

HEALTH FINANCING POLICY REFORM TRENDS: THE CASE OF LATVIA

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Abstract: Health financing policy is one of major challenges for any health care system. The Latvian health care system faces challenges and financial pressures that threaten its long-term sustainability and the values of solidarity. The goal of this paper is to conduct the review of the financing resources of the health care in Latvia, to evaluate the development of the health care reform in Latvia and provide recommendations for future changes. To achieve the goal of the research, comparative analysis and methods of theoretical research, as well as for data processing and analysis, the statistical analysis methods are used.

Keywords: health systems; healthcare financing; taxation; universal health coverage.

1 Introduction

Health financing schemes have to raise revenues in order to pay for health care goods and services that serve the population. There are different types of revenues which can however be closely correlated with the financing scheme. In general, financing schemes can receive funding from the government, social insurance contributions, voluntary or compulsory prepayments (e.g. medical saving accounts, insurance premiums), and other domestic revenues and revenues from abroad as part of development aid (foreign financial assistance). The policy debate on health systems has been dominated in recent decades by concerns about sustainability and the system's ability to fund itself in the face of growing cost pressures (see Kluge et al. (2017), Kutzin (2013); Abiir and De Allegri (2015)). The recent financial crisis that has affected some countries as well as state budget fiscal rules have added to these concerns. The period 2009–2013 saw a general drop in health spending in many countries, but since then expenditure on health systems has been rising again across the region (Karanikolos et al., 2013; Reeves et al., 2014). Since health systems in Europe are mostly publicly financed, this financial pressure is typically expressed as a challenge for public budgets. Health expenditure in many European countries has been growing at a faster rate than the economy, accounting for an increasing percentage of gross domestic product (GDP) and creating unease about its economic competitiveness in an increasingly globalised economy. Containing costs has, consequently, become a significant priority for most health systems in the World Health Organization (WHO) European Region and beyond. Typically, policy-makers have sought to find a balanced combination of different strategies to tackle both the supply and demand sides of health services. While European health policy-makers are committed to shared values, and their systems may to varying degrees reflect them, the regional health systems remain very different. The two main traditional models of health financing – Beveridge and Bismarck have all been adopted in different national contexts and have evolved over time. Moreover, even if these categorisations no longer apply in practice, each regional health system has left its historical legacy in terms of health system structure and design, resources, infrastructure (buildings), and expectations about how the health system should work. Main challenges for Latvian health financing system are the application of different systemic approaches to the financing scheme and acute resource and hospital infrastructure issues. As stated by OECD Secretary-General A. Gurría (OECD, 2019a) Latvia is among the OECD countries

with the highest inequalities in income, health and among regions. One of the important governmental tasks is to build a more inclusive health sector. Out-of-pocket expenditure accounts for 45% of health spending, compared to 21% on average across the OECD. 10% of patients in the lowest income quintile skip doctors' appointments because they cannot afford to pay the fees. A continued commitment to universal access to healthcare and to increase spending will be crucial. Each country makes different choices about how to raise revenues, how to pool them and how to purchase services. Just because several countries decide to raise part of the revenue for health from compulsory health insurance premiums does not mean that they all pool the funds in the same way. Some countries have a single pool – e.g. a national health insurance fund – while others have multiple, sometimes competing pools managed by private insurance companies. Even when countries have similar pooling systems, their choices about how to provide or purchase services vary considerably. Two systems based largely on health insurance may operate differently in how they pool funds and use them to ensure that people can access services; the same applies to two systems that are described as tax-based. This is why the traditional categorization of financing systems into tax-based and social health insurance – or Beveridge versus Bismarck – is no longer useful for policy-making. It is much more important to consider the choices made at each step along the path, from raising revenues, to pooling them, to spending them (Kutzin, 2011; Bump, 2015). Based on early presented research (Pētersone, Ketners, Rakauskienė, (2018)) authors join the view of OECD experts (OECD (2019a)) that higher healthcare spending should be financed from general budget revenues rather than earmarked social contributions to simultaneously improve market labour outcomes and equity while simplifying the tax system. The goal of this paper is to conduct the review of the financing resources of the health care in Latvia, to evaluate the development of the health care reform in Latvia and provide recommendations for future changes. To achieve the goal of the research, comparative analysis and methods of theoretical research, as well as for data processing and analysis, the statistical analysis methods are used.

