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ВСЕМИРНАЯ ОРГАНИЗАЦИЯ ЗДРАВООХРАНЕНИЯ
ЕВРОПЕЙСКОЕ РЕГИОНАЛЬНОЕ БЮРО

Mission Report

Mission and joint meeting on strengthening primary health care in Latvia

22-25 October 2024

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BACKGROUND

In 2016, during the 66th meeting of the Regional Committee for Europe, a resolution was adopted to strengthen people-centred health systems in the WHO European Region: A Framework for Action on Integrated Health Services Delivery (EUR/RC66/R5)[1]. Later, in 2021, at the virtual session of the Regional Committee (EUR/RC71/R3), another resolution was adopted: Realizing the Potential of Primary Health Care (PHC): Lessons Learned from the COVID-19 Pandemic and Implications for Future Directions in the WHO European Region[2].

Further, in 2023, the 73rd session of the Regional Committee (EUR/RC73/8) adopted *the Framework for Action on the Health and Care Workforce*[3] but also the *Global Strategic Directions for Nursing and Midwifery*[4] (WHA/A7 A74/13) during the 74th World Health Assembly, which recognises strategic and comprehensive approaches for Member States to strengthen the availability of the health and care workforce in the European Region. The Framework for Action and the GSDNM propose policy options and implementation modalities and provide guidance to health policy makers, planners, analysts and others with a responsibility for health workforce issues to assist Member States in accelerating progress towards achieving population health objectives through sustainable, transformed and effective health workforces within strengthened health systems.

INFORMATION ON LATVIA: HEALTH OUTCOMES

Latvia faces significant challenges in its health outcomes, particularly with non-communicable diseases (NCDs). The 2023 OECD/European Observatory on Health Systems and Policies Country Health Profile highlights a high burden of NCDs, especially cardiovascular diseases and cancer.[5] Public health interventions targeting risk factors such as smoking and obesity are underway to address these issues.

Despite some improvements, Latvia's premature death rates from NCDs remain higher than the European regional average. The 2024 Health System Summary indicates that high mortality rates from NCDs remain critical for health policy and intervention efforts[6].

Mental health is another pressing issue in Latvia. A 2023 study revealed that 6.4% of the population experiences clinically significant symptoms of depression, 3.9% have generalised anxiety disorder, and 13.1% suffer from alcohol use disorders[7]. The COVID-19 pandemic and subsequent crises have exacerbated these mental health challenges, underscoring the need for enhanced mental health services and support.

Primary health care in Latvia has seen some improvements, particularly with quality incentives for general practitioners, digital health initiatives, and critical fields in PHC (financing at the expense of energy growth, etc.). However, unmet care needs persist,

[1] https://iris.who.int/bitstream/handle/10665/338250/66rs05f-PeopleCentredSystems-160764.pdf?sequence=1
[2] https://iris.who.int/bitstream/handle/10665/345129/71rs03e-PotentialPHCCOVID19-211008.pdf
[3] Framework for action on the health and care workforce in the WHO European Region 2023–2030 (RC73)
[4] Resolution for endorsing the Global Strategic Directions for Nursing and Midwifery
[5] https://www.oecd.org/en/publications/latvia-country-health-profile-2023_bf2b15d6-en.html
[6] https://eurohealthobservatory.who.int/publications/i/latvia-health-system-summary-2024
[7] https://static.lsm.lv/documents/1tk.pdf

especially among low-income groups. Ongoing efforts aim to enhance preventive care and strengthen workforce retention in PHC settings.

EVIDENCE FOR PHC IMPROVING HEALTH OUTCOMES

To improve these outcomes, the Ministry of Health of Latvia embarked on developing a Roadmap for Strengthening PHC in Latvia[8]. Over the next three years, the Latvian government has identified key development trends to strengthen PHC. These include developing and implementing an optimal practice concept, strengthening human capital in PHC, improving the payment system, facilitating the entry of new family doctors into state-paid PHC, and developing a multi-professional PHC team approach. These steps aim to enhance the efficiency, accessibility, and quality of PHC services across Latvia.

PURPOSE OF THE MISSION

The objectives of the mission were as follows:

1. Consult with the Ministry of Health and other key stakeholders to review and refine the proposed PHC Model of Care concept, ensuring a feasible and stepwise development of milestones outlined by the Ministry.
2. Support the development of the PHC Model of Care, providing recommendations tailored to both rural and urban populations.
3. Explore the availability of the health workforce to identify future professional needs aligned with the new model of care.
4. Review the competencies and roles of nurses and other professionals for the new PHC model.
5. Engage with partners working on improving the payment system to understand the performance indicators and patient-reported outcomes.
6. Explore the content and organisation of primary health care services in Latvia.

The expected outcomes were:

1. Assessment of the government's Primary Health Care roadmap.
2. Refined PHC Model of Care incorporating additional healthcare professionals into PHC practices.
3. Recommendations on the organisation of primary health care services in Latvia, aligned with the WHO PHC Action Plan
4. Agreement on the scope and provision of WHO technical assistance for developing and implementing the PHC Model of Care.

METHODS

The WHO mission team used a multi-pronged approach consisting of a desk review of key documents related to health systems, workforce and primary health care developments, and targeted interviews with policy makers and representatives of PHC-relevant stakeholders, including the National Health Service (NHS), representatives of the various professionals engaged in PHC and frontline service providers in urban and rural areas. This has allowed

[8] https://tapportals.mk.gov.lv/legal_acts/44ee00ff-5edc-454e-85de-050003aa0213

the mission to provide reflections on how to optimise the capacity of integrated primary health services. A detailed programme is available in Annex 1.

OBSERVATIONS ON THE CURRENT MODEL OF PRIMARY HEALTH CARE IN LATVIA

Latvia's PHC system is in principle built on strong foundations, providing a robust framework for delivering essential health services to its population. This framework is supported by a clear political commitment to improving health outcomes and ensuring all citizens have access to necessary care. However, there are clear challenges in this area. In terms of workforce, a key strength of Latvia's PHC model is the strong training programme for family doctors. These professionals have the knowledge and skills to provide high-quality care. The rigorous training model ensures that family doctors can manage a wide range of health conditions and promote preventive health measures.

Since EU accession, Latvia's nurses are educated at level 6 to meet the Directive 2005/36/EC of the European Parliament and of the Council of 7 September 2005[9] on the recognition of professional qualifications, those who have graduated before having been obliged to undergo a continuing professional development path to ensure that nurses are equipped with the competencies listed under Article 31 of the Directive. It is expected that by 2027, all nurses will meet this standard of general care, a set of competencies that includes disease screening, assessment, diagnosis, disease prevention, disease management and ensuring patient safety, among others. This presents enormous potential to engage them at the primary care level to improve and address quality of care gaps, including missed and delayed care, duplicated care and counter-indicated care.

Latvia has a growing appetite for a shift towards a multidisciplinary model of care, and the recent developments to advance nursing practice represent even more promise.

