WHO notes on health system financing policy in Latvia: opportunities and challenges in light of international experience

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Introduction

The Minister of Health of Latvia requested a consultation with WHO experts on current health financing policy challenges and options for reform in light of international experience and relevance to country context. In response to this request, the WHO Barcelona Office for Health Systems Strengthening, Division of Health Systems and Public Health, with the support of the European Observatory on Health Systems and Policies invited a delegation of the Ministry of Health and Ministry of Finance for a consultative meeting on the reform proposals and share relevant experience across Europe.

Over the past years, the WHO provided comments on the planned introduction of Compulsory Health Insurance in Latvia. One of the key messages of these reports was that there was no compelling argument in favor of the introduction of a wage-based (payroll tax based) compulsory health insurance system in Latvia especially during and soon after the financial crisis when economic policy favored a reduced tax burden on employment. However, the reports also highlighted that there may be political reasons for a reform that links entitlements to contributions (i.e. introduce social health insurance), but this should then be introduced in a way that minimizes the risk of reducing access to health care and maintains general taxation as the main source of revenues with a small percent of the total coming from individual health insurance contributions.

In 2012, the WHO provided a ‘Ten-point proposal for consideration’ regarding health financing policy in the context of the planned introduction of compulsory health insurance. These recommendations are still valid in case the government decides to go ahead with the implementation of compulsory health insurance that has been delayed since 2012. Even if the Government decided to take a different path to health financing reform, the generic recommendations about the level of public expenditure on health and the need to improve financial protection against the cost of ill health continue to hold true and this report provides further evidence to support those recommendations.
During the financial crisis, the Latvian Government made major steps in the right direction by mitigating adverse effects of the severe financial crisis and by exploring potential efficiency gains. It has been acknowledged that Latvia had no choice but to cut public expenditure when the crisis hit the country. Therefore, Latvia focused on how to make best use of available resources by introducing measures that gave relative priority to primary care, coverage of essential medicines and outpatient specialist services while reducing hospital capacity which was far above the EU average and comparator countries. The World Bank funded Social Safety Net Strategy provided additional protection and better targeting of public resources to the poor. These measures had the potential to improve efficiency, maintain solidarity and keep the policy focus on performance improvement in the health system.

After fiscal consolidation, the WHO recommended that the Government should give higher priority to health within the available fiscal space. International comparison suggests that the Latvian Government does have room to maneuver when we compare government budget spending on health as a share of total government spending. By giving greater relative priority to health within the existing government budget, Latvia could increase public spending on health and improve financial protection especially for the poorer segments of the population. Our recommendation was to allocate at least 12% of general government revenues to health, which is still below EU average, but comparable to Estonia and Lithuania. This would have allowed for a significant increase of public spending reaching close to 5% of GDP without introducing new taxes earmarked for health.

The plan to introduce compulsory health insurance back in 2012 had the promise of generating additional revenues for the health sector. While the plan to increase public spending on health was welcomed by WHO, the chosen instrument carried the risk of excluding non-contributing population groups from public coverage of health insurance. Latvia has universal population coverage and this achievement should be protected and further strengthened with improved financial protection and expanded scope of services covered by the publicly funded system. Our recommendations emphasized that it is possible to maintain universal population coverage even when compulsory health insurance is introduced, but this requires careful system design and strong political commitment. Without the commitment to increase public spending on health, the introduction of compulsory health insurance is unlikely to lead to improved performance of the health system and financial protection may further deteriorate.
Latvia needs to improve financial protection against the cost of ill health

Out-of-pocket payments for health in Latvia are among the highest in Europe – the third highest in the European Union – and have a strong negative effect on financial protection (the extent to which households face financial hardship when using health services). Financial protection is an important dimension of health system performance and a key indicator of universal health coverage, along with unmet need for health care.

Financial protection is weak in the Latvian health system. Financial hardship, as measured by the incidence of catastrophic and impoverishing out-of-pocket payments, is high compared to other countries. Recent analysis suggests a substantial share of the Latvian population faces financial hardship as a result of using health services. In 2013, around 13% of households experienced catastrophic out-of-pocket payments. This is high when compared to other countries in Europe, as Figure 1 shows.

