

CRC 1342 No.35

# Social Policy Country Briefs



Latvia

Liva Stupele

## The Health Care System in Latvia



Global Dynamics  
of Social Policy CRC 1342



Deutsche  
Forschungsgemeinschaft

## **Liva Stupele**

The Health Care System in Latvia

CRC 1342 Social Policy Country Briefs, 35

Edited by Mai Mohamed Abdou Mahmoud and Achim Schmid

Bremen: CRC 1342, 2024



SFB 1342 Globale Entwicklungsdynamiken von Sozialpolitik /  
CRC 1342 Global Dynamics of Social Policy

A04: Global developments in health care systems and long-term  
care as a new social risk

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<https://www.socialpolicydynamics.de>

[DOI <https://doi.org/10.26092/elib/2732>]

[ISSN 2700-4392]

Funded by the Deutsche Forschungsgemeinschaft

(DFG, German Research Foundation)

Projektnummer 374666841 – SFB 1342

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# THE HEALTH CARE SYSTEM IN LATVIA

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Liva Stupele\*

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## 1. COUNTRY OVERVIEW



Source: <https://ontheworldmap.com/latvia/> (Accessed November 11, 2022)

- » Sub-Region: Northern Europe
- » Capital: Riga
- » Official Language: Latvian
- » Population size: 1,883,379 (2022)
- » Share of rural population: 31.5 % (2022)
- » GDP: 41.15 billion in US dollars (in 2022)
- » Income group: High income
- » Gini Index: 35.7 (in 2020)
- » Colonial period and Independence: November 18, 1918
- » Restoration of independence August 21, 1991 (Declaration of independence from the USSR)

Source: World Bank 2023 (<https://data.worldbank.org>)

## 2. SELECTED HEALTH INDICATORS

Indicator	Country	Global Average
Male life expectancy	69 (2021)	69 (2023)
Female life expectancy	78 (2021)	74 (2023)
Mortality rate under 5 per 1,000 live births	4 (2021)	38 (2023)
Maternal mortality ratio (national estimate, per 100,000 live births)	18 (2020)	22 (2023)
Prevalence of HIV, total in % of population aged 15-49	0.7 (2021)	0.7 (2023)
Incidence of tuberculosis per 100,000 of population	16 (2021)	13 (2023)

Source: World Bank 2023 (<https://data.worldbank.org/country/latvia>)

### 3. LEGAL BEGINNING OF THE SYSTEM

Name and type of legal act	Law "On Workers Mandatory Insurance in case of accidents"
Date the law was passed	December 15, 1920
Date of <i>de jure</i> implementation	January 1, 1921
A brief summary of the content	The aim was to adopt healthcare financing and organization regulation in the newly established Latvia by further decentralizing the healthcare system by regulating the organization, coverage and contributions.
Socio-political context of introduction	The blueprint and foundation of the law date back to the Russian Empire, when in 1903, the first regulation was issued on insuring workers in case of work-accidents or work-related sickness. The regulation was supplemented in 1912 by envisaging free-of-charge treatment and allowances in the case of sickness accounting for 50–67 % of regular wages in the biggest industrial companies. After 1917, the Russian government adjusted the regulation by transferring the organization and administration of sickness funds to workers. After the state independence proclamation on November 18, 1918, the Constitutional Assembly adjusted the existing regulation to newly created state structures and in 1920 issued the Law "On Workers Mandatory Insurance in case of accidents" (the Constitutional Assembly, 1920). Later regulations expanded the insured persons and specified sickness fund structure, medical treatment obligations, amount of contributions and their distribution (Aizsilnieks, 1968; Anže, 1999; Glāzītis, 2003; Tragakes et al, 2008; Arāja, Krūzs, 2016).

### 4. CHARACTERISTICS OF THE SYSTEM AT THE INTRODUCTION

#### a. Organisational structure

The healthcare system was decentralized, with the central government setting the regulatory frame and healthcare was organized, administrated and financed in a decentralised manner by the newly created sickness funds. The larger employers (e.g. factories) established their own sickness funds for their workers. In the countryside the sickness funds were established based on the territorial coverage. Despite the fact, that the creation, organization and administration of the sickness funds were employees' responsibility, compared to the system in the Russian Empire, the innovation and the difference was that the Latvian government introduced state allocations to provide more services and develop more generous allowances (Viksna, 1994; Anže, 1999; Glāzītis, 2003; Arāja, Krūzs, 2016).

