A Situation Assessment of Rehabilitation in:

The Republic of Latvia

World Health Organization
REGIONAL OFFICE FOR Europe

Acknowledgements

This report was made possible through the combined efforts of the World Health Organization Regional Office for Europe (WHO EURO), WHO Latvia, and key stakeholders supporting disability and rehabilitation in Latvia.

Sincere appreciation is extended to the Ministry of Health and the Ministry of Welfare, and the WHO Latvia country office for their engagement in the compilation and synthesis of available data related to disability, rehabilitation, and assistive technology. These contributions are essential to the foundations of this report.

Abbreviations

AT	Assistive Technology
BSc	Bachelor of Science
CBR	Community Based Rehabilitation
CME	continuing medical education
CPD	continuous professional development
DPO	Disabled Persons' Organization
ECD	Early Childhood Development
ECI	Early Childhood Interventions
MoF	Ministry of Finance
MoH	Ministry of Health
MoW	Ministry of Welfare
MoE	Ministry of Education and Science
NCD	non-communicable disease
NGO	non-governmental organization
OOP	out-of-pocket
OT	occupational therapy /therapist
PHC	primary health care
PRM	Physical and rehabilitation medicine
PT	physiotherapy/therapist
P&O	prosthetics and orthotics / prosthetist and orthotist
RMM	Rehabilitation Maturity Model
LNG	Sustainable Development Goal
SLT	speech and language therapy /therapist
STARS	Systematic Assessment of Rehabilitation Situation
TRIC	Template for Rehabilitation Information Collection
UHC	Universal health coverage
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
WPT	World Physiotherapy
WFOT	World Federation of Occupational Therapists
WHO	World Health Organization

Abstract

This publication summarizes the rehabilitation situation in Latvia in August 2024. It outlines key strengths, needs and recommendations to develop rehabilitation in Latvia. The situational analysis was conducted under the leadership of the Ministry of Health of Latvia, with technical support from the WHO Regional Office for Europe and the WHO Country Office, Latvia. It was undertaken in collaboration with different Government ministries and State agencies, professional associations, disabled people's organizations and rehabilitation users. It adopted an evidence-based approach, responsive to the unique social, cultural, economic and political circumstances in the country. The content of this document is a snapshot in time – not an in-depth analysis of the entire rehabilitation sector. The analysis focuses on rehabilitation policy and governance, service provision, financing, information management and human resources, with the aim of improving access to high-quality rehabilitation services in Latvia.

Keywords

Rehabilitation. Assistive products. Health system. Human Resources. Person with disabilities. Universal health coverage. World Health Organization. Health policy.

Contributors

Editors:
Cathal Morgan, WHO Regional Office for Europe, Denmark; Tomas Zapata, WHO Regional Office for Europe, Denmark.

Authors:
Cathal Morgan, WHO Regional Office for Europe, Denmark; Justine Gosling, WHO Regional Office for Europe, Denmark.

Peer reviewer:
Shirin Kiani, WHO Regional Office for Europe, Denmark.

Glossary of Terms

Disability	Disability results from the interaction between individuals with a health condition such as cerebral palsy, Down syndrome or depression as well as personal and environmental factors including negative attitudes, inaccessible transportation and public buildings, and limited social support (1).
Environment	Environment encompasses the physical, social and attitudinal environment in which people live and conduct their lives (2).
Functional specialist	A functional specialist (physiotherapist, occupational therapist, technical orthopedist, audiologist, nutritionist, art therapist, optometrist) is a medical professional who has obtained a second-level professional higher medical education and works in accordance with their competence in medical treatment.
Health	Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (3).
Health condition	An umbrella term covering acute and chronic disease, disorders, injury or trauma. Health conditions may also include other circumstances such as pregnancy, ageing, stress, congenital anomaly or genetic predisposition (4).
Impairment	Problems in body function or structure such as a significant deviation or loss (5).
Quality of care	The extent to which health care services provided for individuals and patient populations improve desired health outcomes. To achieve this, health care must be safe, effective, timely, efficient, equitable and people-centred (7).
Rehabilitation	A set of interventions designed to optimize functioning and reduce disability in individuals with health conditions in interaction with their environment (4).
Rehabilitation outcomes	Changes in the functioning of an individual over time that are attributable to rehabilitation interventions. They may include fewer hospital admissions, greater independence, reduced burden of care, return to roles and occupations that are relevant to their age, gender and context (e.g. home care, school, work) and better quality of life (4).
Rehabilitation worker	A person delivering or supporting the delivery of rehabilitation, whether interacting directly or indirectly with a person, their family or service-user groups (2). Typically, the professions include audiologists, occupational therapists, physiotherapists, prosthetists and orthotists, speech and language therapists and physical and rehabilitation medicine doctors, as well as specialized nurses, but there are many other professions that also help to deliver rehabilitation services. Regardless of their profession or specialization, all aim to help an individual function to the greatest extent possible, whether by modifying their environment to accommodate their needs, using assistive products or working with the person to address their physical, psychological, cognitive or sensory impairment.
Rehabilitation workforce	A wide range of professions that deliver care across the different levels of the health system and in settings such as hospitals, schools, workplaces and people's homes.

References:

1. World Health Organization Regional Office for Europe. 2021. Policy brief on disability-inclusive health systems. https://apps.who.int/iris/handle/10665/350143

2. World Health Organization. 2019. Rehabilitation Competency Framework. License: CC BY-NC-SA 3.0 IGO. Available at: https://iris.who.int/bitstream/handle/10665/338782/9789240008281

3. World Health Organization. 1946. Constitution of the World Health Organization. Available at: https://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf

4. World Health Organization. 2017. Rehabilitation in health systems. License: CC BY-NC-SA 3.0 IGO. Available at: https://www.who.int/ publications/i/item/9789241549974.

5. World Health Organization. 2001. International classification of functioning disability and health. Fifty-fourth World Health Assembly on 22 May 2001 resolution WHA 54.21

6. International Society for Prosthetics and Orthotics. 2018. Education standards for prosthetic/orthotic occupations. https://www.ispoint.org/wp-content/uploads/2022/02/ispo_standards_nov2018_sprea.pdf

7. World Health Organization. 2016. Standards for improving the quality of maternal and newborn care in health facilities. Available at: https://www.who.int/teams/maternal-newborn-child-adolescent-health-andageing/quality-of-care

Third-party materials. If you wish to reuse material from this work that is attributed to a third party, such as tables, figures or images, it is your responsibility to determine whether permission is needed for that reuse and to obtain permission from the copyright holder. The risk of claims resulting from infringement of any third-party-owned component in the work rests solely with the user.

General disclaimers. The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by WHO in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by WHO to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall WHO be liable for damages arising from its use.

Contents

Executive summary

In the spring of 2024, the Ministry of Health of Latvia requested technical support from WHO to assess the current situation of rehabilitation with a view to strengthening and scaling access to meet population need. Data from the Global Burden of Disease study evidence that the need for rehabilitation is significant, with 1 in 4 people in Latvia having at least one condition that would benefit from rehabilitation services. Latvia has made significant efforts in recent years to develop its rehabilitation sector and to better integrate rehabilitation so adopt multiprofessional, evidence-based practice and enhance the quality of services.

Notwithstanding positive progress being made, many citizens still lack access to necessary rehabilitation and assistive technologies, and where co-payments to gain access to treatments is a concern. Service waitlists remain a significant feature of the health and care system, with too few professionals, especially in rural areas. Referral criteria and pathways are unclear, and there appears to be a limited understanding of functional rehabilitation across the health and care workforce. Many inappropriate referrals lead to inefficiencies, resource strain, and delays in early intervention. Access to assistive technologies is scarce, forcing many to seek private services and pay out of pocket.

In Latvia, multiple ministries play a role in delivering rehabilitation services, however, leadership is fragmented and there is no overall focal person responsible for rehabilitation. Rehabilitation is included in the national health plan and specifically for a few health conditions, but it does not have its own documented national strategy. Rehabilitation is provided in the state funded basic health package but needs expanding to meet population needs. With an ageing population and rise of NCD's, the already significant need for rehabilitation is set to grow, in a context whereby many are currently not having their rehabilitation and AT needs met.

This rehabilitation situation assessment utilizes standard tools developed by WHO and is structured around the building blocks for health system strengthening (leadership and governance, financing, health workforce, service delivery, medicines and technology, and health information systems). The report describes the situation of rehabilitation in Latvia as of the 22nd of August 2024 and lays out recommendations to develop and further integrate rehabilitation and AT services into the countries health system.

The Ministry of Health of Latvia had 3 main objectives to achieve with undertaking this STARs report; 1) to improve patient experience, 2) make more efficient use of existing costs and, 3) contribute to improvement in population health and functioning.

Key findings

The rehabilitation assessment identified notable strengths in the rehabilitation and AT systems in Latvia, and also identified areas that will benefit from additional attention and investment. The following key findings are grouped under a series of key headings related to health system strengthening building blocks.

GOVERNANCE

1. **Rehabilitation is integrated into key national health polices, laws and state provision.**

Rehabilitation is included in the overarching national health strategic plan and provided for in the populations entitlements to state funded health care services. The law stipulates that medical treatment must include access to rehabilitation, and specific regulation exists for persons with disability and certain health conditions. However, there are gaps, and provision needs expanding to meet the populations need. Without a single, transparent and government-recognized rehabilitation and AT roadmap, strategy or action plan, stakeholders will remain disjointed in their approach to addressing rehabilitation.

2. **Rehabilitation focal points across ministries are neither explicit nor well-defined and there is no inter-ministerial coordination platform on rehabilitation**

Multiple ministries provide for rehabilitation, and there are no formal mechanisms for coordination of rehabilitation between ministries. At the Ministry of Health, there is one person who mostly works on rehabilitation issues, although not full-time. At the MoW, there is currently no identified official specifically charged with leading exclusively on rehabilitation policy and strategy. There is one person who handles matters related to technical aids. The MoE also does not have a designated person for rehabilitation. Therefore, leadership and coordination for rehabilitation and assistive products at government level is currently ad hoc, managed between different personnel and, undertaken in an environment of competing priorities.

3. **There is no standalone national strategy on rehabilitation.**

While it is appreciated that under item number 1 rehabilitation and assistive technology is integrated in Latvian regulations and laws, consideration needs to be given to a standalone strategy or action plan. Services should be developed to ensure that they are aligned with global policy recommendations, such as the rehabilitation 2030 initiative and the 2023 global rehabilitation World Health Assembly resolution.

4. **Rehabilitation users are involved in decision making for rehabilitation.**

Whenever any law, regulation or strategic planning document is drafted, it is subject to public consultation, which means that any public administration organization or NGO can express its views on the document and make proposals. This is a notable strength in Latvia which should be maximized in the context of the report recommendations.

5. **There is minimum reporting to the MoH on rehabilitation.**

Facilities are collecting some data on their patient's function, interventions and outcomes. However, the only rehabilitation data facilities report to the MoH is to invoice them for the rehabilitation services they've provided. There are no national standards on what information should be collected and reporting.

6. **There is limited provision of assistive products.**

In Latvia the availability of AT is very limited despite its growing need, and its management fragmented. The MoH is responsible for very limited provision of AT in hospitals, and outside of hospitals provision is the responsibility of the MoW, with no cooperation or treatment transfer between the 2. This system is primarily designed for individuals with long-term or permanent functional impairments, and not for acute or early subacute recovery periods. This overlapping responsibility highlights inefficiencies and a need for better coordination between the ministries.

FINANCING

7. **Rehabilitation is budgeted for in state funded health services in Latvia.**

Financing is provided for rehabilitation in the 2024 state budget and are distributed to various disability organizations in order to provide both Rehabilitation and Assistive Technology services and products. Specifically, a number of key Ministries provide budget in these categories of services in 2024; these are, MoH (56,657,905 euros), MoW (8,994,894 euros). Disability organizations are also provided with funds totaling 5,324,634 euros.

8. **State funds for rehabilitation are insufficient to meet population need and consequently, service provision is provided on a limited basis, and services cease operating due to a lack of funds.**

The state allocates funding for rehabilitation services, however, once that funding has been utilized, facilities often cease providing services they do not have funding for. Budgets reportedly run out mid-year, leaving patients waiting for services on the wait list until more funding arrives, or they have to pay privately for services to meet their needs.

9. **Co-payments are required for most to access rehabilitation services.**

A one-off payment of 4 euros needs to be paid by the patient to receive an outpatient appointment to see a PRM. The regulatory framework or NHS does not set a limit on the number of visits for PRM physicians; however, custom practice suggests that PRM doctors typically refer patients for 10 government funded rehabilitation from an OT/PT/SLT. GPs' can refer patients to rehabilitation for up to 5 sessions without having to pay a 4-euro fee. Whereas, children and persons registered disability alongside other specified groups are exempt from these co-payments.

10. **Most people must make co-payments for assistive products.**

When receiving an assistive product, a one-time payment must be made. For a child this payment is 1.42 euros; for a person older than 18 years the payment is 7.11 euros. A person whose household is receiving government financial support, is on the disability register, who is in a long-term care, whose place of residence is registered in an inpatient treatment facility, and person who is serving a sentence in a prison is exempt from the one-time contribution.

HUMAN RESOURCES

11. Latvia has multiprofessional rehabilitation workforce.

Latvia has a well-established, multiprofessional rehabilitation workforce with university accredited study programmes, professional organizations and registration. Patients have access to PRM's, physiotherapists, occupational therapists, prosthetists and orthotists, speech and language therapists (audiologopeds), logopeds (speech specialists with pedagogical education), psychologists, psychiatrists and art therapists. These specialists are accessible within the scope of state-funded services, at patients own expense, or funded by private insurance. However, whilst there is an occupations classifier list, this needs to be updated to ensure their alignment with internationally accepted norms and standards.

12. The Latvian government provides funding for the education of rehabilitation professionals.

For each of the rehabilitation professions, the Latvia government covers the cost of tuition fees for a proportion of the undergraduate students to support supply production into the rehabilitation workforce.

13. There is insufficient rehabilitation workforce to meet demand, particularly in rural areas.

There are insufficient rehabilitation professionals available to meet the populations needs, and a plan to develop a sustainable rehabilitation workforce is needed. The state sector struggles to recruit professionals as they receive a higher salary in the private sector and rural areas are particularly underserved; therefore, patients have to wait long periods and travel to major urban centres to receive services.

14. Rehabilitation professionals are not recognized equally and could be empowered to take on greater responsibility to expand capacity in the system.

Service capacity could be enhanced within the rehabilitation system and wait lists reduced if all rehabilitation professionals could refer and triage patients, which currently can only be executed by GP's or PRMs.

15. There is a lack of understanding of what rehabilitation is, its benefits and who provides services.

Rehabilitation professionals believe their role, functional rehabilitation, its benefits, and service providers are poorly understood by referrers, patients, and healthcare professionals.

INFORMATION

16. There is a register for persons with disability and 3 levels of disability, according to severity.

The prevalence of disability among the population of Latvia is estimated to be 11.0% in 2022. In total, 204,158 adults and 9,372 children aged under 17 in Latvia were registered as having a disability in 2023. To be registered as a person with a disability an assessment will be undertaken by a GP or a treating doctor who assesses the patient's health disorders and functioning limitations (according to the ICF) and reports on them in the Medical Report to the State Medical Commission for the Assessment of Health Condition and Working Ability. Based on the given information, a designated SMC expert assessor

conducts the assessment and makes a decision regarding disability status. A person is registered as having a disability in one of 3 category levels of disability, according to their conditions severity and ability to work.

17. No information is available on the population's functioning.

Population health data on condition prevalence is available to imply the potential need for rehabilitation, but no data is available on the populations functioning. For example, from the national census.

18. Insufficient data is collected on rehabilitation availability, utilization, outcomes and quality.

The only rehabilitation usage data that is reported to the MoH is via facility or site-specific invoices to the MoH to receive payments for providing services. Coded data is reported this way on location and type of service received, as well as discharge and outcome. A live website is publicly available which shows the wait times for rehabilitation services at facilities. In summary, data is not available to inform policy and workforce or service planning to meet population need.

19. Latvia's health system has not yet implemented a National Electronic Health system (NEHR).

Referrals and health records are largely paper based. Latvia has incurred significant investment and resource planning to implement its eHealth system which is positive and offers opportunities to address the aforementioned. As of January 1st , 2028, the state eHealth system is mandatory for medical institutions and pharmacies. This system and its ongoing evolution offers an opportunity to report on rehabilitation outcomes for patients by professionals and facilities in the field.

REHABILITATION SERVICE

20. Rehabilitation inpatient beds are available in hospitals and specialist centres, as well as outpatient and day care rehabilitation services.

In Latvia, there are a total number of 606 inpatient rehabilitation beds for adults across 14 facilities and 69 beds for children under the age of 17 in 5 facilities: these are, Bērnu klīniskā universitātes slimnīca [Children's University Hospital], Ziemeļkurzemes reģionālā slimnīca [Regional Hospital], Jēkabpils reģionālā slimnīca [Regional hospital] and , Nacionālais rehabilitācijas centrs "Vaivari" [National Rehabilitation Centre], Rehabilitācijas centrs "Līgatne" [Rehabilitation centre], Vidzemes slimnīca [Regional hospital]

21. Access to early rehabilitation isn't a reality in Latvia.

Long wait lists, a lack of staff, underserved rural areas, delayed referrals, and funding for state services running out means that early rehabilitation for acute conditions often does not happen, and that rehabilitation commences later than ideal.

22. **There are no standardized referral or service priority criteria, and referrals for rehabilitation are often poor and inappropriate patients are referred, taking up time and resources.**

The single biggest issue reported by all rehabilitation professions is that the quality and appropriateness of patient referrals for rehabilitation are often very poor with little information provided. Repeatedly, professionals complain that up to 30-40% of the patients referred to them do not need rehabilitation and do not have functional impairments and are considered as an 'inappropriate referral'. This reportedly happens because patients, and the doctors referring them, including some PRM's, do not understand what functional rehabilitation is, what each rehabilitation profession does, and when services are needed. Such 'inappropriately referred' patients take up significant resources and drive up wait lists.

23. **Currently, a referrer prescribes the number of rehabilitation sessions a patient should receive on the referral, which is often a lot more than needed.**

Currently, a GP or other specialist doctor, in accordance with Latvian regulations, can refer a patient directly to an OT; FT; SLT for 5 visits. Based on further assessment of need, a PRM physician may prescribe additional treatments for the patient beyond the aforementioned regimen. The prescription for the number of rehabilitation sessions a patient should receive is written on the referral form which also sets patients expectations. However, this is often prescribed with little understanding of functional rehabilitation and appears primarily focused on one professional discipline in a key clinical decision-making role, and regardless of whether a patient needs however many sessions for their functional difficulty, the 5 or 10 prescribed sessions has to be provided, as the patient has now come to expect as the standard. In effect, this practice of prescribing is an inefficient use of service capacity which could be allocated more effectively from a workforce point of view.

24. **Access to Rehabilitation in Primary Healthcare**

At the primary health care level, state-funded rehabilitation services are available only to target groups through home care services and within the framework of hospice care and home care. This limited availability will likely limit the potential of the Government to comprehensively respond to the impact of NCDs and ageing where rehabilitation and access to AT can play an invaluable role in supporting people to remain independent and living in their own home.

25. **The are no community services close to the homes of those with chronic conditions and long-term rehabilitation and management needs.**

As stated in the rehabilitation 2030 initiative and emphasized again in the 2023 WHA rehabilitation resolution, those with long term frailty, chronic respiratory, cardiovascular or pain conditions that could benefit from community-based peer support, education and rehabilitation group classes appear non-existent, and therefore this presents as a missed opportunity to respond to the needs of people in a more cost effective and efficient way in the community through, for example providing basic rehabilitation interventions utilizing the existing wider health and care workforce.

26. Interventions which have a poor evidence base for their use and benefit, such as electrotherapy and massage, are widely used and resource intensive.

Interventions which are not functional, evidence based, or measurable in terms of impact, such as massage or electrotherapy are widely provided in Latvia and appear to absorb considerable budget and time without effectiveness.

27. Assess outcomes and attributes of rehabilitation services.

Quality indicators are defined and collected in three state-funded medical rehabilitation programs. Inpatient, day care unit and psychiatric day care unit. At the end of the rehabilitation process, the leader of the multidisciplinary team must fill out a payment document, which also indicates statistical manipulations of the work performed. Statistical manipulations include goal manipulations – whether the therapy goal is achieved or not achieved, or if the therapy course was ceased. The NHS annually assesses the proportion of goal manipulations achieved. Additionally, patient complaints are evaluated and treatment intensity, for example, how many sessions were provided and with how many different rehabilitation professionals. Psychiatric day care units are assessed Re-hospitalizations within 30 days of discharge from the day care unit.

REHABILITATION DURING AND AFTER EMERGENCY EVENTS AND DISASTERS

28. Rehabilitation is not integrated in emergency and disaster response and preparedness plans.

A civil protection plan has been developed and approved in Latvia. The plan includes algorithms on how and in which situations the patient should be taken to a hospital for acute care. However, it does not include specific information on the provision of rehabilitation services or access to assistive technology products in emergency situations.

Considering that rehabilitation professionals are employed and available in all the hospitals mentioned in the plan, rehabilitation services would be available to persons affected during an emergency, if needed. However, there is no specific budget or strategy document for the provision of rehabilitation services in emergency situations and their continued care.

Recommendations

To address some of the challenges that Latvia faces related to rehabilitation and indeed access to assistive technology services and products, these recommendations provide opportunities for future planning, engagement with key stakeholders and may provide a foundation from which to strengthen access to rehabilitation via rehabilitation action planning.

It is therefore recommended that the Government of Latvia consider the following suite of recommendations.

GOVERNANCE

1. **Consolidate rehabilitation leadership and coordination and governance.**

1.1. Formally identify rehabilitation focal points within relevant ministries, their department and specific roles and responsibilities on rehabilitation, and how they coordinate their activities.

1.2. Formally operationalize the rehabilitation expert working group with set roles and an agreed agenda to inform and implement national rehabilitation activities.

1.3. Develop a national strategy on rehabilitation that involves and includes all relevant ministries, departments, and stakeholders.

2. **Update regulatory guidelines to mandate data collection and reporting for rehabilitation.**

2.1. Formulate new guidelines and mandate report pathways for facilities to provide data to the government on rehabilitation referrals, service provision, effectiveness and outcome.

3. **Review and strengthen frameworks related to procurement and provision of assistive products.**

3.1. Consider utilizing the WHO Assistive Technology Capacity Assessment (ATA-C) - a population-based survey to map the need, demand, supply, and user satisfaction with AT and a more in-depth systems-level assessment to evaluate Latvia's capacity to finance, regulate, procure and provide AT.

3.2. Facilitate collaboration between social, education and health systems for unified and coordinated provision of assistive technologies.

3.3. Integrate assistive technologies into rehabilitation system and relate to disability assessment.

3.4. Update regulation so that those all those with chronic and palliative conditions are entitled to rehabilitation and AT within the state services.

4. **Update regulation and national guidance on referrals for rehabilitation.**

4.1. Regulation should be updated to specify that rehabilitation referrals should be facility specific, as chosen by the patient, so that they can only be used once and not multiple times.

4.2. Update national guidelines to set clear criteria and prioritization for rehabilitation referral in a simply 'check list format' and the required information within the referral. Within these guidelines, the practice of prescribing the number of sessions that will be provided in referrals should cease and replaced with a clear policy and procedure based on need in the initial assessment by a rehabilitation professional.

FINANCING

4. Consider redistributing funds from poorly evidenced based interventions to other areas of rehabilitation and AT service provision.

4.1. Significant funds could be transferred from practices with a poor evidence base and unknown effectiveness, such as electrotherapy, message and ultrasound therapies, into other service areas in priority need of additional funds. WHO's evidenced based guidance document 'Packages of Rehabilitation Interventions' could support this recommendations implementation.

4.2 Consider redistributing budget for providing 'off the shelf' orthotic such as compress bandages, wrist and ankle splints to avoid the wait and need for expensive unnecessary custom-made splints.

HUMAN RESOURCES

5. Upskill and empower functional therapists to enhance service capacity and reduce wait times.

5.1. Upskill and empower wider rehabilitation professional disciplines through education, regulation and national guidance to enable all professionals to triage patients, design referral and treatment plans without requiring a PRM or GP referral as routine. In this respect, the competencies of the wider group of disciplines should be reflected in the current training or education curricula. This would in turn would

maximize the potential of the wider rehabilitation workforce to meet growing population rehabilitation need rather than the current over and inappropriate dependence on GP and PRM physicians. As a consequence, this level of reform of the workforce would then contribute to current challenges regarding waiting times for rehabilitation treatment and in line with WHO's recommendations on interventions for rehabilitation.[1]

5.2. Ensure that all rehabilitation professionals are given equal status in key rehabilitation government advisory positions so that the state benefits from a wider pool of appropriate and multi-disciplinary expertise in policy design and implementation.

5.3. Include the current professional organization run, post graduate licensing certification exam as part of completion of the BSc.

5.4. Consider piloting WHO's Rehabilitation Competency Framework[2] and the Guide for Rehabilitation Workforce Evaluation[3] to gain a deeper understanding of the existing situation and gaps related to the rehabilitation workforce in Latvia. In this context the national occupation classifier should also be reviewed and updated in line with international norms and standards.

In this context, consider the establishment of a formal sub-working group to develop proposed standards for rehabilitation workforce terminology, undergraduate education requirements, post-graduate continuing medical education, worksite eligibility, scope of practice and other regulatory standards, as applicable in Latvia.

6. Educate and raise awareness for rehabilitation.

6.1. Develop and implement a national education campaign and relevant materials on what functional rehabilitation is, who could benefit, and who delivers services. The campaign should target patients, employers and health professionals through CPD for health professionals, within undergraduate education, and leaflets and posters for facilities, patients and for the general population.

INFORMATION

7. Incorporate rehabilitation data in routine health system reporting.

7.1 Review rehabilitation data fields and incorporate these in the standard reporting templates for all health facilities when transitioning to the electronic Health Information Management System.

7.2 Include functioning questions in the next population census.

7.3 Conduct a basic multi-facility research project to collect data on the number of inappropriate referrals to quantifiable evidence the issue and its impact on wait times and financial cost.

[1] https://www.who.int/teams/noncommunicable-diseases/sensory-functions-disability-and-rehabilitation/rehabilitation/service-delivery/package-of-interventions-for-rehabilitation

[2] https://www.who.int/teams/noncommunicable-diseases/sensory-functions-disability-and-rehabilitation/rehabilitation-competency-framework

[3] https://cdn.who.int/media/docs/default-source/documents/health-topics/rehabilitation/2942-dar-r-wep-info-sheet-170221.pdf?sfvrsn=81541771_5&download=true

7.4 Examine WHO's 'Routine Health Information Systems Toolkit'[4] to identify potential indicators for use.

REHABILITATION SERVICE

8. Expand service provision to communities, for chronic conditions and to rural areas.

8.1 Access to basic rehabilitation packages and interventions should be integrated into and available within Primary Healthcare and Long-term Care services in order to support people to live independent lives in their own communities and help mitigate against the impact of demographic change in Latvia.

8.2 Provide resources to set up community rehabilitation, education and peer support groups and short courses for those with long term conditions such as falls prevention and frailty, chronic respiratory and pain conditions.

9. Support PWD when accessing health and rehabilitation services.

9.1 Educate all healthcare professionals on the needs and challenges faced by persons with disabilities when attempting to access health care services. Have specifically trained 'disability advocates' in hospitals and emergency departments that can be called on to support the needs of patients with disabilities when admitted.

