ESPN Thematic Report on Inequalities in access to healthcare

Latvia

2018

Tana Lace
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European Social Policy Network (ESPN)

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Summary/Highlights

In Latvia the healthcare system is currently still based on universal coverage and pays for a basic services package. Compared with other European countries, the scope of the benefit package in Latvia is relatively limited. The Latvian healthcare system is characterised by tax-financed statutory healthcare provision, a purchaser–provider split and a mix of public and private providers. Approximately one third of the employed population is enrolled into voluntary health insurance paid for by employers.

In 2019 Latvia will transfer from universal healthcare coverage to a health insurance system. 2018 has been identified as the transition period.

The most important causes of the limited accessibility of healthcare services in Latvia are: lack of funding (financial quotas for state-funded services); lack of human resources; high out-of-pocket payments; regional disparities in service provision; and the low solvency of patients. The Latvian health system is underfunded, thus raising severe accessibility issues. Only 57% of health spending is publicly funded, with most of the remaining spending paid directly out of pocket by households. Very high out-of-pocket payments are experienced by people of all incomes, but are heavily concentrated among poorer people. Out-of-pocket payments for out-patient medicines and medical products are the single largest cause of financial hardship among the poorest half of the population.

In Latvia maximum waiting times for healthcare services are not defined by regulation, and long waiting times constitute a very significant problem. Inequality among regions and local government areas exists in terms of the accessibility, availability and quality of healthcare services. Significant regional inequality in the distribution of physicians still persists. The ratio of practising nurses to the population is almost half the EU average. Health workforce challenges include unequal geographical distribution of staff, emigration of healthcare specialists, unbalanced skill mix, low compensation, and an inappropriate incentive structure compounded by high workloads.

In Latvia the proportion of inhabitants reporting unmet needs for medical care in 2016 due to any of three reasons (too expensive, too far to travel, or waiting lists) was considerably higher than the EU 28 average (8.2%, compared with 2.5% for EU 28). Financial barriers are the main reason for unmet need for medical examinations or treatments. Pensioners in particular are at risk of facing financial hardship due to ill-health. Although there is a cap (ceiling) on co-payments for in-patient, out-patient and diagnostic services, it is set at a very high level. There is no cap on out-of-pocket payments arising from co-payments for medicines.

Measures have been planned and initiated to address a set of challenges that have generated inequality in access to healthcare services for the inhabitants of Latvia, in particular inhabitants with low and average incomes, through additional allocations of funds from the national budget in 2017 and in 2018. Changes have also been introduced in the remuneration system for medical personnel.

To ensure better access to healthcare it is essential to: retain a stable rate of growth in healthcare funding in the coming years; officially establish a maximum waiting time for healthcare services; improve measures to reduce out-of-pocket payments, paying particular attention to the low-income population and elderly persons (for example, a further reduction of patients' co-payments, including for reimbursable medicinal products, and setting a cap on co-payment amounts); and expand the availability of, and access to, long-term care for the elderly and chronically ill patients.

Switching to a health insurance system will not resolve the issue of the high ratio of out-of-pocket payments made by the population. Moreover, there is an immediate danger that some people will fail to register themselves under the new insurance system because of lack of means, and so lose access to healthcare services.

1 Description of the functioning of the country's healthcare system for access

In Latvia the healthcare system is currently based on universal healthcare coverage (Latvians and non-Latvian residents) and pays for a basic services package. Compared with other European countries, the scope of the benefit package in Latvia is relatively limited. The benefit package is defined by 'negative lists' (i.e lists of certain excluded services, such as dental care for adults, rehabilitation with some exceptions, and sight- and hearing-correction aids also with some exceptions). All other healthcare services not on the negative lists are provided. There is also a defined, guaranteed set of healthcare services – 'positive lists' – which are provided to all inhabitants (for pharmaceuticals, for certain preventive, diagnostic and therapeutic interventions, and for emergency medical services) (OECD, 2016b, p.60). The Latvian healthcare system is characterised by tax-financed statutory healthcare provision, a purchaser-provider split and a mix of public and private providers. Resources are raised mainly through general taxation by central government, but out-of-pocket payments are important as well.