#### b. Coverage

Indicator	Value (Year)
Percentage of population covered by government schemes	Unknown
Percentage of population covered by social insurance schemes	18.2% (1938)
Percentage of population covered by private schemes	No private insurance scheme
Percentage of population uncovered	Unknown

Source: Viksna, 1994.

The Law required compulsory health insurance for urban employees. Separate laws regulated the insurance of farmers, soldiers and sailors. In 1920 four sickness funds were operating, which grew rapidly and by 1938, thirty sickness funds covered the entire employed urban and rural population, which was 18.2% of the total state population (Viksna, 1994; Anže, 1999; Glāzītis, 2003; Arāja, Krūzs, 2016).

### c. Provision

Indicator	Value (Year)
Density of physicians (per 10,000 people)	3.4 (1920)
Density of hospital beds (per 10,000 people)	40 (1925)

Source: Štāle, Skrule, Rožkalne, 2018.

Four types of health services were covered: emergency care, outpatient services (including visits at home), maternity care, hospital care and dentistry. Some of them additionally offered extra services, e.g. treatment at health resorts. Specific agreements for services were additionally made with professional medical associations, instead of contracting single medical practitioners. However, an exception was a high-ranking specialist, with whom the sickness fund was buying services directly. In parallel to the social health insurance (SHI) system private hospitals and practitioners existed (Anže, 1999; Arāja, Krūzs, 2016).

### d. Financing

The revenues of sickness funds consisted of employers' (4 % of the salary) and employees' (2% of the salary) contributions and state contributions (1-2 % of the salary) (Štāle, Skrule, Rožkalne, 2018). Other key data on healthcare financing for this time period is lacking.

### e. Regulation

The two main actors were the central government and the sickness funds. The central government's role was to develop framework regulation and general supervision of the system as well as partly contribute financially. The sickness funds were responsible, firstly, for collecting contributions and, secondly, for purchasing and providing services, since they owned or rented the health facilities. There were three types of sickness funds: independent, occupational and territorial. Based on the size and capacity of the fund, they determined the service package. Private practitioners and hospital networks operated parallel to this network (Anže, 1999; Tragakes et al, 2008; Arāja, Krūzs, 2016).

## 5. SUBSEQUENT HISTORICAL DEVELOPMENT OF PUBLIC POLICY ON HEALTHCARE

### a. Major reform I

Name and type of legal act	Regulations of the Cabinet of Ministers No. 63 „On the reform of the financing of the healthcare system“
Date the law was passed	March 8, 1994
Date of <i>de jure</i> implementation	March 24, 1994
A brief summary of the content	The regulation intended to reform in phases, first by creating a decentralized local account fund (so-called- sickness fund) network and the second phase planned to introduce insurance-based revenue collection mechanisms. The regulation determined a decentralized financial and organizational structure for healthcare service provision, by issuing the obligation that each municipality (district and larger city) needed to create its own local account fund until January 1995. At this point, healthcare financing funds were allocated from the general taxation to the local account funds according to covered population size and no insurance contributions were in place. A contribution introduction was planned in the second phase of the reform, but was never implemented, since the political scene and national situation had changed.