2 Health care expenditures and external environment of the Latvian system

Health care reforms are always in the focus of research, even for such countries in transition as post-socialism countries. Latvian health care reform, amongst other Baltic states was analysed by (Bankauskaite and O'Connor, 2008). Authors agree that health care policy in three Baltic States during the period from 1992 to 2004 developed in parallel, diverging or even converging ways. The similarity of the overall goals during this period could be identified, and policy content in primary health care, the hospital sector and financing is comparable. 2000s health policy in Estonia, Latvia and Lithuania have been progressing in parallel towards a Western European social insurance funding model, developing a primary care system anchored on a general practitioner service and lessening the hospital orientation of the pre-1990s system. There is evidence of convergence in key health policy and outcome characteristics. However, for the period after 2006, these patterns are explained partly by differing starting points and partly by political and economic factors over the 1992–2004 period. Similarities could be also accepted by data on total financing (Fig.1)

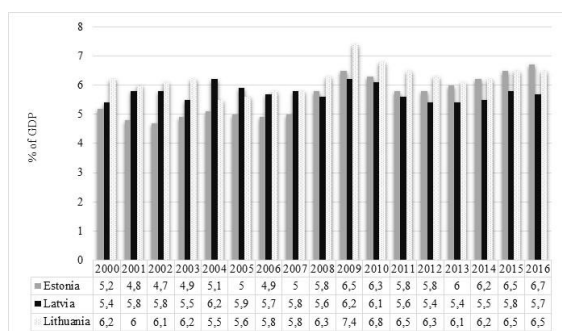


Figure 1: Health financing, % of GDP
Source: (OECD, 2019b)

Before 2008, Estonian and Lithuanian financing schemes show relatively similar amounts; however differences appear in sources of financing and type of financing system, and after 2011 a decrease in the nominal amount of Latvian health care financing is detectable. Early reforms, similar across all the Baltic States, focused on improving quality, efficiency, and geographical and timely access to healthcare, but differences in politics, economy, and culture perhaps explain variations in the implementation of the reforms. After independence restoration, all three Baltic States adopted social health insurance systems. For these countries, with their deep-rooted distrust of government, a system in which organisational and health financing arrangements lay largely outside the state sector was an attractive prospect. Additionally, by introducing a purchaser-provider split, they hoped to increase transparency and efficiency. Finally, in a fragile economic environment, earmarked payroll tax was seen as a more stable funding source than general tax. However, in all three states, the decentralisation of the financing system resulted in an inefficient and fragmented allocation of resources and was followed by a gradual recentralisation. In the course of implementation of the reform, funds allocated in the 1990s for the financing of healthcare measures were divided into two separate programmes: the state programme and the basic programme and were directed towards service providers in several flows of financing. The programmes were financed from two sources: state funds and municipal funds, and the sources of such financing – state budget, municipal budget, and action grants from the state budget – changed every year. Although finance flows had been defined, the question of the sources of financing remained for late 1990 earmarked payroll tax (personal income tax) was used. As analysed by Arāja and Krūzs (2016) according to the principles adopted in 1994, it was planned to introduce a health tax already in 1995, payable in equal parts (three per cent of the taxable income of an employee) by the employee and the employer, but this tax has not been introduced. The basis for the State compulsory health insurance – part of the resident income tax and a grant from the state general budget – was defined in 1996. The state basic budget grant model was accepted in 2003, which abolished the special-purpose healthcare budget and envisaged the healthcare budget as part of the general state budget. Subsequently, because of apparent problems with decentralized planning and financing, a recentralization process was initiated. Recentralization led to the creation of one single fund, the State Compulsory Health Insurance Agency in 2002. In 2005, earmarking of a proportion of the collected personal income tax for health care was abandoned in favour of general tax financing. Finally, the centralization process culminated in the creation of the National Health Service (NHS) in 2011, effectively abandoning the concept of social health insurance. Functions of several previously existing institutions were incorporated into the NHS with the aim of creating one single institution for the implementation of health policies in Latvia (Mitenbergs et al., 2014) However, the purchaser-provider split was retained, with the NHS continuing to purchase care from independent public and private providers – just as the State Compulsory Health Insurance Agency had done before. In recent times, a

