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Healthcare financing reform in Latvia: Switching from social health insurance to NHS and back?☆

Uldis Mitenbergs^{a,*}, Girts Brigis^a, Wilm Quentin^{b,c}^a Riga Stradins University, Department of Public Health and Epidemiology, Latvia^b Department of Health Care Management, Technische Universität Berlin, 10623 Berlin, Germany^c European Observatory on Health Systems and Policies, Brussels, Belgium

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ABSTRACT

In the 1990s, Latvia aimed at introducing Social Health Insurance (SHI) but later changed to a National Health Service (NHS) type system. The NHS is financed from general taxation, provides coverage to the entire population, and pays for a basic service package purchased from independent public and private providers. In November 2013, the Cabinet of Ministers passed a draft Healthcare Financing Law, aiming at increasing public expenditures on health by introducing Compulsory Health Insurance (CHI) and linking entitlement to health services to the payment of income tax. Opponents of the reform argue that linking entitlement to health services to the payment of income tax does not have the potential to increase public expenditures on health but that it can contribute to compromising universal coverage and access to health services of certain population groups. In view of strong opposition, it is unlikely that the law will be adopted before parliamentary elections in October 2014. Nevertheless, the discussion around the law is interesting because of three main reasons: (1) it can illustrate why the concept of SHI remains attractive – not only for Latvia but also for other countries, (2) it shows that a change from NHS to SHI does not imply major institutional reforms, and (3) it demonstrates the potential problems of introducing SHI, i.e. of linking entitlement to health services to the payment of contributions.

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1. Introduction

The Latvian government passed a draft Healthcare Financing Law in November 2013 [5]. If this law is ultimately adopted by parliament, it will fundamentally change the principles of the national healthcare financing system. The aim is to convert the current tax 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 contributions. The reform 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 [16].

However, the reform would not require major institutional changes as the proposed system would be similar to health insurance systems in neighbouring Estonia and Lithuania ([24]). In these countries and in several other central and eastern European countries ([9,25]), reforms since the early 1990s have led to one national insurance fund, which pools revenues from income tax with other government contributions and purchases care from

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* Corresponding author. Tel.: +371 29464223.

E-mail addresses: umitenbergs@gmail.com, uldis.mitenbergs@aya.yale.edu (U. Mitenbergs).

independent public and private providers. Therefore, social health insurance (SHI) systems in these countries share many institutional characteristics with the Latvian NHS system. Consequently, the distinction between NHS and SHI has become less relevant for describing institutional characteristics of healthcare systems internationally than it was in the past [7].

The discussion around the proposed Healthcare Financing Law in Latvia is interesting because of three main reasons: (1) it can illustrate why the concept of compulsory or social health insurance remains attractive – not only for Latvia but also for other countries; (2) it shows that a change from NHS to SHI does not imply major institutional reforms, and (3) it demonstrates the potential problems of introducing SHI, i.e. of linking entitlement to health services to the payment of contributions. Therefore, the purpose of the paper is to describe the context of the current reform proposal and to discuss the expected benefits and potential problems as put forward by proponents and opponents of the reform.

The next section briefly describes the history and the functioning of the Latvian health system, before Section 3 looks at the political and economic context of the reform. Section 4 then presents the rationale and the content of the draft Healthcare Financing Law. Subsequently, the positions of different stakeholders are discussed in Section 5 together with the potential problems put forward by the opponents of the law. Finally, Section 6 concludes with a brief assessment of the reform and provides an outlook for the likelihood of the reform to be implemented in the near future.

2. The Latvian health system

The move towards Compulsory Health Insurance has to be viewed in the context of almost 25 years of reforms, which radically transformed the Latvian health system after independence of the country in 1991. Similar as in Estonia and Lithuania ([24]) and, in fact, as in most central and eastern European countries ([25]), Latvia aimed to create a decentralized SHI system with multiple funds in the early 1990s.

