Eiropas Savienības fondu darbības programmas „Izaugsme un nodarbinātība" 9.2.3.specifiskā atbalsta mērķa „Atbalstīt prioritāro (sirds un asinsvadu, onkoloģijas, perinatālā un neonatālā perioda un garīgās veselības) veselības jomu veselības tīklu attīstības vadlīniju un kvalitātes nodrošināšanas sistēmas izstrādi un ieviešanu, jo īpaši sociālās atstumtības un nabadzības riskam pakļauto iedzīvotāju veselības uzlabošanai" ietvaros īstenotā projekta Nr.9.2.3.0/15/I/001 „Veselības tīklu attīstības vadlīniju un kvalitātes nodrošināšanas sistēmas izstrāde un ieviešana prioritāro jomu ietvaros" 9.nodevums – A summary report for key informant interviews and focus group discussions.

World Bank Reimbursable Advisory Services:
Support to Develop a Health System Strategy for Priority Disease Areas in Latvia

A qualitative study on health system bottlenecks in Latvia

REPORT

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Content

Introduction

Objective

1. This report presents results from a qualitative study that investigated themes difficult to uncover with quantitative data, focusing on
    i. key health system bottlenecks that interfere with timely access to care and quality services for patients and the co-ordination among healthcare providers in Latvia,
    ii. challenges in recruiting and retaining healthcare personnel

2. This analysis was conducted as part of a World Bank Group (WBG) reimbursable advisory services agreement with the Latvian National Health Service (NHS), which aims to provide "Support to Develop a Health System Strategy for Priority Disease Areas in Latvia". The analysis draws on focus group discussions and interviews among various stakeholders in the health sector – including patients, physicians, nurses, and administrators – that were conducted throughout Latvia in November 2015.

Summary of main findings

3. The discussions and interviews related to human resources revealed that most actors in the health system identify a shortage of healthcare personnel as a critical problem. While the problem affects many profiles, it appears the most acute for doctors working exclusively in hospitals, nurses, and doctors in residency training. Study participants suggest that low remuneration of healthcare personnel as well as an unattractive social and cultural environment of rural areas may be important root causes of these shortages.

4. Participants observed that an insufficient amount of time is devoted to prevention measures by both physicians and patients. The current organisation of prevention services puts most of the responsibility on patients. Due to the huge number of patients they must attend to, both patients and GPs feel that GPs do not devote sufficient attention to supervising their patients' prevention activities. In addition, patients, especially, elderly people, do not have a habit of turning to GPs or nurses for prevention issues.

5. Patients, physicians, and administrators observed that access to healthcare in Latvia is quite limited, with the primary obstacle being the low budget allocation for state-funded diagnostics and treatment which leads to long waiting lists.

6. Many discussions highlighted problems related to care that is insufficiently integrated across levels. Family doctors and specialists agree that they predominately communicate only through the official diagnoses written on health records. Thus, from the researcher's perspective, greater coordination and information exchange could help patients receive better quality care. Currently, most of the responsibility for reaching all necessary specialists is shouldered by patients themselves. For patients with co-morbidities, physicians might also focus only on the main disease.

Roadmap for the report

7. The next section describes the study design and the methods used to analyze information from focus group discussions and one-on-one interviews with a broad range of

stakeholders in the healthcare system. The subsequent material consists of three parts. The first is devoted to human resources in healthcare, focusing on the causes of personnel shortages and current strategies for attracting and retaining workers. The second part focuses on the accessibility of care – in particular, the main obstacles for receiving timely diagnostics and treatment, as well as different strategies used by patients to get necessary healthcare services quickly. Part 3 examines the current service delivery model and how it affects care for four dominant diseases and conditions (cardiovascular diseases, cancers, mental diseases and perinatal and maternal conditions), focusing on prevention and screening, diagnostics, treatment and coordination of care among all levels and types of specialists.

8. As the aim of the study was to investigate bottlenecks in the Latvian healthcare system, it is very important to bear in mind that the report focuses mainly on problems rather than strengths of the system. It is therefore by its nature unbalanced, and the strengths of the system are mentioned less. Another consideration is that the report describes bottlenecks from the point of view of investigated target groups, and they might have insufficient information about the rationale and reasons behind various policy decisions. Their statements may not be accurate (for example, a group might have misunderstood or misrepresented some de jure rules), but they are irrefutably these groups' opinions and perceptions of the issues, as can be verified in the transcripts of the focus group discussions. Often there is a divergence between what is supposed to happen (de jure rules) and what does happen (the de facto situation) or what is perceived to happen. The aim of the report is to provide an overview of all types of opinions existing among the target groups. In some cases, the perspective of the target groups is supplemented with references to current regulations and relevant principles of democratic society which have been added by the authors of the report.

Study design and methods

9. The study was conducted by the Baltic Institute of Social Sciences (BISS) between 21 October and 21 December, 2015. The key personnel involved in conducting the study and analysing the results are as follows: Oksana Žabko (team leader), Dr.sc.soc. Inese Šūpule (senior researcher), Iveta Bebriša (senior researcher) and Lelde Jansone (senior assistant).

10. Originally, 15 in-depth interviews and 10 focus group discussions (FGDs) were planned on three key themes: human resources in healthcare, mental healthcare, and utilization of services.

11. In-depth interviews were conducted with representatives of the Association of Hospitals (1 interview), specialist organisations for the four dominant disease groups (4 interviews), patient representative organisations (3 interviews), and mental health patients and their families (7 interviews).

12. The FGDs were divided into three sub-groups, as described in Table 1:
    (1) Patients with chronic diseases and individuals at high risk for each of the four priority disease areas (4 FGDs);
    (2) Family doctors, nurses, other medical specialists and representatives of municipality councils focusing on quality of care and access to services issues (3 FGDs) and;

(3) Representatives of health professionals' associations and trade unions, public and private facility managers, and managers/supervisors on human resources issues (3 FGDs).

Recruitment

13. Recruitment of potential institutions, professional and patient organisations, physicians and municipalities was based on public sources (catalogues of institutions), the list of service provides available on the website of the National Health Service, and, when necessary, the register of healthcare personnel and institutions available on the website of the Health Inspectorate. When preparing the list for FGDs in human resources, both public and private healthcare facilities were included. For the interviews, no particular individual was targeted within each facility or organisation, but rather it was the decision of participating institutions or organisations which person or persons would represent its opinion in the study.

14. From these lists, recruitment of the participants working in the healthcare sector for the FGDs and interviews proceeded through multiple steps. First, the initial contact was established through a telephone phone conversation, which simply drew an individual's attention to the planned event. Second, detailed information about the aims of the FGD or interview and a support letter provided by the National Health Service were sent by e-mail. Third, if the potential participant had not confirmed their participation within a few days, another contact by phone was established. Fourth, all recruited participants received a reminder one or two days before the event.

15. The recruitment of patients for the FGDs devoted to priority disease areas was conducted by phone, in which the initial contact list resulted from random selection from the set of all telephone numbers in Latvia. During the call, the list of targeted patients was further restricted by a screening questionnaire that included questions on lifestyle habits, diseases or conditions that people had faced during last 2 or 3 years. After this screening, BISS selected participants to ensure that a variety of profiles was included (gender, age, type of chronic diseases, socio-demographic backgrounds. When recruiting informants for in-depth interviews related to mental health issues, BISS had to rely on its own personal social networks and contacts with patient organisations.

16. Table 1 demonstrates that the targeted number of participants was not reached in some of the FGDs because several of the original contributors refused to take part or did not have enough time to attend. In the sub-groups lacking sufficient numbers, additional informants were interviewed in person or by phone. It was relatively easy to secure participation among specialists for FGDs related to human resources, as all invited institutions were very interested in the topic. The most difficult target group consisted of any other specialists working in patient care – general practitioners, physicians and nurses who refused to participate due to lack of time, work commitments, or other reasons. Among patients, the most difficult target groups were male participants (some of the recruited did not attend the FGDs) and female participants for perinatal and maternal conditions, as this was perceived as very sensitive issue. During the FGDs, questions related to this topic were discussed at the end, when male participants had left the room (see guidelines in Appendix 3).

Table 1. Description of FGD

#	Data and venue	Topic of the FGD	Target group	Number of participants in the FGD	Number of additional interviews
1.	Riga, 3 November, 2015	Human resources	HR administrators, facility managers, representatives of municipalities, professional associations, trade unions, academic staff	9	1
2.	Riga, 4 November, 2015	Quality of care and access to services issues	Family doctors, gynaecologists, nurses	3	5
3.	Liepāja, 5 November, 2015	Human resources	HR administrators, facility managers, representatives of municipalities	10	0
4.	Liepāja, 5 November, 2015	Quality of care and access to services issues	Patients (in Latvian) with chronic diseases and individuals at high risk for each of the four priority disease areas	8	0
5.	Daugavpils, 11 November, 2015	Human resources	HR administrators, facility managers, representatives of municipalities, academic staff	9	0
6.	Rēzekne, 12 November, 2015	Quality of care and access to services issues	Family doctors, nurses, representatives of municipalities, facility managers	8	2
7.	Rēzekne, 12 November, 2015	Quality of care and access to services issues	Patients (in Latvian) with chronic diseases and individuals at high risk for each of the four priority disease areas	6	1
8.	Vamiera, 17 November, 2015	Quality of care and access to services issues	Family doctors, nurses, representatives of municipalities, facility managers	6	3
9.	Riga, 24 November, 2015	Quality of care and access to services issues	Patients (in Latvian) with chronic diseases and individuals at high risk for each of the four priority disease areas	10	0
10.	Riga, 26 November, 2015	Quality of care and access to services issues	Patients (in Russian) with chronic diseases and individuals at high risk for each of the four priority disease areas	9	0

Composition of participants

17. In total, 56 healthcare professionals and stakeholders participated in the FGDs. Among these participants, 23 were human resources and facility managers (20 public and 3 private), 12 were general practitioners, 10 were municipality representatives, 4 were nurses, 3 were representatives of a professional association, 2 were representatives of medical colleges, and 2 were gynaecologists. Most of the participants actually hold several positions (for example, a specialist may also be the representative of municipality, academic staff, and the representative of professional organisation), and for the purpose of this report, they have been categorized according to the organisation which had been contacted and invited to participate in the FGD.

18. In total, 34 patients participated in FGDs – 13 males and 21 females. Thirteen participants were either patients or part of a risk group for cardiovascular diseases, 10 were cancer patients or part of a risk group for cancer (for example, elderly population who smoke and avoid screening), 7 suffered from a mental health issue, and 4 had received services for perinatal or maternal conditions.

19. Interview and discussion guidelines used for each target group are presented in Appendices 1-5. Despite the division of the FGDs into the separate topics of human resources and quality of care and access to services issues, participants in all groups inevitably brought up human resources as the most acute problem in Latvian healthcare. In some groups, participants argued that the discussion had focused on the wrong problems and had neglected the topic of human resources; there was a practical need to devote part to the time of these FGDs to this topic as well. As a result, some of the themes planned in the FGD guidelines were discussed in less detail.

20. Each FGD and in-depth interview was audio-recorded with the permission of participants to keep all information that was said. After the discussions and interviews, BISS transcribed audio-recordings in a way that preserved the anonymity of participants. For this reason, the full list of participants is not provided. The team leader and team members independently analysed the information provided, searching for common themes. Then the team reconciled and summarized findings from their separate analyses.

1. Human resources

21. This section discusses the main healthcare workforce bottlenecks, their causes, and current practices to reduce an impact of these obstacles. It is based on the views of HR managers, facility managers, and representatives of professional associations, who – it should be noted – are also doctors or teaching staff. As the result, it is hard to distinguish what kind of stakeholders' group each person represents. Thus, in this section, we refer to the type of discussion (human resources vs other) and interview (professional association) where the information has been obtained.

22. It is a wide spread opinion among all types of stakeholders that the main human resource problem is a shortage of healthcare personnel that has been caused by various reasons, including comparatively low remuneration of the healthcare workforce and attractive alternative employment in other related sectors or abroad. The perceived scope and causes of the problem are examined in Section 1.1.

23. HR managers also identified a lack of new entrants as a problem in the healthcare system of Latvia. In addition to a general shortage of medical personnel, another important factor identified by this group is the lack of a mechanism to compel currently practicing doctors to leave healthcare if their performance is not good enough or if they are of retirement age.

24. The shortage of healthcare personnel leads to increasing competition to attract workers, especially in the regions and rural areas. Strategies used by regional HR managers to cope with the problem are characterized in Section 1.2. While both financial and non-financial incentives are important for attracting and retaining a workforce, more attention has been devoted to financial incentives, which participants argue have had limited impact.

25. The shortage of healthcare personnel and dissatisfaction with remuneration have also contributed to the emergence of specific employment and remuneration patterns which include extended normal working hours of the medical workforce, multi-practice, outside employment, and some persistence of informal payments. These issues are examined in Section 1.3.

1.1. Shortage of healthcare personnel

26. Healthcare professionals and human resources (HR) managers have a common view that no human resource planning exists in the healthcare system of Latvia. The target group also thinks that the existing record-keeping system does not provide satisfactory information for the evaluation of shortages of healthcare personnel. Based on their observations of daily practice, a majority of HR managers, especially representatives of the Latvian regions, are convinced that the number of healthcare personnel is insufficient. This observation refers to all groups of professionals, encompassing doctors in a range of specialities as well as nurses and paramedics. To a lesser extent, the problem refers to general practitioners too. Although the problem is spread across all levels of healthcare – primary, secondary and tertiary – it is in local hospitals, especially in the eastern part of Latvia, where the shortages of healthcare personnel are considered the most severe.

27. HR managers and facility managers stress that there is a lack of specialists in particular spheres, including with regard to examinations, even though there is high quality modern

equipment obtained through European Structural Funds, which sometimes stands somewhere unpacked. Many interviewed managers of institutions and specialists admit that during the last twenty years a lot of money has been invested into technologies and infrastructure, but there are no people to work with this equipment. In other words, insufficient attention has been paid to human resources, while an excess of funds might have been allocated for buying certain medical equipment.

28. Some HR managers acknowledge that the total number of Latvian healthcare personnel might not be far behind the EU level. They consider that disparities between statistics and reality arise due to insufficient records of healthcare professionals. Although all healthcare professionals are registered in the Register of Medical Staff and Medical Support Staff (*Ārstniecības personu un ārstniecības atbalsta personu reģistrs*), doctors might be kept in the register even when they work abroad. This might happen for two reasons. First, doctors want to keep their re-certification that allows them to practise independently in Latvia. Second, an informal relationship with their previous workplace allows them to maintain formal employment status in Latvia (with a wage of 0 EUR). However, the information gathered in the study does not allow us to estimate how widespread this trend is.

29. From the discussions and interviews, four general trends were identified by participants as the reasons behind the shortage of healthcare personnel in Latvia that they have observed:

    (1) The migration of doctors from healthcare to the pharmacy industry in the 1990s and beginning of 2000s that caused a shortage of middle-aged staff;
    (2) Restrictions on services provided by certain specialities among doctors and nurses;
    (3) Opportunities to earn more while taking less responsibility in secondary out-patient healthcare created a shortage of specialists in hospitals;
    (4) Increasing migration among healthcare professionals, especially among the younger generation.

30. The following sub-sections explain three of the reasons mentioned above in more detail, namely, the restrictions on services provided by certain specialities of medical staff, opportunities to earn more in secondary out-patient care, and increasing migration among healthcare professionals.. The most discussed reason was opportunities to earn more by taking less responsibility in secondary out-patient care.

1.1.1. Specialization certificates

31. Restrictions on services provided by certain specialities result from the requirement stated by the Medical Treatment Law and respective regulations of the Cabinet of Ministers for a certificate that allows a healthcare professional to work independently in a particular field (for example, internist, cardiologist, vascular surgeon, psychiatrist, etc.) and a sub-field (for example, pneumologist for internists, child psychiatrist for psychiatrists). According to the regulations of the Cabinet of Ministers No.192 issued on 24 February 2009, there are 42 speciality fields in which doctors can be certified; for nurses, there are 10 fields. For doctors, the need to have proper certification limits the possibilities of their providing a service in another speciality. For instance, according to one of the interviews with a representative of a professional association, up to three years ago echocardiography was provided by cardiologists and radiologists. Afterwards, only cardiologists could provide this diagnostic service. As the number of cardiologists in Latvia is considered insufficient, the interviewee argued that the restriction limits accessibility to the diagnostics, especially in the regions. Other HR managers observe that this case is not the only example in the field of Latvian healthcare.

32. As a reaction to this example, two opinions exist among HR managers and healthcare practitioners. On one hand, healthcare professionals (mostly, senior members of professional associations working at university clinics) emphasise that restricting the duties of each doctor's speciality and introducing mutually exclusive duties can increase the quality of care. On the other hand, HR managers believe that restricting the number of competitors allows those doctors who have the proper certification to earn more and creates a shortage of professionals in this area, delaying diagnosis, treatment and a consequent loss in quality of life for patients.

33. According to the legislation, responsibility for the certification and re-certification of doctors (every five years) lies with the Latvian Doctors' Association (*Latvijas Ārstu biedrība*). Due to this, according to the HR managers, the Latvian government has no influence on changes of the rules regarding which specialists are allowed to provide particular kinds of diagnostics and treatment.

34. For nurses, the restriction on services provided by certain specialities limits their labour mobility. For example, an out-patient care nurse and a hospital nurse are different specialties, so if a nurse does not have both certificates, there are no opportunities to work in both fields (see Section 2 for more detail). To work in both types of care institutions, the nurse needs two certificates. In addition, nurses working in hospitals have their own specialties – for example, an operations nurse, surgery care nurse, mental healthcare nurse, oncology care nurse, and so on. As in the case of doctors, responsibility for nurses' certification and re-certification has been assigned to the Latvian Nurse Association (*Latvijas Māsu biedrība*). The need to be re-certified every five years through the fulfilment of certain training and work experience requirements is an expensive procedure for nurses who must fund the costs of re-certification from their earnings. The re-imbursement of these training costs is one of the incentives provided by employers to attract and retain their staff.