Figure 1 Incidence of catastrophic out-of-pocket payments in selected countries in Europe, 2013 or closest available year

Source: WHO Barcelona Office for Health Systems Strengthening 2016
Financial hardship is heavily concentrated among poor households and pensioners and is largely driven by out-of-pocket payments for outpatient medicines. Catastrophic out-of-pocket payments are experienced by people of all incomes, but are heavily concentrated among poorer people. In 2013, nearly 27% of the poorest fifth of households experienced catastrophic out-of-pocket payments, compared to 4% of the richest fifth (Figure 2). Close to 70% of people with catastrophic out-of-pocket payments are pensioners. Out-of-pocket payments for outpatient medicines and medical products are the single largest cause of financial hardship, accounting for 75% of catastrophic out-of-pocket payments on average in 2013, and rising to over 80% of catastrophic out-of-pocket payments among the poorest half of the population (Figure 3).

**Figure 2 Breakdown of households with catastrophic OOPs by quintile**

![Figure 2](image)

Source: WHO Barcelona Office for Health Systems Strengthening 2016

**Figure 3 Breakdown of catastrophic OOPs by type of health service and quintile**

![Figure 3](image)

Source: WHO Barcelona Office for Health Systems Strengthening 2016
The high incidence of financial hardship in Latvia reflects low public spending on health and weaknesses in the design of co-payment policy, especially co-payment policy for outpatient medicines. Co-payments apply to almost all health services, including most prescribed outpatient medicines. Only very poor households (those earning less than €128 per person per month) are exempt from co-payments for medicines. Even though some low-income households (those earning between €171 and €213 per person per month) paid reduced co-payments for many health services in 2010 and 2011, they were required to pay the full out-of-pocket cost for medicines during that time.

Pensioners are in particular at risk of facing financial hardship due to ill health. Pensioners, who account for 70% of people with catastrophic out-of-pocket payments, must also pay all co-payments unless their income falls below €128 per person per month. Although there is a cap (ceiling) on co-payments for inpatient, outpatient and diagnostic services, it is set at a very high level: €356 per hospitalization and €569 per person a year overall. There is no cap on out-of-pocket payments arising from co-payments for medicines.

Out-of-pocket payments for outpatient medicines seriously undermine financial protection in Latvia and may also be an important driver of unmet need. Policy attention should focus on improving access to and the affordability of needed outpatient medicines as a priority. Policy measures to achieve this include:

- introducing additional exemptions from co-payments for prescribed medicines for poor households and people with chronic conditions who currently must pay out-of-pocket
- including out-of-pocket payments for medicines as part of the annual cap on co-payments
- significantly lowering the annual cap on co-payments, so that people do not incur catastrophic out-of-pocket payments before reaching it, or setting it as a proportion of household income rather than as a fixed amount
- ensuring all aspects of co-payment policy design are in line with evidence and international experience
- efforts to lower medicine prices and promote rational prescribing, dispensing and use of medicines and other health services.
Latvia needs to increase public spending on health in order to improve financial protection and equity in access to services

Latvia has one of the lowest levels of government spending on health in Europe. The latest confirmed health accounts data suggest that Latvia’s public expenditure on health was 3.7% of its GDP in 2014. Current estimates provided by the Ministry of Health suggest that this figure has decreased further in 2015. This is very similar to what the country spent as a share of GDP in 2005. The average figure for EU countries was 5.9% of GDP in 2005 and 6.4% of GDP in 2014. If we compare Latvia to countries at a similar level of economic development, the gap is still significant between 0.6-2.3 percentage points (Figures 4 and 5).

Figure 4 Public expenditure on health as a percentage of GDP across the WHO European Region (2013)

Source: WHO database, 2015
The Latvian Government gives very low priority to health measured by the share of government revenues allocated to health. The Latvian Government spent 9.8% of its budget on health in 2013 (Figure 6). In contrast, in the same year Lithuania and Estonia spent around 12% of total government expenditure on health, Croatia close to 13% and Slovakia 15%. If the Latvian Government allocated a modest 12% of its government budget to health, its public expenditure on health as a share of GDP would be more than 4%, which is higher than what the current government set as a target to achieve by 2020. WHO encourages the Latvian Government to reconsider its target expenditure on health as a share of GDP and aim for a comparatively modest 5% of GDP by 2020 to reduce the gap between current spending and the trend line shown on Figure 5. This would allow for a significant improvement in financial protection if coupled with pro-poor policies.
Figure 6 Share of health spending within government budget in countries of the WHO European Region with averages for income groups and selected comparator countries highlighted