9.2 Regulate disability accessibility provisions in health care infrastructure and facilities.

EMERGENCY PREPAREDNESS AND RESPONSE

10. **Integrate rehabilitation considerations and leadership into health emergency management planning.**

10.1. It is recommended that MOH and relevant stakeholders ensure that rehabilitation is included in national and subnational health and emergency disaster and risk management policies, strategies, and legislation as part of the health system response.

10.2 Create rehabilitation services mapping together with modified referral pathways for emergencies.

[4] https://www.who.int/activities/integrating-rehabilitation-into-health-systems/routine-health-information-systems---rehabilitation-toolkit

1. Background and methodology

1.1. International, regional, and national developments for rehabilitation

In February 2017, WHO launched the *Rehabilitation 2030* initiative and raised a 'Call for Action' *(1)*; it identifies ten areas for united and concerted action to reduce unmet needs for rehabilitation and strengthen its role in health. WHO also released the *Rehabilitation in health systems guidelines (2)* which provide foundational recommendations for strengthening rehabilitation in the health sector and better integrating it across health programs. This body of work further supported the development of *Rehabilitation in Health Systems Guide for Action,* released in 2019 *(3)*. Central to WHO guidance is that rehabilitation is a health service for all the population. It should be made available at all levels of the health system, and ministries of health should provide strong leadership to strengthen the health system to deliver rehabilitation and develop rehabilitation strategic plans. Information on the *Guide for Action* and rehabilitation applied to the health system building blocks is in Appendix B. Furthermore, in 2023 WHO Member States adopted resolution 76.6 (4) calling for the timely integration of rehabilitation into health systems, including emergency preparedness and response plans.

1.2. Methodology

This assessment utilizes WHO's method and reporting template called the Systematic Assessment of Rehabilitation Situation (STARS). The STARS is not an academic evaluation of rehabilitation, nor is it intended as a detailed analysis. It is a snapshot in time to review the current status of rehabilitation provision generally in Latvia, identify strengths and gaps, and create a foundation for creating a national rehabilitation strategic plan and or strengthening provision based on Government priorities.

In August 2024, WHO provided technical support to Latvia's MOH to undertake an assessment of the rehabilitation situation in Latvia. The STARS document is a compilation of information available through data provided through the Template for Rehabilitation Information Collection (TRIC), online consultation meetings and an in-country mission.

The STARS process in Latvia occurred in two key stages. These are;
Stage 1: WHO CO leading TRIC data collection with key stakeholders in Latvia (April-August 2024).
Stage 2: WHO EURO consultant in-country mission and zero draft of STARS report (August-October 2024).

Stage 1 (completion and consolidation of a standard questionnaire):
WHO's Template for Rehabilitation Information Collection (TRIC) questionnaire comprises eight sections[5] with over 100 questions. The focal point within WHO CO completed the questionnaire in English based on conversations and email exchanges with relevant stakeholders in Latvia and sent this document to the WHO Euro consultant in June 2024.

[5] These include six sections focused on the health systems strengthening building blocks plus additional sections on infrastructure and emergency preparedness.

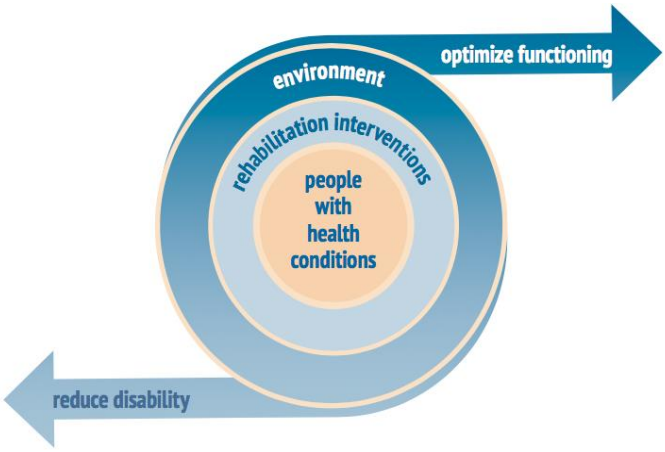
Stage 2 (In country mission and zero draft of STARS report):
In addition to the TRIC, the WHO Euro consultant, with the Latvia CO, undertook an in-country mission in August 2024, culminating in a zero draft of the STARS report. This was shared with WHO Euro and WHO Latvia Country Office on 31st October 2024.

Text Box 1. Rehabilitation Maturity Model
The Rehabilitation Maturity Model (RMM) is another standard tool used during the STARS process. (3) There are 50 components across seven domains in the RMM. Each component has illustrative descriptors that indicate levels of maturity of rehabilitation in the health system. The purpose of using the RMM is to provide an overview on the performance of different rehabilitation components. This overview enables comparison across components and domains that can then assist in the identification of priorities and recommendations for strategic planning. The RMM has not yet been completed as there is insufficient evidence to make determinations in each area. The RMM framework is provided in *Section 11*.

2. Introduction to rehabilitation

WHO describes rehabilitation as a set of interventions designed to optimize functioning and reduce disability in individuals with health conditions in interaction with their environment (see Figure 1).

Figure 1. ***Rehabilitation interventions optimize functioning***



Source: WHO Western Pacific Regional Framework on Rehabilitation 2019.

Health condition refers to disease (acute or chronic), disorder, injury or trauma. A health condition may also include other circumstances such as pregnancy, ageing, stress, congenital anomaly or genetic predisposition.

Rehabilitation interventions are targeted actions to build muscle strength, improve balance, cognitive ability or communication skills. This skill-building can assist people to perform basic daily activities, such as moving around, self-care, eating and socializing.

Rehabilitation also removes or reduces barriers in society through modification to people's personal environments such as home, school or work to safely and efficiently move around.

In many countries, rehabilitation is closely associated with disability, and sometimes considered a disability service. However, rehabilitation is a health strategy for the entire population, including people with disability.

Rehabilitation is for all people, as part of the continuum of health care and within health systems. Rehabilitation is important at all levels of the health system (tertiary, secondary, primary and community). For additional information on rehabilitation please refer to Appendix A.

World Health Assembly resolution on rehabilitation

On 30 May 2023, the World Health Assembly (WHA) unanimously endorsed Resolution WHA76.6 "Strengthening rehabilitation in health systems".[6] The Resolution calls for expanding and integrating rehabilitation in health systems as part of Universal Health Coverage (UHC), emphasizing the importance of rehabilitation in primary care and as part of emergency preparedness and response.[7]

WHA76.6 urges Member States to undertake nine key actions to strengthen rehabilitation in health systems. These priority actions include, but are not limited to;

- raise awareness of and build national commitment for rehabilitation, including for assistive technology;
- develop strong multidisciplinary rehabilitation skills suitable to the country context, including in all relevant health workers;
- enhance health information systems to collect information relevant to rehabilitation, including system-level rehabilitation data;
- ensure timely integration of rehabilitation into emergency preparedness and response, including emergency medical teams;
- ensure the integrated and coordinated provision of high-quality, affordable, accessible, gender-sensitive, appropriate and evidence-based interventions for rehabilitation along the continuum of care, including strengthening referral systems and the adaptation, provision and servicing of assistive technology related to rehabilitation, including after rehabilitation, and promoting inclusive, barrier-free environments.

WHA76.6 also requests the Director General of WHO "*to support Member States to systematically integrate rehabilitation and assistive technology into their emergency preparedness and response... including by addressing the long-term rehabilitation needs of those affected by emergencies*."

[6] https://apps.who.int/gb/ebwha/pdf_files/WHA76/A76_R6-en.pdf

[7] https://www.who.int/news/item/27-05-2023-landmark-resolution-on-strengthening-rehabilitation-in-health-systems

3. Geographical and population country context

The Republic of Latvia is a country in the Baltic region of Northern Europe. It is one of the three Baltic states, along with Estonia to the north and Lithuania to the south. It borders Russia to the east and Belarus to the southeast and shares a maritime border with Sweden to the west. Latvia covers an area of 64,589 km2 (24,938 sq mi) and its capital and largest city is Riga. Latvia gained independence from the Soviet Union on 21 August 1991 and joined the European Union in 2004, adopting the euro currency on 1 January 2014. The World Bank classifies Latvia as a high-income country.

As of 1 July 2021, there are 36 municipalities in Latvia; Adazi, Augsdaugava, Aizkraukle, Alūksne, , Balvi, Bauska, Cēsis, Dobele, Gulbene, Jelgava, Jēkabpils, Ķekava, Krāslava, Kuldiga, Limbaži, Līvāni, Ludza, Madona, Mārupe, Ogre, Olaine, Preiļi, Rēzekne, Ropaži, Salaspils, Saldus, Saulkrasti, Sigulda, Smiltene, Dienvidkurzeme, Talsi, Tukums, Valka, Valmiera, Varakļāni, and Ventspils.
which are further divided into 71 cities/towns and 512 parishes.

Latvia had a population of 1,883,008[8] in 2023 when life expectancy at birth was 74.4 years.[9] The percentage of the population living in urban areas 69.8% and 30.2% in rural areas.[10] In 2023, 26.7% of the population were aged 65 or older (see figure 2).[11] Women represent 53.7% of the population, while men represent 46.3%. The Latvian populations literacy rate as a % of total population was 99.9% in 2021.[12]

Figure 2 demonstrating the Latvia populations age distribution:[13]

Age category	% of population 2022	% of population 2023
0–5 years	6.2%	5.9%
6–15 years	10.9%	11.2%
16–60 years	56.4%	56.2%
> 60 years	26.6%	26.7%

[8] Official statistics portal, IRD041. Population in regions, State cities, and municipalities by gender and age at the beginning of the year (after the 2021 territorial reform) 2021–2023, Central Statistical Bureau
https://data.stat.gov.lv/pxweb/en/OSP_PUB/START__POP__IR__IRD/IRD041/
[9] Official statistics portal, IRP010 Average life expectancy at birth (in years) 1896–2022, Central Statistical Bureau
https://data.stat.gov.lv/pxweb/en/OSP_PUB/START__POP__IR__IRP/IRP010
[10] Official statistics portal, Population in rural and urban areas by gender at the beginning of the year (after the 2021 territorial reform) 2021–2023, Central Statistical Bureau
https://data.stat.gov.lv/pxweb/en/OSP_PUB/START__POP__IR__IRD/IRD071/
[11] Official statistics portal, IRD041. Population in regions, State cities, and municipalities by gender and age at the beginning of the year (after the 2021 territorial reform) 2021–2023, Central Statistical Bureau
https://data.stat.gov.lv/pxweb/en/OSP_PUB/START__POP__IR__IRD/IRD041/
[12] Literacy rate, adult total (% of people ages 15 and above) – Latvia, UNESCO Institute for Statistics (UIS). UIS. Stat Bulk Data Download Service.
https://data.worldbank.org/indicator/SE.ADT.LITR.ZS%E2%80%A8?locations=LV
[13] Official statistics portal, IRD041. Population in regions, State cities, and municipalities by gender and age at the beginning of the year (after the 2021 territorial reform) 2021–2023, Central Statistical Bureau
https://data.stat.gov.lv/pxweb/en/OSP_PUB/START__POP__IR__IRD/IRD041/

In 2023 the ethnicity of the population of Latvia was Latvians: 62.4% Russians: 23.7%, Belarusians: 3.0%, Ukrainians: 3.0%, Other: 7.9%.[14] Latvia's official language is Latvian which, in 2017, was the mother tongue of 60.8% of the population.[15] Russian is the first language of 36.0% of the population and 3.2% have another first language.[16] In 2021, the total number of church congregation members was 1,334,315, of which: 53% attended Evangelical Lutheran Church of Latvia, 26% attended Roman Catholic Church in Latvia, 19% Latvian Orthodox Church and 2% attended 'other'.[17]

Russian Federation's full-scale invasion of Ukraine:
There has been a health and care impact for Latvia as a consequence of the Russian Federation invasion of Ukraine. The provision of health care services for non-citizens and persons with temporary residence permits, such as for Ukrainian refugees, is identical. Since the start of the Ukraine-Russia war, support for Ukrainian soldiers in the context of treatment and rehabilitation has been organized and paid for from the state budget.

Sustainable Development Goals in Latvia

The UN and its partners in Latvia are working towards achieving the Sustainable Development Goals (SDG's). The 17 interconnected and ambitious goals address the major development challenges faced by people in Latvia and around the world. In general, Latvia is on track to meet SDGs. According to the 2024 Sustainable Development Report, Latvia scores 88.8 out of 100 on its statistical performance index, and is ranked 13th out of 167 countries globally, which is progress from 66 of 163 in 2022.[18] Within SDG3 (Good Health and Well-Being), Latvia has made significant improvements, as demonstrated in the below visual summary (see figure 3 of overall trends related to SDGs.

[14] Calculation based on data from the official statistics portal 'IRE010 Population by ethnicity at the beginning of year 1935–2023', Central Statistical Bureau
https://data.stat.gov.lv/pxweb/en/OSP_PUB/START__POP__IR__IRE/IRE010
[15] Results of External Migration Survey (including language data), Central Statistical Bureau
https://stat.gov.lv/en/statistics-themes/population/migration/other/1590-results-external-migration-survey
https://admin.stat.gov.lv/system/files/other_format/2020-03/AMA_2019_0.xlsx
[16] Results of External Migration Survey (including language data), Central Statistical Bureau
https://stat.gov.lv/en/statistics-themes/population/migration/other/1590-results-external-migration-survey
https://admin.stat.gov.lv/system/files/other_format/2020-03/AMA_2019_0.xlsx
[17] Statement on reports for the activities of religious organizations submitted to the Ministry of Justice in 2021 (Annex 1), Ministry of Justice https://www.tm.gov.lv/lv/2021-gada-publiskie-parskati
[18] Sachs, J.D., Lafortune, G., Fuller, G. (2024). The SDGs and the UN Summit of the Future. Sustainable Development Report 2024. Paris: SDSN, Dublin: Dublin University Press. doi:10.25546/108572

Figure 3: **Sustainable Development Goal trends in Latvia in 2024.**

Source: Sustainable Development Report 2024

4. Overview of Latvia's health system and rehabilitation

4.1. The Latvian health service:

Background:

Latvia has a National Health Service (NHS), financed primarily from general tax revenues, and a 1% tax for mandatory state social insurance contributions for health care.[19] The Ministry of Health has overall responsibility for developing national health policy and manages the overall organization and functioning of the NHS. The NHS acts as a single purchaser of care services from national and local providers and is responsible for implementing policies developed by the Ministry of Health.

The NHS and the MoH are the two most important institutions for health system planning in Latvia. The Ministry of Health is the leading public administration institution in the health sector, which develops health policy, organizes and coordinates the implementation of health policy, while non-state actors (NSAs) implement state policy in ensuring access to health care services.

The NHS works under the supervision and political guidance of the MoH, which is responsible for policy implementation. The NHS oversees planning of health care services and health care resources (except for human resources, which are the responsibility of the MoH). The overall planning of the system is based on the contracted care data provided by the NHS and the general health sector statistical information provided by the Centre for Disease Prevention and Control (CDPC).

[19] https://likumi.lv/ta/en/en/id/296188-health-care-financing-law

The Ministry of Welfare provides for national policy on social assistance, social work, social care, social and vocational rehabilitation, develops the national policy on the provision of technical aids, and ensures a high-quality development of the social care and social rehabilitation services network. The Ministry of Welfare provides the budget for social rehabilitation services, which is outside of hospitals. Social rehabilitation services are aimed at restoring or improving social abilities to return a person to social and working life and is not considered a healthcare service.

There is a significant private health sector which includes rehabilitation services. Latvia's health care system features three principal levels: the national service level, which provides tertiary care hospitals; the regional service level, which provides hospitals; and the municipal and community service level, which has primary health care providers.

Local governments are responsible for ensuring geographical accessibility, and, depending on budget and local priorities, maintain hospitals and long-term social care facilities. Local government is not involved in the direct payment of health care services, which is the responsibility of the NHS. Different ownership structures characterize health care provision in Latvia. Smaller hospitals and some larger regional hospitals are commonly owned by municipalities, while the larger hospitals (such as university hospitals) are owned by the state. Providers contracting with the NHS may be public or private; in the case of primary care they tend to be predominantly private; public or private in secondary care, and public in the case of tertiary care, with ownership concentrated at the state (national) or municipality (regional) level.

Latvian law defines the following terms related to health services:

Health care - a set of measures provided by health care service providers for the ensuring, maintenance and renewal of the health of a person.

Primary health care - a set of health care services provided to a person by primary health care providers in an outpatient medical treatment institution or place of residence of a person.

Secondary health care - a set of health care services provided to a person by a medical practitioner specialized in a disease profile in a medical treatment institution and which is focused on emergency, acute or planned health care.

Tertiary health care - a set of highly specialized health care services provided to a person by one or several medical practitioners with additional qualification who are specialized in a disease profile in a medical treatment institution.

4.2. Organization of Latvia's health care system

The Ministry of Health is responsible for 'medical rehabilitation', whilst the Ministry of Welfare is responsible for the provision of assistive products and 'social and vocational rehabilitation' for certain groups of persons with functional impairments.

4.3. Ministries involved in health and rehabilitation

Although the MOH assumes primary responsibility for the health of the population, other ministries in Latvia play a role in the provision of rehabilitation and AT. These include, but are not limited to:

- The **Ministry of Welfare** is the leading state administrative institution in the field of labor, social protection, children's and family rights, as well as equal opportunities for persons with disabilities and gender equality. Under the supervision of the ministry is the responsible agency for disability determination, as well ministry is the leading institution who makes policy for social services for vulnerable populations (e.g., persons with disabilities) as well as for assistive products and social rehabilitation services.

- The **Ministry of Education and Science** provides special education programs for children with disabilities and is the main employer of speech therapists (logopeds). The Ministry of Education and Science does not offer special education programs for children with disabilities nor employ speech therapists (logopēds) as primary staff in this field. Special education is defined under the General Education Law as a form of general education adapted to students with functional impairments. These programs are tailored to students' developmental needs and align with the national education standard. There are nine specific special education programs based on different types of impairments, including visual, hearing, speech, and mental development disorders. Schools provide support through staff such as psychologists, speech therapists, and special education teachers, though audiologists are rarely present. Regulation No. 556, approved in 2019, outlines the requirements for schools enrolling students with special needs, including the provision of speech therapists among support staff.

At the Ministry of Health, rehabilitation issues are overseen by one part time persons in the Department of Healthcare. At the Ministry of Welfare, there is no dedicated official specifically charged with managing rehabilitation strategy or policy on behalf of the Ministry. There is one person who handles matters related to technical aids.

The Ministry of Education and Science does not have a designated rehabilitation focal person, but the Ministry is involved in handling individual matters associated with education.

The Ministry of Welfare develops the national policy on social assistance, social work, social care, social and vocational rehabilitation, develops the national policy on the provision of technical aids, and ensures a high-quality development of the social care and social rehabilitation services network. The Social Integration State Agency' (SISA) is funded by the MoW and has a social and vocational rehabilitation centre for inpatients and outpatients in the region of Jūrmala, which is approximately a 1 hour drive from Riga.

4.4. Ministry of Health mission and organizational structure

The mission of Latvia's MOH is to increase the number of healthy life years of the inhabitants of Latvia and to prevent premature death by maintaining, improving and restoring health. The goal is intended to be achieved by creating a system of quality health care services and equal access to health services for the population of the country.[20]

It intends to achieve its mission by educating the public about the importance of a healthy lifestyle in maintaining health, implementing targeted disease prevention measures, ensuring the availability of high-quality health care services in accordance with the needs of each individual, as well as promoting the development of medical education and science.[21]

Relevant legal definitions:

Medical rehabilitation:

The Medical Treatment Law 11 defines medical rehabilitation as "a branch of medicine that deals with the development or recovery of a person's physical, psychological, social, occupational and educational potential in accordance with his or her physiological or anatomical limitations, or – in case of stable health disorders – the adaptation of the patient's life to the environment and society."

Social rehabilitation:

In the Law on Social Services and Social Assistance 12, social rehabilitation is defined as "a set of measures aimed at restoring or improving social functioning abilities in order to ensure social recovery of status and integration into society and includes services at the place of residence of a person and at a social care and social rehabilitation institution or place of residence or social care and social rehabilitation institution."

Vocational rehabilitation:

The Law on Social Services and Social Assistance 13 defines vocational rehabilitation as "" a set of measures that following an individualised assessment of functional disorders and determination of vocational suitability ensures the acquisition of a new occupation, vocational knowledge or skills or renewal thereof, including the acquisition of a vocational education programme at basic and secondary education level and multidisciplinary services for integration into the labour market for persons of working age.

5. Rehabilitation needs

Health context or trends can serve as proxy indicators that may drive demand for rehabilitation services. These include the age of the population, the situation of noncommunicable diseases (NCDs) and the number of persons with disabilities or functional limitations.

[20] Public Health Guidelines 2021-2027 (likumi.lv)
[21] https://www.vm.gov.lv/lv/veselibas-ministrijas-misija-un-vizija

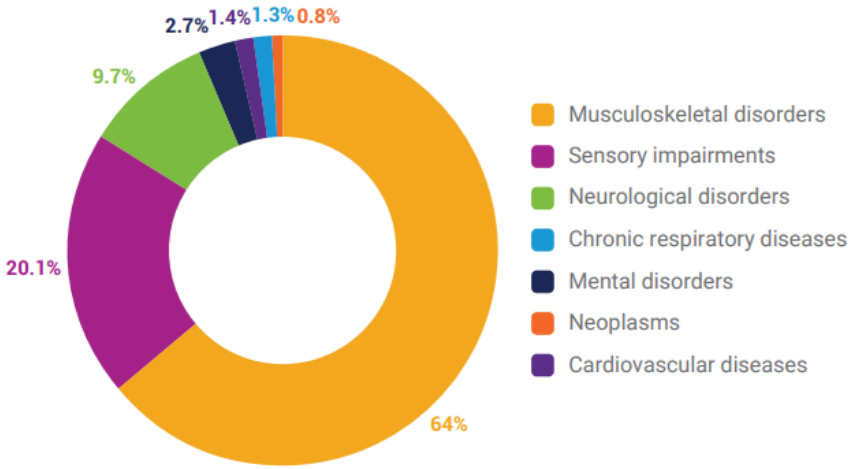
The estimated need for rehabilitation in Latvia

The first study to produce a global estimate of the need for rehabilitation services was published in *The Lancet* in December 2020.[22] The estimates are based on the Global Burden of Disease and are summarized according to global estimate, regional estimate, and figures specific to Latvia.[23]

- Globally, 1 in 3 people could benefit from rehabilitation and in 2019, 2.4 billion people experienced conditions that could benefit from rehabilitation.
- In the European Region, 2 in 5 people could benefit from rehabilitation and 370 million people experience conditions that could benefit from rehabilitation.
- In Latvia 1 in 4 people have at least one condition that would benefit from rehabilitation services.

Further analysis reveals that from a population of 1,915,292 people in Latvia, 897,949 people have a condition that is amendable to rehabilitation. Thus, based on this data, 26.5% of the population could benefit from rehabilitation, and these conditions contribute to 111,206 years lived with disability. The report demonstrates that the top condition driving the need for rehabilitation is musculoskeletal disorders, followed by sensory impairments and neurological disorders. A further breakdown showing prevalence by disease and injury is provided in Figure 6.

Figure 5. Prevalence of condition in Latvia amenable to rehabilitation 2019.



Population ageing

[22] Cieza A, Causey K, Kamenov K, Hanson SW, Chatterji S, Vos T. Global estimates of the need for rehabilitation based on the Global Burden of Disease study 2019: a systematic analysis for the Global Burden of Disease Study 2019. Lancet. 2021 Dec 19; 396(10267):2006-2017. doi: 10.1016/S0140-6736(20)32340-0.

[23] World Health Organization. Regional Office for Europe. (2022). The need for rehabilitation services in the WHO European Region. World Health Organization. Regional Office for Europe. https://iris.who.int/handle/10665/364705. License: CC BY-NC-SA 3.0 IGO

Latvia has an ageing population with 26.7% of the population aged over 60 in 2023. According to the UN demographic aging scale when the proportion of 65 and above population exceeds 7% of the population structure, the latter is considered ageing.

Increasing age correlates with multimorbidity and functioning impairments resulting from frailty, impaired cognition as well as continence, gait and balance problems.[24] Collectively, these functioning impairments lead to a higher risk of disability and difficulties in completing essential daily activities, and consequently, this group is one of the largest user's rehabilitation services. No data was available on the prevalence of age-related conditions such as frailty or dementia in Latvia.

Data for adults:

Traumatic injuries:

The burden of violence and unintentional injuries contributes significantly to the need for rehabilitation services.[25] For serious injuries, such as those sustained in assaults or road traffic crashes, rehabilitation and assistive products are often required to improve the outcomes of emergency and surgical care to limit the physical and psychological impact of injuries and reduce long term disability. Table 1 shows the reported number of cases of traumatic injuries in Latvia in 2022 per 10,000 of the population.[26]

Table 1: Reported number of cases of traumatic injuries in Latvia in 2022 per 10,000 of the population[27]

Injury	Number of persons reported injured in 2022
Road traffic	1399
Significant burns: (based on degree and total body surface area TBSA tool)	302 (diagnosis codes T20–T32 according to ICD-10)
Falls	3484
Total number of trauma, injuries and poisonings	17,726

Neurological conditions

Neurological conditions that affect adults include multiple sclerosis, spinal cord injury, traumatic brain injury. In Latvia, data on such conditions is only collected for multiple sclerosis, and in 2022 0.11% of adults aged 15-47 years old in Latvia had the condition.[28]

[24] Chatterji S, Byles J, Cutler D, Seeman T, Verdes E. Health, functioning, and disability in older adults--present status and future implications. Lancet. 2015; 385(9967):563-75. doi: 10.1016/S0140-6736(14)61462-8.
[25] World report on road traffic injury prevention. Geneva: World Health Organization; who.int/iris/handle/10665/42871 http://apps 2004
[26] Register of patients with certain diseases, Centre for Disease Prevention and Control
[27] Register of patients with certain diseases, Centre for Disease Prevention and Control
[28] Healthcare quality monitoring system: National Health Service (publicly funded healthcare) and Centre for Disease Prevention and Control data

Noncommunicable and communicable diseases (NCDs)

Noncommunicable and communicable diseases can lead to functioning difficulties related to mobility, self-care, communication, pain and cognition that could benefit from rehabilitation services.[29] Latvia has a high burden of NCD's, demonstrated in table 2.

Table 2: Prevalence of noncommunicable disease (% of 15–74-year-olds in the Latvian population unless otherwise stated)

NCD	**% of 15–74-year-olds in the Latvian population**
Cancers	4.0% in 2017 (latest available data)[30]
Diabetes	5.21% in 2022[31]
Cardiovascular diseases: **Hypertension** **angina pectoris** **heart failure**	In 2022[32] 27% 6% 9%
Number of unique individuals treated in hospital for a cardiovascular disease (according to ICD-10):	2% (38,483 people) in 2022[33]
Respiratory disease: **Emphysema or chronic bronchitis** **Asthma** **Number of unique individuals treated in hospital for respiratory diseases (according to ICD-10):**	 4% 2022[34] 4% 2022[35] 1% (17,210 people)[36]
Stroke	Number of unique individuals treated in hospital for stroke (I60-I64 according to ICD-10): 6195. [37]

Table 3 Communicable diseases as a percentage of population at the end of 2022:

Communicable disease	**Percentage of population at the end of 2022**
HIV	0.3%
AIDS	0.05%
Long COVID	Unknown

[29] Global status report on noncommunicable diseases 2010. Geneva: World Health Organization; 2011 (http://apps.who.int/iris/handle/10665/44579.