35. Representatives of several regional healthcare centres and hospitals emphasize that the restrictions on services provided by certain doctors' and nurses' specialties limit opportunities to provide the necessary personnel (that is, the number of specialists

required by regulations) and employ them flexibly. As regulations have stated the number and specialties of doctors for night duties, regional and local hospitals which lack doctors for several specialties may have a problem meeting these requirements. In cases like this, the managers of hospitals consider that substituting a doctor in a particular specialty with one with a related profession might be a solution, which is currently not allowed by law.

36. Obtaining additional specialisations can have significant costs. First, it requires a return to residency studies for up to six years irrespective of a doctor's existing specialties and practical experience. This follows the amendments in the regulations of Cabinet of Ministers No. 268 issued on 24 March 2009. Having experienced professionals returning to residencies also has another impact on healthcare: it decreases the number of state-funded places for young doctors.

37. HR managers also express a need for greater flexibility in certification. Hospitals may sometimes feel the need to increase the number of nurses in one section or another immediately – that is, to re-deploy nurses working in one section to fulfil duties in another if the workload in one area is high and low in the other. As working independently is allowed only for professionals having certificates in a particular field, this kind of flexible employment is impossible. Thus HR managers suggest making specialty groups broader given that the daily practice of hospitals needs to separate only some nurses' specialities (such as, re-animation and intensive care, anaesthesiology, obstetrics). When discussing this solution, HR managers did not indicate a need for additional training for nurses who they would flexibly deploy across different specialties.

1.1.2. Income inequality in different healthcare sectors

38. The problem of staff taking advantage of opportunities to earn more in secondary (mostly, private) out-patient healthcare with less responsibility than when employed in hospitals was emphasized by almost all HR managers, especially, management of hospitals and some representatives of professional associations. Doctors are considered to have more opportunities to do this compared to nurses. However, this also depends on doctors' specialties and whether there is demand or not for this specialty in out-patient healthcare, especially private care. The doctors with advantages in this regard are gynaecologists, psychiatrists, traumatologists, and other similar specialties. HR managers consider gynaecologists to be in a particularly good position as the state's compensation on pregnancy care can be considered competitive. Doctors working in intensive care and anaesthesia are considered by HR managers to be at a disadvantage.

39. HR managers admit that the reason for the attractiveness of secondary out-patient healthcare stems from differences in the compensation system and the workload in secondary and tertiary care. The basic compensation in tertiary care is a wage fixed by the regulations and budget of the hospital, while the wage from working in secondary care depends on the number of patients receiving consultations. As the average cost per consultation in private ambulatory care is around 30 EUR, specialists have the opportunity to earn more than working in tertiary care in a short period of time. In addition, compared with tertiary care, secondary care has a smaller workload as it does not require night duty. This might lead to a situation where doctors leave their job or reduce their workload in hospitals to part-time and earn most of their income in secondary care, including private healthcare (see Section 2 for more detail). As regional

hospitals have fewer staff and the loss of any employee has more impact, the lack of specialists for this reason is felt more there.

1.1.3. Migration among healthcare professionals

40. The problem of increasing migration among healthcare professionals, especially the younger generation, has been attributed to several push and pull factors. First, there is a gap between the remuneration of healthcare staff in Latvia and abroad. Other important pull factors, according to the view of young doctors and experience of their peers completing their residency training abroad, are a smaller workload; better working conditions in terms of infrastructure and equipment; the demand for specialists abroad; and highly active recruitment companies.

41. Some HR managers argue that another important push factor is the insufficient number of state funded residency positions in Latvia. HR managers emphasize that there are around 300 young doctor graduates each year in Latvia, but the state provides only around 200 state paid residency positions to enable student doctors to get the specialisation that would lead to certification and thus the opportunity to work independently. This means that 100 young doctors trained by national sources need to choose between privately paid residency and the same position abroad. HR managers argue that the number of state-funded residency places might actually be less than 200 because young doctors will compete with more experienced doctors to qualify for sub-specialities or related field specialities.

42. According to the experience of young doctors and nurses, companies recruiting healthcare staff for work abroad are experienced in the regulations and requirements of EU states and have developed specific recruitment strategies. Their work is for both groups of graduates: those who have state-funded residency places and those who do not. Young doctors have a clear vision of what should be done during their studies and how their career should be developed in other EU member states to get their ‘dream job’ abroad. The main decisions are taken when their residency studies reach the stage of final examinations and they receive their certificate. At this point several powerful factors support the idea of migration: comparing one’s own study experience with that of fellow students completing residency studies abroad and the advice of experienced senior staff urging them to move abroad because of the low wages of healthcare personnel in Latvia.

43. The main concern of HR managers in this regard is the waste of national budget resources to fund the studies of personnel who then move abroad as well as the loss of human resources in Latvia. Some HR managers propose several solutions for this problem. First, they advocate introducing more accurate human resource planning in healthcare and to remove the gap between the number of graduates of general medicine studies (300) and the number of residency study places (200). Second, they suggest offering additional grants for residency students motivated to migrate due to their low income level. Third, as an alternative, one HR manager believes that Latvia should introduce paid medical studies starting from the second or third year. In this case, if a graduate later choses to work in public healthcare, the state will pay their tuition fee credits for the period they remain in that job. However, the HR manager who has suggested this idea expects it to be rejected by the universities offering courses in medicine.

44. In addition to the reasons mentioned above, another reason offered for a shortage of healthcare personnel, especially of doctors, is the long period of studies that are concentrated in the capital Riga and the Riga region. Regional HR managers have a strong conviction that, upon finishing their studies, young doctors do not want to move to a regional practice for a range of reasons – for example, the wages are lower, the social and cultural environment outside Riga is considered less vibrant, they may have become involved in relationships. Regional hospitals are in a better situation than local hospitals as they can provide places for residency studies due to the availability of teaching staff and the variety of medical cases necessary for good quality training. However, the experience of regional HR managers suggests that the best take-up of training opportunities in the Latvian regions comes from students who are originally from those areas.

1.1.4. Obtaining qualification and its costs

45. HR managers, representatives of professional organizations, and specialists themselves consider that the level of qualification and the knowledge of healthcare personnel differ not only across the country but also across generations of staff. No common view could be reached on this particular issue. The main reason for this conclusion is the variety of motivation and experience among healthcare practitioners, as well as time-consuming daily routines that dull their attention. As representatives of professional associations admit, staff with higher levels of expertise should be concentrated in large healthcare centres (such as university clinics) which would allow observation of a wide variety of diseases, disorders and complications. However, this conclusion is the opposite to that of regional healthcare representatives, who emphasise the need to ensure that access to care is as close to patients as possible.

46. The need for healthcare staff to have certification and re-certification every five years (and the need for all healthcare staff whether certified or not to be registered) are considered by HR managers and healthcare practitioners as both a guarantee of continuing education and as business for health education providers. HR managers have several concerns regarding the training opportunities provided:
    (1) The training provided is mostly in Riga, so therefore regional healthcare personnel are a disadvantage – they need to spend more time attending training;
    (2) The quality of training differs and the rules for those taking part in training are different;
    (3) The costs of training are high, especially for nurses.

47. With regard to the first concern – the accessibility of training – few HR managers suggest increasing the use of ICT and developing an e-learning approach, such as online lectures or video conferences. This approach might have several advantages. First, it allows time and money to be saved, and second, it might provide higher quality lectures without a limit on the number of students. The second advantage is also linked with the second concern mentioned above. In general, most HR managers and representatives of professional associations consider that each topic covered in training should be repeated after a period of time so no one topic is covered more than others. With regard to the aim of reducing the impact of the four dominant diseases and conditions (that is, cardiovascular diseases, cancers, mental health problems, and perinatal and maternal

conditions), the general advice from professional association representatives is to analyse the reasons for delayed diagnosis during training lectures for family doctors.

48. For nurses, college level education is possible not only in Riga but also at regional branches of national colleges such as in Liepāja, in the western part of the country, and at Daugavpils Medical College in the east. However, getting a specialisation certificate after graduating requires studies that are available only in the Riga region. Thus continuing the studies needed to get a nursing certificate involves regular travel and accommodation in Riga. As regional HR managers admit, this requires time and money that is not usually within the reach of the average nursing student.

49. Regarding the accessibility of training in regions, some regional HR managers refer to their experience during the previous programming period funded by the EU (2007-2013). At that time nurse training was funded by the ESF (European Social Fund). Although the funds were intended to provide training, there were still shortcomings. There was insufficient information about who would be eligible and also whether the training would lead to certification. Only medical colleges in Riga were able to provide training paid for by the ESF. Because getting to Riga for training is difficult for many healthcare staff, regional medical colleges wanted to take part in the scheme and provide this training as well.

50. Concerns over the high costs of training are tackled in part by some healthcare institutions (mainly hospitals, including both regional and local facilities) that provide some financial support for their staff. The amount and regularity of this support has not been established precisely within the study. HR managers, who have provided financial support, emphasise that it depends on each particular situation and the need for training, type of staff, duration of contracts, opportunities for employment and so on. However, this kind of support is considered an incentive offered to staff when the employer cannot increase wages.

1.1.5. Labour market entry restrictions

51. HR managers and representatives of professional associations argue that a lack of new entrants in the healthcare sector in Latvia is a problem. The cities where universities and medical colleges are located have an advantage over the rest of the country. Riga city offers all kind of medical specialities. For nursing, Liepaja and Daugavpils have advantages since regional medical colleges are located there.

52. This problem of entry in Latvian healthcare is double-sided. On the one hand, young doctors do not want to move away from Riga city. In these cases, almost all regional HR managers and representatives of municipalities acknowledge that they are happy if older healthcare staff are willing to continue working. However, this means that some segments of healthcare personnel, especially in the regions, are at pre-retirement or even post-retirement age. Some staff are more than 70 years old.

53. On the other hand, some HR managers admit that in the case of doctors with particular specialties, including family doctors, there are obstacles to entering the healthcare labour market, including:

(1) A lack of a mechanism to compel currently practicing doctors to leave healthcare if their performance is not good enough or they are at retirement age, which ties up the already limited number of positions;
(2) The restricted number of residency places for other specialties if the relevant professional association wants to limit the number of providers of this service, thus creating high demand for these professionals.

54. The first problem – the lack of mechanisms for getting rid of poorly performing doctors – stems from everyday working practice. With reference to this problem, HR managers and representatives of professional associations who refer to this problem emphasise that the opportunity for young doctors to enter the labour market is provided by contracts with the National Health Service (NHS). They describe the way that system works as follows: young doctors can enter the labour market if they have direct or indirect contracts (through their workplace) with the NHS. However, the NHS has a limited number of contracts for healthcare service provision according to the number of inhabitants in certain areas. As long as elderly doctors have contracts with the NHS, the younger ones cannot enter the labour market. As contracts with the NHS tend to last for periods of a year or slightly longer, then theoretically there are opportunities to terminate contracts with doctors who are too old or fail to meet the required standards. However, in the reality of daily practice, HR managers emphasise that this does not happen.

55. According to HR managers, who have described the problem mentioned above, the reason why the NHS continues to sign contracts with poorly-performing doctors is that they have valid certificates. As healthcare staff need to pass re-certification every five years, this process is considered proof of conformity to the requirements and good performance in practice. However, HR managers, who have highlighted the problem, have noticed that the requirements established for the passing of re-certification differ from one professional association to another. According to the observations of HR managers, some associations (including that of family doctors) allow re-certification based only on the argument that the physician is a 'person of stature.' This allows poorly-performing individuals to keep their certificate as well. In these cases, HR managers think that the withdrawal of the certificate is possible only in cases of very serious misconduct. To counteract this problem and to facilitate entry of younger, more recently trained physicians, HR managers admit that currently the only way for doing that is by reaching an agreement with a doctor – involving the payment of some form of compensation – that they will leave a workplace and relinquish their contract with the NHS voluntarily.

56. Additional problems arise with family doctors. First, there is a gap in regulations that prescribes how to deal with patient documentation when a GP surgery is closed and how to access (or deliver) documentation for the patient when a new doctor begins work. This problem might be solved by inheritance of a GP practice that is yet to be a developed practice in Latvia.

57. Another problem for new family doctors arises due to the requirement of regulations to achieve at least 600 registered patients during the first six months of having a contract with the NHS. HR managers and family doctors admit – and it is corroborated by findings from focus group discussions with patients – that achieving the required number of registered patients is challenging when first entering the healthcare field. The main reasons for this are the prejudices of patients towards young doctors, who are, because of their age, considered inexperienced and – more generally – the rather low attendance

levels at family physicians. This means that a young doctor needs to actively seek out patients and convince them to register with them.

58. A third issue thwarting natural turnover of family doctors is their legal status. As most GPs have self-employed status, the law allows them to make minimum social insurance contributions. HR managers admit that family physicians have used this opportunity over a long period of time. As a result, when they come to retire, they will have small pensions and thus experience a significant reduction in their income. HR managers consider that it is one reason why family physicians do not want to retire or support the adoption of regulations that allow GP practices to be bought and sold. However, one HR manager cautions against permitting the sale of GP practices which have been equipped through the use of public funds and considering all the patient documentation as property belonging to a practice. The only argument for allowing this might be if the GPs are registered as limited liability companies which would then mean they would have to comply with all the regulations regarding taxation.

59. One proposal for facilitating labour market entry of young doctors made by some HR managers and representatives of professional associations is setting limits on the upper age at which medical staff can have contracts with the NHS. They would prefer this to be 65 years, as that is expected to be the future retirement age in Latvia. This limitation might apply only to employment in the public healthcare system and not to employment in private healthcare or as a private consultant, as the rules of competition will determine the real value of each professional. Limiting the opportunities for employment in public healthcare, however, might raise objections if there are no other professionals in a given specialty in a particular area or region. However, this study also shows that Latvian healthcare sector has not reached internal agreement how to deal with obstacles of labour market entry. Thus, other HR managers and representatives of other professional associations could reject such an idea.

1.2. Current recruitment and retention strategies

60. According to HR managers, labour turnover in Latvia's healthcare sector differs, depending on the type of personnel, specialty, and region. As family doctors mostly have their own practices, they usually rent facilities within larger healthcare centres. HR managers and family doctors have observed that since family doctors have contracts with the NHS, their labour turnover is low. Other doctors within particular specialties mostly have employee contracts with healthcare centres. Nurses are usually employees of family doctors or healthcare centres. However, family doctors sometimes urge nurses to register as self-employed to avoid social contribution payments (see more on this issue below). The highest labour turnover is among nurses. HR managers have observed that the flow of the labour force in Latvian healthcare moves from the public sector to the private sector and from the private sector to other countries. Another flow might be from small locations to either regional centres or to Riga. HR managers link labour turnover in healthcare mainly with low pay.

61. When recruiting doctors, HR managers usually use two approaches. First, young doctors are recruited during their residency studies. For this reason, besides university clinics, the larger healthcare centres have engaged in the training of residents. They also have close co-operation with universities providing medical education which promote them as potential employers. Second, if a doctor has a particular professional reputation, HR

managers might negotiate an individual contract with them to offer attractive terms and thus secure their services. In the case of nurses, most staff are found through the social network of nurses themselves. In most cases, HR managers do not consider professional associations or trade unions to be important sources for recruiting healthcare staff.

62. Regional hospitals are more active in the recruitment of personnel, especially doctors. This is caused by staff shortages and the simultaneous requirements of regulations to fulfil definite standards on the minimum number and range of specialties that have to be available around the clock at every type of healthcare unit. Regional outpatient care institutions are less active in staff recruitment. This is due to less pressure on requirements and the greater availability of doctors in private care work. The managers of regional outpatient care institutions indicate that doctors with particular specialties are ready to travel long distances for private sector work.

63. In general, a large share of HR managers indicates that the main problem is attracting doctors to work in public secondary outpatient care and hospitals since, compared to the opportunities to work in private care, this type of work is very low paid. According to the managers of healthcare institutions, motivating doctors to work in public care needs to come from other attractive factors. Mostly, managers provide opportunities to work in private healthcare. Other motivators might be the good reputation of the healthcare centre, comfortable facilities, new and up-to-date equipment, and permission to select patients for clinical studies and to train young doctors in the employer's facilities. HR managers admit that if doctors of particular specialties are urgently needed, paying above the usual rates might be considered. This approach is a particular characteristic of regional hospitals. To ensure the fulfilment of care level requirements, they might to offer high pay for night duty to motivate doctors from Riga or other regions to travel a long distance there. As this approach has an impact on hospital budgets, it is usual to ask for national budget amendments in the middle of the year.

64. The experience of HR managers indicates that attracting young healthcare staff to areas outside Riga needs a lot of effort. There has been more success with attempts to attract young doctors back to the regions and rural areas where they were born or had lived previously. If the municipality makes an offer both to a doctor and their spouse (especially when the spouse is also a healthcare worker), this might also have good results. The experience of regional hospitals shows the important role the timing of the offer has, as doctors are more open to moving to another place during residency studies.

65. To be attractive, the offer should include both financial and non-financial perspectives, including the promotion in person of both aspects. Financial perspectives include scholarships and sometimes living accommodations provided by municipalities. In the case of family doctors, it might include support to establish a surgery and facilities and equipment desired by the doctor. Non-financial perspectives include municipal services (for example, kindergartens and schools), the work environment (facilities, equipment), and activity in social and cultural life. The application of all these incentives differs among municipalities. The broader opportunities come from the larger municipalities (in regional cities) as they have better developed social infrastructure and more financial resources. Rural areas, especially in the eastern part of the country, have limited opportunities to provide more than financial incentives. In addition, the support provided by municipalities may differ considerably from the expectations of a young doctor.

66. One of the problems that hinder recruitment of the new specialists outside Riga is housing. Good private apartments and private houses are very expensive, and hardly anyone can afford them. The rental market is undeveloped in Latvia, and available options also are very expensive, but municipality apartments are available only to particular groups in a very limited amount with long waiting lists. Healthcare institutions have no resources to help to solve the housing problem of new specialists, and everything depends on the interest of the municipality to support and attract the specialist to the particular territory, although municipalities also have limited housing funds.

67. While EU funding has enabled ageing hospitals in the regions to be renovated and repaired and new facilities for hospitals to be built, there are certain essential spheres in which a sense of 'under-development' remains. Senior doctors may be less knowledgeable than their counterparts in Riga; certain treatment methods may be less developed; the medicine may be old fashioned, and long-serving staff in the regions may not be as open to accepting new ideas and methods. Management styles and relationships with colleagues might also be problematic (to be discussed in more detail later).

