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Transforming the Latvian Health System

Accessibility of Health Services from a Pro-poor Perspective

Dr. Katharina Müller
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German Development Institute (DIE)

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Dr. Katharina Müller, Economist, German Development Institute (DIE).
E-Mail: katharina.mueller@die-gdi.de

Jenni Kehler, Economist, World Health Organization (WHO).
E-Mail: kehlerj@who.int

Stefan Lechner, Economist, Kreditanstalt für Wiederaufbau
(KfW Banking Group).
E-Mail: stefan.lechner@kfw.de

Sven Neunsinger, Economist, Kreditanstalt für Wiederaufbau
(KfW Banking Group).
E-Mail: sven.neunsinger@kfw.de

Florian Rabe, Economist, Kreditanstalt für Wiederaufbau
(KfW Banking Group).
E-Mail: florian.rabe@kfw.de

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Tulpenfeld 4, 53113 Bonn
☏ +49 (0)228 94927-0
🖷 +49 (0)228 94927-130
E-Mail: die@die-gdi.de
www.die-gdi.de

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
CIET	Community Information, Empowerment and Transparency
CSB	Central Statistical Bureau
DAC	Development Assistance Committee
EU	European Union
GDP	Gross Domestic Product
GP	General Practitioner
HIV	Human Immuno-deficiency Virus
ICD-10	International Statistical Classification of Diseases and Related Health Problems, 10th Revision
ILO	International Labour Organisation
LPTB	Latvijas Pacientu Tiesību Birojs (Latvian Patients' Rights Bureau)
LVL	Latvian currency (Lat)
MDGs	Millennium Development Goals
NATO	North Atlantic Treaty Organisation
NGOs	Non-Governmental Organisations
OECD	Organisation for Economic Co-operation and Development
PPP	Purchasing Power Parity
PRS	Poverty Reduction Strategy
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
VOAVA	Veselības Obligātas Aprošināšanas Valsts Aģentūra (Compulsory Health Insurance State Agency)
WHO	World Health Organization

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Bonn, April 2005

Summary

Health is one of the main challenges in the global fight against poverty. Improving the health status of the poor and addressing their specific needs is crucial for poverty alleviation. The already widespread awareness of the importance of the health-poverty linkage is reflected in the Millennium Development Goals (MDGs). Three out of eight MDGs are directly related to health and health care. Reducing child mortality by two thirds, maternal mortality by three fourths and halting the spread of diseases like HIV/AIDS or Malaria belong to the most ambitious goals agreed upon.

In this context, the design of health systems is a key challenge. Two prominent policy documents – the World Development Report 2004 and the Guidelines on Poverty and Health, co-authored by the Organisation for Economic Co-operation and Development (OECD) and the World Health Organization (WHO) – have recently focused on the design of pro-poor health systems. These documents provided the inspiration for this study that applies such considerations to the Latvian context.

Since Latvia regained independence in 1991, its health system has undergone several reforms and is still subject to an ongoing political debate. A recent study by the United Nations Development Programme (UNDP) on human security in Latvia pointed out that the major security concerns were all related to health. Being unable to pay for medical care, not receiving an adequate standard of medical care and the fear of falling seriously ill ranked top in the list of individual security issues. These concerns, in particular the first one, highlight the linkage between the level of income and individual access to health care in Latvia.

This study analyses the accessibility of the Latvian health system from a pro-poor perspective. While considering the broad scope of general interdependencies between poverty and health, it focuses on one selected linkage between poverty and the health system, asking what barriers to acceding to the health system currently affect poor and vulnerable groups, how these barriers can be removed and the health system be made more pro-poor. The study, conducted from November 2003 to May 2004, largely relied on the analysis of existing surveys and on

stakeholder interviews in and around the Latvian health and social protection systems.

This analysis of the Latvian health system focuses on three dimensions of accessibility: the financial, the geographical, and the informational one. For each dimension, barriers to access, existing measures to overcome these and their limits are identified below.

Financial accessibility seems to be the most important of the three dimensions. As indicated above, the fear of being unable to pay for medical care ranks first among the concerns of the Latvian population. Although several mechanisms are already in place to reduce the financial burden of health costs, some problems still persist, in particular from a pro-poor perspective. The high share of out-of-pocket payments for health services in Latvia directly disadvantages vulnerable groups. In addition, the existence of quotas for services, high expenses for pharmaceuticals and informal payments hamper the access of vulnerable groups to health care services. Existing measures – such as exemptions from co-payments, the ceiling of LVL 80 for co-payments, diagnosis-related exemptions from pharmaceutical expenses and municipal health-related benefits – are intended to protect low-income groups, but do not yet suffice. Accordingly, both survey results and stakeholder interviews revealed that the affordability of health care services and pharmaceuticals remains a major issue to be tackled.

Empirical evidence on *geographical accessibility* problems is rather sparse compared with that on the financial dimension, and not many representative studies have focused on this issue so far. However, transport costs, the availability of transport and the opportunity costs of time invested in travelling may have an impact on the accessibility of health services, in particular in rural areas of Latvia. In addition, geographical barriers might gain in importance in the future if the downward trend in the number of general practitioners (GPs) and hospitals in rural areas is not compensated by other measures, i.e. by reimbursing transport costs or by providing free-of-charge municipal transportation services for low-income patients.

Informational accessibility is another significant factor. It is mainly related to the patients' knowledge about entitlements to state-guaranteed

health services, patients' rights, the costs of medical treatment, and health-related social benefits. Empirical evidence indicates a general lack of knowledge on these issues among the inhabitants of Latvia. In addition, some vulnerable groups, in particular low-income households, tend to be even less informed about these topics than the better-off part of the population. This may partially be ascribed to an insufficient tailoring of information to specific needs and preferences of different target groups. Other causes may be found in the rather limited staffing and financial capacities of public and non-governmental institutions providing information to the general public.

The three barriers described above do not exclusively affect those living on an income below the poverty threshold, as defined by the Latvian Cabinet of Ministers. Individuals with an income just above this threshold and thus ineligible for a number of exemptions and reimbursements are particularly vulnerable, and so are groups with high health needs, such as the elderly and chronically ill. Catastrophic health costs – which exceed the individual's ability to pay – may even affect better-off parts of the population.

While a number of detailed reform proposals are presented in the chapters on financial, geographical and informational accessibility, the most important ones are briefly discussed here in the context of the global determinants of accessibility: pooling and funding of health services, overall stewardship for the health system, and the general political framework.

Pooling and funding

In per capita terms, total health expenditure was only $338 in Latvia in 2000, compared to the EU average of $2,136. The share of out-of-pocket payments for health services is high, amounting to an estimated 47.5 % of total health care funding in 2001. Since out-of-pocket payments reduce the pooling of risks and also represent a direct access barrier for vulnerable groups, it would be recommendable to transform a sizeable part of them into pooled funding. This would not necessarily imply an increase in total funding, but rather require a higher share of public funding, in order to transform the current health-financing

scheme into a more equitable one.

At only 3.5 % of GDP, public health expenditure is quite low in Latvia. This spending level puts Latvia last among the new EU members. Increasing the share of public health funding is a necessary first step towards improving the access by vulnerable groups who have little financial resources at their disposal. The Latvian government recognised the need for additional funding and announced the goal of increasing public health expenditure by an annual 15 %.

From a pro-poor perspective, it is not only important how the additional funding is raised, but also how it is spent. While increased funding is a prerequisite for reducing quotas, it does not automatically reduce all other access barriers to the Latvian health system. We propose modifying the current ceiling of LVL 80 for co-payments to health care services to incorporate expenses for prescribed pharmaceuticals, thus contributing to the transformation of out-of-pocket expenses into pooled funding. Similarly, the problem of informal payments could be tackled if some of the additional funding were used to raise the salaries of health care professionals. However, complementary measures on the stewardship level are also required to address this problem.

Finally, the role of municipalities in funding deserves more attention. Although their direct involvement in health funding is limited to subsidies to local health care facilities, municipalities assume an important function by granting health-related social benefits to their inhabitants. Thus, allocating more resources and increasing municipal social budgets could significantly contribute to improving the accessibility of health services for vulnerable groups.

Stewardship

Increasing the volume and improving the allocation of funding does not necessarily eliminate access barriers for vulnerable groups. Some barriers result from insufficient coherence between institutions of the health and social protection systems, while others stem from insufficient transparency and enforcement of regulation.

Coherence is closely related with the division of responsibilities. In

some cases, it seems to remain unclear who is responsible for certain actions, e. g. information provision on health-related benefits. Since with VOAVA, municipalities, GPs and social workers, very different actors with competing interests are involved, it may be difficult to develop coherent action plans and strategies. This makes the role of the steward, i.e. the government, so important: its role is to reduce the leeway for interpretation by defining who can be held accountable and what each entity's responsibilities are.

For example, municipalities are legally obliged to ensure access to health care. Yet, how this is being interpreted and which responsibilities are derived from this stipulation seems to differ among municipalities. In this context, the steward should avoid creating unfunded mandates. In particular, a clearer definition of the tasks to be performed in order to 'ensure access to health care' should not only come at the expense of municipal budgets. Another example is the shortfall of revenues resulting from the refusal or inability of patients to make the stipulated co-payments for health services. Based on our interviews, it seems to be unclear who is expected to cover this shortfall: the service providers (hospitals, physicians), VOAVA or the municipalities. Thus, a clarification or improved communication of these responsibilities is recommended.

Stakeholders also mentioned improved enforcement and transparency of regulations as an important task, e. g. enforcing the abolishment of informal payments and increasing the transparency of the current quota system. Ensuring strict compliance with regulations may require increased personnel and financial capacities in relevant institutions.

Finally, a significant strengthening of research capacities on health and social policy may enable the evaluation of past reforms and the development of medium and long-term strategies for the health system, thereby contributing to reliable planning by health care providers.

General political framework

Obviously, the decisions made by the stewards are subject to the general political framework. In the Latvian context, this framework limits the stewards' ability to reform the health system in several ways.

The Latvian political landscape is characterised by a short duration and high volatility of governments and coalitions. Consequently, the health system is subject to very different strategies, ranging from radical reforms, such as the proposal to introduce a private health insurance system similar to the one in the United States, to maintaining the current tax-financed system. In the absence of a general political consensus on the direction of health sector reforms, it seems very difficult for the Ministries of Health and Welfare to guarantee planning reliability for providers and patients. In addition, implementing long-term reform projects and following-up on reforms is also hampered by the political turnovers and diverging strategies. Thus, improvements made on the stewardship level in strengthening research capacities and developing long-term strategies might be offset by those general political factors.

Another important aspect affected by the political framework in Latvia is the allocation of resources. The stewards' ability to give more financial priority to the health system is constrained by Latvia's need to implement reforms in several policy areas simultaneously. For example, the accessions to the EU and NATO not only required significant financial resources, but were also of higher political priority than health sector reforms. However, Latvia assigned a lower share of public funding to the health system than other new EU members from Central and Eastern Europe facing the same historic challenges. Accordingly, it is often argued that the political will to significantly improve the accessibility of health services seems to be missing in Latvia. Although health and the access to health services are recurrent issues in election campaigns, they do not yet translate into practical political priorities.

The forging of a general consensus on the increasing importance of propoor health reforms and the building up of political will to tackle these problems seem to be prerequisites for improved accessibility. The Ministry of Health and the Ministry of Welfare might not be able to create this consensus within the government yet, but could promote a general discussion in Latvian politics and society on the accessibility of health services.

In order to guarantee equitable, undistorted access to health care services in Latvia, a comprehensive and reliable protection system is required. This involves both the health and the social protection systems.

Stakeholders from both systems need to strengthen their co-operation if the accessibility of health services is to be improved. Although increasing the financial endowment of the health system amounts to a significant contribution, it alone does not guarantee that vulnerable groups will benefit from the additional resources.

1 Introduction

1.1 Background

In the global fight against poverty, health is one of the main challenges. Health is not only regarded as a basic human right, but also as fundamental for human development (OECD / WHO 2003, 14). Improving the health status of the poor and addressing their specific needs is crucial for alleviating poverty.

The already widespread awareness of the importance of the health-poverty linkage is reflected in the Millennium Development Goals (MDGs).[1] Three out of eight MDGs are directly related to health and health care: reducing child mortality by two thirds and maternal mortality by three fourths, and halting the spread of diseases like HIV/AIDS or Malaria. These goals belong to the most ambitious ones agreed upon.[2]

In this context, the design of health systems is one of several key challenges. Two prominent policy documents – the World Development Report 2004 ('Making Services Work for Poor People') and the Guidelines on Poverty and Health, co-authored by the Organisation for Economic Co-operation and Development (OECD) and the World Health Organization (WHO) – have recently focused on the design of pro-poor health systems (World Bank 2003; OECD / WHO 2003). These documents provided the inspiration for this study that aims at applying such considerations to the Latvian context.

Since Latvia regained independence in the early 1990s, its health system has undergone several reforms and is still subject to an ongoing political debate. A recent study by the United Nations Development Programme (UNDP) on human security in Latvia pointed out that the major security concerns were all related to health. Being unable to pay for medical care, not receiving an adequate standard of medical care and the fear of falling seriously ill ranked top in the list of individual security issues (UNDP 2003, 30). These concerns, in particular the first one, highlight the linkage between the level of income and individual access to health care in Latvia.

1 On the MDGs see http://www.un.org/millenniumgoals/ (30.3.05).

2 For further details on the MDGs for health and ways to achieve them see also Wagstaff / Claeson (2004) and World Bank (2004).

1.2 Purpose and methodological approach

The purpose of this study is to analyse the accessibility of the Latvian health system from a pro-poor perspective. While considering the broad scope of general interdependencies between poverty and health, it focuses on one selected linkage between poverty and the health system. It aims at answering the following research questions:

— What access barriers to the health system currently affect poor and vulnerable groups?

— How can these barriers be removed and the health system be made more pro-poor?

The present study was carried out in three phases. In a *first phase*, a preparatory desk study was written in Germany (November 2003 – January 2004). A *second phase* consisted of fieldwork carried out in Latvia from February to April 2004. A total of 59 qualitative interviews with stakeholders in and around the health and social protection system were conducted in Riga and other towns (Daugavpils, Liepāja, Smiltene), as well as in rural areas of Latgale (Ilūkste, Subate, Špoģi, Višķi) and Vidzeme (Melnbārži, Vecpiebalga, Vidriži).[3] Interviewees were mainly asked to evaluate the accessibility of the Latvian health system and to outline possible reform proposals. In addition, several interviews held in Tallinn, Estonia, provided broader insights into the challenge of reforming health systems in transition countries. Moreover, the existing household surveys – the available quantitative evidence on accessibility and utilisation of health services in Latvia – were analysed and health-related newspaper articles published in the Latvian press were consulted, selected from the press archive at the UNDP's Public Information Centre. At the end of the second phase, the preliminary findings on barriers and reform proposals were presented at a workshop in Riga and discussed with different stakeholders. In a *third phase*, conducted in May 2004 in Bonn, the results of this workshop and further household surveys were incorporated in the study. This final report is based on the findings of all three phases.

3 See Annex A.2 for an overview of the different categories of interviewed stakeholders in Latvia's health and social protection system. A complete list of interview partners can be found at the end of this study.

1.3 Structure of the study

The present document starts with a presentation of the conceptual approach used in our study (Chapter 2). This chapter clarifies the definitions of poverty, health and health systems, while also introducing the health-poverty linkage and the concept of a pro-poor health system, with a focus on the accessibility of health services.

The next two chapters provide the reader with some background information on poverty and the health system in Latvia. The chapter on poverty (Chapter 3) outlines the definitions of poverty used in Latvia, the changing problem awareness and the development of Latvia's social protection system. Chapter 4 briefly introduces the Latvian health system, presenting the most important elements of the current system, based on the categories of collection and pooling, purchasing, provision of health services, and stewardship.

Chapter 5 constitutes the core of this study. It analyses the accessibility of health services in Latvia and examines the three most important types of barriers to access identified in Latvia: financial, geographical and informational barriers. For each barrier, empirical evidence, existing compensation measures and reform proposals will be discussed. Finally, Chapter 6 presents our conclusions.

2 The conceptual approach: poverty and health

The purpose of this chapter is to lay the conceptual foundations for the present document by defining and discussing the most important terms and concepts, as well as by identifying relevant linkages between health and poverty. It is mainly based on the OECD/DAC guidelines on poverty and health (OECD / WHO 2003).

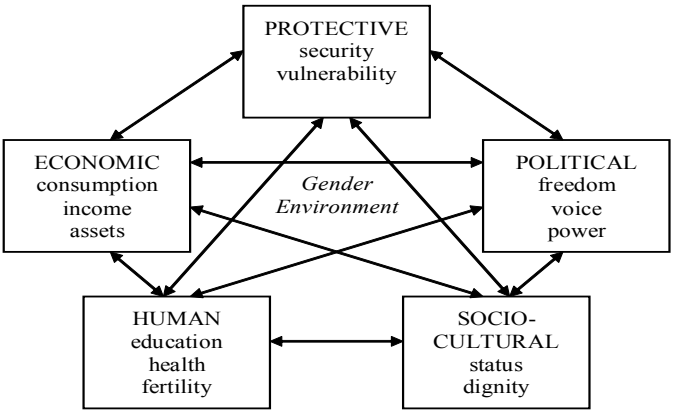
In the light of the vast number of different definitions of poverty, health, and health systems, it is inevitable to narrow them down to the specific definitions applied in this study. Accordingly, this chapter is divided into four sections. The first defines poverty; the second defines health and health systems; the third analyses the health-poverty linkage; the fourth briefly discusses the term 'pro-poor health system' and outlines dimensions of the accessibility of health systems.

2.1 Defining poverty

At present, there is no single and generally accepted definition of the term poverty. Rather, it is subject to a vast number of different approaches.[4] In addition, a clear distinction between poverty and its determinants is often missing.

The scope of definitions varies from *one-dimensional* ones, e. g. income-based, basic-needs or basic rights approaches, to *multi-dimensional* ones, such as the OECD/DAC concept depicted in Figure 1. It uses a compre-

Figure 1: Dimensions of poverty



Source: OECD/DAC (2001)

hensive definition, based on the extent to which the poor possess different capabilities. Poverty is defined as a multiple deprivation of capabilities, comprising protective, political, socio-cultural, human, and economic

4 See, e. g., Kanbur / Squire (2001) for an overview on the different concepts and definitions of poverty.

capabilities (OECD/DAC 2001). Poverty can thus take various forms: not only material needs, but also a lack of education, a lack of political participation or free voice, social exclusion and limited protection against external shocks.[5]

The present study focuses on the dimensions of economic capabilities. This rather restrictive choice of definition has been made for two reasons: first, the availability of reliable data, which is very limited with regard to the other dimensions; second, the Latvian context, with economic disparities having a strong impact on the accessibility of health services.

In the light of the variety of poverty concepts, there are also different approaches to the main determinants of income poverty. Following the approach proposed by the World Development Report 2000/2001 (World Bank 2000), they can be categorised as follows:

— *Lack of opportunities:* Insufficient assets in the form of human capital (education, health, experience), material assets (financial capital, landed property) or social capital (political power, integration into social networks) can lead directly to poverty. Without these assets, people are trapped in mere subsistence and lack the means to improve their situation on their own.

— *Lack of facilities:* Possessing assets may not be sufficient if they only yield low returns. These are mainly caused by limited access to financial capital for investments, commodity markets or new technologies. The lack of access to these means impedes reaching a higher efficiency and improving the living and working conditions.[6]

— *Lack of securities:* External risks pose a major danger and are some of the main reasons why people become poor. Being unable to protect oneself against natural and environmental disasters, political crises, economic shocks or personal risks (health, age) can result in a significant loss of assets and thus lead to poverty.[7]

5 As shown in Figure 1, ill health is sometimes explicitly defined as a sub-dimension of poverty – as a component of the human dimension. However, this study sets out to distinguish conceptually between health and poverty and focuses on their interactions.

6 For example, without access to financial capital it is often impossible to start or expand small businesses and generate a higher income.

7 In addition, poor people are often more exposed to those risks since they tend to live in risk-prone areas. See Section 2.3 on the health-poverty linkage.

Based on this categorisation, this study refers to the importance of health for poverty, both as a component of human capital and as a security issue. Other determinants, such as education or political power, are only considered indirectly through their influence on the individual health status.

It should be noted that alongside 'poverty', this study also uses the term 'vulnerability'. There is no standard definition of vulnerability, neither in the Latvian context nor in the international debate.[8] However, it is generally agreed that poverty relates to vulnerability, and that access to health care helps to reduce or mitigate risk, and hence vulnerability (Holzmann / Jørgensen 2000). According to the Council of Europe's definition, vulnerable groups comprise the chronically ill, the elderly, marginalised populations, prisoners, and single parents' families (Council of Europe 2005). The term 'vulnerable persons' is officially used in regulations on pro-poor measures passed by the Latvian government (see, e. g., Chapter 5.2.2.1); hence its relevance in the context of the present analysis.