In order to deliver on the ambitions and primary care model, the state is however highly dependent on municipal commitment which varies for a range of reasons, introducing quality of care standards, introducing and securing patient pathways to be managed by primary care level, and securing the basket of services inclusive of rehabilitation and mental health services but also cardiovascular and diabetes care that must be delivered in PHC and not in hospitals, reducing out of pocket payments associated with primary care. It would also benefit from increasing the capacity of the health workforce in terms of capitalising on those professions that meet international standards, improving those that do not, increasing skill mix, and improving efforts to coordinate and secure availability of the workforce in cooperation with municipalities. While there is an appetite for multidisciplinary care, it is crucial for this to go beyond a medicalised model and to engage more with allied health professionals, including those outside the health sector, such as social workers, long-term care workers, housing support workers and municipal staff. Such a model can enhance the quality of care by leveraging the diverse expertise of different health and care professionals and providing more comprehensive and coordinated services to patients.

[9] https://eur-lex.europa.eu/eli/dir/2005/36/oj/eng

REFLECTIONS

The following reflections are based on the meetings and interviews held with informants during the mission.

Part I: Responding to changing population health needs

Latvia is clearly committed to strengthening primary health care in the context of universal health coverage, but the focus must shift to the patient.

Strong support exists for PHC, but the strategy focuses on professionals rather than patients. Some health indicators, such as mental health, social issues, cardiovascular disease (CVD), and diabetes mellitus (DM), are missing from NHS payments and do not have enough scope in NHS payments.

Premature death rates from NCDs are higher than the regional average

Non-communicable diseases (NCDs) are the leading cause of mortality in Latvia, with rates higher than the EU average[10]. Cardiovascular diseases (CVD) remain the primary cause of death, with mortality rates more than double the EU average[11]. The rising prevalence of diabetes is also a significant concern[12]. Additionally, Latvia has one of the highest mortality rates from traffic accidents in the EU [13], and deaths from liver diseases are notably high[14]. While there have been improvements in certain areas, such as cancer survival rates[15] and 30-day mortality from cardiovascular events, preventable mortality indicators present a mixed picture[16].

To tackle its health challenges, Latvia must adopt a multifaceted approach. This includes promoting healthy lifestyles through public health campaigns in coordination with PHC, enhancing healthcare coordination for early detection and cancer screening programmes and expanding the role of PHC in disease management, improving road safety with stricter regulations, addressing alcohol abuse with targeted interventions, and bringing the value of PHC in combining opportunistic encounters and structured intervention. Finally, some mental health services should be progressively integrated into PHC in line with other countries such as Sweden, Spain, Denmark and the Netherlands, among others [17][18][19][20][21].

[10] https://data.who.int/countries/428
[11] https://eng.lsm.lv/article/society/health/baltic-states-report-high-levels-of-cardiovascular-disease.a477305/
[12] https://www.theglobaleconomy.com/Latvia/diabetes_prevalence/
[13] https://eng.lsm.lv/article/economy/transport/20.02.2024-traffic-accident-death-figures-on-the-rise-in-latvia.a543650/
[14] https://eurohealthobservatory.who.int/monitors/health-systems-monitor/countries-hspm/section-detail/latvia-2019/introduction/health-status/
[15] https://www.oecd.org/en/publications/eu-country-cancer-profile-latvia-2025_f23ce73c-en.html
[16] https://eurohealthobservatory.who.int/docs/librariesprovider3/country-health-profiles/country-health-profile-2019-latvia.pdf
[17] https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-023-10180-9
[18] https://www.umu.se/en/research/projects/erica-skagius-ruiz-primary-care-behavior-health-pcbh-in-swedish-primary-care--implementation-and-effects/
[19] https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-024-20169-6
[20] https://healthcaredenmark.dk/media/mcockmni/3i-mental-health-pdf-uk.pdf
[21] https://ijic.org/articles/10.5334/ijic.567

Enhancing preventive care is essential to reducing the impact of NCDs. Expanding the role of nurses in health promotion, prevention, and follow-up of NCD conditions and increasing community engagement will encourage healthier behaviours, such as more physical activity, improved nutrition, and reduced alcohol and tobacco use. Furthermore, expanding professional roles and improving training in behavioural change, communication, and patient engagement, particularly for family doctors, nurses, and physician assistants, will enhance the quality of PHC. In addition, enhancing health information systems at PHC, initially with the information from the electronic health records and using it with population health management tools for identifying high-risk populations, and to address targeted interventions tailored to population groups with NCDs will allow to ensure more proactive and responsive and effective PHC services and can help bridge disparities.

Some areas are experiencing gaps in the provision of care, specifically mental health and rehabilitation

Observations from the mission highlight critical gaps in mental health and rehabilitation services within Latvia's Primary Health Care (PHC) system. These shortcomings have led to fragmented care, long wait times, and an overreliance on hospital-based treatment, limiting access to timely and practical support at the community level. Addressing these challenges requires a stronger integration of mental health services into PHC, ensuring that individuals receive comprehensive care closer to home.

A key step in this process is expanding the role of family doctors and primary care teams in mental health screening, early intervention, and the management of common conditions such as depression and anxiety. To support this, training programs for PHC providers, including nurses and physician assistants, should be enhanced to strengthen their competencies in mental health assessment, psychosocial interventions, and referral pathways. Additionally, Latvia should implement collaborative care models where mental health specialists, such as psychologists and psychiatrists, work closely with PHC teams, providing supervision and support through regular case discussions and shared treatment planning. However, a proposal to expand professions to include psychotherapists is on the table. By embedding mental health services within PHC, Latvia can improve accessibility, continuity of care, and overall health outcomes for individuals needing mental health support.

Findings from the mission to Latvia indicate that rehabilitation services, particularly for individuals recovering from stroke, injuries, or chronic illnesses, are not sufficiently integrated into PHC. This gap leads to limited access, delays in rehabilitation, and an overreliance on hospital-based care, which often lacks the continuity and community support necessary for long-term recovery. Strengthening rehabilitation within PHC is essential to ensure that patients receive timely and effective care, improving functional outcomes and overall quality of life.

To address this challenge, Latvia should enhance its multidisciplinary PHC teams by improving coordination between rehabilitation professionals such as physiotherapists, occupational therapists, and speech therapists and the current PHC teams constituted by family doctors, nurses, and physician assistants. Developing community-based rehabilitation programmes is crucial for providing early and sustained support while reducing hospital dependency. Expanding home-based rehabilitation initiatives, particularly in rural and underserved areas, will help ensure patients receive appropriate care within their communities, supporting independent living and long-term recovery.

Opportunities to strengthen quality and patient safety monitoring

The mission team identified significant gaps in monitoring quality and patient safety within the primary health care (PHC) system. While some quality assurance mechanisms are in place, they are not consistently applied across all PHC settings, leading to variability in service delivery and patient outcomes.

Currently, seven indicators are used to measure PHC quality. However, these are limited in scope and require further development. The standardised performance indicators included in the Health System Performance Assessment (HSPA) framework, maintained by the Latvian Centre for Disease Prevention and Control, are outdated. Regular revisions and the inclusion of new, more specific indicators aligned with evolving service delivery models should be considered.

