





Foreword

Dear Reader,

This year Health Compulsory Insurance State Agency has published the annual, already the 16th edition of the News of the Agency, providing comprehensive summary on spending of the state budget resources for providing health care services. Like in previous editions also showings of year 2007 represent useful information to enable everybody make a relative assessment of changes and realize the overall development in health care.

Also in 2007 like in previous years, tariffs for health care services were revised and remuneration of medical personnel in accordance with the main statements "Development of human resources in health care" was taken into account during calculations.

Also the payment for the conduct of preventive medical inspections has substantially changed. Family doctors are paid in addition, in accordance with fixed supplements for each performed case of preventive examination. Moreover, changes have also been introduced in the performance of these preventive examinations, that is, family doctor's prescription for seeing a gynaecologist is no more needed to go through this preventive inspection.

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1. Health care budget

A separate budget program "Health care" provides resources for execution of functions delegated to the Health Compulsory Insurance State Agency (hereinafter referred to as the Agency), whose main objective is provision of health care services at the primary, secondary and tertiary levels within the volume set by the state, as well as provision of compensation for reimbursable medicaments and centralized procurement of medicaments.

The resources from the state basic budget for health care financing are allocated in accordance with the Law on the state budget for the current year and consist of:

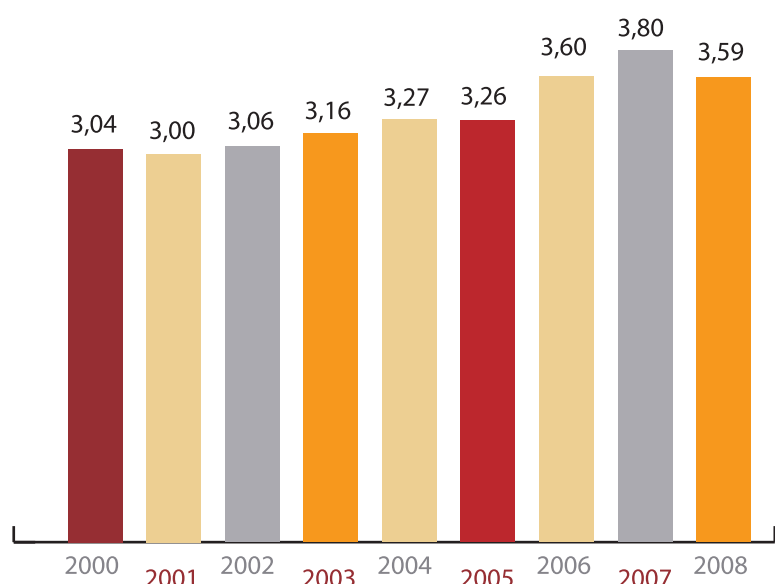
- State basic budget subsidy – resources, which the state budget institutions or self-governments receive according to centralised procedure with a definite objective or without it. These are taxes and fees paid into the state budget as revenues or gained from other payments;
- Services for pay and other own income – resources forming from services for pay provided by institutions to be financed from the state budget and remitted to the basic budget or special budget accounts of budget institutions opened in the State treasury and spent for financing of expenditures;
- Foreign financial assistance – financial assistance received from the European Union (hereinafter referred to as the EU) and foreign governments, international organizations or other foreign assistance providers.

The Agency administers the state budget resources anticipated for health care, concludes contracts on the provision of health care services in accordance with other laws and regulations, within the framework of the annual Law on the state budget.

1.1. Administration of the state budget resources anticipated for health care

518,1 million lats were anticipated for health care in 2007, constituting 3,80% of the gross domestic product. It can be concluded upon examining the dynamics of health care budget proportion out of the gross domestic product that it has had a tendency to stay up within the limits from 3,00% to 3,80% since 2001. In comparison with 2006 health care resources out of the gross domestic product have increased by 0,20%.

Resources for health care, as % of GDP



* Data provided by:

Ministry of Health

* Until 2003 – consolidated health care budget (fulfilment);

2004 - 2005 – basic budget of the field (fulfilment);

2006 – the Law "On the State Budget for 2006";

2007 - the Law "On the State Budget for 2007";

2008 - the Law "On the State Budget for 2008".