68. Some HR managers and representatives of professional associations have observed that in the regions, doctors get training faster. This is because the rate at which resident doctors can care for patients differs between Riga and Latvian regions. Due to the breadth of work and shortage of personnel, resident doctors in the regions start to work independently more quickly than in Riga. In the regions student doctors get hands-on practical knowledge faster, while in Riga they may only observe the process of treatment and start work with patients later. This hands-on exposure to medical practice – along with the new and renovated facilities – is considered one of the advantages to working in the regions.

69. At the workplace, the management style and relationships with colleagues might have a higher importance for the younger generation of healthcare staff than financial incentives. Information obtained in the study shows that management style and relationships among colleagues are not factors considered important by most managers of public healthcare institutions. However, due to these reasons, the existing incentives for practicing in regions and especially in rural areas might have limited impact. In addition, during residency studies, young doctors are attracted by being close to their professor. Having practical residency studies in a regional hospital and having to go to Riga for theoretical studies is considered an obstacle for some young doctors.

70. As most local healthcare centres do not provide residency studies and scholarships do not require that young doctors move to a rural area, many HR managers support a system that existed in Soviet times. The idea is that after residency studies all young doctors are appointed to work in particular areas. This allows doctors to be sent to rural and remote areas according to national need. However, this approach contradicts certain principles of democracy, and some HR managers prefer alternative solutions which includes the introduction of paid medical studies.

71. One HR manager proposes that one solution might be financial support across the country, which would include relocation grants for doctors moving to remote or rural areas and their family members (in decreasing amounts for the latter) and compensation for the rent paid on their apartment rent for several years. Some other rules would need to be introduced in this situation. First, the support should be for almost all doctor

specialties without restricting the list to just the four priority areas. As the HR manager emphasises, oncologic diseases might not be diagnosed promptly if there are no other experienced specialists in the area. In some cases, they may be the first to identify particular disorders (for example, a urologist, pulmonologist or radiologist). Second, the farther away from Riga the doctor is required to move, the higher the grant for moving should be. The main idea behind this proposal is to encourage healthcare staff, doctors and nurses to move to more remote areas. In this case, an additional clause might be introduced so that higher compensation is paid to doctors who move to less populated areas.

1.3. Employment and remuneration patterns

72. The shortage of healthcare personnel and reasons characterized in Section 1.1 lead to emerging of specific employment and remuneration patterns which include extended normal working hours of medical workforce, multi-practice and outside employment and some persistence of informal payments. Another acute problem that stems from holding multiple jobs is fatigue and burn-out of doctors, and all target groups of the study (including patients) stress that the doctors have overworked themselves. These patterns are reviewed in the following sub-sections.

1.3.1. Extended working hours

73. With regard to the workload of healthcare staff, HR managers consider that, first and foremost, the system must meet specific clauses stated by the Medical Treatment Law. According to Section 53^1 of the Law, an extension to the normal working hours of a medical practitioner may be applied which exceeds the normal working hours specified in the national Labour Law. In order to ensure access to medical treatment, a healthcare institution can increase the hours staff work, but they may not exceed 60 hours per week and 240 hours per month. However, HR managers admit this clause refers only to the workload at the same healthcare institution and does not apply to other places healthcare staff work. According to experienced HR managers, the clause was introduced to avoid paying ‘double time’ for overtime work as stated by the Labour Law. This allows healthcare institutions to make budget savings. To work more hours than stated in the Medical Treatment Law, healthcare personnel need to find another workplace.

1.3.2. Multi-practice and outside employment

74. HR managers have seen various forms of ‘outside jobs’ performed by healthcare staff. However, these outside jobs are usually found within the health system. The greatest variety is among specialists who normally have two or three workplaces, while nurses and family doctors have fewer. Some diagnosticians may have more workplaces if they are paid according the number of diagnoses they prepare.

75. The most usual practices of employment for specialists are as follows:
    (1) Working in several outpatient care institutions;
    (2) Working more than full-time hours at the same workplace;
    (3) Working in hospital and outpatient care (within the same hospital or outside);

(4) Working in a healthcare institution and engaging in other healthcare-related activities (e.g. clinical studies, training of students, health promotion units of municipalities etc.).

76. Usually, outside work is located quite close to the first workplace, in the same city or at facilities nearby. It is more complicated in Riga where movement from one place to another might take some time. However some specialists, mostly regional, might travel long distances (up to 200 km) for outside work.

77. For all the types of workplaces mentioned above, cross-sectoral movements apply as well. This means that the work involved could be at both public and private institutions. It also means that a specialist might take several duties simultaneously, for example, having a 24-hour duty and outpatient care consultancy in another branch of the same institution, while being paid for both duties. In cases of combined work in hospital and outpatient care, the most usual spread of work is hospital duty during normal working hours and then evening consultations in outpatient care institutions.

78. With regard to work in several outpatient care institutions, some HR managers admit that it results from poor allocation of public service funding (in everyday conversation called 'quotas') for each institution. On the one hand, this approach increases the geographical accessibility of healthcare. On the other hand, from the perspective of specialists, this increases the mobility of doctors and the need for them to have several workplaces in order to reach an acceptable wage level.

79. HR managers, facility managers and representatives of some professional associations consider that family doctors are better paid compared to other specialists. However, it is also a common view among different healthcare professionals that family doctors are overworked due to the large number of patients that they have. According to a view commonly held by a range of experts, a family doctor might have a comfortable wage if they have a wide practice (that is, with more than 2,000 patients). However, serving such a wide practice leads to overwork and lowers their attention to health prevention issues. Due to having these large practices, family doctors seldom have outside work. Some provide related services, for example, working as an occupational health specialist, for medical commissions, at emergency aid services, or at accident and emergency branches at hospitals.

80. With regard to nurses, a majority of HR managers say that due to their specialties in out-patient and hospital care, nurses have lower cross-sectoral mobility opportunities. Consequently, if nurses want to earn more, they need to have several specialties. According to examples provided by HR managers, different professional associations and nurses themselves, outpatient care nurses usually have outside work in schools, kindergartens, and sporting venues where having medical staff in attendance is required. If they have a particular side specialty, nurses might get night duty in hospitals. Nurses who have a hospital nurse specialty usually work 24-hour duties in several hospitals as this type of work is paid more. According to the experience of HR managers, the most intensive work involves nurses working in surgery, anaesthesia, and intensive therapy. As the pay is not enough, they also try to find another job in less intensive branches or in private hospitals.

1.3.3. Remuneration trends

81. As with the various types of outside work, the pay structure also differs between healthcare systems. A summary of all examples provided by HR managers suggests that pay structure depends on the type of care (outpatient vs. hospital), the specialties (family doctors vs. other specialists, and across different types of specialties), between capital source (public vs. private) and management style (whether incentives are included in the pay structure). What is common to all grades and specialties of healthcare staff is that they refer mainly to financial incentives as the most crucial – and insufficient – component of their compensation.

82. In hospitals, the main basis of pay is a fixed wage for each staffing area. Extra pay is offered for a degree, for management or administrative duties, night duty, and hazardous duties.[1] In outpatient care, wages depend on the number of patients having consultations. However pay does not depend on the length of consultations, which might vary from five minutes to much longer. According to experience of representatives of all target groups working in healthcare, the usual doctor's consultation in the public care system is 15 to 20 minutes per patient. The share of the fee which staff receive from every patient seen in private outpatient care also varies among healthcare institutions. According to the views of some HR managers and representatives of professional associations, this might be a reason for doctors to establish their own private practice or take undeclared payments from patients.

83. Some public and private healthcare institutions have introduced more generous compensation systems, which award all types of medical staff and make additional payments for every extra manipulation or duty. These compensation systems depend on opportunities of an institution to offer extra services in the private healthcare sector. Public healthcare centres aim to balance their budget and offer competitive remuneration for specialists by providing both state-funded healthcare services and paid services. For example, paediatric dentistry is a state-funded healthcare service that is subsidized by other dentistry-related services that charge patients.

84. As most family doctors are self-employed, their income involves declaring "what's left after paying all the bills" instead of a fixed wage. However HR managers, fellow professionals, and some family doctors admit that GPs are better paid in comparison with their colleagues in other healthcare sectors. Public funding for family doctors includes pay for every additional manipulation, nurse, and, in the case of larger practices, a second nurse, a receptionist, and also money to cover maintenance of a surgery. By comparison, according to HR managers, compensation for a nurse, receptionist, and the costs of maintenance of the surgery is not included in the existing budgets of secondary outpatient care.

85. In general, the lowest range of pay for healthcare staff working in public hospitals and outpatient care institutions is stated by the regulations of the Cabinet of Ministers No. 595 issued on 29 June 2010. Managers of healthcare institutions set the wage of each staff

[1] Hazardous duties include treatment of AIDS patients, mental patients, alcoholics and drug addicts, infections, and tuberculosis patients; and work in radiology, X-ray, and burn treatment units. The regulations of Cabinet of Ministers No. 595 issued on 29 June 2010 "Regulations on the lowest monthly wage and specific payments for healthcare personnel" (Noteikumi par zemāko mēnešalgu un speciālo piemaksu ārstniecības personām). Available: http://likumi.lv/doc.php?id=212565

category based on the institution's budget and the minimum requirements set by the regulations. When criticising government policy regarding HR in healthcare, medical workers and HR managers emphasise that the minimum pay requirements are too low and do not correspond to the real value of human capital. One example often cited is that the average wage of a doctor working full-time is around 600 EUR gross a month. According to the regulations, the wage of doctors working full-time without any additional payment falls in a range between 529 and 737 EUR gross per month. The wage of young doctors studying during their residency varies between 421 and 529 EUR gross. Nurses' wages fall in a range between 370 and 737 EUR gross per month depending on their level of education, their degree, and their certification[2].

86. HR experts admit that the differences between the wages of various types of healthcare staff are comparatively small. In addition, when the national minimum wage is increased, the wages of the lowest paid healthcare staff also increase, while the wages of other positions remain approximately the same, which effectively closes the gaps in their compensation. As there are significant differences in the length of education required and the responsibilities of positions, HR managers want to see greater variation and dynamics in the wages of the various types of healthcare personnel.

87. Furthermore, the application of the rules mentioned above differs. In local and (some) regional public healthcare institutions, staff pay is set according to the lowest range of wages. University clinics and larger healthcare institutions have greater opportunities to increase wages above minimum requirements. This depends on the possibilities to participate in and earn income from providing other services (including private healthcare). However, most of the funding allocated to the managers of public healthcare institutions is channelled into staff wages and, as a result, the funding for maintaining and buying new equipment and purchasing medicines is not sufficient.

88. The state funding allocated to each healthcare institution depends on the tariffs for each type of care and the number of patients forecast within a year (known as 'quotas'). The managers of public healthcare institutions emphasise that the tariffs used for accounting in Latvian healthcare were developed more than 15 years ago and do not reflect the real costs of maintenance of facilities, equipment, and personnel. The only exception is in the tariffs for gynaecology consultations and treatment which were increased three times under Minister Ingrida Circene (a gynaecologist by specialty) several years ago. Currently (along with this study), a new accounting system based on diagnosis is being introduced. However, no particular results or comments regarding payments under the new system are available.

1.3.4. Informal payments

89. Two of the HR managers interviewed and the experience of patients emerging from the focus group discussions indicate that a 'shadow economy' persists in the Latvian healthcare system. As there is considerable variation in opinion and information is fragmentary, the information gathered cannot be a reliable basis for making any generalisations about the scale, spread, and amount of 'informal payments'. The only

[2] The regulations of Cabinet of Ministers No. 595 issued on 29 June 2010 "Regulations on the lowest monthly wage and specific payments for healthcare personnel" (Noteikumi par zemāko mēnešalgu un speciālo piemaksu ārstniecības personām). Available: http://likumi.lv/doc.php?id=212565

observation HR managers made is that the public healthcare shadow economy seems to be more widespread the closer a patient gets to Riga. Patients report various experiences starting from refusals to accept an informal payment up to an established system to prompt patients to make informal payments. However, patients are very cautious when speaking about informal payments; thus it is hard to collect reliable examples. The information gathered from HR managers and patients suggests that informal payments may take place in both public and private care, as well as outpatient care (including GPs) and hospitals. HR managers who have mentioned this problem admit that senior managers at public hospitals may not be aware of the existence of informal payments – or try not to be. This strategy of ignoring the issue is caused by the need to offer a living wage and retain healthcare staff with limited means.

90. In general, the shadow economy in Latvian healthcare operates in the following ways:
    (1) Patients make an informal payment to a doctor who allocates part of the sum to nurses and other staff;
    (2) Patients do not receive a check or receipt regarding a payment to the doctor for that visit or treatment (a technique widespread especially among small practices);
    (3) Undeclared tips.

91. With regard to the second method mentioned above – avoiding the issue of a check or receipt – HR managers believe that the introduction of an e-health system could help combat the scale of the shadow economy. Their experience shows that recording the patient twice – in the cash register and also the electronic patient documentation system (instead of a paper system) – is a good opportunity to control and compare patient flow.

1.4. Recommendations

Perspective of study participants

92. According to study participants, the most important problem that needs an immediate solution is recruitment of physicians in regions, especially, family doctors in rural areas. As this problem is perceived as acute, measures applied to tackle it should include both short and medium term solutions (for example, support relocation of doctors already having practice rights and support to residency students). Although many HR and facility managers support a system that existed in Soviet times (appointment of doctor to work in particular area after residency studies), this approach contradicts principles of modern governance. As two alternatives suggested by a few HR that might not be acceptable to some stakeholders are the introduction of paid medical studies and the introduction of relocation grants for doctors moving to remote or rural areas and their family members. In the case of the first solution, the state would pay tuition fee credits of graduates for the period they choose and remain to work in public healthcare. In case of the second solution, relocation grants and compensation for the rent paid on their apartment would be provided for doctors moving to remote or rural areas and their family members (in decreasing amounts for the latter).

93. The second important problem in human resources identified by study participants is low labour market entry of young doctors. One potentially polarizing solution proposed by some HR managers and representatives of professional associations is limiting the upper age at which medical staff can have contracts with the NHS (to 65 years). This limitation

might apply only to employment in the public healthcare system (that is, having contracts with the NHS). Limiting the opportunities for employment in public healthcare, however, might raise objections if there are no other professionals in a given specialty in a particular area or region.

Researcher perspective

94. The study indicates a necessity to develop more comprehensive HR planning in Latvian healthcare sector. First, there is a need for continuous evaluation and forecasts of the shortage of healthcare personnel and for disaggregation by age, specialty and region, calculated at least for the next 10 years. Second, according to the results of this evaluation and forecasting, a national human development plan has to be developed.

95. It is also important that policy measures tackle the most acute problems in the recruitment and retention of human resources, especially the retention of the young generation in Latvia. It is also important that policy measures refer to all types and specialties of healthcare personnel as previous experience (for example, of increasing remuneration for pregnancy care) creates concentration of staff in particular, better paid fields.

96. Third, to address acute shortages of healthcare personnel and limitations of municipalities to provide financial support to facilitate relocation of staff, a national level support policy should be introduced in this regard. Recommendations provided by the study participants should be evaluated and discussed with stakeholders.

2. Access to care

97. The FGDs and interviews suggest that access to healthcare is Latvia is severely limited – first, by the quota system of state-funded healthcare services in particular areas and long waiting lists; second, by an uneven distribution of state-funded healthcare services in the regions; third, by insufficient financial means of patients to pay for private services and pay the cost of transport; and fourth, by a custom in many healthcare institutions that requires informal payments from patients. This chapter describes these problems and reveals opinions of different stakeholders, including general practitioners, specialists, representatives of professional associations, and managers of healthcare institutions. However, the main group whose opinion has been considered here are patients, especially in analysing strategies that they must employ to get necessary healthcare services in a timely manner.

2.1. Wait lists

98. Cardiovascular diseases and oncological diseases are the top priority health areas for healthcare specialists who see major problems in the availability of both state-funded and private healthcare services in Riga and the Latvian regions.

99. Healthcare specialists point out that there are long waiting lists due to a lack of specialists not only for the state-funded examinations and consultations of cardiologists for patients with cardiovascular diseases (including children), but also for private healthcare services. One of the patient organisations interviewed also drew attention to the long waiting lists for post-stroke rehabilitation services. Following a stroke experience, patients have to wait several weeks – and in some cases up to one month – for these services if paid for from their personal funds and 2 to 3 months or more for state funding.

100. When explaining the availability of healthcare services within oncology, the representative of the professional association distinguishes three types of treatment and their different availability: "*Of course, most patients are treated surgically. In my opinion, there are no problems with surgery. All of them get operations within a period of four weeks. That's also a standard in the West. In my opinion, that covers 100% of patients. I think that with individual localisations – breast or something else – they may even have the operation within two weeks. What a very good progress! There are problems with other services though. Radiotherapy is sometimes delayed due to an insufficient number of medical physicists or a lack of staff capable of physically performing it. It seems to me that the saddest situation is with the systemic therapy, with chemotherapy. The problem there is not even the lack of doctors but the lack of paramedic personnel and nursing staff. (..) To my mind, if the reality of the situation that currently exists in chemotherapy is that patients have to wait more than a month or even six weeks for the regular chemotherapy cycle, then that really is not normal. It then calls into question the point of giving such therapy.*"

101. Several healthcare specialists welcome the introduction of the so-called 'green corridor' for patients suspected of having a cancer by state-funded cancer screenings. In these cases patients are entitled to see a specialist for additional examinations as soon as possible. However, according to healthcare specialists and the representative of the professional association, the principle of the 'green corridor' should be applied to every

patient when a doctor's suspicions that they have a tumour have been established. In this way the diagnosis can be confirmed as soon as possible to allow treatment to start.

102. There are significantly lower numbers of both patients and healthcare specialists within the focus group discussions and interviews who complained about the availability of specialists and examinations within gynaecology and psychiatry. Many gynaecologists see both private and state-funded patients, but then state-funded patients have to wait several weeks - and at some institutions several months - for services while private services are often available the next day. Following an assessment of the availability of psychiatric services, the representative of the professional association admits that it is possible to get an appointment with a specialist in Riga within one, two or three days. That, according to him, is a good standard of service. However, it must be noted that psychotherapy, for example, is not a state-funded service.