In addition, the system lacks routine audits and structured feedback mechanisms, which are essential for ensuring adherence to evidence-based clinical guidelines. Patient safety protocols—such as incident reporting, analysis, and follow-up mechanisms—are also underdeveloped, limiting the system's ability to identify, learn from, and prevent medical errors.

Moreover, Latvia currently does not have a comprehensive national framework for quality improvement in PHC. This makes it challenging to assess service effectiveness and implement targeted quality interventions. Fragmentation in digital health systems exacerbates these challenges, as incomplete or non-interoperable electronic health records (EHRs) impede real-time data collection and quality monitoring. The limited presence of a strong quality culture within PHC means that patient-centred care and safety initiatives are often deprioritised in favour of more immediate service delivery pressures.

To address these shortcomings, Latvia would benefit from establishing a robust, standardised framework for monitoring quality and patient safety in PHC. This could include the development of national quality standards and performance indicators, along with introducing a national patient safety strategy featuring clear protocols for adverse event reporting and analysis. Systematic training for PHC professionals on patient safety, infection prevention and control, and risk management should also be prioritised. Finally, efforts should be made to strengthen the role of digital health in quality monitoring, including ensuring interoperability across healthcare providers to support seamless patient care and reduce the risk of medical errors.

Prevention needs rapid scaling up but also incentives and coordination

There is an urgent need to scale prevention efforts and improve incentives and coordination within PHC. While municipalities play a key role in public health and health promotion, one of their 22 mandated responsibilities, the effectiveness of these initiatives varies. As the smallest yet most densely populated region, Riga benefits from strong public transportation access to health services. The concept of community health centres is under exploration, with growing interest in Scandinavian models such as social prescribing. Expanding existing community centres to include state-funded nurses could enhance preventive services at the local level. Pilot projects, such as midwives delivering sexual health education and prevention materials, demonstrate municipal commitment, but further scaling is needed. Community engagement mechanisms, such as surveys, public consultations, and hotlines, provide valuable input but require stronger integration into policy decisions.

While several policies address behavioural and social health determinants, technical efficiency improvements remain necessary, particularly in strengthening links between health promotion and primary care. A more coordinated approach would help ensure that prevention strategies are embedded within PHC rather than functioning as isolated municipal efforts. Communication with the population about the ongoing transformation of PHC is essential to build public trust and engagement from the outset.

The government and multiple reports acknowledge that efforts to tackle modifiable risk factors such as tobacco and alcohol consumption, are still in the early stages. Despite some progress, these remain major public health concerns that require more robust regulatory measures, enforcement mechanisms, and targeted interventions within PHC settings. Strengthening prevention must go hand in hand with policy incentives for PHC providers – especially nurses, to engage in health promotion actively, ensuring that financial and structural enablers support a shift toward proactive rather than reactive care.

PHC is highly medicalised, and the unsupervised task shifting to physician assistants and nurses perpetuates this, but also risks higher out-of-pocket payments

To create a more balanced and patient-centred PHC, Latvia will benefit from addressing the over-medicalisation of care. PHC remains highly medicalised, focusing on curative treatment rather than prevention and health promotion. A key concern is the reliance on physician assistants (PAs) for tasks internationally recognized as within the scope of family doctors. While task shifting can improve access to care and alleviate workforce shortages, this process has occurred without standardised supervision, or clear needs assessment of what needs improvement. And while the law distinguishes between physician assistants and family doctors, in practice it was reported that due to the shortage of family doctors, physician assistants are often having to do the work of family doctors.

There is a clear commitment from the government to build multi-professional family practices and indeed this optimization was observed in some facilities to support the presence of family doctors as the core of primary health care. Where teams are in place, there is better use of physician assistants but there still seem to be opportunities to make better and more strategic uses of nurses who are trained in line with Directive 2005/36/EC of the European Parliament and of the Council of 7 September 2005 on the recognition of professional qualifications at level 6 and practicing as ISCO code 2221 “Nursing professionals”. This means they can already take on responsibilities of disease prevention, health promotion, chronic disease management and even prescription renewals. At the time of the mission Latvia was tabling a decision to advance nurses' roles in PHC with the new advanced practice standard. This was approved after the current mission, and is an example of Latvia linking up with international practice and quality standards. It will enable PHC centres improve prevention measures, chronic disease management, and follow-up care. Granting nurses prescribing as is already being done with PAs would further enhance access and represent a more accountable and transparent process, given that nurses are bound to a professional code of conduct and body of international body of evidence and practice on what they can and cannot prescribe.

There is also a concern about quality, cost and patient safety when it comes to physician assistants. Physician assistants training is 3 years at level 5, but with doubtful monitoring and evaluation and is not internationally recognized, or standardized raises some concerns. In such a context, and in international practice is such in the United Kingdom (Royal College of General Practitioners and Royal College of Physicians) and the United States (The Medical Board of California; Pennsylvania Code; Texas Medical Board) it is required that

physician assistants are supervised by family doctors. This however, may put more strain, not less on this limited number of family doctors As they are not governed by their own professional accountability framework that characterize a profession or a distinct body of complex knowledge as is the case for nurses and doctors and internationally recognized standards their scope remains very unclear and was reported to be practicing above the scope defined for paramedics, ISCO code 2240 professionals, under which feldshers are classified and higher than professionals educated at level 6 (ie.nurses) who have more established evidence based professional accountability frameworks.

During the mission it was reported that the physician assistants also have financial implications, with physician assistant prescriptions resulting in higher out-of-pocket (OOP) payments than by family doctors and further unnecessary treatments. This issue is particularly pressing given Latvia's already high rate of patient-borne healthcare costs. Furthermore, emphasising pharmaceutical interventions over preventive and non-medical treatments strains healthcare resources.

Promoting rational prescribing is crucial to reducing unnecessary medicalisation and high out-of-pocket (OOP) patient costs. Strengthening PA and nurse training in evidence-based prescribing, implementing digital prescribing tools with decision-support systems (CDSS). These systems provide real-time alerts and recommendations helping them make informed decisions at the point of care such as implementing real-time alerts for drug interactions, allergies, and dosage errors that can prevent adverse drug events[22] and integrating more non-pharmaceutical interventions—such as lifestyle counselling, physiotherapy, and psychological support—can help optimise treatment approaches.

Additionally, Latvia should work towards reduction of Out-of-pocket (OOP) payments. OOP in Latvia are notably high, amounting to 37.1% of total health expenditures in 2019, more than double the EU average of 15%. This high proportion of OOP spending is primarily due to patients paying user charges for statutorily financed care provided by NHS-contracted providers and for care provided within the private sector[23]. The financial burden of OOP payments in Latvia and the need for policy interventions to reduce these costs may include strategies such as reviewing referral procedure, introduction of patient pathways, monitoring referrals in patient pathways, developing telemedicine services, improving prescription monitoring, regulating medication expenses, incentivising preventive care with the leadership of PHC and maximising the role of nurses. This can help alleviate this burden[24].