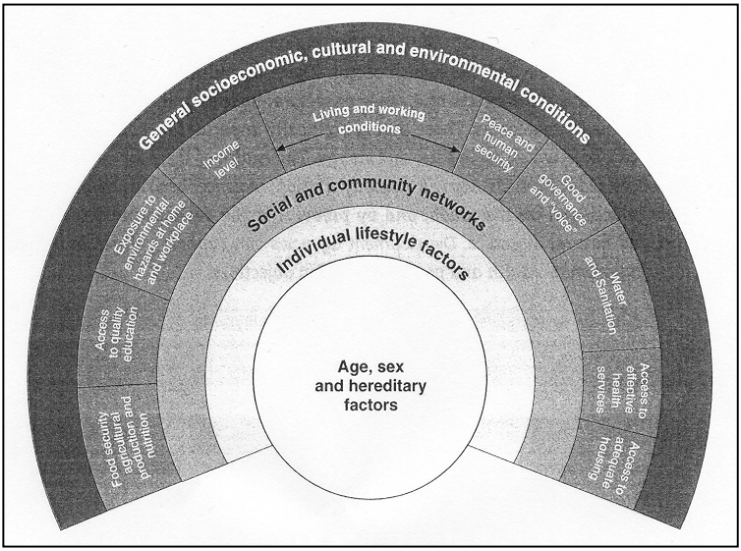
2.2 Defining health and health systems

Health – as defined by the WHO – is a 'state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (WHO 1946, 100). In this context, 'ill health' describes the deterioration of this status. Health is a basic prerequisite for human development, since the individual health status directly affects one's ability to earn a living and to be involved in social participation. To mention just two examples: productivity and, hence, income often depend on the health status. Furthermore, attendance rates in school and therefore the level of education are also related to children's health.

The health status of individuals is determined by a highly complex variety of factors. These range from individual characteristics to general socio-economic aspects and can be summarised in five tiers (see Figure 2):

8 For the latter see, e. g., Alwang / Siegel / Jørgensen (2002) and Ligon / Schechter (2004). In the following, the respective Latvian definitions are added if available.

Figure 2: Main determinants of health



Source: OECD / WHO (2003, 54).

— The *individual* level focuses on genetic factors and characteristics such as gender, age, etc.

— The individual *lifestyle factors* refer to the individual behaviour such as nutritional habits, consumption of alcohol or tobacco, sports, etc.

— The *social and community factors* include the integration in formal or informal welfare systems, social networks, etc.

— The *living and working conditions* cover the economic and political situation individuals face, as well as the amount of their assets. In addition, access to water, sanitation and health care are important factors.

— The *general socio-economic, cultural and environmental* set of factors describes the framework in which individuals live. Examples are political or armed conflicts, religion, traditions, air and water pollution, etc.

From this broad scope of factors it can be concluded that a national health system is just one of several different policy areas that determine the health status of individuals. Nevertheless, it is of utmost and direct importance. Hence, without disregarding the variety of determinants of health, this study will focus on the particular aspect 'access to effective health services' presented on the right hand side of Figure 2.

A *health system* is the general framework for the provision of health services. It includes public and private services, not-for-profit and for-profit organisations (OECD / WHO 2003, 22). The services provided comprise primary, secondary and tertiary care, as well as other services beyond these categories, for instance vaccination, reproductive health services, and health campaigns.[9] *Primary care* is usually provided by general practitioners and includes basic services, such as first treatment, diagnosis or general dental services. *Secondary care* is provided by specialists or hospital staff members. In most cases, general practitioners refer clients to specialists for advanced treatment. *Tertiary care* is provided by specialised hospitals and centres or doctors that are uniquely qualified. Examples are trauma centres, cancer treatment or inpatient care for AIDS patients (Shakarishvili 2003, 4).[10]

The definition of health systems is not limited to formal services but also comprises informal and traditional services.[11] Yet, it does not include other policy areas such as education or sanitation, which also affect the health status, for better or worse.

In any health system, there are four kinds of actors: first, the clients; second, the providers; third, the purchasers; fourth, the policymakers. The relations between the different actors are characterised by the flow of services or payments.

— *Clients* demand health care and use the health services that are being offered. The extent to which they use the latter depends not only on

9 An alternative and broader categorisation is: population-oriented prevention (e. g. vaccination), clinical services for cure and rehabilitation, and campaigns to raise awareness for health issues (World Bank 2003). However, this study uses the OECD / WHO approach presented above, with a focus on curative health services.

10 For terminological clarifications see also the glossary at the end of this study.

11 These are especially relevant in developing countries, as formal structures are often insuffient.

their need for health services, but also on their access to these services and their ability to pay for them.

— *Providers* (e. g. doctors, hospitals, specialised centres) offer services, whether in a formal or informal context, and receive payment from clients or are being reimbursed by purchasers.

— *Purchasers* contract services from providers and monitor their delivery to clients. Central or local government, private companies, insurance funds or, in certain cases, clients can assume the role of purchasers.

— *Policymakers*, or the so-called *stewards*, set the regulatory framework of the health system. This framework can be established and enforced on a national or a local level, depending on the degree of decentralisation of health regulation.

Finally, the *financing side of a health system* is composed of the following elements: collection of revenues, pooling and purchasing.[12] These categories can be used to describe the financing mechanisms of a health system and to analyse to what extent the health financing system is equitable. However, besides formal financing mechanisms informal ones also need to be considered. While formal payments are stipulated by national health systems, informal ones are not officially endorsed and often illegal.

2.3 The health-poverty linkage

Health and poverty are strongly intertwined – in a causality running in both directions (Bichmann 2004). Ill health is one of the major causes of poverty, poverty one of the main determinants of ill health (Wagstaff 2002, 97). In the following, both directions will be examined more closely.

How does ill health lead to poverty? In general, health affects poverty – especially economic capabilities – in two ways: first, by reducing the capacity to generate income and second, through so-called 'catastrophic health shocks'. Both aspects are discussed in the following.

The generation of income depends strongly on the health status. Productivity, attendance at the workplace and hence employment are negatively affected by ill health. If members of a household fall ill, they often risk

12 For a detailed definition of these terms see Figure 4.

losing their jobs, especially in the context of developing countries.[13] In addition, other household members may have to care for the individual, thereby not being able to compensate for the household's loss of income. This situation can lead to the impoverishment not only of the sick individual, but also of families or households that depend on just a few sources of income.

The concept of catastrophic health shocks is applied to situations of disability, injuries or diseases that exceed the individual's or household's capacity to cope. In most cases, this refers to the financial capacity to afford the costs of suddenly needed health services, which are not covered by insurance or government mechanisms. In addition, due to invalidity or loss of assets those affected might lose the ability to generate income. By definition, individuals do not possess enough monetary savings to cope with catastrophic health expenses and are therefore often forced to sell their remaining assets, which may have been their only source of income (for example landed property, animals, etc.). Thus, catastrophic health expenses can lead to permanent impoverishment of formerly non-poor households or aggravate previously existing poverty levels.[14]

How does poverty lead to ill health? Poverty affects the health status mainly through the living and working conditions. The poor tend to live in areas that lack basic infrastructure such as water, sanitation, electricity, heating, etc. Therefore, they are more exposed to diseases. In addition, behavioural components such as poor nutrition, alcoholism or lack of exercise and higher exposure to environmental pollution make the poor even more vulnerable and risk-prone.

Apart from inadequate living and working conditions, the poor often have insufficient access to health services. Their restricted access can be caused by a number of factors, e. g. financial affordability, distance, opportunity costs, lack of information, social exclusion, and lack of insurance. Financial affordability of health services is determined by the level of formal and informal payments. A lack of financial means to afford health services

13 Labour markets in many developing countries are characterised by an ample workforce, non-specific labour, weak unions and low barriers for dismissing employees. Therefore, sick employees can often easily be replaced.

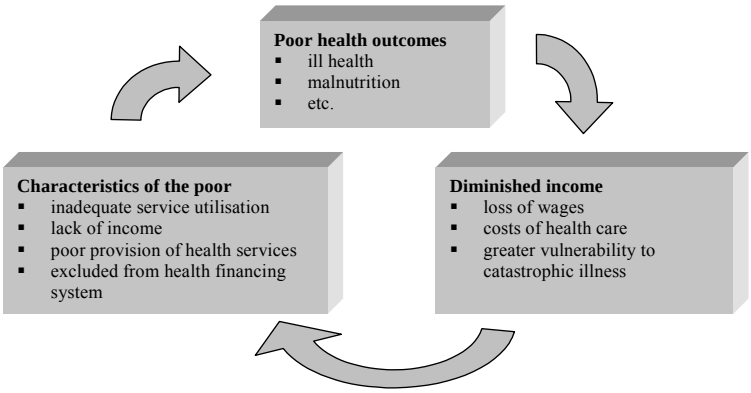
14 The theory of catastrophic health expenses leading to poverty is supported by empirical evidence (Wagstaff 2002, 101).

can result in refused or delayed treatment, thus further worsening the health status. Generally, the poor are forced to devote a relatively higher share of their income to health services, compared to the better off. Informal out-of-pocket payments tend to be particularly regressive, thus placing the poor at a disadvantage.

In the context of the influence of poverty on health, gender disparities can also play a major role in some countries. Women are often more affected by poverty and social exclusion and tend to suffer even more from the lack of health services, in particular with regard to reproductive health services. In addition, women usually promote health standards in their households. Evidence shows that the poorer women are, the less they can assume this responsibility, resulting in an even more deteriorated health status of the entire household.

The result of the dual causality between health and poverty is a *vicious circle* of poor health outcomes, diminished income, and the characteristics of the poor, as depicted in Figure 3 (Wagstaff 2002, 98).

Figure 3: The health-poverty circle



Source: Wagstaff (2002, 98).

The dual causality is of significance in two different contexts: first, with regard to differences in health status in developing and industrialised

countries; second, with regard to differences in health status between the poor and the better off within countries (including OECD countries). In both comparative contexts, a look at the main determinants of health reveals significantly worse conditions for the poor.[15] Accordingly, the available evidence underlines that disparities in the health status are generally to the disadvantage of the poor, whether referring to countries or individuals (Wagstaff 2002, 98).

The existence of significant disparities in health – not only between countries but also between the rich and poor within countries – suggests that many national health systems suffer from deficiencies in delivering services to the poor. In fact, empirical evidence suggests that most health systems in developing and transition countries favour the better off over the poor (Devarajan / Reinikka 2003; World Bank 2003). The following section analyses the characteristics of a pro-poor health system with a special focus on its accessibility.

2.4 Characteristics of a pro-poor health system

In outlining the characteristics of a pro-poor health system, the present study basically follows the concept developed by the OECD and WHO in their guidelines on poverty and health (OECD / WHO 2003).

By definition, a pro-poor health system is characterised by the priority given to the health of the poor and its commitment to reducing poverty-induced inequalities in the health status. It encompasses not only health services, health funding and risk pooling, but also related policy areas, in particular social protection (OECD / WHO 2003, 22). By including these policy areas, the pro-poor approach comprises more than just the classical elements of a health system described in Section 2.2.[16]

15 This is not limited to external conditions such as housing, sanitation, etc., but may also refer to behavioural factors such as the consumption of alcohol, which is especially important in some transition countries.

16 Considering the vast amount of different national frameworks, no single blueprint for a pro-poor health system can be applied to all situations. Nevertheless, some basic guidelines have been identified. For examples of pro-poor health policy in some Western European and transition countries see Ziglio et al. (2003).

The degree to which health services are accessible by vulnerable groups can be used as the main indicator in evaluating health systems from a pro-poor perspective. Accessibility, in turn, is determined by a number of decisions and policies made in and outside of the health system. Thus, the concept of accessibility and an overview of its determinants shall be outlined in more detail. This framework will be reflected in the following chapters of the study, notably Chapter 5.

2.4.1 Accessibility of the health system

In general, accessibility of a health system simply means that patients have the opportunity to use the services that are being provided by the system. More specifically, in the pro-poor context, *equitable* access to the health system implies that all patients have access to treatment and medication, regardless of individual factors such as income, place of residence, level of education, gender, and ethnicity.

Limited accessibility can have severe consequences, not only for individuals but also for the entire health system. If patients cannot accede to basic health services, treatment of illnesses may be delayed, thus aggravating health problems. In the long run, limited accessibility may thus result in chronic illnesses or emergency cases, requiring more complicated and expensive treatment and hence more financial resources.[17]

In the context of this study, three dimensions appear to be the most relevant: financial, informational and geographical accessibility.

Financial accessibility

Financial accessibility is achieved when clients can afford to use health services, regardless of their income level. An analysis of financial accessibility must consider both formal and informal costs or payments (OECD / WHO 2003). A lack of individual financial means should not restrict access to health services, but general public budget constraints may obvi-

17 The same logic applies to health prevention. It is often the most cost-effective alternative in the long run to avoid health problems from occurring or aggravating, e. g. by means of free vaccination or health campaigns.

ously limit the range of services that can be provided in a financially affordable way.

Financial accessibility is also related to the equitable financing of health services. Hence, the financial contribution to the provision of health services should be linked proportionally to the individual ability to pay.[18] It is in this context that formal and informal out-of-pocket payments tend to place a relatively higher burden on vulnerable and low-income groups. However, financial accessibility and high health costs may not only pose a problem to low-income groups. As explained in Section 2.3, catastrophic health expenses can also lead to permanent impoverishment of formerly non-poor individuals. Thus, the importance of financial accessibility of health care is not only restricted to vulnerable groups.

Geographical accessibility

Geographical accessibility is achieved when there is physical access to health services within appropriate distance and time. In remote rural areas or poor suburbs where poor people tend to live, service providers and health facilities are often scarce. In addition, poor people rarely posses sufficient means of private transport, and public transport may often not be affordable or not available in time. Hence, geographical aspects can pose a major barrier for acceding to health services.

Informational accessibility

Informational accessibility mainly relates to the level of knowledge that patients have about available treatment and the mechanisms of applying for state benefits, exemptions, ceilings for co-payments, etc. If such benefits are available for vulnerable groups but not sufficiently communicated, lack of information can become a significant barrier for acceding to health services.

A second aspect of informational accessibility concerns public health. Providing information on health risks, health-damaging behaviour such as

18 For a detailed discussion of the Fairness of Financial Contribution Index see WHO (2001b) and Wagstaff (2001).

smoking or the abuse of drugs, nutrition, etc. is a major task of any health system.[19]

In all cases, the provision of information has to be adjusted to the needs of vulnerable groups, starting from the selection of adequate channels of communication to the adaptation of informational content. In particular, people with special physical disabilities – e. g. blindness, deafness – and people living in remote areas often do not have sufficient access to regular sources of information. Furthermore, health-related information is often highly complex and not easy to comprehend. Therefore, it should be adjusted to the level of education of different target groups.

2.4.2 Determinants of accessibility

The degree of accessibility of health services is determined by a number of decisions made with regard to pooling and funding, stewardship of the health system, and the general political framework. Those categories will be presented in more detail below, before being taken up in the following chapters to identify causes of shortcomings and to discuss reform proposals to improve the access of the poor to health services in Latvia.

2.4.2.1 Pooling and funding

Pooling in health systems intends to spread individual risk across the population. It diversifies risk among the healthy and the sick, the rich and the poor, or across the life cycle through the accumulation of prepaid revenues.

Risk pooling in health systems is a complex issue, but boils down to two basic dimensions: first, who is in the pool? Second, what services does the care package include? The larger the pool of members or the bundle of services, the better from a pro-poor point of view. The exclusion of certain high-risk groups from the pool, e. g. because of income, gender or ethnicity may improve the pool's overall risk profile, but comes at the expense of the excluded groups. If they are excluded from a large pool and

19 The present study focuses on the first dimension of informational accessibility. Hence, this second aspect will not be addressed in more detail.

forced into a smaller, separate pool or to insure individually against risks, the diversification of individual risks is lowered, which may raise insurance costs. Excluding certain services from the contracted package, e. g. dental or reproductive health care, has the same effect. While the better-off are often able to afford additional services out-of-pocket or by means of private insurance, the poor cannot.

Both formal and informal barriers, such as quotas for treatment, high individual co-payments for services, high costs of prescribed pharmaceuticals or insufficient information on the services covered may reduce the degree of pooling and make the health system less equitable. Therefore, it is necessary to evaluate whether these barriers are a relevant factor in a given health system.

The issue of *funding* encompasses available sources and the allocation of financial resources. The sources can either take the form of pooled or non-pooled funding.

The pooling of funding can be implemented directly via the public budget (e. g. through a tax-financed health system, as in Latvia), via voluntary or obligatory insurance schemes, or via subsidies by municipalities to health institutions and individuals (Kutzin 2001, 177). In the case of voluntary insurance or subsidies of municipalities, the pool is usually smaller, as it is restricted to the inhabitants of a single municipality or to those that can afford voluntary health insurance. Thus, in both cases the degree of pooling is lower than if funding is based on the public budget.

However, health financing is not only based on pooled funding, but can also rely on non-pooled funding, such as individual co-payments or informal under-the-table payments for health services. In developing and transition countries, non-pooled funding often constitutes the main share of health funding; e. g. up to 90 % in Georgia.[20] From a pro-poor perspective, it should be noted that the regressive character of these individual out-of-pocket payments disadvantages the poor (see also Section 2.3).

As mentioned above, funding also refers to the allocation of resources to different sectors of the health system, for example the amount of money to be spent on primary care, secondary care or tertiary care. Obviously, the

20 See WHOSIS Database.

distribution of resources across the different sectors of a health system can have a significant impact on its performance and on the accessibility of those health sectors for poor patients.[21]

2.4.2.2 Stewardship

Stewardship has been defined as the 'function of a government responsible for the welfare of the population and concerned about the trust and legitimacy with which its activities are viewed by the citizenry' (WHO 2001b, 119). Applied to the health sector, stewardship refers to the government's obligation to 'oversee and guide the working and development of the nation's health actions' (WHO 2001b, 119) and to formulate a comprehensive health policy, primarily through the Ministry of Health. In addition, the government should provide clear guidelines and thus allow for long-term planning of health service providers and patients. Finally, following-up on reforms and permanent monitoring of the outcomes of reforms constitutes yet another important element of effective stewardship.

More specifically, stewardship for a *pro-poor health system* implies that the government places special emphasis on the health needs of vulnerable groups and considers the impact that any reform might have for the accessibility of health services. Consequently, stewardship ranks above the mere aspect of funding and pooling, encompassing other policy issues that will be presented below.

Political will for reforms and for mobilising additional resources is fundamental to the establishment of a pro-poor health system. However, conflicts between health and other policy areas with regard to the allocation of scarce resources are common. Competing political priorities often limit the amount of resources that are available for public health expenditure.

Giving political priority to the health system presupposes awareness of the problem and the importance of health for general human and economic development. In general, pro-poor policies can be implemented more easily and sustainable in societies that do not regard one's health and material

21 However, the allocation of resources and its impact are not an explicit subject of this study.

status merely as self-inflicted, and part of the poor as 'undeserving' with regard to public assistance.

Policy coherence in the public sector implies that related policy areas – such as social protection and taxation, but also education and transportation – need to be included in a comprehensive pro-poor health strategy (Wagstaff 2002, 102). For example, education clearly has a positive impact on the health status of individuals and health-related behaviour. Taxation and social protection can have a significant impact on the financial accessibility of a health system, whereas the area of transportation can be key for geographical accessibility. Thus, the government ought to ensure coherence of reforms and strategies across departments and sectors (WHO 2001b, 119).

The main challenge of guaranteeing policy coherence lies in dividing responsibilities between the social protection and the health system, between different ministries on the national level, and between the central government and municipalities[22] while avoiding insular thinking of these different institutions. Furthermore, the steward should not create unfunded mandates by assigning additional responsibilities to stakeholders without ensuring adequate financial resources.

Regulation comprises both *transparency* of decision-making and *enforcement* of legislation. Transparency implies that lawmakers clearly assign responsibilities to institutions and health service providers and establish criteria for decision-making processes that can be observed independently. Thus, transparency is a prerequisite for enforcement, or in other words, for 'monitoring compliance with legislation' (WHO 2001b, 121–124). However, enforcement requires not only transparency, but also personnel capacities in the health ministry and subordinated institutions.

Often, stewardship remains limited to issuing laws and regulations as a means of health policy (WHO 2001b, 121). Yet, transparency and enforcement are important factors to ensure that the purchasing and the provision of health services are actually carried out in accordance with legislation and overall policy. For instance, strict control of service providers can contribute to increasing the quality of services or avoiding corruption

22 Local municipalities are important, since they often manage health care facilities and provide health care services along with the private sector (WHO 2001a, 33).

and informal co-payments of patients. In addition, setting positive incentives, e. g. monetary rewards for providers that meet certain quality standards, might complement these actions and add to an improved provision of health services.

2.4.2.3 General political framework

In a complex political environment, a health system is not only shaped by decisions made within the system nor by the current government, but also by external factors. In particular, transition countries face a number of challenges to their political systems and societies, such as the simultaneous need for reforms in several sectors and, in some cases, the rebuilding of the nation-state. In this context, the ability and willingness to assign priority and allocate resources to the health system may be limited. In addition, a rather volatile political environment – characterised by short-term governments, many political changes and strongly diverging reform agendas – may hamper the development of a health system. Furthermore, the population's acceptance of further reforms may be reduced if too many of them have already been carried out in the past.

3 Poverty in Latvia

To enable a better understanding of the problems facing the poor in terms of access to health care services in Latvia, this chapter outlines the incidence of poverty and the social protection system in this Baltic country.

Latvia faces a widespread poverty problem, which exceeds the extent in the other new EU member states. Despite rapid economic growth in recent years, Latvia was characterised by an average income of only LVL 80 (€137.6) per capita in 2002.[23] In the same year, 16 % of Latvia's population was living below the national poverty line of LVL 48 (Ministry of Welfare / European Commission, DG for Employment and Social Affairs 2003, 60).

Furthermore, the income distribution is becoming increasingly unequal. Since the regained independence in 1991, the Gini coefficient has risen

23 The corresponding exchange rate was €1.72 per LVL 1 (CSB 2005).

from 0.25 to 0.34 in 2002 and is now above the EU-15 average of 0.29 (UNICEF 2003, 109; Ministry of Welfare / European Commission, DG for Employment and Social Affairs 2003, 60).[24] Consequently, the poorest part of the population does not seem to benefit proportionally from the economic upturn. E. g. from 1999 to 2000 the monthly income per household member of the poorest quintile decreased by LVL 1.49 (5.9 %), while the average disposable household income per capita increased from LVL 64.73 to LVL 69.19 (Bite / Zagorskis 2003, 12).