103. Other fields listed by healthcare specialists, where patients face long waits for examinations, include traumatology and orthopaedics. However, patients indicate that it is necessary to wait for several months to get an appointment with a neurologist and a physiotherapist for children and also for examinations such as computed tomography, electroencephalogram, and magnetic resonance. Patients also say the waiting time for eye surgery can be between two and four years.

104. However, the long waiting lists for these and other examinations are only for state-funded healthcare services. Private services and examinations can be accessed quickly. Patients who cannot wait due to illness for state-funded services, or can pay themselves, use the private services. Patients also say there are specialists, who only provide private services.

105. For the majority of patients, however, lack of money is an obstacle to visit a specialist or get examination at their own expense, as they can cost up to 100 – 200 Euros. Patients in the regions often have problems accessing state-funded healthcare, mainly because they live too far away from their healthcare centres, and they have to pay the cost of transport (see the subsequent sub-section on Geographical variation). Members of focus groups formed of specialists and residents in the regions, as well as representatives of patient organisations, admitted that people do not have the money for private healthcare. If they have to choose between buying food or having health tests or examinations for themselves or their children, or buying medicines, they would choose buying food. Patients acknowledge that needing expensive healthcare services *"causes additional stress and reflection about whether I can afford to visit a doctor. But I understand that I have to afford it, because otherwise I may remain lying in this bed. Such a situation puts you in a dilemma, makes you almost helpless. It all plays on your nerves so nicely. (..) Then you have to choose [between paying for health care, eating or paying rent], I think it drives sick people even deeper into despair and if patients are stressed then all the diseases, plus all the ones that could have been stopped, come out.*"

106. As a result the availability of healthcare services is affected both by long waiting lists and a lack of money. The representatives of professional associations and the managers of healthcare institutions stress that state-funded services in healthcare centres in many cases are provided only because they provide also private services, by means of which the state-funded healthcare services are being co-financed. This, to them, clearly reveals the underfunding of healthcare in Latvia.

107. If the patients cannot access healthcare services quickly, then additional complications may result, such as diseases that 'are being neglected' and the treatment that becomes both longer and more expensive. In the case of young children it is even more critical to act quickly, because children grow and normal development may be hindered due to health problems.

2.2. Informal payments

108. In order for patients to get the medical services they need they are sometimes forced to pay extra money to the doctors. This trend is acknowledged both by the patients and the specialists involved in healthcare. This issue of informal payments was naturally a sensitive one, and participants of the discussions talked very little on this issue. The topic surfaced slightly more often in the interviews, because respondents in a conversational one-to-one situation probably felt freer to express themselves on the issue.

109. In most cases these informal payments are 'compulsory' in a sense, since without them, the patients do not receive treatment. However there are also patients who will voluntarily pay more to their doctor because they consider that then they will get a better service and more attention from the doctor.

110. These 'compulsory' payments are already an expected part of the system in many healthcare institutions, and the money received from the patients is split between the medical personnel involved. Respondents admit that this practice is especially popular within oncology, where doctors have low salaries and patients are asked for extra payments. Some participants suggested that there are also healthcare institutions or specialists (for example, gynaecologists and dentists), who do not take extra money from the patients but rather do not issue receipts for the services rendered in case of private services to avoid paying taxes. Interviews with specialists and patients suggest that also some GPs do not issue receipts for all visits in order to lessen their tax obligations.

111. Patients who have come across these 'compulsory' payments consider that this system is not fair, because not all the patients can afford to pay for services. It also places patients in an awkward situation of not knowing when to pay, whom to pay, or how this illegal payment should be made.

2.3. Geographic variation

112. Accessing healthcare services for patients living both in larger and smaller municipalities in different Latvian regions is hindered by the uneven distribution of services in the regions and of options to get to the closest place where these services are being provided. For example, patients from municipalities around Liepaja have to travel to Liepaja, Kuldiga or Riga to visit specialists, but inhabitants of Rezekne and healthcare specialists report that to access specialists and diagnostics, patients from their region travel to Ludza, Preili, Madona, Valmiera, Daugavpils and Riga. There are also patients and healthcare specialists who live in Liepaja and Rezekne or in their neighbourhood who report that there are specialists or diagnostics that can be found only in Riga. The distance from Liepaja to Riga is approximately 220 km, while from Rezekne to Riga, it is 240 km.

113. In order to improve access to various specialists for their residents, individual municipalities make arrangements so that various specialists – surgeon, psychiatrist,

endocrinologist, ophthalmologists and others - visit them on regular basis, for example, once a week or once a month. Municipalities also organize mobile teams of various specialists from Riga health centres and Children's Clinical University Hospital that provide state-funded healthcare services. Municipal specialists from Liepaja and its surroundings give mobile mammography and dental hygiene services as an example and greatly appreciate services of cardiologist and ophthalmologists for children that allow them to obtain high quality examinations that the parents cannot provide otherwise. Also municipalities from around Valmiera have a similar experience, as they also attract mobile mammography and mobile teams of various specialists from Children's Clinical University Hospital. However, people from Rezekne complain that such mobile teams do not visit their municipalities, while, in their opinion, it would improve access for people of many municipalities to various specialists. This points to the fact that availability of healthcare services depends on the initiative of municipalities and their opportunities to provide the necessary services to their people.

114. Representatives of almost all municipalities also complained about the lack of general practitioners in many municipalities and the ageing of practicing physicians. Thereby healthcare specialists welcome the operation of paramedical stations, where patients can obtain basic healthcare services such as, injections and prescriptions for medicines.

115. The viewpoint of healthcare specialists differs regarding the availability of specialists and examinations in the regions in priority health areas. For example, some healthcare specialists and representatives of patient organizations believe that oncologists should be more accessible outside of Riga – for example, in the regional hospitals, where consultations of specialists and simpler procedures could be provided – but the representative of the professional association considers that the services should be concentrated in a single place, in order for them to have adequate quality. At the moment certain services within the field of oncology are available also in the regions, for example, in Daugavpils, where, according to both the patients and healthcare specialists, these services can be obtained even sooner than in Riga; however, there are examinations and procedures that can be performed only in Riga hospitals. For example, patients have to travel to Riga from different places in Latvia for radiotherapy. Since these procedures have to be carried out on regular basis and patients experience various adverse side effects during these procedures, these travels become both physically and emotionally hard on the patients.

116. Opinions of the respondents on the availability of the specialists in the regions differ also in the field of psychiatry. Healthcare specialists and representatives of the patient organizations consider that availability of specialists in the regions are not sufficient, but according to the representative of the professional associations, the arrangement of the practices of the specialists with minor exceptions is good.

117. Similar to the view that was expressed regarding the availability of oncological specialists in the regions, the representative of the professional associations in the field of gynaecology also considers that healthcare services and knowledge should be concentrated in order to maintain an adequate level of service quality. At the same time, she emphasizes that it is necessary to ensure in parallel the availability of gynaecological services at the primary healthcare level. She recommends introducing midwife services within the practices of general practitioners that could provide physiological care of pregnant women within the scope of state-funded healthcare services, thereby providing

women more accessible primary care and the opportunity to receive referrals to specialists in more complicated cases.

118. Healthcare specialists within the field of cardiovascular diseases share the opinion that it is necessary to ensure better availability of specialists and examinations within the regions, because there are cases when even regional hospitals do not have cardiologists and patients cannot consult a specialist.

119. Upon summarizing opinions of the healthcare specialists, patient organizations and representatives of the professional associations on availability of healthcare services in the regions, it must be concluded that this issue is closely connected with the quality of services. Although patients in the regions complain about the availability of services and healthcare specialists also consider that healthcare services should be more widespread in the regions, both patients, specialists of various healthcare sectors, and representatives of patient organizations also admit that particular healthcare services outside Riga are not being provided in sufficient quality, because specialists in these regions do not have relevant experience in carrying out the relevant examinations. As a result, specialists working in the regions are not being able to timely diagnose illness and there are cases when healthcare specialists working in Riga do not trust examinations that have been carried out in the regional healthcare institutions. Respondents mainly mentioned examples from oncology and gynaecology, consistent with the opinion of the representatives of the professional associations of these sectors that it is necessary to concentrate the services within these sectors in a single place to ensure adequate quality.

2.4. Strategies of patients and healthcare specialists to get necessary healthcare services quickly

120. When patients need an appointment for an examination or specialist consultation, they call all the possible health centres, including those in other towns, to find out where the waiting lists are the shortest. Patients and healthcare specialists alike admit that certain services in some healthcare institutions and the more distant regions are often available sooner than in the major national hospitals. Some services are available the next day in some regional hospitals in one city, while in another the same service has a month-long waiting list.

121. Sometimes patients call one health centre repeatedly, hoping that one patient will cancel their appointment and they can visit the doctor instead. Some even sit all day in the doctor's waiting room and hope to be seen and examined at the end of the day. However these strategies – both calling the health institutions and waiting at the cabinets of the doctors, as well as going to another city for examinations or consultations – need more of the patient's time and money. Even if the service is available in another town, the physical condition of the patient does not always allows them to travel to another town to get the treatment or consultation. Besides, a single examination or consultation is often not enough and there will have to be subsequent appointments.

122. Doctors use mutual contacts in order for their patients to see specialists or have examinations sooner. Healthcare specialists, patient organisations, and patients themselves talk about cases where it is only possible to see certain specialists or have certain examinations if the referring doctor has colleagues in that field who can arrange it. Such a system means that patients who have doctors with 'good contacts' can get access

to the necessary medical services, but patients who do not, cannot get the same standard of treatment.

123. Healthcare specialists admit that in acute cases patients get prompt treatment by calling for emergency medical assistance. When the medical situation for a patient is not yet acute, but they have to wait a long time for their treatment, specialists themselves often recommend the patients call 'emergency', considering that because of the long waiting lists for examinations and specialists, as well as patients' lack of money, calling for emergency medical assistance is often justified, because the patients have not received the treatment they need and as a result of the delays their health may have worsened significantly.

124. If the main obstacle to getting healthcare services is the lack of money, then patients try to consult with another specialist to find out if the examination they have been referred for is really necessary. This situation has been highlighted both by patients and some general practitioners, who consider that: *"You have to be knowledgeable; [to know] when to make that person spend the money and when you can tell them they can wait for their state-funded turn*". If, however, state-funded healthcare is not available, then the patients often borrow the money they need for the private service from friends or acquaintances. In certain cases assistance is provided by the municipalities. For example, in the locality of Liepaja, transport is provided for residents to get them to where medical services are available.

125. If an employer provides health insurance to employees, they are more willing to use private healthcare services. These patients often say they are happy to use private services, because, in their opinion, they are of better quality. They point out that the attitude of 'doctors for a fee' is better; the doctors take more time with patients and the patients do not feel guilty if they want to ask additional questions or consult with a specialist by telephone. In addition, patients feel better psychologically because 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. Of course there are also cases when the private insurance does not cover all the medical expenses. Then the patients have to pay the difference or even cover the full expense of certain treatment or services.

126. When relying on insurance coverage, patients have found that, in their opinion, healthcare specialists have been exploiting reimbursement rules unfairly. For example, a gynaecologist had offered one woman all the available services and examinations without special reasons. She considers that this was because the gynaecologist knew her insurance would cover everything and therefore knew that she would receive extra money.

2.5. Recommendations

Perspectives of study participants

127. Solutions for the problem of long waiting lists for state-funded healthcare services in Latvia, according to participants of the study, mostly relate to the increase of the state budget for particular areas and for the healthcare as a whole. It has been indicated for many years that the share of GDP allocated to the healthcare sector is insufficient in Latvia.

128. In terms of more optimal organization of the state-funded healthcare services, some study participants suggest that the principle of 'the money follows the patient' should be introduced in the healthcare sector instead of the existing quota system.

Researcher perspective

129. In analysing the share of GDP allocated to the healthcare sector, a comparative perspective should be taken. It would be useful to compare both government contribution and patient contribution of total medical expenses in general in all three Baltic states – Latvia, Estonia and Lithuania, and, if possible in particular areas, for example, government contribution and patient contribution in oncology, government contribution and patient contribution in respect of cardiovascular diseases, and the share of state financing of particular diagnostic services with the longest wait lists and others.

130. However, increasing the share of GDP allocated to the healthcare sector, may not be an ultimate solution. Many things in healthcare sector have been implemented with delay in Latvia (for example, the establishment of an e-health platform and incentives to reduce administrative burdens in healthcare), and that can cause some problems. For example, medical personnel still spend a lot of time on paperwork, and there is an information gap between doctors about their patients. Both of mentioned problems could be solved with an effective e-health platform.

131. It should be mentioned, that the efficient use of financing may have been hindered by different lobbying groups –, for example, big building companies or particular areas of the healthcare sector due to the private interests of particular politicians and high level managers in healthcare. At the same time many specialists, both doctors and nurses, are heading to other EU countries to work. This leads to suggestion that, first, it is necessary to continue the involvement of municipalities in providing access to particular services to people in remote areas. Second, it is important to continue to fight against corruption and bribery in health sector, as informal payments have very negative impact on availability of healthcare services, especially among vulnerable groups.

3. Service delivery model

132. This section covers different problems related to the coordination of healthcare across levels, the division of roles and duties among different participants in healthcare system, often through the lens of the four top priority health areas – oncological diseases, cardiovascular diseases, mental health and mother and child healthcare.

3.1. General description of service delivery model

133. This sub-section reviews the most general issues of care service delivery and integration based on view of different stakeholders – HR managers, representatives of professional and patient associations, specialists and family doctors.

134. Family doctors, secondary out-patient care institutions, and hospitals are mutually independent healthcare sectors in Latvia, according to the view of HR managers. This conclusion is based on the fact that majority of family doctors, as well as a number of specialists, have independent practices which are not subordinated to any larger healthcare institution. Another reason, which comes indirectly from opinions expressed within interviews and discussions, is that no particular unit (family doctor or specialists) is responsible for the coordination of treatment of the patient with co-morbidities.

135. It is a common opinion among family doctors and specialists that coordination exists only through official doctor conclusions. There is nobody who coordinates when and which particular specialist the patient should visit, responsibility for these decisions rests with patients themselves. Moreover, each specialist deals with the patient only in the framework of his own specialisation. Information included in official doctor conclusions differs – it might be more and less detailed.

136. Most of the participants of the study have experienced the healthcare system during Soviet times when care was more focused on the tertiary level. Although healthcare workers have accepted a shift of care from the tertiary level to outpatient care and to primary care, they admit that primary care does not perform as well as had been expected. Part of the problem refers to the healthcare system itself while another problem area concerns public services in a broader sense (for example, public transport, and social work).

137. Some HR managers and representatives of professional associations argue that, from the perspective of the national budget, primary care has received the greatest support; however, the performance of that sector has been moderate due to unwillingness on the part of family doctors to change their ways of thinking and their attitude towards patients. Some HR and facility managers and family doctors themselves have observed a gap between the attitude and level of knowledge of the younger and older generations of family doctors – where the younger generation conforms more to the ‘ideal standard’ of performance expected from family doctors. In addition, as it is observed in focus group discussions, patients – especially among the older generation – might believe that the family doctor is not an expert able to deal with their particular health problems and might insist on being referred to another specialist (for example, a cardiologist). This, in turn, causes secondary outpatient care to become over-burdened, resulting in long waiting times for consultations and diagnostics. Accordingly some HR managers and representatives of professional associations argue that some additional instruments should

be introduced to facilitate better performance of GPs, according to good practice in the field (see more on these instruments below).

138. When discussing the overall organization of healthcare in Latvia, some HR managers and representatives of professional associations support the idea that the aim of tertiary care is to deal with the most complicated care issues. However they expect that, on average, Latvian hospitals might not reach all the standards of good performance due to having operated on limited budgets over a long period of time. This view refers mostly to the insufficient wages of healthcare workers. Some managers of private healthcare institutions also maintain that part of the problem is also due to the ineffective management of public healthcare institutions (including, ineffective investments in infrastructure and physicians' distrust of diagnostic examinations that have been made in another healthcare institution).

139. Some representatives of professional associations admit that an obstacle standing in the way of the management and integration of care is insufficient information about the Ministry of Health's vision of how the healthcare system will be developed in future years. In particular, there are questions about which institutions will be developed as the main regional centres and whether this vision is based on well-grounded calculations regarding the accessibility of services for all inhabitants, including people living in remote areas.

140. In expressing these doubts representatives of professional associations refer to the hospital reforms introduced in 2009 during the economic crisis, when, they argue, decisions about which regional and local hospitals should be maintained were based on the size of the city and the strength of support and lobbying for certain outcomes. As a result, regional hospitals are located in the biggest Latvian cities – ignoring the fact that, for some living in their catchment area, these hospitals cannot be reached within an hour. Although reforms of the hospital network have been planned to increase the efficiency of budget spending in healthcare, some experts consider that the real outcomes of the reforms show that savings in one area of the healthcare system (for example, the closure of small local hospitals) have increased spending in another area (such as, emergency aid). They argue that the concentration of the main resources in regional hospitals weakens the remaining local hospitals, which could increase deaths due to delays in emergency first aid, such as in high-risk pregnancy conditions like a detachment of the placenta.

141. The concentration of healthcare services in large cities (which for some specialities, such as oncology and cardiology, are mostly in Riga) is supported by management and specialists working there. The main argument for the concentration is the higher level of expertise and knowledge which arises from the variety of cases examined there. However, managers of regional hospitals and the patients themselves support the idea of maintaining care in regional centres to ensure better accessibility of these services. Some representatives of professional associations and regional managers support the idea that the system should be developed so that all 'ordinary' cases are solved at a lower level of expertise, and only exclusively 'complicated' cases should be referred to a higher level. This approach holds that since the difficult, 'complicated' health problems are dealt with at a national centre of excellence, the rest of the 'ordinary' less complicated (lower level) and thus less expensive care should be provided at regional centres. For example, in the case of oncology, only the complicated surgeries should be performed at the Centre of

Oncology in Riga (no particular examples mentioned with this regard), while the rest of the treatment should be delegated to regional centres like Liepaja and Daugavpils if they are closer to where the patient lives.

142. However, representatives of professional associations, who proposed solution mentioned above, admit that to make the idea above viable, a system of referral of patients from the lower level of expertise to the higher – and vice versa – needs to be developed. Although a system of patient referral has been developed in oncology (the so-called 'green corridor'), the experience of healthcare staff shows that it does not work in a proper way.