challenging economic climate has required some harsh austerity measures to balance public budgets.

As shown in (OECD, 2017b), governments provide a multitude of public services out of their overall budgets. Hence, health care is competing with many other sectors such as education, defence and housing. The size of public funds allocated to health is determined by several factors including, among others, the type of system in place and the demographic composition of the population. Relative budget priorities may also shift from year to year as a result of political decision-making and economic effects. In 2015, health spending by government schemes and compulsory insurance stood at around 15% of total government expenditure across the OECD (Fig. 2).

In Japan, Switzerland, New Zealand, the United States and Germany, more than 20% of public spending was dedicated to health care. On the other hand, less than 10% of the money spent by governments or compulsory health insurance was allocated to health care in Latvia and Greece.

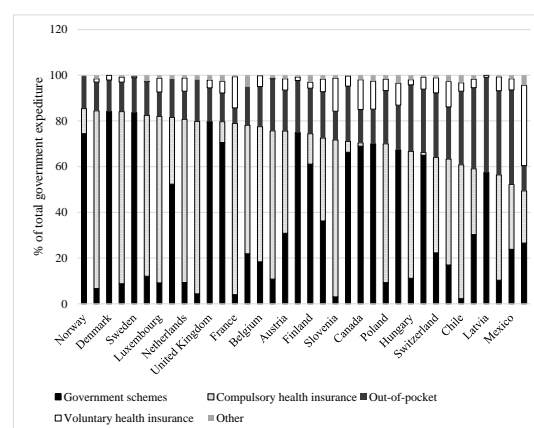


Figure 2: Health expenditure by type of financing, 2015 (or nearest year)
Source: (OECD, 2017b)

The revenues of a country's government are strongly correlated with a country's system of health care financing. The role of governments as a financial source can be highlighted more clearly when only focusing on the composition of revenues for compulsory health insurance, which in most OECD countries consists of social health insurance (SHI). In the analysed OECD countries, governmental transfers are a source of revenue in each case but the importance differs significantly. In Japan, more than 40% of the revenues of SHI stems from governmental transfers. On the other hand government transfers in Estonia, Poland and Slovenia are less than 5%. In those countries, SHI funds finance their outlays nearly exclusively via social contributions. But variations exist when analysing the burden of SHI in more detail. For example, in Poland, employees bear the majority of social contributions, whereas in Estonia the financing responsibility falls on employers' side. Authors conclude that there is no optimal approach to the structure of the funding and basically relies on historical trends of financing. Some countries are planning to reduce their reliance on wage-based contributions in the face of shrinking labour markets and financial shocks, and are increasingly looking for ways to diversify their revenue base (OECD, 2015). While there is a little year-to-year change in the health financing structure and composition of revenues, some trends can be discerned over a longer time horizon (OECD, 2017a). In Belgium, for example, the share of social contributions in all revenues has fallen from over 50% to around 43% over the last decade. At the same time, governmental transfers have gained importance. The latter is also true for the United States, where the share from government transfers increased from 34% to 41% over the same period. In Korea, on the other hand, government transfers have stagnated while the share through social contributions has increased (OECD, 2017a).

Authors came to the same conclusion as (Mitenbergs et al., 2014), that financing scheme has to be viewed in the context of almost 27 years of reforms, which radically transformed the Latvian health system after the restoration of independence of the country in 1991. Similar as in Estonia and Lithuania, (van Ginneken et al., 2012) the reforms have been aimed at making a clear break with the Soviet-style Semashko model, which was characterised by central planning and universal access but suffered from inefficiency, hospital overcapacity, and inadequate healthcare.