Population coverage	<p>Since the state proclamation (1991) the main principle of population coverage is based on the universal healthcare principle (The Constitutional Assembly, 1922), where health service coverage extended to all citizens and residents of Latvia. After the proclamation of independence, Latvia had a relatively high proportion of permanent residents (around amount of 27 % of the population in 1996) who were not citizens of Latvia, or of any other country. The number of “non-citizens” decreased to 12 % of the population in 2017 (Zvidriņš, 2022).</p> <p>The same coverage principle is still the case today, with no other access criteria (like employment status, income, ethnicity, or place of residence) are applied. This regulation did not affect nor change the criteria for population coverage.</p>
Type of benefits	<p>The generosity (depth and scope) of the service packages as well as the quality of provided services varied greatly across local account funds and over time. It mainly depended on the wealth of the municipality, since municipalities were the owners of the funds and additionally held the main responsibility of providing primary and secondary healthcare services for its population. In general, local account funds covered primary healthcare, outpatient specialist healthcare, as well as stays at the corresponding municipality-owned hospital. The state was responsible for covering specialized tertiary care and staying at state hospitals. Regarding pharmaceuticals, patients had to pay the full price of most medications for outpatient care (World Bank, 1995; Glāzītis, 2003).</p>
Socio-political context of introduction	<p>Since Latvia was occupied by the Soviet Union (1945), a highly centralized Semashko healthcare system was forced on, with general tax allocation for healthcare, single-payer and total state ownership and control of healthcare facilities (Davis, 2010). In the newly independent Latvia (1991), the overall political aim was to cut ties with the Soviet past in all policy areas. In healthcare, it meant searing away from the centralized system and returning to a pre-war decentralized system. In 1989, the re-established Latvian Medical Association (LMA), demanded to reform the healthcare system and formulated a SHI reform proposal, aiming to diminish the role of the state, replacing it with market-driven initiatives and increasing the emphasis on individual responsibility by establishing a decentralized SHI network covering only the basic set of services for the entire population, with additional voluntary health insurance (VHI) for complementary and supplementary healthcare services. After the restoration of independence, in 1991, the preference was given to the welfare reforms. The detailed implementation of healthcare financing reforms was postponed at the time. The attention was brought back in 1994, by issuing the regulation „On the reform of the financing of the healthcare system” followed the 1989 LMA reform proposal (Kaminska et al 2021; Stupele, Kaminska, 2024, forthcoming).</p>

## b. Major reform II

Name and type of legal act	The law “On State Social Insurance”
Date the law was passed	October 1, 1997
Date of <i>de jure</i> implementation	January 1, 1998
A brief summary of the content	<p>The goal was to re-centralize the healthcare financing organization and administration, equalize the accessibility and quality of the healthcare services across the country, determine the minimum service basket and introduce the patient co-payments and voluntary healthcare insurance (Saeima, 1997).</p>
Population coverage	This regulation did not affect nor change the criteria for population coverage.
Available benefits	<p>Until now healthcare services were organized and financed via revenue streams, each of them covering a respective service package (Meikšāns &amp; Strazdiņš, 1989). The first stream came directly from the annual state budget and covered specialized health services under the State Healthcare Program. The second stream was paid for by local account funds that were managed by the municipalities and financed from both the municipal budget and state subsidies. The local account funds financed the so-called Basic Care Program that covered primary and secondary care services (World Bank, 1995).</p> <p>In line with the aim of the reform, the two healthcare service packages and financial streams have been merged. The covered statutory services did not per se extend since it was annually reviewed by the Parliament, depending on the budget allocations. On the one hand, the service availability and coverage equalized</p>



Available benefits (Continued)	and levelled out across the country and was not directly dependent on the wealth of the municipality, therefore all population theoretically had equal access to statutory healthcare services, which included primary, secondary and tertiary care and special state care programs (aimed at specific diseases, e.g. tuberculosis, HIV/AIDS, etc.) (World Bank, 1998; 1998a; 1999; 2004). On the other hand, the introduction of the patient co-payments (aiming to limit healthcare use and to generate additional resources), which, in 1998, accounted for about 40 % of total healthcare expenditure (World Health Organization's Global Health Expenditure Database, 2023), have limited access to health services. Most of the outpatient pharmaceuticals were not statutorily covered. Also, VHI was established. Initially designed to only cover the newly introduced user charges, it was later extended to include complementary and supplementary services (World Bank, 1999; World Health Organization, 2001).
Socio-political context of introduction	The first reform wave to decentralize healthcare financing and service provision resulted in an extremely fragmented and ineffective healthcare system with high inequalities in the quality and provision of services since there were two separate financing streams and care programs. Therefore, the domestic politicians, representatives of the Ministry of Welfare, which was responsible for the healthcare area, and LMA came to the consensus that the decentralized healthcare in such a small territory and population was inefficient in using limited resources (Stupele, Kaminska, 2024, forthcoming). Between 1997 and 1998, 33 local account funds were merged into eight, creating larger sized risk pools (minimum 200,000 people), thus allowing the system to manage the risks more efficiently. Moreover, the two financial streams (corresponding state and municipality-covered services) were merged and were from now on administrated at the national level by the newly established State Sickness Fund (Saeima, 1997; World Bank, 1998; 1999). Thus, the purchaser-provider split was introduced into the system (World Bank, 1998) and municipalities ceased to be responsible for financing service provision but remained responsible for maintaining healthcare facilities and ensuring access to healthcare (World Bank, 1998; 1998a; 1999; 2004). This was a pivotal shift away from the decentralized SHI idea and a move towards the general taxation (NHS type) system (with purchase-provider split), which was incrementally developed and finalized in 2011.