143. Another solution mentioned by some representatives of professional associations is the system which existed in Soviet times, when each region had its own co-ordinator at the national level. However, experts cannot evaluate whether that system will work nowadays, as there are indications that it might lead to inefficiencies in the provision of care. Representatives of professional associations, who have indicated this problem, have observed, and some family doctors confirm this observation, that every new system which allows the sending of patients for further diagnostics could lead to inefficiencies, for several reasons, such as:

(1) Patients' wanting to bypass waiting lists, even when their cases are not urgent
(2) A decline in personal responsibility by family doctors and;
(3) Excessive responsiveness to the pressure of patients insisting on particular kinds of diagnostics.

144. To deal with the problems mentioned above, one HR manager proposes the introduction of a requirement for doctors to do duty turns in the accident and emergency units of hospitals at least several times per year. According to the expert's view, it helps to develop comprehension of family doctors on functioning of other care levels, to expose them to a variety of cases, and to increase their diagnostic skills. As this manager does not consider it reasonable to integrate GPs around hospitals due to their location in the suburbs of cities (especially in the regions), duty shifts in emergency units would increase the understanding of family doctors about the whole system and provide training that is impossible to experience in outpatient care.

145. The expert admits this duty would have to be voluntary and that to encourage them to join the system, additional compensation should be offered to family doctors. However, as Latvia already has experience with the introduction of voluntary systems in healthcare which have not given the expected results, several potential risks should be taken into account. First, extra pay for duty in the emergency unit of the hospital would have to be tangible and reasonable. Experience of the introduction of quality criteria for family doctors shows that some impossible-to-achieve target criteria might be included within the criteria that could undermine the whole idea (for example, family doctors were required to make year-on-year reductions in the number of emergency calls their patients make – which cannot necessarily be endlessly reduced year after year). Second, there is a risk that family doctors will start to use the system to bypass waiting lists and start asking their patients to come to the emergency unit during their duty shift. Third, duty at the emergency unit requires a specialty in internal medicine that only some family doctors have. The introduction of such a requirement will need current regulations to be amended. This HR manager suggests a similar proposal for gynaecologists working in outpatient

care and having a specialisation in obstetrics to increase the knowledge of gynaecologists about possible complications during childbirth.

3.2. The roles of doctors and nurses

146. While many specialists agree that nurses could do more, the main problem they identify is the insufficient number of nurses in healthcare institutions to provide the functions currently assigned to them. However, managers of healthcare institutions, GPs, physician-specialists, representatives of professional associations, and mass media have expressed doubt that the available human resources and the funding allocated for the healthcare would allow increasing the number of nurses and attribute the lack of the nurses in health institutions in Latvia to profile's low remuneration. However, since there are so many current duties of nurses, it might not be possible solve this problem by broadening the functions of nurses. Some nurses already work in several institutions, and the likelihood of burn-out syndrome among them is high.

147. Many nurses in Latvia are currently at pre-retirement or retirement age because younger nurses look for opportunities to work abroad or in better paid jobs. However, physicians and HR managers characterize older nurses as having lower motivation to acquire new duties.

148. Several healthcare specialists and managers of institutions acknowledge that the nurses should be more involved in educating patients on healthcare issues, thereby enabling patients' skills to help themselves, to follow treatment rules and adhere to drug prescriptions. To implement this, however, managers of healthcare institutions, GPs, and physicians-specialists argue that nurses would have to be released from part of their current duties – for example, by delegating their more secretarial functions and some care functions to assistant nurses.

149. Another group of health professionals in Latvia is paramedics, and this area is still not fully developed in Latvia. According to a regulation adopted in Latvia, paramedics provide emergency medical assistance for individuals in life-threatening, critical conditions prior to the stationary stage and in the stationary admission departments, by performing diagnostics and treatment. They can also operate within primary care, where they are a member of the general practitioner's working team.[3] Some study participants consider it a problem that paramedics cannot be engaged by the hospitals, even though they are available and trained. Similarly, paramedics cannot be employed instead of nurses, because these are two different professions and educations. A regulation defines paramedics as only primary health care providers[4].

3.3. Collaboration between GPs and patients

150. Regarding appointments with general practitioners the main criticism from patients is that general practitioners, when the patient visits them, do not have time to talk, and patients feel as though they are on a conveyor belt. They believe that general practitioners

[3] The regulation of Cabinet of Ministers No. 1529 issued on 17 December 2013 "Healthcare organization and financing arrangement" (Veselības aprūpes organizēšanas un finansēšanas kārtība). Available: http://likumi.lv/ta/id/263457-veselibas-aprupes-organizesanas-un-finansesanas-kartiba
[4] Ibid

have an excessively heavy workload. This is consistent with comments of doctors who considered the established norm – 1800 patients for one general practitioner – too high because it translates into 26-30 patients a day. Add to this documentation, telephone consultations, and home visits, and it is a sizeable amount of work.

151. Patients are also not satisfied with the fact that general practitioners issue referrals for specialists, where the waiting time for the specialist appointment can last for months, especially if the referral is made in November or December, when planned quotas have been used, in which case, the appointment must be made for the next year, or the service must be paid for completely out of pocket. Several participants of the discussion mentioned that they only bring their children to general practitioners and specialists because they do not have time to also take care of themselves. Activities connected to visiting doctors require a lot of time – sitting and waiting at the general practitioner, making an appointment with the specialist by calling them during certain hours a month, and sitting and waiting at the specialist – all during working hours. Due to these reasons many self-medicate, search for information on the Internet, or choose alternative medicine like homeopathy, phytotherapy, ayurveda, or services of different healers.

3.4. Collaboration between GPs and specialists

152. General practitioners report that almost half of the direct access specialists – including oculists, dermatologists, endocrinologists, gynaecologists, neurologists, and psychiatrists – do not issue their medical opinions to general practitioners. Thus GPs are left facing a shortage of information with regard to the medical history of their patients – the diagnostic services they have received, the diagnoses they have been given, and the medicines they have been prescribed. Some general practitioners say that it is useless sending a patient to a specialist if they do not get any kind of information back. "*The answer comes back from the specialist, but the diagnosis isn't written. Instead there are 25 different laboratory parameters for tests and three examinations written up, including magnetic resonance tests (we are not allowed to prescribe MRI tests – it is expensive and there it is a long waiting list). Time passes. The patient must undergo these examinations and tests at their next appointment with a specialist. So I have to wait more than a month".* GPs are unhappy that they have to refer patients to another specialist or to diagnostic services, relying only on what those patients tell them about what is happening. They also complain about being asked to extend sick-leave certificates on the say-so of a specialist, without being provided with any additional information.

153. General practitioners call the co-operation with specialists as the 'circle dance'. It is not always possible to clarify a diagnosis sufficiently with the examinations and tests prescribed by the general practitioner, but the specialists rarely schedule additional examinations and tests themselves. Instead of the specialists' sending patients for the tests required, they repeatedly suggest visits to the general practitioner to get a referral.

154. In cases of uncertainty the general practitioners interviewed say they always try to contact specialists. They say that it is easier to get in touch with specialists in the hospitals because their contact information can be found from their opinions filed in the patient's medical records. Communication with specialists at healthcare centres can be limited, especially if the only information about them that a patient can provide is a promotional leaflet of medications with an indication about how they should be used.

155. In cases involving the need for traumatologists, general practitioners sometimes have to call in favours from a personal acquaintance. Patients are not always able to assess the severity of their injuries themselves. For instance, if a patient has been injured but the acute stage has passed, he may have to wait several months for treatment. In these cases general practitioners try to get the necessary treatment quickly with the help of their personal contacts to avoid delays: *"It is a grey area, when a person has realised that he is in a really bad way but the first acute stage has passed. In despair I call a colleague – we have corporate communication – and ask them to write that an accident has happened recently. It's the only way to get the treatment quickly. Why should we lie? This entire system requires constant lying from us: we are trying to do everything possible for the benefit of our patients so that they don't become disabled. I'm talking about young people, people who are able to work".*

156. One of the experts notes that patients' moving to higher level hospitals is problematic during the process of treatment both in cases of the provision of planned assistance and also in acute cases. For example, in situations, when the patient needs tertiary level assistance that cannot be provided within the local healthcare institutions, the attending physician has to use his personal contacts in order to be able to move the patient. According to the expert, it is usually possible to agree on admission of the patient with regional hospitals. With university hospitals, this agreement is almost impossible.

157. To sum up, the answers of GPs and specialists on question about the exchange of information regarding further patient treatment demonstrate that collaboration among general practitioners, specialists, and various healthcare institutions on the diagnosis and treatment of diseases has not been institutionalized. Both specialists and general practitioners admit that collaboration is mainly carried out via documents and that feedback is missing on the diagnosis or on the development of the treatment plan. General practitioners point out that personal contacts among various specialists still play an important role within the field of Latvian healthcare, because quite often this kind of bypassing the waiting list is the only option to provide the necessary examinations or treatment for the patient in a timely manner.

3.5. Use of the clinical guidelines

158. Only few of the specialists and general practitioners admit that they do not use in their daily work clinical guidelines for treatment of various diseases which are published in the website of the National Health Service. More often healthcare specialists indicate that they are familiar with these guidelines and that they try to keep the information in their mind to use it in the treatment process – therefore, according to them, there is no reason to doubt that they use the clinical guidelines in their daily work.

159. Some general practitioners emphasize that the use of the clinical guidelines for treatment of various diseases in their daily work is prevented by the limited number of quotas – *„We have quotas. How can I follow the guidelines after the contract with the National Health Service, if it's been threatened that I'll get all the possible controls as I have already exceeded the quotas provided for this year?! How do you think, where are these guidelines? Absolutely nowhere!"*

160. One of the specialists believes that the current accessibility of the clinical guidelines is hampered because the documents are not user-friendly. The database of clinical

guidelines is available on the website of the NHS, the full text of each of the guidelines exceeds ten pages. Given the workload of healthcare specialists, this makes it inconvenient to use the guidelines on a daily basis. This specialist recommends displaying the clinical guidelines in a structured way, as for example in Great Britain where a well-organized and transparent system of clinical guidelines is available electronically, and with a few mouse clicks it is possible to get an answer on how to proceed in each case.

3.6. Oncology

3.6.1. Prevention, screening and diagnostics

161. The amendments of the Regulations of the Cabinet of Ministers No. 1529 issued on 17 December 2013, which entered into force on 1 January 2015, envisage that first-time patients get to visit an oncologist with a contract with the National Health Service within ten working days of the moment a patient has turned to healthcare institution[5]. This system has been called the 'green corridor'. However, according to the specialists interviewed and the opinion of general practitioners, the so-called 'green corridor' does not work in all cases. First, it is guaranteed only for those patients suspected of having oncological diseases following screening tests. Since there may be a long waiting list for the screening tests, these physicians argue that the 'green corridor' should be applied to anyone suspected of having an oncological disease as soon as possible to confirm the diagnosis and start treatment as soon as possible.

162. Second, the 'green corridor' has not made visits to oncologists more feasible. The situation was summed up in one interview like this: *"There are only so many oncologists in Latvia, and only so many opportunities to arrange operations in certain areas"*. General practitioners report that social contacts and acquaintances are still used in order to have a timely visit to an oncologist.

163. Timely diagnosis is a problem because of a lack of knowledge and experience of some general practitioners as well. Our study reveals cases in which even symptoms such as a prolonged cough have been missed by some general practitioners for cases of lung cancer. As a result, in many cases the opportunity to diagnose the disease at the first or second stage has been missed.

164. An even bigger problem is the availability of diagnostic services like ultrasonography, computer tomography, and magnetic resonance. These services are provided according to settled quotas, and the waiting time is often a month or even two. One healthcare professional said: *"It is an absolutely preposterous situation. An oncologist can't lift up the patient to the light and just say the diagnosis. Diagnostic services are necessary"*.

165. Time is also wasted in making the results of diagnostic services known to patients. For example, mammography results are known within a day or two, but a patient is told to come back for results in two weeks. Although European Guidelines for Quality

[5] Although oncologists are the direct access specialists and according to the regulations of the Cabinet of Ministers No. 1529 issued on 17 December 2013 (76.2.), the referral of GPs is not necessary to visit the direct access specialists, first-time patients get to visit an oncologist with a contract with the National Health Service within ten working days only with referral of GPs or specialists. See: http://m.lvportals.lv/visi/skaidrojumi/267836-izmainas-veselibas-aprupe-2015-gada/

Assurance in Breast Cancer Screening and Diagnosis [6] suggest that time from mammography to result should be less than 5 working days, the procedures in Latvia do not guarantee that.

166. Diagnostic services are provided in many places – both at public and private healthcare institutions – but at the same time the quality of these services is not assessed. According to the Association of Latvian Oncologists, it could be extremely valuable to discuss all unclear or wrongly diagnosed cases among oncologists and specialists in diagnostic services to help cut the number of cases where an oncological disease is not detected at an early stage.

167. The representative of Association of Latvian Oncologists considers that lack of experience is the main reason for the low quality of diagnostic services in some cases. A higher quality of service comes from those providing particular diagnostic services on a daily basis, performing ten or more diagnostic services per day. It has been suggested that patients with an uncertain diagnosis should be referred to specialists with daily experience in particular diagnostic services.

168. Specialists and general practitioners consider that oncologists should be available close to home as was the case in the previous system. *"The old model was optimal. An oncologist was available in each district* (there were 26 districts in Latvia)*, and he or she took responsibility for monitoring the situation after an active treatment period. They also carried out examinations of new patients to reach a diagnosis"*. Nowadays, if a person has to travel 100 km or more to visit an oncologist, then quite often they will choose not to do so.

169. The timely diagnosis of oncological diseases is also hampered by the reluctance of patients to go to general practitioners if they have any suspicions about oncological disease. According to the view expressed by patient organizations and GPs, oncological diseases are associated with fear and doom in Latvia, and also by uncertainty about the cost of treatment and the extent to which the patient will have to contribute from their personal funds[7], especially due to long waiting lists and private services as a possible alternative to state guaranteed medical services.

170. Another problem identified by specialists is the lack of attention paid to prevention issues. For example, general practitioners rarely evaluate genetic risk. If the patient's parents or grandparents have had oncological diseases, then taking into account the increased risk of the patient, regular diagnostics would be important – but it is hardly ever done. General practitioners themselves admit that they *"have no time to deal with prevention issues."*

[6] http://www.europadonna.org/short-guide/a-short/

[7] Health care is only partly state-funded in Latvia, and patients have to cover the cost of the health care services themselves as well. This principle is applied also to state guaranteed medical services, with exception in respect of children and pregnant women (if medical treatment is related to pregnancy). The amount of patient fee is defined in the supplement of Regulations of the Cabinet of Ministers No. 1529 issued on 17 December 2013. According to this pricelist the visit to GP costs 1,42 EUR, visit to specialist costs 4,27 EUR, computed tomography (CT) examinations with intravenous contrast costs 21,34 EUR, treatment in a hospital with oncological diagnoses costs 7,11 (every day). Although these are reduced fees, they form an important share of income of a large part of society. For example, average amount of old-age pensions paid in 2014 was 266,26 EUR per month.

171. At the same time general practitioners emphasise other problems in the field of oncological diseases that interfere with preventive work. First, general practitioners lack information on whether their patients have been invited for cervical cancer screening and mammography because the information prepared by the National Health Service is not always up to date. For example, the National Health Service information may say a woman is on a list and has been sent an invitation for screening, but in reality she has not received this invitation.

172. Secondly, as reported by GPs, additional access to information on cancer-screening data is available only to GP practices which employ two or more nurses. Such an arrangement is incomprehensible to general practitioners because additional access to information on cancer-screening data is necessary even if only one nurse is working in the practice – as the nurse is the person who deals with prevention issues in many GP practices.

3.6.2. Treatment

173. The treatment of oncological disease is hindered both by delayed diagnostics and also by the fact that not all of the target medicines for research of specific cancer cells are available in Latvia. In cases of the most typical oncological diseases the treatment is provided, but in cases of specific diseases, both examination and treatment are not always provided as appropriate (when more expensive medicines are needed).

174. According to the representative of the patient organization, the psycho-emotional condition of the oncology patients is a special problem that in general receives insufficient attention, and some blame is attributed to the routine attitude of health professionals. Specialists are blamed for perceiving patients as objects rather than human beings with their own needs. According to patients, it is insufficiently recognized among the physicians that an oncological disease is not purely physical disease, but also a psycho-emotional disease, and they feel that a more empathetic approach is needed. One of the solutions for this problem, mentioned by the representative of patient organization, could be multidisciplinary teams with psychologists involved to support the patient both at the time of diagnosis and before and after any operations. Alternatively, nurses can be trained to provide such support.

175. Patients have observed that treatment is much more successfully organized for those patients with good connections, with friends among the doctors or who are doctors themselves, or among those whose relatives are doctors, because in these cases individual attention is ensured and the doctors consider the particular case in-depth. Treatment in other cases is often carried out in very routine manner.

176. Experiences of patients reveal that the two main centres of oncological diseases – Oncology Centre and Stradins Hospital – may have a competing relationship that interferes with patient care. Instead of health institutions collaborating with each other, instead of providing exchange of experience and mutual consultations, patients can be subjected to warnings that “they are lucky having got out alive of the rival centre”.

3.6.3. Follow-up

177. General practitioners and other physicians interviewed admit that complications after the stage of the intensive treatment are caused by the fact that general practitioners and oncologists do not always collaborate with each other and discuss the needs of the particular patient during the remission period. Some general practitioners feel insecure about oncology patients, and they do not exactly know how to help them in their situation, when the body is weakened as a result of treatment of the oncological disease, and special monitoring is required. Also patients quite often prefer that the monitoring of therapy be carried out by the oncology specialist. In general, it demonstrates a lack of confidence in the ability of a general practitioner to monitor therapy.

178. Patients consider the current support provided for oncology patients' psychosocial rehabilitation as absolutely insufficient and that in order to return to society as a full-fledged member and to feel psychologically and emotionally stable, psychosocial rehabilitation is important. Both participants in focus group discussions and the representative of patient organization stress that oncological diseases within society are still connected with very high number of lethal results that cause insecurity for people and fear from recurrent disease. They still also carry a certain stigma – if you have an oncological disease you are going to die soon and this is God's punishment for something evil you have done.