The reasons for this shift towards SHI included a desire to return to pre-Soviet institutions, to limit the influence of politicians over the health system, and to create more stable and independent revenue streams for the healthcare sector ([18,25]).

Subsequently, because of apparent problems with decentralized planning and financing, a recentralization process was initiated. This first 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 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 [14]. 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.

The Latvian health system provides coverage to the entire population (Latvians and non-Latvian residents) and pays for a basic services package, which is guaranteed by the constitution. The NHS receives its resources from general tax revenues and purchases care from independent public and private providers [14]. Most hospitals are publicly owned, 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 GP of their choice (and more than 96% do so) who will then act as a gatekeeper. After referral, patients can freely choose a specialist care provider, although actual choice is often limited – in particular in rural areas – and waiting lists are substantial.

One of the most important problems is that the system is severely underfunded: total health expenditure in 2012 was only US\$1188 PPP per capita (corresponding to 6% of GDP), which was the third lowest amount spent on health in the EU [23]. Furthermore, only about 57% (2012) of total spending came from public sources—a share, which is lower only in Bulgaria and Cyprus. Insufficient public funding means that patients are exposed to substantial user charges and direct payments, in particular for pharmaceuticals [14]. Out-of-pocket (OOP) payments account for 37% of total health expenditures, one of the highest rates in the EU (behind only Bulgaria and Cyprus).

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 2012 [6]. In Estonia, Lithuania, and Slovenia less than 1% of the population report an unmet medical need because of costs, and the proportion is below 3% on average in the EU. Furthermore, important 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 richest income quintile (10%).

3. Economic and political context of the reform

During the recent financial and economic crisis, GDP dropped more strongly in Latvia than in any other EU member state, declining by almost 18% in 2009 [22]. As part of the Economic Stabilization and Growth Revival Programme, significant spending cuts were made in the health care sector [1]. The Ministry of Health's budget dropped by 12.6% in 2009 (to LVL 503.7 million) [12]. Salaries of all health workers were cut on average by 20% ([24]), and patients' co-payments were raised significantly [14]. Public spending on health as a share of GDP dropped from 4.3% of GDP in 2007 to about 3.4% in 2012 [23].

Following parliamentary elections in 2011, a new coalition government consisting of two centre-right parties (Zatlers' Reform Party and Unity) and one right-wing party (National Alliance) took office. Members of Unity (or more precisely of a predecessor party) had strongly supported the idea of returning to SHI already under the previous

government (2009 until 2011). Under the impression of the economic crisis, the most important arguments at the time were that linking health services to the payment of income tax would contribute to increasing income tax revenues and that excluding Latvians who emigrated abroad (and consequently did not pay income tax) from receiving health services at home would improve service availability for residents in Latvia. In 2009, a working group was established to assess the feasibility and benefits of introducing SHI [2] but the resulting report did not support a change of the financing system [11].

Nevertheless, when Dr Ingrida Circene from Unity was appointed Minister of Health in 2011, the idea of introducing compulsory health insurance re-emerged. The government included the introduction of compulsory healthcare insurance in its action plan, principally arguing with the aim of increasing public spending for health [3]. In May 2013, the Cabinet of Ministers formally supported the introduction of compulsory healthcare insurance [4], and a draft “Healthcare Financing Law” was passed by the Cabinet of Ministers in November 2013 [5]. The law was originally scheduled to be enacted in July 2014. However, by September 2014 it had not yet passed the second (of three) readings in parliament because of strong opposition from multiple stakeholders (see Section 5).

4. The proposed Healthcare Financing Law and its expected benefits

The main aim of the draft Healthcare Financing Law is to overcome the lack of public resources for health, to ensure financial sustainability, and to improve access of the population to health services. Specifically, expenditures are to be increased by 0.25% of GDP per year in order to reach 4.5% of GDP by 2020 [16]. The benefits of such increased spending are explicitly mentioned (see Table 1): more rehabilitation services, improved access to pharmaceuticals, reduced cost sharing, and increased salaries of healthcare professionals.