Greater integration of health and social care is critical to address changing population health needs

Latvia's changing population health needs, driven by an ageing population and a growing prevalence of chronic diseases, demand greater integration between health and social care services. However, the current system remains fragmented, with limited coordination between PHC providers, long-term care facilities, and municipal social services. The mission found that while some Family Doctors take the initiative to coordinate with long-term care providers, these efforts are inconsistent and largely dependent on individual motivation rather than a structured, system-wide approach. Without stronger institutional collaboration, many patients, particularly older adults and those with complex health conditions face

[22] https://bmcmedinformdecismak.biomedcentral.com/articles/10.1186/s12911-020-01376-8
[23] https://iris.who.int/bitstream/handle/10665/361203/9789289059077-eng.pdf?sequence=1
[24] https://iris.who.int/handle/10665/340526

disjointed care, leading to poorer health outcomes and increased pressure on hospital services.

A key barrier to integration is the low level of multidisciplinary collaboration, particularly the limited role of nurses in PHC. Despite their education aligning with Directive 2005/36/EC of the European Parliament and of the Council of 7 September 2005 on the recognition of professional qualifications (Level 6), nurses remain disempowered, unable to fully utilize their competencies. At the time of the report legislative constraints prevent them from documenting medical decisions in e-health systems and obtaining prescription authority, which hinders efficiency and restricts their potential role in chronic disease management, prevention, and follow-up care. In December 2024, after the mission, a new law was signed to develop the training of Advanced Practice Nurses which will include prescription authority and will provide additional training to general nurses to prescribe a specific set of medications. The progress of this is yet to be felt by the Latvian population.

To improve care coordination and address the needs of Latvia’s ageing population, health and social care services must be better integrated, with more explicit links between PHC, municipalities, and long-term care facilities. This requires formalising coordination between health and social care, with structured collaboration mechanisms between PHC providers, long-term care facilities, and municipal social services to ensure seamless patient transitions. A feasible action is to develop integrated care pathways for older adults and patients with chronic conditions, reduce hospital admissions, improve home-based care, and strengthen inter-ministerial and municipal cooperation to align policies, financing, and service delivery across health and social sectors. As mentioned, nurses' role in PHC should be expanded by enhancing communication and coordination with other health and social care professionals. This could be supported by ensuring that some of the 100 continuing education points that nurses need to take every 5-year period if they work in primary health care, cover these vital areas of referring to social services, assessing social needs, developing hospital discharge plans and providing or liaising with home care.

Patient pathways need to be identified and clarified

To address this, Latvia should develop national guidelines for integrated care pathways, prioritising key conditions such as diabetes, musculoskeletal disorders, and post-hospital rehabilitation. Clearly defining the roles of healthcare and social care professionals will improve coordination, prevent duplication, and ensure continuity of care. Integrating these pathways into digital health systems will facilitate seamless communication and data sharing.

Stronger coordination between PHC, hospitals, and municipal social services is essential and feasible. Establishing joint care plans and multidisciplinary case management teams, including FMDs, nurses, and social workers, will enhance patient-centred care, particularly for complex cases. Nurses should take on case management roles to oversee care transitions and ensure structured referrals.

Regulatory and infrastructure environment for Family Medicine Practices in Latvia

During its mission, the WHO team engaged with family medicine (FM) providers, municipal representatives, and national authorities to assess the regulatory and infrastructural environment affecting the development and expansion of Latvia's PHC services. While some stakeholders initially described the regulatory framework as overly stringent, particularly

regarding room size, layout, and equipment, a closer review of the applicable legislation revealed a more nuanced picture.

1. Room size and layout: Latvian legislation does not mandate specific room sizes, apart from a minimum requirement for the patient reception room (12 m²). Instead, regulations define a set of functional spaces that must be present in FM practices: a waiting area (which may include a registration desk), a patient reception room (which may also serve as a manipulation room), and separate toilets for staff and patients. The Health Inspectorate verifies these once the premises have been registered with the State Land Service under the designated category for medical use.
2. Accessibility standards for accessibility: One of the most challenging regulatory requirements is ensuring accessibility for patients with functional disabilities, including the need for ramps, lifts, adapted toilets, and wider doorframes. These modifications are especially difficult to implement in older or municipal buildings, which are often not designed to accommodate such structural changes.
3. On equipment, requirements at the time of registration are relatively modest, focusing on basic diagnostic tools (e.g., phonendoscope, blood pressure monitor, scales with height measurement) and emergency equipment available within the premises. More specialised equipment linked to reimbursed services, such as ECG or spirometry, can be acquired within a two-year transition period. Thus, regulatory obligations are not considered burdensome. However, limited financial incentives and investment mechanisms pose a significant constraint, impeding the ability of FM practices to modernise, adopt new technologies, or expand their service scope.

The WHO mission found that the primary bottleneck to PHC expansion is not the regulatory framework but the availability of suitable premises. Many family doctors rent their practices from public institutions that do not allow renovations or expansions, leaving providers unable to accommodate additional services or team members. This is especially problematic in urban areas with a competitive real estate market and rural regions with ageing infrastructure.

To support the expansion and modernisation of PHC services, Latvia may consider:

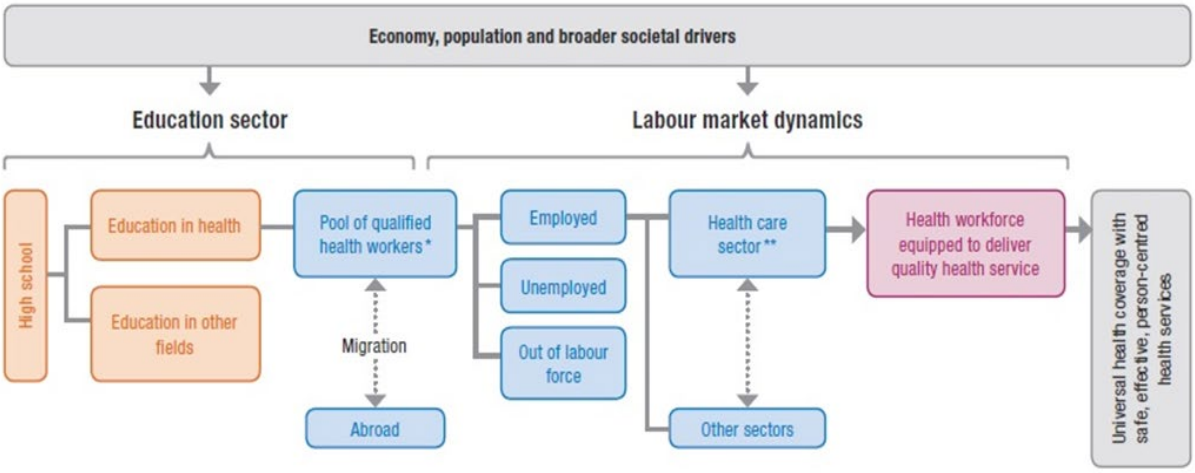
- Reviewing existing regulations to ensure alignment with evolving care models, including multidisciplinary practices.
- Providing financial incentives or grants to support infrastructural upgrades and acquisition of advanced equipment.
- Encouraging municipalities to make public spaces available for FM practices or co-locate them with other services, drawing on examples from the United Kingdom, Canada, and Australia.
- Introducing flexibility for practices in rural or underserved areas, ensuring regulatory compliance does not become a barrier to access.