179. After intensive treatment, patients of oncological diseases need consultations of a nutritionist, a dietician, certain physiotherapy procedures, as well as support groups, but currently this is not available to many. At the moment only patient organizations are providing free of charge psychosocial rehabilitation from collected donations, the amount of which is very limited. State-funded psychosocial rehabilitation for chronic patients, including oncological, is not yet being provided in Latvia.

180. Another problem identified by the representatives of the patient organizations is palliative care in Latvia – both for oncological diseases and for other conditions. Overall minimal support is provided to ease the condition of a patient and slightly improve the quality of his remaining life. There are even cases when the medical personnel of the hospitals do not have the skills to provide analgesia or decide which medicines to give. One suggestion of the representative of patient organization would be to train the relatives of patients to assist the patients, who need care, in a more professional manner.

3.6.4. Coordination among levels

181. A majority of the experts, most of them general practitioners, consider that the principle of personal contacts operates within the sphere of oncology. Since consultations with oncologists and various examinations have shorter or longer waiting lists, then personal contacts are often the only option to ensure timely diagnosis and treatment – "*you, being a doctor, can search for your group mates and colleagues, who work in the Oncology Centre of Latvia. If it is possible, then we bypass this electronic system. In such case it is possible to arrange something and to help that person. You can do absolutely nothing without contacts"*.

182. Neither specialists, nor general practitioners talk about ethical considerations in using personal contacts, because everybody is aware that in case of oncological diseases it is

not allowed to hesitate – *"if there is a child with oncology, who can be seen for appointment after three months, so examined after four months, then sorry. Oncology is oncology – it does not have to be discussed. If you have contacts, you get. If not, then nobody is interested in that".*

183. There is insufficient collaboration between general practitioners and oncologists because of several reasons mentioned by general practitioners and the representative of patient organization. Many general practitioners are not satisfied with official conclusions prepared by oncologists. In their opinion they lack detailed information and substantiation. If the patient is incapable of working after oncological disease, then the general practitioner has to get involved into the procedure of arranging disability status that cannot be done without detailed opinion of the attending physician. In addition to this, some general practitioners complain that doctors in hospitals blame them for sending oncologic patients to get treatment in hospital in cases when it is evident that patients cannot be cured.

3.7. Cardiovascular disease

3.7.1. Prevention, screening and diagnostics

184. The situation regarding the timely diagnosis and treatment of cardiovascular disease is a little better than in oncology, but the speed of diagnosis is a problem. Experts point out that cardiologists are concentrated mainly in Riga and other big cities, and the availability of cardiologists in the regions is limited. Another problem is the lack of specialists that can perform echocardiography. As a result there is a waiting list not only for state-funded services but also for private services, which are paid for by patients' personal funds.

185. The availability of cardiologist consultations and various examinations is determined by quotas. General practitioners criticise the allocation of quotas for cardiologist consultations because their observations show that the quotas are not divided according to regional demand: *"We need a cardiologist in Riga now, not in six months, but I was told to drive to Liepaja in two weeks. Now the man will drive 200 kilometres with their heart rhythm disorders to Liepaja to see a cardiologist! This is not logical"*. One of interviewed general practitioners suggests that this problem could be addressed if the principle of 'the money follows the patient' was introduced in the healthcare sector[8].

186. Even for children, cardiologist consultations are set by quotas. Organised trips of specialists to particular areas can be arranged in a much shorter period of time than a private consultation in Riga: *"I applied for a clinical bus, then the quota suddenly appeared. The same month, these professionals were here. When I applied for a consultation with the same professionals in the Children's Clinical Hospital, I could only get an appointment six months' later. If your child needs tests on their heart rate, then after half a year these tests might not be necessary anymore."*

[8] At the moment quotas are allocated to different institutions, and people can apply for services in any institution, providing particular service and having contract with the National Health Service. Many physicians (both GPs and specialists), however, consider that services should be provided in those institutions where there is a corresponding demand, and the state financing should follow that. This approach would allow patients to choose a health care institution they trust, and specialists will have no need to work in many places and travel from one institution to another. At the same this approach would cost more as it would be difficult to set up quotas like it is now.

187. State-funded services are available for nine or ten months a year, a time period covered by quotas. This problem was reported by all groups involved in the study: GPs, physicians-specialists, representatives of professional associations and patient organizations. This was also mentioned in focus group discussions with inhabitants, and this problem has gained a wide media attention in Latvia. When the quotas run out, the waiting list starts for the next year. In many cases – but not always – patients can have diagnosis services and consultations at their own expense, but not everyone can afford this.

188. General practitioners stress that if a patient has to wait for a cardiogram for two months that can be too late. In many cases the pre-infarction and pre-stroke situation has been identified in private consultations and tests funded by the patients themselves, which means that waiting in a queue for state-funded consultations could be fatal. Patients with cardiovascular diseases who have received insufficient treatment very often are taken to hospital by ambulance, but the treatment of acute cases costs more. In many cases elderly people are afraid that their call for ambulance will be considered as unjustified and they will have to pay for it. In these cases they hesitate to call and delay seeking treatment – which might have serious medical consequences.

189. Many specialists think that general practitioners could do more to prevent cardiovascular disease. However, general practitioners currently have too many patients and are too busy to identify those patients at risk of developing cardiovascular disease, or to discuss issues of prevention with them. This is acknowledged by GPs themselves, physicians-specialists, representatives of professional associations and patient organizations, and inhabitants in focus group discussions.

190. To sum up, according to the views expressed by the representatives of professional associations and patient organizations, one of the main reasons for delayed diagnostics of cardiovascular system diseases is the lack of awareness among patients on cardiovascular system diseases and risks that facilitate them. For example, people are not fully aware of the possible consequences of high blood pressure or hypertension, such as stroke or infarction. People do not pay necessary attention to increased blood pressure and do not start timely treatment. The second problem is the fact that there are general practitioners, who do not consider these issues in-depth and do not notice signs of diseases such as cardiac arrhythmia. Thirdly, national quotas limit opportunities of people to timely meet the specialist and timely diagnose the disease.

3.7.2. Treatment

191. Treatment of cardiovascular diseases, as with all diseases, is hindered by delayed diagnostics, but one very important factor is also the cost of medicines. Cardiac patients admit that that they do not use medicines recommended by the doctor because they cannot afford them. For cardiovascular diseases, often several medicines must be used (for example, in order to treat both hypertension and reduce the level of cholesterol) and altogether the treatment course turns out to be expensive. Sometimes patients decide themselves, as they feel, which medicines to use and which not to use, because they cannot afford to buy all of them. Decisions taken by the patients on interruption of treatment or inadequate use of medicines can also hinder the treatment. There is no understanding among the patients on the necessity to follow the treatment course and

directions of the doctors. If the person feels better, they discontinue their intake of medicines.

192. With regard to the option that general practitioners could undertake more treatment of diseases of cardiovascular system and reduce demand for the cardiologists, one obstacle may stem from situations in which patients do not trust general practitioners and doubt their competence in case of these diseases.

193. Another problem identified by one cardiologist is that there is no treatment centre in Latvia for patients suffering from heart failure. Currently, most of these patients are taken to hospitals only when the medical situation is acute when treatment is more complicated and more expensive. If a specialist heart failure centre existed in Latvia, it could be a place for patients to have consultations on this issue, to discuss the risks of heart failure and possible treatment routes with specialists, to carry out investigations, and to monitor a patient's health situation.

194. One of the representatives of the professional associations indicates that in the context of talking about cardiovascular disease we have to also talk about the increasing number of patients with kidney disease. Stents in blood vessels and the subsequent life-long use of medication have contributed to the increasing number of patients with kidney disease. Therefore it is important not only to improve cardiovascular disease prevention and reduce the need for stents, but also to develop nephrology in Latvia to prevent the situation in which *"a stent has been placed, but the patient died of renal insufficiency."*

3.7.3. Follow-up

195. A representative of the patient organization and patients in focus group discussions stress that provision of rehabilitation measures following a stroke is still an acute problem in Latvia. State-funded rehabilitation measures are provided in the hospital department during the acute stage of the disease, but afterwards state-funded rehabilitation measures are very limited. These services have a long waiting list, which can put patients at risk, since it is important to carry out rehabilitation measures as soon as possible. Moreover, irrespective of the fact that rehabilitation measures are state-funded, they have a high patient co-payment that not everybody can afford. Rehabilitation at the patient's place of residence in the case of a stroke has been included in the state-funded home care basket of services since 2012, but in practice it is necessary to wait for it for several months. There is also a waiting list for the services for a fee because specialists are missing, but the wait is not as long as for state-funded services.

3.7.4. Coordination among levels

196. Both specialists and general practitioners admit that collaboration in treatment of cardiovascular diseases is mainly carried out via documents – namely, by signing out the patient from the hospital, specialists prepare recommendations for further monitoring of the health condition of the patient. However, coordination of the treatment is rather limited, because specialists do not always receive feedback from general practitioners, which general practitioners say is due to their high workloads.

3.8. Mental health

3.8.1. Diagnostics

197. Stigma is one of the most significant reasons hindering a timely diagnosis of the mental health. Since people with psychological diseases and their family members are subjected to stereotypical attitudes and a feeling of shame for their disease, many people do not want to admit for a long time that they are in need of professional help. Moreover, there are people who are afraid of being included on *The register of patients with particular diseases on patients with mental and behavioural disorders*, because inclusion in this register is connected with several prohibitions, such as a driving licence prohibition and prohibition to work in certain professions. It must be emphasized that a very limited number of persons have access to this register and restricted information, however, concerns exist among the patients and their families. In the case of certain diseases (for example, schizophrenia), the patient might not consider perceptual disorders as a disease and can resist diagnosis and treatment due to this reason.

198. Another problem is that general practitioners may not always identify risks promptly and refer patients to a psychiatrist for consultation. This is explained by lack of knowledge, overload, burnout, and bias of some GPs. The last is related to the heritage of Soviet times, when people with mental health problems were mostly kept in notorious closed institutions. In some cases political dissidents also were kept in the closed mental hospitals, and the only treatment usually was very strong medicines. The possibility to recover and live a normal life with diagnoses like schizophrenia or manic depression was strongly questioned at that time.

199. At the same time, it should be stressed that the availability of consultations with psychiatrists is not a problem in Latvia. Consultations with psychiatrists are available within a few days in both the large cities and the regions. However, most people choose to visit specialists in the big cities in order to maintain confidentiality. Mental health problems are associated with a fear of stigma, and therefore confidentiality issues are particularly important. But when it comes to psychiatrists in the regions there are – according to the representative of patient organization – doubts about the maintenance of confidentiality and the quality of their services.

200. In acute cases treatment can be obtained almost immediately in mental hospitals. However, it is possible that help may sometimes be delayed during public holidays when mental health problems become more pronounced.

201. One of the problems identified by the representative of the patient organization is that mentally ill patients do not get adequately assessed for other complaints connected with somatic problems. Both general practitioners and personnel of other hospitals in cases when mentally ill patients have somatic problems usually refer patient to psychiatric hospitals and seem to want to get rid of such a patient. But since psychiatry is not integrated within somatic medicine in Latvia, then this may not be a right decision, because psychiatric hospitals do not provide diagnosis and treatment of somatic diseases.

202. In Latvia, medicines are reimbursed at 100 percent only for certain groups of diseases. If medicines have to be purchased for money, they are very expensive. In order to make medicines more available, there are psychiatrists, who offer the patients the opportunity

to have a diagnosis that does not correspond to their disease but ensures that the necessary free of charge state-reimbursed medicines are available. Such situations show up both within several interviews with people with mental diseases and in the interview with the representative of the patient organization. Unfortunately, these people themselves may get serious problems with the "ascribed" diagnosis, because of the ensuing restrictions to work in certain professions and to obtain a driving licence, but it is very difficult to achieve amendment of the diagnosis. There are no clearly established and known procedures for patients to request a revision of this diagnosis.

203. Another problem connected with setting diagnoses refers to autism for adults. There is a common practice in Latvia that children with autism are diagnosed with schizophrenia once they turn 18 years old, which is a very unpleasant surprise and shock for the family.

3.8.2. Treatment

204. The key problem regarding the treatment of mental diseases in Latvia identified by the representative of the patient organizations is that there is no developed ambulatory service in this sector. There are established modern ambulatory centres of mental health in places like Riga, Daugavpils, Jelgava, and Cesis, but not in all regional centres in Latvia. It must be noted that in general psychiatrists are available across Latvia, but the advantage of an ambulatory centre is the presence of a multidisciplinary team. Thus, if a psychiatrist sees that the patient could be helped by an occupational therapist or psychologist or by the various music and art therapies available in the ambulatory centre, then he can direct that person there. Such an approach may compensate for the fact that on average the visit with the psychiatrist lasts 15 minutes, during which documents are mainly filled out and medicines prescribed, leaving little time for a longer discussion that many patients might really need.

205. Another issue in Latvia is information flows between healthcare providers and patients. According to the representative of the patient organizations, patients do not always receive an explanation on the necessity of adhering to their prescribed dosage and frequency of medication, especially in hospitals. Improvements that have been made by adopting amendments to the Medical Treatment Law, however, must definitely be stressed. These amendments provide a single regulation for the application of compulsory measures and restriction of personal life within neuropsychiatric health institutions. Amendments of the Medical Treatment Law list the rights of the patients, who have been stationed in the psychiatric institution without their consent. The new regulation provides that restrictive means can be applied in the health institutions in cases where the patient, due to mental disorders, may cause injuries to himself or other persons or where the patient demonstrates violence against other persons and it has not been possible to interrupt the threat by oral persuasion. The listed restrictive means include physical restriction, upon using physical power, mechanical restriction with strings or belts, administration of medicines against the will of the patient, as well as placement into an observation ward. It is essential that the application of restrictive means is registered in documents, including the administration of medicines against the will of the patient. Afterwards the patient may request his medical history and understand why such means were applied. The patient is also entitled to dispute restrictive means applied to him to the manager of the institution. The decision of the manager of institution can be challenged in the Health Inspectorate, but the decision of the Health Inspectorate can be challenged in the court.

206. Positive improvements in the rights of patients with mental diseases also came in 2013, when along with amendments in the Civil Law, Civil Procedure Law, Law on Orphan's Courts and others, Latvia rejected full deprivation of legal capacity, and a new regulation on legal capacity entered into force. Now, if a person has a mental disorder or other health disorders, his/ her legal capacity can be limited only if it is necessary in the interests of the particular person and is the only way to protect them.

207. With regard to home visits in Latvia, it must be noted that an additional obstacle within the current system had been introduced in order to reduce the number of such visits as much as possible. Now in order to make an appointment, the patient or his relative with the patient's passport has to book an appointment on-the-spot. This is a puzzling requirement because, if a patient can go and book the appointment on-the-spot, he most probably can go also to the ambulatory center. Thus, these services are requested only by active relatives, who have to go and book them, and home visits are very rare.

208. It can be concluded from the interviews with patients and patient organizations for treatment of the mental diseases that they urge greater emphasis on the provision of ambulatory healthcare and less emphasis on in patient care in hospitals, so that treatment in a less restricting environment can be provided close to people's home.

3.8.3. Follow-up

209. The current Latvian situation is still characterized by the fact that many patients with mental disorders whose treatment has been completed and maintenance therapy could be continued at home are in hospitals or public social care centres because they have no place to go or no housing of their own and by the fact that community based services are still underdeveloped.

210. It has been stressed by the representative of patient organizations that there are not enough group apartments in Latvia, to which patients can move after an intensive treatment in hospitals. The main problem is that municipalities are not able to provide necessary group apartments after hospital care to patients who have no relatives. At the same time it must be noted that the number of persons with mental disorders benefiting from group apartments has been increasing a little by each year. In 2009 there were only 59 persons with mental disorders receiving group apartment service, while in 2014, there were 242[9]. The Action Plan on Implementation of Deinstitutionalization for 2015-2020 developed by the Ministry of Welfare calls for an increase of the number of persons with mental disorders that receive social care services supported by European Structural Funds at their place of residence and an increase in the proportion living outside the institution with access to community based services (group apartments, day centres).

211. According to the opinion of the representative of patient organizations, the main challenges for implementing deinstitutionalization are the understanding and capacity of municipalities to provide group apartments and day centres, although there are municipalities where good services are being offered. In Talsi, for example, parents with

[9] Action Plan on Implementation of Deinstitutionalization for 2015-2020. Page 11. Approved by the decree No. 63 of 15 July, 2015 of the Welfare minister. Available at: http://www.lm.gov.lv/upload/aktualitates/null/2015_15_07_ricplans_final.pdf Accessed on 11.12.2015.

children with mental disorders have access to a family assistant[10]. In Tukums, mental health patients have access to group apartments and a day centre. Such services for persons with mental disorders are also offered in Riga, but demand outstrips supply.

3.8.4. Coordination among levels

212. Both specialists and general practitioners admit that the coordination of treatment within the field of mental health is minimal. A psychiatrist can be accessed directly without a referral. Thus, patients need not involve general practitioners; there is no mechanism to ensure that the GP is informed when their patient has visited a specialist and has received treatment.

213. As mentioned before, Latvia lacks ambulatory centres of mental health, where the treatment of patients is teamwork. At the moment patients are mainly assisted by medications, but ambulatory centres would allow talking not only with psychiatrists, but also other specialists, as well as obtaining non-medicinal therapies.

3.9. Pregnancy

3.9.1. Treatment and follow up

214. In general, consultations with a gynaecologist are directly accessible and do not need referral from a GP. According to interviewed gynaecologists, women have every opportunity to receive prompt gynaecological care. At the same time, experts draw attention to the fact that there are women who are not monitored even during pregnancy. These women mostly live outside Riga, have low socio-economic status, and are already raising several children. According to several experts, it is imperative to ensure monitoring of pregnant women in small regional healthcare institutions in order to guarantee assistance to women who have limited financial resources.

215. Some representatives of professional associations believe that the care of pregnant women could be provided by general practitioners or midwives working in GP practices, unless they are high-risk cases. However, the general practitioners interviewed recognise that they do not currently address gynaecology-related issues in their practice, leaving them fully reliant upon the competence of gynaecologists.