The part of health care state budget resources from the common health care budget to be administered by the Agency

Showings	2005	2006	2007
Resources for health care, million LVL	295,5	405,8	518,1
The part to be administered by the Agency, million LVL	276,2	385,9	471,3
Increase of resources in comparison with previous years, %	119,6	139,7	122,1
From the common health care budget, %	93,5	95,1	91,0

Fulfilment of health care budget programs in 2007, %

Health care budget programs	LVL
Payment for medicaments	61 325 383
Medicare	368 366 346
Centralized procurement of medicaments	4 589 507
Reserve fund	1 408 612
Other programs	35 631 820
Total	471 321 668

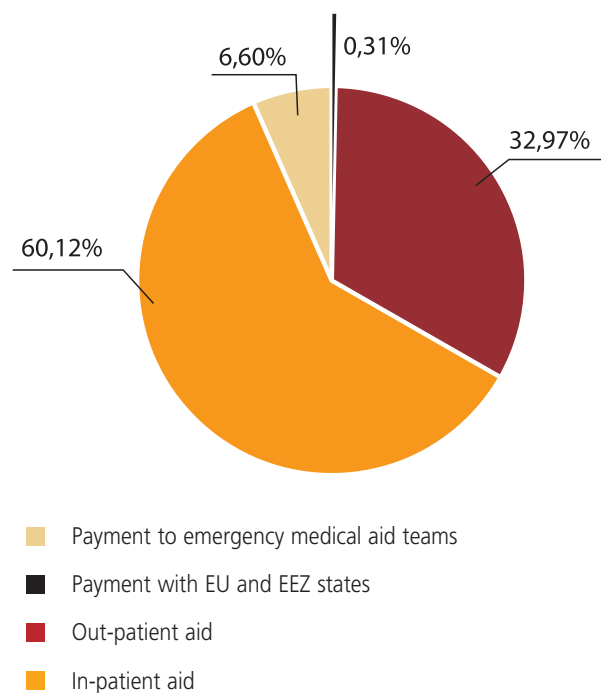
1.2. Medicare

Funds in the sub-programme "Medicare" are intended to pay for out-patient and in-patient aid services paid up from the state budget, for services by emergency medical aid teams, as well as for payments with EU and European Economic Zone (hereinafter referred to as the EEZ) member states in respect of health care services provided to the population of Latvia.

The Agency's headquarters is responsible for concluding contracts with medicare institutions on the provision of and payment for in-patient health care services and emergency medical aid services, but the Agency's territorial offices conclude contracts on the provision of and payment for out-patient health care services.

Payment for provided health care services is executed in accordance health care service tariffs prescribed in Regulations No 1046 of 19 December 2006, issued by the Cabinet "The Procedure of Health Care Organization and Financing" In accordance with paragraph 5 of Regulations No 1046, the anticipated amount to be paid for out-patient health care services shall not be less than 32%, for in-patient health care services shall not exceed 61,6% and, for services of emergency medical aid teams shall not be less than 6,4%.

Application of funds made available to pay for services in 2007, %



1.3. Application of the reserve fund

The application of funds in the sub-program "Reserve Fund" shall be as follows:

- There occurs an unscheduled change of the amount of patients (except for epidemics in accordance with laws and regulations which regulate the epidemiologic safety);
- For meeting requirements prescribed in international agreements which regulate the sphere of health care;
- For unscheduled measures related with informing the public on possibilities to receive health care services;
- For ensuring the health care reform and optimisation of the structure of service providers.

Dynamics of application of the reserve fund, breakdown into objectives, LVL

Measures	2005	2006	2007
Unscheduled change in the amount of patients	1 931 879,98	115 991,62	0,00
Meeting requirements prescribed in international agreements which regulate the sphere of health care	109 363,80	1 010 472,04	16 545,97
Measures related with informing the public on possibilities to receive health care services	145 921,83	787 469,94	305 285,15
Ensuring the health care reform and optimisation of the structure of service providers	467 119,79	3 002 808,69	1 086 781,16
Total	2 654 285,40	4 916 742,29	1 408 612,28
Increase/decrease of funds against the previous period (LVL)		2 262 456,89	-3 508 130,01
Funds against the previous period (%)		185,24	28,65

Most of monies from the reserve fund were channelled to ensure the health care reform and optimise the structure of service providers – LVL 1 086 781 or 77,15%, out of which LVL 120 000 went to the Agency of Health Statistics and Medicine Technologies to establish an EU Structural Fund Cooperation Office, but LVL 100 000 went to "Jelgava Hospital for Tubercular Patients" Ltd., to ensure the process of liquidation, as well as other.