[30] Register of patients with certain diseases, Centre for Disease Prevention and Control

[31] Register of patients with certain diseases, Centre for Disease Prevention and Control

[32] Health Behaviour Among Latvian Adult Population, 2022, Centre for Disease Prevention and Control, https://www.spkc.gov.lv/lv/media/18708/download?attachment

[33] Healthcare quality monitoring system: National Health Service (publicly funded healthcare) and Centre for Disease Prevention and Control data

[34] Health Behaviour Among Latvian Adult Population, 2022, Centre for Disease Prevention and Control, https://www.spkc.gov.lv/lv/media/18708/download?attachment

[35] Health Behaviour Among Latvian Adult Population, 2022, Centre for Disease Prevention and Control, https://www.spkc.gov.lv/lv/media/18708/download?attachment

[36] Healthcare quality monitoring system: National Health Service (publicly funded healthcare) and Centre for Disease Prevention and Control data

[37] Healthcare quality monitoring system: National Health Service (publicly funded healthcare) and Centre for Disease Prevention and Control data

Table 4: Prevalence of other conditions that could benefit from rehabilitation:[38]

Condition group	**Condition**	**% prevalence among the Latvian population aged 17-74 years in 2022**
Mental health conditions	Depression	0.61% (diagnosis codes F32–F33 according to ICD-10)
	Anxiety	0.20% (diagnosis codes F40–F42 according to ICD-10)
	Schizophrenia	0.77% (diagnosis code F20 according to ICD-10)
	Bipolar disorder	0.05% (diagnosis code F31 according to ICD-10)
Musculoskeletal conditions	Prevalence of osteoarthritis and rheumatoid arthritis	According to population survey, in 2022, 7% of 15–74-year-olds were treated or diagnosed over the past year.
	Unique individuals treated in hospital for hip fracture	2647 people or 141 per 100,000 population[39] in 2022.
	Unique individuals with new lower limb amputations	As of 2022 1250 unique individuals in the last 5 years, excluding deceased.[40]
	Other, such as lower back pain	Not available

Data for children:

Table 5 shows the prevalence of developmental and neurological conditions in children as % of population aged 0-17.[41]

Condition	**% of the population ages 0-17**
Intellectual impairment (diagnosis codes F70–F79 according to ICD-10)	0.64%
Developmental disorders (diagnosis codes F80–F89 according to ICD-10)	0.72%
Childhood and atypical autism (diagnosis codes F84.0, F84.1 according to ICD-10)	0.13%

Table 6: shows the number of cases of defined congenital anomalies of those aged under 17 as of 07.07.2023 according to their year of birth:[42]

If necessary, based on ICD-10 diagnosis codes, other congenital anomalies can be selected from the register of patients with certain diseases with congenital anomalies.

[38] Register of patients with certain diseases, Centre for Disease Prevention and Control

39 Healthcare quality monitoring system: National Health Service (publicly funded healthcare) and Centre for Disease Prevention and Control data

40 Healthcare quality monitoring system: National Health Service (publicly funded healthcare) and Centre for Disease Prevention and Control data

41 Healthcare quality monitoring system: National Health Service (publicly funded healthcare) and Centre for Disease Prevention and Control data

42 Register of patients with certain diseases, Centre for Disease Prevention and Control Needs link

Cleft lip:	2019 – 1 2020 – 9 2021 – 1 (diagnosis code Q36 'Cleft lip' according to ICD-10).
Club foot:	2019 – 17 2020 – 16 2021 – 5 (diagnosis code Q66.0 'Talipes equinovarus' according to ICD-10)

Data on Persons with disabilities

Rehabilitation intersects with the disability sector, as persons with disabilities are a key population group who may benefit from rehabilitation. The United Nations (UN) Convention on the Rights of Persons with Disabilities (CRPD) defines persons with disabilities as "those who have long term physical, mental, intellectual, or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others[43]." 135 million people in the WHO European Region are estimated to experience disability.[44] This number is expected to increase with an ageing population and the rise in prevalence of non-communicable diseases. Persons with disabilities often face barriers to accessing and using health information and services, including vital rehabilitation services and assistive technologies. Such barriers often lead to unmet health care needs, increased protection risks, and poorer health outcomes than persons without disabilities.

The prevalence of disability among the population of Latvia is estimated to be 11% in 2023.
In total, 204,158 adults and 9,372 children aged under 17 in Latvia were registered as having a disability in 2023. Table 7 shows the number of registered persons with disabilities in Latvia by disability group and type of functional limitations in 2021, 2022 and 2023.

Disability group, functional impairment and year from the Latvian disability register:[45]

Disability group	Impairment	2021	2022	2023
Total	**Total**	201984	206386	213487
	Vision impairment	9794	9964	10294
	Hearing impairment	2602	2632	2683
	Restricted mobility	36791	38517	40791
	Mental and behavioural disorders	28118	29039	30276
	Other or not stated	124837	129404	132784
Adults with disabilities	**Total**	193292	197397	204158
	Vision impairment	9481	9643	10002
	Hearing impairment	2122	2151	2216
	Restricted mobility	36432	38091	40384
	Mental and behavioural disorders	25194	25724	26579
	Other or not stated	120221	121956	125206
Group I	**Total**	26736	27431	28353
	Vision impairment	2653	2644	2737
	Hearing impairment	2	3	3

[43] Committee on the Rights of Persons with Disabilities. Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities. The right to liberty and security of persons with disabilities. Geneva: OHCHR; 2015. Available here: https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-persons-disabilities

[44] World Health Organization Regional Office for Europe. 2021. Policy brief on disability-inclusive health systems. https://apps.who.int/iris/handle/10665/350143

[45] Official statistics portal. Persons with disabilities by disability group and functional limitations in State cities and municipalities 2021–2023, Central Statistical Bureau, institution responsible for table preparation: Ministry of Welfare https://data.stat.gov.lv/pxweb/en/OSP_PUB/START__VES__VD__VDE/VDE070/)

	Restricted mobility	2524	2563	2633
	Mental and behavioural disorders	5013	5279	5729
	Other or not stated	16548	16947	17265
Group II	**Total**	87967	89532	91742
	Vision impairment	2530	2621	2717
	Hearing impairment	58	62	65
	Restricted mobility	13392	14121	14884
	Mental and behavioural disorders	18492	18697	18893
	Other or not stated	53507	54045	55208
Group III	**Total**	81508	83485	87283
	Vision impairment	4350	4419	4574
	Hearing impairment	2063	2086	2149
	Restricted mobility	20617	21507	22970
	Mental and behavioural disorders	1708	1778	1984
	Other or not stated	52802	53727	55644
Children with disabilities	**Total**	8746	9056	9372
	Vision impairment	316	280	266
	Hearing impairment	480	481	466
	Restricted mobility	366	326	304
	Mental and behavioural disorders	2947	3285	3670
	Other or not stated	4637	4685	4667

** One person may have several types functional limitations and several disability groups in the same reference period, therefore the total number of people in the sum of all types of limitations or all disability groups is greater than the number of unique cases.*

Type of functional limitations is based on the basic diagnosis (classified under Statistical Classification of Diseases and Related Health Problems (ICD-10)). During the reporting period one person may be both a child and an adult.

6. Rehabilitation governance

Key Components	Status
Rehabilitation Legislation and Policies	Rehabilitation is integrated into the main health policy strategy and some health laws and specific guidance.
Rehabilitation Strategic Plan	Latvia has not yet developed a rehabilitation strategic plan.
Leadership and Coordination	Rehabilitation leadership is not centralized in one ministry and coordination mechanisms on rehabilitation are very weak. There is no one government person who has responsibility for rehabilitation.
Rehabilitation accountability and reporting	Very limited information is collected and reported on for rehabilitation, with no national reporting standards or guidelines.
Regulatory Mechanisms	Licensing in Latvia is legislated at facility level and for professionals.
Assistive Technology (AT) Policies, Plans, Procurement	The MoH is responsible for AT in hospitals whilst responsibility for provision outside of hospital sites is the responsibility of the MoW, with no apparent cooperation or treatment transfer between agencies. There is legislation for access to AT, its procurement and financing, and an essential products list.

6.1. Rehabilitation governance and regulatory documents

Key health policy regulatory documents for rehabilitation:
Rehabilitation is included in the national health strategic plan "Public Health guidelines 2021-2027"[46] in specific fields of action: (3) Human-centred and integrated healthcare, sub-goal: To promote the availability of people-centered and integrated health care services. Furthermore, rehabilitation is in included in legislation and provided for in the populations entitlements to state funded health care services in the State minimum paid medical assistance, and the State mandatory health insurance.[47]

The Medical Treatment Law 210[48] stipulates that medical treatment must include access to medical rehabilitation. According to the Law on the Rights of Patients 211, a patient has the right to high-quality and qualified medical treatment, regardless of the nature and severity of his or her illness.[49]

Since 2019, the state procures rehabilitation services from facilities through strategic selection. Specific criteria, minimum requirements and organizational arrangements are defined for the strategic selection. The services provided are defined in Cabinet Regulation No. 555 'Procedures for the organization of and payment for health care services' of 28 August 2018.[50] This Regulation prescribes the health care services included in the state paid medical assistance minimum and State mandatory health insurance, the procedures for organizing the provision of these services and making payment for them, and also the amount of payment for the abovementioned services.

[46] Public Health Guidelines 2021-2027 (likumi.lv)
[47] Republic of Latvia Cabinet, Regulation No. 555, Adopted 28 August 2018, Procedures for the Organization of and Payment for Health Care Services. Available here: https://likumi.lv/ta/en/en/id/301399
[48] Ārstniecības likums. https://likumi.lv/ta/id/44108
[49] https://likumi.lv/ta/id/203008
[50] Cabinet Regulation No. 555 'Procedures for the organization of and payment for health care services' of 28 August 2018. https://likumi.lv/ta/en/en/id/301399-procedures-for-the-organisation-of-and-payment-for-health-care-services

As described in annex 12 of the regulation, rehabilitation services are provided for in areas with a population of more than 30,000 people. Previous year's uptake (number of visits/bed-days) and waiting lists for services are taken into account when planning funding for the following year.
Cabinet Regulation No. 682 'Procedure for receiving state-funded professional rehabilitation services and professional suitability assessment services'[51] determines the procedure and priority by which a person of working age, if she/he has a functional disorder or certain disability, receives state-funded rehabilitation services.

Despite legislation entitling Latvians to state funded rehabilitation, there is no overarching government strategic plan for rehabilitation, nor is there a dedicated governmental official who has responsibility for rehabilitation strategy or policy formulation in Latvia. Multiple ministries provide for rehabilitation, and there are no formal mechanisms for coordination of rehabilitation between ministries. However, it should be noted and emphasized that inter-ministry work groups are regularly organized to find solutions to current challenges.

At the Ministry of Health, rehabilitation policy matters are handled by the Department of Healthcare. There is one person who mostly works on these issues, although not full-time. It is important to note that the rehabilitation issues are also being integrated into other healthcare fields, such as cardiovascular diseases, oncology, and mental health, and the care plan for rare diseases.

At the MoW, no one is specifically charged with dealing with rehabilitation policy matters. There is one person who handles matters related to technical aids, among other duties. The MoE also does not have a designated person for rehabilitation. A MoH rehabilitation expert working group exists whose purpose is to plan the development of the respective sub-sector of healthcare, to address problems, and to coordinate the activities of medical institutions and other sectoral bodies, but it is currently dormant. Therefore, leadership and coordination for rehabilitation and assistive products at government level is currently fragmented and on a task-by-task basis. At inter-ministerial level, it appears that there is a lack of understanding of what functional rehabilitation is and its benefits.[52]

Within the MoH, the delivery of rehabilitation is referenced or specified across many documents and for specific conditions. Some key documents and their relevance are referenced in Text Box 1.

[51] The procedure by which a person receives state-funded professional rehabilitation services and professional suitability assessment services' Number: 682Adopted: 02.11.2022.Enters into force:08.11.2022.Published:Latvijas Vēstnesis, 216, 07.11.2022.OP number:2022/216.4
https://likumi.lv/ta/id/336971-kartiba-kada-persona-sanem-valsts-finansetus-profesionalas-rehabilitacijas-pakalpojumus-un-profesionalas-piemerotibas-noteiksanas-pakalpojumu

[52] 'Is medical rehabilitation possible given to patients who have it needed and at the right time? 07.12.2018' https://www.lrvk.gov.lv/lv/getrevisionfile/uploads/reviziju-zinojumi/2016/2.4.1-44_2016/Revizijas%20zinojums_Mediciniska%20rehabilitacija_07122018.pdf

Text box 1: Key examples of rehabilitation integration in policy documents:

On the Healthcare Services Improvement Plan in Oncology 2022–2024[53] One of the purposes of this planning document is to develop and promote a multidisciplinary approach to the treatment and care of oncology patients and to improve their quality of life with access to medical rehabilitation, psychosocial rehabilitation, palliative care services, and psycho-emotional support.
On the Plan for Improving the Organization of Mental Healthcare 2023-2025[54] The purpose of this planning document is to ensure access to evidence-based, high-quality mental health care that meets the needs of the public through the development of community-based services, promotion of early diagnosis of mental illnesses, assurance of timely and consistent treatment, and high-quality medical rehabilitation. The plan includes the development of new service programs (autism spectrum disorders, eating disorders), placing the greatest emphasis on the development of follow-up rehabilitation programs.
Rare Diseases Plan 2023–2025[55] The plan seeks to improve the availability and quality of medical rehabilitation services for patients with rare diseases, including improvements in the knowledge and skills of service providers working with such patients.
On Social Security and Labour Market Policy Guidelines 2021–2027[56] The aim of the social protection and labor market policy is to promote the social inclusion of the population, reducing income inequality and poverty, developing an accessible and individual needs-appropriate social service and legal support system, as well as promoting a high level of employment in a quality work environment. Professional rehabilitation and social rehabilitation services are accommodated for in this policy document.
The Improvement and Development of Social Services 2022–2024.[57] The purpose of the plan is to determine the measures to be taken in the short term in order to promote the smooth development of social services that meet the needs of individuals. To achieve the goal, the plan envisages a set of complex measures to attain 2 goals: 1. A modern and accessible system of social services, which, among other things, improves citizens' opportunities to live independently and live in society, to be included in education and the labor market; 2. Strengthening the management of the field of social services.

[53] https://likumi.lv/ta/id/333775-par-veselibas-aprupes-pakalpojumu-uzlabosanas-planu-onkologijas-joma-20222024-gadam
[54] https://likumi.lv/ta/id/338032-par-psihiskas-veselibas-aprupes-organizesanas-uzlabosanas-planu-20232025-gadam
[55] https://likumi.lv/ta/id/336729-plans-reto-slimibu-joma-2023-2025-gadam
[56] https://likumi.lv/ta/id/325828-par-socialas-aizsardzibas-un-darba-tirgus-politikas-pamatnostadnem-2021-2027-gadam
[57] https://likumi.lv/ta/id/331256-par-socialo-pakalpojumu-pilnveidosanas-un-attistibas-planu-2022-2024-gadam

From. Pk	Task	Deadline (year)	Responsible institution [30]	Co-responsible institutions [31]	Linkage to policy outcome and performance indicator
3.2.4.	Develop rehabilitation services and improve their availability and timeliness in the subsequent treatment process (related to task 5.7).	2021-2027	WC	LM, NGO	PR: 18./ RR: 18.1., 18.2.PR: 19./ RR: 19.6.

6.2 Rehabilitation accountability, reporting, and transparency

National rehabilitation data collection and reporting:

Data is collected by the MoH from NHS facilities via their invoicing to the MoH to receive income for their provision of rehabilitation services. From this NHS payment system, information can be obtained on:

1) the type of rehabilitation service received (e.g. outpatient rehabilitation for children, outpatient rehabilitation for adults, day hospital rehabilitation for children, day care rehabilitation for adults, early intervention etc.
2) service provider for rehabilitation (e.g. medical institution; specialist).
3) an overview of the scope of the service provided in the number of visits, with which professional and for what treatment (e.g. with a neurological patient, sensory stimulation).

Additionally, the achievement of an individual's rehabilitation goals is reported by facilities using the following codes:

• 60422 Rehabilitation course plan goal achieved
• 60423 Rehabilitation course plan goal partially achieved
• 60424 Rehabilitation course plan goal not achieved
• 60425 Rehabilitation course discontinued due to patient's absence
• 60426 Rehabilitation course discontinued for other reasons

On discharge from hospital, a patient's pathway is reported as:

• 60387 Referral issued for social rehabilitation services
• 60388 No further rehabilitation required
• 60389 Referral issued for rehabilitation at home
• 60390 Rehabilitation plan issued for mono-professional outpatient rehabilitation
• 60391 Rehabilitation plan issued for day hospital rehabilitation
• 60392 Rehabilitation plan issued for inpatient rehabilitation
• 60393 Dynamic observation plan issued
• 60394 Repeat physical medicine and rehabilitation physician consultation required after mono-professional rehabilitation

However, despite collecting this data, it is not publicly reported or used, and analysis is not carried out systematically, only upon individual requests. Furthermore, there is no assessment of service quality, and it is not possible to obtain data on patients' functioning status, and data is not collected at individual level. There are no national standards on what information should be collected. Thus, it is difficult to transfer or compare information between facilities or see what services a patient has received, as the functionality of the existing IT system does not currently provide for this.

Accountability regulation for rehabilitation service providers:
Specific health care regulatory frameworks exist that apply to rehabilitation service provision, these include:

- Workforce: Cabinet Regulation No. 943 'Procedures for certification of medical practitioners' of 18 December 2012 (Cabinet of Ministers, 2012).[58]
- Facilities: Cabinet Regulation No. 60 'Regulations regarding mandatory requirements for medical treatment institutions and their structural units' of 20 January 2009 (Cabinet of Ministers, 2009).[59]

6.2 Requirements for outpatient rehabilitation institution

- Outpatient rehabilitation institution is a medical treatment institution or its structural unit, which provides rehabilitation services as various comprehensive or specialized (including technical orthopedics) rehabilitation programmes.
- Outpatient rehabilitation institution complies with general requirements for outpatient medical treatment institutions referred to in this Regulation.
- Outpatient rehabilitation institution has:
    - rehabilitation rooms for PRM physician and at least one functional specialist;
    - medical devices for diagnosis, patient's physical examination and assessment of functional ability (functional laboratory);
    - patient WC suitable for persons with functional disorders, including equipped with a nurse call button.
      [10 December 2013]

6.3 Requirements for orthopedic technology institution

Orthopedic technology institution is a specialized outpatient rehabilitation institution, which provides production and adaptation of individual or reusable assistive technology devices in accordance with a patient diagnosis, functional disorders and social situation. Orthopedic technology institution complies with general requirements for outpatient medical treatment institutions referred to in this Regulation.

There are the following orthopedic technology institutions:

- Orthopedic technology offices;
- Orthopaedic technology centers;
- Hearing prosthetic centers.
- Orthopedic technology institution ensures.

[58] https://likumi.lv/ta/id/352922-arstniecibas-personu-sertifikacijas-kartiba
[59] Regulations Regarding Mandatory Requirements for Medical Treatment Institutions and Units Thereof

Orthopedic technology institutions provides:

- Compliance of the layout of the premises with the technological processes for production and adaptation of assistive technology devices;
- Patient rooms separately from workshop premises, including patient WC suitable for persons with functional disorders.
- Choice of assistive technology devices in accordance with a patient diagnosis, functional disorders and social situation.
- Production and adaptation of assistive technology devices.
- Disinfection, washing and drying of leased and returned assistive technology devices (if assistive technology devices have been leased).
- Patient training for use of assistive technology devices and necessary quantity and quality of exercises control of further results.
- Orthopedic technology center provides services related to industrial and individual production of assistive technology devices, as well as rehabilitation services to train patients for their use.
- Orthopedic technology office provides adaptation of industrially produced assistive technology devices to the patient or production of individual assistive technology devices.
- Hearing prosthetic center provides production of individual ear insert appropriate to the patient or provides adaptation of hearing prosthesis in accordance with a patient's hearing functions (hearing aid, cochlear implant), the appropriate verification, adjustment or programming.
- Hearing prosthetic center has:
    - Otoplasty office;
    - Hearing aid programming and adjustment office.
    - Cochlear implant verification and programming office.

Specialized rehabilitation hospital has:

- An in-patient unit.
- Out-patient department, which has at least:
- Physical medicine and rehabilitation physician's office;
- Functional ability assessment laboratory.
- Functional specialist offices.

Specialized rehabilitation hospital provides:

- Assessment of the patient's health status, determining the most appropriate reception time (performs selection of patients), reception and development of individual rehabilitation plan in accordance with patient's diagnosis, limitations in functional ability and social situation.
- Use of rehabilitation technologies in the necessary amount and quality in accordance with the rehabilitation plan.
- Development of a post-treatment care and social rehabilitation plan for the patient after discharge from a hospital.

Rehabilitation users' inclusion in planning for rehabilitation:
Whenever any law, regulation or strategic planning document is drafted, it is made available for public consultation, which means that any public administration organization or NGO can express its views on the document and make proposals through the public portal for draft legislation. However, there is no user satisfaction assessment or monitoring of this process.

The SSDC (Social Services Development Council)[60] supervises the implementation of the Social Security and Job Market Policy Guidelines 2021–2027, and the Social Service Improvement and Development Plan 2022–2024, to coordinate the implementation of planned activities in order to support the development of a modern and accessible social services system. SSDC includes representatives of line ministries, regional authorities, and disability NGOs.

The technical Aids Council[61] includes representatives of 12 NGOs and professional organizations in the sector that makes proposals for the inclusion of new technical aids to be financed by the state and raises awareness of matters related to the provision of technical aids.

According to its statute, the Council of Representatives of NGOs and Professional Organizations is an advisory body to the MoW funded Vaivari Rehabilitation Centre, which monitors changes in the laws and regulations that governs technical aids.

7. Governance, procurement, and regulation of assistive products

Overview:
In Latvia, APs are often referred to as 'assistive devices' or 'AD,' for short. The 'Social Services Improvement and Development Plan 2022-2024'[62] includes previously mentioned regulations referring to access to rehabilitation and AT. However, the overarching summary of the situation for providing AT in Latvia is that the availability of AT is very limited. Therefore, access to AT is mostly through private services and OOP. For state funded services, co-payments are required for most people to receive a product, and access to AT in acute settings is extremely limited. Further complicating the issue, the MoH oversees assistive technology in hospitals, while the MoW manages provision outside hospitals, with no coordination or transfer of care between them.

There is in place a complex and burdensome administrative process for obtaining state-funded, custom-made products such as splints. Hospitals do not have P&O departments or employ P&O professionals, and therefore this service operates outside of hospitals and under the MoW, not the MoH. Wait lists are long and needs often go unmet. AT can be fixed for free at Vavari if the product was provided there, or in a few other town centres only.

[60] https://www.lm.gov.lv/lv/socialo-pakalpojumu-attistibas-padome-0 - Available in English
[61] https://vtpc.lv/lv/nevalstisko-organizaciju-un-nozares-profesionalo-organizaciju-parstavju-padome
[62] On the Plan for the Improvement and Development of Social Services 2022–2024.Improvement of social and psychosocial rehabilitation services and introduction of new services. Order of the Cabinet of Ministers no. 231 in Riga on March 30, 2022 (Prot. No. 18 § 36)https://likumi.lv/ta/id/331256-par-socialo-pakalpojumu-pilnveidosanas-un-attistibas-planu-2022-2024-gadam

Almost all mobility assistive devices, some alternative communication AT, functional beds, and some pediatric hygiene ATs are intended for reuse if they meet the necessary standards after inspection and refurbishment. However, there are instances where assistive devices reach a condition that renders them beyond repair or unsuitable for reuse. Additionally, there are established usage periods for various types of AT, after which individuals may request a replacement if needed. For example: active wheelchairs: Intended for a usage period of 4 years. After this period, the individual is eligible to receive a new one if required.AT for hygiene is typically intended for a usage period of 2 years, after which the individual may request a replacement.

Regulation

The order in which persons can receive assistive products, the list of products to be financed from the state budget, as well as the one-time financial contribution that patients make for their product are determined by Cabinet of Ministers decree no. 878 "Rules for technical aids."

Specific legislation for AT provision for persons with visual and hearing impairments exists in regulation number 250 "The order in which the Society of the Blind of Latvia and the Union of the Deaf of Latvia provide social rehabilitation services and provide technical aids - tiflotechnics and surdotechnics".[63] According to the regulation, resources are provided in the state budget for 41 AP to people with hearing or visual functional impairments, including equipment with speech functions, orthoses and prostheses, personal mobility aids (tactile canes), household aids (devices with speech and tactile functions), communication and signaling aids (binoculars, monoculars, hearing aids, etc), aids for environmental improvement and assessment (devices with speech and tactile function).

When receiving an assistive product, a one-time payment must be made. For a child this payment is 1.42 euros; for a person older than 18 years the payment is 7.11 euros. A person whose household is receiving government financial support, who is in a long-term care, whose place of residence is registered in an inpatient treatment facility, and person who is serving a sentence in a prison is exempt from the one-time contribution.

Assistive products provided by the MoW budget and their regulation:

The direct provision of assistive products to service recipients is regulated by Regulations No. 878,[64] "Regulations on Technical Aids". The regulation also stipulates the quality and provision of AT. According to these regulations, 225 different types of assistive products are provided at the expense of the state budget. These products are intended for the "support, training, or replacement of body functions." Examples of state-funded equipment and products include:

- Long-term oxygen therapy for use outside of medical institutions.
- Anti-bed sore pillows and mattresses.
- Specialist tables and chairs for children with disabilities.
- Self-care products, such as stocking pullers, toilet chairs, and bath chairs.

[63] Regulation number 250 "The order in which the Society of the Blind of Latvia and the Union of the Deaf of Latvia provide social rehabilitation services and provide technical aids - tiflotechnics and surdotechnics". https://likumi.lv/ta/id/322623-kartiba-kada-latvijas-neredzigo-biedriba-un-latvijas-nedzirdigo-savieniba-sniedz-socialas-rehabilitacijas-pakalpojumus-un-

[64] https://likumi.lv/ta/id/328672-tehnisko-paliglidzeklu-noteikumi

- Mobility aids, including wheelchairs, crutches, canes, tripods, and quadripods.
- Orthoses and prostheses.
- Aids for household activities and participation, including furnishings and equipment like functional beds and support handles.
- Alternative communication technical aids.
- Other types of technical aids designed to facilitate daily activities.

Cabinet Regulation No. 899 'Procedures for the reimbursement of expenditures for the acquisition of medicinal products and medical devices intended for the outpatient medical treatment'[65] describes the provision of products and the cost to patients.

Example equipment and products provided include long-term oxygen therapy outside a medical institution, anti-bed sore pillows and mattresses, specialist tables and chairs for children with disabilities, self-care products such as stocking pullers, toilet chairs, bath chairs, mobility aids (wheelchairs, crutches, tripods, quadripods, etc.), orthoses, prostheses, aids for household activities and participation in household, furnishings, equipment and other aids to facilitate activities (functional beds, support handles, etc.), alternative communication technical aids, and other types of technical aids. The catalog of state funded assistive products is available on the website of the Vaivari assistive devices center.[66]

Regulation No. 461 addresses aspects that are not directly related to the provision of ATts but instead focus on essential requirements for medical devices, inclusive of the following.

- Essential requirements for medical devices.
- Procedures for recycling single-use medical devices.

Cabinet Regulation No. 899, "Procedures for the Reimbursement of Expenditures for the Acquisition of Medicinal Products and Medical Devices Intended for Outpatient Medical Treatment," outlines the reimbursement policies for medications and certain medical devices. This regulation includes provisions for Incontinence products and urinary catheters, medication inhalation chambers, stoma care products, glycemia test tripes.