3 Health care expenditures and problems of financing sources structure of the Latvian system

In Latvia (Fig.3) despite various institutional reforms and changes in financing sources done during the past 30 years, the the European Union (EU) and high-income countries.

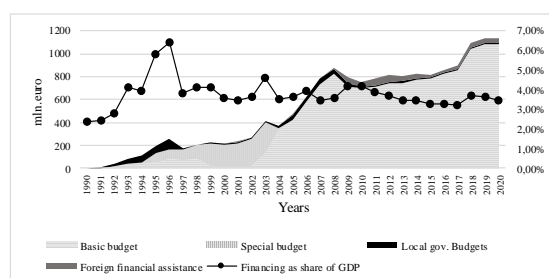


Figure 3: Public sector budget financing sources of health care. Source: Authors calculations based on Latvian annual report data (State Treasury), Ministry of Health data and Central Statistical Bureau data

In 2017 the Latvian health system provided coverage to the entire population (Latvians and non-Latvian residents) and paid for a basic services package, which is guaranteed by the constitution. The Latvian single health care purchaser – National Health Service (NHS) receives its resources from general tax revenues, and purchases care from independent public and private providers. Most hospitals are publicly owned by state or local government, while most general practitioners work as independent professionals. Specialists work either as independent professionals or as employees of hospitals. All dental practices and pharmacies are privately owned. Patients are encouraged to register with a general practitioner (family doctor) of their choice who expected to act as a “system gate-keeper”. After referral, patients can freely choose a specialist care provider, although the actual choice is often limited – in particular in rural areas – and waiting lists are substantial. For the health care system, two main problems could be defined – underfunding from public funds and significant amounts for direct payments and user charges.

As main problems of health systems authors see that the health care system is severely underfunded: total health expenditure in 2016 was only US\$1'466 PPP per capita, which was one of lowest amounts, spent on health in the OECD (OECD, 2017b). Furthermore, only about 57% of total spending came from public sources (OECD, 2017b). Inadequate public funding means that patients are exposed to substantial user charges and direct payments, in particular for pharmaceuticals.

Out-of-pocket (OOP) payments - expenditures are borne directly by patients and include cost-sharing arrangements and any informal payments to health care providers are amongst the highest in EU and OECD.

level of total public financing remains approximately the same – 3-4% of GDP. Above-mentioned level of financing corresponds with low-income countries health financing and could be explained with the historical trend in the former Soviet Union (Balabanova et al., 2012) more than with sound and reasonable practice. Starting with 1996, when part of personal income tax and part of excise tax revenues was earmarked to special state budget for health, and financing scheme was changed from decentralised local financing into a regional system with centralised financing notwithstanding further changes from social health insurance to national health service, and single purchaser amounts remain the same - total health expenditure as a proportion of GDP is quite low compared to the levels seen in

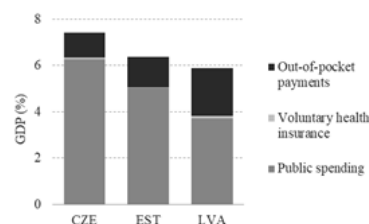


Figure 4: Public sector and OOP financing sources of health care. Source: WHO Regional Office for Europe, 2017

As shown in (OECD, 2017b) on average across the OECD, private households directly financed around one-fifth of all health spending in 2015. This share is above a third of health spending in Greece (35%), Korea (37%), Mexico (41%) and Latvia (42%), while in France it is below 10%. With the implementation of universal health coverage in some OECD countries over previous decades, there have been some significant reductions in the share of health care costs payable by households.