It should be noted that LVL 305 285 or 21,67% had been channelled for informing the public on possibilities to receive health care services. Out of these LVL 161 311 were applied to purchase transmission time for series of radio and television programs through which to inform the population on the structure of the health care system, as well as on the health care budget and its formation.

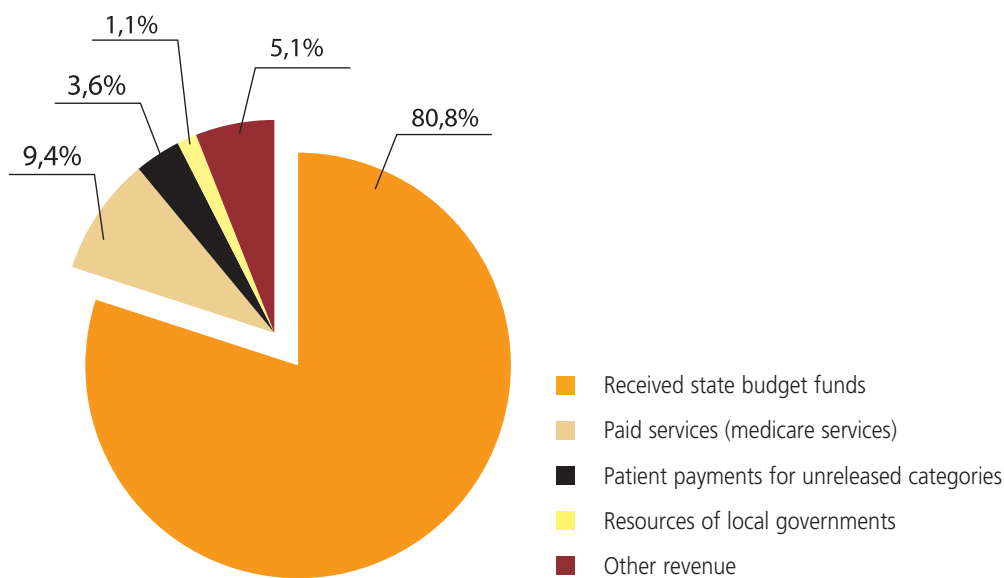
LVL 16 546 or 1,18% had been channelled to meet the requirements prescribed in new international contracts which regulate health care. These funds were channelled to medicare institutions in accordance with the mutual agreement "Agreement between the Republic of Latvia and the Ukraine on Cooperation in Social Security".



2. Operational characteristics of medicare institutions

The sub-division "Operational Characteristics of Medicare Institutions" contains information on the income and expenditures of medicare institutions, the average salary of their employees, collected patient payments and the structure of employees. The above mentioned data have been obtained from reports submitted by medicare institutions.