Cabinet Regulation No. 461 'Medical device regulations' of 15 August 2023 addresses aspects that are not directly related to the provision of assistive technology but instead focus on essential requirements for medical devices, including:[67]

- Essential requirements for medical devices;
- Procedures for recycling single-use medical devices;
- Procedures for placing medical devices on the market and putting them into operation;
- Procedures for registering information on manufacturers of medical devices, medical devices manufactured by them, as well as distributors of medical devices;
- Procedures for the distribution, operation, vigilance, after-market and technical supervision of medical devices.

[65] https://likumi.lv/ta/en/en/id/147522-procedures-for-the-reimbursement-of-expenditures-for-the-acquisition-of-medicinal-products-and-medical-devices-intended-for-the-outpatient-medical-treatment
[66] https://vtpc.lv/lv/kategorija/parvietosanas-paligierices
[67] Cabinet Regulation No. 461 'Medical device regulations' of 15 August 2023. https://likumi.lv/ta/id/344674

Essential requirements for medical devices, basic rules for recycling single-use medical devices, prerequisites for putting medical devices on the market and putting them into operation, basic rules for distribution of medical devices, vigilance and after-market monitoring are determined by Regulation (EU) No. 5 of the European Parliament and of the Council of April 5, 2017. 2017/745 concerning medical devices amending Directive 2001/83/EC , Regulation (EC) No. 178/2002 and Regulation (EC) No. 1223/2009 and repeals Council Directives 90/385/EC and 93/42/EEC.

In line with WHO guidance, Latvia has an essential list of AP's. The 'Rules for technical aids'[68] regulations contain a complete list of state funded products. Products, referred to as aids in Latvia law, are divided into 11 categories as follows;

1. Aids for measuring, supporting, training or replacing body functions.
2. Training and skill acquisition aids.
3. Custom-made orthoses.
4. Prostheses.
5. Orthopedic shoes.
6. Aids for self-care and participation in self-care.
7. Aids for activities and participation related to personal mobility and transportation.
8. Aids for performing household activities and participating in the household.
9. Arrangement, equipment and other aids to facilitate activities in an environment arranged by persons in indoor and outdoor spaces.
10. Alternative communication technical aids.
11. Aids for controlling, carrying, moving or grasping objects and devices.

Whenever a person is issued with a factory-made technical aid, they are provided with training in the use and adjustment of the technical aid, while custom-made technical aids are built according to the person's individual needs.

When issuing a technical aid, the center or service provider is required to;

- Performs an assessment of the person's functioning.
- Adjusts the technical aid according to the person's individual anthropometric indicators.
- Trains a person to use a technical aid.
- Issues instructions for the use and technical maintenance of the technical aid to the person.
- Concludes an agreement with the person on the transfer of the technical aid to the person for ownership, leasing or rent.

Depending on the type of aid and applicable regulations, individuals can request a replacement or extend the lease after a set period. Each state-issued aid has a specific renewal timeframe—for instance, an adult bimanual wheelchair can be requested again after three years, typically under a lease agreement. In contrast, items like a toilet chair become personal property, and a new one can only be requested through state funding after four years.

If the issued aid does not suit the person, the person has the right to apply to the center within a month after receiving the technical aid with a request to exchange or transfer the technical aid. Also, persons have the right to request a new aid before the deadline specified in the regulations, if the type and

[68] Rules for technical aids Regulations of the Cabinet of Ministers No. 878 in Riga on December 21, 2021 (Prot. No. 81 § 44)https://likumi.lv/ta/id/328672-tehnisko-paliglidzeklu-noteikumi:

severity of the person's functional impairment has changed, so the previously issued technical aid has become unsuitable for further use.

The State Agency of Medicines is responsible for medical devices compliance, and medical products must have a CE certificate.[69] The state procures products in bulk purchase according to the public procurement law,[70] which also stipulates technical specifications for all technical aids.

8. Laws, regulation and the situation of disability:

UN Law on Convention on the Rights of Persons with Disabilities (UNCRPD)

Latvia ratified the UN Law on Convention on the Rights of Persons with Disabilities (UNCRPD)[71] on 1 March 2010. By signing and ratifying the Convention, Latvia is legally committed *"to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity".* Upon the ratification, the UNCRPD was adopted to delegate the protection of rights of persons with disability to the Ombudsman of the Republic of Latvia.

Obtaining disability registration:
Those registered as having a disability can apply for social insurance benefits and financial support, free rehabilitation services, care services, free AT, disability social pension, and to social assistance. To be registered as a person with a disability the persons GP must send the necessary referral documents to the 'State Medical Commission for the Assessment of Health Condition and Working Ability (SMC).' if a person's GP has given an opinion that person needs "special care" then "Questionnaire of Assessment of Everyday Activities and Environment of the Person" is filled by social worker or occupational therapist where person is evaluated face to face at the residence of this person. The rest of the process is done remotely. In the situations where medical information does not provide enough information or there is uncertainty about the adequacy of the information submitted, the person may be asked to appear before the state commission for an in-person assessment.

In line with the UNCRPD, in 2015 criteria for disability assessment were changed to include a select sample of ICF items from body functions, activities and participation to guide the assessment. Furthermore, a self-assessment of functioning was introduced, a "Questionnaire of Assessment of Everyday Activities and Environment of the Person" was added to determine care needs, which is completed by a social worker or occupational therapist.[72] The assessment is based on review of the documents and is not a face-to-face assessment.

A person is registered as having a disability and a reduced capacity to work on an ordinal scale, according to their conditions severity and ability to work:

[69] Regulations of the Cabinet of Ministers No. 878, Regulations on Technical Aids https://likumi.lv/ta/id/328672-tehnisko-paliglidzeklu-noteikumi
[70] Public procurement law https://likumi.lv/ta/en/en/id/287760-public-procurement-law&sa=D&source=docs&ust=1734000771034641&usg=AOvVaw0Fa6ZTO11VxnCF00qgot28
[71] United Nations. "Convention on the Rights of Persons with Disabilities." *Treaty Series*, vol. 2515, Dec. 2006, p. 3.
[72] "World Bank. 2020. Disability Policy and Disability Assessment System in Latvia. Available at: Disability Policy and Disability Assessment System in Latvia v2 (lm.gov.lv)

Disability level	Functional impairment level:
No disability	No functioning restrictions (a loss of general ability to work by up to 24.99 percent, not regarded as a disability for the purposes of the assessment).
Group III disability	Functioning restrictions are moderate (a loss of ability to work is assessed at 25.0-59.99 percent).
Group II disability	Functioning restrictions are severe (a loss of ability to work is 60.0-79.99 percent).
Group I disability	Functioning restrictions are very severe (a loss of ability to work is assessed as 80.0-100.0 percent).

Rehabilitation within disability-related documents

Specific to disability, listed in the text box 2 are the key documents that provide information related to rehabilitation:

Text box 2: key disability documents that provide information related to rehabilitation

Disability Law:
The purpose of the law is to prevent or reduce the risk of disability for persons with predictable disability and to reduce the consequences of disability for persons with disabilities. It defines disability, sets up an organization of disability assessment and provides for support measures to reduce disability, disability risk and the consequences of disability. Section 3 prescribes the procedures by which a disability expert-examination shall be performed and the measures necessary to reduce the risk of a disability and the consequences of a disability.

The law defines a 'predictable disability' as: *restriction of functioning caused by illness or injury, which, in the event that the necessary medical treatment and rehabilitation services are not provided, may be a reason for determining disability.'*
Disability is defined as '*a long-term or permanent restriction of a very severe, severe or moderate degree of functioning, which affects a person's mental or physical abilities, ability to work, self-care and inclusion in society.'*

For children disability is determined without categorization and based on the existence of a specific medical condition from 12 category options, which has been diagnosed by a treating doctor who has provided documentation to confirm the diagnosis.
Disability law 1997. https://likumi.lv/ta/en/en/id/211494-disability-law

Cabinet Regulation No. 805 'Regulations regarding the criteria, time periods and procedures determining predictable disability, disability, and the loss of ability to work':
This Regulation prescribes the criteria, examination and time periods for determination of predictable disability, disability and loss of ability to work.
https://likumi.lv/ta/en/en/id/271253-regulations-regarding-the-criteria-time-periods-and-procedures-determining-predictable-disability-disability-and-the-loss-of-ability-to-work

Rules for technical aids:
The rules determine the National rehabilitation center "Vaivari" of their delegated state duty to ensure the provision of technical aids service to the persons specified in the first part of Article 25 of the Law on Social Services and Social Assistance - conditions of performance and order.
https://likumi.lv/ta/id/328672-tehnisko-paliglidzeklu-noteikumi)

Cabinet Regulation No. 578 'Regulations on receiving social rehabilitation services funded from state budget in a social rehabilitation institution':
Rules how a person with functional impairments at working age (from the age of 15 to the age required for the granting of a state old-age pension) or a person with functional impairments after working age who works (considered an employee or self-employed according to the law " On state social insurance " can receive social rehabilitation services to restore working capacity. https://likumi.lv/ta/id/311143-noteikumi-par-socialas-rehabilitacijas-pakalpojuma-sanemsanu-no-valsts-budzeta-lidzekliem-socialas-rehabilitacijas-institucija

Cabinet Regulation No. 682 'Rules for receiving state-funded professional rehabilitation services and professional suitability assessment services':
The rules determine
1. the procedure by which a person of working age, if he has a functional disorder or certain disability, receives state-funded professional rehabilitation services and professional suitability determination service at the State Agency for Social Integration.
2. the procedure by which a person with a foreseeable disability of working age receives priority services in accordance with the individual rehabilitation plan, as well as the types, scope and conditions of receipt of services.
3. functional disorders for receiving services.
4. Requirements for the service provider. https://likumi.lv/ta/id/336971-kartiba-kada-persona-sanem-valsts-finansetus-profesionalas-rehabilitacijas-pakalpojumus-un-profesionalas-piemerotibas-noteiksanas-pakalpojumu

Regulation No. 250 'Procedure for the Latvian Society of the Blind and the Latvian Association of the Deaf to provide social rehabilitation services and technical aids: typhlo and surdo methods':
The Latvian Association of the Blind and the Latvian Association of the Deaf have the duty delegated by the state to provide social rehabilitation services to persons with visual and hearing disabilities, as well as to provide the service of technical aids – tiflotehnika and surdotehnika to the persons specified in the first part of Article 25 of the Law on Social Services and Social Assistance
https://likumi.lv/ta/id/322623-kartiba-kada-latvijas-neredzigo-biedriba-un-latvijas-nedzirdigo-savieniba-sniedz-socialas-rehabilitacijas-pakalpojumus

Health Care Financing Law:

Section 5(1)(7) of the Law states that public funding must also be allocated to medical rehabilitation, including for persons with disabilities. The law stipulates that persons with a Group I type disability are exempt from all co-payment service charges.
https://likumi.lv/ta/en/en/id/296188-health-care-financing-law.

Challenges reported by DPO's:
The organization of persons with disability feels that the disability register is not accurate or representative of persons with disability as it records conditions but does not measure functional limitation and therefore variation within conditions.

Persons on the register may be eligible for a government disability allowance – even if they are working and earning an income. For those who are registered in category 1, the highest level of disability, they can obtain a government allowance of around 400 euros per month. This is not enough if the person needs carers daily to support with activities of daily living. A personal assistant benefit is separate allowance but can be up to 40 hours per week if you are working, and less if not working.

Persons with disability group I or II, persons under the age of 18 with a disability and a person accompanying a person with disability group I or a person under the age of 18 with a disability are entitled to free public transport (exemption – ferry, plane transportation); however, most of it is not wheelchair friendly. Further, it was reported that there is no wheelchair accessible taxi's in Latvia, and that taxis to health appointments are an OOP. Many health facilities reportedly do not have wheelchair accessible toilets.

Children and young persons with disability under the age of 18:
The organization of persons with disability reports that young children are often referred late to be assessed for disability registration and rehabilitation services. Early years intervention services are available; however, they are overwhelmed, and wait lists are months long.

The MoH provides free AT for children who are inpatients in hospitals, but not to take home with them upon discharge. Once they are discharged from the hospital the MoW are responsible for proving AT. The MoW will provide one item of AT for the child per year, but many children need more than one product, and products may need to be upgraded during the year due to their growth. Therefore, there is some unmet AT need for children and significant OOP. Furthermore, there were some reports that products such as wheelchairs are cheap and of poor quality and do not fit, or are not quite suitable for a child's needs, and so the parents pay out of pocket for alternatives so that their child's needs are met. If the required AT is not available in Latvia, it can be purchased from another EU country and some of the cost will be reimburse by the state, which varies among product.

Of particular concern with the disability register for those under 18 is that they lose their registration and benefits upon turning 18. To be added to the adult register, they must undergo a new assessment, often facing significant delays. There is no automatic transfer between registers, even for individuals with lifelong disabilities. For instance, only 50 people in Latvia are officially registered with autism, despite a much higher known prevalence. The commission for persons with disabilities recommends offering registrants the option of an annual check-up to assess their status and needs. Additionally, a lack of communication between the MoH, MoE, and MoW creates further challenges, leading to delays in assessments and service provision.

Most schools are not accessible for children with disabilities who use a wheelchair or who have vision and hearing impairments, and it is felt that teachers do not have the training to support children with disabilities in the mainstream setting. However, the state policy and regulatory position confirms that parents have the right to choose the educational institution where their child will receive an education,

while simultaneously ensuring the conditions necessary for the child's education, health, and development (Education Law, Sections 57 and 58)[73]. Additionally, educational institutions must comply with the Cabinet of Ministers Regulation No. 556 of November 19, 2019, 'Requirements for General Educational Institutions to Enroll Students with Special Needs in Their Educational Programs'.

[73] See Section 57 and Rights of Parents (Persons who Exercise Custody) in the Provision of Education of a Child [https://likumi.lv/ta/en/en/id/50759].

Summary of Rehabilitation Governance Situation

- **Decentralized Leadership & Weak Coordination:** Rehabilitation and assistive technology (AT) leadership is spread across multiple ministries with weak coordination mechanisms. No single government official is responsible for rehabilitation within or across ministries.
- **Split Responsibilities for AT:** The MoH oversees AT in hospitals, while the MoW manages provision outside hospitals, with no coordination or transfer of care between them.
- **Policy Integration:** Rehabilitation is included in the main health policy strategy, certain health laws, and specific guidance for some populations and conditions.
- **Regulations & Strategic Planning:** While regulations exist for rehabilitation services, AT procurement, and quality standards, Latvia has yet to develop a strategic plan for rehabilitation or AT.
- **Public Involvement:** Rehabilitation users can participate in decision-making through public consultations on laws, regulations, and strategic planning documents. NGOs and public organizations can provide feedback and proposals.
- **Limited Reporting:** Minimal national reporting on rehabilitation and AT exists, with no standardized guidelines.
- **Restricted Access & Out-of-Pocket Costs:** Access to AT is highly limited, and most users must make out-of-pocket payments.
- **Legislation on AT:** Laws govern access, procurement, and financing of AT, including an essential products list.
- **Licensing & Regulation:** Rehabilitation professionals and facilities must be licensed under existing legislation.
- **Disability Prevalence:** In 2022, 11% of Latvia's population had a disability. In 2023, 204,158 adults and 9,372 children under 17 were registered as having a disability.
- **Disability Classification:** Individuals are registered in one of three disability categories based on severity and work capacity. Those with chronic, severe, or progressive conditions are not eligible for rehabilitation, as they are not considered to have potential for improvement.

9. Rehabilitation public financing

Key Components	Status
Mechanisms for Rehabilitation Financing	Through MoH and MoW budgets in 2024
Rehabilitation Expenditure	• MoH (56,657,905 euros). • MoW (8,994,894 euros). • Disability organizations are also provided with funds totaling 5,324,634 euros.
Assistive Product Expenditure	• 7,670,532 euros in 2023 just for products at Vaivari assistive devices centre
Out-of-Pocket Costs for Rehabilitation	• 27% of all health expenditure in Latvia is estimated to be out of pocket expenditure in respect of health and care services generally. • Rehabilitation OOP is not known at this time but is anecdotally reported to be significant.

9.1. General financing information

The responsibility for setting the state budget for health in Latvia lies with the Ministry of Health, the Ministry of Finance, the Cabinet of Ministers, and the Saeima. The Ministry of Finance is responsible for gathering budget requests for submission and approval by the Cabinet of Ministers. The budget for the health sector is under the Ministry of Health, with the majority allocated to the National Health Service through programmes and sub-programmes. The national budget is the primary source of funds for the NHS. Other sources of financing include co-payments, EU funds, local government budgets, and the own revenue of state and municipal medical institutions.

For some public services and facilities, the NHS government reimbursement tariffs are below the cost of providing the service. This results in fewer specialists willing to contract with the NHS, which has an impact on the availability and quality of services offered in public hospitals. Low service tariffs also motivates health professionals to seek employment in the private sector where the pay is better, exacerbating staff shortages and constraining capacity in the public sector.

9.2. Financing for rehabilitation:

The total estimated MoH budget for rehabilitation in 2024 was 56,657,905 euros. It is reported that this annual budget quota is usually spent mid-way through the year, limiting the annual number of rehabilitation interventions to be financed from the statutory health budget**.** Once providers reach the defined annual spending cap, services at the facility are often suspended and patients have to either wait until the following year when the quota is renewed or seek health services privately.

Additionally, the Ministry of Education and Science provided a budget of 213.43 euros per year to the Smiltene Technical School to enable access to vocational education in accordance with Paragraph 4 of Cabinet Regulation No. 655 'Regulations on the minimum costs per student in implementation of vocational education programmes' of 2nd October 2007. The regulation stipulates the provision of

rehabilitation for disabled students, taking into account the different types and manifestations of disability based on their functional impairments.

Table 8: The MoH budget for all rehabilitation services provided in 2024.

Service	Budget, 2024 EUR
TOTAL in country	**56 657 905**
Stationary (in-patient rehabilitation)	**21 820 307**
Medical rehabilitation of long-term artificially ventilated patient	6 718
Rehabilitation of victims of the national Socialist regime	35 609
Rehabilitation of patients with spinal cord cross-damage (spinal patients)	935 994
24-hour inpatient second-stage medical rehabilitation services for adults	10 542 601
24-hour inpatient second-stage medical rehabilitation services for children	2 842 625
Acute rehabilitation allowance in mixed-profile beds	3 834 595
Rehabilitation allowance for psychiatric patients	3 622 165
Day rehabilitation	**14 071 268**
Rehabilitation in a day inpatient for children	3 908 317
Rehabilitation in a day inpatient for adults	10 162 951
Outpatient services	**19 474 984**
Rehabilitation services for children	9 967 075
Rehabilitation services for adults	9 507 909
Primary healthcare, home care services	**1 291 345**
Rehabilitation professionals for home healthcare	1 273 018
Home visits of a physic-rehabilitative medical doctors to patients by providing a medical rehabilitation service at home	18 328

MoW Social Integration State Agency (SISA) budget for rehabilitation:
The MoW budget for social rehabilitation, professional suitability, and vocational rehabilitation services in 2024 was 7,994,678 euros.

Co-payments:
Basic health services – such as GP visits, specialist visits, hospital stays and pharmaceuticals – are subject to OOP copayments, although these are capped by ceilings on the maximum annual expenditure. Several groups of patients are exempted from copayments – including those aged under 18, people registered with disabilities and women before and after childbirth.

A one-off payment of 4 euros needs to be paid by the patient to receive an outpatient appointment to see a PRM. The PRM doctor can then refer the patient for 10 government funded rehabilitation from an OT/PT/SLT. GPs' can refer patients to rehabilitation therapists for up to 5 sessions without having to pay a 4-euro fee. PRM supervised, multiprofessional, day rehabilitation co-payments are 7 euros per day for an average duration of 10 working days, amounting to 70 euros.

Hospital inpatient rehabilitation services have a fee 5 euros per day for around 10 days and a maximum of 30 days. Additional fees are charged for meals and accommodation services according to the facilities price list if the patient needs to stay longer than 10 days.

Government funded non-governmental organizations (NGOs) for disability and rehabilitation:

The Latvian government funds NGO's to provide rehabilitation, AT and disability services through the following organizations: Latvian Association of the Deaf (LAD); Latvian Association of the Blind (LAB), Tree of Life in government legislation.[74]

Table 9: Government funded non-governmental organizations (NGOs) for disability and rehabilitation in 2023:

Organization	Activities	MoW funding in 2023
Latvian Association of the Deaf	Provides sign language equipment, sign language interpreters, and social rehabilitation	EUR 1,918,767 (TA) EUR 695,810 (sign language interpreter) EUR 85,093 (sign language interpreter in study process) EUR 671,073 (social rehabilitation) = total of EUR 3,370,743
Latvian Association of the Blind	Provides typhlo equipment, social rehabilitation and assistive aids.	EUR 645,870 (social rehabilitation) +EUR 1,103,832 (TA) = total of EUR 1 749 702
Tree of Life	Provides social rehabilitation for oncology patients and their relatives	EUR 204 198 (social rehabilitation)

Cost of rehabilitation services to the MoH in 2024

The MoH sets budgets for rehabilitation services based on costs charged by service providers. Table 9 below provides an overview of the service type provided as well as an estimated cost for each service.

[74] Cabinet Regulation No. 250 'Procedure for the Latvian Society of the Blind and the Latvian Association of the Deaf to provide social rehabilitation services and technical aids: typhlo and surdo methods' of 20 April 2021 (https://likumi.lv/ta/id/322623).

Table 9: Price the MoH pays the facility for rehabilitation services:

Service	Price (the state pays for the treatment facility per day, EUR)
Multiprofessional rehabilitation base service in a day hospital (2-3 hours) provided by 1-2 specialists	69.39
Multiprofessional rehabilitation base service in a day hospital (2-3 hours) provided by 3 or more specialists	69.39
Intensive multi-professional rehabilitation service in a day hospital (3-4 hours) provided by 1-2 specialists	86.27
Intensive multi-professional rehabilitation service in a day hospital (3-4 hours) provided by 3 or more specialists	86.27
Multiprofessional inpatient rehabilitation base service (2-3 hours)	68.30
Intensive multi-professional inpatient rehabilitation service (3-4 hours)	91.33
Multiprofessional rehabilitation base service for psychiatric patients (2-3 hours) (per calendar day)	68.30

Alternative therapy modalities with a low level of scientific evidence, such as electrotherapy, are also available on an outpatient basis and are funded from the state budget for rehabilitation. Table 10 below lists the amount paid by the government to the provider for each of these such treatments.

Table 10: The amount paid by the government to facilities for alternative therapy modality (paid only for children)

Method	Rate (euro)
Electrophoresis	5.88
Transcutaneous Electroneurostimulation (TENS)	4.99
Phonophoresis	8.26
Diadynamic current (DDS) therapy	4.99
Diadynamic current (DDS) phoresis	6.09
Sinusoidal Modulated Current (SMS) therapy	4.99
Sinusoidal Modulated Current (SMS) phoresis	6.09
Darsonvalization	7.16
Inductothermy	4.67

Ultrashort wave therapy, centimeter wave therapy or decimeter wave therapy	3.56
Alternating magnetic field therapy or permanent magnetic field therapy	3.56
Ultrasound therapy	8.23
Aerosol therapy (inhalations)	4.80
Ultraviolet irradiation	4.99
Laser therapy or magnetolaser therapy	7.16
Paraffin-ozokerite therapy	8.49
General massage for children up to one year old (up to 40 minutes)	8.09
General massage for children from one to three years of age (up to 50 minutes)	10.34
General massage for children from three to 18 years of age (up to 60 minutes)	12.93

Vaivari assistive devices centre

Table 11 below shows that the wait list for devices has steadily increased, as has provision, whilst financing for AT was reduced in 2023 from a high in 2021. The table shows a buck in trends during the COVID-19 pandemic years, which normalizes in 2023 once COVID funding has finished.

Table 11: MoW budget allocated by year to the Vaivari assistive devices centre for the provision of AT and the centres services:[75]

Year:	**2010**	**2015**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**
Criteria:								
Funding for just AP (EUR)	1,665,365	3,199,243	5,412,368	5,345,959	7,774,763	8,786,914	7,670,532	8, 994,894
Number of persons in the wait list at the end of the year	4542	3528	3147	3079	2860	4409	4819	6697
Number of persons admitte	-	-	15867	14903	14945	18691	20682	21670

[75] https://vtpc.lv/lv/budzets

d to the queue for AT								
Number of persons who received technical aids	-	-	14195	12249	12730	14014	17005	16856
Number of issued technical aids	4333	10602	16622	14537	15181	16594	19877	20112

Table.... shows the type and number of AT provided by Viavari each year data is available, and demonstrates a general increase in provision.

Table 12: Type and number of AT issued each year by Vaivari from 2010-2023:[76]

Number of issued technical aids by group:	**2010**	**2015**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**
Prostheses	479	991	1036	845	898	859	896	841
Orthoses	1018	2391	4295	4250	4793	5323	6097	6459
Shoes	947	1983	2920	2530	2625	3279	4527	4247
Mobility assistive devices – wheelchairs, rollators, electrical wheel chairs etc There is a link for catalogue[77]	1148	2758	4354	3017	2929	3116	4101	4123
Custom-made seating systems for wheelchairs	-	-	-	-	-	21	78	59
Self-care products	741	2456	3645	3555	3561	3499	3585	3588
Communication products	-	23	18	19	19	18	47	99

[76] https://vtpc.lv/lv/budzets
[77] https://www.vtpc.lv/lv/kategorija/parvietosanas-paligierices

Respiratory products	-	-	354	321	321	420	460	612
Oxygen concentrator rental service for chronic patients	-	-	-	-	35	59	86	84
Totals							19,877	20,112

Summary of Rehabilitation Financing Situation

Rehabilitation Financing (2024 State Budget):

- MoH: €56,657,905
- MoW: €7,994,678
- Disability organizations: €5,324,634

Budget Limitations:

- The annual budget quota is typically exhausted midway through the year.
- Once the spending cap is reached, rehabilitation services are often suspended.
- Patients must either wait until the following year or seek private care.

Co-Payments for Rehabilitation Services:

- Most patients must pay a co-payment to access rehabilitation.
- A one-time fee of €4 is required for an outpatient appointment with a PRM doctor.
- Whilst it is reported that there is no restrictions on the number of referrals that can be made, typically PRM doctors can refer patients for 10 government-funded sessions with an OT/PT/SLT.
- GPs can refer patients for up to 5 sessions without the €4 fee.
- Children, individuals with registered disabilities, and certain other groups are exempt from co-payments.

Co-Payments for Assistive Products:

- A one-time payment is required when receiving an assistive product:
  - Children: €1.42
  - Adults (18+): €7.11
- Exemptions apply to individuals receiving government financial support, those in long-term care or inpatient facilities, and prisoners.

Funding Challenges:

- Financing for assistive technology (AT) is insufficient to meet demand.
- Out-of-pocket (OOP) expenses for rehabilitation and AT are unknown but believed to be high.
- Limited access to public services forces many to seek private care.

Data Gaps:

- There is no available breakdown of financing for adult and child services.

Table 13: Rehabilitation human resources and infrastructure/equipment

Key Components	Status
Total Number of Rehabilitation Personnel	Official statistics regarding all health and care professionals, including rehabilitation professionals are contained in the Health Inspectorate's Register of Medical Practitioners and Medical Practitioners: See: https://www.vi.gov.lv/lv/media/10974/download?attachment
Number of Rehabilitation Personnel per 10,000 Population	Unknown for rehabilitation professionals
Distribution of Rehabilitation Personnel Across Geographic Areas	Rehabilitation and AT services and personnel are largely based in and around the capital, Riga.
Licensure and regulations for rehabilitation personnel	Rehabilitation personnel attain their license to practice via passing a one-off exam upon graduation.
Rehabilitation Infrastructure / Equipment	Minimum standards for outpatient rehabilitation infrastructure are available.