216. One of the gynaecologists underlines a problem of the lack of state-funded contraception. She considers that state-funded contraception should be available regularly, possibly once a month, and should be provided to women with low socio-economic status and those with HIV. That would allow at least a partial elimination of high-risk pregnancies. State-funded contraception could be issued by general practitioners and midwives working in a GP's practice.

217. Since the remuneration of gynaecologists in healthcare centres depends on the number of patients, gynaecologists are naturally interested in having more patients. However, as acknowledged by experts, increasing numbers of patients might prevent the quality of

[10] A family assistant service provides a support to families with children in case if one of parents or both are persons with mental disorders. They provide help in childcare, to solve and cope with problems in everyday lives, and acquiring necessary social skills according to an individually developed plan of social rehabilitation.

care. For example, if the gynaecologist has not had enough time to listen to every pregnant woman, they may fail to notice health problems which need immediate treatment.

218. Interviewed gynaecologists mentioned that in many cases the cost of additional ultrasonography must be paid by the expectant mothers themselves, but in cases when a pregnant woman cannot afford it, she can go on a waiting list for state-funded ultrasonography. But if ultrasonography cannot wait, the gynaecologist can hospitalise a patient where the procedure can be carried out immediately in order to get a diagnosis with the minimum of delay. But here another problem is encountered: the ultrasonography teams are overloaded in hospitals as well.

219. One facility manager identifies a problem of a shortage of medical help in acute cases. If during pregnancy a placental detachment starts, then emergency help can only be provided in Riga and at seven regional hospitals across Latvia. That means emergency help in life-threatening episodes involving heavily pregnant women is not always available at the nearest hospital across large parts of the country. This is largely due to a shortage of healthcare professionals who want to work day and night duty in hospitals.

220. Some women who have had a baby in the last three years also expressed dissatisfaction with the attitudes and behaviour of healthcare specialists. Regardless of whether a woman has given birth before, she expects support, empathy and encouragement at this special moment of her life. However, women's experiences sometimes reflect the opposite, they complain that some gynaecologists are impatient, treating them in a routine manner: "*She shouted at me and cursed, and as a result the birth process almost stopped. She cried out that women in times of war gave birth and did not complain, but I have come here and scream. It made me feel worse*".

221. One woman observed that the attitude of medical staff changed when a spouse arrived in the hospital to be involved in the labour process: "*I was placed in the operating room, but they forgot to turn on the heating. I was cold and my husband wasn't there. I asked if I could get to another room, where it could be warmer. All of them were full. Then I asked if somebody will come because I wanted to give birth. I was told to close the door because the staff will know when to come. My husband arrived and took out his telephone. To the question what is he doing, he answered that he is filming family labour. Then immediately they found a free room and the doctors started to do everything*".

222. Some women expressed that they have also been dissatisfied with postpartum care, because their general practitioners were very formal, not willing to give detailed consultations, and behaved as though a woman should naturally know everything after giving birth: "*I was a mother with experience, and the doctor was talking fast as a robot. To be honest, I had forgotten something. I asked the doctor, but she told me that I should already know it.*"

3.9.2. Coordination among levels

223. When pregnant women are monitored, collaboration between gynaecologists and general practitioners is mostly implemented via documents. Specialists indicate that it is possible to obtain state-funded examinations via general practitioners. It is especially important in cases, when the woman is visiting a gynaecologist who does not have

contractual relationship with National Health Service[11]. At the same time, according to experts, general practitioners do not always issue referrals and sometimes doubt the necessity of certain examinations.

224. With regard to the monitoring of pregnant women, some general practitioners consider that there is no collaboration between gynaecologists and general practitioners at all. Often the only contact a general practitioner has with a pregnant woman is when she, as instructed by the gynaecologist, has arrived for a stamp for her mother's passport (an official document of a pregnant woman required for receiving assistance in a hospital during childbirth in Latvia) that confirms that general practitioner is informed about the pregnancy or confirms to take care of a new-born.

225. According to one of the general practitioners, the collaboration of gynaecologists and other specialists often lacks coordination, as while taking care of a pregnant women each monitors only things being under his responsibility but does not assess the situation as a whole. For example, one of GPs in the focus group discussion discussed a real case when an endocrinologist prescribed insulin for a woman with type I diabetes mellitus, but analyses for the level of glucose were monitored by a gynaecologist, and due to a lack of coordination this case ended lethally, because *"endocrinologist knew nothing about that pregnancy, but only about the diabetes, while gynaecologist thought that everything goes normally with the pregnancy"*.

226. One of the specialists considers that monitoring of cases that are no high risk could be done by general practitioners or midwives working at the practices of general practitioners, where GPs would undertake the role of a coordinator for routine cases and refer pregnant women to a gynaecologist and also other specialists for high risk cases.

3.10. Recommendations

Perspectives of study participants

Healthcare personnel and managers

227. Healthcare personnel and managers suggest that the quality of primary care could be increased if the work load of GPs were more balanced. There are several alternatives identified by different experts. Some suggest that more nurses in GPs practices could be a solution. Others mention that the tasks of secretarial functions have to be removed from duties of nurses.

228. In order to increase a competence of GPs, one HR manager proposes the introduction of a requirement for doctors to do duty turns in the accident and emergency units of hospitals at least several times per year. In this case, an additional compensation would be offered to GPs as well.

[11] State guaranteed medical services are provided only by specialists having a contract with the National Health Service. In a case a gynaecologist is working as a private physician and does not have a contract with the National Health Service, referrals to some examinations and services may be issued by a general practitioner who has a contract with the National Health Service. This is important for a patient to save some money and use some state guaranteed medical services.

229. To increase a quality of diagnostic services, the Association of Latvian Oncologists, suggests organizing discussions on all unclear or wrongly diagnosed cases among oncologists and specialists. Another suggestion is that patients with an uncertain diagnosis should be referred to specialists with daily experience in particular diagnostic services, in particular those that perform ten or more diagnostic services a day.

Patients

230. The main dissatisfaction with health services among patients is connected with the wait lists and the attitude of doctors. Patients expect empathy and support, but they do not get that in all cases. Many patients complain that they are treated in a routine manner, with an indifferent or uncaring attitude. In some cases, the attitude of doctors has been characterized as impatient, and sometimes patients feel that they are a burden, because a doctor is very busy with many other things.

231. Patient organizations suggest that more attention should be paid to psychosocial rehabilitation in cases of oncological diseases and the provision of rehabilitation measures following a stroke. For treatment of mental diseases, patients and patient organizations suggest that more emphasis in Latvia should be placed on the provision of ambulatory health care, supporting the work of ambulatory centres and involvement of multidisciplinary teams. One of the obstacles for providing treatment in a less restricting environment is a problem of housing of patients. It has been indicated that there is an insufficient supply with group apartments to which patients could move after an intensive treatment in hospitals in Latvia.

Researcher perspective

232. To use the healthcare budget more effectively, efforts to improve the efficiency of primary care should be made. First, more attention should be paid to prevention issues, and in general both GPs and their nurses have to do more to educate patients on healthcare issues and to encourage them to follow treatment rules and adhere to drug prescriptions. GPs have to follow more the results of screenings and the diagnostic services patients have received. The genetic risks of patients also should be estimated as accurately as possible.

233. Second, the problem of coordination and information exchange identified by many GPs and specialists could be solved by implementing an effective e-health system, as this solution could decrease administrative burden in healthcare system.

234. Third, we suggest that the main responsibility in coordination of treatment of the patient in multi-diagnoses cases should be taken by GPs, but this has to be discussed among the particular doctors involved in the treatment.

Conclusions and recommendations

235. A workforce shortage has been identified as the most crucial human resource problem in the Latvian healthcare system by HR managers, facility managers, professional associations, and representatives of municipalities. Study participants associate the problem with low remuneration of healthcare personnel as well as an unattractive social and cultural environment of rural areas. The problem refers to different types of healthcare personnel, most crucially, to doctors working exclusively in hospitals, nurses, and doctors studying in residency.

236. To tackle these challenges, a comprehensive approach has to be developed. First, the notion of human resource planning may need to be further developed to deal with acute problems in the recruitment and retention of human resources in all levels of care. As municipalities have limited resources to provide financial support to facilitate relocation of staff, a national level support policy based on forecasts of human resources in healthcare may be necessary, which could include relocation grants for medical personnel and their family members and compensation for the rent paid on their apartment for several years. However, these measures should be discussed with stakeholders.

237. The second important problem in human resources identified in this study is the lack of labour market entry of young doctors. Some HR managers and representatives of professional associations suggested upper age limits for medical staff. A related problem is the performance of existing physicians. Professional associations have to work with transparent recertification standards for all healthcare staff. The NHS also has to keep its right to terminate contracts with healthcare service providers if there are clear indicators of poor performance. Greater introduction of premiums for high-quality performance is also recommended.

238. The third problem in human resources is the excessively small differences between the wages of various types of healthcare staff who display large variation in skills and responsibilities. When the national minimum wage is increased, the wages of the lowest paid healthcare staff also increase; however, other positions remain approximately the same. The study participants stressed the need to increase wages of healthcare staff. However, the feasibility of accepting this recommendation is linked to overall amount of budget devoted to healthcare in Latvia.

239. The FGDs and interviews suggest that access to healthcare is Latvia is severely limited – first, by the quota system of state-funded healthcare services in particular areas and long waiting lists; second, by an uneven distribution of state-funded healthcare services in the regions; third, by insufficient financial means of patients to pay for private services and pay the cost of transport; and fourth, by a custom in many healthcare institutions that requires informal payments from patients.

240. There also appears to be scope to use the existing healthcare budget more effectively. More attention could be paid to prevention issues. The current organisation of prevention measures puts most of the responsibility on patients, and due their high volumes of patients, GPs may not devote sufficient attention to supervision of their patients' prevention activities (timely screenings, evaluation of impact of lifestyle on health). In addition, patients, especially elderly people, do not have a habit of turning to GPs or nurses for prevention issues. Thus, both GPs and their nurses have to do more to educate

patients on healthcare issues, to follow the results of screenings and the diagnostic services patients have received, and to track drug adherence.

241. Second, coordination and information exchange among all levels of care should be improved and diagnostics services should be used in a more focused manner. The study indicates that no particular unit (family doctor or specialists) is responsible for coordination of treatment of patients with co-morbidities. It is a common opinion among family doctors and specialists that coordination exists only through official doctor conclusions, that each specialist deals with the patient only in the framework of his own specialisation, and that too much responsibility is given to patients themselves. Coordination could be improved by implementing an effective e-health system and by assigning the main responsibility for coordination to GPs.

Appendix 1: FGD in human resources

Thank you for finding time to take part in the discussion organized by the foundation „Baltic Institute of Social Sciences". This is one of six discussions with specialists that we organize in cooperation with the World Bank which provides consultative services to the National Health Service.

The goal of our discussion is to speak about attraction and quality of education of healthcare specialists and their availability in Riga and regions. This information will be used to get complete understanding of the reasons which prevent patients from receiving timely healthcare in priority healthcare fields from the point of view of healthcare specialist availability. Priority health care fields are: cardiovascular diseases, oncologic diseases, mental health, and mother and child health.

The information gathered in the discussions will be used for the development of guidelines of health networks in priority healthcare fields, paying special attention to the improvement of healthcare for people at risk of poverty.

'Rules of the game' or description of the discussion

We ask you to give your personal opinion freely and without fear. It is possible that your opinion will differ from what other participants think but it is very important that each person has a different experience. There are no right or wrong answers in this discussion and we do not have to reach one opinion.

Please, speak one at a time, do not interrupt each other and do not take offence if I interrupt you at some moments. Otherwise we might have not enough time for everyone to express their opinion. My task is to ask questions, moderate our discussion. If there is something unclear, you can ask me.

Necessity for recording and guarantee of confidentiality

Equipment for recording is used only to record everything that is discussed here and afterwards summarize your opinions. In order to clearly record all expressed opinions, it is important that several persons do not speak at once, therefore each of you will have your turn and if you want to add something or contradict, please, give a sign (for example, raise your hand) and I will give you opportunity to speak.

Length of our discussion is about two hours. Opinions expressed during discussions will be used only summarized and neither the World Bank, nor the National Health Service will know which opinion belongs to which specialist or organization. The record of our discussion will be deleted in six months after the end of the research.

Introduction

To organizations: Please, tell about the most urgent issues on the current agenda of your organization's work? *If necessary*: What are the most urgent issues regarding human resources – attracting and keeping employees, their training and reward?

To representatives of municipalities: Please, tell about issues that your committee/agency supervise regarding healthcare. Which are the most urgent healthcare issues in your municipality at the moment?

To representatives of medical institutions: Please, tell what institution/ organization do you represent, how many employees (doctors, nurses, administrative and other

staff) do you have, how constant is the composition of your employees (doctor practices situated in your premises)? What affects changes in your staff?

Availability of specialists

In your opinion is the number of healthcare specialists sufficient in healthcare institutions of … *(name city or region where the discussion takes place)*? Why yes/ no? Please, evaluate:

- the number of general practitioners and specialists in different subfields;
- the ratio of doctors and nurses in general and in subfields;
- in out-patient care institutions, hospitals and rehabilitation institutions.

Which specialists are lacking the most? In your opinion what are the reasons why there is a need for theses specialists?

Is there an overproduction of any specialists? Which are they? Why?

Is there an option for all young doctors to work in a specialty they have initially studied, for example, for general practitioners to establish a practice? Why yes/no?

If it is not mentioned before, specify: How do you evaluate sufficiency of doctors and nurses in the following fields: practices of general practitioners, cardiology, oncology, gynecology and psychiatry?

To representatives of medical institutions: Please, tell what do you do to attract new employees to your institution? What do you do to attract:

- doctors who are hard to attract/ who are not enough in your institution?
- other doctors?
- nurses?

Which methods have been effective and which – ineffective? Why? Do you plan to apply other methods for attraction and support?

If necessary, specify what kind of financial and non-financial incentives/ support is offered. If it does not lead to expected results, why?

What do you do if you cannot attract the necessary specialist to your institution?

If necessary: When do you make the first contact with new doctor or nurse (for example, before or during residency or later)?

How do you motivate doctors and nurses, who already work in your institution, in order to keep them?

Ask all:

What kind of cooperation is there between institutions and municipality regarding attraction of healthcare specialists?

What kind of cooperation is there between healthcare institutions and:

- professional associations of the field,
- trade unions regarding attraction of healthcare specialists?

Are there any conditions which limit the options to attract and keep healthcare specialists in your institution? If there are, please tell in detail.

Education and training of specialists

Is the education, training and experience of healthcare specialists sufficient in …. *(name city or region where the discussion takes place)* in order to fulfill their functions according to their work requirements? If not, then specify what exactly is not sufficient and in which fields.

What kind of additional training is necessary? Who could offer/ ensure it? What prevents its provision?

Amount of work and remuneration of healthcare specialists

Is the amount of work of healthcare specialists optimal in healthcare institutions of … *(name city or region where the discussion takes place)*? Why yes/ no? Please, assess:

- work amount of specialists in different subfields (especially of cardiologists, oncologists, gynecologists and psychiatrists),
- amount of work of doctors and nurses,
- in out-patient care institutions, hospitals and rehabilitation institutions.

In which fields there is the biggest work load of specialists? Why? How does it affect work organization and patient care in healthcare institutions?

To what extent is it common to work in several healthcare institutions or doctors practices? What are the most common forms of combining places of work? What is geographic location of several places of work? What is the most characteristic distribution of work hours between these places?

What composes the salary of healthcare specialists? What determines the rate of remuneration? *Specify, if necessary*: Who determines the rate, if institution and doctor has an agreement with the National Health Service? Who and on what basis determines the rate if the doctor works privately (without agreement with the National Health Service)?

Is the remuneration of healthcare specialists determined in the agreements with the National Health Service sufficient? Why yes/ no? Please, describe the average salary and its correspondence to the duties accomplished:

- by general practitioners,
- by specialists (especially of cardiologists, oncologists, gynecologists and psychiatrists),
- by nurses,
- by out-patient care institutions, hospitals and rehabilitation institutions.

Specify, if necessary: When speaking about remuneration of general practitioners, are rules clear how incentive for high quality performance is paid? How fulfilment of these criteria (13 in total) influences remuneration of other staff working together with general practitioner?

To your opinion, is there useful to clarify any other parts of remuneration of general practitioners, for example, for coordination of treatment of patients by other specialists etc.?

Will incentive for high quality performance (like it is for general practitioners) be useful to introduce for other specialists working in out-patient care institutions? Why yes/ no?

Is it possible to introduce the same system for doctors working in hospitals? Why yes/ no?

Duties of healthcare specialists

To representatives of medical institutions, if it is not already explained: Please, tell about the daily work organization in your practice/ institution? What is the distribution of duties between doctor and nurse? To what extent is the nurse involved in patient care?

To everyone: In your opinion could a nurse take more duties and involve more in patient care? Why yes/ no? What kind of functions could a nurse do? Would it require extra education? What kind?

What is your attitude towards current organization of patient care, namely, assigning the main responsibilities to specialists of primary ambulatory healthcare (in opposition to care in hospital or ambulatory specialist)? In your opinion does the system work well? What are the weak points that you see in patient care?

Conclusion

Summarizing the topics discussed today, in conclusion, please, give your comments on the main questions that in your opinion should be solved regarding availability of human resources in healthcare field. What would be the desirable changes?

Appendix 2: FGD guidelines for specialists

Thank you for finding time to take part in the discussion organized by the foundation „Baltic Institute of Social Sciences". This is one of six specialist discussions that we organize in cooperation with the World Bank which provides consultative services to the National Health Service.

The goal of our discussion is to speak about reasons that prevent patients to receive timely healthcare services in priority healthcare fields. They are cardiovascular diseases, oncologic diseases, mental health, and mother and child health. The information gathered in the discussions will be used for the development of guidelines of health networks in priority healthcare fields, paying special attention to the improvement of healthcare for people at risk of poverty.

'Rules of the game' or description of the discussion

We ask you to give your personal opinion freely and without fear. It is possible that your opinion will differ from what other participants think but it is very important that each person has a different experience. There are no right or wrong answers in this discussion and we do not have to reach one opinion.

Please, speak one at a time, do not interrupt each other and do not take offence if I interrupt you at some moments. Otherwise we might have not enough time for everyone to express their opinion. My task is to ask questions, moderate our discussion. If there is something unclear, you can ask me.