The two main actors in the health system are the Ministry of Health, which is responsible for developing national health policies, and the National Health Service (NHS), which implements health policies and purchases of publicly financed health services. Providers contracting with the NHS tend to be predominantly private in the case of primary care; public and private in the case of secondary care, with public ownership concentrated mainly at the municipal level; and predominantly public in the case of tertiary care, with ownership concentrated at the national level.
The situation will change following the enactment of the Healthcare Financing Law by Parliament on 14 December, 2017. In 2019 Latvia will transfer to a state compulsory health insurance system. 2018 has been identified as the transition period, when the current procedures for receiving healthcare services will still operate. From 2019 insured persons will be able to receive the 'full basket' of state-paid healthcare (see Chapter 2).

Accessibility (including affordability) of healthcare services is a topical policy issue in Latvia. The most important causes of the limited accessibility of healthcare services are: lack of funding (financial quotas for state-funded services); lack of human resources; high out-of-pocket payments[1]; regional disparities in service provision; and the low solvency of patients. The cost of healthcare services is the main factor. As research data reveal, patients frequently have insufficient financial means to pay for private services and for transport costs, as well as for the informal payments customarily required by healthcare institutions (World Bank 2016d, p.54). For example, according to Eurobarometer survey data, 9% of respondents in Latvia say they had to make an extra payment on top of the standard fees (Special Eurobarometer 470, 2017, p.85).

The Latvian health system is underfunded, thus raising severe accessibility issues. In 2015, Latvia spent €1,071 per capita on health, the second lowest level in the EU, with total expenditure accounting for only 5.8% of GDP compared with an EU average of 9.9%. Only 57% of health spending is publicly funded (whereas the EU average is 79%) (European Commission, 2017), with most of the remaining spending coming directly from out-of-pocket payments by households (in 2013 – 38.47%, in 2014 – 39.11%, in 2015 – 42.07%) (Eurostat 2018). The share of out-of-pocket payments in Latvia is one of the highest across EU countries – in 2015 it was the third highest.

Co-payments apply to almost all types and levels of healthcare services and out-patient pharmaceuticals prescribed by doctors. A fixed amount has to be paid, for example, per

[1] Official expenses for medical care not reimbursed by insurance.

visit to the general practitioner, for home calls made by the family doctor, for hospital stays, and for in-patient surgical interventions. A fixed proportion (50%, 75% or 100%) of the price of prescribed reimbursable drugs and medical devices usually has to be covered by patients. Regulations cap the co-payments for out-patient and in-patient healthcare services at €569 per person per year; co-payments for hospitalisation are capped at €356 per episode. However, the cap does not apply to co-payments for pharmaceuticals and medical devices. Children under the age of 18 are exempted from any fees. Exemption from mandatory co-payments is also extended to disabled people; pregnant women and women up to 42 days after childbirth; victims of political repression and participants in the national resistance movement; tuberculosis patients; mentally ill persons under treatment; and some other categories. Households with income below €128 per person are also usually exempted. Two preventive programmes are available without co-payments: annual check-ups at the family doctor's practice, and a cancer screening programme. Patients have access to the state-established pricelists at medical care institutions as well as information that is accessible on the webpages of the Ministry of Health and other institutions. Patients have to pay in full for all services received from providers not contracted by the National Health Service.