## 6. DESCRIPTION OF CURRENT HEALTHCARE SYSTEM

### a. Organisational structure

Despite attempts in the late 1980s and early 1990s to move away from the centralized Semashko system, by creating the SHI with a decentralized local account funds network, since 1997 there has been an incremental process of healthcare financing administration and organization centralization. After severe experimenting with institutional setting (see Kaminska, Stupele, 2024, forthcoming), the centralization process was finalized in 2011 with the creation of the National Health Service, indicating the settlement of the nationally organized and centralized general tax-based system both in terms of its administrative setting and in terms of unified revenue collection, with a purchaser-provider split and a mix of public and private providers (Mitenbergs et al, 2014, Stupele, Kaminska, 2024, forthcoming). The NHS creation was rather a new label than a new social policy. The National Health Service, which alongside the Ministry of Health, is the key institution, responsible for not only purchasing healthcare services for all populations on behalf of the state but also planning the health budget, calculating the service reimbursement tariffs, and implementing e-health (Cabinet of Ministers, 2011; Behmane et al, 2019).

Municipalities are owners of regional hospitals and outpatient healthcare centres. Their responsibilities are predominantly to supervise the activities of their own establishments. Additionally, municipalities are responsible to ensure the availability and accessibility of healthcare services to the population (Law "On Local Governments"). Municipalities are left free to interpret the article on its own, though mostly it results in efforts to attract medical personnel (doctors and nurses in hospitals) and independent general practitioners for primary healthcare.

## b. Coverage

Population coverage, or the breadth of health service coverage (Kutzin et al., 2010), is based on universal principles and extends to all citizens and residents of Latvia, no other eligibility criteria (like employment status, income, ethnicity, or place of residence) applied. Since 2004, the same criteria apply to citizens of EU Member States, European Economic Area states and Switzerland who resided in Latvia. However, the service and cost coverage (Kutzin et al., 2010), are limited and embedded in the Latvian Constitution, where Article 111 States that „*The State shall protect human health and guarantee a basic level of medical assistance for everyone*” (The Constitutional Assembly, 1922), therefore Latvia is operating with a negative service list, without defined state-covered benefits package. All state-covered services require co-payments (see the section on service package below).

Percentage of population covered by government schemes	100%
Percentage of population covered by social insurance schemes	N/A
Percentage of population covered by private schemes	N/A
Percentage of population uncovered	N/A

Source: Behmane et al. 2019; OECD and European Observatory on Health Systems and Policies, 2021.

## c. Provision

Provider density per 1,000 of population	Value (Year)
Physicians	3.4 (2020)
Nurses and midwives	4.4 (2020)
Hospital beds	5.5 (2018)

Source: World Bank 2023 (<https://data.worldbank.org/country/latvia>)

