	:	:	2.5	:	:	27.9	29.3	29.9	27.8	28.7	30.4

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP*	2013	2020	2030	2040	2050	2060	Change 2013 - 2060	EU Change 2013 - 2060
AWG reference scenario	3.8	4.0	4.2	4.4	4.5	4.4	0.6	0.9
AWG risk scenario	3.8	4.3	4.8	5.2	5.4	5.3	1.5	1.6

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

Population projections	2013	2020	2030	2040	2050	2060	Change 2013 - 2060, in %	EU - Change 2013 - 2060, in %
Population projections until 2060 (millions)	2.0	1.9	1.6	1.5	1.5	1.4	-30.7	3.1

Sources: EUROSTAT, OECD and WHO

Latvia

Long-term care systems

2.16. LATVIA

General context: Expenditure, fiscal sustainability and demographic trends

With a GDP of around EUR 23 bn or 14,900 PPS per capita in 2013, Latvia is below the EU average GDP per capita of EUR 27,900.

During the coming decennia the population of Latvia will gradually decline, from 2.0 million inhabitants in 2013 to 1.4 million inhabitants in 2060. This 31% fall is very different from the EU average increase of 3%.

Health status

Life expectancy at birth for men and women was, in 2013, respectively 69.3 years and 78.9 years, below the EU average (77.8 and 83.3 years respectively). In 2013 the healthy life years at birth were 54.2 years (women) and 51.7 years (men) below the EU-average (61.4 and 61.5 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 (39.7% and 32.5% respectively in 2013). The percentage of the population indicating a self-perceived severe limitation in its daily activities was in 2012 10.1%, below the EU-average (8.7%).

Dependency trends

The share of dependents in Latvia is set to increase over this period from 7.2% in 2013 to 9.5% of the total population in 2060, an increase of 32%. This is slightly below the EU-average increase of 36%. From 0.14 million residents living with strong limitations due to health problems in 2013, an increase of 8% is envisaged until 2060 to 0.16 million. This is in contrast to the increase in the EU as a whole (40%).

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 0.1 pps of GDP by 2060. ([406]) 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 2.7 pps of GDP by 2060. Overall, for Latvia no significant short-term risks of fiscal stress appear at the horizon, though some macro-financial indicators point to possible short-term challenges.

Risks appear to be low in the medium term from a debt sustainability analysis perspective due to the low stock of debt at the end of projections (2026).

No sustainability risks appear over the long run thanks to the pension reforms implemented in the past. ([407])

System Characteristics ([408])

Administrative organisation

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. 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.

All types of LTC 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 adults with mental disorders and LTC (including both social and health) of chronic psychiatric patients are the responsibility of the Ministry of Welfare and the Ministry of Health.

Public spending on LTC reached 0.2% of GDP in 2010 in Latvia, below the average EU level of 1% of GDP. 84.8% of the benefits were in-kind, while 15.2% were cash-benefits (EU: 80 vs 20%).

([406]) The 2015 Ageing Report: http://europa.eu/epc/pdf/ageing_report_2015_en.pdf

([407]) Fiscal Sustainability Report 2015: http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf

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

In the EU, 53% of dependents are receiving formal in-kind LTC services or cash-benefits for LTC. This share is with 20.1% lower in Latvia. Overall, 1.4% of the population (aged 15+) receives formal LTC in-kind and/or cash benefits (EU: 4.2%). On the one hand, low shares of coverage may indicate a situation of under-provision of LTC 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 (in-kind) services makes up 93% of public in-kind expenditure (EU: 61%), 7% being spent for LTC services provided at home (EU: 39%). 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 2014 there were 84 municipal nursing homes for elderly (known as “social care centres” in the Latvian LTC systems) providing care for 5953 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 2015 there were 28 state owned/financed nursing homes for adults and children with mental disorder with 4431 recipients.

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 2014 there were 12,519 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, halfway houses for people with mental disorders, social residential facilities as well as group houses. These services are however relatively underdeveloped.