Necessity for recording and guarantee of confidentiality

Equipment for recording is used only to record everything that is discussed here and afterwards summarize your opinions. In order to clearly record all expressed opinions, it is important that several persons do not speak at once, therefore each of you will have your turn and if you want to add something or contradict, please, give a sign (for example, raise your hand) and I will give you opportunity to speak.

Length of our discussion is about two hours. Opinions expressed during discussions will be used only summarized and neither the World Bank, nor the National Health Service will know which opinion belongs to which specialist or organization. The record of our discussion will be deleted in six months after the end of the research.

Participant profile

To medical personnel: At the beginning, please, tell about your place of work/ medical practice. For example: for how long do you have practice, area you cover, number of patients, types of patients (elderly, chronically ill patients, children etc.).

How often do you contact your patients? On average how much time do you spend in a week to diagnose/ treat patients? And how much time for preventive measures?

How many patients do you have who already at the moment have the mentioned disease or high risk to get: cardiovascular diseases, oncologic diseases, mental health problems and how many women there are among your patients who could potentially have a high risk pregnancy?

To representatives of municipalities: Please, tell about issues that your committee/agency supervise regarding healthcare. Which are the most urgent healthcare issues in your municipality?

Health prevention

To medical personnel: To what extent are your patients interested in maintaining their health condition and preventing diseases? How would you describe patients who care for their health? What do they do?

Does a patient himself somehow encourage or prevent your cooperation on health prevention issues? What are the main problems that you face in cooperation with patients on health prevention issues?

Ask all: Do you currently do anything or have tried to do to encourage your patient/ municipality inhabitant to pay attention to health prevention and timely diagnosis of illnesses? Please, tell in more detail what did you do and in what areas. Was there responsiveness from patients/ inhabitants? How do you evaluate impact? What were the results? How long did the results last?

If such activities took place several years ago but not now: Why have not you repeated such kind of activities?

Is your and your employee education and experience sufficient to do health preventive activities of patients? What kind of additional education of health prevention would be necessary?

Patient care

Please, tell how daily work is organized in your practice/ institution? How are duties distributed between the doctor and nurse? To what extent is nurse involved in patient care?

In your opinion could a nurse fulfill more duties and involve more in patient care? Why yes/ no? What duties could a nurse do? What additional training and support would enable nurses to do more duties?

Are your education, training and experience sufficient to fulfill your (doctor's/ nurse's) duties according to requirements of the job? If not, then specify what is not sufficient.

What kind of additional training would be necessary for you to function fully and effectively in your main job?

Diagnosis and treatment

Does your practice/ institution have all of the necessary equipment (premises, equipment for diagnosis, medicine and IT equipment) in order to make quick examination of patient? *Question*: What is available in the institution and what – elsewhere? How far is it?

What do you do if a patient needs diagnosis procedures from other specialists? *If necessary*: In what cases do you decide that a patient needs a consultation from other specialist?

How do you communicate with other specialists who work ambulatory? How do you get information about the treatment if a patient has been in a hospital?

How do you evaluate exchange of information regarding further treatment of patient between you and specialists (both those who work ambulatory and those who work in a hospital)?

How do you decide who will do further treatment of the patient – you or specialist? What are the reasons for this choice?

Ask, if necessary: When speaking about four priority fields, to what extent do you treat such patients: in cases of cardiovascular diseases, oncologic diseases, mental health problems and care of pregnant women/ risk pregnancy.

Summarizing the previously mentioned, what difficulties do you face when you send your patients to:

- diagnostics,
- to other specialists,
- to hospital?

Are there any additional problems that you face regarding patients with cardiovascular diseases, oncologic diseases, mental health problems and risk pregnancy?

Remuneration of healthcare specialists

What composes your salary? What determines the rate of remuneration? *Specify*: What is the rate if you are a doctor with your own practice? What is the rate if you are employed by a health center?

Is the remuneration of healthcare specialists determined in the agreements with the National Health Service sufficient? Why yes/ no? Please, describe the average salary and its correspondence to the duties accomplished:

- by general practitioners,
- *if there are in a group*: by specialists (especially of cardiologists, oncologists, gynecologists and psychiatrists),
- by nurses,
- *by other healthcare specialists who take part in a group*.

Specify: Is the variable part of a remuneration of general practitioners for fulfilling quality criteria clear enough? To what extent does fulfillment of these criteria affect remuneration of other employees working in your practice?

In your opinion, is it necessary to clarify any other components of your salary, for example, for coordinating treatment of your patients by other specialists?

Conclusion

Summarizing the topics discussed today, in conclusion, please, give your comments on the main things that in your opinion should be changed in the current organization of patient care in order to promote timely diagnosis of illnesses and prevention in terms of:

- organization;
- education and preparation of doctors and nurses;
- informing and educating patients;
- relations between general practitioners, specialists and hospitals;
- organization (system) of health prevention.

Appendix 3: FGD guidelines for patients

Thank you for finding time to take part in the discussion organized by the foundation „Baltic Institute of Social Sciences". This is one of four patient discussions that we organize in cooperation with the World Bank which provides consultative services to the National Health Service.

The goal of our discussion is to speak about your experience of receiving healthcare – about situations when you go and do not go to the doctor and about the result, to what extent healthcare is available, what satisfies you and what does not satisfy in its current organization. The information gathered in the discussions will be used for the development of guidelines of health networks.

'Rules of the game' or description of the discussion

We ask you to give your personal opinion freely and without fear. It is possible that your opinion will differ from what other participants think but it is very important that each person has a different experience. There are no right or wrong answers in this discussion and we do not have to reach one opinion.

Please, speak one at a time, do not interrupt each other and do not take offence if I interrupt you at some moments. Otherwise we might have not enough time for everyone to express their opinion. My task is to ask questions, moderate our discussion. If there is something unclear, you can ask me.

Necessity for recording and guarantee of confidentiality

Equipment for recording is used only to record everything that is discussed here and afterwards summarize your opinions. In order to clearly record all expressed opinions, it is important that several persons do not speak at once, therefore each of you will have your turn and if you want to add something or contradict, please, give a sign (for example, raise your hand) and I will give you opportunity to speak.

Length of our discussion is about two hours. Opinions expressed during discussions will be used only summarized and neither the World Bank, nor the National Health Service will know what you have said during this discussion. The record of our discussion will be deleted in six months after the end of the research.

Participant profile

In the beginning tell a little about yourself – your age, from what place in Latvia do you come from and what is your occupation?

How have you dealt with your health issues till now?

Do you do anything for your health? What kind of activities do you do? Why in your opinion are these activities important?

Do you feel you have received enough information from your general practitioner/nurse or other medical professional on how to prevent diseases such as cardiovascular diseases or cancer?

What do you do in case of illness? To what doctors or specialists do you go for help? Where do you go in the first place? Why?

Do you have any long term/ chronic diseases that require regular supervision of doctor?

Personal experience of cooperation with general practitioner and specialists

Please tell about your cooperation with general practitioner? How often have you met your general practitioner over last year? *Question, if necessary*: Why do you visit general practitioner so rarely?/ Why do not you visit your general practitioner?

In your opinion is it necessary to go for preventive health check to your general practitioner? In your opinion how often should it happen?

Does your general practitioner or his/ her nurse go on home visits? If yes, who?

How does general practitioner promote preventive activities?

How do you cooperate in case of illness? How does general practitioner promote treatment?

Has there been a need to look for assistance of other specialist after visiting general practitioner?

Has general practitioner sent you to other specialists in order to diagnose a disease? If yes, then, please, describe cooperation with specialists:

- How long did it take to get a visit? Did you have to wait in a queue to make a visit/ get a visit?
- To what tests and examinations he/ she sent you? How long did it take you to get these tests? How long did it take you to get their results?
- After diagnosis who took over the further treatment? If it was not general practitioner, then why?
- What was necessary for receiving further treatment? How long did it take for you to receive it?
- Did the state cover expenses of your medical treatment or did you contribute yourself (or used health insurance)? How much did your treatment cost? What payments did you have to make? Did you have to borrow money to pay for your medical treatment?
- *If disease requires further supervision*: Does your general practitioner somehow involve in treatment or supervision of your disease? How does it happen?

Would you like to change your general practitioner? If yes, then why?

Mental health

Ask all: Have you experienced emotionally hard situations (for example, death of a family member, divorce) or overwork during the last years that caused anxiety, exhaustion, and insomnia? Please, tell about this situation.

Did you suffer through this situation? Who helped you? *Question, if necessary*: Did you go also to a doctor or other specialist (for example, homeopath, psychologist, astrologer etc.)?

Ask all: What would you do if you felt exhausted in emotionally hard situations, if you suffered from insomnia or anxiety? *Question*: Would you go also to a doctor? Why yes/ no? If yes, to what doctor would you go?

Men participants are asked to leave the discussion:

Supervision of pregnancy

To women: Have you been pregnant/ had a baby in the last years? Who supervised your pregnancy – general practitioner or gynecologist?

How did you choose a doctor who will supervise pregnancy? Describe the main reasons.

Was your pregnancy supervised by a doctor who has an agreement with the state (the National Health Service) or a private doctor? What were your considerations? How much did the supervision of your pregnancy cost?

Please, describe cooperation with the doctor who supervised your pregnancy.

Question, if necessary: To what indicators of your health did the doctor pay most attention? What questions did he/ she ask about your health?

To what tests and examinations did he/ she send you? How much time did it take for you to get these tests? And how long did it take you to get the results?

How did you choose a place for birth? Describe the most important reasons.

Conclusion

In the conclusion of our discussion, do you have any suggestions to improve medical care?

Appendix 4: interview guidelines for professional and patient organisations

Questions included in the guidelines for professional associations of doctors and patient organizations should be asked according to one of the four priority disease groups of the organization's work (for example, with oncologist organization and patient organization speak only about oncology).

Groups of diseases: cardiovascular diseases, oncologic diseases, mental health, mother and child (sexual and family) health

Introduction

Thank you for finding time to take part in the interview organized by the foundation „Baltic Institute of Social Sciences". This is one of the interviews with professional associations/ patient organizations that we organize in cooperation with the World Bank which provides consultative services to the National Health Service. The aim of our interview today is to talk about reasons that prevent patients from receiving timely healthcare in priority health fields. In your case we talk about the field where you work, that is … (*name the appropriate*). During this research we also organize discussions and interviews with specialists and individuals both in Riga and in regions. The information gathered in the research will be used for the development of guidelines of health networks in priority healthcare fields, paying special attention to the improvement of healthcare for people at risk of poverty. Your opinion is anonymous. Equipment for recording is used only to record everything that we discuss here and afterwards summarize the expressed opinions. The length of our conversation is about one hour. Opinions expressed during discussions and interviews will be used only summarized and neither the World Bank, nor the National Health Service will know which opinion belongs to which specialist or organization. The record of our discussion will be deleted in six months after the end of the research.

Diagnosis and treatment of illness

Please, tell what in Latvia at the moment prevents timely diagnosis of … (*name the disease group, in case of pregnancy – pregnancy risks*)?

Please, pay attention that all of the involved issues are covered: knowledge of doctors, motivation to supervise their patients, opportunities to do tests and other examinations for diagnosis, time spent for doing tests and receiving results etc.

Question, if necessary: Do general practitioners timely identify the risks of … (*name the group of disease*) and send patients to you for consultation? Why yes/ no?

In case of risk pregnancy: Is there sufficient cooperation between general practitioners and gynecologists or other specialists (for example, endocrinologists) to provide timely care in case of risk pregnancy? Why yes/ no?

What should be improved in order to diagnose diseases/ identify risks sooner?

What prevents timely treatment of … (*name the group of disease, in case or pregnancy – prevention of pregnancy risks*) in Latvia at the moment?

What should be improved in order to receive medical treatment sooner?

Is the patient care and further supervision in the period of remission optimal? Why yes/ no? What should be improved?

Ask only to professional associations:

Description of healthcare personnel

In your opinion is the number of healthcare specialists of … (*name the field*) sufficient? Why yes/ no?

Specify the sufficient number of ambulatory and hospital doctors and nurses.

If not, in your opinion what are the reasons why these specialists are not enough?

What kind of cooperation is there between your organization and employers in order to provide the necessary number of specialists in your field? Specify about the cooperation both with employers in Riga and in regions. What are the results of the cooperation?

Is the education, training and experience of healthcare specialists (doctors, nurses) working in your field enough in order to fulfill their functions according to the job requirements? *If not*, then specify, what exactly is not sufficient and in which fields.

What kind of additional training is necessary? Who could offer/ provide it? What prevents it?

Is the education, training and experience of general practitioners and their nurses sufficient in order to timely diagnose …(*name the disease*)? *If it is according to the context*: And in order to continue supervision of patients in the period of remission? If not, then specify what exactly is not sufficient and in which fields.

What kind of additional training is necessary? Who could offer/ provide it? What prevents it?

Is the workload of healthcare specialists of your field optimal? Why yes/ no?

How does it affect work organization and patient care in health care institutions?

To what extent is it common in your field to work in several healthcare institutions or doctor practices? What are the most popular forms of combining jobs? What is the geographical placement of jobs? What is the most common distribution of work hours between these places?

What composes the salary of healthcare specialists in your field? Specify the forms of remuneration according to

- whether specialist works ambulatory or in hospital,
- differences for doctors and nurses.

Is the remuneration of healthcare specialists determined in the agreements with the National Health Service sufficient? Why yes/ no? Please, describe the average salary and its correspondence to the accomplished duties in your field.

Ask to everyone:

What is your attitude towards current organization of patient care, namely, assigning the main responsibilities to specialists of primary ambulatory healthcare (in opposition to care in hospital or ambulatory specialist)? In your opinion does the system work well? What are the weak points that you see in patient care?

Ask only to professional associations:

How do you evaluate the current distribution of duties between doctor and nurse in outpatient care and in hospital? To what extent is nurse involved in patient care? In necessary, add: the World Bank has found out that in Latvia there is relatively large number of doctors and small number of nurses, as a result doctors have duties that a nurse could do.

In your opinion could a nurse have more functions and involve more in patient care (*specify about ambulatory nurses and hospital nurses*)? Why yes/ no? What functions could a nurse do?

Would it require additional education? What kind? What kind of additional training is necessary?

Ask to everyone:

Citizen education and health prevention

To what extent are citizens interested in maintaining their health condition and preventing diseases? What are the main problems that you face?

Do you currently do anything or have tried to do to encourage your patients/ inhabitants to pay attention to health prevention and timely diagnosis of illnesses?

Please, tell in more detail what did you do and in what areas.

What kind of responsiveness there was from patients/ inhabitants? What were the results? How long did the results last?

If activities took place several years ago but not now: Why have not you repeated such kind of activities?

Conclusion

Summarizing the topics discussed today, in the conclusion, please, give your comments on the main issues that should be solved regarding availability of health care in your field. What are the necessary changes?

Appendix 5: interview guidelines in mental health issues

Thank you for finding time to take part in the interview organized by the foundation „Baltic Institute of Social Sciences". The aim of our interview is to talk about your experience when receiving mental healthcare – about situations when you go or do not go to the doctor, to what extent is healthcare available and about attitude from other people towards your treatment. We organize these interviews in cooperation with the World Bank which provides consultative services to the National Health Service.

Equipment for recording is used only to record everything that we discuss here and afterwards summarize your opinions. Your opinion will be used only summarized. The record is available only to us and it will be used only for summarizing information. The record will be deleted in six months after the end of the research.

Introduction and description of the situation

In the beginning tell a little about yourself – your age, from which place in Latvia do you come from, what is your occupation? What kind of disease was diagnosed to you?

Medical history

Please, tell shortly how diagnosis of your disease took place. When did it begin? How did you feel?

Did you look for some kind of help? Did you go to the doctor? Why yes/ no? If yes, to what kind of doctor did you go? What kind of help did you receive? What was the attitude from the doctor?

Who first determined what might be wrong?

What kind of treatment did he/ she offer you – outpatient treatment (spending time at home, regularly visiting doctor) or treatment in hospital? Why?

How do you evaluate the treatment you received …. (*name the corresponding answer according to the experience of respondent*)? How did it take place? How often did you have contact with the doctor? How often with the nurse?

What kind of information did you receive about the disease that was diagnosed to you and about its treatment during the treatment you received? Was this information sufficient?

How do you evaluate the results of the treatment? In your opinion would they be different if you had …. (*name the opposite answer, if respondent received hospital treatment, then outpatient treatment*) treatment?

Were your family members, friends and acquaintances informed about the disease diagnosed to you?

If yes, how did they find out? What was their attitude? How did they treat you? Was it different from the time before the disease was diagnosed? What changed?

If no, what are the reasons why you have not talked to your family members, friends or acquaintances about the disease diagnosed to you?

Did you face any difficulties to return to your daily life after recovery/ leaving hospital… (*choose the words according to the experience of respondent*)? What kind? How did you solve them?

Experience of cooperation with healthcare personnel

Do you need any treatment or supervision at the moment? Please, tell how your cooperation with the doctor takes place? What kind of doctor is it (general practitioner, psychiatrist etc.)? How often do you visit doctor? Who decides about frequency of visits?

What you usually do if you feel worse?

In case of psychiatrist: Does your general practitioner know that you have a mental illness? Why yes/ no?

Do you need any additional support from general practitioner when visiting … (*psychiatrist or other specialist whom the respondent mentions regarding illness)*? What kind? Do you receive it?

What kind of support for doctor or nurse do you want to receive regularly?

Prevention of mental health

Do you do any preventive activities for your (*if necessary*: mental) health? What kind of activities do you do? In your opinion why are these activities important?

Do you think that you have received enough information from your doctor on avoiding declining of your health?

Evaluation of treatment alternatives

From your experience does the outpatient treatment differ from the treatment in hospital? How?

If necessary, question: What kind of treatment would you like better – outpatient or hospital? Why?

When having outpatient treatment, do you prefer regular visits to doctor or doctor's home visits? Why?

How do you prefer to live: by self, with family or in a half-way house (*explain term if needed*)?

What kind of support do they need on a regular basis from healthcare professionals? How often? *Clarify for each group of specialist*: general practitioner, psychiatrist, social worker.

Conclusion

In the conclusion of our conversation, do you have any suggestions to improve medical care?