This chapter is divided into three sections. The first gives an overview of poverty definitions in Latvia, the second outlines the changing problem awareness, and the third describes the existing social protection system.

3.1 Definitions of poverty

Latvia's Poverty Reduction Strategy (PRS) defines poverty as follows:

'situation where an individual or a certain part of the population find themselves when, because of insufficient material and social resources, they have limited opportunities to obtain the essentials (food, shelter, clothing, and in some cases also care) and participate in society to the extent considered acceptable in that society'.[25]

Before adopting the EU's poverty definition, Latvia had developed several other poverty lines (see Table 1). In 2002, the Central Bureau of Statistics calculated the monthly 'complete subsistence minimum' at LVL 88.76 per capita (Ministry of Economics 2003, 70). Given that the average income amounted to only LVL 80 in 2002, the average inhabitant of Latvia lived below the subsistence minimum (CSB 2005).

Poverty definitions in Latvia are set as a percentage of the average annual income per household member (LVL 80 in 2002). The PRS defined 'low income' persons as those earning less than 50 % of the average income, i.e. LVL 40 (Cabinet of Ministers 2003). This poverty line is used as a threshold for granting different social benefits. In the context of Latvia's

24 It should be noted that the increase in inequality was politically intended in the transition to a market economy (Müller 2002b, 21–22).

25 Quoted after Bite / Zagorskis (2003, 22).

Table 1: Poverty lines, average income and income definitions in Latvia in 2002	
Low income persons (Latvian PRS definition)	LVL 40.00 (€ 68.80)
Low income persons (EU definition)	LVL 48.00 (€ 82.56)
Complete subsistence minimum	LVL 88.76 (€152.67)
Average income	LVL 80.00 (€137.60)
Official minimum wage	LVL 70.00 (€120.40)
Guaranteed minimum income[a]	LVL 15.00 (€ 25.80)
Sources: Cabinet of Ministers (2003), CSB (2005) a In 2003, when the corresponding law was enacted.	

EU accession in 2004, it is important to note that the EU defines 'low income' differently – as 60 % of the average income, i.e. LVL 48.

The official minimum wage was increased from LVL 70 to LVL 80 in 2004, which is still below the 'complete subsistence minimum'. All these poverty lines, however, are far above the guaranteed minimum income of only LVL 18, which was provided to the poorest as social assistance in 2004, after amounting to only LVL 15 in 2003 (see Chapter 3.3.2 below).

3.2 Changing problem awareness

3.2.1 'Undeserving poor': beyond the legacy?

Many inhabitants of Latvia hold the poor themselves responsible for their fate. 29 % of the population blame them to be 'lazy or lacking of will-power', while 32 % consider 'injustice in society' as a reason.[26] There is a historical explanation why many Latvians do not acknowledge the responsibility of society as a whole for the poor. In Soviet times, society sup-

26 The figure blaming 'injustice in society' as major reason for poverty is below the results found in comparable countries. E. g. in Lithuania this attitude was shared by half of the population (Halman 2001).

ported special groups, such as veterans, the elderly, and labour heroes. These groups were perceived as 'deserving' because of their prior contributions to society. There seemed to be no need for an income-based social assistance system because everyone enjoyed job security. By contrast, those who dropped out of society were deemed 'undeserving'. Consequently, society did not take action to improve the fate of this group.

During the transition, this insufficient problem awareness turned out to be disastrous for many in Latvia. Economic transformation resulted in increasing unemployment and falling wages. The risk of becoming poor increased significantly. However, Latvian policy makers were unable to solve these emerging problems in the first years, not least because of the collapse of state revenues. The persisting notion of the 'undeserving poor' in Latvia increased their social exclusion even further (Gassmann 2004). As a consequence, the poor try to escape the stigma of poverty. They often tend to avoid the term 'poor' when asked to describe their situation, and prefer more operational expressions, such as 'needy' (Institute of Philosophy and Sociology / Dudwick 2003, 384).

3.2.2 National poverty reduction strategy

Latvian policy makers did not prioritise poverty reduction in the first years after the regained independence. Moreover, our qualitative interviews indicated that Latvian politics focussed on EU and NATO accession instead of social issues in recent years. However, the persistence of poverty made it obvious that the problem was not just transitional and could not be solved by trickle-down effects of economic growth alone.

In 1998, the Latvian Ministry of Welfare joined forces with UNDP, the World Bank, and the International Labour Organisation (ILO), launching a project to develop a comprehensive programme to 'promote sustainable human development through poverty reduction efforts'.[27] After lengthy discussions, the Latvian Cabinet of Ministers finally approved the Poverty Reduction Strategy in 2000, the main objective of which was to bring down poverty, following the EU definition, from 16.2 % in 2000 to 10 % in 2015. Besides economic development, the strategy proposed to create

27 Quoted after Bite / Zagorskis (2003, 65).

employment, to improve employability and to implement an effective social protection system. Moreover, poor people's access to education and health care was to be expanded.

3.3 Progress in creating a social protection system

When Latvia became independent in 1991, it inherited a fairly comprehensive social protection system, the main pillar of which being an old-age security system with broad coverage. Most other social benefits were based on categorical targeting. In the Soviet period, there were neither means-tested benefits nor a basic right to a minimum income. The introduction of a guaranteed minimum income in Latvia in 2003 indicates a transition to a social protection system based on income testing as in Western welfare states.

Latvia developed its first social insurance system during the brief period of independence at the beginning of the 20th century. Today, Latvia's constitution continues this interwar tradition by guaranteeing social security in case of old age, incapacity for work, and unemployment. Moreover, it states that families and marriage shall be protected. Finally, everyone is entitled to basic medical assistance.

Nowadays, Latvia's social protection system consists of social insurance, social benefits, social assistance, and social services. The following sections distinguish between benefits financed on state and on municipal level.

3.3.1 Social protection provided by the state

Social insurance covers the risks of old age, maternity, unemployment, and incapacity for work. It is financed by contributions from employers (16.5 % of wage costs) and from employees (19 % of the employee's wage).[28] By 2006, both groups shall pay 16.5 % of the gross salary. In recent years, total social insurance contributions have been reduced and shifted towards employees, while formerly employers had paid a larger

28 Contribution rates as of 2004. For details on the design and post-1991 evolution of the Latvian pension system see Müller (2002a) and Bite / Zagorskis (2003).

share. This measure is intended to curb non-wage costs for employers in order to promote employment. While social insurance coverage used to be near universal in Soviet times, it is now limited to the shrinking group of those in dependent employment whose employers are effectively contributing to the system.

In 2002, 16 % of Latvia's population fell below the EU 'low income' definition. It is estimated that without the existing social protection system, 40 % of all Latvians would have fallen into this group. Interestingly, pensions alone would have reduced this figure to 24 % (Ministry of Welfare / European Commission, DG for Employment and Social Affairs 2003, 60). As old people are widely considered to be the most vulnerable or 'deserving' group, pension spending amounts to more than three fourths of all social insurance expenditure.

State social benefits are tax-financed and aimed at two major purposes. First of all, they mirror social insurance at a minimum level for all those who (or whose employers) did not contribute to social insurance. Second, state social benefits support specific groups, above all families with child care benefits and child allowance. Other supported groups are e. g. orphans and victims of Chernobyl. However, these benefits were very low during the 1990s.

3.3.2 Social protection provided by municipalities

Municipalities provide social protection via social assistance, social services and municipal social benefits. Although there is a compensation fund for inter-municipal transfers, spending levels vary, depending on the financial resources, the political priorities, and specific needs at the local level. Municipal budgets are less pooled than the state budget.

Social assistance is an important element of the social security system. Following some pilot projects since 1993, a nation-wide system was only introduced in 1995, following the transitional recession of 1994. Social assistance is paid out by municipalities and is mainly financed by the personal income tax. Municipalities were allowed to decide freely on how to spend the social assistance budget until 2003. This resulted in the poorest quintile of the population receiving less social assistance (LVL 0.13 per month per household member in 2000) than the average Latvian (LVL

0.23). Hence, social assistance did not fulfil its main objective – to support the poorest (Bite / Zagorskis 2003, 85).

Since the introduction of the guaranteed minimum income (GMI) in 2003, social assistance is means-tested.[29] This move helped to improve the situation of those most in need, although the new benefit amounts to only LVL 18 per month per person today, which is way below the poverty lines quoted in Table 1. One of the main advantages of the new social assistance system is the exclusive use of income as the qualifying criterion. Hence, the needy now no longer need to convince local authorities of their 'deservingness'.

Social services are also financed by municipalities. They comprise day care facilities for children at risk, institutions for mentally or physically retarded people, and homes for the elderly and orphans up to 3 years.

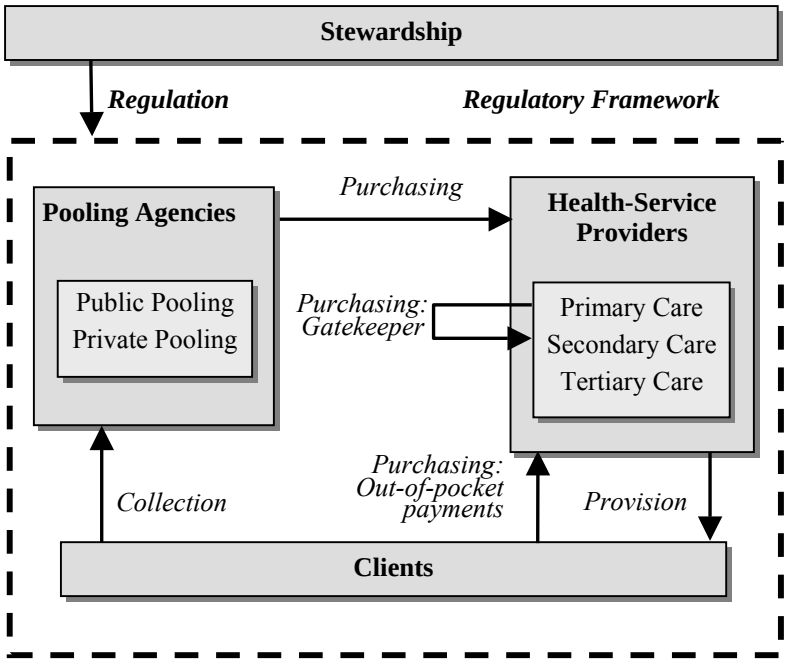
Municipal social benefits aim at addressing specific social needs of the respective population. Municipalities can decide freely on whom and for what purpose to spend these benefits. Therefore, spending levels and patterns vary between municipalities. Among other things, out-of-pocket payments for health care delivery may be reimbursed in case of need. However, every municipality sets its own conditions and defines its own distribution patterns. Thus, nation-wide pooled funding of health care expenses for the poor may not be achieved via this mechanism (for more details see Chapter 5.2.2.2).

4 The Latvian health system

This chapter outlines the current Latvian health system and thereby serves as a starting point for the evaluation of its accessibility conducted in Chapter 5. The Latvian health system can be analysed by using the functions of revenue collection and pooling, purchasing and provision of health services, and stewardship (see Figure 4). This chapter is organised around these functions.

29 For early evaluations of the new GMI system see Gassmann (2004) and Rajevska (2004).

Figure 4: Overview of the functions of the Latvian health system



Pooling amounts to the accumulation of prepaid health care revenues. It spreads the risk of individual health care costs by compensating for individual losses at the expense of all insured persons. In Latvia, there are both public and private pooling agencies (VOAVA, private insurance).

The collection of pooled revenues presupposes that individuals and corporate entities pay for health care. Payments are made in the form of taxes and private insurance premiums. They are collected by the central government and private insurance companies.

Purchasing occurs when health care services are paid for by pooled funds and by out-of-pocket payments. In Latvia, general practitioners who serve as gatekeepers to secondary care may also purchase secondary-care health services on behalf of their patients.

Provision is carried out by primary, secondary, and tertiary care providers.

Stewardship is the oversight function of the health system. The 'stewards' decide upon the organisation of the health system, set the regulatory framework, and monitor its outcome.

Source: own illustration

4.1 Collection and pooling

Latvia's health system is financed through taxes, private insurance premiums and formal and informal out-of-pocket payments. This section describes the collection of pooled resources (taxes and insurance premiums).

Public pooling: Tax revenues are the main source of pooled funding in Latvia. In 2001, public health-care expenditure amounted to LVL 69.92 per registered sickness fund member[30] and to 3.5 % of GDP (VOAVA 2003, 12–13). The Compulsory Health Insurance State Agency (VOAVA), which is under the supervision of the Ministry of Health, receives the centrally collected taxes and is responsible for their administration.[31] VOAVA transfers a part of these nationally pooled revenues to six regional VOAVA branches and Regional Sickness Funds[32] according to an age-adjusted capitation[33] formula (WHO 2001c, 33).

Private pooling: Individuals or corporate bodies can contract with private health insurance companies covering supplementary health care services or refunding user charges (for more details see Chapter 5.2.2.3). Up to now, private pooling through insurance companies has not played any major role in Latvia. In 2001, private health insurance covered less than 0.1 % of private expenditures on health care (WHO 2004b). A 2003 household survey conducted by the CSB reveals that only 15 % (954/6321) of respondents were covered by supplementary private insurance.[34]

30 In 2002, 91.8 % of all inhabitants of Latvia were registered with a general practitioner (VOAVA 2003, 55).

31 It should be noted that in spite of VOAVA's official denomination as 'health insurance', it is a tax-financed system.

32 There are three VOAVA branches and three Regional Sickness Funds. While the VOAVA branches are owned by VOAVA, the Regional Sickness Funds are owned by local governments. In the following the term VOAVA will be used for both VOAVA branches and Regional Sickness Funds.

33 Capitation is a prospective payment mechanism whereby an organisation receives a fixed amount of money per time period for each individual for which it is responsible, regardless of the volume of services rendered (European Observatory on Health Systems and Policies 2005).

34 Own calculation based on CSB (2003b).

4.2 Purchasing

In general, health services can be purchased by public agencies (e. g. VOAVA) or by private actors (individual patients and private insurance companies). In the following, the existing purchasing mechanisms through pooled funds and through out-of-pocket payments will be presented. Moreover, the allocation mechanisms used by VOAVA when channelling financial resources to service providers will be outlined.

4.2.1 Purchasing through pooled funds

The Basic Care Programme (BCP) comprises the *services* purchased completely or partly by VOAVA. In addition, VOAVA offers patients with chronic diseases price reductions for *medication*. All citizens and permanent residents of the Republic of Latvia are entitled to the services and price reductions offered by VOAVA.

The BCP covers e. g. emergency care, treatment for acute and chronic diseases, prevention and treatment of sexually transmitted and contagious diseases, maternity care, and dental care for those below 18 years of age. The *services* that are covered are not defined explicitly on a positive list. Instead, a negative list defines all excluded services, e. g. dental care for adults (Cabinet of Ministers 1999). However, the *medication* for which price reductions are available is specified on a positive list. Yet, only patients falling into certain illness groups – patients with severe and chronic diseases – are entitled to price reductions (Cabinet of Ministers 1998).

Supplementary private insurance schemes available in Latvia differ in scope. They may cover formal co-payments for the services within the BCP and payments for the services excluded from this programme, and may provide access to health service providers that contract exclusively with private insurance (for more details see Chapter 5.2.2.3).

4.2.2 Purchasing through out-of-pocket payments

As indicated in Figure 4, pooled funds are not the only purchasing mechanism to be observed in Latvia. Formal and informal out-of-pocket payments also play a sizeable role. E. g. within the BCP only a few services

are offered free of formal co-payments.[35] In 2002, the existing medical institutions collected an average of LVL 4 in co-payments per registered sickness fund member for provided services.[36] Beyond these fees, there is evidence that a large proportion of visits and consultations is not paid from the public budget: more than a third of all outpatient health care services used are privately paid (Briģis 2004, 85).

In the Latvian health system, out-of-pocket payments made to purchase goods and services take different forms: formal co-payments, out-of-pocket payments for services covered by the BCP in theory but not in practice, out-of-pocket payments for services not covered by the BCP, and out-of-pocket payments for medication. A detailed discussion of these payments and the financial barriers they may imply is provided in Chapter 5.2 below.

4.2.3 Resource allocation to service providers

VOAVA contracts with health-service providers to purchase the services covered by the BCP. The payments for outpatient and inpatient care follow different allocation mechanisms.

Outpatient care: The allocation of resources within outpatient care follows a capitation model and uses primary-care general practitioners (GPs) as gatekeepers. The GPs are paid by VOAVA according to a capitation formula. Capitation is essentially a fixed amount of money per enrolled patient per unit of time paid in advance to the physician for the delivery of health care services. The Latvian formula is based on the number of registered patients and on their age structure, while GPs are paid a supplement if their practices are located in a low-density area. They are supposed to use the capitation fee to cover all treatment costs, including their own salary. Moreover, GPs located outside of Riga are obliged to use part of the capitation fee to pay secondary care specialists to whom they refer their patients, whereas specialists in Riga are paid directly by VOAVA

35 See Appendix A.1 for detailed information on the level of formal co-payments.

36 Own calculation. In 2002, medical institutions collected LVL 8.57 million in payments from patients. The total number of sickness fund members was 2.14 million (VOAVA 2003, 32 and 56).

(see also Box 1 below). Under both models specialists are remunerated according to a variation of the fee-for-service model.[37]

Inpatient care: VOAVA's payments to hospitals are based on a combination of bed-day payments and fixed payments for 64 diagnosis-related groups.[38]

4.3 Provision of services

Primary care in Latvia is mainly provided by GPs.[39] Patients must register with a GP in order to obtain publicly financed health services. While they can choose freely with which GP to register, they cannot change their GP more than twice a year. Once a patient registers with a GP, the practitioner receives a capitation fee from VOAVA. As a gatekeeper, the GP refers a patient to a secondary care specialist or to a hospital for further treatment, if necessary. General physicians, internists and paediatricians can be registered as GPs after having been retrained. In 2002, 13 % of all physicians in Latvia were GPs. The number of GPs had increased from 141 in 1995 to 1,027 in 2002. This amounts to 4.4 GPs per 10,000 inhabitants (Ministry of Health 2003, 72).

Secondary care is provided by outpatient specialists and inpatient hospitals. Normally, a patient can receive secondary-care treatment only if directed to the respective institution by a GP. However, patients may accede to secondary care specialists directly if they pay them out of pocket or through private health insurance. Patients can freely choose among the hospitals within their administrative area. State, municipal and private health care institutions provide secondary care.

Tertiary care is provided by specialised hospitals equipped with treatment and diagnostic facilities unavailable at general hospitals. In Latvia these

37 According to the fee-for-service model, a retrospective payment mechanism, the physician receives a pre-specified payment for each service provided.

38 Diagnosis groups follow the International Statistical Classification of Diseases and Related Health Problems (ICD-10). Diagnosis-related groups (DRG) are a 'way of categorizing patients according to diagnosis and intensity of resources required, usually for the period of one hospital stay' (European Observatory on Health Systems and Policies 2005). DRG payments are the most common kind of case-based payments.

39 Primary care physicians include general physicians, internists, and paediatricians.

hospitals are state centres that are financed directly by the central VOAVA. All tertiary care facilities are located in Riga.

In 2002, 129 secondary and tertiary care hospitals provided 18,143 beds, amounting to 77 beds per 10,000 inhabitants.[40] Only 11 hospitals were privately owned. The central government controlled 42 and the municipalities 74 hospitals. The remaining two hospitals were public joint-stock companies (Ministry of Health 2003, 60).

4.4 Stewardship

The central government is responsible for legislation, policy and planning of the health-care system. The Cabinet of Ministers decides each year on the range of services to be provided within the BCP. Together with the Saeima (Parliament), it fixes the share of the basic state budget spent on health services (WHO 2001c, 75). The Ministry of Health supervises VOAVA. VOAVA either contracts with autonomous Regional Sickness Funds or establishes regional branches that fulfil the function of a Regional Sickness Fund. Local governments manage health-care facilities and provide health-care services along with the private sector (WHO 2001a, 33). The Quality Control Inspection on Medical Care controls the quality of health services, irrespective of the ownership of the health care institution (Ministry of Welfare 2002, 11).[41]

5 Accessibility of health services in Latvia

The above description of the Latvian health system is followed here by an evaluation of its accessibility. As explained in Section 2.4, the degree to which health services are accessible by vulnerable groups is one of the main indicators when assessing health systems from a pro-poor perspective. This chapter outlines the available evidence on accessibility and utilisation of health services in Latvia and discusses financial, geographical

40 Excluding temporary social care beds (Ministry of Health 2003, 55).

41 The Ministry of Welfare, the Ministry of Regional Development and Local Governments, and the municipalities are involved in the provision of health-related benefits to low-income groups and thus also act as stewards at the health-poverty interface.

and informational access barriers in detail. Empirical evidence on each barrier is presented, existing measures to reduce the observable barriers are described and evaluated, and reform proposals to reduce access barriers are made.

5.1 Accessibility and utilisation: an overview

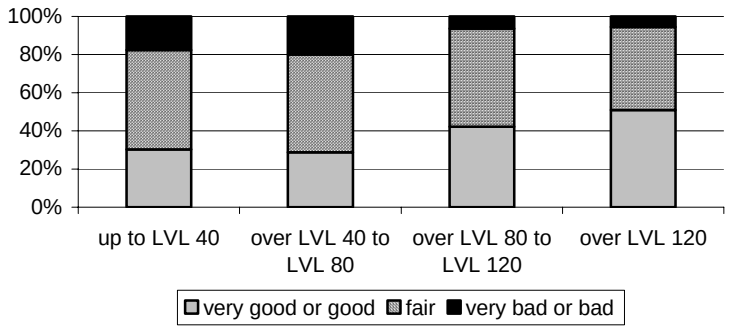
The available evidence on accessibility and utilisation of health services in Latvia is based on a number of household surveys. Apart from a general assessment of accessibility, these surveys allow first insights into differences in the utilisation of health care services among different social and income groups.