The draft law suggests that raising more resources for health could be achieved through the introduction of “Compulsory Health Insurance”. According to the law, two main changes would have to be implemented: (1) Earmarking a proportion of income tax revenues for health; and (2) linking eligibility to health services to the payment of income tax or contributions. The underlying assumption is that making eligibility to healthcare services dependent on income tax 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.

As a result of the reform, the composition of the NHS budget would change (Fig. 1). In 2014 (pre-reform), the budget is entirely based on general tax revenues, thus including resources collected through different forms of taxes. From 2015 onwards (post-reform), the CHI budget would consist of three parts: (1) an earmarked “State Compulsory Health Insurance Payment”, which would be equal to the central government’s share of income tax (i.e. currently 20%) (the remaining 80% of income tax revenues are currently allocated to municipalities). (2) Other allocations from general tax revenues, which would still account for

the majority of CHI resources, i.e. an estimated 63% in 2015. (3) Voluntary insurance contributions from people who do not pay income tax, which would, however, contribute only a very small proportion to overall CHI revenues. Growth of the CHI budget from 2015 to 2016 is expected to come mainly through a growth of the central government’s budget allocation (Fig. 1).

Eligibility to the full set of healthcare services currently available in the NHS would be limited to three categories of the population:

1. Payers of income tax who have paid taxes for at least 11 months during the calendar year or who have an annual taxable income above the minimal monthly salary (€320 in 2014) times twelve.
2. Exempt groups, including children under 18, retired or disabled people, registered unemployed, full time students between age 18 and 30, people receiving social benefits and others.
3. Payers of regular voluntary insurance premiums (€28 per month) or those who make a one-time payment of three times the minimum wage at the time of needing healthcare and subsequently continue to pay regular premiums. It has been estimated that this group would consist of only about 7250 people (an estimated 5% of the 145,000 Latvian residents who do not pay income tax and who do not belong to any of the exempt categories) [16].

Nevertheless, a narrowly defined package of basic healthcare services would continue to be available to the entire population in order to ensure conformity with the constitution. This would include emergency care and all reimbursed pharmaceuticals, plus elective care for selected patient groups (e.g. diabetics, psychiatric and cancer patients) and conditions (e.g. pregnant women).

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. Money 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.

5. Stakeholder positions and potential problems of the reform

The Minister of Health was strongly supportive of the draft Healthcare Financing Law. She believed that there was no political and public support for increasing the share of the government budget for health, and that introducing insurance was the only option available for increasing public expenditures on health [21]. In addition, the Ministry argues that the current way of financing is unfair because tax payers have to cover the costs of services consumed by others [16].

However, there is no uniform support of the draft Law even among Unity party members, with the Ministry of Finance being opposed to the idea of earmarking income tax for health. In fact, “differences in opinions”, including those related to the draft Law, and “lack of constructive

Table 1

Healthcare spending and provision: 2011 compared with targets for 2016 and 2020.

	2011	2016	2020
Central government healthcare budget as a percentage of GDP ^a	3.4%	3.7%	4.5%
Share of general government spending as a percentage of THE	59%	64%	68%
Share of private spending (OOP and VHI) as a percentage of THE	41%	36%	32%
Volume of publicly financed rehabilitation services			
Children	1417	9239	19,739
Growth	n/a	552%	114%
Adults	1438	22,166	154,896
Growth	n/a	1441%	599%
Number of patients receiving reimbursed pharmaceuticals	524,282	581,927	661,927
Growth	n/a	11%	14%
Cost-sharing			
Patient fee (co-payment) per day for in-patient stay (starting from the second day) ^b	12.81	6.40	6.40
Co-payment for inpatient surgical interventions	42.69	21.34	21.34
Share of publicly financed outpatient specialist visits	35%	49%	74%
Salary ratio versus average salary			
Physicians	1.18	1.58	2.18
Nurses	0.71	0.95	1.31
Nurse assistants	0.47	0.63	0.87

Source: [4,16].