More recently, the share of OOP spending has been generally stable but with some notable increases in some European countries, also in Latvia. Out-of-pocket (OOP) problems in Latvia are stated by OECD experts and are subject to separate researches (See e.g., Cylus, Thomson, and Evetovits, 2018; Vāne, 2018). However since the share of OOP payments in total health spending is consistently among the highest in the EU, the necessity of additional financing to replace OOP with traditional financial sources is required for financial protection and universal health coverage assurance.

Based on authors analysis financing amounts could also be correlated with such health care outcome ratio as amenable mortality (Fig.5). Increase in public financing strongly correlates with a decrease in amenable mortality rates. The “additional financing break-even point” seems to be at approx — 1'300 EUR per capita. Based on authors calculations “full-service basket” for insurance of the entire population in comparable terms and prices could be 1'400 – 1'600 EUR per capita. Similar results were presented at Conference “Health Care System in Latvia - Structural Reforms and Financing Models” in 2016. However, Bank of Latvia (2016) proposed compulsory health insurance model with payments of 300 EUR. Based on the Cabinet of Ministers (2017) Conceptual report, additional financing necessary for health care services could be evaluated at 500 – 600 mln. EUR, which corresponds with the Ministry of Health presentations (see for example Ministry of Health (2017)).

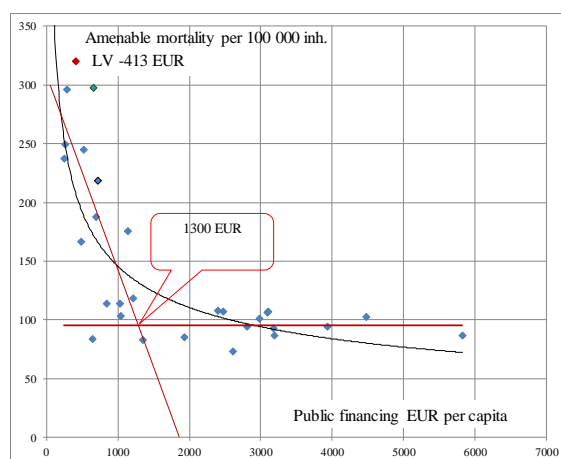


Figure 5: Correlation of granted public financing and amenable mortality ratio for EU and Norway (2013 data or latest available).
Source: Authors calculations based on OECD Health Statistics, 2017 (OECD, 2017b).

Similar results for the existing relationship between health care expenditures and life expectancy (Fig.5) was obtained by Ortiz-Ospina and Roser (2017). Countries with higher expenditure on healthcare per person tend to have a higher life expectancy, and also by looking at the change over time, we can detect that as countries spend more money on health, the life expectancy of the population increases.

Based on the European Commission DG ECFIN note (European Commission (2015) and Przywara, B. (2010).we can conclude that ageing-related expenditure is projected to increase by 1.8% of GDP. Non-demographic factors are estimated to be the main drivers of health spending. Demand for health care is likely to increase with higher economic prosperity, as a better standard of living changes people's attitudes to their health. Since advances and improvements in medical technology, techniques and pharmacology are critical factors in delivering quality care, but also they are increasingly expensive. With a focus on high-cost products, medicine and technology are a major factor in driving health system expenditure. During the recent financial and economic crisis, GDP and public expenditures declined more in Latvia than in any other EU member state. Based on fiscal constraints significant spending cuts were made in the health care sector and public spending on health as a share of GDP dropped from 4.3% of GDP in 2007 to approx. 3.4% in 2012 (Taube et al., 2014). The proportion of the population reporting an unmet medical need because of costs doubled during the financial crisis, reaching more than 14% in 2011 before reducing to just above 10% in 2014. (Eurostat, 2018) Furthermore, essential inequities exist in Latvia as the proportion of the population with unmet medical needs (not only because of costs) is much higher in the poorest income quintile (29%) than in the wealthiest income quintile (10%). (Eurostat, 2018). In Latvian Stability program for 2016, Latvia requested a temporary deviation of 0.5% of gross domestic product from the required for the medium-term budgetary objective to implement structural reforms in health care with a positive impact on the long-term sustainability of public finances, based on the Public Health Guidelines 2014-2020. This solution solved short-term accessibility problems as well as provided additional financing for the health care system.