When utilisation is taken as an indicator for accessibility, it needs to be considered that the actual need for health care might differ among social groups. A representative health survey conducted by the CSB in 2003 finds that a bad or very bad self-assessed health status correlates with a poor economic self-assessment. As illustrated in Figure 5, only 30.27 % (630/2081) of those with a monthly income below LVL 40 described their health status as good or very good compared to 50.93 % (246/483) of those with an income above LVL 120. In line with this, 17.64 % (367/2081) of those with an income below LVL 40 described their health status as bad or very bad compared to only 5.59 % (27/483) of those with an income above LVL 120.[42] These figures point to the existence of a health-poverty linkage in Latvia, implying an increased need for health care services for people with lower income.

If there is an increased need for health care services among people with lower income, equitable access would translate into an above average utilisation of services by low-income groups. As other groups may also experience a higher-than-average need for health care, data on utilisation as an indicator for equitable access need to be interpreted with care. This is especially true for patients with chronic diseases and for utilisation rates of pensioners because the need for health care services tends to increase with age.

42 Own calculations based on CSB (2003b).

Figure 5: Self-assessed health status by income groups 2003



Source: Own calculation based on CSB (2003b).

A survey conducted by BISS in 2002 assessed the general accessibility of state-guaranteed health care services, as perceived by a representative group of 1,020 inhabitants. 36 % (28 % in 2000) of respondents considered health care services not or rather not accessible (BISS 2002, 10).[43]

The 2003 CSB survey indicates differences in the use of outpatient care by income level (Briģis 2004, 81). Only 24.65 % (513/2081) of those with an income below LVL 40 per person per month had discussed health problems with medical staff during the last month, compared to 30.23 % (146/483) of those with an income above LVL 120.[44] On the other hand, 22.57 % (353/1564) of respondents with an income below LVL 40 needed a consultation or visit during the last month but did not see any medical staff, compared to only 16.02 % (54/337) of those with an income above LVL 120.[45] These figures may suggest that people with lower income have less access to outpatient care than the better off.

43 This is also reflected in a survey conducted by the CSB in 1999 in which 24.3 % of a representative group of 3,081 households responded to be fairly or very dissatisfied with the accessibility of health care (Briģis 2001, 178).

44 Own calculations based on CSB (2003b).

45 Own calculations based on CSB (2003b).

Moreover, the CSB survey shows the utilisation rates of outpatient care among different social groups. With 19.50 % (78/400), consultations within the last month were lower for the unemployed than for the average respondent with 27.26 % (1864/6837).[46] The former is supported by the FINBALT study on health behaviour conducted in 2002. Among respondents who were unemployed, 66 % had visited a doctor in the previous year compared to an average of 74 % (Pudule et al. 2003, Table 9A). These figures may suggest that the unemployed have less access to outpatient care.

Another indicator of reduced access for low-income groups can be found in a survey conducted in 2002 by Boroņenko in the regions of Kurzeme, Southern Latgale and Riga. Coefficients of correlation suggest that higher income increases the utilisation of different types of health care, e. g. consultations of specialists (Boroņenko 2003, 32).

The Boroņenko survey indicates that 33.4 % of all respondents renounced one or more health care services during the year prior to the survey. Among the services people renounced, visits of doctors were mentioned by 14 % of all respondents, physical or medication therapy by 11.4 %, rehabilitation by 9.9 %, hospital treatment by 6.6 %, and surgery by 2.6 % (Boroņenko 2003, 15). When asked for the reasons, 23.1 % of all respondents mentioned scarcity of money or lack of a private insurance policy. Compared to this, only 9.4 % mentioned scarcity of time, 3.7 % waiting time, 3.4 % distance, 1.5 % problems to travel and 2.2 % problems to be transferred to a specialist as a reason for access problems (Boroņenko 2003, 15).

These figures indicate a variety of barriers to access. In the following three sections financial, geographical and informational barriers to the Latvian health care system will be discussed in more detail.

5.2 Financial accessibility

The first section of this chapter presents empirical evidence on financial barriers to accede to health care services in Latvia. The second section analyses why these financial barriers persist even though different systems

46 Own calculations based on CSB (2003b).

intended to provide protection against health-related costs are in place. In this context, the chapter assesses the protection systems offered by VOAVA, the municipalities and private insurance. The third section discusses how the insufficient level of protection granted by these systems could be improved.

5.2.1 Financial barriers to access

Several household surveys conducted in Latvia indicate that vulnerable groups may have difficulties in affording health care services.

The Boroņenko survey cited above identifies scarcity of money as the main reason for renouncing health services. This result is underlined by the assessment of human security concerns by the UNDP Latvia in 2002. It revealed that the inability to pay for medical care in the case of illness was a widespread concern: 83 % of respondents expressed this fear (UNDP 2003, 30).

A survey published in 2003 by Pranka et al. focused on vulnerable groups.[47] These groups were asked if they had to reject medical treatment due to lack of money within the last year. Among those who answered the question, 64.4 % had renounced one or more health services in the past year because of lack of money. The services most often rejected were the visit to a dentist (44.9 %), the purchase of drugs (40.0 %), dental technician services (30.8 %), the visit to a doctor (28.2 %) and the treatment at a hospital (16.4 %) (Pranka et al. 2003, 93).

In a survey conducted in 1999 by Karaškeviča, people were asked why they refused medical services and could choose among the following categories: shortage of money, worry about the total amount of treatment expenses, and worry about the medical personnel's knowledge and experience. The two financial categories – shortage of money and worry about the total amount of treatment expenses – were mentioned by 88.1 % of those with an income of less than LVL 42 per family member, as com-

47 In this survey, vulnerable groups are defined as persons with disabilities, young dropouts, single parents, persons staying on childcare leave, ex-prisoners, young persons without job experience after leaving the educational institution, and persons of pre-retirement age (Pranka et al. 2003, 8).

pared with 48.8 % of those with an income over LVL 100 per family member (Karaškeviča 2001, 85).

In the 2003 CSB survey, people who gave up consultation in an outpatient care institution were asked for the reason and could choose among six standard answers.[48] 49.3 % (174/353) of those respondents with an income below LVL 40 gave up because of the payment, compared to only 3.7 % (2/54) of those with an income above LVL 120.[49]

A survey conducted by CIET in 2002 did not ask interviewees directly about financial barriers and draws a more positive picture. Representative Latvian households were asked whether they were satisfied with the overall care they received under the government health care system. Only 9 % (276/3,151) of respondents said they were dissatisfied or very dissatisfied. When this group was asked for the reason of their dissatisfaction, 8 % answered that the services were too expensive. Public health service users were also asked about their satisfaction with the prescribed medication. In this case, 24 % of respondents were not satisfied. Out of those dissatisfied with the prescribed drugs, 22 % said that they were dissatisfied because the drugs were too expensive (CIET International 2002, 47–49). The cost of medication stands out as a financial barrier in this study.

SUSTENTO, a patients' association, conducted a survey among patients with chronic diseases and asked whether they currently had the money to purchase all the necessary medicines. 77.2 % (470/609) of those who answered said that they could not afford all of them (SUSTENTO 2003, 2). The CSB survey reveals that 46.0 % (308/669) of those with an income below LVL 40 could not afford all of the prescribed medicines, compared to 10.6 % (17/161) of those with an income above LVL 120.[50]

The surveys indicate different magnitudes of the financial barriers to accede to health services that may be due to differences in methodology. Yet, all surveys indicate that financial barriers exist.

48 'Because of payment', 'because of transport and its costs', 'I do not trust the doctor', 'I cannot or do not want to follow the doctor's recommendations and referrals', 'I do not know whom to apply to', and 'because of business or some other reasons' (CSB 2003b, Question G11).

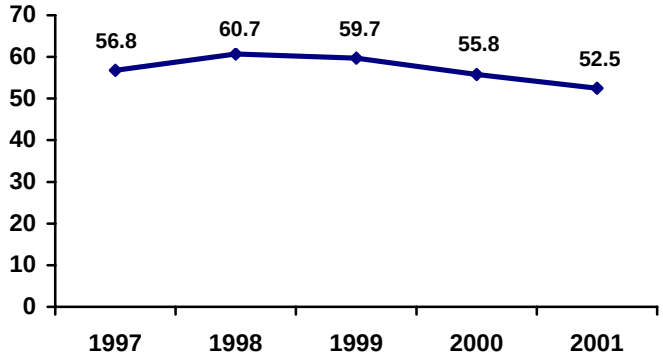
49 Own calculation based on CSB (2003b).

50 Own calculation based on CSB (2003b).

5.2.2 Existing measures to reduce financial barriers

As explained in Section 2.4.1 above, out-of-pocket expenditures may represent the main access barrier to a health system. In Latvia, three pooling systems can provide protection against high out-of-pocket payments in case of illness: the state-funded VOAVA, reimbursements of and exemptions from out-of-pocket payments provided by municipalities, and supplementary private health insurance.

Figure 6: Public / total expenditure on health, 1997–2001, WHO estimates

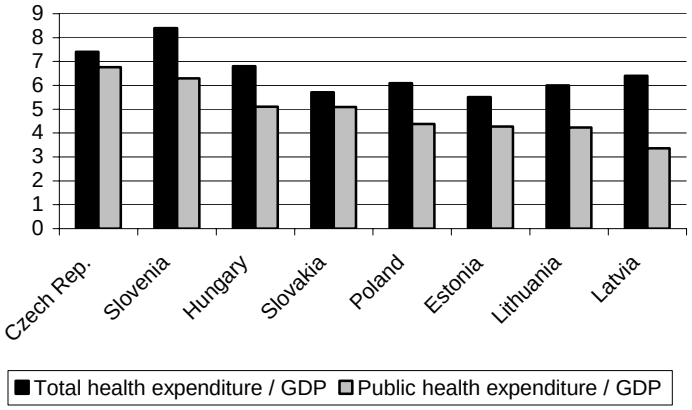


Source: WHO (2004b)

As depicted in Figure 6, out-of-pocket payments for health services were relatively high in Latvia, with an estimated share of 47.5 % of total health care funding in 2001 (WHO 2004b).[51] Moreover, out-of-pocket payments have been increasing since 1998, while the share of general government spending has been decreasing (see Figure 6). Figure 7 illustrates that in 2001 Latvia had the lowest share of public health expenditure among the new EU members from Central and Eastern Europe. Inversely, Figure 7

51 Total expenditure on health = private health care expenditure + public health care expenditure.

Figure 7: Health expenditure in selected new EU member states, 2001, WHO estimates



Source: WHO (2004b)

indicates that Latvia had the highest share of out-of-pocket payments in this country group.[52]

The following sections describe and assess the three pooling systems in place to protect vulnerable groups from out-of-pocket payments. First, they indicate where out-of-pocket payments persist as a financial barrier to access, despite the existence of the pooling systems. Second, they describe how these systems could be improved to increase protection against high out-of-pocket payments made by vulnerable groups.

5.2.2.1 Protection offered by VOAVA against out-of-pocket payments

The state-financed BCP includes all health services that are not explicitly specified on a negative list (see Chapter 4.2.1). Within this programme

52 The share of private insurance in private expenditure on health can be neglected in Latvia (WHO 2004b).

most services are offered only provided that co-payments are made.[53] This section begins by explaining these formal co-payments and the existing protection schemes against such costs. Then, additional out-of-pocket payments for services covered in theory by the BCP but not in practice, are identified. Subsequently, out-of-pocket payments for services not included in the BCP are discussed. The cost of medication follows another scheme that is also presented.

Formal co-payments

A regulation of the Cabinet of Ministers states that vulnerable persons are exempted from co-payments. Among them are children up to the age of 18, persons living in municipal old-people's homes and poor persons categorised as such in accordance with the Regulation of the Cabinet of Ministers (Cabinet of Ministers 1999). Persons considered 'in need' are those whose income did not exceed 50 % of the minimum wage in the past three months (Cabinet of Ministers 2003).[54] This threshold is currently lower than half the value of the monthly minimum consumer basket of goods and services.[55]

According to this regulation, co-payments should not constitute an important financial barrier for low-income households when acceding to health services, provided they are in possession of a municipal exemption certificate (see Section 5.2.2.2 below). However, co-payments may form a barrier to access health services for those still relatively poor, but with an income above the poverty threshold defined by the Cabinet of Ministers.

Our stakeholder interviews revealed that hospitals and outpatient facilities do not always receive the stipulated co-payments from their patients. The 2002 CIET household survey comes to a similar conclusion: 37 % (964/2,643) of those who used government health services had not paid the consultation fee to GPs and specialists (CIET International 2002, 50). There are no quantitative data on the reasons for not paying these fees. Hence it is not clear if those not paying were exempted from co-payments

53 However, emergency care is offered free of charge.

54 This poverty threshold currently amounts to LVL 40. In the case of multi-person households, the income ceiling applies as per family member.

55 The value of the minimum consumer basket was LVL 97.71 in March 2004 (CSB 2005).

or not. Our qualitative interviews indicated that many patients had difficulties in affording co-payments or were not informed about the possible exemptions.[56] There is also some degree of confusion about who should pay the co-payments on behalf of the exempted groups – the municipalities or VOAVA – or whether providers are expected to cope with this shortfall in revenues.

There is a ceiling for co-payments of LVL 80 per patient per year.[57] Patients are exempted from further co-payments for the rest of the calendar year after handing in receipts for a total of LVL 80 in co-payments at the Regional Sickness Fund or VOAVA branch, collected from January onwards (Cabinet of Ministers 1999). This ceiling is intended to prevent patients from catastrophic health costs caused by co-payments for services. Yet, a ceiling of LVL 80 may be too high for income groups not exempted from co-payments, but with a relatively low income. For those with a monthly income of LVL 50, for example, LVL 80 may be more than catastrophic.

Interviews with Regional Sickness Funds and VOAVA officials indicated that patients rarely submit receipts to get exemptions from co-payments, hence the LVL 80 ceiling remains virtually unused. Possible reasons for this might be that the ceiling is hard to reach, that it is difficult to collect all the necessary receipts, that patients are not informed about this option, or that the ceiling is ill-designed, as it does not cover the substantial out-of-pocket payments described in the following sections. It excludes out-of-pocket payments for services rationed by quotas, informal payments, payments for services excluded from the BCP, and payments for medication.

Out-of-pocket payments for services covered in theory but not in practice

Rationing: Many of the health services included in the BCP are rationed in some way or the other (Deabaltika 2002, 25–31). Regulation No. 13 of the Cabinet of Ministers explicitly allows quotas for planned surgery. Moreover, there are quotas for laboratory tests, prescribed medicines, services provided by specialists, and even for emergency care (Harmsena 2003, 3).

56 For more details on this informational barrier see Section 5.4 below.

57 In addition, the patient's fee per period of hospitalisation may not exceed LVL 25 for adults and LVL 5 for children (Cabinet of Ministers 1999).

Quotas result in waiting lists or out-of-pocket payments for those unwilling or unable to wait.

With respect to waiting lists for planned surgery, stakeholders most frequently cited the example of hip-replacement, for which waiting lists of up to 10 years exist. It was explained that this might also be due to the fact that patients are foresighted and ask to be put on the waiting list very early, even if they do not need a hip-replacement yet. GPs sometimes seem to identify patients as acute cases when referring them to hospitals for surgeries when they are not, to shorten their waiting time (Harmsena 2003, 3). In some cases, however, waiting lists for surgery may have severe consequence. Interviewees mentioned cases of patients dying before getting needed surgery. There seems to be only one mechanism in place that ensures timely surgery: patients ready to pay the full cost of the operation out-of-pocket are treated without waiting time.[58]

The different forms of rationing (see also Box 1) produce a two-tiered health system in which better-off patients pay for health care services, especially specialists, out-of-pocket (Briģis 2004, 83), while the poor have to wait to obtain a treatment. This may result in cases of delayed treatment and chronic diseases for the vulnerable. Stakeholders frequently mentioned the problem of delayed treatment of low-income groups. Many of these patients make their first contact with the health system at emergency care institutions. This may be due to the fact that emergency care is offered free of co-payments, whereas according to the 2003 CSB survey over one third of all outpatient visits and consultations were entirely privately paid (Briģis 2004, 85).

In the 2002 CIET survey people were asked whether they were willing to pay to avoid a waiting list. More than half of the interviewees (56 %, 1,730/3,086) answered in the affirmative. Interviewees from vulnerable households (43 %, 527/1,213) were clearly less inclined to pay than interviewees from non-vulnerable households (64 %, 1,203/1,873) (CIET International 2002, 59).

58 This option is guaranteed by the Cabinet of Ministers (2001a). See also Deabaltika (2002, 7).

Box 1: Access to specialists under both capitation models

In both the Riga gatekeeper model and the rural gatekeeper model, services provided by specialists may be rationed. In both models, patients need a referral from their GP to get state-financed services from specialists, and the GP is paid according to a capitation fee.

In the Riga model, specialists are paid directly by VOAVA. The GPs may therefore have an incentive to refer their patients to specialists. But since VOAVA purchases only a fixed amount of services provided by specialists, waiting lists are common. Riga patients can, however, accede to specialists directly by purchasing their services privately.

In the rural gatekeeper model, the GPs must use part of the capitation fee to pay the specialists to whom they refer their patients. The capitation fee may not be sufficient to cover the GP's salary, the costs of maintaining the practice and to pay specialists for their services. Rural GPs may thus have an incentive to provide more services themselves than the Riga GPs. Depending on the GP's qualifications this may be inadequate. VOAVA regulates the referrals by applying financial sanctions to those GPs who do not refer patients often enough. Nevertheless, rural patients often complain about the difficulties in receiving a referral to a specialist. Better-off patients consult specialists by paying completely out-of-pocket (see, e. g., Briģis 2004, 83).

Quotas are also problematic due to the lack of transparency for the patients. As long as the patients do not know if the quotas are already filled, they are not sure whether a certain service has to be paid out-of-pocket or whether it is covered by VOAVA. Our stakeholder interviews suggested that the medical personnel might have some discretionary room to decide whether services are to be paid by the patient or by VOAVA. Hence, quotas can foster informal payments.

Informal payments: There is indication that informal payments are made for services included in the BCP, and that these payments are often offered by patients themselves.[59] In the CIET survey, 3 % of the users of government health services admitted to having made informal payments, of

59 Informal payments can be defined as payments to individuals in cash or in kind made outside the official payment channels or for purchases meant to be covered by the health system. This encompasses 'envelope' payments to physicians and 'contributions' to hospitals as well as the value of medical supplies purchased by patients and drugs obtained from pharmacies but intended to be part of the government-financed health care services (Lewis 2002, 184).

which 83 % had offered the payment. In the same survey, 14 % of users of government health services said they had made gifts – mostly flowers, chocolates and alcohol of a mean value of LVL 4.4 – during their last contact with the health service. If gifts made before the end of the treatment are included in the category 'informal payments', 6 % of the users of government health services had made informal payments (CIET International 2002, 52–53). In contrast, the Boroņenko survey states that 13.8 % of all respondents had made informal payments.[60]

A survey conducted by Babarykin among physicians in 2002 revealed that 44 % of respondents reported unofficial income connected with their work. 94 % of respondents indicated that the share of their patients making informal payments was up to 25 %, 3 % said this share was up to 50 %, and 3 % said that more than 50 % of their patients made informal payments. With respect to the amount received per patient, 77 % reported an amount up to LVL 5, while 22.4 % received higher informal payments per patient (Babarykin 2002, 7).

The CIET survey indicates that vulnerable households are somewhat less likely to make an informal payment than non-vulnerable households: 5 % of the vulnerable had made informal payments, compared with 7 % of the non-vulnerable category (CIET International 2002, 54). The Boroņenko study indicates more pronounced differences: 11 % of those with an income below LVL 100 per capita had made informal payments, compared with 23 % of those with an income above LVL 100 per capita (Boroņenko 2003, 50).

Stakeholders considered envelope payments to be more common in the area of surgery than in primary care. Both the Babarykin and the CIET survey support this assessment. According to the former, the average informal payment physicians received per patient was LVL 22.39 for surgeons, LVL 7.36 for gynaecologists, LVL 5.90 for paediatricians, LVL 4.98 for internists, LVL 3.83 for GPs, LVL 2.55 for dermato-venereologists, and LVL 7.14 for other physicians (Babarykin 2002, 7). According to the latter, patients treated in hospitals were more likely to report infor-

60 Another possible indication is that medical personnel do not always give receipts for out-of-pocket payments. Only 45.6 % of the respondents of the Boroņenko survey had received receipts, 24.6 % had not and 29.8 % did not remember (Boroņenko 2003, 18).

mal payments (12 %) than those treated in other health care facilities (5 %) (CIET International 2002, 54).

Stakeholders perceived informal payments mostly as a tradition from Soviet times that still persists. Apparently, many people are used to offering at least a small amount in order to show that they are grateful for the medical care received. Yet, the results of quantitative household surveys indicate that the most important benefit of informal payments is a shorter waiting time for treatment (CIET International 2002, 51). This confirms the existence of a two-tiered health system in Latvia.

Out-of-pocket payments for services not covered by the BCP

Regulation No. 13 of the Cabinet of Ministers specifies a negative list of the services excluded from the BCP. The list excludes services such as dental care for adults, injections in outpatient facilities for adults that do not belong to the limited list of diagnosis groups, treatments in sanatoria and spas, psychotherapeutic assistance and some vaccinations.