^a 2011 data is based on WHO Regional Office for Europe (2014) and refers to all public expenditure on health (not only from the central government).^b According to the Draft concept of healthcare system financing model – the actual patient fee per day for in-patient stay was 13.52 EUR in 2011 (Cabinet of Ministers. Regulations Nr. 1046. Available at: <http://likumi.lv/doc.php?id=150766#piel1>).

cooperation” led to the resignation of the Minister of Health on July 7, 2014 [13]. Among the supporters of the draft Law is The Latvian Umbrella Body for Disability Organizations (SUSTENTO). SUSTENTO’s support is related to the aim of increasing public expenditures for health; and the organization supports the idea of introducing compulsory health insurance ([26]).

Opposition to the proposed law comes from municipalities, from the Ombudsman of the Republic of Latvia [17], and from professional organizations of physicians. Municipalities are mostly concerned about losing some part of their share of income tax. Other criticism is related to four main problems, which were also highlighted during a consultative meeting held by experts of the World Health Organization upon request of the Ministry of Health (the results of which were leaked to mass media) [21]:

- First, it is questionable if the reform would lead to increased public expenditures on health and sustainability of financing. As is evident from Fig. 1, the size of the total public healthcare budget would depend largely on the size of the general state’s budget allocation. There are no binding expenditure targets in the draft law [16]. The healthcare budget would continue to depend on political negotiations in parliament.
- Second, it is unlikely that the willingness to pay income tax would increase as a result of the reform. Despite its name, the compulsory health insurance would be voluntary for those working in the informal economy. As a result, 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 income tax.

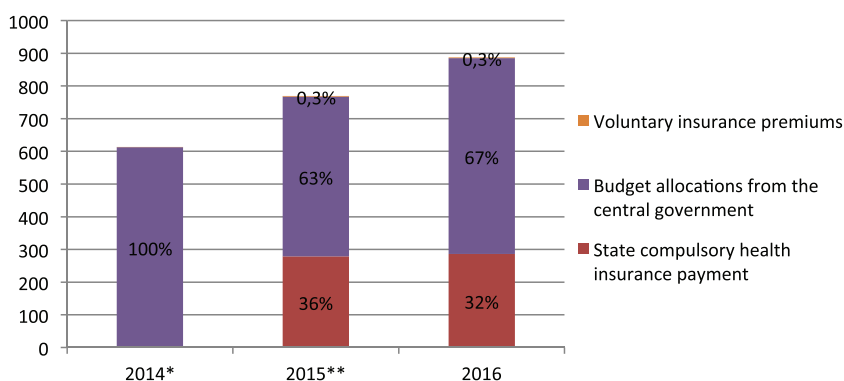


Fig. 1. Budget (in million EUR) for provision of healthcare in 2014* and projected composition of the Compulsory Health Insurance budget 2015–2016. *According to the draft Law, some voluntary insurance premiums would be collected in 2014: those joining the system voluntarily must start payments of insurance premiums as of July 2014 in order to be eligible for public healthcare services as of July 2015. **Based on planned budget for July–December 2015, adjusted to annual budget. Note: The budget for provision of healthcare in 2014 includes a small amount of income from paid services and other income; the final approved budget for provision of healthcare in 2014 was 609.9 million Euros, which included 608.8 million budget allocation from the central government and 1.1 million Euros from paid services and other income [10]. Source: [16].

- Third, the reform would compromise universal coverage: an estimated 137,000 people [16] would be left out of the public healthcare system (beyond basic healthcare services). This would include vulnerable people with irregular or low income if they do not fall into any of the exempted categories and are unable or unwilling to pay voluntary premiums.
- Fourth, the reform would lead to considerable additional administrative burden: verification of insurance status, administering the collection of voluntary contributions, ensuring access for exempted population groups, raising awareness of the need to obtain healthcare insurance – sufficient resources for these tasks would have to be made available in order to ensure proper transition to an insurance system.
- Fifth, the reform could undermine the established primary care system. People excluded from coverage and unable to pay for timely primary or secondary ambulatory care, would still be eligible to receive emergency care at hospitals. This could lead to an increased use of emergency services in hospitals, potentially contributing to less efficient patterns of service provision.