Giving higher priority to health could fill much of the gap between Latvia and comparator countries within and outside the European Union. In light of historical trends and recent developments this increase of health expenditure seems to be unlikely to happen without a paradigm shift in public policy priorities and the health sector in particular. As the country recovered from the financial crisis and a modest GDP growth has been realized in recent years, the health sector continues to lose out in budget allocations and recent reforms aiming at efficiency improvements in the health sector did not lead to a higher level of political support in the form of increased public expenditure on health. WHO recommends a minimum of 12% of the government budget allocation to the health sector for countries of the WHO European Region. Only a few high-income countries are below this threshold (Figure 7). A more ambitious target of 14% would allow reaching 5% public spending on health as a share of GDP without increasing the size of the government through additional taxes. Figure 8 provides data on how OECD countries allowed the health sector to gain a greater share of government spending over time at the expense of other sectors except for social protection (including pensions). This reflects priorities to pro-poor policies and ensuring access to health services at the same time in OECD countries.
Figure 7 Health sector’s share of government budget in the WHO European Region ranked in groups of high-, upper-middle- and lower-middle-income countries

Priority to health in public spending: a political choice

Health as a share (%) of the government budget in the European region high-, upper-middle- and lower-middle-income countries

Minimum 12%

Source: WHO data for 2013

Figure 8 Change in the structure of general government expenditures on average in OECD countries by function (2001 to 2011)

Source: OECD National Accounts Statistics, 2014
The level of public spending on health as a percentage of GDP depends on the share of health within government spending and the overall size of the government budget. Latvia has a comparatively small size of government sector as a result of a political choice on taxation policy. The current level of public expenditure on health provides poor financial protection to the population and international evidence suggests that it is unlikely to achieve major progress towards universal health coverage without increasing public spending on health to around 5% of the GDP. This may be achieved by increasing share of government budget allocated to health to 14% or by a combination of increasing priority to health to 12% and increasing the size of government to 42% of the GDP (Figure 9). Comparative analysis of health expenditure in Europe suggests that both options are feasible for Latvia and primarily depend on political choice rather than choice of the instrument for collecting revenues for health.

**Figure 9** Public spending on health depends on fiscal context and priority to health: alternative scenarios for increasing public spending on health to 5 percent of GDP

**Accounting for public spending on health**

\[
\begin{align*}
\text{5%} & \quad \text{36-42%} \\
\text{Gov't health spending} & \quad \text{Total gov't spending} \\
\text{GDP} & \quad \text{GDP} \\
\text{Government health spending as share of the economy} & \quad \text{Fiscal context} \\
\text{Public policy priorities} & \quad \text{Public policy priorities}
\end{align*}
\]

**Health outcomes could be significantly improved by increasing health spending and improving services.** Latvia does not perform well in international comparison when we look at mortality amenable to the performance of the health system itself. Relevant comparator countries at similar level of economic development have significantly better health outcomes. Latvia has a great potential to improve health outcomes in a cost-effective manner which in this case means better health outcomes at higher, but still below average level of health spending in international comparison (Figure 10).
Latvia considers the introduction of compulsory health insurance: high risk of fragmentation of the benefit package

The Latvian Government has been considering the introduction of compulsory health insurance, but this option may exclude some population groups from public coverage. The current system of financing falls short in meeting the health needs of the population and according to the assessment of the Ministry of Health there has been no political support for increasing priority for health in the form of higher share of government budget to be allocated to health. As a result, out-of-pocket payment continues to be very high and waiting times are increasing, which further increase dissatisfaction with the current system. Those who contribute to the system by paying their taxes do not feel that they get good quality health service in return, while the system provides access to publicly funded services for those who avoid paying taxes. This may undermine support for solidarity and reduce willingness-to-pay income tax, therefore the Government considered to link entitlement (to health benefits) to payment of health insurance contribution. In 2012, WHO provided comments on this proposal and the arguments against this approach still hold therefore we refer to the WHO notes from 2012. Here we only highlight one key concern that is related to providing health insurance coverage to the whole population: introducing a contributory health insurance system carries the risk of moving away from universal population coverage which is a stated priority in the Sustainable Development Goals by the United Nations as well as in relevant resolutions by the member states of the World Health Organization. In turn, our recommendation is to preserve universal population coverage even if health
insurance contribution payments are introduced in Latvia. This means that entitlements to publicly funded benefit package should continue to be based on residence instead of payment of health insurance contributions.