Most stakeholders considered the BCP to be rather comprehensive and thought that very few or only 'luxury' services were excluded. Nevertheless, patients appear to have problems affording the services not covered by VOAVA. The quantitative survey conducted by Pranka et al. reveals that visits to dentists and the purchase of dental technician services belong to the services most often rejected by vulnerable households because of lack of money (Pranka et al. 2003, 93).[61] The 2003 CSB survey confirmed that visits to dentists varied strongly by income: while more than 50 % of those with a monthly income of LVL 500 or more had seen a dentist within the last year, less than 20 % of those with a monthly income of LVL 25 or lower had (Briģis 2004, 101).

Out-of-pocket payments for medication

While medication in inpatient facilities is free of co-payments, patients must purchase most of the medication prescribed by outpatient physicians completely or partly out-of-pocket. Exemptions from payments for outpatient medication treatment are specified in the Regulation No. 428 of the Cabinet of Ministers. Patients can be partly or completely exempted from

61 For more details see Chapter 5.2.1 above.

payments for medication specified on a positive list. Patients entitled to a discount are divided into different diagnosis groups that correspond to certain exemption levels. There are four different exemption levels (100 %, 90 %, 75 %, 50 %), depending on the severeness of the illness but not on the cost of the medication nor the income of the patient. A national law exempting low-income patients from co-payments for medication does not exist. The ceiling of LVL 80 described above does not cover medication expenses. Hence, VOAVA does not systematically insure patients against catastrophic health costs resulting from the cost of medication. Financial support for medication purchases, however, is available from municipalities. This option will be discussed in the next section.

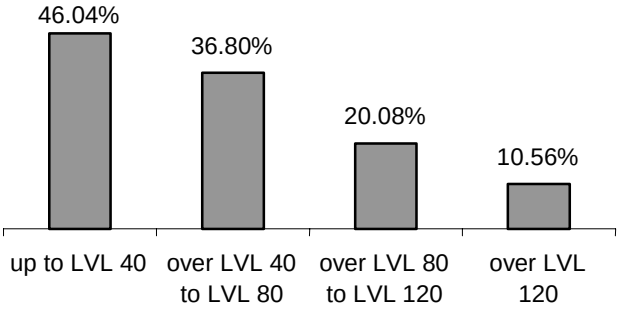
The qualitative interviews suggested that poor patients had major difficulties in affording the necessary medicine. This may be due to several reasons: some patients are not entitled to exemptions because their diagnosis is not specified in the Regulation No. 428, those entitled to a discount but not getting a full exemption may have difficulties in affording the difference, and, finally, those entitled to exemptions may not always get a prescription for the necessary medication since there are quotas for medication prescribed by GPs.

Based on the 2003 CSB survey, Figure 8 illustrates the affordability of prescribed medication by different income groups. People were asked whether they could afford all the prescribed medication. 46 % of those with a monthly per capita income of up to LVL 40 said they could not, compared to only 11 % of those with an income above LVL 120 (see also Briģis 2004, 116).

A survey on the accessibility of pharmaceuticals conducted by SUSTENTO among patients with chronic diseases supports these statements: 83.8 % (485/579) of respondents needed pharmaceuticals that they had to purchase out-of-pocket. 77.2 % (470/609) said they could not afford all the necessary medication. 59.5 % (304/511) responded that they were entitled to state-reimbursed pharmaceuticals, but only 46.8 % (152/325) had actually obtained the respective prescriptions from their doctors (SUSTENTO 2003, 1).

In comparison with its Baltic neighbours, Latvia spends relatively little on the reimbursement of medication: in 2002 Latvia reimbursed $12.55 per

Figure 8: Affordability of prescribed medication



"I could not afford all the prescribed medication".
Percentage of the respective income group, monthly per capita income.

Source: Own calculation based on CSB (2003b).

capita, compared with $28.34 in Lithuania and $37.63 in Estonia (State Medicine Pricing and Reimbursement Agency 2003).

5.2.2.2 Protection offered by municipalities against out-of-pocket payments

Municipalities play an important role in making health care accessible to low-income groups. This is mainly done by exempting individuals from co-payments, by reimbursing health care expenses incurred by individuals, by subsidising health and social care institutions directly, and by providing public transportation. The different mechanisms of municipal protection against health care expenses will be discussed in detail below.

According to the 1995 Law 'On Local Governments' (Section 15, Article 6), municipalities have to 'ensure access to health care'. From this general obligation, a number of specific municipal responsibilities might be derived. These are not specified in national law (Cabinet of Ministers 1999). Instead, municipalities are granted much leeway to interpret their obligation. To improve the access of low-income inhabitants to health care, it is

most common for municipalities to reimburse some of the health-related expenses incurred by vulnerable groups.

Exemptions from co-payments for health care

It is an important task of municipalities to issue exemption certificates for their low-income residents. These certificates exempt a person from official co-payments for health services. Certificates are valid for three months, and their use is not restricted to health services. Therefore, the number of certificates issued is no indicator of health service use. Moreover, many people apply for exemptions only shortly before undergoing surgery or medical examinations.

Contrary to the reimbursements to be discussed below, the financial shortfall caused by this exemption mechanism is not necessarily funded by the municipal budget. Other possible funding sources are VOAVA or health care providers themselves, such as hospitals. Since some hospitals collect data on patients who have not paid and may refuse further treatment except in case of emergency, exemption certificates play an important role in ensuring current and future accessibility.

Reimbursements of health care expenses

Reimbursements of health care expenses are not strictly regulated. Therefore, municipalities are not obliged to offer a certain level of protection against health care costs. National law stipulates, however, that municipalities must pay a guaranteed minimum income to poor residents (see Chapter 3.3.2 above). Once the latter is ensured, municipalities can decide on the allocation of their remaining funds.

According to the evidence collected, the municipal reimbursements granted are targeted by means testing and by categorical targeting, reflecting some of the categories of deservingness from the Soviet period. Municipalities' practice differs not only regarding the criteria for eligibility applied, but also regarding their administrative discretion in case-by-case decisions. Reimbursement procedures applied by municipalities also differ. Our interviews indicated that reimbursements are mostly granted based on receipts submitted by patients, and therefore retrospectively. Advance payments are sometimes made in the case of planned operations.

Beneficiaries may also receive a letter of reference from their municipality, serving as guarantee for municipal reimbursement.

The kind of medical expenses and the percentage reimbursed (full or partial) varies between municipalities. Apart from reimbursements made for health services, many municipalities subsidise the purchase of pharmaceuticals that are not on the national reimbursement list, as well as the cost of hospitalisation. Some municipalities are granting subsidies for the purchase of private health insurance policies, replacing case-by-case reimbursements for health-related expenses. Sometimes, reimbursements for transport costs to accede to health care are also granted (see also Section 5.3 below).

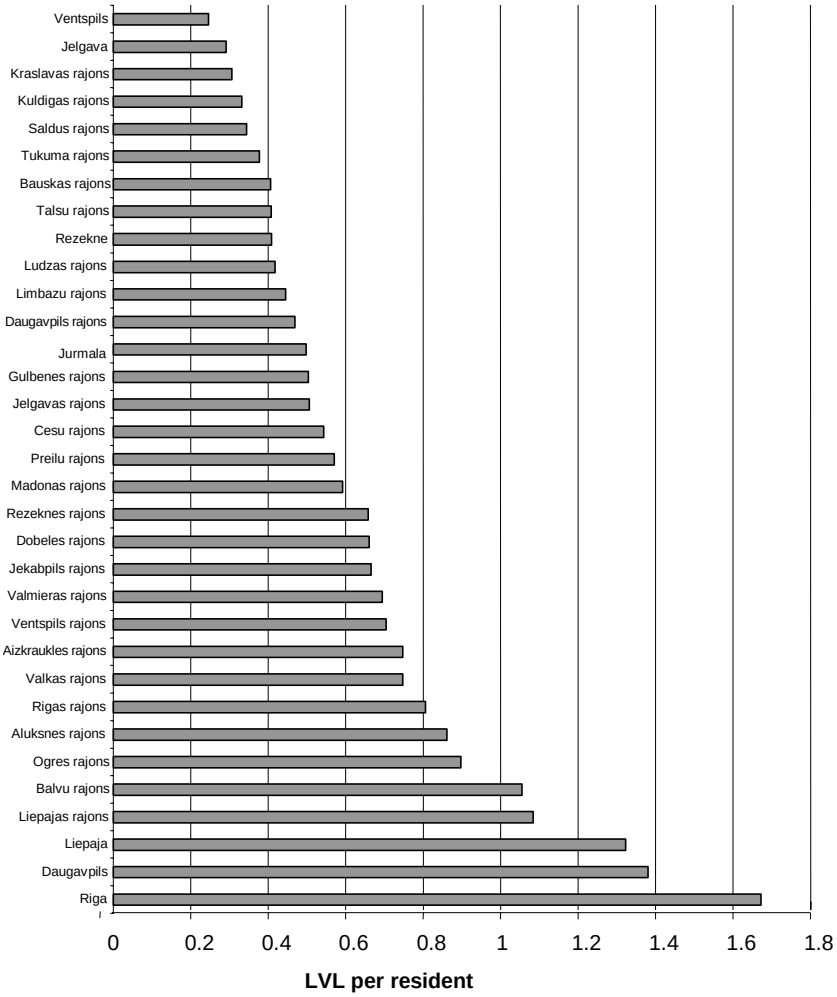
It is an important limitation that municipalities reimburse only official co-payments. Our interviews indicate that unofficial expenses or payments that could have been avoided by using the system of referral are rarely reimbursed. The national ceiling of LVL 80 described above also limits the expenses that municipalities subsidise. As noted above, all co-payments exceeding LVL 80 per calendar year for one person are covered by VOAVA (Cabinet of Ministers 1999, Chapter IV, Article 26).

Evaluation of municipal assistance

Even though reimbursement schemes are in place, not all people in need are benefiting from this possibility. Some people are discouraged after encountering problems with obtaining reimbursements or allowances for health care expenses. Another problem is that patients do not collect or obtain receipts for their health care expenses, in which case they cannot apply for reimbursements. Moreover, patients are not always able to advance cash for purchasing pharmaceuticals or health care services. Finally, there is some evidence that many people are not informed about the benefits they could receive from municipalities (see also Section 5.4 below).

The 2002 Boroņenko survey indicates that 13.8 % of all respondents sought municipal assistance to cover health expenses, yet only 32.6 % of these requests were successful (Boroņenko 2003, 17). A UNDP study based on data from 1998 reveals that people in urban areas applied more often for municipal assistance to accede to health services, as compared with residents of rural areas. It is most striking that only 10.6 % of those in

Figure 9: Estimates of municipal social benefits for health per resident in LVL in 2002



Sources: LM Sociālas palīdzības fonds (2003) and CSB (2003a), own calculations

the poorest quintile applied, whereas 18.67 % to 22.08 % of people in all other quintiles applied. The likelihood of receiving the requested amount did not differ much among income quintiles. However, 77.6 % of applicants in rural areas received the full amount, compared to 60.15 % in urban areas (Gassmann / de Neubourg 1999, 57).

The amount of money allocated to the municipal social budget and particularly to the reimbursement of health-related expenses depends on the financial situation and the priorities of each municipality. The financial situation of a municipality is determined by its ability to raise taxes and the amount of transfers it receives from or pays to the municipal equalisation fund. Municipalities with many low-income residents are raising less tax revenues than others, while their inhabitants require higher reimbursements for health care expenses. The municipal funding mechanism thus only partially allows for the pooling of municipalities with different risk profiles and limits their capacity to provide insurance against catastrophic health costs.

A look at the share of the social budget allocated to health care in different districts and cities in 2002 reveals large disparities in total spending (see Figure 9).[62] The estimated annual social benefits for health per resident range from LVL 0.25 (Ventspils) to LVL 1.67 (Riga). Given that Ventspils is Latvia's richest city, these numbers confirm that not only total budget amounts but also spending priorities and citizens' needs are critical. Another example is that in Kurzeme, with the second lowest average personal income level in the country, every resident receives the same level of municipal support as in Riga region. Kurzeme municipalities are thus more active in granting benefits without having a larger budget at their disposal (Bite / Zagorskis 2003, 101).

As noted above, the existing legislation does not specify the extent to which municipalities are obliged to provide access to health care services. However, access problems for low-income groups persist in spite of VOAVA's protection mechanisms. Hence, municipalities are charged with a de facto responsibility to facilitate access, in the context of their general obligation to 'ensure access to health care'. Municipalities perceive this to

62 Since reimbursement levels are defined in each municipality, data on district level (rayons) as quoted in Figure 9 aggregate several budgets and need to be interpreted with care.

be an unfunded mandate. It can be concluded that due to insufficient budgets and differing standards, the municipal potential for improving accessibility is not fully used yet.

5.2.2.3 Protection offered by private insurance against out-of-pocket payments

The clients of private health insurance companies operating in Latvia are mostly employers that buy insurance policies for their staff (Briģis 2004, 91). Moreover, some municipalities contract with private health insurance companies to insure low-income persons against co-payments. To a lesser extent, individuals purchase private insurance policies themselves.

Private insurance offers a variety of protection levels. The cheapest insurance schemes cover only co-payments for patients using government funded health services. Other insurance plans cover co-payments and additional expenses not covered by the BCP, such as dental care or the cost of certain medication. Some insurance schemes protect against out-of-pocket payments in the case that quotas are filled. The most expensive insurance schemes cover treatment with private physicians not co-funded by VOAVA. Patients covered by the more expensive insurance schemes may enjoy faster access to health services and are better protected against out-of-pocket payments for services not included in the BCP or resulting from rationed services.

Insurance companies prefer to contract with employers, thus avoiding the risk of adverse selection related to individual contracts.[63] Only one insurance company, the publicly owned Rīgas Slimokase, offers individual contracts. As only those with higher health risks buy insurance contracts in Latvia, insurance premiums are relatively high compared to the benefits they offer. Low-income persons are unlikely to benefit from private insurance, either because they are not in dependent employment or because

63 Adverse selection refers to the problem of asymmetric information between the insurance company and the person who wants to insure against health-related costs. The individual health risk is known to the person, but not to the company. If the insurance company sets a fixed premium for an individual contract, the contract is only attractive for patients whose health-related costs are higher than this premium. Hence, with individual contracts the company attracts only bad risks that produce high costs.

they cannot afford the price of an individual insurance contract. This is supported by the 2003 CSB survey: only 8.6 % (164/1909) of those with an income below LVL 40 were covered by private insurance, compared to 26.7 % (124/464) of those with an income above LVL 120.[64] Yet, supplementary private insurance may protect the vulnerable group of the 'working poor' if their employers offer this voluntary benefit.

Low-income persons may also have access to private insurance through municipalities, e. g. in the city of Daugavpils. In 2003, the city supported 777 persons by purchasing a private insurance policy for them. Following a tender procedure, the city contracted with a private insurance company to cover 50 % of the cost of medication and co-payments for LVL 22.50 per capita. The city supported persons from vulnerable groups by reimbursing 100 %, 50 %, or 25 % of the insurance premium.

The scope of private insurance in protecting vulnerable groups against out-of-pocket payments is limited. They may be affordable only when the social departments of municipalities purchase them for a pool of persons. In this case, private insurance is not tantamount to an additional source of health funding, but relies on state revenues.

5.2.3 Discussion of reform proposals

Improving the protection against out-of-pocket payments involves transforming these individualized payments into pooled funding. The following sections discuss how a larger share of funding could be pooled in order to improve the financial accessibility for vulnerable groups. This involves a discussion on how the two protection systems provided by VOAVA and municipalities could co-operate in a more coherent way.

5.2.3.1 Improving protection against co-payments

This section discusses how the existing ceiling and exemption schemes could be modified in order to create a more reliable protection system against co-payments and catastrophic health expenses for people with lower income. First, a modified version of the current ceiling of LVL 80

64 Own calculation based on CSB (2003b).

for co-payments will be presented that would limit co-payments for services and pharmaceuticals by all inhabitants. Second, two exemption schemes will be outlined that would be based on the current exemption certificates for low-income groups. These exemptions are tailored to people with lower income for whom the 'modified ceiling' would still be too high.

An additional layer of protection, complementing the ceiling and the exemptions, is the currently existing municipal reimbursement scheme. The latter should be strengthened to provide protection against those out-of-pocket payments not covered by other schemes and will be discussed in a separate section.

Creating a modified ceiling against catastrophic health costs

The annual ceiling of LVL 80 for co-payments is an existing protection mechanism against catastrophic health costs (see Section 5.2.2.1). One reason why the ceiling is not used or reached by many patients today is that it covers only co-payments for health care services, i.e. only part of the actual out-of-pocket payments.

To make the ceiling more meaningful, prescribed pharmaceuticals should be included. Under this 'modified ceiling', patients would collect receipts for co-payments for services and for pharmaceutical expenses. If the level of the ceiling remained unchanged, this would rapidly increase the number of eligible patients, thus resulting in a substantially higher amount to be funded by VOAVA.

The appropriate level for the ceiling depends on the definition of catastrophic health costs. The amount of annual out-of-pocket payments affordable to a richer group is catastrophic for a group with lower income. Increasing the ceiling would have a negative impact on the number of people reaching it and therefore benefiting from it. At the same time, a higher ceiling would have the beneficial effect of reducing benefits for those who can afford high co-payments. A ceiling protecting patients of all income levels should thus reflect the maximum amount of co-payments per year affordable to the average income group. In order to improve access to health care by lower income groups and to protect them from the risk of impoverishing health costs, complementary protection schemes need to be available.

As to the kind of pharmaceuticals to be included in the ceiling, two types of 'modified ceiling' could be considered:

— One option, the 'modified ceiling A', would supplement the current reimbursement scheme for pharmaceuticals. The latter reimburses a certain percentage, defined according to diagnosis groups, for pharmaceuticals on a positive list (see Section 5.2.2.1). The 'modified ceiling A' would therefore include all co-payments for prescribed pharmaceuticals on the positive list.[65]

— Another option would be to turn from the current diagnosis-related reimbursement scheme to a scheme that addresses the affordability of pharmaceuticals irrespective of the patient's diagnosis. Such a 'modified ceiling B' could improve financial accessibility of pharmaceuticals to a larger group but would disadvantage certain patients benefiting from the current scheme, e. g. those diagnosis groups currently exempted from 100 % of co-payments for their medication.

Creating two levels of exemptions from co-payments

People with lower income might be unable to afford co-payments up to the ceiling described above. Therefore, exemption certificates currently protect low-income groups from co-payments (see Section 5.2.2.1). Issued by municipalities, these certificates can be targeted to the vulnerable groups by using income data and other sources of information available at municipal level.

However, the existing mechanism could be made more effective in protecting low-income persons against catastrophic health costs. First, it should also exempt beneficiaries from co-payments for pharmaceuticals, comparable to the 'modified ceiling' described above. Second, not only people with low income should be entitled to exemptions, but also people who are just above the poverty threshold and, thus, may also prove unable to afford co-payments up to the ceiling described above.

65 To address catastrophic health costs resulting from pharmaceuticals that are not on the positive list, a selection of other pharmaceuticals could be included in the 'modified ceiling A'. The selection should focus on further essential pharmaceuticals, without undermining the current incentives for the use of generics.

In order to relate the exemption scheme closer to the income of the individual, a proportional ceiling could be introduced.[66] Since this induces high administrative costs, an alternative would be to introduce two exemption certificates that would complement the above-mentioned 'modified ceiling'. One certificate would protect vulnerable persons who are currently eligible for exemption certificates, exempting them from 100 % of co-payments. A second type of certificate could be granted to those still relatively poor, exempting them from only 50 % of co-payments. The latter would halve their out-of-pocket payments up to the 'modified ceiling' offered by VOAVA.

This differentiation would link exemptions more closely to the purchasing power of low-income individuals and provide some degree of protection to those for whom the 'modified ceiling' is out of reach.[67] The income thresholds to be fixed for such exemption certificates need to take into account the upper ceiling ('modified ceiling') already existing for all income groups. These exemption certificates would provide protection against co-payments ranging from LVL 0.10 to this upper ceiling.[68]

Funding the shortfall resulting from ceilings and exemptions

The shortfall arising in the budgets of health care providers due to the ceiling and the exemptions described above could be covered by different funds, such as VOAVA, the municipal social budgets or the state social protection budget. Questions to be solved include the following ones: Does the financial responsibility lie within the health care or the social protection system? Which funding source is most suitable from a risk-

66 Such proportional ceilings exist in Germany, where a ceiling of 2 % of annual gross income for co-payments (including in- and outpatient care) has been introduced. All co-payments exceeding this amount are covered by the health insurance. The ceiling for the chronically ill was set at 1 % of annual gross income.

67 The drawback of this strictly income-based proposal is that it does not explicitly take above-average need for health care into account, affecting mostly the elderly and the chronically ill.

68 It is interesting to note that the municipality of Smiltene has differentiated poverty thresholds in place, thus combining means testing and categorical targeting. The threshold is LVL 60 for pensioners, as compared to LVL 40 for working-age individuals. In a similar vein, the municipality of Riga pays a guaranteed minimum income of LVL 39 to pensioners, as compared to LVL 18 to working-age individuals.

sharing point of view? Which funding source creates the strongest incentives towards financial discipline?

The 'modified ceiling' described above addresses catastrophic health expenses of all inhabitants. It would serve to protect the (relatively) better off and would leave the protection of low-income groups to complementary exemption schemes. This would indicate that it is to be financed out of the health budget, administered by VOAVA.