10.1. The rehabilitation workforce in Latvia

Latvia has a well-established rehabilitation workforce with university accredited courses, professional organizations and registration. Patients have access to PMR's, physiotherapists, occupational therapists, audiologists, prosthetists and orthotists, audiology and speech therapists, psychologists, psychiatrists and art therapists. These specialists are accessible within the scope of state-funded services, at patients own expense, or funded by private insurance. In Latvia, rehabilitation professionals that are not PRM's are collectively referred to as 'functional specialists' This section provides details on each profession including their education, workforce, professional organization and the reported challenges for each profession.

Physiotherapy

Education:
A 4-year physiotherapy BSc is taught at 2 universities in Latvia. Until 2024, there was 3 with the Latvian Sport Pedagogy academy, but this university has now merged into the Riga Stradiņš University. The other university offering a BSc in physiotherapy is Daugavpils University. Details of tuition fees, intake and graduates for both universities are provided in table…..

Commented [si1]: Maybe year 2024 should be indicated.

Commented [CM2R1]: Agreed.

The BSc includes a research study dissertation component, and students need to gain 30 ETC's credit to pass their course. Supervised clinical placements are also mandatory to pass, and these can be in the private or public sector. Students keep a diary during clinical placements that must record patient cases and the number of hours they've completed must be signed off by their supervisor. They must complete 20 weeks of 6 hour long days in clinical practice.

Once the 4-year BSc has been completed, students need to pass a separate exam run by the physiotherapy professional organization to gain their certificate to be able to practice independently. The examination costs around 50 euros.

Since since 2000 till 2022, a 2-year masters course in Physiotherapy was available (at RSU), also at Latvian Academy of Sport Education, till 2025. Discussions about development of new Master course at RSU are initiated. Since 2015 master course "Rehabilitation" is available. Course is available which enables those who pass to potentially earn a higher salary in the private sector, teach undergraduate physiotherapy students and supervise students on their clinical placements. However, due to the lack of physiotherapists with a masters degree, experienced physiotherapists have been allowed to supervise students.

Table 14: Detailing tuition fees, intake and graduates for the 2 universities offering a BSc in physiotherapy:

	Riga Stradins University	**Daugavpils University**
Annual full time BSc student tuition fees 2024	EUR 6500	€6400
Number of full time BSc students in 2024	31	Unable to provide
Number of full time BSc student places paid for by the government 2024	22	Unable to provide
Number of students BSc who were studying part time over 5 years in 2024 (tuition fees 3600 euros per year)	16	Unable to provide
Number of BSc students who self-fund their studies in 2024	50-70	Unable to provide
BSc annual course drop out rate in 2023	10% or less	10 % or less
Student graduates in 2024	47	13

Masters studies:

Since 2015 master course "Rehabilitation" is available. Since 2017, there have been around 8-12 master's graduates per year in the rehabilitation disciplines of physiotherapy, occupational therapy or speech and language therapy, collectively. Many other students' complete master's in health management, public health, sports science, or similar. The government fund the tuition fees for 12-16 places per year for master's in health-related topics. For those self-paying, fees are 3000 euros per year.

Rehabilitation Phd's and research:

Rehabilitation research in Latvia remains limited, with only a small number of individuals conducting studies. There is little institutional support for research generation in this field, and securing funding is a challenge. The government offers 25 funded PhD grants annually, but applicants must compete with medical professionals such as doctors, nurses, public health experts, dentists, and pharmacists.

Rehabilitation professionals rarely receive funding, as the selection board reportedly does not prioritize the field. In 2023, 65 applicants competed for these grants, yet in 2024, only four students were pursuing a PhD in rehabilitation at Riga Stradiņš University. Attracting PhD students and academics remains difficult, as salaries in academia are lower than those in clinical practice.

Professional organizations and workforce:

The Health Inspectorate maintains two registers of medical practitioners, including functional specialists, in Latvia: Registered medical practitioners Medical practitioner workplaces and certificates in specialties. In 2024, there were 2005 registered physiotherapists in Latvia, with 1,234 who had passed the post-graduate certificate exam. As of July 31st, 2024, there were 1,426 physiotherapists who were actively working. Many who have not passed the exam are older professionals and graduated before the certification process was in place, and work with supervision and are not motivated to sit the exam. The exams take place every September.

The national physiotherapy association currently has 1,350 members and its annual fees are 30 euros, which will increase to 50 euros in 2025. Physiotherapists do not need to be a member to be able to practice. Members receive free seminars, online conferences, and attendance at an annual, in-person conference. The organization has 6 active interest groups, aligning with World Physiotherapy. The organization also acts like a union providing legal advice to members. They also have an ethics committee that advises on good practice. Only the part-time secretary in the organization is paid, all others are volunteers.

Challenges:
Salaries are significantly higher in the private sector, making it the preferred choice for professionals over state services. Additionally, the quality of student clinical placements varies, impacting their service delivery after graduation.

Occupational therapy

Education:
There is only one university in Latvia that offers a 4 year long, BSc in occupational therapy: Riga Stradiņš University. As is the case for physiotherapists, after completing their 4-year university course occupational therapists also have to pass their certificate exam, administered by their professional organization, to be able to work independently.

The Health Inspectorate maintains two registers of medical practitioners, including functional specialists, in Latvia: Registered medical practitioners Medical practitioner workplaces and certificates in specialties. The Latvian government provides funding for the tuition fees for 22 students annually. This is a decrease from 36 before 2021. In 2024, there were 10 spaces available of the course for students who wanted to self-fund their students, at a cost of 6,537 euros per year. It was reported that the number of undergraduate student places needs to increase to expand the workforce and meet the occupational therapy needs of the Latvia population.

Professional organization and workforce:

In 2024, there are 256 registered occupational therapists in Latvia, 154 who were 'certified' and had passed the certification exam. 196 occupational therapists are employed under the MoH, while the others are employed in the education, social services or private sector.

There are many occupational therapists that remain uncertified in Latvia. This is thought to be because many occupational therapists graduated before the certificate system was in place, and now there is little incentive to gain the certificate. Most of the new graduates take and passing the certificate exam, after multiple attempts, if needed.

Membership fees for the professional organization are 25 euros per year. A typical, full time, monthly salary for an occupational therapist in a government hospital is around 1,600 euros, 1,200 euros per month without their certificate, before tax, which deducts around 30% of their salary.

Challenges:

There are currently 13 positions for occupational therapists being advertised by MoH services which cannot be filled owing to a lack of occupational therapists and interest in the profession.
Clinical speech and language therapist (in Latvia referred to as audio-logoped)

Clinical speech and language therapist are medical professionals who assesses, diagnoses, treats, and rehabilitates patients with communication, speech/language, phonation (voice production), and swallowing disorders. They work with people of all ages in health and education settings and are recognized as a health professional in the Latvian occupation classifier.

Education:

Riga Stradiņš University delivers a 4-year BSc in audiology and speech therapy and produces 15-30 new graduates per year. Graduates generally work in health settings, but also in schools and specialist education settings for children with additional needs. Audio logopeds can work independently in education or health settings, which is what distinguishes them from logopeds who work in education, or in health settings with supervision from an audio logoped.

Workforce and professional organization:

As with all the other rehabilitation professions, graduates have to pass their certification exam to be able to practice independently. The exam includes a theory exam and case practical study. All graduates are added to the register of the professional organization and whether they have passed the certificate exam or not, but do not have to be a member of the professional organization.

The Health Inspectorate maintains two registers of medical practitioners, including functional specialists, in Latvia: Registered medical practitioners Medical practitioner workplaces and certificates in specialties. As of July 2024, the organization had 170 members. Membership benefits include discounts off courses for continuing professional development and union support. Membership fees are around 22 euros per year for graduates and 11 euros for students but will increase next year. The organization is run by volunteers and only the certification examiners are paid for their time. Of 150 audio logopeds in Lativia, 111 have passed the certification exam. Being certified isn't a requirement to work in the education system, and those without certification can work as audio logoped assistant on a lower salary.

Challenges:
The audio logoped profession isn't well understood and there is often confusion between audio logopeds and logopeds. It could be helpful to change the profession's title from 'audiologist and speech therapist' to 'speech and language therapist' to align with international terminology and to clearly distinguish themselves from logopeds. The lack of research generation capacity and outcome measures for language means that it is difficult to assess the effectiveness of audio logopeds interventions. Logopeds support speech impairments in adults and children, and generally work in educational settings.

Education:
Rīga Technical University (RTU) Liepāja Academy (formerly Liepāja University until 2024) in Latvia offers a four-year Bachelor of Science (BSc) program in Logopedics. Graduates must also pass a certification exam to practice independently. The program admits 22–24 students annually and attracts high interest, with some students self-funding their tuition. In 2024, there were 28 government-funded and 6 self-funded places available. For self-funded students, the annual tuition fee was €2,500. The program includes mandatory supervised clinical placements as a requirement for graduation. Currently, no master's degree in Logopedics is offered in Latvia. Upon completion, graduates of the Liepāja Academy program receive the professional qualification of teacher–speech therapist, awarded as part of the professional bachelor's degree.

Work force and professional organization:

Challenges:
Logopeds can work in health or education once they graduate. Educational settings are preferred among graduates as professionals work less with a shorter workday (just during school hours) and they have more holiday leave than those professionals who work in health as they have the school holidays off. It is also felt that the profession is underrecognized and poorly understood by other health professionals and is frequently mixed up with audiologopeds.

An audiologist is a medical professional who assesses, diagnoses, corrects, treats and rehabilitates patients' communication skills, speech/language, phonation (voice formation) and swallowing disorders in persons of any age who have speech, language (oral and written language), voice, hearing and swallowing disorders of various etiologies (origins). Whilst it is reported that audiologists are not currently trained in Lativa, certain functions are carried out by audiologopēds and speech therapists. An audiologist obtains his/her education only at Riga Stradiņš University in the study programme "Audiology". Degree to be obtained: professional bachelor's degree in healthcare and audiology qualification.[78]

A speech therapist is a specialist who performs speech therapy work with persons of any age who have speech, language, communication or oropharyngeal function disorders of various pathogenesis. Performs assessment of speech, language, communication and oropharyngeal function and speech therapy determination of disorders. Performs speech therapy correction when working with persons who have speech disorders (articulation, speech tempo and rhythm, voice), language disorders (oral and written language), oropharyngeal function disorders or secondary speech, language, communication

[78] https://audiologopedi.lv/audiolokas-ir-audiologopeds/

disorders in relation to other functional disorders. Cooperates and provides consultations in the acquisition and implementation of speech therapy correction techniques for persons with speech, language, communication or oropharyngeal function disorders and their relatives. Cooperates with specialists involved in the education, treatment or rehabilitation process and participates in the assessment process.

A speech therapist is a functional specialist - a medical professional who has obtained a second-level professional higher medical education and works in accordance with their competence in medical treatment.

Physical rehabilitation medical (PRM) doctor

Education:
Riga Stradiņš University is the only university that trains PRM's. After students have completed their 6 years of study for general medical education at a university, they can apply for one of ten government funded places offered annually for a PRM 'residency.' This is an increase from the previously offered 4 places, due to a shortage of PRM's in Latvia. The residency is in partnership with the Riga Stradiņš university and the curriculum is in line with ESPRM standards. There are on average 2-3 graduates most years.

Workforce and professional organization:
According to data from the Department of Registers of the Health Inspectorate of Republic of Latvia, as of July 2024 there were 145 registered and certified PRM's in Latvia.[79] As of September 2024, 131 of these PRM's are working in health care facilities in Latvia across the private and public sectors. According to the State Revenue Service, in 2024 PRM'S average salary rate per hour was 23.42 euros.[80]

There are two professional organizations for PRM's in Latvia. The Association of Latvian Rehabilitation Doctors was founded in 2005 and has 139 members. According to the website, the main tasks of organization are:

1. maintaining links between rehabilitation doctors
2. support and popularization of the development of rehabilitation in Latvia;
3. coordination of postgraduate training for PRM doctors;
4. participation in the certification of PRM doctors;
5. representation and protection of the interests of the members of the association.

The main benefits of membership with this organization are member's meetings for education teaching that provides credits for recertification. The second PRM organization was founded for members to develop the rehabilitation sector in Latvia.

[79] Department of Registers of the Health Inspectorate of Republic of Latvia. 2024 https://www.vi.gov.lv/lv/strukturvieniba/registru-nodala?utm_source=https%3A%2F%2Fwww.google.com%2F
[80] https://www.vid.gov.lv/lv/informacija-par-darba-vietam-2024gada-atbilstosi-profesiju-klasifikatoram?utm_source=https%3A%2F%2Fwww.google.com%2F.

The second professional organization for PRM's was founded in 2017 and is called the 'Society of Rehabilitation Doctors in Latvia' that has 24 members. Most PRM's are members of both organizations. They do not have a website, but their main tasks are to develop the medical rehabilitation system based on scientific evidence and to promote professional cooperation of PRM's with other rehabilitation specialists and their organizations.

Challenges:
In 2008 the title of the specialty was changed from "doctor-rehabilitologyst" and "physical medicine doctor" and the professions merged to form "Physical and rehabilitation medicine doctors (PRM)." The rehabilitologysts were educated in contemporary rehabilitation medicine as Western Europe knows it today, but the Physical medicine doctors were educated in using physical modalities as treatment. This has been an issue that means poorly evidenced practices persist, and influence high level decision making.

Prosthetics and orthotist (P&O)

Education:

Riga Stradiņš University offers a four-year BSc in Prosthetics and Orthotics, with graduates required to pass a certification exam to practice independently. The government funds tuition for 14 students, and self-funding is rare due to low demand. Tuition fees are set at €2,600 per year, discounted to attract more applicants. The program has a high dropout rate, as reflected in enrollment numbers: 20 first-year students, 9 in the second year, and 12 in the third year. On average, only 5-6 students graduate annually from an initial intake of 20. However, interest in the profession is reportedly growing. Despite this, prosthetists and orthotists is recognized in Latvia's health occupations register and they have professional standard.

Workforce and professional organization:
The only jobs available for P&O's are at the MoW funded assistive devices centre in Viavari, which is about an hour's drive from Riga. All other centres where P&O's work are private. The private sector is increasingly recruiting students to keep up with demand for devices.

There are around 101 P&O's working in the country, with around 50 having a BSc, there is an official register of professionals, that is; the Health Inspectorate maintains two registers of medical practitioners, including functional specialists, in Latvia: Registered medical practitioners Medical practitioner workplaces and certificates in specialties. The professional organization has around 70 members and is run by volunteers. Professionals don't have to be registered with the organization to work. Membership fees are 30 euros per year which provides members with free access to 1-2 zoom conferences annually. Reportedly, many P&O's have masters degrees in a health sciences topics, while 2 have PhD's gained in other countries. There is a level of research being undertaken in P&O in Latvia. For example, in the area of biomaterials and 3D printing which is commendable and relevant to advances being made in P&O services.[81]

[81] See Baltic Biomaterials Centre of Excellence https://bbcentre.eu/ and https://bbcentre.eu/partners

Challenges:
It was reported by P&O's that the profession is not well recognized or understood by the Latvian population or other health professionals, including by fellow rehabilitation professionals.

The patient wait list to access AT is very long, so most purchase the products they need and pay OOP through private services. Even when they get to the top of the list and obtain their product they need, patients must pay a co-payment, and they are only allowed one product per year from the government service.

Referrals for P&O services come from PRM's or GPs. However, due to the lack of understand about P&O services and AT, there are a lot on inappropriate referrals for products that are not needed. It was reported that inappropriate referrals account for as much as 30-40% of all referrals P&Os receive. Professionals report that there is no accountability for the workforce or its services, there is no regulation or accountability for prescriptions. Nor is there any CPD, professional regulation, standards of practice, ombudsman, reporting structure, or any assessment for a license to continue to practice.

Art and music therapy

Education:
Art and music therapies are offered in Latvia. Professionals must have a BSc in social sciences, and then complete a 2.5 year master's at Riga Stradiņš University.

Workforce and professional organization:
The Health Inspectorate maintains two registers of medical practitioners, including functional specialists, in Latvia: Registered medical practitioners Medical practitioner workplaces and certificates in specialties. As of July 2024, there were more than 300 art therapists, 55 movement therapists, 85 music therapists, and 40 drama therapists working in Latvia. Most professionals work in health, social care or education settings, which means that they are funded by multiple government ministries and the system is very fragmented. Each profession has a small organization that is run by volunteers. Professionals work with adults and children, and referrals can be made by PRM's only.

Challenges:
There are limited employment opportunities and wages are low for professionals, but the situation is getting better. Emotional and psychosocial health has been neglected in Latvia, but this has improved since the pandemic with increased awareness of the importance of emotional and psychosocial health.

Only PRM's or psychiatrist can refer to art therapy but many do not know that the profession exists, so many patients who could benefit from art therapies are not referred. This results in unemployment of professionals and the underutilization of services. Consequently, there is no wait list for patients who can be seen as soon as they are referred.

Common challenges reported by all functional therapists:
The single biggest issue reported by all rehabilitation professions is that the quality and appropriateness of patient referrals for rehabilitation are often very poor. Repeatedly, professionals complain that up to 30-40% of the patients referred to them do not need rehabilitation and do not have functional impairments and are considered as an 'inappropriate referral'. This reportedly happens because

patients, and the doctors referring them, including some PRM's, do not understand what functional rehabilitation is, what each rehabilitation profession does, and when services are needed. This is compounded by patients who demand a referral for rehabilitation as per their prescribed entitlement by their referrer, without understanding the services that can be provided and with expectations beyond a rehabilitation professional's scope. Such 'inappropriately referred' patients take up a significant proportion of capacity within a rehabilitation service and professional's time.

Compounding this referral and entitlement issue is the prescription of the number of rehabilitation sessions in the rehabilitation referral. Currently, a GP can refer a person for a maximum of 5 rehabilitation sessions per referral, whilst a PRM usualy refers for a maximum of 10 sessions with a rehabilitation professional. The reality of this is that many patients do not need even one session of rehabilitation, or who may only need one session for some advice and education, but they will receive another 4 or 9 because this is what they were referred for and are entitled to, what they want, and the rehabilitation professional cannot reason with them otherwise. Consequently, these patients take up a significant amount of time for professionals and their service, which also contributes to the long wait lists patients experience.

Rehabilitation professionals working in NHS government funded settings:

Primary health care level:
At PHC level there are 47 rehabilitation settings under contract with NHS providing state-funded rehabilitation services, namely, care at home as per the patient groups defined in Cabinet Regulation No. 555 such as stroke patients during the sub-acute period, patients with spinal cord injury after their first inpatient rehabilitation course and children's with are in palliative care register; there is one more programme for adults in the hospice phase, which also includes a functional specialist and a nutritionist: these services are permitted to be provided by PMRP; certified physiotherapists, occupational therapists, audiologists and speech therapist.

Secondary healthcare level:
In secondary health care there are 417 rehabilitation settings under contract with NHS providing state-funded outpatient and day hospital rehabilitation services for children and for adults.
These state social care and social rehabilitation institutions employ physiotherapists, occupational therapists, Audiologist and Speech Therapist (Audiologopeds), art therapists, psychologists, massage specialists, Nutritionists (Nutritionist) Nutritionists, art therapists.

Tertiary healthcare level:
In tertiary health care there are 17 rehabilitation settings under contract with NHS providing state-funded inpatient rehabilitation services, using rehabilitation beds, more detail provided in the Annex: Service providers by level_NHS_2023

Legislated remuneration for rehabilitation professionals working in the NHS:
In accordance with Paragraph 153 of Cabinet Regulation No. 555 'Procedure for the organization of and payment for healthcare services'[82], this regulation provides the mechanism for how work remuneration

[82] Cabinet Regulation No. 555 'Procedure for the organization of and payment for healthcare services.' https://likumi.lv/ta/en/en/id/301399

is incorporated into tariffs, while Regulation No. 851, 'Regulations on the Minimum Monthly Wage and Special Allowances for Employees in the Healthcare Sector,' defines the principles for how medical workers are paid.

The remuneration for a healthcare worker for the average full time work amount per month, before tax:

- For doctors and functional specialists - EUR 2304.00.
- For medical practitioners, patient care persons and assistants of functional specialists - EUR 1388.00.
- For support persons of medical treatment and patient care - EUR 925.00.

In addition, there are financial and accommodation incentives for health specialists working outside Riga, including for medical rehabilitation professionals.[83]

Rehabilitation workforce Occupation Classifier[84]

In Latvian law, physiotherapists, occupational therapist, audiologists and speech therapists, and ophthalmologists, Prosthetics and orthotist (P&O), nutritionists are officially named and recognized as professionals. The classifier does not protect the usage of the professional titles as it does not state who can use it and what criteria the professional needs to meet to use it, for example, by having a BSc in physiotherapy from a recognized university.[85]

Occupation 2264: Physiotherapists

Persons employed in the professions of the separate group "2264 Physiotherapists" are familiar with the assessment of functional limitations of a person and the principles of rehabilitation, carry out treatment using appropriate diagnostics, assessment and medical technologies, and provide opinions, carry out vocational education work.

Physiotherapists scope of practice:

- Perform tests of muscles, nerves, joints and functional abilities, diagnose and assess physical disorders; develop a treatment plan with the patient; carry out treatment, reduce pain, improve blood circulation, strengthen musculature, improve cardiovascular and respiratory functions, restore joint mobility, improve a sense of balance and coordination; in the treatment use gymnastics, ultrasound, heat, cold, massage, hydrotherapy, electrotherapy, ultraviolet and infrared procedures; evaluate and document the treatment process of a person; advising patients and their family members on performing physical therapy procedures at home; to provide and receive the information necessary for the treatment of the patient from other

[83] https://www.vm.gov.lv/lv/4125-pasakumiem-lai-piesaistitu-un-noturetu-arstniecibas-personas-darbam-valsts-apmaksato-veselibas-aprupes-pakalpojumu-sektora-ipasi-stacionaros

[84] Classification of Occupations. Updated August 16, 2024. https://www.lm.gov.lv/lv/klasifikacija/profesiju-klasifikators-5/profesiju-klasifikators-aktualizets-2024gada-16augusts?search=ergoterapeits

[85] See https://registri.visc.gov.lv/profizglitiba/dokumenti/standarti/2017/PS-264.pdf; https://registri.visc.gov.lv/profizglitiba/dokumenti/standarti/2017/PS-264.pdf; https://likumi.lv/ta/id/26021#p5; https://www.visc.gov.lv/lv/profesiju-standarti-un-profesionalas-kvalifikacijas-prasibas

healthcare professionals; develop and implement screening and prevention programs for physical disorders or lesions.

Occupation 2266: Audiologists and Speech Therapists

Employees of the separate group "2266 Audiologists and Speech Therapists" are engaged in the diagnosis and treatment of hearing, speech/language, phonation and swallowing disorders.

Audiology and Speech Therapist scope of practice:

- To carry out assessment, diagnosis, correction and rehabilitation of hearing, speech and language, sound production and swallowing disorders in persons who have hearing, speech, language, voice and swallowing disorders caused by various etiologies; using diagnostic means and methods, determine the degree of damage; perform speech therapy correction and rehabilitation, working with speech and language disorders, disorders of oral pharyngeal function, as well as speech and language disorders that are secondary to disorders of other functions; promote the development of speech and language, as well as communicative function; decide on the need for hearing and other assistive devices for the patient and advise on their correct use; refer patients to other specialists; to advise, cooperate and train relatives of the person, other specialists involved in correction and rehabilitation; carry out the prevention of speech and language disorders.

Occupation 2267: Optometrist

Those employed in the profession of the separate group "2267 Optometrists" are engaged in the diagnosis and treatment of visual impairments and prescribe optical aids or other procedures for the treatment of visual impairment.

The profession of the separate group "2267 Optometrists" and the corresponding basic tasks:
– check vision and diagnose visual impairments and pathologies; prescribe glasses, contact lenses or choose other methods of treatment of visual impairment; in difficult cases, refer to a doctor; to advise on issues of vision health, the use of glasses, contact lenses or other means of improving vision.

Occupation 3255: Physiotherapy Specialists

Those employed in the professions of the separate group "3255 Physiotherapy Specialists" perform physical therapy procedures in accordance with the instructions of a physiotherapist or other senior health care specialist.

The professions and corresponding tasks of the separate group "3255 Physiotherapy Specialists":

Physiotherapist scope of practice:

- Performs massage to improve blood circulation, calm the nervous system, eliminate tightening of dry strands and give other therapeutic effects; instruct, motivate and assist patients during

physical exercise; perform manual therapy, heating, light, sound, water, ultrasound and other physical therapy procedures; observe the patient's condition during medical procedures, evaluate their effectiveness; discuss the patient's course of treatment together with a senior healthcare professional and decide on the adjustment of the treatment plan; train patients in the use of technical aids; perform acupressure, shiatsu and other recovery-enhancing procedures; advise groups of the population or individuals on the correct position of the body in the process of work; to practice in medical treatment and, using different types of massage, to contribute to the improvement of the health and functional condition of the patient or client, as well as the quality of life and well-being related to health.

10.2 Rehabilitation facilities and their human resources

It is known which state facilities employ at least one rehabilitation professional, however, the composition of rehabilitation professionals and number is not known. Therefore, it is difficult to evaluate the geographical distribution and availability of rehabilitation professionals across Latvia.

Table 14: Total number of MOH facilities in Latvia and those delivering rehabilitation services and their type.