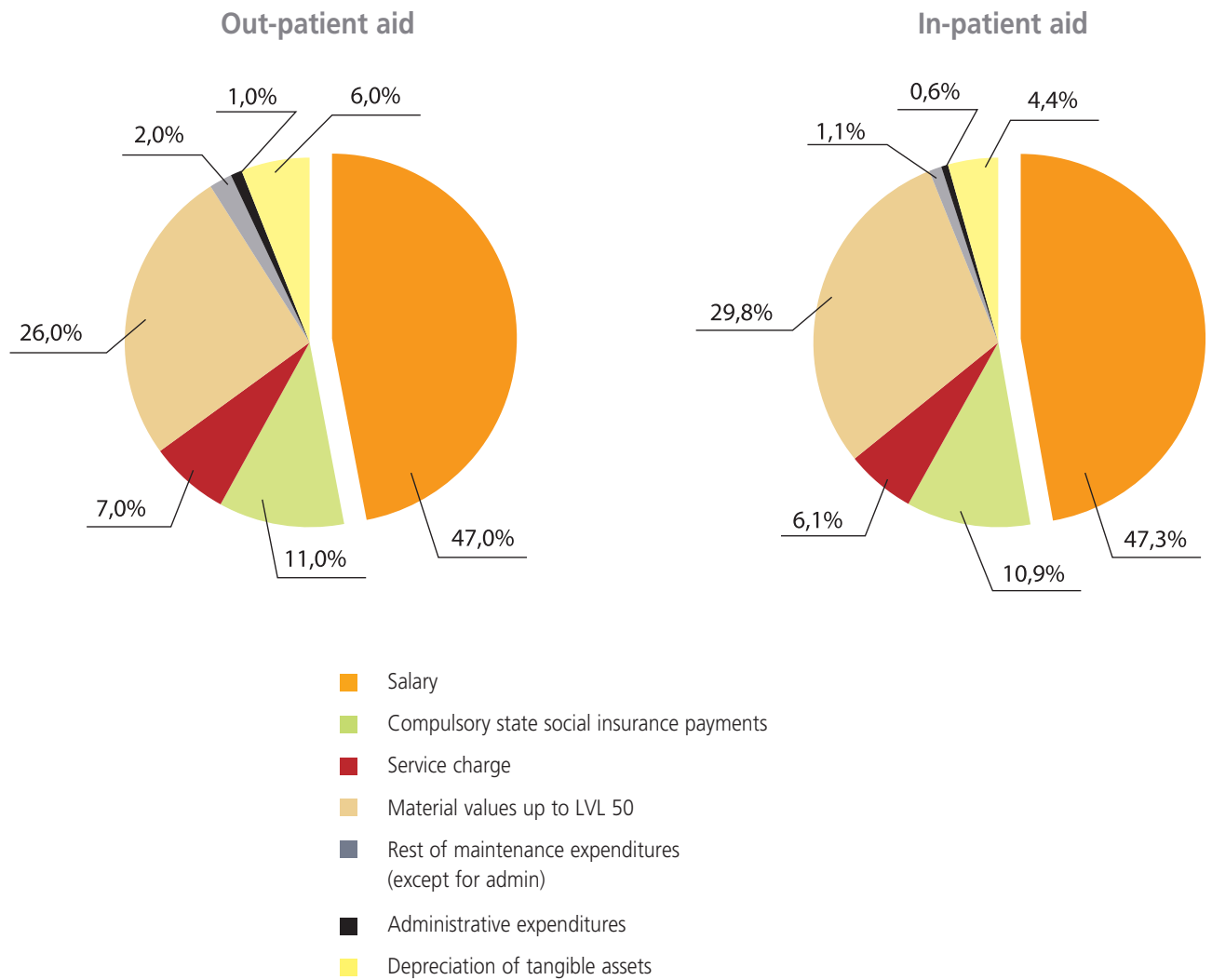
Income structure of medicare institutions in 2007, (%)



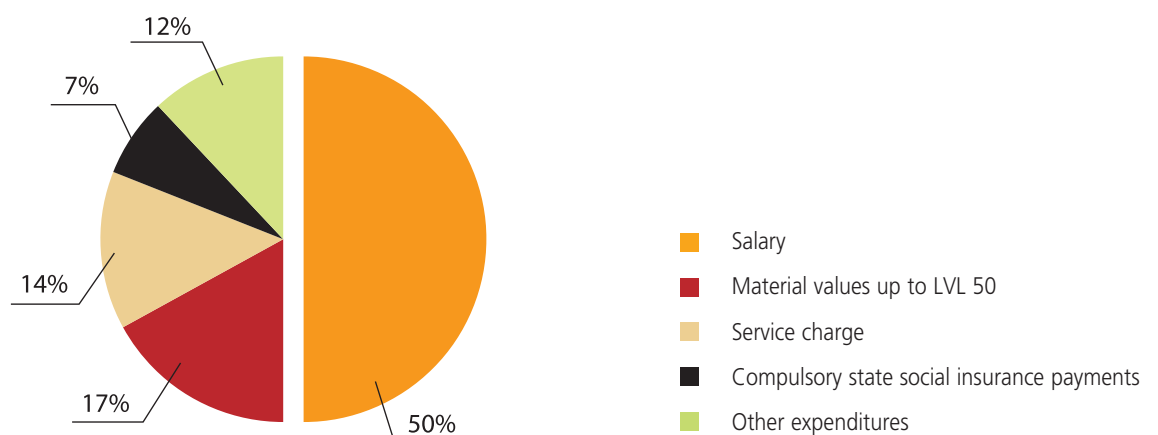
Patient payment collected by medicare institutions, LVL

	2005	2006	2007	%
	LVL	LVL	LVL	
Collected patient payment	12 898 361	17 077 938	15 234 007	58
Compensation of patient payments from the state budget funds for freed categories	9 077 445	13 946 493	11 257 941	42
Patient payment TOTAL	21 975 806	31 024 431	26 491 948	100