A closer look at possible funding sources also reveals differences in terms of risk pooling, as described in Sections 2.4.2.1 and 4.1. As VOAVA is tax-funded, it draws on a large pool of individual taxpayers. In financing health care, it is important to pool many individuals with different medical and financial risks in order to insure them against health expenses. The state social protection budget fulfils the same pooling criterion.

On the contrary, municipal social budgets essentially pool the medical and financial risks of one municipality. The size of the budget depends on the capacity of each municipality to raise taxes, on the priorities of the municipality in the area of social and health issues, and on the amount of transfers a municipality receives from the central equalisation fund. Equal access to health care services cannot be achieved only by relying on municipalities with their different financial capacities. However, municipalities are in charge of issuing the exemption certificates. Using their own budget to fully or partly finance the shortfall resulting from exemptions may help to increase the municipalities' discipline in improving their targeting to the needy.

Changes in the design of the existing protection schemes may shift the financial burden between the health and the social system. For example, an increase in the level of the upper ceiling would shift the financial burden of exemptions from VOAVA to other funds reimbursing health costs, such as the municipal social budgets.

A rough division of responsibilities could be for the health system to provide access to basic health care services to all inhabitants with co-payments affordable to those with an average income, and for the social system to provide access to people with lower income by fully or partly covering the cost of medication and co-payments for services.

If municipalities were assigned such strictly defined responsibilities in providing access to the poor, economically poor municipalities should be provided with the necessary funding. In the light of the protection scheme presented above, funding of exemption certificates could involve transfers from the state social protection budget to municipalities. Such subsidies from the central level would increase the share of pooled funding but leave the issuing of exemption certificates to municipalities, disposing of detailed information on the target group.[69]

The aspects described above show that decisions on funding sources need to be taken with care. However, the assignment of responsibilities for the funding of health care is part of the efforts to improve accountability and transparency in the health system.

5.2.3.2 Improving protection against payments for excluded services

Section 5.2.2.1 showed how the current system of quotas for health services results in out-of-pocket payments. From a pro-poor perspective it would thus be best to avoid quotas altogether. To adapt the amount of provided services to the demand of patients, particularly to the demand of patients from vulnerable groups, VOAVA would need considerably more funding. Yet, less rationing of services should at least be envisaged for the medium term.

In the short term, two reform areas could be addressed: an introduction of more equitable mechanisms of rationing and the expansion of the existing system of social benefits for health costs provided by municipalities. Both options will be discussed in the following sections.

Using other rationing mechanisms

Rationing of health services occurs when demand for a service at a given price is higher than the amount of services available. Increasing the price of the service, e. g. by increasing patients' co-payments, is undesirable

69 Subsidies should be based on the share of low-income inhabitants. If municipalities were to receive transfers for each certificate issued, there would be no incentives for cost containment.

from a pro-poor perspective. Rationing is applied in various forms in different national health systems. With the introduction of quotas, the Latvian government decided to ration services by a 'first-come, first-served' approach, while at the same time offering a comprehensive basket of services. This form of rationing leads to the inequalities described in Section 5.2.2.1.

Compared to a 'first-come, first-served' approach, other more equitable forms of rationing might be applicable. In the qualitative interviews, various stakeholders mentioned that there should be a minimum basket of services for which no quotas should apply, e. g. for emergency care. Yet, granting a minimum basket of services without simultaneously increasing funding implies a reduction of the remaining services. Hence, some services may have to be excluded from the BCP. Stakeholders considered it to be very difficult to define such a warranted minimum basket of services, applicable to all patients. The former Health Minister Ingrīda Circene also dismissed the idea of a positive list of services (Zālīte 2004, 3).

A compromise solution may be to provide a minimum basket of essential services without quotas and to use a rationing mechanism adapted to the individual patient for the remaining services, instead of excluding all patients from a predefined set of services. An example of such an approach is applied in Scotland (Deabaltika 2002, 19). Health services are ranked according to an individual benefit-cost ratio. Those services with the highest ranking are provided by the public health system. While it is relatively easy to calculate the cost of certain health services, it is more complicated to evaluate the benefits. In Scotland these benefits are scored using a multi-dimensional index, which is calculated for the individual patient. One dimension is the possible health benefit for the patient: 'life-saving measures' score higher than 'health services that provide less effective but lasting physical and mental health maintenance'.[70] A committee of professionals assesses the benefits for the individual patient, which may help to make decisions more transparent than at present.

From a pro-poor perspective, this form of rationing would be preferable to a 'first-come, first-served' approach, because it would allow those unable to wait to be treated first, irrespective of their ability to pay. However, the

70 Other dimensions are e. g. the 'prevention of poor health' or the 'quality of life' (Deabaltika 2002, 21).

question of how to weight and compare the cost of a health service to its benefit, or whether to consider the costs at all when prioritising health services is a difficult topic. Nevertheless, a discussion about this issue may be worthwhile in Latvia.

Reforming the social benefits provided by municipalities

Co-payments for services and pharmaceuticals can be addressed to a large extent by the standardised protection schemes described above. In addition, there are other out-of-pocket payments causing barriers to access, such as payments for medical treatment at hospitals and pharmaceuticals not included in ceilings and exemptions. Municipalities should expand their activities to protect patients against such catastrophic health costs. Not only can this be seen as part of the municipal responsibility to help local inhabitants in case of crisis, but municipalities also seem to be best suited for this task.

Granting reimbursements often requires discretionary decisions. Municipalities enjoy the advantage of better community outreach, providing them with information on their inhabitants unavailable at the state level. This information enables the committee or social worker to decide upon individual eligibility. The municipal role of granting benefits to cover catastrophic health costs should therefore be reinforced by the provision of adequate funding. Moreover, differences between municipalities in granting social benefits for health, as discussed in Section 5.2.2.2, suggest that a certain standardisation of criteria for eligibility and benefits may be necessary to reach equitable access to health care services throughout Latvia.

5.2.3.3 Improving protection against informal payments

The problem of informal payments needs to be addressed from two sides. On the one hand, more pooled funding is necessary to cover the real costs of services provided by medical personnel (including salaries). On the other hand it is important to tackle the issue of informal payments through better control of and stricter sanctions against informal payments.

When asked how to prevent informal payments, 51 % of the respondents of the CIET survey proposed increasing salaries for doctors, as compared with 9 % that proposed better inspection and supervision (CIET Interna-

tional 2002, 57). Stakeholders perceived low salaries for medical personnel as one reason for persistent informal payments, but doubted that it would be sufficient just to increase salaries.[71]

Transforming informal payments into formal co-payments that would allow patients to submit receipts either to VOAVA or private insurance companies is no easy solution either. If compliance by health care providers cannot be enforced, informal payments may persist in addition to the higher formal co-payments, thus aggravating the problem of financial accessibility.

Higher salaries for health care personnel should be accompanied by an increased control of and sanctions against informal payments. Patients need to play a more active role in helping to control informal payments because they can observe the behaviour of medical personnel directly. Nevertheless, patients seem to be reluctant to report informal payments.[72] For this reason, it is important to increase public awareness that informal payments are illegal, thus changing patients' attitudes towards those payments. VOAVA or the Ministry of Health could launch a nation-wide campaign against informal payments. This campaign should also make it clear where patients can report informal payments.

Moreover, it is important to make the system of quotas more transparent to patients. Currently, patients may not always be sure whether medical personnel demanded a formal or an informal payment. This may be the case when patients are denied services due to an actually or allegedly filled quota. Regional Sickness Funds and VOAVA branches offer special phone numbers for patients' feedback. Patients should be encouraged to use these numbers more.

Effective sanctions against doctors demanding informal payments presuppose that the medical profession remains attractive in Latvia. VOAVA

71 In 2002, the average monthly salary for physicians contracting with VOAVA was LVL 200 in inpatient facilities, LVL 146 in outpatient facilities, LVL 213 in doctor's practices, and LVL 205 in first aid and emergency medical care stations (VOAVA 2003, 36). In the same year, the average monthly wage or salary was LVL 155 in the private sector and LVL 200 in the public sector (CSB 2003a, 45–46).

72 When asked whether they would report informal payments, 38 % of the respondents of the CIET survey said they would, while 62 % said they would not (CIET International 2002, 58).

cannot credibly threaten to withdraw a doctor's licence when no other is available to be placed in the position.

5.3 Geographical accessibility

Although the available quantitative evidence does not point to geographical barriers as a major accessibility problem, qualitative interviews suggest that these barriers may play an important role for low-income persons.

In the Boroņenko survey published in 2003 covering Kurzeme, Southern Latgale and Riga region, only 3.4 % of respondents referred to distance and 1.5 % to personal problems to travel when explaining their difficulties to accede to health care services. Most of them did not live in the urbanised Riga region (Boroņenko 2003, 16 and 46).

Compared to income as the explanatory factor (23.1 %), these percentages are low. Nevertheless, geographical distance as a barrier to access should not be underestimated since transport to doctors may have been one of the things that respondents indicating low income as the main barrier were unable to afford (Boroņenko 2003, 16).

The following section analyses several dimensions of geographical access problems. The subsequent section summarises and evaluates some measures implemented by national and municipal administrations to tackle these issues. The last section provides some recommendations on how to improve the geographical access to health care services by low-income groups living in remote areas in Latvia.

5.3.1 Geographical barriers to access

In order to analyse the particular challenge faced by low-income groups living in remote rural areas of Latvia, geographical access problems will be split into the following aspects: transport costs, availability of means of transport, and the costs arising from the time lost during travelling (opportunity costs). It will also discuss the ongoing changes in the structure of health care providers.

Transport costs

Compared with the cost of medical treatment and pharmaceuticals, the cost of public transport in the countryside is still relatively low. However, it adds to medical costs and therefore contributes to an increased burden when low-income patients seek the needed treatment. In particular, the cost of transport to specialist care or pharmacies in cities may represent a significant barrier to rural inhabitants living on less than the minimum subsistence basket. Cases of multiple referrals further increase transport costs, because patients may have to travel back and forth between health care providers in order to receive treatment.

Availability of means of transport

Regular public transport matching patients' needs is unavailable in small municipalities. This means that inhabitants sometimes have to walk a long distance to the closest bus stop, which is a major obstacle, especially in winter, or even impossible for ill persons. Similarly, the means of public transport available are often inadequate for people suffering from illness or disabilities. Moreover, the low frequency of transport service in remote areas – sometimes only once a week – may make it impossible for patients to return the same day. This may cause further costs, such as for overnight stay.

To avoid the inconveniences of public transport, many people use private cars to accede to health care services. But for low-income patients living in remote areas, this is rarely an option. It is thus important for them that doctors are able and willing to visit them at home. However, there is a patient fee for home visits of LVL 2, another direct financial burden for low-income patients who are not exempted from co-payments.[73]

Opportunity costs

Opportunity costs of the time spent travelling to health care services are another important aspect of geographical access. For those patients who are working, travel time decreases the time they can spend earning money.

73 In 2003, there was a government attempt to increase the fee for home visits to a cost-covering LVL 4 that met with a wave of protest (Kozlovska 2003b).

Moreover, people involved in agricultural production may not be able to care properly for their animals or fields if they are away for too long.

In Boroņenko's analysis of the major reasons for renouncing health care services, a lack of time was the second most important answer. It was mentioned by 9.4 % of all respondents, but only by 4.5 % in Riga region, where distances to health care providers are shorter (Boroņenko 2003, 46). These results indicate that excessive travelling time might be the main obstacle among the different geographical accessibility barriers to health care.[74]

Changes in provider structure

Like other transition countries, Latvia is witnessing a reduction in the number of hospitals. It is hoped to obtain efficiency gains by providing more specialised care in fewer institutions. In accordance with the so-called 'Master plan', Latvia's health investment programme planned to reduce the number of local hospitals from 132 in 2000 to 60 in 2007 (CHIP 2002, 19). Although the Master plan has not been officially adopted so far, a further restructuring of health care institutions seems inevitable to achieve efficiency gains within the underfinanced system. In rural areas, however, this process implies the challenge to maintain geographical access to health care services in the future.

The proximity to health care providers is decisive for the access of low-income patients to health care services. However, there seems to be a trend of doctors leaving remote areas. Furthermore, our interviews revealed a substantial future need for additional GPs due to a wave of imminent retirements, while only three to five GPs finish their university education per year. Consequently, the problems described above are likely to become aggravated in the near future (Kozlovska 2003a).

5.3.2 Existing measures to reduce geographical barriers

In order to tackle the multiple accessibility problems mentioned above, Latvian municipalities and VOAVA have implemented several measures

74 As mentioned above, only 3.4 % of respondents directly considered travelling to be a reason for renouncing health care services in the Boroņenko study.

to reduce geographical barriers faced by low-income patients. As noted above, municipalities are legally obliged to ensure access to health care (Law 'On Local Governments' 2000, Chapter II, Section 15.6). Apart from this general legal stipulation, municipalities are relatively free to interpret how to meet this obligation. Other measures have been put in place by VOAVA.

Municipalities

Municipalities try to improve the access to health care services within their means and according to their political priorities. The referral of patients to urban specialists and hospitals can result in access barriers for low-income patients if they have to cover transport costs themselves. In several places, municipalities reimburse transport costs or even provide municipality-owned vehicle services.

There are also examples of municipalities that support GPs by providing them with a free workplace in order to attract them to remote areas. However, all measures taken by a municipality are subject to its respective financial capacity and priorities, as pointed out in Section 5.2.2.2 above.

VOAVA

Besides providing free-of-charge emergency transport in ambulances, VOAVA has also created some incentives for GPs in order to improve the geographical access of patients. Given that a sufficient distribution of GPs throughout the country is an important aspect to ensure access to health care, GPs receive a supplement from the Sickness Fund if their practice is located in a low-density area. Second, since 2003, 'the State maintains the right to send young doctors to regions in Latvia […], thus guaranteeing access to medical professionals and health care services in rural areas' (Ministry of Welfare / European Commission, DG for Employment and Social Affairs 2003). These measures are intended to reduce doctors' migration from the countryside.

In remote areas, GPs fulfil not only a gatekeeper function, but also hold a quasi-monopolistic provider position. Therefore, it is important that they enjoy sufficient incentives to care for all patients registered with them. However, GPs may rather face disincentives to visit patients in remote areas. The fee for home visits of LVL 2 is not cost covering, and doctors

directly decrease their income when out of their office. Moreover, many patients in rural areas are unable to pay the fee. Consequently, the number of home visits has diminished in recent years (Kozlovska 2003b).

5.3.3 Discussion of reform proposals

Covering travel costs

In order to enable low-income groups to accede to health care facilities, it is essential that their transport costs be covered. As positive examples show, one possible way is that municipalities provide transport themselves via school buses or other municipal vehicles. In other cases, a guaranteed reimbursement of transport costs by the municipality may be sufficient.

Further support for vehicle use by doctors might be helpful. VOAVA could reallocate a part of the capitation fee to make a certain share of doctors' salaries dependent on their transportation efforts.

Reducing distances

As mentioned above, the process of reducing the number of health care facilities in rural areas translates into the challenge to maintain geographical access to health care services, in particular for low-income patients. Therefore, emerging efficiency gains should be used in part to compensate for geographical access barriers.

A sufficient number of GPs and emergency care stations in remote areas should be guaranteed, even if this implies providing further financial and non-financial incentives for medical staff to work there. In Liepāja, for example, the municipality has helped to open a workplace for doctors in a poor neighbourhood far from the city centre to improve the accessibility of health care services. However, it is in rural areas that transportation is least developed. Comparable measures in those areas would thus have even more positive effects on access to health care facilities by the poor. As mentioned above, some rural municipalities encourage GPs to remain in the community by providing incentives, such as a workplace free of charge.

Moreover, inter-institutional co-operation within the health care system is important to reduce access barriers for low-income groups in remote areas.

The process of diagnosis, analysis, and treatment should be organised in a way requiring as little travel as possible. Similarly, co-operation between the health and social system seems important, particularly in remote areas, to meet the needs of low-income patients in the light of existing transport facilities. GPs and social workers should be in close contact so that the latter can arrange municipal transportation for patients in need.

The importance of geographical access to health care services should also play a role in investment decisions taken at the Ministry of Transport. Further investments in remote areas for road construction, public transport as well as vehicles to clean roads in winter would help to improve the situation in the health care system. This is also true for other investments in infrastructure. There are patients who have no access to a telephone to call a nurse or a doctor when needed. Therefore, a further improvement in the rural communications infrastructure is also desirable to enable low-income patients to access health care services.

5.4 Informational accessibility

Insufficient information may be a significant barrier to health care services for low-income groups. The CIET survey revealed that only a quarter of the responding households felt that they had all the information they needed about their health care entitlements (CIET International 2002, 11). Low-income persons seem to be among the least informed. Respondents who reported that their income was sufficient for their expenditure needs were somewhat more likely to say that they had all the information they needed than others (31 % against 24 %) (CIET International 2002, 46). These results correspond to the findings of another survey in which people were asked if they had heard about the state-guaranteed minimum in health care. Two thirds said that they had not (BISS 2002, 3). Our stakeholder interviews confirmed these findings.

People often lack precise information about payments and reimbursement schemes. The UNDP study revealed that the inability to pay for medical care in the case of illness was the worst fear of Latvia's inhabitants (UNDP 2003, 30). Consequently, low-income groups may not visit a doctor in case of illness for fear of not being able to pay.

The first section of this chapter describes informational barriers to access, i.e. the types of information that are missing to ensure equal access to health care services. The second section outlines the existing sources of information in Latvia, their limitations and their utilisation by patients. The third section contains some reform proposals to improve the informational accessibility of health care services.

5.4.1 Informational barriers to access

It is a precondition for equal access to health care services that all inhabitants know to which services they are entitled. However, opinions on who has the right to receive state-guaranteed health services differ widely. In a BISS survey conducted in 2002, only 41 % of respondents answered correctly that all inhabitants registered with a GP are entitled to obtain these guaranteed services. 36 % thought it was necessary to pay taxes, another 12 % regarded a voluntary insurance policy as mandatory, and 11 % did not reply or did not know how to answer (BISS 2002, A.3).

The same survey also identifies the key health issues on which people in Latvia demand most information. 47 % of the respondents would like to have more information about patients' rights and obligations. Other areas of interest were information on prices of services (45 %), the health care system in general (41 %), payments for health care services (37 %), and possibilities to accede to a specialist (35 %). Only 5 % of respondents indicated that they did not need any additional information about the health care system (BISS 2002, A.5). The high percentages reflect both the importance of the respective issue and the subjectively perceived lack of information.

Two specific examples will be described in more detail. The survey shows that only 24 % of the respondents knew that the entrance fee to hospitals is LVL 5. A majority assumed LVL 3 to be the right amount, and nearly a quarter did not know how much to pay (BISS 2002, A.12). Even more striking are the differences in perceptions concerning the maximum total amount of co-payments to be paid per one hospital treatment. Only 11 % of respondents knew of the LVL 25 ceiling, whereas 66 % considered LVL 15 to be the maximum amount, and 23 % did not answer this question (BISS 2002, A.13).

This survey thus highlights three major areas in which information is missing most: patients' rights, the health care system in general, and prices and payments for health care services. Many of the prices are legally fixed, but the amounts are not sufficiently known. Moreover, the existence of discretionary prices for some health services – e. g. informal payments and payments to avoid queues – contributes to the existing confusion about payments.[75]

The importance of information about patients' rights and obligations, as well as the fact that the concept of patients' rights still remains unclear to many Latvians is also described in a survey conducted by the Latvian Patients' Rights Office in 2002. It revealed that only 20 % of respondents considered themselves informed about patients' rights, while 37 % deemed themselves insufficiently informed, and 43 % would like to be more informed (LPTB 2002, 5). These results may also reflect a rising awareness of patients' rights due to activities by non-governmental organisations (NGOs) and the coverage of the topic in the media.

5.4.2 Existing measures to reduce informational barriers

This section takes a brief look at the existing sources of information on health care and social benefits before highlighting some potential causes for the current lack of information among patients.

5.4.2.1 Sources of information

VOAVA, the Ministry of Health and other related institutions, municipalities and GPs stand out among the entities providing information on the Latvian health system.

Among other topics, *VOAVA* provides information on the prices of health care services and on the ceiling of LVL 80 for patients' co-payments by means of posters and booklets that can be found in the regional branches and in most health facilities. The *Ministry of Health* supervises health campaigns and provides general information on the health system.

75 See Section 5.2.2.1 for a detailed description of these payments.

Municipalities generally provide information on the available social benefits and municipal reimbursements for health services. Some larger municipalities have established public information offices or specialised departments for this purpose, offering booklets, special telephone lines and personal assistance by social workers, e. g. in Riga and Daugavpils. In addition, a number of municipalities publish and distribute municipal newspapers and informational brochures free of charge, for example in Liepāja.

Finally, *GPs and other health personnel* are also important in addressing the patients' need for information.[76] In addition, patients rely on other sources such as NGOs, associations, families and friends.

In addition to referring to various providers of information, the population of Latvia is also using a number of different channels of communication to accede to health system information, ranging from informal conversations to brochures and TV spots. Since the categories of providers of information and channels of communication tend to overlap, a comprehensive survey conducted by CIET in 2002 combined both aspects when analysing the main sources of information on health issues actually used by the population in Latvia. 40 % of respondents did not indicate using any specific source, but rather collected information from a variety of sources. Mass media and health personnel ranked second and third, with 24 % and 23 %, respectively. Further sources, in particular information received through the mail and brochures, were almost insignificant (CIET International 2002, 45–46).

5.4.2.2 Problems in the communication of health-related information

The following section outlines the main reasons why the population of Latvia is insufficiently informed on health issues in spite of all present institutional efforts to provide information. The different causes will be subsumed under the categories of *tailoring information* and the general difficulty of achieving *coherence* between health and social information.