Even when universal population coverage is preserved, the introduction of health insurance contributions carries the risk of fragmentation of the publicly funded health system which leads to inefficiency. Current proposals include a scenario where universal coverage is maintained, but the benefit package would be split according to the source of financing i.e. a separate package funded by the state budget and another set of services funded by health insurance contributions. In this scenario where the state budget would only cover emergency medical assistance, inefficiency arise through shifting services between packages, delaying care seeking and provision until the use of emergency services are justified, lack of coordination between providers of care due to different streams of funding for services.

Diversification of the sources of revenue for the health system should not lead to a split benefit package or exclusion of non-contributing population groups. Latvia should maintain universal population coverage for publicly funded benefit package which is generous enough to ensure access to a wide range of services at all levels of care to cover all diseases regardless of payment of contribution.

Introduction of health insurance contributions should be viewed as a source of additional revenue for health which should be pooled together with state budget funding in a single purchaser of health services. A single purchaser of the full scope of services included in the same benefit package for all can ensure efficient use of resources and careful coordination of care across settings and over time for the whole population if appropriate policies are in place to incentivize good performance by providers and purchaser alike.

Introduction of health insurance contributions should not make anyone worse off compared to the current situation, but additional revenues gained can make people better off. Instead of thinking about excluding services or people from the state budget funded benefits, the Government should consider using the political opportunity of the introduction of health insurance contribution as an additional source of financing which can be used to improve financial protection for the population. Currently, patients face large amounts of out-of-pocket expenditure due to ill health. Latvia should improve coverage of the cost of health services and reduce co-payments required at the point of use of these services. Entitlement to a higher level of cost coverage may be linked to payment of health insurance contributions which would provide an incentive for the population to pay their contributions either through their employers when in formal employment or through direct payment of monthly contributions defined for groups not exempt (workers in informal sector, self-employed and other groups with sufficient income to be able to contribute). Vulnerable populations groups (pensioners, children, poor, unemployed)
should be covered by the state budget and therefore exempt from payment of health insurance contributions. No-one should be left behind, but at the same time those who have the means to contribute should see the benefits of making their contribution payments otherwise the introduction of health insurance contributions will be seen as an additional tax burden without tangible benefits.

**The cost of introducing compulsory health insurance can be very high and outweigh the benefits.** While the above considerations and approach to implementation may make the system of compulsory health insurance attractive for users of the health system and policy makers as well, the cost of administration of such a system may outweigh the benefits. A well-functioning integrated information technology needs to be in place in order to monitor status of payment of taxes, insurance contributions and most importantly the eligibility for exemption. If such system is not available at the time of introduction of a contribution-based entitlement system, it is very likely that patients become unsure about their entitlements which may lead to delaying access to needed care and frustration about the administrative and financial barriers created. Both the actual costs of administration and the political risk in case of poor implementation can be high enough to consider alternative approaches to diversification of resources for health.

**The option of addressing health financing reform as a taxation policy issue may be most practical from a political and technical perspective as well.** It is clear that the current level of public spending on health is insufficient to provide good financial protection and timely access to a wide range of services with sufficient quality to be effective. Moving towards universal health coverage requires increased public funding and this is ultimately a taxation policy challenge. The proposal that envisages earmarking some of the current social insurance contributions to health focuses on the taxation policy nature of the reform. This option would not change rules for entitlement to benefits neither would it split the benefits package, which are both in line with our recommendations. As the fiscal space improves, the government can easily increase this earmarked share of revenues for health without major administrative cost involved. All public revenues for health would continue to be pooled in a single fund and services covered by a single purchaser.