3 The future reform projections

Solving long-term financing structure issues there is the possibility to increase financing from general tax revenues or from earmarked revenues (e.g. mandatory social insurance). Under the pressure of the economic crisis, the most essential arguments at that time were that linking health services to the payment of tax would contribute to the increasing of tax revenues and that excluding Latvians who emigrated abroad (and consequently did not pay tax) from the receiving health services

at home would improve service availability for residents in Latvia. The discussion around the proposed financing reform illustrates that the concept of compulsory or social health insurance remains attractive – especially in condition of insufficient general budget revenue, it shows that a change from National Health Service to Social Health Insurer does not imply major institutional reforms, and it demonstrates the potential problems of introducing earmarked social health insurance, i.e. of linking entitlement to health services to the payment of contributions.

The Latvian parliament passed the Healthcare Financing Law in December 2017 and it will fundamentally change the principles of the national healthcare financing system. The aim is to convert the current system from general tax revenue funded National Health Service (NHS) system into a Compulsory Health Insurance (CHI) system by linking entitlement to health services to the payment of income-related mandatory social insurance contributions. The main aim of the Law is to ensure sustainable financing and raise revenues for health care system, to ensure solidarity in the system and linking entitlement to health services with the payment of social insurance contributions or special payment from persons, which are not covered by Social Health Insurance.

The Law would have major implications for the health system by modifying the modalities for the raising of revenues, by excluding the uninsured from comprehensive coverage, and possibly by compromising the effectiveness of the established primary care system. Reform does not require major institutional changes as the proposed system would be similar to health insurance systems in neighbouring Estonia and Lithuania.

Initially the Law stated that starting on 1st January of 2019 state-funded health care services will be provided for persons who are covered by general social insurance (employees and self-employed persons) who made social insurance mandatory contributions according to general provisions (social health insurance insured persons). However further on its implementation was postponed. According to the Law of 2017, two main changes should be implemented: (1) Earmarking a proportion of social insurance contribution revenues for health (1 percentage point). According to the estimation provided in the annotation to the law additional public funding raised by earmarked revenues will be 85 million Euros in 2018 and will increase gradually until 105 million Euros in 2020; and (2) linking eligibility to health services to the payment of state social insurance mandatory contributions. The underlying assumption is that making eligibility to healthcare services dependent on contribution payment will provide incentives to pay taxes, which would contribute to reducing the share of the shadow economy, and consequently lead to higher tax revenues. The estimation provided during discussions on the concept of the law by social partners (e.g. the Employers' Confederation of Latvia) shows approximately 300 thousand persons that are not paying social insurance contributions. This estimation includes persons who, according to the law "On state social insurance" are expected to pay state social insurance contributions or are paying state social insurance contributions under special conditions (microenterprises, patent payments, royalties). However, authors don't have any detailed break-down for these sub-groups at this time.

Eligibility for a full set of health care services would be also provided for "exempt" groups, including children under 18, retired or disabled people, registered in State employment agency unemployed persons and others.

For persons not covered by general social insurance regime or persons paying special microenterprise tax or patent fee eligibility of services is ensured if they make voluntary health contributions:

- In 2018 - 1% of minimum wage (430 EUR = 1% = 4.30);
- In 2019 – 3% of minimum wage amount;
- In 2020 and further – 5% of minimum wage amount.

It is also stated in the law that voluntary contributions should be paid for the current year of insurance and two previous calendar years (if contributions are not made).

Persons which are insured will be able to receive state-funded health care services (according to the regulations of Cabinet of Ministers) including family doctor (general practitioner) care, care provided by specialist doctors, diagnostic examinations, day care treatment, in-patient care (medical care in hospitals, observation beds, scheduled in-patient care, emergency medical assistance in outpatient hospital admission department), reimbursed pharmaceuticals and medical rehabilitation.