76 Our interviews could not clarify whether GPs are legally obliged to provide information on both health care and social benefits.

Insufficient tailoring of information to people's needs

Attempts to provide information become ineffective when coverage is limited and information fails to reach its recipients. If the communication of information is mainly targeted towards average Latvians and fails to respect specific needs of different groups, it can often not be absorbed by all recipients. In the following, an overview of coverage problems in Latvia and some specific needs of vulnerable groups will be given.

First evidence for the *limited coverage* and uneven distribution of information can be found in the regional differences in knowledge on health issues, as stated by the 2002 BISS survey. In Latgale, the poorest Latvian region, 38 % of respondents deemed themselves 'badly informed' about health issues, compared to the country average of 31 %. Compared to this, in Vidzeme only 24 % fell into the same category (BISS 2002, 1 and Fig. 1.1). Thus, public information does not seem to reach all parts of Latvia to the same extent.

Further evidence for this can be found in the effectiveness of specific TV spots, booklets and newspaper supplements on health issues. The BISS survey revealed that, for instance, only 22 % of the population received the booklet 'The most important things you have to know about the state health care', while different TV spots reached between 25 % and 67 % (BISS 2002, 9–11). Thus, a large part of the population was still not being reached.

This may correspond to the problem of *inadequately chosen channels of communication*: as shown by the CIET survey, most people (36 %) would prefer to obtain information by mail and brochures. Yet, according to the same survey, these sources are currently almost irrelevant.[77] Thus, the channels of communication used by organisations of the health system do not seem to coincide fully with the channels that are being preferred by the population of Latvia. However, mass media such as TV and radio rank second (29 %) both among the preferred and among the actually used services (CIET International 2002, 46).

77 The relatively high costs of providing information via mail and brochures may be one reason why these channels are not used more extensively.

Taking Latgale as an example, two further factors may contribute to the lack of information: language barriers – as Latgale is inhabited by the largest group of Russian speakers – and the rural structure of the area.

Language is without any doubt crucial for tailoring information to recipients' needs. Empirical evidence suggests that Latvian speakers feel better informed about the health system than the non-Latvian-speaking part of the population: 28 % of Latvian-speaking households felt they had all necessary information, as compared to 21 % of the non-Latvian-speaking households (CIET International 2002, 45). These figures are consistent with statements by interviewees that a significant part of the publicly provided information on the health system has only been provided in Latvian and was therefore not accessible to non-Latvian speakers.[78]

In rural areas, large distances hamper the access to local sources of information. E. g. posters and booklets that are only available in distant health facilities, local VOAVA branches or municipal departments cannot be acceded to easily. Furthermore, the overall coverage of newspapers and TV may be limited in poor rural areas.

In addition, the recipients' level of education and physical disabilities may be other reasons for the failure to receive and absorb information:

Education can be a limiting factor, not only due to the complexity of the terminology related to health care and social benefits. Individuals with a low level of education account for a large share of low-income households, and low income generally limits the access to sources of information, such as newspapers or TV. The BISS survey revealed that 46 % of the individuals with incomplete primary education regarded themselves as 'badly informed' about the health system, as compared to just 31 % of all participants. The general results of the survey showed that the higher the level of education, the lower the number of poorly informed patients. This correlation is also backed by our interviews. However, some efforts are already being made to translate information into a more understandable language, for example by the Riga municipality.

78 For instance, the materials provided by VOAVA on the price of health care services (see Appendix A.1) and on the ceiling of LVL 80 are usually available in Latvian and can only occasionally be found in Russian, such as in VOAVA's Latgale Branch.

Individuals with special *physical disabilities* – such as blindness or deafness – have very limited access to common channels of communication. Representatives of persons with disabilities stated that so far no specially targeted information exists for these groups. Thus, public institutions could intensify their co-operation with representatives of persons with disabilities and provide information in ways that respect specific needs, for instance by publishing some brochures in Braille.

In conclusion, the empirical evidence and the stakeholder interviews suggest that the targeting and tailoring of information on health care and related benefits needs to be improved. Though not many studies have dealt with this issue so far, there is some evidence of the need to target information to those who need it most, such as the elderly and vulnerable households (Institute for Philosophy and Sociology 2001, 30; CIET International 2002, 46).

Insufficient coherence between information on health and social benefits

From a pro-poor point of view, combining information on health issues and available social benefits – e. g. for the reimbursement of co-payments – and providing it to the needy is vital. If people are not aware of these benefits, they might refrain from using health services, resulting in the previously mentioned consequences of delayed treatment.

On the *municipal level*, co-ordination between social workers and health workers is crucial. As stated in some stakeholder interviews, local health personnel, in particular GPs, are often not well informed about social benefits and thus hardly able to give relevant advice to patients. Good co-operation with local social workers would allow the doctor to be sure that patients are aware of the available options, thus decreasing the possibility that patients would renounce needed health care. A number of municipalities have already acknowledged the need to improve the co-operation between social workers and health institution and have taken effective measures (see Section 5.4.3.2). However, the fact that not all municipalities even have a social worker further hampers the provision of information on the local level.[79] It should also be noted that currently only 24 % of all social workers in Latvia have a vocational or higher education.[80]

79 Currently, 434 of the 536 municipalities employ one or more social workers on a full-time or part-time basis. From 2008, all Latvian municipalities will be obliged to employ

A similar coherence problem may also exist at the *state level*, since the Ministry of Health and Ministry of Welfare distribute information only within their respective realms of competence and within the limits of scarce financial resources.

5.4.3 Discussion of reform proposals

The Ministry of Health has already recognised the insufficient level of information about state-guaranteed health care services as a major issue to be tackled (Zalīte 2004, 3). It is thus important to improve information strategies and to implement them in spite of frequent political changes.

The following sections will discuss some basic proposals for improving the knowledge of the Latvian population on health care and health-related benefits, focusing on two aspects: first, a more suitable targeting and communication of information; second, the need for improved accountability for the provision of information.

5.4.3.1 Improving the targeting and communication of information

Strengthening personal sources of information

Potential personal sources of information are GPs, social workers and NGOs, such as patients' organisations or pensioners' associations. Stakeholders most often expressed the desire to strengthen the role of GPs in the provision of information.

General Practitioner: Though health professionals in general are 'not cited as often as preferred sources as they are as present sources' (CIET International 2002, 46), GPs may nevertheless be best suited to provide information, for several reasons. First, many patients show a rather high level of satisfaction with the work of their personal GP (BISS 2002, 15). Second, providing information through these personal channels may help

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one social worker per 1,000 inhabitants (information provided by the Ministry of Welfare).

80 In 2003, 921 out of the 1,211 social workers employed in Latvia had no vocational or higher education (information provided by the Ministry of Welfare).

to overcome language barriers. It can be assumed that in their choice of GP, patients try to minimise such barriers. Third, the problem of terminology can be addressed because GPs are already familiar with 'translating' complex issues to patients.

There are, however, obstacles to be overcome. First, the current number of patients per family doctor may prevent the GPs from providing detailed information. Strengthening the role of the GP as a source of information would require increasing the amount of time dedicated to consultations and, correspondingly, a reduction in the number of patients per GP. Unless patient numbers were reduced, GPs would have less time to provide medical treatment. If this extra work were not compensated – by reducing the number of patients or by monetary rewards – it would only place an additional burden on GPs, reducing their incentive to perform this task. Hence, additional funding would be needed, were GPs to provide more information. From a pro-poor perspective, the funding should not come from additional co-payments for these consultations, since this would disadvantage vulnerable groups and further raise the informational barrier.

Second, asymmetric information between patients and GPs may become an obstacle. Thus, patients need to be able to refer to other independent sources, enabling them to confirm and verify the information provided by GPs. Otherwise, some GPs could charge poorly informed patients for services that are actually being covered by the capitation fee.

There have already been attempts and pilot projects to increasingly involve GPs, for example by explicitly assigning one local GP as advisor on public health and nutrition. Yet, combining information on health care and social benefits in the hands of GPs has not been a priority. Accordingly, GPs often regard themselves as not being sufficiently informed about social benefits (Institute for Philosophy and Sociology 2001, 31). Our stakeholders also indicated a certain level of confusion and lack of information on the type and volume of services covered by the BCP and the capitation fee. Consequently, additional measures on a more general level are required to address these deficiencies.[81]

81 The question of how to improve and combine these kinds of information will be addressed in Section 5.4.3.2.

Chances are that the role of GPs can actually be strengthened. The concept seems to enjoy the general support of the Latvian Family Doctors' Association, one important precondition for success. Full approval by the association would still depend on the details of implementation, however (Zalīte 2004, 3). Other associations, such as the Latvian Pensioners' Federation, also seem to be supportive of the concept.

Social workers and NGOs: Social workers possess specific knowledge about health-related financial benefits, in particular those granted by municipalities, and are thus in a position to complement the GPs' specific knowledge on health services and the BCP.

NGOs, some of which representing vulnerable groups, can serve as independent sources of information on specific benefits – e. g. exemptions and reimbursements for chronic diseases –, and on patients' rights. Because of their familiarity with the needs of their members, NGOs may be well aware of current and future information deficits. However, some NGOs stated during the interviews that they themselves required more and better information. The government could improve its efforts to provide NGOs with more timely and detailed information, thus enabling NGOs to communicate the relevant issues more effectively.

From a pro-poor perspective, involving both social workers and NGOs would allow for a better targeting of information. Low-income groups may best be addressed via social workers, whereas for other vulnerable groups, e. g. pensioners with high health needs, persons with chronic illnesses and with disabilities, NGOs may be more appropriate. Furthermore, both social workers and NGOs can serve as supplemental, independent sources to avoid the problem of asymmetric information described earlier.

Thus, improving the qualification of social workers, their co-operation with GPs, and strengthening the role of NGOs could help to improve the provision of information on health services, reimbursement, exemptions, and patients' rights to low income groups.

Improving the use of mass media as a preferred source of information

Although expanding the role of GPs can contribute to achieving a better level of information among the population of Latvia, some problems may still persist. First, a number of people do not visit doctors' practices regularly or do not visit them at all. The 2002 BISS survey indicated that about

one fifth of the Latvian population had not visited their GP in the previous two years (BISS 2002, 5). Consequently, personal conversations with health personnel and posters in health facilities fail to reach this group. Second, according to this survey and supported by our interviews, a certain level of dissatisfaction about GPs seems to prevail among parts of the population of Latvia (BISS 2002, 6).

Therefore, strengthening the GP as a provider of information does not render the use of mass media superfluous. Mass media remain indispensable as a supplemental source of information. They can also reduce the problem of asymmetric information between GPs and patients. Nevertheless, the targeting of mass media should be improved, as described in Section 5.4.2.1.

Legislation can have an important impact on the use of the mass media. By legally obliging the mass media to offer lower subscription rates for public, health-related spots and articles, the government could expand the coverage of its campaigns without requiring additional financial resources. In the light of scarce public financial resources, this intervention could be justified by the overall importance of health for individual and economic development.

5.4.3.2 Strengthening accountability for the provision of information

A framework that guarantees accountability is indispensable for the success of the mentioned reform proposals. It can be divided into capacity, regulatory aspects and policy coherence.

Capacity

Sufficient capacity for public relations in the responsible institutions, i.e. the Ministry of Health and VOAVA, is a precondition for a successful campaign on health care accessibility. Improved targeting also requires more human and financial resources, e. g. when designing specialised campaigns for persons whose needs are different from those of the average Latvian. Several interview partners stated, however, that current financial constraints limit the ability of these institutions to assign enough staff to this issue. Obviously, more staff means more salaries to be paid. Yet,

combined with the proposal of cheaper TV spots mentioned above, public campaigns provide a chance to improve accessibility to health care services for low-income groups at a relatively low cost.

Regulation

Information campaigns also concern stewardship. A basic prerequisite for their success is the transparency of regulations on the national and municipal level about criteria for social benefits and exemptions from payments, and administrational procedures to obtain them. From an informational point of view, more standardised criteria ease dissemination and description tasks. Consequently, a partial replacement of discretionary measures on the municipal level by nation-wide guidelines could contribute to transparency and enforcement. Such a move could be considered an element of successful stewardship of a pro-poor health system, but should not create unfunded mandates for municipalities.

Transparency also comprises a clear identification of responsibilities. Although the responsibilities concerning the provision of information and the procedures to obtain exemptions in the health care system should be clearly stated by law, our interviews revealed that many actors in the system are not informed about them. NGOs might contribute to a more transparent information policy by communicating regulations concerning these issues.

Policy coherence

Finally, policy coherence between the social protection system and the health care system is an essential element of successful stewardship for implementing reforms. This does not only include the active involvement of all groups that could possibly provide information to those who need it, but also a reasonable sequencing of measures. In order to enable GPs to assume a more prominent role in providing information about exemption and reimbursement possibilities, GPs themselves must be comprehensively informed about these issues.

Policy coherence also calls for active co-operation among the providers of information. The Ministry of Health might launch an information campaign on existing measures to guarantee access to health services. Moreover, suitable providers of information, such as GPs, should be ensured all

necessary information. This process could include workshops or seminars on the national as well as on the local level. Apart from the social and health administration, social workers, and NGOs that patients trust as independent sources of information should be included.

As mentioned in the previous section, active co-operation between social workers and health personnel is required to enable doctors to inform patients successfully. In Liepāja, for example, some social workers located in hospitals are providing the link between the health and social welfare systems. If a patient cannot pay fees, nurses inform a social worker who discusses the problem with the patient on the spot. If needed, the social worker sends an application for exemption directly to the social committee. This procedure also spares poor patients the humiliation of personally requesting support from the municipality. Consequently, ill people with low income are less afraid of hospitalisation. Another advantage of this initiative is that it relieves medical staff of this additional task. A similar initiative could be launched nation-wide. Yet, a sufficient number of social workers in hospitals are crucial for a significant improvement of the situation.

6 Conclusions

Improving the health status of low-income groups is crucial for alleviating poverty, while also being regarded as a prerequisite for general socio-economic development. This basic correlation is widely acknowledged in Latvia. Nevertheless, vulnerable groups within the population still face a number of barriers when acceding to health services.

This study relied both on stakeholder interviews in and around the Latvian health and social protection systems and on the analysis of existing surveys, aiming at answering two main research questions: What access barriers to the health system currently affect poor and vulnerable groups? How can these barriers be removed and the health system be made more pro-poor?

In order to address these questions in detail, our analysis of the Latvian health system has focused on three dimensions of accessibility: the financial, the geographical, and the informational one. For each dimension, barriers to access, existing measures to overcome these, their limits, and

possible reform proposals have been identified above.[82] This concluding chapter will briefly summarise the main findings on the relevance and causes of these three specific barriers to acceding to health care services in Latvia before moving on to a discussion of crosscutting issues.

Financial accessibility seems to be the most important of the three dimensions. As mentioned earlier, the fear of being unable to pay for medical care ranks first among the concerns of the Latvian population (UNDP 2003, 30). Although several mechanisms are already in place to reduce the financial burden of health costs, some problems still persist, in particular from a pro-poor perspective. The high share of out-of-pocket payments for health services in Latvia directly disadvantages vulnerable groups. In addition, the existence of quotas for services, high expenses for pharmaceuticals and informal payments hamper the access of vulnerable groups to health care services. Existing measures, such as exemptions from co-payments, the ceiling of LVL 80 for co-payments, diagnosis-related exemptions from pharmaceutical expenses and municipal health-related benefits, are intended to protect low-income groups, but do not yet suffice. Accordingly, both survey results and stakeholder interviews revealed that the affordability of health care services and pharmaceuticals remains a major issue to be tackled.

Empirical evidence on *geographical accessibility* problems is rather sparse compared with that on the financial dimension, and not many representative studies have focused on this issue so far. However, transport costs, the availability of transport and the opportunity costs of time invested in travelling may have an impact on the accessibility of health services, in particular in rural areas of Latvia. In addition, geographical barriers might gain in importance in the future if the downward trend in the number of GPs and hospitals in rural areas is not compensated by other measures, i.e. by reimbursing transport costs or by providing free-of-charge municipal transportation services for low-income patients.

Informational accessibility is another significant factor. It is mainly related to the patients' knowledge about entitlements to state-guaranteed health services, patients' rights, the costs of medical treatment, and health-related

82 It should be noted that our study focuses on specific proposals to improve the access of vulnerable groups to health services. It does not aim at elaborating recommendations for all other areas of the Latvian health system.

social benefits. Empirical evidence indicates a general lack of knowledge on these issues among the inhabitants of Latvia. In addition, some vulnerable groups, in particular low-income households, tend to be even less informed about these topics than the better-off part of the population (CIET International 2002, 46). This may partially be ascribed to an insufficient tailoring of information to specific needs and preferences of different target groups. Other causes may be found in the rather limited staffing and financial capacities of public and non-governmental institutions providing information to the general public.

The three barriers described above do not exclusively affect those living on an income below the poverty threshold, as defined by the Latvian Cabinet of Ministers. Individuals with an income just above this threshold and thus ineligible for a number of exemptions and reimbursements are particularly vulnerable, and so are groups with high health needs, such as the elderly and chronically ill. Catastrophic health costs – which exceed the individual's ability to pay – may even affect better-off parts of the population.

Since a number of our reform proposals, presented in the previous chapters, concerned financial, geographical and informational dimensions simultaneously, it is thought useful to discuss those issues combined. In order to do so, we come back to the three global determinants of accessibility introduced in Chapter 2.4.2: pooling and funding of health services, overall stewardship for the health system, and the general political framework.

Pooling and funding

In per capita terms, total health expenditure was only $338 in Latvia in 2000, compared to the EU average of $2,136 (WHO 2004a).[83] The share of out-of-pocket payments for health services is high, amounting to an estimated 47.5 % of total health care funding in 2001 (WHO 2004b). Since out-of-pocket payments reduce the pooling of risks and also represent a direct access barrier for vulnerable groups, it would be recommendable to transform a sizeable part of them into pooled funding. This would not necessarily imply an increase in total funding, but require a higher share of

83 All data in PPP$.

public funding, in order to transform the current health-financing scheme into a more equitable one.

At only 3.5 % of GDP (VOAVA 2003, 12–13), public health expenditure is quite low in Latvia.[84] This spending level puts Latvia last among the ten countries that acceded to the EU in 2004. Increasing the share of public health funding is a necessary first step towards improving the accessibility for vulnerable groups who have little financial resources at their disposal.[85] The Latvian government recognised the need for additional funding and announced the goal of increasing public health expenditure by an annual 15 % (Government Declaration 2004).

From a pro-poor perspective, it is not only important how the additional funding is raised, but also how it is spent. While increased funding is a prerequisite for reducing quotas, it does not automatically reduce all other access barriers to the Latvian health system. We propose modifying the current ceiling of LVL 80 for co-payments to health care services to incorporate expenses for prescribed pharmaceuticals, thus contributing to transforming out-of-pocket expenses into pooled funding. Similarly, the problem of informal payments could be tackled if some of the additional funding were used to raise the salaries of health care professionals. However, complementary measures on the stewardship level are also required to address this problem.

Finally, the role of municipalities in funding deserves more attention. Although their direct involvement in health funding is limited to subsidies to local health care facilities, municipalities assume an important function by granting health-related social benefits to their inhabitants. Thus, allocating more resources and increasing municipal social budgets could significantly contribute to improving the accessibility of health services for vulnerable groups.

Stewardship

Increasing the volume and improving the allocation of funding does not necessarily eliminate access barriers for vulnerable groups. Some barriers

84 Data from 2001.

85 Increasing the share of public health funding is closely related with the political will for pro-poor reforms on the stewardship level.

result from insufficient coherence between institutions of the health and social protection systems, while others stem from insufficient transparency and enforcement of regulation.

Coherence is closely related with the division of responsibilities. In some cases, it seems to remain unclear who is responsible for certain actions, e. g. providing information on health-related benefits. Since with VOAVA, municipalities, GPs and social workers, very different actors and interests are involved, it may be difficult to develop coherent action plans and strategies. This makes the role of the steward, i.e. the government, so important: its role is to reduce the leeway for interpretation by defining who can be held accountable and what each entity's responsibilities are.

For example, municipalities are legally obliged to ensure access to health care. Yet, how this is being interpreted and which responsibilities are derived from this stipulation seems to differ among municipalities. In this context, the steward should avoid creating unfunded mandates. In particular, a clearer definition of the tasks to be performed in order to 'ensure access to health care' should not only come at the expense of municipal budgets. Another example is the shortfall of revenues resulting from the refusal or inability of patients to make the stipulated co-payments for health services. Based on our interviews, it seems to be unclear who is expected to cover this shortfall: the service providers (hospitals, physicians), VOAVA or the municipalities. Thus, a clarification or improved communication of these responsibilities is recommended.

Stakeholders also mentioned improved enforcement and transparency of regulations as an important task, e. g. enforcing the abolishment of informal payments and increasing the transparency of the current quota system. Ensuring strict compliance with regulations may require increased personnel and financial capacities in relevant institutions.

Finally, a significant strengthening of research capacities on health and social policy may enable the evaluation of past reforms and the development of medium and long-term strategies for the health system, thereby contributing to reliable planning by health care providers.

General political framework

Obviously, the decisions made by the stewards are subject to the general political framework. In the Latvian context, this framework limits the stewards' ability to reform the health system in several ways.

The Latvian political landscape is characterised by a short duration and high volatility of governments and coalitions. Consequently, the health system is subject to very different strategies, ranging from radical reforms, such as the proposal to introduce a private health insurance system similar to the one in the United States, to maintaining the current tax-financed system. In the absence of a general political consensus on the direction of health sector reforms, it seems very difficult for the Ministries of Health and Welfare to guarantee planning reliability for providers and patients. In addition, implementing long-term reform projects and following-up on reforms is also hampered by the political turnovers and diverging strategies. Thus, improvements made on the stewardship level in strengthening research capacities and developing long-term strategies might be offset by those general political factors.