Recipients of home care and institutional care (except institutional care for people with mental disorders) 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 are not dependent on family members or relatives, municipalities will cover all 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. If there are family members that are obliged to take care for the person (parents, children, spouse), but the family can’t take care for the person themselves, the family members have to cover part of the expenses about the relative in the nursing home.

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 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. In 2012 about 50% of the municipalities had reported providing some long-term care benefits.

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

Eligibility criteria

In principle there is no means-testing for access to home care, although in practice there is some ambiguity. Local municipalities are legally required to fully cover long-term care expenses of the very poor, but due to limited capacity of their social services they usually decide to provide care service only for those whose income is below the officially set poverty threshold line and who are not dependent on family members. The rest of the demand for LTC is then taken care of by private providers or NGOs.

The universal state benefit for disabled people is granted on the basis of the formal disability status of the recipient (either Category 1 or Category 2) and the level of care needed, irrespective. The assessment is based on the ability of the disabled person to perform daily living activities (based on the Barthel Index of Activities of Daily Living); and it is performed by the State Medical Commission for the Assessment of Health Condition and Working Ability. In December 2012 there were 11,480 recipients of this benefit, 58.3% of whom were aged 65 years and above. The amount of this benefit was set at 142 euro per month in 2013 and was increased by 50% in 2014.

Co-payments, out of the pocket expenses and private insurance

Municipalities have to provide services to everybody who needs them, if the recipient has his own resources (income) or providers, then they need to partially or fully share the costs of this service. The state has defined the amount of money that has to remain in possession of the family 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 that are more beneficial to the client. The threshold is set at a very low level, therefore the access to LTC for people with the income above this threshold is 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.

If a person needs specialised care in a nursing home, their family members are legally obliged to cover part of the expenses. The sum of money the family member (or members) has to pay depends on their net income – once the bill for the received care services is paid, the family has to have the amount of monthly minimum wage (360 euro in 2014) for the person, and half the minimum wage (180 euro in 2014) for every other person in this family. The municipalities can set more beneficial rules for the families.

Role of the private sector

As LTC 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. ([409])

Formal/informal caregiving

As explained above, municipalities are also free to grant their own long-term care cash benefits. If the municipality is unable to provide 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 2014 only 21 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 and 848,543 euro in 2014. 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 family member providing the informal care or can be formulated as a formal

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

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

The possible future policy changes are not going to be targeted towards changes of the long-term care services, but the Ministry of Welfare is planning to support more community-based services (primarily for children and persons with mental disabilities), deinstitutionalisation – to create more affordable and more diverse services for the target groups.

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 2.16.1: **Statistical Annex – Latvia**

GENERAL CONTEXT

GDP and Population	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU 2009	EU 2010	EU 2011	EU 2012	EU 2013
GDP, in billion euro, current prices	10	12	14	17	23	24	19	18	20	22	23	9,289	9,545	9,800	9,835	9,934
GDP per capita, PPS	15.3	15.8	15.9	16.2	15.4	13.9	12.7	13.3	13.8	14.5	14.9	26.8	27.6	28.0	28.1	27.9
Population, in millions	2.3	2.3	2.2	2.2	2.2	2.2	2.2	2.1	2.1	2.0	2.0	502	503	504	506	507
Public expenditure on long-term care																
As % of GDP	:	1.5	1.4	0.2	0.2	0.2	0.2	0.2	:	:	:	1.0	1.0	1.0	1.0	:
Per capita PPS	:	151.4	159.1	28.8	28.7	31.4	28.2	32.3	:	:	:	297.1	316.7	328.5	317.8	:
As % of total government expenditure	:	4.2	4.0	0.6	0.5	0.5	0.5	0.6	:	:	:	2.1	2.2	2.2	2.1	:
Note: Based on OECD, Eurostat - System of Health Accounts																
Health status																
Life expectancy at birth for females	75.7	76.0	76.3	76.1	76.2	77.5	77.7	78.0	78.8	78.9	78.9	82.6	82.8	83.1	83.1	83.3
Life expectancy at birth for males	65.3	65.6	64.9	65.0	65.3	66.5	67.5	67.9	68.6	68.9	69.3	76.6	76.9	77.3	77.4	77.8
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	:	62.6	62.1	62.1	61.5
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	:	61.8	61.7	61.5	61.4
People having a long-standing illness or health problem, in % of pop.	:	:	36.4	36.1	33.6	34.4	34.3	35.6	36.4	36.0	39.7	:	31.4	31.8	31.5	32.5
People having self-perceived severe limitations in daily activities (% of pop.)	:	:	11.1	10.3	9.1	8.2	6.9	7.5	6.7	7.1	10.1	:	8.1	8.3	8.6	8.7