Facility level and number	**Facilities with a rehabilitation professionals and type of service**
Level 1: 5 facilities Livani Hospital Aizkraukle Hospital Bauska Hospital Limbazi Hospital Ludza Medical Center	**4 facilities have at least one rehabilitation professional:** 3 facilities – Ludzas, Aizkraukles, Bauskas have acute inpatient rehabilitation in mixed-purpose beds 1 facility – Limbaži, has rehabilitation in day hospital for adults 4 facilities – Aizkraukles, Bauskas, Limbaži, Ludza have outpatient rehabilitation services for children and adults

Level 2: 4 facilities Aluksne Hospital Preili Hospital Tukums Hospital Kraslava Hospital	**4 facilities have at least one rehabilitation professional:** 3 facilities - Alūksnes, Preiļi, Tukums have acute inpatient rehabilitation in mixed-purpose beds Rehabilitation in day hospital for adults Rehabilitation in day hospital for children – 4 Outpatient rehabilitation services for adults Outpatient rehabilitation services for children
Level 3: 7 facilities Madona Municipality Madona Hospital Cēsis Clinic Dobele and surrounding hospital Jurmala Hospital Ogre District Hospital Balvi and Gulbene Hospital Association Kuldiga Hospital	**7 facilities have at least one rehabilitation professional:** 7 facilities have acute inpatient rehabilitation in mixed-purpose beds 5 facilities - Cēsis, Dobele, Kuldiga, Madona, and Ogre have rehabilitation in day hospital for adults and children. Outpatient rehabilitation services for children: Outpatient rehabilitation services for adults – 7

Level 4: 7 facilities Liepaja Regional Hospital Daugavpils Regional Hospital North Kurzeme Regional Hospital Jelgava City Hospital Vidzeme Hospital Jekabpils Regional Hospital Rezekne Hospital'	**7 facilities have at least one rehabilitation professional:** All 7 facilities have acute inpatient rehabilitation in mixed-purpose beds. 3 facilities - Liepaja, Vidzeme, and North Kurzeme have 24-hour long-term rehabilitation services/dynamic observation for children. 5 facilities - Daugavpils, Liepaja, Rezekne, Vidzeme, and North Kurzeme have 24-hour long-term rehabilitation services/dynamic observation for adults 3 facilities - Jēkabpils, Liepaja, and Vidzeme have 24-hour rehabilitation of perinatal conditions 4 facilities - Jēkabpils, Liepaja, Vidzeme, and North Kurzeme have 24-hour second stage day hospital medical rehabilitation services for children All 7 facilities have 24-hour second stage day hospital medical rehabilitation services for adults 1 facility - 1 North Kurzeme has 24-hour sub-acute rehabilitation services for children 5 facilities - Daugavpils, Liepaja, Rezekne, Vidzeme, and North Kurzeme have 24-hour sub-acute rehabilitation services for adults 3 facailites - Liepaja, Rezekne, and Vidzeme had Post-COVID rehabilitation 4 facilities - Daugavpils, Liepaja, Vidzeme, and North Kurzeme have rehabilitation in day hospital for children 5 facilities - Daugavpils, Liepaja, Vidzeme, North Kurzeme, and Rēzekne have rehabilitation in day hospital for adults 6 facilities - Daugavpils, Liepaja, Vidzeme, North Kurzeme, Rezekne, Jēkabpils have rrehabilitation services for children and adults

Level 5: 6 facilities Pauls Stradiņš Clinical university hospital (PSKUS) Riga East University Hospital (RAKUS) Children's Clinical University Hospital (CCUH) **3 specialised:** Hospital of Traumatology and Orthopaedics (TOS) Riga Municipality Riga Maternity Hospital (does not provide rehabilitation) National Rehabilitation Centre Vaivari (Vaivari)	**5 facilities have at least one rehabilitation professional:** 4 facilities - BKUS, PSKUS, RAKUS, and TOS have acute inpatient rehabilitation in mixed-purpose beds 2 facilities - BKUS and Vaivari have 24-hour long-term rehabilitation services/dynamic observation for children: 3 facilities - PSKUS, RAKUS, and Vaivari have 24-hour long-term rehabilitation services/dynamic observation for adults 1 facility - BKUS has 24-hour rehabilitation of perinatal conditions 2 facilities - BKUS and Vaivari have 24-hour second stage day hospital medical rehabilitation services for children 3 facilities - PSKUS, RAKUS, and Vaivari have 24-hour second stage day hospital medical rehabilitation services for adults 2 facilities – BKUS and Vaivari have 24-hour sub-acute rehabilitation services for children 4 facilities – PSKUS, RAKUS, Vaivari, and TOS have 24-hour sub-acute rehabilitation services for adults 1 facility – Vaivari has medical rehabilitation for a long-term artificially ventilated patient 1 facility – RAKUS, has rehabilitation of victims of the National Socialist regime 2 facilities – Vaivari and RAKUS had post-COVID rehabilitation 1 facility – Vaivari, has rehabilitation of patients with spinal cord injury 1 facility – BKUS has rehabilitation in a psychiatric institution 1 facility – RAKUS has paediatric audiology (temporary or permanent hearing and language impairments) 2 facilities – BKUS and Vaivari have rehabilitation in day hospital for children 3 facilities - PSKUS, RAKUS, and Vaivari have rehabilitation in day hospital for adults

	5 facilities - BKUS, Vaivari, PSKUS, RAKUS, and TOS have rehabilitation services for children and adults
Specialized: 9 facilities	**6 specialized facilities have at least one rehabilitation professional:**
Riga Psychiatry and Narcology Centre	2 facilities – Sigulda and Rigas 2. Hospital have acute rehabilitation in mixed-purpose beds
Riga 2 Hospital	1 facility – Sigulda has 24-hour second stage day hospital medical rehabilitation services for adults
Children's Psychoneurological Hospital Ainaži	1 facility - Riga 2. Hospital has 24-hour sub-acute rehabilitation services for adults:
Aknīste Psychoneurological Hospital	1 facility - Ģintermuiža has inpatient drug rehabilitation for children
Seaside Hospital	1 facility - Sigulda had post-COVID rehabilitation
Daugavpils Psychoneurological Hospital	6 facilities - Ainaži, Daugavpils psih, Ģintermuiža, and Strenču psih has rehabilitation in a psychiatric institution
Hospital Ģintermuiža	4 facilities - Ainaži, Daugavpils psih, Riga 2nd hospital, and Sigulda have outpatient rehabilitation services for adults
Strenči Psychoneurological Hospital	1 facility – Sigulda, has outpatient rehabilitation services for children
Sigulda Hospital	5 facilities - Daugavpils psih, Seaside Hospital, RPNC, Ģintermuiža, and Strenču psih have rehabilitation in a psychiatric day hospital

10.3 Rehabilitation infrastructure/equipment

Secondary and tertiary hospitals have limited designated purpose-built space or gyms available for rehabilitation assessment and interventions. Rehabilitation sessions are delivered at patients' bedside and on the ward, and there is no bedside seating for patients who wish to sit out of their bed. Within rehabilitation day centre and outpatient facilities, much of the equipment isn't available to state funded services and is for privately paying patients only. State-funded robotic technologies are provided only in specific medical institutions such as NRC Vaivari, regional and university hospitals, mainly within the framework of inpatient rehabilitation. Examples of such equipment include anti-gravity treadmills, robotic devices and computer aided devices.

No data is collected and stored on rehabilitation space and equipment. However, according to the 'Regulations Regarding Mandatory Requirements for Medical Treatment Institutions and Their Structural Units'[86] the mandatory requirements that must be met by the medical treatment institution are defined:

[86] Regulations Regarding Mandatory Requirements for Medical Treatment Institutions and Their Structural Units. Cabinet Regulation No. 60 https://likumi.lv/ta/en/en/id/187621

Requirements for outpatient rehabilitation institution

An outpatient rehabilitation institution is a medical treatment institution or structural unit, which provides rehabilitation services as various comprehensive or specialized (including technical orthopaedics) rehabilitation programmes. An outpatient rehabilitation institution complies with general requirements for outpatient medical treatment institutions referred to in this regulation.

The regulation goes further to stipulate that an outpatient rehabilitation institution has:

- Rehabilitation rooms for PRM physician and at least one functional specialist.
- Medical devices for diagnosis, patient's physical examination and assessment of functional ability (functional laboratory).
- Patient WC suitable for persons with functional disorders, including equipped with a nurse call button.

Common equipment in state funded outpatient rehabilitation centres typically will include the following suite of equipment.

- Exercise couches, Swedish wall, exercise balls, balance surfaces, dumbbells, resistance bands, exercise bike, motomed, technical aids, equipment for performing adapted activities, therapy puzzles.

Summary of Rehabilitation
Human Resources and Infrastructure/Equipment Situation

Established Rehabilitation Workforce:

- Latvia has a well-developed, multiprofessional rehabilitation workforce with university-accredited courses, professional organizations, and postgraduate licensing certification.

Access to Rehabilitation Specialists:

- Patients can access a range of specialists, including PMRs, physiotherapists, occupational therapists, audiologists, prosthetists and orthotists, audio logopeds, speech and language therapists, psychologists, psychiatrists, and art therapists.
- Services are available through state-funded programs, private payments, or private insurance.
- Service capacity could be enhanced within the rehabilitation system and wait lists reduced if all rehabilitation professionals could refer and triage patients, which currently can only be executed by GP's or PRMs.

Government-Funded Education:

- The Latvian government covers tuition fees for a proportion of undergraduate students in rehabilitation programs to support workforce development.

Workforce Shortages:

- The number of rehabilitation professionals in Latvia is insufficient to meet demand.

Lack of Workforce Data:

- There is no available data on the composition and geographic distribution of rehabilitation professionals.
- Most services are concentrated in and around Riga.

Referral Challenges:

- Many healthcare professionals lack understanding of functional rehabilitation, its benefits, and appropriate referral criteria.
- This results in numerous inappropriate referrals, straining resources and increasing wait times.

Legislative Framework:

- Rehabilitation infrastructure is governed by existing legislation.

9. Rehabilitation information

Key Components	Status
Data on Disability, Rehabilitation Needs, and Population Functioning	Latvia has a disability register which categorizing by condition and severity, kind of functional impairment in 5 large groups - vision, hearing, movement, mental and psychic disorders and other impairments. Population health data on condition prevalence is available to imply the potential need for rehabilitation, but not on functioning.
Data, Digitalization and Latvia's Health Information Systems (HIS)	Referrals and health records are largely paper based; however, a new digital health technology system is due to be introduced in 2025
Data-driven Decision Making	The only rehabilitation usage data reporting that is reported to the MoH is facilities invoices to receiving payments for providing services.
Government Funding for Rehabilitation Research	No government funding is made available for rehabilitation research

11.1 Data on rehabilitation availability, usage and outcomes

NHS rehabilitation service delivery data:

From the NHS payment system, that is, the system that facilities invoice the MoH for rehabilitation services, data can be obtained on the type of service received (outpatient rehabilitation for children, outpatient rehabilitation for adults, day hospital rehabilitation for children, day hospital rehabilitation for adults, early intervention, etc. services); service provider (medical institution; specialist); an overview of the scope of the service received (number of visits) for the work performed, for example work with a neurological patient; sensory stimulation, etc. However, data analysis is not carried out systematically. This billing data is the only data the MoH receives, and it is used for billing purposes only.

For a facility to receive payment from the MoH for the rehabilitation services they've provided for a patient, upon discharge the NHC receives a report in the form of one of the following manipulation codes:

- 60422 The goal of the rehabilitation course plan was achieved
- 60423 The goal of the rehabilitation course plan was partially achieved
- 60424 The goal of the rehabilitation course plan was not achieved
- 60425 The rehabilitation course was interrupted because the patient does not attend it
- 60426 The rehabilitation course was interrupted for other reasons

Furthermore, the patient's referral pathway must also be reported with the following codes:

- 60387 Referral issued for social rehabilitation services
- 60388 No further rehabilitation required

• 60389 Referral issued for rehabilitation at home
• 60390 Rehabilitation plan issued for mono-professional outpatient rehabilitation
• 60391 Rehabilitation plan issued for day hospital rehabilitation
• 60392 Rehabilitation plan issued for inpatient rehabilitation
• 60393 Dynamic observation plan issued
• 60394 Repeat physical medicine and rehabilitation physician consultation required after mono-professional rehabilitation

Additionally, information about the phase that rehabilitation services were provided to the patient is collected. For example, in the acute stage, manipulations 55156- (15 min PT, OT or SLT intervention) can be used, and in the subacute stage, manipulations 55180 and 55181 moderate or high intensity rehabilitation can be given. Specifically for new stroke patients, information is collected on their functioning status upon discharge from the stroke unit according to the according to the modified Rankin scale (manipulation codes 60380-60385).

Data on availability/utilization of rehabilitation
The NHS collects data on the length of waiting lists for state-funded rehabilitation services every month. The information is publicly available so that people can choose a healthcare facility with shorter waiting lists. As previously mentioned, it is widely accepted that many patients use their paper referrals to gain access to multiple services and simultaneously occupy their wait lists. Information about accessibility of rehabilitation services in secondary outpatient healthcare is available here: http://rindapiearsta.lv/lv/mekle_isako.

Individual patient information collection and storage:
NDV contracted facilities that provide rehabilitation services at the expense of the state budget must create a document detailing the patient's medical history, a rehabilitation plan, goals, their assessment, and any interventions. For most facilities, this information is documented on paper and stored in the organizations' internal systems and is not shared beyond. Latvia does not have a standardized national policy on patient data collection, storage or utilization.

Individual patient functioning data for the provision of AT:
To receive assistive products (technical aids) paid for by the state, attending physician or functional specialists fill out an opinion on the need for a technical aid on the referral, where the assessment of functioning is based on the ICF.

11.2. Data, digitalization, and Latvia's health information system

On 15 August, the Cabinet of Ministers approved the Digital Health Strategy for 2029, prepared by the Ministry of Health. The strategy has been aligned with the EU Structural Funds programming period, which ends in 2029, and aims to use EU funding for digital health development. Although other healthcare plans may include digital health, this strategy focuses specifically on digital transformation to support public health goals for 2021–2027.

The strategy serves as an informational guide for advancing digital health in Latvia, aiming to build a shared vision among stakeholders, including healthcare providers and digital solution developers. Key objectives include improving data access, interoperability, and digital service development.

The strategy aims to reduce paper-based medical records, promote digitization of health data, and give medical staff access to patient data from all healthcare providers, whether government-funded or private. It also focuses on empowering patients to actively engage in their healthcare through digital solutions and remote technologies. The goal is to offer more accessible, higher quality, and efficient health services, particularly in regional areas, while raising awareness of digital health solutions among healthcare professionals.

11.3. Data on quality and efficiency of rehabilitation

In Latvia, no service information and quality assessment system has not been established, and therefore, it is not possible to obtain data on patients' functioning status, and it is also difficult to transfer subsequent information between medical institutions, as the existing IT system does not currently provide for this.

However, state-funded rehabilitation has healthcare monitoring systems and reporting processes in place, and rehabilitation service providers must comply with these. Supervision is carried out by the Health Inspectorate and the Control and Supervision Department (CSD) of the NHS. NHS CSD monitors the quality of the services provided and conducts an annual quality assessment of service providers in accordance with the quality criteria defined in their contract. The quality criteria for each of the services are shown in the tables below.

If a specific service provider has reported that the goal of rehabilitation has been achieved in more than 70% of patients, then the result is marked as acceptable; if less than 70% of patients goals are achieved, then the NHC may decide on the need for an in-depth inspection at the medical institution. These marks are self-reported and subjective.

24-hour stage-two inpatient medical rehabilitation:

Name of criterion	Target indicators	
	Unacceptable	Acceptable
Percentage of rehabilitation course objective achieved (manipulation code 60422)	<70%	≥70%
Percentage of reasoned complaints from patients in the event of a breach of the conditions regulated by the legislation and a valid decision of the Health Inspectorate or the Service	>5%	<1%

24-hour stage-two inpatient medical rehabilitation:

Rehabilitation in day hospital:

From.	Name of criterion	Target indicators in 2022	
		Unacceptable	Acceptable
1.	Medical rehabilitation day hospital services are provided by at least 3 functional specialists with different specialties	<3	≥3
2.	Proportion of medical rehabilitation day hospital course objectives achieved	<65%	≥65%
3.	Proportion of excerpts/conclusions for medical rehabilitation day hospital services entered in the VVIS*	not assessed in 2022	
4.	Proportion of justified complaints from patients	≥5%	<5%

Rehabilitation quality

Name of criterion	Unacceptable	Acceptable
24-hour stage-two inpatient medical rehabilitation:		
Rehabilitation course objective achieved (manipulation code 60422)	**<70%**	**≥70%**
Reasoned complaints from patients in the event of a breach of the conditions regulated by the legislation and a valid decision of the Health Inspectorate or the Service	**>5%**	**<1%**
Rehabilitation in day hospital:		
Medical rehabilitation day hospital services are provided by at least 3 functional specialists with different specialities	**<3**	**≥3**
Proportion of medical rehabilitation day hospital course objectives achieved	**<65%**	**≥65%**
Proportion of justified complaints from patients	**≥5%**	**<5%**
Outpatient psychiatric care in day hospital:		
Percentage of course objectives achieved	**<50%**	**≥85%**
A range of services involving a multi-professional team (at least 2 functional specialists)	**<50%**	**≥90%**
Proportion of cases in which the patient was admitted to an emergency psychiatric bed within 30 days of discharge from a psychiatric day hospital	**>12%**	**<8%**

Government funding on rehabilitation research

Effectively, there is no state funding earmarked for rehabilitation research, beyond funding tuition fees for those who obtain a place on a PhD program.

Summary of Rehabilitation Information Situation

Disability Register:

- Latvia has a disability register that categorizes by condition and severity which relate to a number of functional domains such as vision, hearing, mobility mental health challenges etc.

Health Data:

- Population health data on condition prevalence is available, suggesting potential need for rehabilitation.
- No data is available on the population's functional abilities.

Rehabilitation Data:

- Little data is collected on rehabilitation availability, utilization, or outcomes.
- The only data reported to the MoH comes from facility invoices for payment, which include coded information on location, type of service, discharge, and outcomes.

Public Information:

- A live website is available, showing wait times for rehabilitation services at facilities.

Referrals and Records:

- Referrals and health records are largely paper-based.
- A national digital health system is set to be introduced in 2025.

Rehabilitation Research Funding:

- There is no government funding for rehabilitation research.

10. Rehabilitation service delivery, accessibility and quality

Key Components	Status
Percentage of tertiary and secondary hospitals with rehabilitation services	In Latvia there are a total number of 267 inpatient rehabilitation beds for adults across 11 facilities and 70 beds for children under the age of 17 in 4 facilities.
Percentage of districts/communities covered by rehabilitation services	tbc
Number of specialist rehabilitation facilities/units	Vaivari, RAKUS (English – REUH), BKUS, PSKUS
Number of rehabilitation beds, and rate per 10,000 populations	tbc

12.1. Overview of rehabilitation service delivery and accessibility

In Latvia there are a total number of 267 inpatient rehabilitation beds for adults across 11 facilities (RAKUS, PSKUS, Liepaja, North Kurzeme, Vidzeme, Rēzekne, Jēkabpils, Jelgava, Vaivari, Riga 2nd Hospital, Sigulda) and 70 beds for children under the age of 17 in 4 facilties (BKUS, North Kurzeme, Jēkabpils, Vaivari). The largest are:

The national rehabilitation centre 'Vaivari' - https://www.nrcvaivari.lv
Located around 1 hours drive from the capital, patients come from all over Latvia to the national rehabilitation centre 'Vaivari' which is funded and operated by the MoH and the MoW. The centre has 3 main structures- the Medical Rehabilitation (inpatient and outpatient), the Assistive Technology Provision Center, and the prosthetic and orthotic center.

Vaivari has 183 rehabilitation beds for adults and 58 for children and patients can only be referred by a PRM. Specifically, there are 16 post-ICU beds, 25 for cardiac rehabilitation, 50 (30 for adults, 20 for children) for orthopedic needs, a 25-bed spinal cord injury unit, 45 beds for neurorehabilitation, 38 paediatric beds, and 42 beds for general rehabilitation needs. also offers hydrotherapy, day care rehabilitation and outpatient rehabilitation.

Outpatient rehabilitation services are offered in both Jūrmala and Riga. In these locations, patients can access monoprofessional allied health services, such as physiotherapy, occupational therapy, PRM consultations, and others. In Jūrmala, additional specialist consultations, including cardiologists, dermatologists, and other doctors, are also available as well as diagnostic services like x-ray, ECG, ECG with stress tests, Electroencephalography, Ultrasonography etc.. Both locations also provide multiprofessional day care rehabilitation services.

Vaivari also supports Ukrainian civilians and military that have been injured in the war and who require rehabilitation. Over 370 in 2024 Ukrainians have been transferred to the centre and their treatment is paid for from special government budget that is separate to the centre's overall budget.

The mission statement of the center is "*to help people with functional impairments to gain independence and a dignified life*" and it aims "*to combine high multidisciplinary professionalism, modern capabilities of rehabilitation technologies and scientific achievements, contributing to the long-term and balanced development of the rehabilitation in the country.*"

A multiprofessional team of 522 professionals provides care and rehabilitation at the center, including: 89 nurses, 85 physiotherapists, 49 admin personnel, 47 doctors (of which 18 are PRM's), 39 nurse assistants, 25 occupational therapists, 22 P&Os, 12 masseurs, 8 SLTs, 8 psychologists, 5 rehabilitation assistants, 3 social workers, 3 art therapists, and 1 nutrition specialist and 102 non clinical support workers such as maintenance workers, admin etc.

The center has multiple gyms and spaces equipped for functional rehabilitation including adapted kitchens and bathrooms for rehabilitation. Equipment such as standing hoists, tilt-tables, weights, gait analysis digital technologies, double width plinths, mobility aids and robotics are widely used. Patients have their own rooms with bathrooms and specialist stationary and mobile seating. Those on the SCI unit have ceiling tracked hoists and pressure reliving mattresses.

The center is a certified training center of the European union of medical specialist (UEMS) and has accredited PRM programs for the care of patients after amputation, SCI, Lumbar spine surgery, and cerebral palsy. Functional measures are utilized such as goniomtrey, dynamometry, maximal inspiratory pressure, 6 minute walk test, 10 meter walk test, 1-minute sit-to-stand test, Berg balance scale, Motor assessment scale, Tardieu scale, Montreal cognitive assessment (MoCA), instrumental gait analysis, amputee mobility predictor assessment tool (AMPRO), spinal cord independence measure (SCIM), gross motor function function classification system (GMFCS) etc. Also, FIM evaluation method is used, but the official version has not been purchased. Most clinical information is saved as word doc and printed out for the patients' medical card. All patient notes, functioning information and referrals are on paper records.

State and privately funded services are provided at Vaivari. In 2024 the center admitted a total of 5008 in 2024 patients, 4807 who had their treatment funded by the state and 214 who were funded privately. The length of patients' stay varies, most commonly patients stay for a period of 2 weeks but some patients stay much longer, for example, the SCI patients. Privately and mostly state funded 'day rehabilitation' was provided to 975 patients in 2024. Day rehabilitation is where patients come to the centre for the day to receive multiple rehabilitation interventions, often from a range of professionals. Outpatient services were delivered to a total of 13027 state and privately paid patients, both adults and children in 2024.

The prosthetic and orthotic centre provides custom made AT through Latvia's only state funded AT. The centre employs 15 P&O's, 3 orthopedic technicians, 1 warehouse worker, 1 head of department and a deputy head, and one client coordinator. The P&O center offers services in various locations, with two convenient spots in Jūrmala and one in Rīga, along with monthly visits to Valmiera, Cēsis, Rēzekne, and Kuldīga to ensure accessibility for clients. The assistive devices P&O centre serves adults and children for custom made upper and lower limb prosthesis, soft orthosis, orthopedic shoes, rigid orthosis and custom-made compression garment. Regardless of whether a suitable product can be 'taken off the

shelf' from a bulk order that meets the patients needs, everything provided is custom made as this is what the state funds. Therefore, patients often acquire more expensive and labour-intensive custom-made splints that could have been sourced more quickly and cheaply. At the time of visiting, as an example, the wait list for a custom-made compression garment was 1-2 months.

AT Center operates under a delegation from the Ministry of Welfare (MoW) to distribute AT in accordance with Regulation No. 878.AT can be provided using state funds and the co-payment, bought outright, leased by patients or by full private payment with an expedited delivery. Referrals to the centre can be made by functional therapists. The centre doesn't provide any AT for vision and hearing, this is delegated to the Latvian association for the blind and the Latvian association for the deaf. In 2024 20112 APs were provided to patients via state funding. A new P&O centre is being built next to the existing one that is due to open in 2025.

Vaivari has smaller AT branches with employees in facilities in other 2 areas of Latvia, Rezekne and Kuldga, that patients are often referred between. The Rezekne facility employs x 2 physiotherapists, x 1 occupational therapist, and x 1 maintenance person, while Kuldiga employs x2 physiotherapists and x 1 maintenance person.

Challenges reported by the centre:

Personnel report that they receive many inappropriate referrals for patients that do not meet the centres criteria for rehabilitation and that they have to accept. Many patients referred walk independently and do not have functional impairments, who are admitted as an inpatient. It has been widely reported that there is a poor understanding of what functional rehabilitation is and who needs it among referrers, health professionals and patients. These inappropriately referred patients take up resources and capacity and drive up already long wait lists. Additionally, referrals are often poorly written with little information provided as there is not standardized referral criteria in Latvia.

Wait lists for services at Vaivari are long and the service cannot meet the population’s need within an appropriate timeframe. As reported by other facilities and rehabilitation professionals, wait lists are lengthened by patients taking their paper referral for rehabilitation to multiple providers, thereby occupying a position on multiple wait lists to see which treats them first, or multiple their treatments.

The benefits of preventative rehabilitation services are widely recognized in scientific literature and service models, however, despite the need, rehabilitation services for falls prevention, long term conditions such as chronic pulmonary conditions etc are not offered in Latvia. Patients who need such lifelong rehabilitation and community management are not served and therefore end up in the acute system which does not best meet their needs. Specialist services are needed to support this population outside of the acute system and closer to their homes. Due to the lack of rural and community-based rehabilitation services and the paper referral system, continuity of care for patients is poor and ongoing treatment up to the patients to organize, leading to delays in accessing services.

Demand for state funded P&O services and AT is significant in Latvia and Vaivari does not have the capacity or resources to meet the population's needs. There are not enough P&Os working in the centre or in Latvia and is it more desirable to work for the private sector as the salary is more and the scope of AT the private sector can provide is larger. Therefore, wait lists for AT are long and the centre can only

provide a limited number of AT from the state budget, which often does not meet specific needs, and in a timely manner.

Due to the wait times and a long, complicated administration process to access AT and equipment, and the lack of community services, SCI patients are often discharged home with essential equipment and services such as hoists, pressure mattresses, commodes and enough care provision to meet their needs. Therefore, many such patients go home and are cared for in bed until these arrive or privately rent the equipment they need, leading to potential preventable complications such as pressure sores and contracture. Wait times can be up to 6 months. It is reported that there is no system in place to ensure the production of orthoses/splints during inpatient acute rehabilitation, even though these should be provided by the rehabilitation unit. Most rehabilitation units lack technical P&O specialists and the necessary equipment, and hospital or centre budgets do not account for these costs. Vaivari have p&o specialists, and system, but that is subcute or long-term/dynamic rehabilitation.

The AT Center faces several challenges, including limited funding and resources, long waiting times caused by lengthy procurement and administrative processes, and fragmented management with insufficient coordination between healthcare and welfare services. The outdated administrative information system and reliance on manual processes further hinder efficiency. Patients and healthcare specialists often lack awareness of available services, and prescription documents are frequently of low quality. It is further reported that a significant portion of the funding goes toward custom-made splints, including simple functional hand splints. However, industrially manufactured splints—which are often cheaper and more cost-effective—are not included in the list of reimbursed devices Additionally, reimbursement policies may fail to cover full costs or support customized or multiple devices needed. Additionally, while reimbursement policies may not always cover the full costs, if multiple or customized devices are needed—such as in the case of a person with SCI requiring an active wheelchair, a standing wheelchair, an electric wheelchair, and self-care assistive devices, splints u.c.—these are provided as necessary.

The SISA funded and operated Jurmala rehabilitation centre: https://www.siva.gov.lv/lv
Social and vocational rehabilitation services are provided 52 weeks of the year by SISA free of charge in the rehabilitation centre and College located in Jurmala, which opened in 1991. SISA focuses on improving social functioning and wellbeing, vocational training and provides psychosocial rehabilitation to support a return to work. The Rehabilitation centre for social rehabilitation has 250 beds, of which 180 are usually occupied and all meals, accommodation and services are free to patients. Approximately 3,000 people receive social rehabilitation services annually. Not all patients have physical functional limitations, some patients are admitted for emotional or psychological support. Referrals are made by email, post or bought on paper by hand. At the time of writing there was no waiting list for patients and patients can choose the dates of their stay.

Services are delivered by 318 employees which include social workers (4 personnel), electrotherapy nurses (5 personnel), massage therapists (6 personnel), psychologists (3 personnel), PRM's (1), physiotherapists (12 personnel), occupational therapists (4 personnel), gym/fitness personnel (2), speech and language therapist (1), art therapists (2 personnel), teachers, counselors, care givers and a nutritionist. The centre's mission is to 'provide timely, targeted and high quality social and vocational rehabilitation services, promoting the patients independence and ability to work.' The centre is financed by the MoW with a budget of 6,5MM for 2024 and serves an average number of 3,583 patients per

year.