Such measures would enable Latvia to equip its PHC system better to meet future health needs, support team-based care, and improve equitable access across the country.

Part II: Building a sustainable health workforce aligned to population health needs

Developing a strategic approach to human resources for health aligned with health needs.

Given the changing population health needs in Latvia and the importance of addressing these in a comprehensive way that bridges social and health care and integrates care, the Latvian Health Workforce Strategy[25] approved in 2024 is a strategic approach to human resources for health, and is aligned with the WHO European Framework for Action[26] and the Health Labour Market Analysis[27], a multidisciplinary perspective, and workforce indicators. It aligns with the EU Cohesion Policy Programme 2021–2027, under the specific objective 4.1.2 "To improve equal and timely access to quality, sustainable and affordable healthcare services by enhancing the effectiveness and resilience of the healthcare system." In the context of ESF+ measure 4.1.2.5 "Attracting and retaining healthcare professionals in the state-funded healthcare sector, particularly in inpatient care" financial support is available to encourage the recruitment and retention of medical professionals. This initiative is part of the ESF+ funding framework aiming to improve equitable access to quality, sustainable, and affordable healthcare services while strengthening system efficiency and resilience. As part of this measure, medical professionals may receive compensation for: a) joining the public healthcare system; and b) family doctors transferring their practice, in recognition of the transfer of specific knowledge, information, and experience to a successor.



As part of such an approach, consideration could usefully be given to securing the scopes of family doctors and nurses in primary care, the need to organize providers along patient pathways and the need for team-based care to address the challenging burden of disease.

Ensuring that the professional classification system is in line with international standards and the international classification system is a question of quality of care

The training and qualifications of physician's assistants (PAs) were discussed, highlighting the need for clarity on their roles compared to doctors and nurses but also the level of education, which currently corresponds to level 5 according to the Directive 2005/36/EC of the European Parliament and of the Council of 7 September 2005 on the recognition of professional qualifications and is below that of the nurse (level 6). PAs undergo a 3-year program with 180 ACTS, including practical training in various medical fields. They can specialise further with an additional year in emergency or ambulatory medicine. - However, PAs cannot prescribe certain medications like cancer drugs and morphine, and they cannot write referrals like family doctors. There is a vast difference between transferring roles and

[25] https://likumi.lv/ta/id/357507-par-planu-veselibas-darbaspeka-attistibas-strategija-no-2025-gada-lidz-2029-gadam
[26] https://iris.who.int/bitstream/handle/10665/372563/73wd08e-HealthCareWorkforce-230575.pdf?sequence=5
[27] HLMA. https://iris.who.int/bitstream/handle/10665/362199/Eurohealth-28-3-18-23-eng.pdf?sequence=1

responsibilities from one profession to another, such as among medicine, nursing, and pharmacy, and to occupations, such as physician assistants, who must be supervised and who lack the features of a profession, such as a distinct body of complex knowledge.

Scopes of practice in primary care need to be optimised

The absence of clear patient pathways and a situation where the majority of family doctors in Latvia work in solo practices leads to a situation where they tend to quickly steer patients towards more specialised care where preliminary diagnoses take place rather than care for them at the primary care level. This is compounded by the lack of effective roles for nurses to provide basic primary health care. This leads to a situation where the acute [hospital sector] is overloaded and family doctors and nurses, highly educated professionals are underutilised.

If the Ministry of Health is to fully capitalize on the potential of family doctors, to manage, diagnose, and treat patients with increased complexity, it might be more efficient to delegate the tasks of patient education and monitoring of lower risk patients with chronic diseases to nurses.

The introduction of legislation to support the development of advanced practice nurses and changes in nurse qualifications have also been noted since the mission. This is a positive step in addressing the acute shortage of nurses in Latvia, which ranked as having the lowest density of nurses until 2018. Retention problems for physicians and nurses were identified, with advanced roles being considered as a potential strategy. However, the need for agreement from the medical community on these roles was emphasised. The transformation of family medicine was recognized as a cultural paradigm shift, requiring strong competencies from family doctors and nurses for higher efficiency.

International evidence exists for the benefits of enhanced nursing roles in primary care. In many countries, nurses are engaged in the delivery across the full spectrum of care - including first contact, chronic diseases and end of life care. There is international evidence of the effectiveness of enhanced nursing roles on outcomes and patient satisfaction. Employing nurses in enhanced roles would effectively increase primary care’s role in prevention, manage the interface between the health and social care sector, and coordinate with secondary care.

The work of the primary care task force was noted as a very effective measure to improve this situation, but it requires more representation from the nursing community. As new care models are considered, including the engagement of other professionals, it is likely that the task force may need to include representatives of the social care system, not only nursing and other professionals (e.g., physiotherapists and mental health workers).

Primary health care, family doctors and nurses in primary health care face low prestige

The family medicine association, nursing association and municipal authorities all reported that the prestige and reputation of the professionals working in PHC are low. Communication with the population about the ongoing transformation of PHC is crucial from the outset. Collaboration between hospitals and PHC will also be essential for promoting a transition. Hospitals can either support or hinder the transformation process. Municipalities struggle to motivate new family doctors to work in some areas (like Bolderāja) despite creating new, well-equipped premises. Rural doctors face work overload, non-medical problems, and inefficient replacement systems for leaves. There is a high risk of burnout, especially for

young doctors. Solutions such as physician assistants and the preferential employment of them, without appreciation that nurses with their higher level of education and internationally recognized competencies, further exacerbates the reduced prestige of nurses.

Ageing of family doctors will require creative responses, but at least more clarity in the scope of practice

Approximately 30% of all family doctors are at retirement age, highlighting the need to attract new professionals. There is concern that the family doctors' workforce may be pushed out by PAs with no evidence of their impact. The culture of sharing information is very low, and family doctors are not well-networked internationally or nationally. The efforts to invest in the family doctors' workforce at the university level are highly commendable. Still, they may not be the only way to tackle the dilemma of an ageing family doctors' population. Measures that target and motivate the current physician workforce to move into general practice, especially where there is evidence of oversupply, may be worth considering. Financial incentives, such as loan repayment programmes, higher salaries, and bonuses, have significantly influenced medical students' choice of primary care specialities[28][29]. Educational reforms that emphasise the importance and rewards of general practice, including increased exposure during medical training and mentorship programmes, can shift perceptions[30]. Improving work-life balance through flexible working hours and support for continuing education is also crucial. Policy interventions that support workforce redistribution and professional development opportunities can further enhance job satisfaction and retention[31].