Importance of inpatient and outpatient sectors: There have been continuing efforts of shifting away from hospital care towards primary and outpatient care, by increasing the spending on outpatient care almost by 20 % (since 2010) to 32 % of the total health spending (2018), but the healthcare system in Latvia is still very much inpatient (hospital) oriented (Behmane et al, 2019). Hospitals by their legal status can be organized by ownership: for example, state (e.g. university hospitals), municipality (regional and municipal hospitals) or privately owned. As of 2019, there were 63 hospitals providing inpatient care. The NHS has contracts with 31 hospitals for state-covered services, including both public and private ownership. Secondary ambulatory care is provided in a range of institutional settings, including self-employed specialists (a private sector agent), health centres and hospital outpatient departments. Patients are free to choose any specialist contracted by the NHS for state-funded services. Regarding primary healthcare (PHC), the main providers are the General Practitioners (GPs), that act as the main point of entry into the healthcare system and as the gatekeeper to secondary ambulatory and hospital care. The majority of the PHC professionals operate as independent providers and have a contract with the NHS to provide state-covered PHC services (Mitenbergs et al, 2012; European Hospital and Healthcare Federation, 2018; Behmane et al, 2019). The hospital-centred healthcare system also reflects the spending division between levels of healthcare services covered by the NHS, which is predetermined by the Regulation of the Cabinet of Ministers No. 555 (Cabinet of Ministers, 2018), stating that no less than 45 % of the NHS budget should go to cover outpatient health care services, no more than 53 % for inpatient health care services and no more than 2 % for payments for cross-border settlements. Since there is no compliance for the private healthcare sector to provide any data to the NHS or MoH on performed services that are not NHS-covered, there is no exact data on the proportion and size of the private healthcare sector in Latvia compared to the state-operated.

Service package: The NHS determines and accordingly purchases a wide range of health services for the population, that include primary outpatient medical care, specialized outpatient medical care, outpatient diagnostic services, and inpatient services. The benefits package is rather limited in scope, and excludes, among others, dental care for adults, most rehabilitative and physiotherapy services and most outpatient pharmaceuticals. Instead of a positive list, where the state has defined the statutory service package and coverage scope, in Latvia,

the NHS operates with a negative list of the services, where it explicitly states which of the healthcare services the state is not covering. The annually updated regulation of the Cabinet of Ministers No. 555 explicitly excludes certain services, such as dental care for adults, rehabilitation (with a long list of exceptions), medical check-ups required for occupational reasons, sight correction and hearing aids (except for children), spa treatment, abortions (if there are no medical or social indications) and others. Additionally, all statutory healthcare services require a patient's co-payment. Children under the age of 18, pregnant women, severely disabled people and some other groups are excluded from service co-payments. By regulation, dental care for children under 18 is state covered, but the quota system results in long waiting times. Regarding pharmaceuticals, the NHS operates with a positive list of medicine, stating which medicine and the degree of coverage (100 %, 75 % or 50 % NHS covered).

#### d. Financing

Healthcare in Latvia is financed from general taxation via annual state budget allocations approved by the Parliament. Tax collection is centralized and carried out by the National Revenue Service (NRS), which distributes the revenue directly to the State Treasury of Latvia, which transfers it further to the NHS. The NHS then plans the healthcare budget and purchases services for the whole population.

Indicator	Value (Year)
Total expenditure for health as % of GDP	8.8 (2022)
Government health spending as % of GDP	5.9 (2022)
Domestic general government health expenditure in % of current health expenditure	66.9 (2022)
Voluntary healthcare payment schemes in % of current health expenditure	3.6 (2021)
Out-of-pocket expenditure in % of current health expenditure	27.0 (2021)
External health expenditure in % of current health expenditure	N/A

Source: OECD Stat database (<https://stats.oecd.org/#>).

Latvia allocates a little share of the public spending to healthcare, with only 5.9% of the government spending on health as percentage of GDP in 2022, which is at the bottom compared between EU countries (OECD, 2016; 2017; 2019). The role of VHI is low at 3.6% of the current health expenditure (2019) (OECD Stat database, 2023).

Patients are being exposed to substantial user charges and direct payments, in particular for pharmaceuticals and inpatient procedures, that lead to 37.1% (2019) of the total health expenditure being out-of-pocket payments (OECD, 2017; 2019), which was extraordinarily high compared to other European countries. By 2021 this share declined to 27.0 %. The largest share of the total OOPs is expenditure for pharmaceuticals, since patients pay the full price for a significant portion of prescribed pharmaceuticals and the full price of all non-prescription drugs in the outpatient sector (OECD, 2016; 2017; 2019). The healthcare financing system in Latvia puts vulnerable groups and low-income populations at risk of poverty when receiving healthcare services and increases the ratio of unmet health needs. In 2015, 8.4% of the population reported unmet health needs for medical care for financial reasons (Taube et al., 2018).