Currently, before the implementation of the Law the Latvian benefits basket is determined by a number of explicit inclusion and exclusion lists as well as by certain implicit criteria (Mitenbergs et al., 2012). On the one hand, explicit inclusion lists are the positive list of pharmaceuticals and a list of diagnostic, preventive and therapeutic interventions appended to the Regulation of the Cabinet of Ministers of Latvia No. 1529: "Regulations on organization and financing of healthcare." (hereinafter – the Regulation No.1529). Implicit criteria are the standard NHS contracts, e.g. with GPs, which broadly define that providers have to "ensure prevention, diagnostics and treatment of patients corresponding to the disease and normative legislation". On the other hand, the Regulations No. 1529 explicitly exclude certain services, such as dental care for adults, rehabilitation (with a long list of exceptions), medical check-ups required by occupational circumstances, sight correction and hearing aids (except for children), spa treatment, abortions (if there are no medical or social indications) and others. Furthermore, the terms of the contracts between the NHS and providers determine that children, pregnant women and people with urgent medical care are priorities for resource allocation, exposing other patients to substantial waiting lists for non-prioritized services, up to a point where they are implicitly excluded. In general, a referral from a family doctor is required in order for care or diagnostic examination from a specialist or hospital to be covered by the NHS (except for urgent cases). If patients do not have a referral, e.g. because they wish to avoid waiting times, all costs have to be covered out-of-pocket or through Voluntary health insurance (VHI).

Narrowly defined package of basic healthcare services would continue to be available to the entire population in order to ensure conformity with the constitution. Citizens of Latvia, non-citizens of Latvia, foreigners with permanent residence permits, stateless persons with temporary residence permits, refugees, persons granted alternative status would receive family doctors care (general practitioner's care), pregnancy and maternity care, emergency care and elective care plus reimbursed pharmaceuticals for selected patient groups (e.g. psychiatric, HIV, tuberculosis and cancer patients) and conditions (diseases with significant impact on public health or which pose a risk to public health).

The Law does not propose significant institutional changes to the health system, i.e. the pooling of resources by a single institution and the purchasing of care from independent providers would be retained. Funding would continue to flow from the state budget to the NHS, and care would continue to be purchased by the NHS with its regional branch offices. Cabinet of Ministers also will establish tariffs (prices) for state-provided services. Started in 2018 reform could be summarised as follows (Tab.1):

Table 1: Features of proposed Latvian health financing system

Dimension	Expected benefits	Potential problems
Public health budget	Earmarked revenues will lead to the growth of the public health budget and greater	There are no specific binding expenditure targets in the law. The assumption that an insurance system with earmarked revenues for health through payroll

	sustainability of the healthcare financing system	contributions offers more stable revenue for health is not supported by evidence.
Effect of earmarking	Linking eligibility to payment of contributions will provide an incentive to pay taxes, leading to a reduction of the shadow economy and higher tax revenues	It is unlikely that motivation to pay taxes would increase if earmarking is in place. Workers in the informal economy could choose to remain uninsured or to pay voluntary premiums, which—at current premium levels—would be more attractive than paying social insurance contributions and personal income tax.
Access to care	More public resources for health will lead to improved access to healthcare services (for those covered by insurance)	Universal coverage will be compromised: an estimated 300,000 people would be excluded from the public healthcare system (beyond basic healthcare services). There is also a risk of being excluded from the system despite eligibility for exemption. This could lead to delays in receiving services only after appeal.
Equity	Improved equity because tax evasion will be reduced, making everybody contribute to health according to the ability to pay	General tax financing has a greater potential to achieve equity in financing – the rich contribute with a greater share of their income than the poor.
Efficiency	Improved efficiency	Undermining the established primary care system and potentially contributing to less efficient patterns of service provision. Additional costs associated with the implementation of the reform.

Current Law and the annotation does not include any estimates of the cost of the proposed model and long-term impact on the health status of the population; though a major difficulty in completing such a costing analysis is the lack of detail about how the proposed model would operate in practice, including what basket of services would be financed through NHS in 2019. Also there is no assessment of the impact on tax evasion and increase of contributions.