Violence and threats directed at primary care professionals, especially FMDs, are an increasing concern in Latvia. The isolated nature of many PHC practices, combined with the absence of security personnel, can leave staff vulnerable to aggression from patients or their relatives. Ensuring the physical and psychological safety of PHC providers is critical for maintaining service continuity, workforce morale, and the profession's attractiveness.

WHO recommends that health systems adopt a comprehensive approach to preventing and managing violence against health workers, which includes:

- Developing national policies and protocols for violence prevention and response in health care settings,
- Providing training in de-escalation, communication, and conflict resolution skills,
- Improving facility infrastructure to enhance safety (e.g. panic buttons, controlled entry points),
- Strengthening collaboration with local authorities and emergency services, and
- Offering psychosocial support for affected staff.

In addition, models of care led by nurses or other health and social care professionals might be usefully considered as they can be highly effective. For instance, Australia has implemented nurse-led care in emergency departments, diabetes education, and walk-in clinics, improving access and patient experiences[32]. In New Zealand, nurse-led clinics and enhanced roles for nurse practitioners in primary healthcare have improved health outcomes and reduced the burden on general practitioners[33]. Germany has explored integrating

[28] The substitution effect of financial and non-financial incentives at different income levels in physician recruitment: evidence from medical students in China | BMC Medical Education | Full Text
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medical and non-medical services in primary care, such as social prescribing and in-practice social work, to address health-related social problems and provide holistic care[34].

Telehealth solutions represent a partial but promising solution for Latvia

Telemedicine has become more prevalent, with 1/3 of consultations now conducted via telephone. There is a critical need for better out-of-hours services, with suggestions to place on-call doctors in hospitals near emergency services. The lack of an efficient electronic record system is a significant issue, with a need for centralised discharge papers and notifications for family doctors.

Education, training and CPD for physicians, nurses and other health and social care professionals need to be aligned with the population health needs

Population health needs in Latvia are changing. In this context, it is necessary to consider the development of additional competencies for current health workers and a broader group of health and care workers (physiotherapists, mental health workers, social workers) from other sectors. Transformative, high-quality professional, technical and university education, training and lifelong learning are needed so that all health workers have skills that match the population's health needs and can work to their full potential. In this regard, informants reported limited opportunities for different professional groups to learn together during initial education and training.

Links between universities and community-based services need to be strengthened

Latvia has made progress in integrating universities with community-based health services, yet further strengthening is needed to enhance public health outcomes. Paula Stradiņš Clinical University Hospital in Riga exemplifies successful collaboration, partnering with the University of Latvia and Riga Stradiņš University to train medical professionals and advance research. Latvia's involvement in the European Cancer Mission Hubs: Networks and Synergies (ECHoS) consortium further demonstrates its commitment to linking research with healthcare through National Cancer Mission Hubs. The Institute of Public Health at Riga Stradiņš University also plays a crucial role in education and policy development, addressing community health challenges. However, challenges remain in fully integrating universities with community services. Strengthening interdisciplinary research, fostering community-based participatory methods, and establishing joint academic-community roles are essential to ensuring that research and education align with real-world health needs, ultimately improving health outcomes.

The role of associations in improving conditions for the workforce

The mission delegates met several professional and patient associations. The Family Medicine Association has 1493 participants, with 1080 currently working in their practices and 400 not working as family doctors. The association represents 80% of all family doctors in Latvia and provides information, legal support, and negotiation with the government. According to the association’s opinion, there is a desire to extend the residency programme from 3 to 4 years to cover more topics like palliative care and pain management. The association supports expanding roles for physiotherapists, midwives, and psychologists in practices. There is also a push for nurses to be empowered to prescribe medication and

[34] GPs’ perspectives on care models integrating medical and non-medical services in primary care—a representative survey in Germany | BMC Primary Care | Full Text

open sick leave. There is a need for better integration of social workers, who are currently underpaid and have high turnover.

The Young Family Medicine Doctors Association (YFMDA) includes junior doctors still in training and those up to five years into practice. It has around 180 members and collaborates closely with the Family Medicine Association. The association advocates extending the Family Medicine's residency programme from 3 to 4 years to cover more comprehensive training, including communication, management, finance, and legal aspects. According to their view, there is a need for cultural shifts towards better collaboration with other medical professionals and moving away from hierarchical structures. Training in non-patriarchal communication styles is limited. Major social issues include poverty, low health literacy, and inadequate social services, which impact patient care and push patients into secondary healthcare when conditions worsen.

Patient organisations emphasise the need for better system interoperability and reducing the burden on small Family Medicine practices. They support delegating tasks like extending prescriptions and follow-up of chronic conditions to qualified assistants. Trust in PAs and nurses depends on their training and qualifications. According to their view there is a need to empower nurses and improve their status within the healthcare system. Patient organisations feel underrepresented in the Ministry of Health and advocate for continuous involvement in healthcare policy development.

Human resources for health information systems can support integration across the health and social care sectors

There is considerable activity by the NHS, which is developing significant human resources for health information and data processing capability. This capability appears to be focused on providing more granularity on both human resources for health and patient information (including care) that can be used to project workforce demands and needs, which in turn can be used to develop workforce production strategies for the short, medium and longer term.

Engagement of patients and patient stakeholders to improve health literacy

Health literacy and patient involvement were identified as important elements of improving integrated care and assuming more responsibility in self-care. Their engagement is necessary for improving the efficient use of resources and clarifying patient pathways. The existence of a patient forum in the Ministry of Health is noted, which could be of assistance in this regard.

Funding opportunities represent an essential opportunity for rural family practices to expand and optimise physicians' and nurses' scope of practice.

EU funds are supporting PHC through infrastructure, equipment, and training. However, challenges in utilising these funds and the conditions for applying were discussed. Additional support for rural areas and practices with optimal patient numbers was highlighted, including compensations for specialists working in these areas.

RECOMMENDATIONS

A series of targeted recommendations should be implemented to strengthen Latvia's PHC model and professional development.

- To ensure measurable progress, **a three-year stepwise plan** should be implemented with a structured evaluation framework. This plan must outline specific milestones, accountability mechanisms, and periodic reviews to adjust strategies as needed.

- The **PHC financing model** must be refined by integrating social determinants of health, capitation mechanisms, and quality indicators, ensuring that funding aligns with patient-centred outcomes and efficiency.

- The **roll out of advanced practice roles** should be accelerated, particularly for nurses, to expand service delivery capacity and improve access to care in vital areas that are core to improved quality of care (e.g., disease prevention, disease management, coordination of care, and health promotion), especially in underserved and rural areas.

- **Reviewing the practice of physician assistants** to address concerns of professional accountability, expenses for patients, international practice, patient safety, and impact on family doctor workloads.

- **Family doctor education** should be expanded to a four-year residency programme, incorporating management, leadership, communication, and rural practice training to better prepare physicians for diverse healthcare environments.