For physicians, lack of access to care for uninsured is the most important argument against the reform. However, speculations about more palpable financial reasons also exist: GPs might lose some of their capitation payments, if the reform was implemented because they currently receive payment for registered emigrants who never use their services.

Only relatively little attention has been paid to implications of the reform for progressivity of financing. This is because the reform is not expected to have a significant impact on how the system is financed: it will continue to be financed mainly through taxes (an earmarked proportion of income tax plus general taxation). It is difficult to predict the effect of voluntary contributions on progressivity. If they contribute to raising revenues from people with good incomes in the informal economy, they may, in fact, increase fairness. However, if they place a disproportionate burden on low income households, they will be unfair.

6. Conclusions: assessment of and outlook for the reform

Table 2 summarizes the expected benefits of the proposed Healthcare Financing Law and the potential problems put forward by opponents of the reform. Both, the expected benefits and the potential problems mirror those discussed for other countries [8,19]. Governments contemplating the introduction of SHI mostly do so based on arguments that it would improve the ability of raising revenues for health, making healthcare financing more predictable (independent of political interference), and that people would be more willing to contribute if eligibility for healthcare services is linked to making contributions [19]. However, it is clear that the healthcare budget could also be increased independently of whether income tax is earmarked for health or not, and that linking healthcare entitlement to the payment of contributions will create access problems for the uninsured [20]. In addition,

Table 2

Expected benefits and potential problems of the Healthcare Financing Reform Law.

Dimension	Expected benefits ^a	Potential problems
Public health budget	Earmarked revenues will lead to growth of the public health budget and greater sustainability of the healthcare financing system	There are no specific binding expenditure targets in the draft law [16]. The assumption that an insurance system with earmarked revenues for health through payroll contributions offers more stable revenue for health is not supported by evidence [9].
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 chose to remain uninsured or to pay voluntary premiums, which—at current premium levels—would be more attractive than paying income tax [21].
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 137,000 people [16] 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 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 [21].
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 [16].
Health status	Improved health status because more public resources allow to provide more health services	Deterioration of health status due to worsening of access.

^a Based on [4].

the administrative burden of collecting contributions and running a comprehensive exemption system can be substantial.

The development of the Latvian healthcare system since 2002 shows that switching between SHI and NHS is not related to large institutional reforms. Pooling of resources and purchasing of care are carried out by one national

institution under relatively tight control of the government, independent of whether the institution carries the word insurance in its name. Therefore, the concepts of NHS and SHI are unable to adequately describe institutional characteristics of a health system [7]. Nevertheless, as illustrated in Table 2, the regulatory change of linking entitlement to healthcare services to the payment of contributions can imply significant changes to the functioning of the health system, which can have potential benefits but may also create important problems.

Despite being accepted in a first reading in Parliament at the end of 2013, it is unlikely that the draft Healthcare Financing Law will be enacted in its current form. In response to considerable opposition from stakeholders, Parliament's Budget and Finance Commission decided in March 2014 to establish a working group to prepare the second reading of the draft Healthcare Financing Law. Yet, by September 2014, a second reading for the law had not been scheduled. Minister of Health Ingrida Circene was one of the most important supporters, pushing for the law to be enacted. However, as mentioned above, she resigned in July 2014 because of lack of support from the government coalition [15]. Her resignation makes it even more unlikely that the law will be passed by Parliament prior to the upcoming elections in October 2014. It is unclear whether the introduction of compulsory health insurance will become a point on the agenda of a future government. While multiple stakeholders are strongly opposed to the idea, the apparent lack of public financing for health and the support from certain (right-wing) politicians, might bring the topic onto the agenda once again.

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