Interventions can be single outpatient appointments and day care for a fee, or an annual 2-week inpatient stay which is free of charge. Within the centre there are adapted bedrooms, rehabilitation kitchens and bathrooms, and plentiful functional and cognitive rehabilitation equipment. During inpatient rehabilitation, SIVA provides AT such as a walking frame, shower chair, or toilet chair, etc, but these cannot be taken home. Additionally, they demonstrate, educate, and train individuals in their use, as well as prepare recommendations for obtaining AT from the Vaivari Assistive Devices Center upon discharge. Group sessions are provided for social rehabilitation and enjoyment.

Functional outcome measures such as the Barthel index and functional scale are used, and all records are paper based. SISA provides the opportunity to obtain a professional qualification and offers various types of support services to improve their competitiveness in the labor market, including driving lessons and job application assistance. These services are available to those who have impaired functioning according to the ICF, National Armed Forces personnel and their families (219 patients in 2023) and Ukrainian service personnel (49 patients in 2023). The centre also admits politically repressed persons (370 patients in 2023), and those injured in the Chernobyl nuclear accident in 1989 (858 patients) for an annual 3-week inpatient stay.

Challenges reported by the centre:
Personnel at the centre feel that many patients are referred to them who do not need their services as the entry criteria is too broad and needs to be more precise. This would enable them to provide services to those who would receive most benefit, and provide them sooner.Whilst Government sources have noted there is no waiting list at this centre, it is nevertheless reported by the Centre that demand for their services is greater than they can provide, and that funding is not enough to serve those in need. Its due to the lack of resources that the centre cannot operate at full patient capacity. A reported lack of funding also means that there is not resources to develop infrastructure, update technology or innovate with new interventions. It is acknowledged that there is insufficient data and outcome measures to understand the effectiveness of the services they provide, and this affects evidenced based decision making and assessment.

The centre reports a shortage of personnel, making it difficult to attract, retain, and motivate quailed professionals and causing personnel to be overloaded. The centre does not provide AT for discharge, which is needed by many of their patients.

Vidzeme hospital rehabilitation centre
The Vidzeme hospital serves children and adults in the regions of Valmiera and Valka and provides state and private funded services. In 2023, the hospital provided multiprofessional rehabilitation to more than 250 inpatients and 5,000 outpatients for medical, neurological, trauma, ICU and chronic and palliative conditions.

The hospital has a 15-bed inpatient rehabilitation ward, of which 12-13 are usually occupied, for up to 2 week stays. They cannot use the space to full capacity due to a lack of staff, even though there is demand for the service. After the patients 2 week stay, they can be referred to other inpatient rehabilitation centres; for example, at rehabilitation centers such as Līgatne, rehabilitation unit in

Limbaži. However, they can stay longer if they live more than 2-3 hours distance away. One bed is always kept free to be able to admit a stroke patient within 24 hours of referral. Patients are referred from the rest of the hospital but may need to wait a week or more until a bed becomes available. Referrals to the centre are made and accepted by a PRM. If the PRM is on holiday or sick, patients cannot be accepted and wait longer for rehabilitation, and beds sit empty.

The ward is supported 24/7 by nursing and medical staff and has a wide range of rehabilitation equipment including standing hoists, AT, adaptive chairs and a full OT kitchen and bathroom. Functional rehabilitation was observed with patients being supported to carrying out their ADL's. Depending on a patients capacity, inpatients receive a minimum of 2 hours of rehabilitation per day between 8am and 16:30pm, and if needed, therapist can double up for session, for example with mobility practice.

Patients are on one of two intensity pathways for their rehabilitation program with differing tariffs.

- 'High intensity' with 3+ hours of rehabilitation per day which costs 90 the state euros per day
- 'low intensity' with 2-3 hours of rehabilitation per day which costs the state 70 euros per day

Admission criteria to the rehabilitation ward includes.

- A score not less than 5 on the modified Rankin scale
- At least 2 functional impairments
- Achievable goals
- Patient must be motivated
- Patient must be unable to get the inpatient rehabilitation they need elsewhere.

Rehabilitation staff at the hospital include:

- 1 x part time PRM outpatient
- 2 x PRM's for inpatient and outpatients
- 2 x SLT's
- 3 x electrotherapy and ultrasound nurses
- 19 x physiotherapists
- 4 x occupational therapists (2 of which are part time)
- 3 x massage therapists
- 1x social worker
- 1x clinical psychologist

The centre uses a range of validated outcome measure to monitor patients progress, such as the MOCA, depression scales, Rankin and the scale. Upon discharge from rehabilitation, patients are scored using these such outcome measures to ascertain if their goals were achieved. This data is not reported anywhere and does not leave the hospitals records.

As with other inpatient facilities in Latvia, there is some AT available for use in hospital, but not to take home. OT's and PT's can write a government prescription for AT to take home, if needed, which can take months and the patient will need to make a co-payment for. It is reported that most patients buy the AT they need privately, as it is essential to complete their ADL's safely and independently. The centre does

not have capacity for home or discharge planning visits, but patients can come back as outpatients. A new ward is currently being built for rehabilitation with a large gym and hydro pool, however, this ward will be only available to privately paying patients.

Challenges reported:
It was reported that it is very difficult to recruit and retain SLT's and PRM's as so few come through training, and they are paid more in the private sector. The lack of PRM's and their role in referring and accepting patients can delay patients accessing rehabilitation and drive up wait lists and complications. For example, a patient with humeral fracture who has just had their immobilization cast removed may have to wait weeks or months to see a PRM to be referred to physiotherapy, and then has to wait for their outpatient appointment. In the weeks or months that have passed an elbow or shoulder movement limitation or contracture has likely occurred. This preventable complication would need extensive rehabilitation that may not restore previous function and delay recommencing employment and take up greater resources.

Although they strive to provide early rehabilitation, the reality is that they do not have the personnel to get to inpatients in the rest of the hospital, and that patients who need early rehabilitation experience delays or missed altogether. The centre also reports a high prevalence of poorly written and inappropriately referred patients that takes significant resources and drives up waiting lists. It was suggested that functional therapists could refer and triaged patients to review the appropriateness of the referral and the patients motivation.

Due to the annual funding allocation system, many services cease providing state services when the money runs out, often mid-way through the year. This puts extra pressure on their services, as it means wait lists go up, and even some of their services are affected and close. For example, the wait list for SLT was already up to December in early August.

The hospital has no P&O, if their services are needed, a referral to the national rehabilitation centre Viavari is made, and it is over 2 hours away with long wait lists. For example, if an amputee needs a prosthetist, they may wait 6-8 months just for their initial appointment. Generally, there is a lack of rural rehabilitation services and so patients have to travel far. Demand for rehabilitation services is increasing and patients are becoming more complex, and this need cannot currently be met.

The hospital has nurses who provide electrotherapy and ultrasound, modalities' that have a poor evidence base for its use and benefits. With this, rehabilitation personnel at the centre would like to limit these interventions, but say that patients demand it and so by providing it as part of their rehabilitation, it helps to improve patient adherence.

Rehabilitation personnel would like to provide group classes education, exercise and peer support classes for those needing long term or life long rehabilitation and condition management as this population are not currently catered for and are therefore treated in the acute system, which does not meet their specific needs.

Every interaction with patients is documented on paper, and referrals are also on paper. The centre reports what has already been widely reported; that single paper referrals are used multiple times to increase their number of sessions, referrals are often poorly written and inappropriate, in that often the patient referred does not have an impairment that would benefit from rehabilitation. It is felt that functional rehabilitation and the role of each rehabilitation profession is poorly understood, particularly among PRM and GP referrers.

Furthermore, patients with chronic conditions that need long term management aren't catered for, and so end up in the acute system. Support groups, prevention and education sessions, and exercise classes don't exist in the community, and so they come to the hospital. Conditions such as low back pain, arthritis, Parkinson's, cardiac and respirations conditions could benefit from such community services. This drives up wait lists and drains resources that could be better used elsewhere.

Riga East University Hospital (RAKUS)

RAKUS is the largest hospital in Latvia that has more than 2,000 beds and in 2023 provided healthcare services to 60,000 inpatients and 710,000 outpatients, while 72,000 different types of operations were performed. The rehabilitation Clinic within the hospital provides 25 beds for acute inpatient rehabilitation, subacute and long-term rehabilitation, as well as day care and outpatient rehabilitation.

The hospital employs 8 PRM doctors, 62 rehabilitation specialists: (Physiotherapists (34), occupational therapists (12), speech and language therapists (10), clinical psychologists (4) and art therapists (3)), as well as inpatient nurses (10) and their assistants. The clinic served 460 inpatients for rehabilitation in 2023. Wait times for inpatient admissions were, at the time of writing this report, less than 1 month, while stroke patients waited less than 1 week for a bed. The average length of stay for rehabilitation was 19 days.

Physiotherapists deliver services on the 16 bed ICU, mostly for post-op laparotomies for breathing and bed exercises, and mobilization, if appropriate. The 58-bed trauma ward is served by 2 physiotherapists and an occupational therapist, as needed, who deliver bedside rehabilitation and mobilization upon verbal referral from doctors. There is one physiotherapist and occupational therapist and two SLT's delivering rehabilitation on the hospital's 55 bed neurosurgical unit. Rehabilitation personnel reviews almost all of the stroke patients on the 60 bed stroke unit and accompanies the medical team on their morning ward round to pick up referrals. Patients usually only spend a week on the unit before being discharged or referred to inpatient rehabilitation. The unit is served by 2 physiotherapists, SLTs and occupational therapists who often link up for multiprofessional rehabilitation sessions.

In 2023 the clinic also delivered day care rehabilitation services to 240 patients, state funded outpatient rehabilitation services to 233, while 275 patients paid for private outpatient rehabilitation services. The clinic served patients with neurological disorders such as after a stroke, acquired brain injury, neurodegenerative diseases, and neuro-oncological conditions, patients with musculoskeletal problems such as bone fractures and joint replacements, and deconditioned patients who required intensive therapy, such as those with post-intensive care syndrome (PICS).

The clinic collects data on diagnosis, assessment according to the ICF, and level of functioning on admission and discharge according to the modified Rankin scale. They also collect information on discharge planning, involved professionals, the intensity of rehabilitation, commencement and duration of rehabilitation. Outcome measures such as the 6 Minute Walk Test (6MWT), the Gugging Swallowing Screen (GUSS), Functional Independence Measure (FIM), Rivermead Mobility Index (RMI) are utilized. The clinic has designed and uses assessment and treatment protocols for ICU, stroke, and general rehabilitation patients and all records are electronic but not transferable beyond the hospital.

Table.... shows the number of patients the clinic served in 2022 and 2023, with the largest number of patients receiving rehabilitation after a stroke.

	2022	2023
Total number of patients hospitalized	57,685	60,306
Total number of patients who received acute rehabilitation and percentage of these from all those hospitalized	9,560 (16.6%)	9,339 (15.5%)
Total number of stroke patients hospitalized and their percentage of all patients hospitalized	2,309 (4.0%)	2,370 (3.9%)
Total number of patients with stroke who received acute rehabilitation during their stay and their percentage from all the stroke patients admitted	1,656 (71.7%)	1,7,97 (75.8%)

Table ..... showing number of unique patients who received rehabilitation services in hospital from 2018 till 2023.
S

	2018	2019	2020	2021	2022	2023
In-patient rehabilitation 24-hour stationary	-	268	366	451	381	457

Day patient rehabilitation service	90	166	165	168	216	253
Out-patient rehabilitation	13 027	12 980	6 073	3 528	3 576	6 817
Acute rehabilitation (% from the total number of RAKUS hospitalized patients)	-	-	7 301 (13%)	8 316 (16%)	9 560 (18%)	9 339 (16%)

*Note that the outpatient numbers have declined due to building works eliminating the service space and the new focus on inpatient services. The table shows that early rehabilitation is not happening and wait times to commence rehab have gone up since 2021.

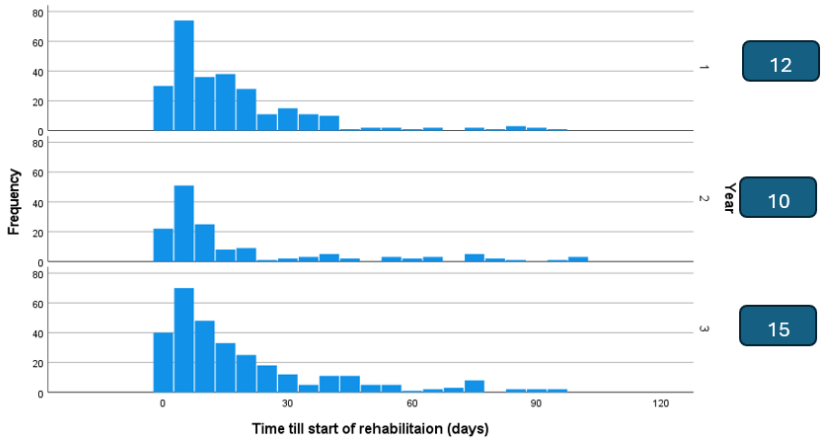


Figure ... shows the number of days an inpatient had to await before rehabilitation commenced in 2021/2022/2023.

The duration of rehabilitation has increased from an average of 16 days in 2021 to 20 days in 2023

Challenges reported by the rehabilitation clinic

There is no dedicated rehabilitation gym, space or bedside supportive seating for patients, so patients are mostly in bed and cannot access toilets that are at a distance. AT provision is very limited and for in hospital use only. Patients have to purchase the mobility aids they need, such as crutches, from a private provider. Rehabilitation personnel report that 30-50% of the patients referred to by doctors do not have a functional impairment or need their rehabilitation services. Referrals are usually verbal with very limited information provided. Patients often do not commence rehabilitation as early as they ideally should due to delayed referrals. There are not enough rehabilitation personnel to deliver the rehabilitation services needed, and services are only Monday to Friday.

6

Riga First hospital

Riga First hospital is a municipal health care facility for children and adults that has a large rehabilitation outpatient and day care centre that provides MoH and privately funded rehabilitation services. Among more basic equipment, the facility has high tech equipment such as anti-gravity treadmill and robotics, however, these are only for private patient use. The centre is staffed by PRM's, physiotherapists, occupational therapist, SLT's, masseurs, psychologists and electrotherapy nurses. Referrals are in a paper format and patient records are digitalized but the system is not compatible with other facilities.

Challenges:

Personnel report that a large proportion of their patient referrals are inappropriate and for those who are not motivated, may only need one session of rehabilitation or none at all, and that referrals often contain no information other than the patients demographic details. They also see that many patients use their single paper referral many times to gain access to multiple services and wait lists, which is a drain on resources and drives up wait lists. Personnel at the Riga first rehabilitation centre would like to see the abolishment of the set number of rehabilitation sessions prescribed on referrals, as patients are often prescribed more sessions than they need, which they are forced to provide and sets unrealistic expectations for patients. The situation could be helped if functional therapists could refer and triage referrals.

Challenges reported by the rehabilitation clinic

The clinics operates on a digital system for patient records and data collection, but this data is not utilized beyond the clinics use, and referrals are still paper based. A lack of financing means that not enough rehabilitation personnel are employed to meet demand, and this means that patients are on a wait list to commencing rehabilitation, and referrals can be delayed due to a lack of understand among other health personnel about the need for rehabilitation. Furthermore, access to AT in the clinic is limited and they cannot provide essential AT for patients to be discharged with.

CCUH

The Children's clinical university hospital (BKUS) is the largest specialized multiprofile children's medical institute in Latvia. Last year the hospital served around 14,000 inpatients and 13,000 outpatients in total, and sees around 200 visits per day to its A&E. The hospital provides multiprofessional in and outpatient rehabilitation services for those aged under 18 and has a separate children's mental health facility. The centre has 6 inpatient rehabilitation beds or patients can be referred for a bed at Vaivari, if they live closer or this is preferred.

Patients are referred by their doctor to the PRM who aims to review them in within 24 hours of referral. The PRM will then write goals and tasks for the OT/PT to complete with the child, with no limit on the volume of rehabilitation that can be provided. If the child has just one functional impairment they are seen as an outpatient, if they have 2 or more, they come to the day care rehabilitation service. The centre ulitsed telerehabilitation during COVID, but this has since ceased. Patient records are online and referrals to different professions within the hospital can be made online.

Rehabilitation personnel at the centre include:

- 4 full time and one part time PRM who see up to 12/15 patients per day
- 3 OT's

- 20 physiotherapists
- 1 SLT

Challenges:

The centre struggles to recruit and train PRM's who refer and accept patients for rehabilitation. Without a PRM review, patients cannot access inpatient or outpatient rehabilitation, leading to delays in access rehabilitation services. At the time of writing, wait times for outpatient rehabilitation were longer than 6 months long and the centre had 2 long-standing PRM vacancies. It was reported that up to 30% of GP referrals to the PRM for rehabilitation were inappropriate as that child did not need rehabilitation. Most of these 'inappropriate referrals' were for 'asymmetric posture' and it was reported that most referrals are of poor quality with very limited information. Personnel at the centre would like to have clear and standardized referral criteria to improve the quality and appropriateness of referrals from GPs.

The centre has limited to access to AT and does not provide AT to take home. Referrals are made to Vaivari or parents self-purchases the AT their child needs.

Rehabilitation in tertiary health care:
Rehabilitation is available in tertiary health care and is provided in 3 university hospitals and in the National rehabilitation centre "Vaivar"

Level 3: In Latvia there are 7 medical institutions
Madona Municipality limited company 'Madonas slimnīca'
limited company 'Cēsu klīnika'
limited company 'Dobeles un apkārtnes slimnīca'
limited company 'Jūrmalas slimnīca'
limited company 'Ogres rajona slimnīca'
limited company 'Balvu un Gulbenes slimnīcu apvienība'
limited company 'Kuldīgas slimnīca'
Acute rehabilitation in mixed-purpose beds are provided for all 7 hospitals;
Rehabilitation in day hospital for adults, children provided 5 hospitals from 7 (Cēsis, Dobele, Kuldīga, Madona, Ogre)
Ambulator monorofesional Rehabilitation services for children and For adults are provided all 7 hospitals in each hospital there ir atleast one rehabilitation specialist.

Rehabilitation in secondary health care:
As part of the secondary healthcare level, rehabilitation services are mainly provided as outpatient and day hospital services. There are 86 state funded outpatient rehabilitation service providers in total: 28 in the region of Kurzeme, 36 in Latgale, 79 in Riga, 38 in Vidzeme, 31 in Zemgale.

Rehabilitation at community and primary healthcare level:

Currently, the state does not provide rehabilitation at primary healthcare level. Rehabilitation services outside of facilities can be accessed through private services or with private health insurance.

Rehabilitation day care services whereby patients can access multiprofessional rehabilitation are provided by all 36 municipalities across the country, but they are based within hospitals.

Rehabilitation in long-term care:
In general, the state provides services in live-in care institutions for the following populations:
- adult blind persons and persons with severe and very severe mental disorders (with registered level 1 and 2 disabilities)
- children with severe and very severe mental developmental disorders or children with severe and very severe physical developmental disorders, as well as children with combined severe and very severe mental and physical developmental disorders under the age of four;
- for children with severe and very severe mental disorders between the ages of four and 18, for whom family care cannot be provided due to the severity of functional disorders;
- as well as for orphans and children left without parental care under the age of two years - for the time until the child returns to the family or his care with a guardian or in a foster family begins.

In total, 4 state funded and operated long-term social care centers exist, and between them they have 25 sub branches located in smaller cities throughout the country.
Municipalities provide social care services in the institution for the following populations:
- orphans and children left without parental care between the ages of 2 and 18, if it is not possible to provide their care and upbringing in a foster family or with a guardian;
- for children with severe functional disorders, if the amount of service required exceeds the amount determined for care at home or in a day care and social rehabilitation institution;
- for persons of retirement age and persons with severe and very severe functional impairments.

A total of 122 institutions are located throughout the country (15 for children, 107 for adults). Long-term care social care centers employ rehabilitation specialists (physiotherapist, occupational therapist etc.), but not all centers have these specialists because of the financial constraints, or because of the difficulties in attracting specialists regionally or on a part-time basis.

Rehabilitation for children

Early interventions:
Early intervention services for children are provided, if the municipal government provides them. Applied Behavior Analysis therapy is paid for as part of the Deinstitutionalization process, which will take place with EU funding until the end of 2023. After that, the service will be provided by the municipal governments that have set up such services, at their own expense.

In regulation no. 555,[87] adopted 28 August 2018, 'Procedures for the Organisation of, and Payment for Health Care Services,' children's early and preventive examinations are defined. Assessments are conducted by the family doctor and, after evaluating the child's development, if needed, a referral to a specialist consultant is made.

[87] Republic of Latvia Cabinet, Regulation No. 555, Adopted 28 August 2018, Procedures for the Organization of and Payment for Health Care Services in 1. attachment Children's preventive examinations.

A common set of methodological tools for assessing early development needs in children is currently being developed for use in education and healthcare, including a special needs assessment tool for learners before the beginning of compulsory pre-school education.

Since 2023, an early intervention programme for children aged 0-6 with autism spectrum disorders has been introduced in Latvia in 9 medical institutions in different regions. The program is developed individually for each child and provided according to the child's needs, involving a very broad multi-professional team, including rehabilitation professionals. This programme is a priority activity, and therefore a non-quota programme in terms of funding, so whoever needs the service will receive it.

MoW social rehabilitation for children:
Under the MoW, a psychosocial rehabilitation service is provided for children with autistic spectrum disorders which include ABA therapy, occupational therapy, speech therapist, and special pedagogue classes. Psychological consultations, support groups, chaplain consultations are also available to them and their families.

Day care centres for children with disabilities are provided by the municipality and includes access to social workers and carers. The centres provide children with assistance with self-care, maintaining of cognitive skills, lessons for improving skills that help with employment, art and artistic skill development, physical activities, leisure time activities, client information and education events, and specialist consultations, as needed.

There are 16 Day care centres for children with disabilities in the following regions of Latvia:
1 in Daugavpils, 1 in Jūrmala, 3 in Riga, 1 in Alūksne Municipality, 1 in Dobele Municipality, 2 in Bauska Municipality, 2 in Balvi Municipality, 2 in Ludza Municipality,1 in Sigulda Municipality, 1 in Tukums Municipality, and 1 in Ventspils Municipality.

MoE provision of rehabilitation for children in schools:
In preschool educational institutions and schools, speech therapists, psychologists, audio pedagogues provide rehabilitation for children with various learning difficulties and functional impairments.
There are also separate special schools in Latvia for children with various developmental disabilities, where a small number of functional specialists are employed.

Provision of rehabilitation to enable access to vocational education, taking into account the different types and manifestations of disability for a disabled learner according to their functional impairments at the Smiltene Technical School in Alsviķi. Municipal governments can also provide sign interpreter services and assistant services in educational institutions.

Rehabilitation for older persons:

Rehabilitation for elderly people is carried out in a general way, there are no separate programs for the prevention of the risk of falls, etc. If an older person has a functional impairment, they can be referred to rehabilitation by a PRM or their family doctor, as per the rest of the adult population.

12.2 Overview of rehabilitation quality

In Latvia, other than for stroke patients, there are no national clinical practice guidelines, models of care, standards or protocols that support delivery of effective evidence-based rehabilitation services. The country has not introduced quality assessment indicators for rehabilitation services that would analyze the system. Therefore, it is difficult to understand the quality level of rehabilitation services being provided between different facilities. For stroke patients there is evidenced based clinical guidance available for all stages of rehabilitation, including documentation guidance and functional measurement tools.[88]

Within secondary and tertiary care, multiprofessional rehabilitation is practiced and rehabilitation is tailored towards the patients' specific needs. Functional measurement tools, such as the MOCA, Barthel etc are used, but it is unclear how widespread their use is. Documentation is thorough and includes assessment, diagnosis and treatment plans with goals. Person-centred care is emphasized in the healthcare policy[89] and in the work of some healthcare facilities, such as in BKUS: https://www.bkus.lv/lv/profesionaliem

Geographical distribution of rehabilitation professionals

It is widely reported that there is a shortage of rehabilitation professionals in Latvia, particularly away from the Capital, Riga. The below diagrams demonstrate the density of the rehabilitation workforce across the country in 2023, evidencing the regions in red where there are severe shortages.

PRM density:

Total number of PRMs working in Latvia in 2023: 322

Total number of PRMs employed by the NHS in 2023: 109

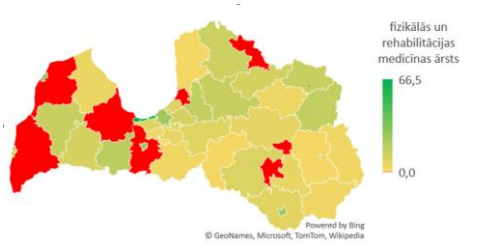
Density of PRMs per 100,000 of the population: 5.8

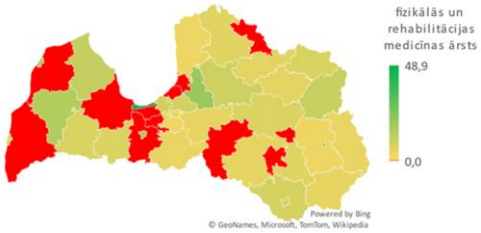
Total number of PRMs employed in the private sectors and NHS by region:

Number of PRM's employed within the NHS by region:

[88] Clinical algorithms, patient pathways, indicators (ESF project) 2024. https://www.spkc.gov.lv/lv/kliniskie-algoritmi-pacientu-celi-indikatori-esf-projekts

[89] Ministry of Health: Latvia must continue to move towards people-centered healthcare. 2021. https://www.vm.gov.lv/lv/jaunums/veselibas-ministrija-latvijai-jaturpina-virzities-uz-cilveku-centretu-veselibas-aprupi

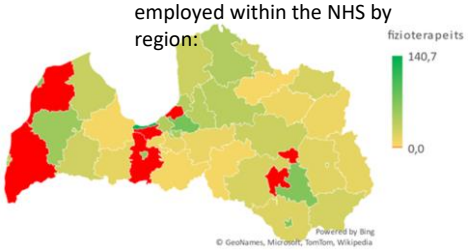




Physiotherapists:
Total number of working physiotherapists in Latvia in 2023: 1670
Total number of physiotherapists employed by the NHS in 2023: 659
Density of physiotherapists per 100,000 of the population: 35

Total number of physiotherapists employed in the private sectors and NHS

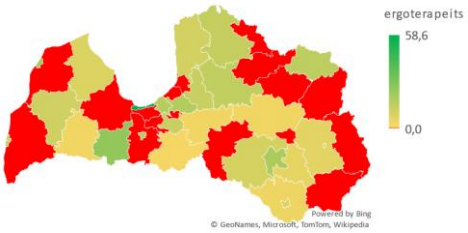
Number of physiotherapists employed within the NHS by region:

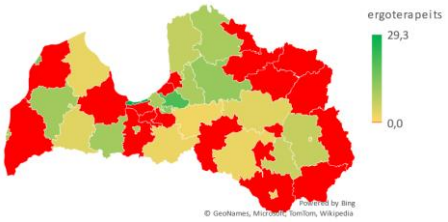


Occupational therapists
Total number of working occupational therapist in Latvia in 2023: 226
Total number of occupational therapists employed by the NHS in 2023: 157
Density of occupational therapists per 100,000 of the population: 12

Total number of occupational therapists employed in the private sectors and NHS

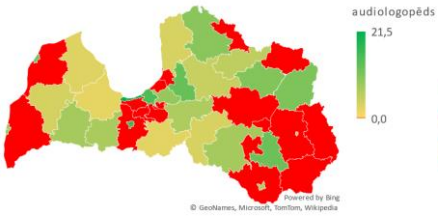
Number of occupational therapists employed within the NHS by region:



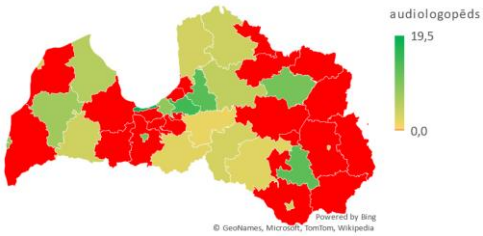


Speech and language therapists:
Total number of working SLTs in Latvia in 2023: 164
Total number of SLTs employed by the NHS in 2023: 123
Density of occupational therapists per 100,000 of the population: 8.7

Total number of SLTs employed in the private sectors and NHS



Number of SLTs employed within the NHS by region:



11. Vision and hearing

Hearing:
To receive hearing aids, a person needs to be referred to by their GP and co-payments are the same for any other AT. Hearing impairment as the main diagnosis as of July 2023: 2668 person whilst approximately 42,000 people in Latvia have been prescribed hearing aids and approximately 150 children are estimated to receive hearing aids per year.