- To **improve health outcomes, enhance health literacy, and increase patient involvement,** a multi-level approach should be in place, emphasising cross-sectoral collaboration and involving PHC professionals in various initiatives. Locally, family medicine providers and municipalities should collaborate to provide workshops and seminars, with nurses playing a critical role. Policymakers should prioritise health literacy in national strategies and fund research on effective interventions, involving PHC professionals in research and fostering cross-collaboration between professional associations and academia. Additionally, **PHC methodological centres** should be maximised as hubs for monitoring, evaluation, and research, providing evidence-based insights to refine PHC strategies and ensure data-driven policy decisions are continuously made. To encourage **best practices**, **champions and demonstration sites** should be established within Latvia’s PHC centres and municipalities. These sites can serve as models for innovation, quality improvement, and training.

- Stronger **university engagement** is needed in PHC development, including establishing a **dedicated PHC learning centre** that fosters training, interdisciplinary collaboration, and innovation in primary care education. A more **inclusive stakeholder approach** should be adopted, ensuring representation from patients, nurses, and other key healthcare professionals. This will create a more holistic perspective in decision-making and policy formulation.

- Improve **care coordination for Latvia’s ageing population**. In this phase, coordination between health and social care services should be enhanced with explicit links between PHC, municipalities, and long-term care facilities. Expand nurses' roles through case management and care coordination with tailored education, revisiting the

current curricula, continuing professional development, and professional recognition frameworks.

- Develop **national guidelines for integrated care pathways**, prioritising key conditions such as cardiovascular disease, diabetes, dementia, and post-hospital rehabilitation. Clearly defining the roles of healthcare and social care professionals to enhance coordination, prevent duplication, and ensure continuity of care. Integrating these pathways into digital health systems will facilitate seamless communication and data sharing. The expected impact will reduce hospital admissions, enhance home-based care, and strengthen cooperation across health and social sectors. The **interoperability of digital health systems** must be improved, particularly in discharge information sharing and notification systems, to facilitate seamless communication between different healthcare providers. This is essential for advancing **integrated care** and ensuring patient data flows efficiently across primary, secondary, and social care settings. A well-connected digital infrastructure will enable coordinated care planning, reduce duplication of services, enhance patient safety, and improve overall health outcomes. Emphasising interoperability will also support multidisciplinary collaboration, allowing PHC teams to work more effectively with hospitals, specialists, and social care providers, ultimately leading to a more patient-centred and holistic healthcare system in Latvia.

- Enhance access, continuity, and responsiveness of PHC. Latvia should prioritise the strategic integration of telemedicine into routine PHC consultations. This includes developing national guidelines for safe and equitable teleconsultations, ensuring appropriate reimbursement mechanisms, and training PHC providers in digital communication and clinical decision-making. Special attention should be given to bridging digital divides, particularly for older adults and rural populations. Telemedicine should complement, not replace, in-person care, and its use must be aligned with evidence-based protocols, patient safety standards, and robust data protection frameworks to ensure quality and trust in remote care delivery.

- **Support the expansion and modernisation of family medicine practices** by prioritising and optimising space by co-locating healthcare services with social services, libraries, or community hubs, particularly in urban areas, to improve accessibility and efficiency. Regularly **reviewing and updating regulations**, offering financial incentives, and providing municipal practice spaces are essential steps. Additionally, ensuring flexibility in the regulations for rural areas and specific urban environments such as Riga and implementing legislative reforms to improve access to care and enhance the capacity of PHC professionals to deliver high-quality, team-based care.

- To ensure **continuous PHC service provision**, strategies for providing **locum coverage** during annual leave, maternity leave, and sick leave must be reinforced, reducing workforce shortages and ensuring continuity of care.

Implementing these recommendations will significantly strengthen **PHC in Latvia**, ensuring a more **integrated, resilient, and patient-centred healthcare system**.

SCOPE OF WHO TECHNICAL ASSISTANCE AGREED WITH THE MOH

Following the mission and consultations with national stakeholders, the WHO team and Latvian counterparts reached a preliminary agreement on the areas where the WHO will provide technical assistance to support the development and implementation of the PHC Model of Care. These areas build on Latvia's current PHC transformation priorities and align with WHO's technical expertise and capacity.

WHO technical assistance will focus on the following areas:

1. **Design and operationalisation of a comprehensive PHC Model of Care**
    - Support the definition of PHC service packages across levels of care, with particular attention to the role of Family Doctors and expanded nursing roles.
    - Provide guidance on service redesign toward integrated, people-centred PHC, based on population health needs and local delivery capacity.
    - Advise on incorporating prevention, health promotion, and chronic disease management into the PHC model.
2. **Strengthening the PHC workforce**
    - Provide technical inputs on models for task-sharing and team-based care, including expanded roles for nurses and allied health professionals.
    - Support capacity-building efforts, including curriculum review and on-the-job training aligned with the new model of care.
    - Facilitate peer learning from countries with effective PHC workforce reforms.
    - Further engagement in EU-funded "Nursing Action" initiative to tackle critical shortages in the EU nursing workforce.
3. **Performance monitoring and accountability**
    - Assist in defining PHC indicators and designing a performance monitoring framework that aligns with national digital health capacities.
    - Support integrating routine health information systems with quality improvement initiatives at the PHC level.
4. **Population Health Management (PHM) and Digital Innovation**
    - Share practical tools and case studies for implementing PHM approaches to stratify populations by risk and proactively manage chronic conditions.
    - Advise on using digital tools for care coordination, patient follow-up, and service delivery across dispersed and rural areas.
5. **Policy Dialogue and Intersectoral Governance**
    - Provide support to interministerial and multi-stakeholder engagement on PHC and integrated care reforms.
    - Contribute to ongoing national dialogues around the financing, regulation, and governance of PHC services.

This agreed technical cooperation will be refined in coordination with the Ministry of Health and relevant stakeholders and reflected in WHO's biennial collaborative workplan. It will also inform resource mobilization efforts and the prioritization of WHO country-level engagement in Latvia.

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ANNEX 1

PROGRAMME

Time/venue	Activity
Day 1. Tuesday, October 22	
9.00 -10.45	**Meeting with the MOH, incl PHC team** *Ministry of Health, Room No 309;* *Participants:* *MOH Director of the Healthcare Department: Sanita Janka;* *MOH Head of the Healthcare Organization Division: Ineta Būmane;* *MOH Senior Expert of the Healthcare Organization Division: Ieva Špironoka;* *MOH Senior Expert at the Sectoral Human Resources Development Division: Laura Vanaga;* *MOH Director of the European Affairs and International Cooperation Department: Elīza Bērziņa;* *MOH Senior Expert of the European Affairs and International Cooperation Department: Kārlis Panteļejevs;* *MOH Representative of the Investment and European Union Funds Monitoring Department*
11.00 - 11.45	**Meeting with the Latvian Nursing Association (LNA)** *Ministry of Health, Room No 309;* *Participants:* *LNA Board Member Agita Melbārde Kelmere;* *LNA Board Member Līga Ārente;* *MOH Senior Expert of the Healthcare Organization Division: Ieva Špironoka;* *MOH Senior Expert at the Sectoral Human Resources Development Division: Laura Vanaga*
11:45 – 12:30	**Latvian Association of Physician Assistants (LAPA)** *Ministry of Health, Latvia Room No 309;* *Participants: Representatives of LAPA;* *MOH Senior Expert of the Healthcare Organization Division: Ieva Špironoka;* *MOH Senior Expert at the Sectoral Human Resources Development Division: Laura Vanaga*
14.00 – 15.00	**Visit to an Urban Family Medicine Practice (Nr.1.)** *Health Centre "Možums"* *Dr Evitas Gorajas Family Medicine Practice* *Bruņinieku street 8* *Participants:* *MOH Senior Expert of the Healthcare Organization Division: Ieva Špironoka*
15.00 - 16.00	**Visit to an Urban Family Medicine Practice (Nr.2.)** *Dr Artūrs Kupčs Family Medicine Practice,*