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU 2009	EU 2010	EU 2011	EU 2012	EU 2013
Number of people receiving care in an institution, in thousands	:	:	:	:	6	8	9	11	11	11	11	3,433	3,771	3,851	3,931	4,183
Number of people receiving care at home, in thousands	:	:	:	:	6	8	9	10	11	11	9	6,442	7,296	7,444	7,569	6,700
% of pop. receiving formal LTC in-kind	:	:	:	:	0.6	0.7	0.8	1.0	1.0	1.0	1.0	2.0	2.2	2.2	2.3	2.1
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 2.16.2: **Statistical Annex - continued – Latvia**

PROJECTIONS

Population	**2013**	**2020**	**2030**	**2040**	**2050**	**2060**	**MS Change 2013-2060**	**EU Change 2013-2060**
Population projection in millions	2.0	1.9	1.6	1.5	1.5	1.4	-31%	3%
Dependency								
Number of dependents in millions	0.14	0.14	0.14	0.14	0.14	0.13	-8%	40%
Share of dependents, in %	7.2	7.7	8.7	9.4	9.6	9.5	32%	36%
Projected public expenditure on LTC as % of GDP								
AWG reference scenario	0.6	0.6	0.7	0.7	0.8	0.8	22%	40%
AWG risk scenario	0.6	0.8	1.1	1.5	2.3	3.4	441%	149%
Coverage								
Number of people receiving care in an institution	10,741	10,532	9,914	9,683	9,402	8,821	-18%	79%
Number of people receiving care at home	9,218	9,121	8,638	8,501	8,305	7,777	-16%	78%
Number of people receiving cash benefits	9,083	8,764	8,049	7,699	7,566	7,140	-21%	68%
% of pop. receiving formal LTC in-kind and/or cash benefits	1.4	1.5	1.6	1.7	1.7	1.7	18%	68%
% of dependents receiving formal LTC in-kind and/or cash benefits	20.1	19.7	18.8	18.2	18.1	17.9	-11%	23%
Composition of public expenditure and unit costs								
Public spending on formal LTC in-kind (% of tot. publ. spending LTC)	84.8	84.6	85.3	85.6	85.9	85.8	1%	1%
Public spending on LTC related cash benefits (% of tot. publ. spending LTC)	15.2	15.4	14.7	14.4	14.1	14.2	-7%	-5%
Public spending on institutional care (% of tot. publ. spending LTC)	93.0	92.9	92.9	92.9	92.8	92.8	0%	1%
Public spending on home care (% of tot. publ. spending LTC in-kind)	7.0	7.1	7.1	7.1	7.2	7.2	2%	-1%
Unit costs of institutional care per recipient, as % of GDP per capita	92.2	90.0	91.8	91.4	95.5	96.0	4%	-2%
Unit costs of home care per recipient, as % of GDP per capita	8.1	7.9	8.0	8.0	8.4	8.4	4%	-3%
Unit costs of cash benefits per recipient, as % of GDP per capita	21.1	21.1	20.9	20.8	21.0	21.1	0%	-2%

Source: Based on the European Commission (DG ECFIN)-EPC (AWG), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060)