Structure of expenditures by medicare institutions

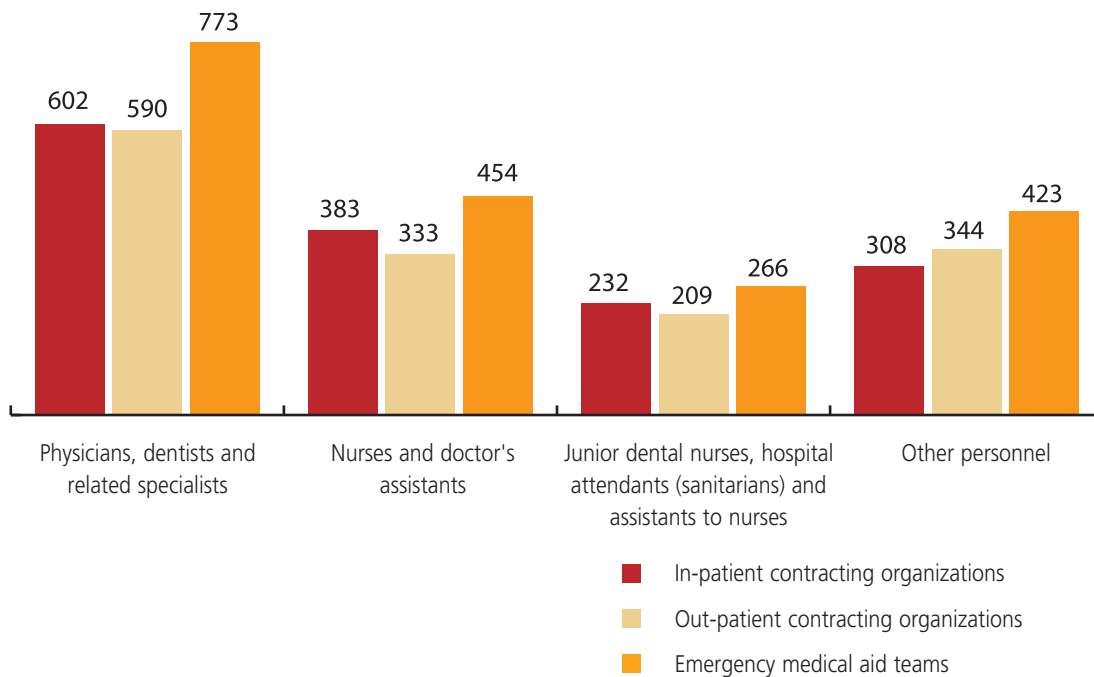


Structure of expenditures by practises of physicians





Average monthly salary in contracting organizations of the Agency's offices per employee, in 2007 (LVL) *