In Latvia, maximum waiting times for healthcare services are not defined by regulation. In view of the limited accessibility of state-financed healthcare services and the insufficient quotas for them, as well as the low solvency of the population, long waiting times for state-financed healthcare services constitute a very significant problem. Depth of coverage is thus very limited. The waiting time for various out-patient healthcare services is from 20 days to 680 days. There are significant problems of transparency in formation for waiting lists. Waiting times vary across the country; patients have to request information on waiting times from each medical institution. Waiting times for state-paid healthcare services are affected also by the disparity between the state-established tariffs and the actual costs of services: this may result in situations where providers refuse to conclude agreements for the provision of state-paid healthcare services, and provide only paid services. For example, the number of medical institutions concluding agreements with the NHS for the provision of state-paid dental services has been diminishing with every year, and the main reason cited is the insufficient tariffs for dental manipulations (the number of contracted institutions decreased from 303 in 2014 to 249 in 2017) (Veselības ministrija, 2017a, p.10-11). Patients are likely to make informal payments[2], to jump waiting lists or receive preferential treatment. The number of patients who report having used unofficial payments, gifts or acquaintances is above the EU average (European Commission, 2017).

According to information collated by the Latvian Association of Insurers (Latvijas Apdrošināšanas asociācija, 2017) the ratio of voluntary health insurance indemnities (organised on a commercial basis) in the national healthcare budget (as a proportion of treatments) reached a peak in 2009 (17.9%), experiencing a significant fall during the crisis period to 7.7% and gradual growth to 10.7% by 2016. Voluntary health insurance paid for by employers (including occupational insurance schemes) is provided to approximately one third of the employed population; moreover, 25-30% of those insured in this way are employees of public and local government institutions. In absolute terms the largest number of private health insurance policies is bought by employers (legal persons); the number of private health insurance policies purchased by natural persons does not exceed 1% of the total number.
The analysis undertaken by the Latvian Association of Insurers reveals that, for the most part, insurers cover the costs of the same services that are financed by the national healthcare budget – 64.9% of private health insurance indemnities are paid for out-patient and in-patient healthcare services, 11.5% for patient co-payments, and almost 8% for out-patient rehabilitation services. Voluntary healthcare insurance in Latvia plays a dual role – it partly covers out-of-pocket-payments, but it also provides an opportunity for patients to

[2] Outside the official payment channels.

skip waiting lists for state-financed healthcare services and allows access to care of better quality. According to research data, employees with health insurance are more willing to use private healthcare services because: they are of better quality; the attitude of 'doctors for a fee' is better; and they do not have to worry about medical expenses if, for example, an illness persists and it is necessary to have expensive examinations or undergo treatment in hospital. On the other hand, patients have found that healthcare specialists have been exploiting private insurance reimbursement rules unfairly by offering and providing services and examinations without special reasons (World Bank, 2016d, p.32).

The healthcare assessment undertaken by the World Bank, as well as healthcare planning documents, emphasises the problem of inequality in access to healthcare services between different regions. Healthcare planners point out that inequality among regions and local governments arises not only from differences in incomes and economic activity but also in respect of the accessibility of healthcare services – in particular, restricted access to specialised healthcare services in areas located farthest from the capital, Riga. Such inequality has a negative impact on the quality of life in the regions affected. Regional cooperation models and clear 'patient pathways' for ensuring accessibility of services evenly across the country have not yet been fully developed (Veselības ministrija 2017a, p.8). According to research data, various stakeholders also consider that healthcare services should be more widespread in the regions and admit that particular services outside Riga are not being provided in sufficient quality, because specialists in these regions do not have relevant experience in carrying out the examinations concerned. As a result, specialists working in the regions may not be able to diagnose illnesses in a timely fashion, and there are cases where specialists in Riga do not trust examinations carried out in regional institutions (World Bank, 2017d, p.31).

One of the most important factors in providing good-quality healthcare services to the population at each level is human resources – having well-qualified staff in the appropriate numbers and deploying them efficiently. Health workforce challenges are considered to be among the main bottlenecks for the development of the Latvian health sector. The challenges for those providing state-financed healthcare services may include unequal geographical distribution of staff, an unbalanced skill mix, low rates of compensation, and an inappropriate incentive structure compounded by high workloads. These shortcomings often create other challenges faced by the Latvian health system, and the ability to address them will determine the medium- and long-term success of any health sector reform effort (World Bank, 2016a, p.5). Research data (World Bank, 2016d, p.5) shows that there is a common perception among human resource managers and health professionals that the number of healthcare personnel is insufficient in Latvia: the shortages affect all groups of health professionals and all levels of care, but the shortage is particularly severe at the hospital level and in the eastern part of Latvia.