Latvian Association of the Deaf
Founded in 1919, the Latvian Association of the Deaf is one of the oldest associations in Latvia.

Since 2010, according to law, the MoW provides funding to the LAD for 2 functions: 1) the provision of assistive technologies and 2) services for deaf people. The LAD also develops technical indicators for MoW to approve. GP's refer deaf person to the association for their initial contact, after which no GP referral is needed, they can just contact the association directly.

Deaf interpretation:
The association reports that there are not enough interpreters in Latvia. The association has 1500 deaf clients, but only 32 interpreters. Each deaf person is entitled to receive 120 hours of free interpretation per year from the government. Young deaf people in education are entitled to 960 free hours of interpretation in school, but this isn't enough to cover their school day. Training to be an interpreter takes 2 years and tuition is covered by the government.

Access to assistive technology for deaf persons:
The association buys assistive products at the price set by the government within the scope of public procurement and allocated financial resources. If there is a product the patient needs that association doesn't provide, the person has to pay OOP. When extra/replacement parts are needed, this is an OOP unless registered as a low-income household After a certain period that is unique for each product, a person can return to the center and request a new aid.

A person may ask for a new product before the specified time if the type or severity of the person's functional impairment has changed, and therefore the previously issued product has become unsuitable for use. At the time of writing there are no wait lists for hearing AT, and patients get what they need within a month.

The Latvian association of the deaf provides services in 8 regions of Latvia: Riga, Rēzekne, Daugavpils, Smiltene, Valmiera, Ventspils, Kuldīga, and Liepāja. Here, they provide services which include the provision of equipment for the hearing impaired, social rehabilitation (learning of sign language, developing of communication skills, etc.), sign language interpreters for communication, education, etc. Table ..... shows the number of people served for AT and interpretation services by the LAD, disaggregated by age and gender in 2023.

Table... showing number of people served for AT and interpretation services by the LAD, disaggregated by age and gender in 2023.

Number of recipients of surdo-technical aids

Age	**Together**	Women	Men
0 - 17 years (full)	**214**	104	110
18-25 years	**47**	28	19
26-39 years	**153**	80	73
40-64 years	**719**	396	323
over 65 years	**4 441**	2 794	1 647

Number of recipients of sign language interpreter services in the interface

Age	**Together**	Women	Men
0 - 17 years (full)	**22**	12	10
18-25 years	**53**	28	25
26-39 years	**236**	107	129

40-64 years	**576**	324	252
over 65 years	**281**	185	96

Number of recipients of sign interpreter services in professional education

Age	**Together**	Women	Men
0 - 17 years (full)	**1**	1	0
18-25 years	**7**	4	3
26-39 years	**5**	2	3
40-64 years	**4**	1	3
over 65 years	**0**	0	0

Number of recipients of social rehabilitation services

Age	**Together**	Women	Men
0 - 17 years (full)	**10**	7	3
18-25 years	**18**	11	7
26-39 years	**149**	63	86
40-64 years	**489**	282	207
over 65 years	**284**	189	95

Challenges reported by the deaf community:
The LAD reports that conditions affecting the ears and hearing that can lead to disability are not being picked up or referred early enough, and they recommend training for GP's on this. They also report that not enough is done among health professionals to raise awareness of the difficulties experienced, or to support those who are deaf. The association feels that 150 hours of interpretation is not enough, particularly for those in work and education.

Vison:

Children's vision services

National, state-funded children's vision screening and clinical guidelines for 0–6-year-olds was introduced in Latvia 2013. Vision screening is conducted by ophthalmologists and GPs in hospitals, child healthcare centres, or private clinics. No data is available relating to the coverage, utilization, treatment effectiveness and quality of vision services in Latvia. However, diagnostic condition data is reported by facilities to the Centre for Disease Prevention and Control (CDPC).

Latvian society of the blind
The Latvian society of the blind provides social rehabilitation for the visually impaired. The society currently supports 580 people with vision loss on their register, and the government provides 400 euros per person per year to the society to support their needs. The society reports that this isn't enough, and they ask for more financial support every year, which they sometimes receive.

The society offers 4 programs to registrants. 1) once in their lifetime they can receive a 3-month inpatient stay for social rehabilitation in Riga that teaches the use of IT devices, mobility, cooking, other ADL's, and Braile, according to the visually impaired person's needs 2) each year registrants can have 60 hours of social rehabilitation as an outpatient, if they need it 3) social rehabilitation at home to support activities such as mobility and use of transport 4) the society runs a school in Riga for blind children. They also provide AT such as canes, magnifiers, eye prostheses, Binocular or telescopic glasses, for example. Glasses are a self-funded OOP.

The Latvian association for the blind operates in regions of Latvia to provide social rehabilitation services which includes provision of assistive technology, orientation in the environment,
training of service dogs, development of permanent functional skills (cooking, handling finances, home care, computer work, braille training, etc.), publishing of a newspaper for the visually impaired, and day care.

Challenges:
The society reports that they have wait lists for all services and they cannot meet the needs of their registrants with the resources the government provides. They also feel that not enough is being done to prevent vision loss, with medical prophylaxis to prevent worsening of vision loss as being their number one unmet need. Additionally, they report that the guidelines for vision loss need improving.

Children with disabilities:
Disability inclusion projects provide rehabilitation services to children with disabilities, based on assessment. This service is co-funded by the EU and the MoH. Every municipality must provide this service, either by setting up its own centre, of which there are many, or by procuring the service from another municipality. The EU funding may run out, in which case the municipal government must provide funding.

Individual NGOs that provide rehabilitation services for donations ("Poga", association "Latvian children with mobility impairments"). Thus, some children are provided with additional rehabilitation services, but at the same time it also affects the rehabilitation system by fragmenting the service. Evidence-based rehabilitation methods are not always used in rehabilitation services provided by non-governmental organizations.

12. Rehabilitation in emergency or disaster

A civil protection plan has been developed and approved in Latvia, but it does not include specific information on the provision of rehabilitation services in emergency situations.[90] The plan includes algorithms on how and in which situations the victim should be taken to a hospital of which level. Taking into account that rehabilitation professionals are employed and available in all the hospitals mentioned in the plan, rehabilitation services would be available to any patients, if needed. However, there is no specific budget or strategy document for the provision of rehabilitation services in emergency situations. There is also no stockpiling of assistive technologies.

[90] Order of the Cabinet of Ministers of August 26, 2020 no. 476 "On the State Civil Defense Plan". https://likumi.lv/ta/id/317006

In the case of an emergency event, a national medical emergency response commission will be set up to decide on additional resources to be allocated to address the situation, which could consider rehabilitation.

Summary of Rehabilitation Accessibility and Quality Situation

Inpatient Rehabilitation Beds:

- Latvia has 267 inpatient rehabilitation beds for adults across 11 facilities.
- There are 70 inpatient rehabilitation beds for children under 17 in 4 facilities: Vaivari, RAKUS, REUH, and PKUS.

Early Intervention Services:

- Early intervention services are available for children, including those with autism and hearing impairments.

Disability Registration:

- Disabilities are categorized into three levels based on condition severity and ability to work.
- The disability register records conditions but does not measure functional limitations or variations within conditions.

Emergency Preparedness:

- Rehabilitation is not included in emergency response and preparedness plans.
- Latvia's civil protection plan is approved but lacks details on the provision of rehabilitation services in emergencies.

Vision and Hearing Services:

- No data is available on services related to vision and hearing through the desk review.

Rehabilitation Quality:

- The quality of rehabilitation interventions cannot be determined through the desk review.

15. Conclusions

In Latvia, multiprofessional rehabilitation services are integrated into the national health system and funded through the state. Despite this, significant human resource shortages hinder equitable access, contributing to long waiting times, high out-of-pocket (OOP) expenditures, and unmet needs for rehabilitation and assistive technologies (AT). Co-payments are required for most services, and referral pathways remain unclear. There is limited awareness and understanding of functional rehabilitation among both the general population and healthcare providers, leading to inefficient service utilization and increased reliance on private, self-paid care.

While regulatory frameworks supporting rehabilitation exist, governance is fragmented across multiple ministries, and there is no designated national focal point for rehabilitation. Data collection and reporting mechanisms to the Ministry of Health are inadequate, limiting evidence-based service planning. Access to AT is constrained, with most products acquired through OOP spending.

Rehabilitation is referenced in the national health plan and across various condition-specific strategies; however, there is no standalone national rehabilitation strategy. Although rehabilitation is included in the state-funded basic health package, current coverage is insufficient to meet demand. With an ageing population and rising burden of noncommunicable diseases (NCDs), the need for rehabilitation and AT is expected to increase substantially, exacerbating existing gaps in service provision.

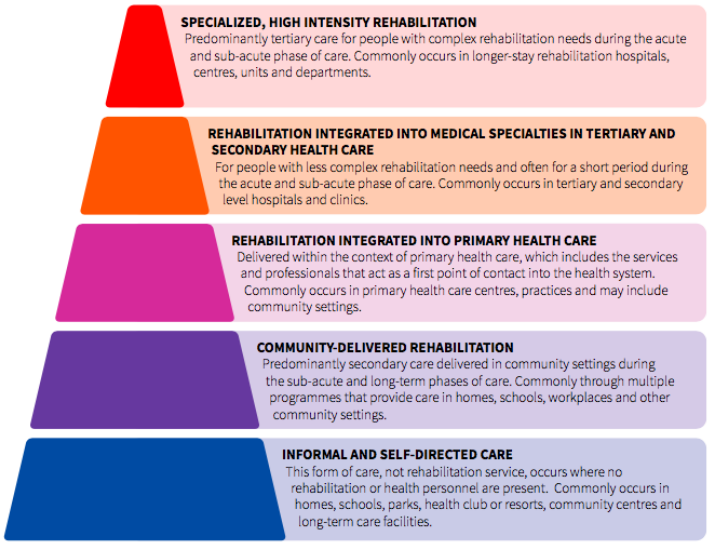
References:

1. Rehabilitation 2030: a call for action. Geneva: World Health Organization; 2017 (https://www.who.int/initiatives/rehabilitation-2030, accessed 10 Aug 2022).
2. Rehabilitation in health systems. Geneva: World Health Organization; 2017 (https://www.who.int/health-topics/rehabilitation#tab=tab_1, accessed 10 Aug 2022).
3. Rehabilitation in health systems: guide for action. Geneva: World Health Organization; 2019 (https://apps.who.int/iris/handle/10665/325607, accessed 10 Aug 2022). License: CC BY-NC-SA 3.0 IGO.
4. Universal health coverage (UHC) (fact sheet). In: World Health Organization [website]. Geneva: World Health Organization; 2021 (http://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(UHC), accessed 20 October 2021).
5. World Health Organization. 2023. Strengthening rehabilitation in health systems. SEVENTY-SIXTH WORLD HEALTH ASSEMBLY WHA76.6 Agenda item 13.4 30 May 2023. Available at: https://apps.who.int/gb/ebwha/pdf_files/WHA76/A76_R6-en.pdf

Annex A – Overview of rehabilitation

Rehabilitation is a health strategy alongside other health strategies, including promotion, prevention, curative, and palliative care *(1)* (see Fig. A.1.1). It is a fundamental part of health services and integral to the realization of Universal Health Coverage *(2)*. Rehabilitation covers multiple areas of health and functioning, including physical, mental health, vision, and hearing. 'Rehabilitation interventions'[91] primarily focus on improving the functioning of an individual and reducing disability. Rehabilitation is a highly-integrated form of healthcare with most rehabilitation delivered within the context of other (not rehabilitation specific) health programs, for example orthopedic, neurology, cardiac, mental health and pediatric. Rehabilitation improves peoples everyday functioning and increases their inclusion and participation in society, by doing so it is an investment in human capital.

Fig. A1.1 Rehabilitation in health framework



Source: *(1)*

Rehabilitation should be available at all levels of healthcare, from specialist referral centers through to primary and community settings[92]. Rehabilitation interventions are delivered in health facilities as well as in the community, such as in homes, schools and workplaces. Rehabilitation is a highly person-

[91] Rehabilitation interventions are a form of health interventions. Health interventions are: a health intervention is an act performed for, with or on behalf of a person or population whose purpose is to assess, improve, maintain, promote or modify health, functioning or health conditions. Examples of these acts, in the context of rehabilitation include; manual therapy, exercise prescription, provision of assistive products, education and modification of home environment.

[92] The Services Framework for Rehabilitation reflects the distribution of rehabilitation required to meet community needs.

centered form of health care, it is goal orientated (i.e. very individually tailored), time bound and an active rather than passive process. Rehabilitation is most commonly delivered through a multi-disciplinary team including therapy personnel, namely physiotherapists, occupational therapists, speech and language therapists, prosthetists and orthotists, psychologists and through specialist rehabilitation medicine doctors and nurses, it can also be delivered through appropriately trained community-based rehabilitation personnel and other health personnel. In this report, as with other WHO documents, the word rehabilitation also includes habilitation[93]. Rehabilitation is for all the population; this includes people with disabilities as defined by the United Nations Convention on the Rights of Persons with Disabilities[94] (UNCRPD), as well as many others. People with short-term health conditions also benefit from rehabilitation and it commonly contributes to the prevention of impairments associated with disability. Rehabilitation regularly optimizes surgical outcomes, decreases the length of hospital stay, prevents complications, decreases re-admissions and facilitates a return to optimal functioning. Many people with disabilities also benefit from rehabilitation, and in addition to rehabilitation many people with disabilities require other programs, such as those that support their social inclusion, their participation in education, their attainment of a livelihood or their access to justice. Programs that include people with disabilities and whose primary aims are education, training, employment or social inclusion should be delivered through non-health ministries and align to the mandate of that ministry.

[93] Article 26 of the UN Convention on the Rights of Persons with Disabilities refers to both Rehabilitation and Habilitation. Habilitation refers to rehabilitation in the context of people who were born with congenital health conditions.

[94] As defined by the UNCRPD, People with disabilities are 'those who have long term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis to others'. However, rehabilitation is for all the population, for example people with short-term functioning difficulties as well and for many people who do not identify as having a disability or are legally acknowledged as disabled by a governments processes.

REHABILITATION 2030

REHABILITATION IN HEALTH SYSTEMS – A GUIDE FOR ACTION

Overview

"Rehabilitation in Health Systems – A Guide for Action" (the Guide) assists governments to **strengthen the health system to provide rehabilitation.**

This initiative is a result of the February 2017 **"*Rehab 2030: A call for Action*"** meeting in Geneva.

The Guide is a 4-step process that is estimated to take about one year to complete (each country is different). WHO has developed standard data collection tools; these were first used in 2018.

In general, the process starts when the Ministry of Health expresses interest in the process and/or requests technical support from WHO for this activity.

The assessment is based around the six building blocks for health systems strengthening. Application to rehabilitation is outlined for each building block.

The Four-Phase Process

Objective	WHO Guidance	Tools	Activity Timeline
1. Assess the situation	Systematic Assessment of Rehabilitation Situation (STARS)	*Template for Rehabilitation Information Collection (TRIC):* 8 domains, 97 questions; MoH self-assessment *Rehabilitation Maturity Model (RMM):* 7 domains, 50 questions; consultant-supported scoring	TRIC: May-July 2024 In country mission: August 2024 Zero-draft: October 2024 First draft:
2. Develop a rehabilitation strategic plan.	Guidance for Rehabilitation Strategic Planning (GRASP)	Results from STARS report contributes to development of strategic plan.	Anticipated dates:
3. Establish monitoring evaluation and review process	Framework for Rehabilitation Monitoring and Evaluation (FRAME)	FRAME guidance assists in establishing a monitoring framework including the selection of indicators.	To happen simultaneously with Strategic Plan
4. Implement the strategic plan	Action on Rehabilitation (ACTOR)	Planning, action, and evaluation cycle	After Strategic Plan and Monitoring Framework are in place

The WHO health system building blocks are an important framework reflected within the Guide. Across the six building blocks are components that reflect rehabilitation. The table below illustrates the health system building blocks and corresponding rehabilitation components. The assessment and measurement of these rehabilitation components is a subject of the tools in the Guide.

Health system building blocks and rehabilitation

The Six Building Blocks of the Health System	Components Reflecting Rehabilitation
1. Leadership and governance	● Laws, policies, plans and strategies that address rehabilitation. ● Governance structures, regulatory mechanisms and accountability processes that address rehabilitation. ● Planning, collaboration and coordination processes for rehabilitation.
2. Financing	● Health expenditure for rehabilitation. ● Health financing and payment structures inclusive of rehabilitation.
3. Health workforce	● Health workforce that delivers rehabilitation interventions - primarily rehabilitation medicine, rehabilitation allied health / therapy personnel and rehabilitation nursing.
4. Service delivery	● Health services that deliver rehabilitation interventions, including rehabilitation delivered in rehabilitation wards, units and centers, in hospital settings and rehabilitation delivered in primary care facilities and other community settings. The availability and quality of rehabilitation are considered.
5. Medicines and technology	● Medicines and technology commonly utilized by people accessing rehabilitation, primarily assistive products.
6. Health information systems	● Data relevant and inclusive of rehabilitation in the health information systems. For example, population functioning data, rehabilitation availability and utilization data, rehabilitation outcomes data.

Annex D – WHO Rehabilitation Maturity Model

The Rehabilitation Maturity Model (RMM) is a standard tool used during the STARS process. There are 50 components across seven domains in the RMM. Each component has illustrative descriptors that indicate levels of maturity of rehabilitation in the health system. The purpose of using the RMM is to provide an overview on the performance of different rehabilitation components. This overview enables comparison across components and domains that can then assist in the identification of priorities and recommendations for strategic planning. The international consultant took data from the RCQ and in-country data-collection, and aligned this information with the 50 components.

The table below summarizes the seven domains, the components within each domain, and provides space for scores for each component and the rationale for the score. Rationale is taken directly from the description in the RMM associated with each score.

Key to scores:		**JUSTIFICATION**
4	Already present, needs no immediate action	The RMM provides standard descriptive content for each maturity level. Overlap exists between levels. Rationale (justification) for the score describes the key attributes that led to the selection of the score.
3	Needs some strengthening	
2	Needs a lot of strengthening	
1	Very limited; needs establishing	
GOVERNANCE		**SCORE / JUSTIFICATION**
1	Rehabilitation legislation, policies and plans	3 – Legislation for rehabilitation and AT is strong but requires additions and updating with stakeholder input.
2	Leadership, coordination and coalition building for rehabilitation	3 - Ministry leadership and interministerial coordination for rehabilitation is limited with no designated focal persons.
3	The capacity and levers for rehabilitation plan implementation	3- There are moderate levels of human, technical and financial resources for implementation of plans for rehabilitation.
4	Accountability, reporting and transparency for rehabilitation	2- Accountability and reporting for rehabilitation is at a low level, whilst roles and responsibilities are not clear.
5	Regulation of rehabilitation and assistive technology	2 – Regulation for rehabilitation and AT needs updating to enhance accessibility, with the formation of national strategy for rehabilitation.
6	Assistive technology policies, plans and leadership	2- There is no government focal person for AT and leadership is fragmented. Policy frameworks encompass AT.
7	Assistive technology programs and procurement	2 - Programs that support the provision of assistive product are very limited, and access to AT in Latvia is very restricted.
FINANCING		**SCORE / JUSTIFICATION**
8	Rehabilitation financing and coverage of the population	2- The rehabilitation financing mechanisms and available expenditure is limited, meaning many do not have access to what they need.

9	Scope of rehabilitation included in financing		2- A small range of rehabilitation services are financed and available to the population, and there are many unmet needs.
10	Financing of rehabilitation and out-of-pocket costs		2- The extent of the financing for rehabilitation and AT results in regular restrictions in service access because of out-of-pocket costs.
HUMAN RESOURCES AND INFRASTRUCTURE			**SCORE / JUSTIFICATION**
11	Rehabilitation workforce availability		2- The number of rehabilitation personnel is insufficient to meet demand and challenges exist with recruiting and retaining personnel
12	Rehabilitation workforce training and competencies		3 - There is a moderate standard of rehabilitation training courses and satisfactory training opportunities at the undergraduate level.
13	Rehabilitation workforce planning and management		3 - Rehabilitation workforce planning practices are at a moderate level, and in some cases integrated into wider health workforce planning.
14	The rehabilitation workforce mobility, motivation and support		3- The rehabilitation workforce is motivated and supported by professional organizations. Majority work in the private sector.
15	Rehabilitation infrastructure and equipment		3 - Most of the necessary rehabilitation infrastructure and equipment for effective rehabilitation is available in most places.
HEALTH INFORMATION SYSTEMS			**SCORE / JUSTIFICATION**
16	Information about rehabilitation needs, including population functioning and disability		2 - There have not been population surveys on functioning and disability but there is information regarding prevalence and trends in health conditions that impact and inform rehabilitation needs in the population.
17	Information about rehabilitation availability and utilization		2 – Little information on rehabilitation is reported to the government and there are no national standards on information collection.
18	Information on rehabilitation outcomes and quality		2 – Little information is generated from health facilities regarding the quality and outcomes of rehabilitation. Scientific research is limited.
19	Rehabilitation information used during decision making		2 - There are a small number of ad hoc reports regarding the status and performance of rehabilitation to inform decision makers.
SERVICE - ACCESSIBILITY			**SCORE / JUSTIFICATION**
20	Availability of specialized, high intensity rehabilitation		2 – There are long wait lists for rehabilitation and rural areas and those with long term needs are poorly served. Specialist services exist.
21	Availability of community-delivered rehabilitation		2 - There is a low level of availability of community delivered rehabilitation.
22	Availability of rehabilitation integrated into tertiary care		2 – Access to early rehabilitation in tertiary care hospitals is limited
23	Rehabilitation integrated into secondary care		3 - Rehabilitation is moderately available across secondary care hospitals and clinics, but there a few geographic gaps in its availability.

24	Rehabilitation integrated into primary care		2 - There is a low level of integration of rehabilitation into primary health care and a small number of rehabilitation personnel at this level
25	Occurrence of informal, self-directed rehabilitation		2 - There is a low-level of people undertaking informal and self-directed rehabilitation, there is low understanding and acceptance in the community of its value and how to do it.
26	Availability of rehabilitation across acute, sub-acute and long-term phases of care		1 - There is a low level of rehabilitation available during the acute, sub-acute (including post-acute) and long-term phases of care for many health conditions. There are large gaps in all phases.
27	Availability of rehabilitation across mental health, vision and hearing programs		3 - Rehabilitation interventions are moderately integrated and available in most appropriate levels of mental health services. Rehabilitation interventions, including AT, are moderately integrated and available in most appropriate levels of vision and hearing care, low vision and audiology services are available but there are gaps in some geographic areas.
28	Availability of rehabilitation for target population groups based on country need		2 - There is a low level of understanding regarding the rehabilitation needs for target populations.
29	Early identification and referral to appropriate health and rehabilitation programs for children with developmental difficulties and disabilities		3 - There is a moderate level of monitoring developmental milestones in children and referral practices are moderately well established, most children with difficulties and disabilities are identified early.
30	Availability of rehabilitation in hospital, clinical settings and the community for children with developmental difficulties and disabilities		3 - Within secondary and tertiary care there is a moderate level of service availability for early interventions and for children with developmental difficulties and disabilities, but there are gaps.
31	Availability of assistive products, including those for mobility, environment, vision, hearing, communication and cognition		1 - There is a very low level or no assistive products available in health services, the provision is very slow, and co-payments are needed.
32	Availability of assistive products and their service delivery		2 - There is a low number of health personnel expertise for the delivery of assistive products and there many cannot get the AT needed.
33	Affordability of rehabilitation		2 - There is a low level of knowledge of the affordability of health care including rehabilitation and assistive products.
34	Acceptability of rehabilitation		2 - The population lacks an understanding of rehabilitation and services are often inconvenient to reach. There are many barriers for people with different impairment types.
SERVICE – QUALITY			**SCORE / JUSTIFICATION**

35	Extent to which evidence-based rehabilitation interventions are utilized		3 - Evidenced based rehabilitation interventions are utilized and there are some national clinical practice guidelines, but more are needed.
36	Extent to which rehabilitation interventions are of sufficient specialization and intensity to meet needs		3 – The timely commencement and intensity of rehabilitation interventions is sometimes less than required for effective outcomes.
37	Extent to which rehabilitation interventions empower, educate and motivate people		2 – Due to the referral system, empowerment, education and motivation of patients are lowly common goals of rehabilitation.
38	Extent to which rehabilitation interventions are underpinned by appropriate assessment, treatment planning, outcome measurement and note-taking practices		3 - Comprehensive assessments, goal setting and outcome measurement occurs for most in specialised rehabilitation services.
39	Extent to which rehabilitation is timely and delivered along a continuum, with effective referral practices		1 - There is a very low level of timely rehabilitation across all levels of care and during all phases of care (acute, sub-acute and long term) and services commonly have long waiting lists, including for AT.
40	Extent to which rehabilitation is person-centered, flexible, and engages users, family, and carers in decision-making		3 - The concept and practice of person centred care is moderately understood and the delivery of rehabilitation is tailored.
41	Extent to which health personnel and community members are aware, knowledgeable and seek rehabilitation		2 - Across health personnel and patients there is a low level of knowledge regarding rehabilitation, and who would benefit.
42	Extent to which rehabilitation is safe		3 - There is a moderate level of patient safety as healthcare has a few mechanisms in place to support delivery of safe care and rehabilitation
OUTCOME & ATTRIBUTES OF REHABILITATION			**SCORE / JUSTIFICATION**
43	Coverage of rehabilitation interventions for population groups that need rehabilitation		2 - Rehabilitation is accessible for some in the population that need it but there are many groups that miss out.
44	Functioning outcomes of rehabilitation for those who receive rehabilitation		2 - Rehabilitation is considered mostly effective, where it is available but sometimes under-achieves the expected functioning gains.
45	Equity of rehabilitation coverage across disadvantaged population groups		2- There are some disadvantaged population groups that miss out on the rehabilitation they need, particularly in rural areas
46	Allocative and technical efficiency of rehabilitation		2 - There is a low level of allocative efficiency as the overall architecture/structure of rehabilitation services.
47	Multi-level accountability for rehabilitation performance		2 - There is a low-level of accountability for rehabilitation within governing agencies, service providers and health personnel.
48	Financial and institutional sustainability of rehabilitation		2 - There is a low-level of financial sustainability and sufficiency for rehabilitation.
49	Resilience of rehabilitation for crisis and disaster		1 - There is a low level of resilience of rehabilitation because services are extensive enough that they can absorb shocks in emergencies.

50	The functioning of the population		1 - There is no measurement and understanding of population functioning.

END OF REPORT