#### e. Regulation of the dominant system

The most important actors in the system are the parliament (Saeima), the government (Cabinet of Ministers), the Ministry of Health (MoH) and the NHS. Saeima and the Cabinet of Ministers issue the principal normative acts and regulations for the health sector. The government is responsible for resource collection for health, mainly through general taxation and a small part through social tax. The parliament is responsible for both the annual state budget approval and the NHS budget for health service purchasing. The MoH is responsible for determining and planning health priorities, policies and strategies, additionally the MoH organizes and supervises its implementation. The NHS, under the MoH, is the central national institution, responsible for the implementation of state health policies and for ensuring the availability of health care services in the country, by administrating the public financial recourses of the health sector and contracting services from both public and private healthcare service providers. In addition, to the above-mentioned tasks, the NHS calculates healthcare tariffs, determines a

positive list of pharmaceuticals and implements e-health. Lastly, the NHS is a contact point and information centre for the cross-border healthcare provision and runs the Medical Treatment Risk Fund (Cabinet of Ministers, 2011; Behmane et al, 2019).

Healthcare professionals, e.g. physicians, dentists, pharmacists and nurses, must be certified and registered by the respective professional association, which are the Latvian Medical Association, the Latvian Nurses Association or the Latvian Confederation of Professional Organizations of Health Care Personnel (responsible for allied sciences, such as speech therapists, dental technicians, dental prosthetists, laboratory assistants, etc.). Certification requirements are regulated in the legal acts ("Medical Treatment Law" (1997) and "Regulations of the Cabinet of Ministers on Certification of Treatment Persons" (1997)). The professional organizations determine examination programs and conditions for the professionals' re-certification process (Tragakes et al, 2008; Mitenbergs et al, 2012; Behmane et al, 2019). Healthcare providers are registered by the MoH and the Health Inspectorate, which is responsible for evaluations of healthcare premises, equipment, personnel and documentation to assess compliance with government regulations. The State Agency of Medicines deals with regulating and registering pharmaceutical companies and products, and additionally with the registration of medical technologies (Tragakes et al, 2008; Mitenbergs et al, 2012; Behmane et al, 2019).

## 7. CO-EXISTING SYSTEMS

The role of the VHI is low at 3.6% of the current health expenditure (2022) (OECD, Stat database, 2023). It covers supplementary services (those not covered by the NHS, including faster access) as well as complementary services (user charges). In 2017, only four insurance companies offered VHI, where only limited insurance packages are available at the individual level since most companies only work with employers. The VHI covers 35 % of the employed individuals, in 2018 (OECD, 2019; Behmane et al, 2019).

## 8. ROLE OF GLOBAL ACTORS

Global actors do not play a role in providing, financing or regulating healthcare in Latvia. Several international organizations, such as the World Bank, the World Health Organization, the OECD and the European Union, have been periodically involved in health reform processes since the early 1990s, providing technical and policy advice and financial support (Stupele, Kaminska, 2024, forthcoming). The only instance, where global actors were involved in partly financing healthcare services, was the 2008/2009 economic and financial crisis, where in order to overcome it, the World Bank's short-term loan covered the co-payments for healthcare services to the most vulnerable and poorest of the population (World Bank, 2010a; 2010b). As a member of the European Union, EU Structural Funds represent an important source of funding for investment and development activities in Latvian healthcare. The funding is mostly used to improve GP practices, healthcare facility renovation, projects and innovations in hospitals and public health (Tragakes et al, 2008; Mitenbergs et al, 2012; Behmane et al, 2019).

## 9. LIST OF ADDITIONAL RELEVANT LEGAL ACTS

- » The Constitution of the Republic of Latvia (1922) Article 111.
- » Regulation of the Cabinet of Ministers "The Basic Care Program" (1994)
- » Medical Treatment Law (1997)
- » Regulations of the Cabinet of Ministers "Program of Development of Primary and Hospital Care Services for 2005–2010" (2005)
- » Regulations of the Cabinet of Ministers No 560 "About "e-Health in Latvia" guidelines" (2005)
- » Regulations of the Cabinet of Ministers No 490 „A Social Safety Net Strategy" (2009)
- » Cabinet of Ministers Regulations No.134 "On United Health Sector Information Systems" (2014)
- » Regulations of the Cabinet of Ministers No 384. "On health care system reform" (2016)

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