In addition to the above, the ageing of the healthcare workforce will be a factor in the medium and long term. Employees over the age of 50 constitute 34-47% of professional staff in the healthcare sector (compared with 29% for the whole workforce) (Veselības ministrija, 2017a, p.9-10). According to OECD data, the number of physicians in Latvia is slightly below the EU average – in Latvia there are 3.2 practising physicians per 1,000 inhabitants, while in EU countries the average is 3.5 (OECD, 2016a, p.159). In Latvia the ratio of practising nurses is almost half the EU average (4.8 per 100,000 inhabitants, compared with 8.4) (Veselības ministrija, 2018, p.41). According to the analysis undertaken by the Ministry for Health (*Veselības ministrija*), approximately 250 persons qualify as nurses annually; however, only about 60 start to work in hospitals. According to the recommended methodology there is currently a deficit of about 1,500 nurses in hospitals (Veselības ministrija, 2017a, p.9-10).

Information collated by the Ministry of Health shows that significant regional inequality in the distribution of physicians (working in their basic place of work) still persists. 62% of the total number of physicians work in Riga, 9% in the Riga region, 7% in the Kurzeme

region, 9% in the Latgale region, 6% in the Vidzeme region, and 7% in the Zemgale region (Veselības ministrija, 2017a, p.9-10). Availability of healthcare personnel is further aggravated by the emigration of healthcare professionals. Due to the high quality of medical education and low salaries, Latvia has for several years been a donor country of medical professionals.

2 Analysis of the challenges in inequalities in access to healthcare in the country and the way they are tackled

Latvia has universal health coverage, although the breadth and depth of coverage is more limited than in most other EU countries. As a result, a large share of people report problems in obtaining care; mainly because of financial barriers, but also because of geographic reasons or long waiting times (OECD/European Observatory on Health Systems and Policies, 2017).

The EU-SILC data reveal that in Latvia the ratio of inhabitants reporting unmet needs for medical care due to any of three reasons (too expensive, too far to travel or the waiting list) remains high. Note that the figures for 2015 and for 2016 differ considerably from those for the preceding years, which can largely be explained by changes in the survey methodology. Although the figures for Latvia are gradually declining, they still remain considerably higher than the EU 28 average (2.5% in 2016) (see Table 1).

Table 1
Self-reported unmet need in Latvia for medical care (too expensive, too far to travel or waiting list) (% of population aged 16 and over)

2008	2009	2010	2011	2012	2013	2014	2015	2016
9.9	9.9	15.1	16.1	12.4	13.8	12.5	8.4*	8.2

* *In 2015 there was a change in survey methodology relating to unmet need for a medical examination or treatment (except dental).*
Data source: EU-SILC.

Women are more likely than men to report unmet needs for medical care (for any of the three reasons) – 9.2% in 2016, compared with 7.1% for men. Certain differences can be observed in various age groups. 6.9% of respondents aged 16-64 report unmet medical need, compared with 12.6% of those over the age of 65.

The labour status of inhabitants also correlates with problems in obtaining care. In 2016 this indicator did not reach 6% among employed persons, whereas it was much higher for unemployed persons – 16.7%, retired persons – 13.6%, and non-employed persons – 11.6%. Individuals with higher (tertiary) education were half as likely in 2016 to report unmet need than people with lower education (less than primary, primary, and lower-secondary) – 5.2% compared with 10.5%.

Significant differences in self-reported unmet need for medical care can be also observed among people in different income quintiles. Among people in the first quintile (the poorest), 16.8% reported unmet need (for any of the three reasons), whereas only 2.4% of respondents in the fifth quintile did so. Catastrophic out-of-pocket payments are experienced by people of all incomes, but are heavily concentrated among poorer people. In 2013, nearly 27% of the poorest fifth of households experienced catastrophic out-of-pocket payments, compared with 4% of the richest fifth. Out-of-pocket payments for out-patient medicines and medical products are the single largest cause of financial hardship, accounting for 75% of catastrophic out-of-pocket payments on average in 2013, and rising

to over 80% of catastrophic out-of-pocket payments among the poorest half of the population (World Health Organization, 2016).