At the beginning of the 2019 year, Parliament adopted a final reading of a law to postpone the division of health services in two baskets by July 1. This was due to the fact that healthcare authorities did not actually have the possibility to verify the extent of individuals' rights to state-paid healthcare services, as the system was not fully prepared for the task to be carried out, the draft law was indicated at the time.

In June 2019 Latvian Parliament (Saeima) accepted amendments to the Health Care Finance Law to postpone the so-called two-service basket state health insurance system by 2021, which was originally scheduled to be introduced from the 2019 year.

The proposal by the Minister for Health, Ilze Vinkele, was also supported, providing that persons who are not insured under the law are not required to pay voluntary contributions. Amendments have also been accepted to ensure automatic reimbursement for people who have already made contributions. At the moment health insurance is introduced for all who earn income from employment and self-employment will pay the social security contribution to health at 1% of the social security contributions paid from the minimum wage. As the minimum wage increases, the payment will also increase accordingly, the minister added. As accepted in amendments to the law at the beginning of the year, individuals who will not be covered by the insurance scheme will have to make a health insurance payment of EUR 51, explained the minister. Similarly, as in the case of the real estate tax, they will be notified that this amount should be paid by a certain time, but people who have not made this contribution will be able to receive national health services at the time of need. It is currently envisaged that if a person has not made a compulsory contribution but will be in a situation where state-paid healthcare is required, he will be provided with a reminder that the payment has to be made. Regulations foresee that non-insurance contributions will accrue as debt, but this will not prevent a person from having access to health services.

4 Conclusions and suggestions for further research

The Latvian Health Care Financing Law is meant to restore the operation of the compulsory health insurance system (SHI-Social Health Insurance) system, incorporating the opportunity for users to join the SHI system or to use only baseline health care basket which could affect those residents of Latvia for whom the state compulsory insurance contributions have not been paid and who are not members of the group secured by State.

In order to increase financial protection, financing of the healthcare system should be sharply increased. However, the proposed new law does not solve this problem, since, according to the proposed system, every inhabitant would be insured with the same basic healthcare packages and supplementary packages in certain circumstances, but the unmet needs are significantly higher than the additional funding available in 2018-2020. Although the Latvian Health Care Financing Law has the principle of receiving health care in accordance with SHI, general taxes will remain the main source of revenue for financing the health care system in the coming years. To date, there have been only a few studies which identify issues that could arise if the Dutch health system will be introduced in Latvia (Krasnopjorov and Wilerts, 2016). An analysis of the implementation of budgetary policies in the health sector gives the evidence that also in the future the health financing should be considered in the context of a reform of the whole health care system which should be viewed through the prism of interfering factor for the introduction of UHC and the achievement of SDGs target.

Out-of-pocket (OOP) payments, including informal payments to health care providers in Latvia, have been the highest in the EU and OECD countries until now. In Latvia, financial support within the family has traditionally been preserved, including covering the need for out-of-pocket (OOP) payments (in case of sickness), as there is a very low level of trust to the health care system.

Main suggestions for future research and policy decisions are to define minimum state-funded medical assistance guaranteed by the Latvian Constitution (Satversme) for anyone. To assure provisions of health care - access to publicly funded health care services for all residents of Latvia. Based on tax residency as criteria for health insurance continue realization of health insurance through general state social insurance mandatory contributions. Changes in state compulsory health insurance realized at the same time as changes in the tax system, considering an increase of funding of health care through general taxation revenues (e.g. value added tax) and introduction of health care related taxation (e.g. taxes on unhealthy products and

excises on tobacco). Increase in public financing should be accompanied by a reduction of OOP considering abolishment of co-payments for pensioners, people with chronic conditions or the introduction of the cap on co-payments to €100. This paper seeks to contribute to the debate, and the way for future researches is not only how to obtain money for health care but also ensure optimal financing source structure.

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