**Introduction of health insurance contributions should not lead to lower level of public spending on social protection.** The above proposal of earmarking part of the existing social insurance revenue to health would reduce spending on social protection which leads to worse financial protection against the cost of ill health through lowering pensioners’ capacity to pay for health services and medicines. While this may be mitigated by reducing co-payments for health services/prescribed medicines for pensioners and other groups of population receiving social protection benefits, reducing financial burden on vulnerable population groups should not come at the expense of social protection. Pensioners should be protected as they are the single largest group exposed to financial hardship due to ill health.
Comments on a proposal to introduce competition among health care purchasing agencies: not a solution to current challenges and likely to create new ones

The Bank of Latvia has proposed introducing competition among health care purchasing agencies. Its recommendation is that the NHS should compete with private insurance companies to offer a mandatory, publicly financed benefits package. The rationale for this move away from having a single purchasing agency (the NHS) is to use competition as an instrument to strengthen the way in which health care is purchased and, in doing so, to improve the overall performance of the health system. Proponents of purchaser competition look to the strong performance of the health system in the Netherlands and hope that purchaser competition will achieve similar results in Latvia. This hope is unlikely to be realised in Latvia for several reasons.

Purchaser competition would introduce fragmentation, add complexity and increase transaction costs. The launch of purchaser competition in the Netherlands in the early 1990s and its extension to the whole health system in 2006 was in part an attempt to address the negative effects of two types of fragmentation – the fragmentation caused by having multiple health insurance funds and the fragmentation caused by having two separate systems of health coverage (a publicly financed one for two-thirds of the population and a privately financed one for the richest third of the population). Establishing competition in Latvia would actually introduce fragmentation, add substantial complexity and increase transaction costs.

Purchaser competition requires strong institutions, significant capacity and sophisticated information systems: it makes the role of government much more demanding, not less. For purchaser competition to result in improved performance, the government will need to ensure that three preconditions are met:

a) all people can freely choose their purchasing agency and move easily from one agency to another; this means benefits must be carefully defined and legally guaranteed and both the purchaser and the health care provider market must operate with a high degree of transparency;

b) purchasers do not have incentives to select risks – if they can select risks, they will not have any incentive to improve performance and the main objective of introducing competition will not be achieved; to prevent risk selection, the government will have to establish a sophisticated risk adjustment mechanism before introducing competition; this requires a unified information system that is capable of bringing together in one place individual-level data on socioeconomic status, health status and health care use and expenditure;

c) purchasers have tools to influence health service quality and costs; for this they will need access to reliable and meaningful data on health care provider performance and must have leverage over provider behaviour.
Achieving (a) and (b) will take up a substantial amount of government time and energy, potentially drawing attention and resources away from (c), which is critical to improving performance in all health systems.

None of the European countries with purchaser competition has successfully met all of these preconditions, in spite of having at least twenty years of experience. Although they all use risk adjustment, so far only a few have been able to develop sophisticated risk adjustment formulas. The slow pace at which countries have strengthened risk adjustment is due to lack of data and information systems in some instances. It also reflects regulatory capture – government failure to act as a result of resistance and lobbying by purchasers.

Competition between a public purchaser and private insurance companies is a recipe for risk segmentation, fiscal pressure and two-tier access to health care. The Bank of Latvia proposal envisages competition between the NHS and private insurance companies. It is difficult to find examples of health systems in which public and private purchasing agencies compete with each other to offer mandatory health benefits for the whole population under identical or very similar conditions. It is an approach that has not been adopted in any European country, only in some countries in Latin America (Chile, for example). The Czech Republic has an insurer of last resort which has slightly different governance arrangements from other insurers. These few examples all share serious problems: inadequate risk adjustment due to lack of data and regulatory capture; risk segmentation, in which the public purchaser covers a disproportionate share of older, sicker and poorer people; significant fiscal pressure for the public purchaser due to risk segmentation; and, as a result, inequalities in financial protection and access to health care. EU law may also present a challenge.

Finally, it is worth noting that the Netherlands spends far more on its health system (publicly and in total) than Latvia and the introduction of purchaser competition across the whole system in 2006 has not helped to control the growth of health care expenditure. Figure 11 and Figure 12 below provide information on the increase of public and total expenditure on health after the introduction of the reforms in the Netherlands. While increasing health expenditure may be viewed as a positive development for Latvia, there are better ways of increasing expenditure and improving health outcomes at the same time.
Figure 11 Public spending on health as a share of total spending on health, selected countries

Source: Van Ginneken 2016

Figure 12 Total spending on health per person (PPP$), selected countries

Source: Van Ginneken 2016