According to EU-SILC data, unmet needs for medical care are more often reported by: women: the unemployed and individuals outside the labour market: the elderly, in particular pensioners; people with a lower educational level (less than primary, primary and lower-secondary education); and the low-income population.

Table 2
Self-reported unmet need in Latvia for medical care (too expensive) (% of population aged 16 and over)

2008	2009	2010	2011	2012	2013	2014	2015	2016
6.8	8.0	13.4	16.1	14,.5	10.5	12.0	6.8*	5.3

** In 2015 there was a change in survey methodology relating to unmet need for a medical examination or treatment (except dental).*
Data source: EU-SILC.

Among the three reasons for unmet need, financial problems ('too expensive') are the most important. The ratio of the population in Latvia who mention financial barriers as the main reason for unmet needs for medical examination or treatment (see Table 2) has consistently since 2008 been considerably higher than the EU 28 average (the latter was 1.6% in 2016) and also one of the highest in EU member states – equal with Romania and only lower than Greece.

Over the years travel distance as a reason for unmet needs for medical care has fluctuated, from 0.7% in 2008 to a low point in 2015 (0.3%) and then 0.5% in 2016 (EU28 – 0.1% in 2016).

There is no clear trend concerning waiting lists as the reason for unmet needs for medical care in Latvia. In 2008 it was 2.4%; in the following years it fluctuated between 0.9% and 1.6%; but in 2016 it again increased, to 2.5%. A recent World Health Organization (WHO) report indicates that 'out-of-pocket payments for out-patient medicines seriously undermine financial protection in Latvia and may also be an important driver of unmet need' (World Health Organization, 2016, p.5). Dental charges are also not compensated by the NHS, with the result that (according to EU-SILC data) in 2016 16.9% of respondents needing dental treatment during the preceding 12 months had not in fact visited a dentist. 79.2% of the respondents mentioned as the main reason the fact that they could not afford it or that it was too expensive (Centrālās statistikas pārvalde, 2018).

Rural inhabitants mention travel reasons (too far to travel or no means of transportation) more often than urban residents. Research confirms (World Bank, 2016b, 2016c), that accessing healthcare is also hindered by the uneven geographical distribution of services.

When assessing inequalities in access, one of the groups that should be mentioned is the elderly and pensioners – in particular single pensioners, a majority of whom are women. The current healthcare system does not take sufficient notice of the situation of the elderly: their health condition, their need for medicinal products, and for many their low pensions. WHO experts indicate (World Health Organization, 2016), that pensioners are in particular at risk of facing financial hardship due to ill-health. Pensioners, who account for 70% of people with catastrophic out-of-pocket payments, must also pay all co-payments unless their income falls below €128 per person per month. Although there is a cap (ceiling) on co-payments for in-patient, out-patient and diagnostic services, it is set at a very high level (€356 per hospitalisation and €569 per person a year overall). There is no cap on out-of-pocket payments arising from co-payments for medicines. In their turn, OECD experts

emphasise that, given the high health and social care needs among the elderly, Latvia will also need to address access and quality in the long-term care sector (OECD, 2016b).