Another important aspect affected by the political framework in Latvia is the allocation of resources. The stewards' ability to give more financial priority to the health system is constrained by Latvia's need to implement reforms in several policy areas simultaneously. For example, the accession to the EU and NATO not only required significant financial resources, but were also of higher political priority than health sector reforms. However, Latvia assigned a lower share of public funding to the health system than other new EU members from Central and Eastern Europe facing the same historic challenges. Accordingly, many participants of the workshop in Riga argued that the political will to significantly improve the accessibility of health services seems to be missing in Latvia. Although health and the access to health services are recurrent issues in election campaigns, they do not yet translate into practical political priorities.

The forging of a general consensus on the increasing importance of pro-poor health reforms and the building up of political will to tackle these problems seem to be prerequisites for improved accessibility. The Ministry of Health and the Ministry of Welfare might not be able to create this consensus within the government yet, but could promote a general discussion in Latvian politics and society on the accessibility of health services.

In order to guarantee equitable, undistorted access to health care services in Latvia, a comprehensive and reliable protection system is required. This involves both the health and the social protection systems. Stakeholders from both systems need to strengthen their co-operation if the accessibility of health services is to be improved. Although increasing the financial endowment of the health system amounts to a significant contribution, it alone does not guarantee that vulnerable groups will benefit from the additional resources.

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List of interview partners in Latvia

Aiga Rūrāne	National Programme Officer	WHO Liaison Office in Latvia	Riga, February 20, 2004
Inita Paulovič̆a	Assistant Resident Representative	UNDP Latvia	Riga, February 24, 2004 (and other meetings)
Māris Baltiņš	Professor of Public Health	University of Latvia, Faculty of Medicine	Riga, February 25, 2004
Egita Pole	Deputy Director of Public Relations Department	VOAVA	Riga, February 25, 2004
Lūcija Akermane	Deputy Director of Finance Department	VOAVA	Riga, February 25, 2004
Atis Mārtiņsons	Deputy Director of Health Care Department	VOAVA	Riga, February 25, 2004
Viesturs Šiliņš	MP, Subcommittee on Health	Saeima of the Republic of Latvia	Riga, February 25, 2004
Andris Lasmanis	Family Doctor	ALMA Clinic	Riga, February 26, 2004
Signe Dauškane	Director	Latvian Patients' Rights Office	Riga, February 26, 2004

Jautrīte Karaškeviča	Deputy Director of Statistics Department	Health Statistics and Medical Technology Agency	Riga, February 27, 2004
Hans-Detlev Küller	First Secretary	German Embassy	Riga, February 27, 2004
Edmunds Vaskis	Director of Social Statistics Department	Central Statistical Bureau of Latvia	Riga, March 1, 2004
Maranda Behmane	Deputy Director of Social Statistics Department	Central Statistical Bureau of Latvia	Riga, March 1, 2004
Renāte Pupele	Director of Strategic Planning Department	Ministry of Health	Riga, March 2, 2004
Sarmīte Veide	President	Family Doctors' Association	Riga, March 2, 2004
Dominic S. Haazen	Senior Health Specialist	World Bank	Riga, March 3, 2004
Ruta Vīksna	President	Trade Union of Health and Social Care Employees	Riga, March 3, 2004
Ija Rudzīte	Vice-president	Trade Union of Health and Social Care Employees	Riga, March 3, 2004
Inta Gavariņa	Adviser	Trade Union of Health and Social Care Employees	Riga, March 3, 2004

Ilze Jēkabsone	Inter-Agency Coordinator on Young People's Health	UNDP Latvia	Riga, March 4, 2004
Silvija Šimfa	Adviser on Social and Health Issues	Union of Local and Regional Government of Latvia	Riga, March 4, 2004
Sigita Rozentāle	Director	Social Assistance Fund	Riga, March 5, 2004
Laima Čakste	Head of Department of Information	Social Assistance Fund	Riga, March 5, 2004
Olga Lapinska	Deputy Head of Department of Information	Social Assistance Fund	Riga, March 5, 2004
Iveta Pudule	Head of Health Promotion Research Unit	Health Promotion Centre	Riga, March 8, 2004
Viesturs Boka	President	Latvian Doctors' Association	Riga, March 8, 2004
Anda Masajeva	Head of Social Assistance Policy Unit	Ministry of Welfare	Riga, March 9, 2004
Valdis Nagobads	Director of Department of Welfare	Riga City Council	Riga, March 9, 2004
Maruta Pavasare	Head of Social Benefit Department	Riga City Council	Riga, March 9, 2004

Ģirts Briģis	Head of Department of Public Health and Epidemiology	Rīgas Stradiņa University	Riga, March 10, 2004
Anita Villeruša	Dean	Rīgas Stradiņa University	Riga, March 10, 2004
Helēna Soldotjonoka	Social Assistance Department	Daugavpils City Council	Daugavpils, March 11, 2004
Viktors Butāns	Adviser to Mayor	Daugavpils City Council	Daugavpils, March 11, 2004
Nona Jakubovska	Director	Social Care Centre	Daugavpils, March 11, 2004
Gunārs Grigulis	Deputy Head of Latgale Department	VOAVA	Daugavpils, March 11, 2004
Vera Boroņenko	Researcher	Faculty of Social Sciences, Daugavpils University	Daugavpils, March 11, 2004
Juris Bicāns	Family Doctor	Social Care Home Višķi	Višķi, March 12, 2004
Iveta Grotkere	Family Doctor	Social Care Home Višķi	Višķi, March 12, 2004
Marija Strode	Social Worker	Višķi Municipality Council	Špoģi, March 12, 2004
Anita Ločmele	Director	Health and Social Centre Ilūkste	Ilūkste, March 12, 2004
Ligita Martinova	Family Doctor	Family Doctor's Office	Subate, March 12, 2004

Inese Dzene	Vidriži Municipality Secretary	Vidriži Municipality	Vidriži, March 15, 2004
Edīte Vītola	Family Doctor	Vidriži Doctors' Office	Vidriži, March 15, 2004
Aina Verze	President	Pensioners' Federation	Riga, March 16, 2004
Aija Kušķe	Chairman of Board	Pensioners' Federation	Riga, March 16, 2004
Ilze Aizsilniece	Family Doctor	Former Adviser to Minister of Health	Riga, March 17, 2004
Viktors Jaksons	Public Health Specialist	Former Minister of Welfare	Riga, March 17, 2004
Gunta Anča	Chairwoman of Board	SUSTENTO	Riga, March 23, 2003
Rita Paeglīte	President	Latvian Asthma and Allergy Association	Riga, March 23, 2003
Oļegs Deņisovs	MP, Social and Labour Law Committee	Saeima of the Republic of Latvia	Riga, March 23, 2003
Māris Kučinskis	MP, Social and Labour Law Committee	Saeima of the Republic of Latvia	Riga, March 23, 2003
Māris Rēvalds	President	Latvian Health Care Employers' Association	Riga, March 24, 2004
Jānis Averčenko	Head of Personal Insurance Department	Parex Insurance	Riga, March 24, 2004

Eižens Lelis	Director	Insurance company 'Rīgas Slimokase'	Riga, March 24, 2004
Ilze Kukute	State Secretary	Ministry of Regional Development and Local Government	Riga, March 24, 2004
Anita Čemme	Deputy Director of Welfare Funding Department	Ministry of Finance	Riga, March 25, 2004
Valda Larionova	Senior Expert of Budget Department	Ministry of Finance	Riga, March 25, 2004
Sanita Broka	Chairperson	National Tripartite Co-operation Board	Riga, March 25, 2004
Jānis Ceika	Deputy Head Doctor	Liepāja City Hospital	Liepāja, March 26, 2004
Tālivaldis Deklaus	Vice-Chairman	Liepāja City Council	Liepāja, March 26, 2004
Brigita Dreize	Head of Municipal Social Committee	Liepāja City Council	Liepāja, March 26, 2004
Ineta Stadgale	Project Coordinator, Health and Social Projects	Liepāja City Council	Liepāja, March 26, 2004
Aija Barča	Director of Social Services	Liepāja City Council	Liepāja, March 26, 2004

Jānis Grīnvalds	Director	Ziemeļaustrumu Slimokase	Smiltene, March 29, 2004
Evita Zušmane	Primary Health care Specialist	Ziemeļaustrumu Slimokase	Smiltene, March 29, 2004
Ainars Mežulis	Chairman of Smiltene City Council	Smiltene City Council	Smiltene, March 29, 2004
Inta Siliņa	Social Worker	Smiltene City Council	Smiltene, March 29, 2004
Jānis Krūmals†	Chief Doctor	Smiltene Red Cross Hospital	Smiltene, March 29, 2004
Aija Meldere	and 16 other members	Pensioners' Club	Smiltene, March 29, 2004
Velga Kalniņa	Director	Social Care Home	Vecpiebalga, March 30, 2004
Zaiga Zariņa	Family Doctor	Feldsher Point	Melnbārži, March 30, 2004
Aigars Stirna	Head of Division	Ministry of Welfare	Riga, March 31, 2004
Jevgēņijs Kalējs	Chairman	Latvian Hospital Association	Riga, March 31, 2004
Edvīns Platkājis	Director	Hospital 'Gaiļezers'	Riga, March 31, 2004
Gundars Prolis	Financial Director	Hospital 'Biķierniki'	Riga, March 31, 2004
Daiga Behmane	Director	State Medicine Pricing and Reimbursement Agency	Riga, April 1, 2004

Uldis Līkops	State Secretary	Ministry of Health	Riga, April 1, 2004
Laila Ruškule	Director of Finance Department	Ministry of Health	Riga, April 1, 2004
Dmitry Babarykin	Chairman of Board	Ārstu Konsultatīvais Dienests (ĀKD)	Riga, April 1, 2004

Glossary

Capitation

A fixed payment to a provider for each enrolled person served per period of time. The term is also used for the allocation of money on a per-capita basis to third-party payers. Payments are prospective and vary according to the number of patients enrolled, but not with the number of services rendered per patient.

Case-based payments

Payments by third-party payers to physicians or hospitals according to the cases treated rather than per service or per bed days.

Co-payment

Cost-sharing in the form of a fixed amount to be paid for a service. A provision of health insurance or third-party payment that requires the individual who is covered to pay part of the cost of medical care received.

Diagnosis-related group (DRG)

A way of categorizing patients according to diagnosis and intensity of resources required, usually for the period of one hospital stay. Diagnosis-related group payments are the most common kind of case-based payments.

Fee-for-service

A retrospective payment mechanism whereby a provider or health care organization receives a payment each time a reimbursable service is provided (e. g., office visit, surgical procedure, diagnostic test, etc.).

Gatekeeper

A primary care physician, general practitioner or other provider responsible for overseeing and coordinating all the medical needs of a patient. The gatekeeper must authorize any referral of the patient to a specialist or hospital. Except in cases of emergency, the authorization must be given prior

to care. Gate keeping is a way to deter patients from unnecessary self-referrals to costly specialist services.

General Practitioner (GP)

A general doctor, or family doctor, who is the first point of contact with the health services for all non-emergency cases.

Informal payments

Unofficial payments made in cash or in kind in order to obtain one's health needs fulfilled in a timely manner and/or to a larger extent than by following the official rules and regulations in a given health system. Also called envelope payments or under-the-table payments and often prohibited.

Inpatient care

Formal admission of a patient to an institution for treatment and/or care, if patient stays for a minimum of one night in the hospital or other institution providing inpatient care.

Out-of-pocket payments

Fee paid by the consumer of health services directly to the provider at the time of delivery. Includes cost sharing, user fees and informal payments to health care providers.

Outpatient care

Services provided in a physician's office, clinic, or other ambulatory setting. Includes a patient attending a hospital for treatment or a consultation, but not staying overnight in a hospital.

Primary health care

The first level contact with people taking action to improve health in a community. In a system with a gatekeeper, all initial consultations with doctors, nurses or other health staff are termed primary health care, as opposed to secondary health care or referral services. In systems with direct access to specialists, the distinction is usually based on facilities,

with policlinics, for example, providing primary care and hospitals secondary care.

Private health care expenditure

That part of total expenditure on health which is not public; it is mainly comprised by out-of-pocket payments and premiums for voluntary health insurance.

Prospective payment

A payment whose level is fixed in advance of actually providing a service. Examples of this are fixed budgets and capitation payments.

Public health care expenditure

Expenditure made by public funds, i.e. state, regional and local government bodies and social security schemes.

Rationing

Restricting supply of services according to implicit or explicit criteria, where demand exceeds supply.

Retrospective payment

A payment scheme whose level is determined only after services have been provided; also called reimbursement. Examples of this are fee for service, cost/fee per case and per diem payments.

Risk pooling

Forming a group so that individual risks can be shared among many people.

Secondary health care

Specialized ambulatory medical services and commonplace hospital care (outpatient and inpatient services). Access is often via referral from primary health care services. Does not include highly specialized, technical inpatient medical services, which is tertiary health care.

Stakeholders

Groups that have an interest in the organization and delivery of health care, and who either conduct, sponsor, or are consumers of health care, such as patients, payers, and health care practitioners.

Tertiary health care

Refers to medical and related services of high complexity and usually high cost. Tertiary care is generally only available at national or international referral centres.

Third-party payer

Any organisation, public or private, that pays or insures health care expenses for beneficiaries at the time at which they are patients. Refers to situations where the first party (patient) does not pay directly for the activities of the second party (provider), but where this is done through a private insurer, sickness fund or government agency (third-party payer).

User fee

Charges for goods or services that the user, or patient, is required to pay.

Source: European Observatory on Health Systems and Policies (2005); modified.

APPENDIX

A.1 Patients' information on co-payments provided by VOAVA

HOW MUCH DOES HEALTH COST?[86]

Health cannot be bought; it must be taken care of and preserved. If you have fallen sick, recovery will cost money. In those health care institutions which have a contract with the sickness fund your health recovery will be paid for by the sickness fund. You will only pay a part of the cost – the patient's co-payment.

— When registering with the General Practitioner, you are entitled to receiving the state-guaranteed health care services by contributing a patient's co-payment: 0.50 LVL for your visit to the doctor's office or 2.00 LVL for doctor's visit to your home.

— If a hospital has a contract with the sickness fund and you have a doctor's referral for planned treatment, you will be obliged to pay LVL 5.00 as a hospital admission fee while your share in covering all the other days spent in the hospital will be LVL 1.50 per day, LVL 2.50 when being admitted to a day hospital (come for the treatment in the morning, leave for home at night) and LVL 1.00 for every day of treatment.

— You will be paying LVL 0.45 for every day spent in a hospital when being treated in a psychiatric, oncological, oncohaematological hospital, when being treated in a programme for alcohol, drug or toxic substance addiction as well as for the second stage of your rehabilitation.

— The total amount of the patient's co-payment may not exceed LVL 25.00 per one hospital treatment, excluding the payment for treatment manipulations.

You do not have to pay for the lab tests (if you have a referral sheet from the doctor who is in contractual relationship with the sickness fund)!

Regulations of the Cabinet of Ministers No. 13 'Regulations on the Health Care Funding' adopted on January 12, 1999 along with the respective amendments adopted on December 27, 2001.

86 Poster 'Cik maksā veselība?', to be found in health care establishments around Latvia. Translation from the Latvian original by Līga Mitenberga.

Price list for patient's co-payment for diagnostic examination and treatment manipulations (in LVL).

Following the Order No. 248 by the Ministry of Welfare of September 25, 2001.

This price list defines the amount of a patient's co-payment for planned treatment manipulations – for ambulatory and hospital (including the day hospitals) health care services included in the minimum list of health care services.

	Out-patient	Day hospital	In-patient
Examination of the cardio-vascular system			
Electrocardiography	0.50	0.50	
Non-invasive functional heart examination	1.50	1.50	–
Examination of the magisterial head and limb blood vessels	1.00	1.00	–
Examination of the neural system			
Neuro-electrophysiological examination (encephalography, myography)	1.00	1.00	–
Examination of the gastro-intestinal system			
Functional examination of the gastro-intestinal system	2.00	2.00	–
Endoscopic examination	3.00	3.00	3.00
Ultra-sound examination			
Ultra-sound screening	1.00	1.00	–
Radiological examination			
X-ray examination without a contrasting substance	0.50	0.50	–
X-ray examination with a contrasting substance	1.50	1.50	–
Radio-nuclear diagnostics	1.50	1.50	–

Computer-tomographic examination			
Without a contrasting substance	2.50	2.50	2.50
With a contrasting substance	5.00	5.00	5.00
Examination with magnetic resonance			
Without a contrasting substance	6.00	6.00	6.00
With a contrasting substance	9.00	9.00	9.00
Treatment manipulations if no surgery is prescribed			
Sum total for treatment manipulations amounting to more than LVL 4.00 performed in the course of one hospital term (except endoscopic, computer tomography and magnetic resonance examinations for which patient's co-payment is charged separately)	–	–	5.00
Treatment manipulations if surgery is prescribed (except endoscopic, computer tomography and magnetic resonance examinations for which patient's co-payment is charged separately) The patient's co-payment for surgery includes payment for anaesthesia.			
In otolaryngology (including endoscopies), ophthalmology, face and jaw surgery, traumatology and orthopaedics, performing surgeries on surface veins.	3.00	3.00	15.00
In gynaecology, urology (including lithotripsy), neural surgery, abdominal surgery, performing thyroid surgeries, in thoracic surgery, diagnostic invasive cardiology, performing the implantation of electro-cardiac stimulators, in spinal surgery, performing arthroscopic surgeries, in plastic (reconstructive, palm) surgery.	3.00	25.00	25.00

Small gynaecological surgeries (abrasion of cervical cavity, Bartolini gland surgery, polyp removal).	3.00	5.00	5.00
In reconstructive vascular and plastic surgeries.	–	30.00	30.00
Endoprosthetic surgeries (without the value of the prosthesis) of major joints (knee, hip), medical invasive cardiology	–	45.00	45.00
Laparoscopic surgeries (including those of gynaecology and urology), cardio surgery.	–	50.00	50.00

The following groups are exempt from patient's co-payment:

— Children up to 18 years of age;

— Pregnant women and women in the post-partum period up to 42 days after delivery, if they receive services related to the pregnancy and post-partum monitoring;

— Victims of political persecution, victims of the consequences of the cleaning-up operations after the Chernobyl nuclear plant catastrophe;

— Poor persons categorized as such following the Regulations of the Cabinet of Ministers;

— TB patients and patients being examined for TB;

— Patients receiving treatment in cases of infectious diseases which have been approved in lab tests and are subject to registration according to the Procedures for Registering Infectious Diseases issued by the Cabinet of Ministers;

— Patients receiving emergency medical care – after the receipt of primary emergency medical care in the pre-hospital stage, on provision of primary and secondary emergency medical care during the first two days at the hospital in the course of treatment in the intensive care unit of the hospital;

— People in the national specialized social care centres and social centres (houses) of municipalities;

— All residents undergoing preventive examination following the procedures defined by the Ministry of Welfare;

— All residents undergoing immunization defined in the normative acts or passive immune therapy following the procedures defined by the Ministry of Welfare;

— Patients whose co-payments in the course of one year starting from January 1 amount to LVL 80. This sum total shall include patient's co-payments at outpatient clinics, physicians' practices and hospitals (including the payment for treatment manipulations). A patient must control this amount on individual basis, collecting the receipts, whereon the first and last name of the patient have to be indicated, the individual code of the person and the name of the treatment institution. Receipts must be issued by the treatment institution which has a contract with the sickness fund. After receiving the certifying receipts, the sickness fund shall issue this patient a note certifying that the person is exempt from patient's co-payments until the end of the year.

Useful phone numbers […].

In case of complaints on the quality of the medical services received, please call 7144966.

A.2 Stakeholders of the health and social protection system

External experts:

Health Statistics and Medical Technology Agency, Social Statistics Department at CSB, Universities (Social Sciences and Public Health), WHO, UNDP, World Bank, German Embassy.

Stewards / public policymakers:

Ministry of Health (State Secretary, Advisors, Strategy), Municipal Health Departments, Saeima Parliamentary Committee, Political Parties, Health Promotion Agency, Ministry of Welfare (State Secretary, Social Assistance Department), Ministry of Regional Development and Local Governments (State Secretary), Ministry of Finance (Health Budget), State Medicine Pricing and Reimbursement Agency, National Tri-partite Co-operation Board, Union of Local and Regional Government of Latvia.

Direct actors:

Pooling agencies / purchasers:	Providers:	Clients:
– VOAVA	– Administration of hospitals	– Patients' Rights NGO
– Regional Sickness Funds	– Social care homes	– Patients' Organisations
– Private insurance companies	– Doctors	– Pensioners' Associations
– Social Assistance Fund	– Association of doctors	
– Social Integration Fund	– Association of GPs	
– Municipalities	– Union of Hospitals	

Source: own elaboration

A.3 Latvia at a glance

Latvijas Republika (Latvian Republic)	
Political system	Parliamentary Democracy
Year of independence	Nov. 18th, 1918 (regained Aug. 21st, 1991)
Capital	Riga
Surface	64,597 sq km
Population	2,345,800 (Riga: 740,000)
Economic indicators 2004	
Currency exchange rate	LVL 1 = €1.49
GDP (in million)	LVL 7359 (€10,968)
GDP increase	8.5 %
GDP per capita	LVL 3,182 (€4,742)
Average gross monthly wages and salaries	LVL 211
Average net monthly wages and salaries	LVL 150
Annual real wage and salary increase	2.5 %
Annual consumer price changes	6.2 %
Unemployment rate	8.5 %
Source: CSB (2005)	

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