	Skolas street 22a *Participants:* *MOH Senior Expert of the Healthcare Organization Division: Ieva Špironoka*
16.00 – 17.00	**Meeting with the Riga City Council** *Ministry of Health, Room No 309* *Participants:* *RCC Division Head, Deputy Chief of Administration Nikola Tilgale-Platace;* *RCC Healthcare Access and Supervision Division Chief Specialist-Expert Sandra Titāne* *MOH Director of the Healthcare Department: Sanita Janka;* *MOH Head of the Healthcare Organization Division: Ineta Būmane;* *MOH Senior Expert of the Healthcare Organization Division: Ieva Špironoka*
Day 2. Wednesday, October 23	
9.00 – 10.00	**Meeting with the Family Medicine Association (LFA)** *Ministry of Health, Latvia Room No 309;* *Participants:* *President of LFA Alise Nicmane-Aišpure;* *Jevgeņijs Bondins*
10.15 – 11.15	**Meeting with University Departments (Riga Stradins University / Latvia University; FMDs; Nurses)** *Ministry of Health, Room No 309;* *Participants:* ***RSU Red Cross Medical College**:* *Deputy Director Sanita Litiņa;* *Head of Studies Department Solvita Belova;* *Director Ritvars Ziedonis* ***Latvian University Riga 1st Medical College**:* *Director Inta Miķele;* *Deputy Director for Professional Education Inita Mieze* ***Latvian University*** *Associate Professor of the Faculty of Medicine and Life Sciences Juris Bārzdiņš* ***MOH*** *Director of the Healthcare Department: Sanita Janka;* *Senior Expert of the Healthcare Organization Division: Ieva Špironoka;* *MOH Senior Expert at the Sectoral Human Resources Development Division: Laura Vanaga*
11.30 -12.30	**Meeting with the Young FMDs Association (YFMDA)** *Ministry of Health, Room No 309;* *Participants:* *YFMDA Board member Katrīna Priede (+ 1-2 representatives TBC)*
14.30 – 15.30	**Meeting with the Patients' organisations** *Ministry of Health, Room No 309;* *Participants:*

	Latvian Patient Organization Network Board Member Gunita Berķe (+1-2 representatives TBC) *International Cooperation Expert at "Dzīvības koks" Jūlija Dmitrijeva* *Representative from SUSTENTO (TBC)* ***MOH (if required):*** *Director of the Healthcare Department: Sanita Janka;* *Senior Expert of the Healthcare Organization Division: Ieva Špironoka*
16.00 – 17.00	**Meeting with NHS** *Conference hall on the 3rd floor.* *Participants:* *NHS experts Līga Gaigala, Linda Celmiņa-Ķeze (+ 3 experts TBC)* *MOH Senior Expert of the Healthcare Organization Division: Ieva Špironoka*
Day 3. Thursday, October 24	
9.00 – 11.00	**Visit to municipality of Tukums district** **Municipality** *Talsu street 4, Tukums* **Dr. Pūce Family Medicine Practice** *Raudas street 8,Tukums* *Participant: MOH Senior Expert of the Healthcare Organization Division: Ieva Špironoka*
13.15 – 14.30	**Visit to Dr Dzalbs Family Medicine Practice/meeting with with local Jelgava district municipality** *Lielupes street 5, Staļģene, Jelgavas district* *Participants:* *Deputy Chairperson of Jelgava Municipality Council: Irina Dolgova* *Head of Jelgava Municipality Welfare Department: Karīna Voitkāne* *MOH Senior Expert of the Healthcare Organization Division: Ieva Špironoka*
16.00 – 17.00	**Meeting the Rural FMD association (RMFDA)** *Ministry of Health, Room No 309;* *Participants:* *President Līga Kozlovska;* *Ainis Dzalbs (VTC)*
Day 4. Friday, October 25	
9.30 – 10.30	**Meeting with the MOH PHC Team prior to the meeting with the Minister of Health/Deputy State Secretary** *Ministry of Health, Latvia Room No 309;* *Participants:* *MOH Director of the Healthcare Department: Sanita Janka;* *MOH Senior Expert of the Healthcare Organization Division: Ieva Špironoka;* *MOH Senior Expert at the Sectoral Human Resources Development Division: Laura Vanaga;* *MOH Director of the European Affairs and International Cooperation Department: Elīza Bērziņa;*

	MOH Senior Expert of the European Affairs and International Cooperation Department: Kārlis Panteļejevs; MOH Representative of the Investment and European Union Funds Monitoring Department
10.30 – 11.30 ***(time tbd by the MOH)***	**Debriefing with the Minister of Health/Deputy State Secretary** *Ministry of Health, Latvia Room No 309;* *Participants:* ***Minister of Health Hosams Abu Meri*** *Representative of Minister's Office* *MOH Deputy State Secretary Antra Valdmane* *MOH Director of the Healthcare Department: Sanita Janka;* *MOH Senior Expert of the Healthcare Organization Division: Ieva Špironoka;* *MOH Senior Expert at the Sectoral Human Resources Development Division: Laura Vanaga;* *MOH Director of the European Affairs and International Cooperation Department: Elīza Bērziņa;* *MOH Senior Expert of the European Affairs and International Cooperation Department: Kārlis Panteļejevs;* *MOH Representative of the Investment and European Union Funds Monitoring Department*
11:30- 13.00	**Expectations workshop for the Demonstration Platform visit in Sweden (9.12 – 13.12.2024) - hybrid** ***(MOH PHC Team, Minister's office and other Latvian delegates to the Demonstration Platform)*** *Ministry of Health, Room No 309;* *Participants:* *Minister of Health Hosams Abu Meri* *MOH Advisor to the Minister Renārs Lazdiņš* *MOH Deputy State Secretary Antra Valdmane* *MOH Senior Expert of the Healthcare Organization Division: Ieva Špironoka;* *MOH Director of the European Affairs and International Cooperation Department: Elīza Bērziņa;* *MOH Senior Expert of the European Affairs and International Cooperation Department: Kārlis Panteļejevs;* *NHS expert Linda Celmiņa – Ķeze (VTC)* *Board member at YFMDA Katrīna Priede (VTC)* *President of RFMDA Līga Kozlovska (VTC)* *President of LFA Alise Nicmane-Aišpure (VTC)*