In order to address the underfinancing problems in healthcare and to increase access to state-funded healthcare services, on 14 December 2017 the Parliament enacted The Healthcare Financing Law, changing the healthcare funding system and making healthcare part of the state social insurance system, with 1% of social contributions directed to healthcare financing. The law divides the healthcare basket into two parts – the so-called 'full basket' and 'minimum basket'. Starting on 1 January 2019, two categories of persons will receive the full basket of healthcare services: persons who make social contribution payments (for them, payments will be increased by 1 percentage point – 0.5 paid by employers and 0.5 by employees – by 2018); and groups of the population for whom health insurance contributions will be made by the state (including children, pensioners, the unemployed registered with the state employment agency, and certain categories of persons with disabilities). 2018 is a transition period. The main task for people will be to work out whether they are insured or not insured. People who are not paying social contribution payments (e.g. certain groups of micro-enterprise workers, seasonal workers, and recipients of royalties) will have the possibility to join, on a voluntary basis, the health insurance scheme and thus to receive the full basket of services by making additional health insurance payments. The law for these people proposes a payment that corresponds to a fixed percentage of the minimum monthly wage. If no health insurance payment is made these people will only have access to the minimum basket of healthcare services (ESPN, 2017).
The state-paid medical assistance minimum that will be received by all inhabitants, irrespective of the size of their social contribution payments, will include emergency medical assistance, obstetric assistance, services of a family doctor and medicinal products and appliances required for treatment that are reimbursed by the state budget. It will also include treatment for diseases that have a significant impact on public health indicators or pose an actual threat to public health, including psychiatric disorders and tuberculosis as well as medicinal products required for the treatment of these diseases.

To receive the full basket of healthcare that includes other state-paid services, the inhabitant must have state compulsory health insurance.

Although the Ministry of Health points out positive developments starting in 2018, many problems and unclear issues concerning the new healthcare financing model still remain, especially regarding access and affordability.
The law will not resolve the issue of the high ratio of out-of-pocket payments made by the population. Similarly, more attention should be paid to the identification of those groups of individuals who might 'fall out' of the spectrum of healthcare recipients. Concern has been expressed regarding the 100,000 to 300,000 individuals who currently do not pay social insurance contributions – including seasonal agricultural workers, people employed under the micro-enterprise tax regime, and certain types of self-employed people. There is a danger that people in these groups will fail to register themselves under the new insurance system because of lack of means, and so lose access to healthcare services (ESPN, 2017).

Measures have been planned and initiated to address a set of challenges that have generated inequality in access to healthcare services for the inhabitants of Latvia, in particular those with low and average incomes, within the framework of the healthcare reform and the additional allocation of funds from the national budget – €34.3 million in 2017 and €79.1 million in 2018 (Veselības ministrija, 2017c, p.2). The additional funding is directed towards: improving access to healthcare services and reducing waiting lists; improving access to diagnostics and cancer treatments; reduction of the spread of contagious diseases; improving the quality and accessibility of the primary healthcare system; reducing cardiovascular morbidity; and improving the effectiveness of the treatment of diseases (Veselības ministrija, 2018, p.3).

Access to healthcare services should be significantly improved by the additional funding and by the designation of priority support areas (including cancer diagnosis and treatment; treatment of cardiovascular diseases; provision of endoprotheses; prevention of long-term illnesses of adults of the working age; dental services for children; and treatment of rare diseases). The initial assessment of the results of investments shows their positive impact on access to healthcare. According to the progress assessment by the Ministry for Health in the first half of 2017, additional funds have allowed waiting lists for specialist services to be reduced by an average of 24.26%; for out-patient examinations and treatment by 12.35%; for state-paid services in a day hospital by 39.43%; and for out-patient rehabilitation services by 6% (Veselības ministrija, 2018, p.3). It is envisaged that in 2018 additional funding will allow the provision of an extra 108,700 specialist consultations, 207,200 out-patient examinations, 35,100 services in a day hospital, 33,300 examinations for diabetes, 29,500 out-patient rehabilitation services, 981 endoprothesis operations, seven liver transplant operations, the operation of 11 diabetes training facilities, and care for 33,000 chronic patients (Veselības ministrija, 2017a, p.27).

In order to supervise the effectiveness of healthcare spending, the government has charged the Ministry of Health with the task of collecting data concerning the achievement of planned outcomes every six months (Ministru kabinets, 2017).

A range of measures has been planned, including within the framework of EU co-financed activities, to reduce regional inequality and to improve access to medical specialists. Since 2015, applicants for specialist training have been given preference if they agree to work outside Riga at the end of their training residency (Veselības ministrija, 2018, p.42). In 2018 it is also planned to start using EU funds to attract medical personnel (physicians and nurses) to work in regions outside Riga. The funds will also be used to improve the qualifications of medical professionals, thus enabling those who do not practise in their speciality to return to the labour market in the healthcare sector(Ekonomikas ministrija, 2018, p.12-13).

Pay increases and reductions in working hours are being introduced for medical personnel, supported by additional funds of €26.4 million in 2014, €7.7 million in 2015, €million in 2016, €3.8 million in 2017 and €85.3 million in 2018 (Cabinet of Ministers 2017). In 2018 it is planned to raise the average monthly salary of physicians and functional specialists from €859 to €1,125, of medical and patient care workers and assistants of functional specialists from €537 to €675, and of medical and patient care support staff from €400 to €450. These increases are aimed at improving the supply of medical personnel and improving healthcare accessibility.

During discussion of the healthcare funding reforms, one issue was establishment of a maximum waiting time for particular groups of diagnoses: but so far a maximum time has only been officially prescribed for diagnostic examinations for patients with a suspected tumour (of any type). According to information provided by the Ministry for Health, it would be necessary to invest €136.1 million by 2023 in order to reduce all waiting times to a maximum of 90 days, and the waiting time for radiological examinations to a maximum of one month (Veselības ministrija, 2017a, p.55).

To ensure better access to healthcare it is essential to: retain a stable rate of growth in healthcare funding in the coming years; officially establish a maximum waiting time for healthcare services; improve measures to reduce out-of-pocket payments, paying particular attention to the low-income population and elderly persons (for example, a further reduction of patients' co-payments, including for reimbursable medicinal products, and setting a cap on co-payment amounts); and expand the availability of, and access to, long-term care for the elderly and chronically ill patients.

3 Discussion of the measurement of inequalities in access to healthcare in the country

The primary task in measuring and assessing access to healthcare is to improve the quality and methodology of data in the national administrative registers, taking into consideration the significant changes in the funding of healthcare and in the population of service recipients. The year 2018 has been identified as the transition year to the new insurance-based system, so that persons who are not covered by compulsory insurance can make voluntary payments and thus qualify for the full basket of state-paid healthcare services. Unfortunately, by the middle of 2018 the necessary information systems and the linking of administrative registers were not yet in place. Thus, people cannot clarify their status under the new system and decide whether make payments to join it. Under these circumstances it is not possible to assess what portion of the population, and which social-economic groups, will not be covered by the new system and will therefore have restricted access to healthcare services.

Data on patients' debts to medical institutions can shed useful light on the affordability of healthcare services. Unfortunately, these data are collected by each medical institution individually, and are not collected, collated or analysed at the national level on regular and systematic basis. Administrative registers should systematically collect and collate data on patients' debts in order to allow better analysis of inequalities in access to healthcare and the affordability of healthcare services, as well as to promote better interinstitutional and sectoral solutions to support access by specific target groups.

Concerning commonly used indicators such as the unmet need for medical care, there is evidence of certain changes since 2015 when methodological changes were introduced. A long and complicated question in the initial survey was split into two questions which, according to statistical experts, has considerably improved the understanding and perception of the question among respondents. This change also had a significant effect on the value of the indicator. Indeed, the overall results for the unmet need for medical care indicator are significantly lower in comparison with previous years (3 reasons - *too expensive, too far to travel or waiting list* and other reply options). (This has been confirmed in the statistical databases of Eurostat and the CSB Latvia). Thus, it is important to formulate questions in a more uniform way so that interpretations become more uniform (as far as possible in different countries), and to provide simpler response options. Statistical experts working with EU-SILC data had no objections to translations as these were paid due attention. Potential limitations to measuring the unmet need for medical care in a comparative perspective include cultural differences and different expectations towards service provision (accessibility, affordability and quality) in different countries. In view of the above, it would be advisable to improve the quality and methodology of administrative data by using internationally harmonised surveys and registering data for the measurement of access to healthcare in a comparable way.

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