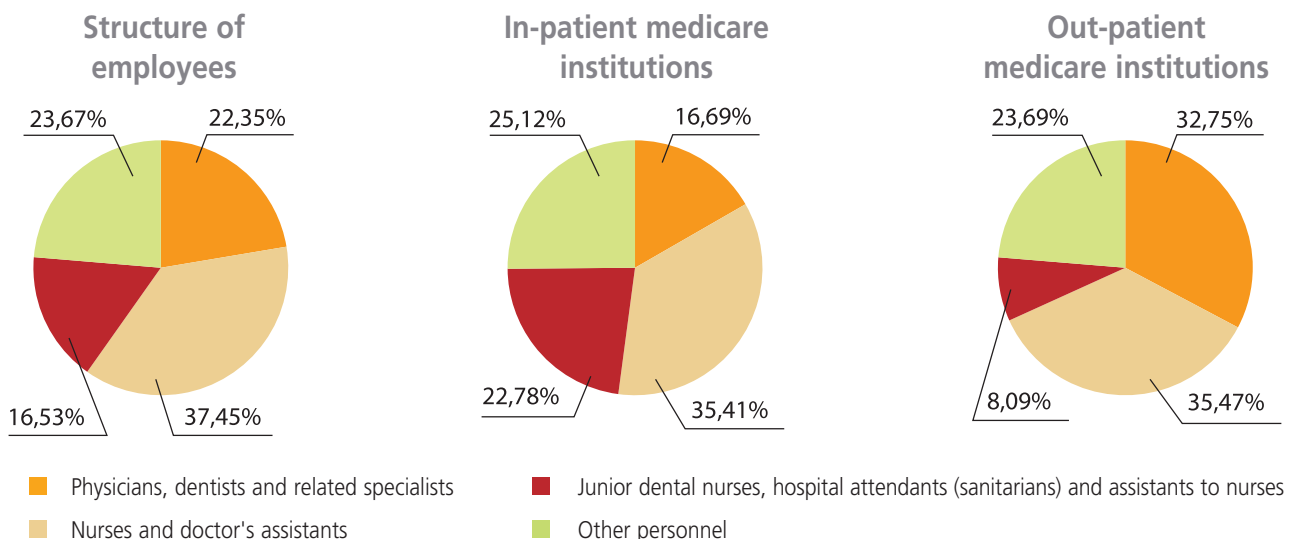


* Salary from the state budget resources is included in accordance with the information submitted by medicare institutions. No information has been included about the salary of primary health care physicians who are self-employed persons as to their legal status.

Structure of employees

In comparison with 2006 the proportion of physicians and related specialists within the structure of health care employees has increased by 1,54 %, ie. from 20,81 % in 2006 to 22,35 % in 2007. The proportion of nurses and doctor's assistants, in its turn, has decreased by 3 % in comparison with 2006 (40,45 %).

The proportion of junior dental nurses, hospital attendants (sanitarians) and assistants to nurses has also decreased by 0,07 % (16,60 % in 2006). Proportion of the rest of personnel has increased by 1,53 % in comparison with 2006 (22,14 %).



3. Procurement of and payment for medicaments

Funding made available for procurement of medicaments*, LVL

Subprogram	2005	2006	2007
Procurement of medical remedies, total	74 984 624,56	91 466 598,01	127 693 579,00
of which			
from the subprogram "Payment for Medicaments"	30 413 006,00	42 689 612,00	61 325 383,00
from the subprogram "Reserve Fund"	46 053,00	-	-
from the subprogram "Centralized Procurement of Medicaments"	7 382 437,00	3 397 680,00	4 589 507,00
from the subprogram "Payment for Services Medicare" – funds used to procure medicare remedies for out-patient and in-patient medicare institutions*	36 855 853,00	45 045 936,27	59 841 210,00
from the subprogram "Health Care Services for Pay/ Health Care of Retired Russian Federation Military Persons"	287 275,56	333 369,74	1 937 479,00
Health care budget, total	276 195 340,00	385 859 105,00	471 321 668,00
Proportion in health care budget (%)	27,15	23,70	27,09

* Information is summarized in accordance with data submitted by medicare institutions on resources spent for the procurement of medicaments

3.1. Ensuring of reimbursable medicine in out-patient treatment

Funds made available in the subprogram "Payment for Medicaments" are used to ensure the reimbursement of procurement expenses as to medicine and medical remedies anticipated for out-patient treatment, in accordance with the patient's sickness diagnosis, nature and seriousness. The reimbursement of expenses is executed in accordance with Regulations No 899 of 31 October 2006 issued by the Cabinet "The Procedure of Reimbursement of Procurement Expenses as to Medicine and Medical Remedies Anticipated for Out-patient treatment" (hereinafter referred to as "Regulations No 899").



Application of funds to reimburse procurement expenses as to medicine, medical devices and products anticipated for out-patient treatment, LVL

Showings	Reimbursement of procurement expenses as to medicine, medical remedies and products anticipated for out-patient treatment in 2007	
	Cash flow	Actual expenses
Balance as at 01.01.2007	940,96	X
Income, total	63 253 668,28	X
from the program "Payment for Medicaments"	61 318 032,57	X
from the program "Health Care of Retired Russian Federation Military Persons"	1 916 410,00	X
Income from paid services and other own income	6 547,99	X
Repayment of debtors, 2006	12 677,72	X
Expenditures, total	63 254 470,93	63 649 367,03
Balance as at 01.01.2008	138,31	X

In 2007 the subsidy from general income to the tune of LVL 61 318 033 was anticipated to reimburse the procurement of medicine, medical equipment and goods for outpatient treatment within the state budget subprogram "Payment for Medicaments", as well as funds channelled from the program "Health Care of Retired Russian Federation Military Persons" in the amount of LVL 1 316 410, and other own income in the amount of LVL 6 548 were anticipated.

For the reimbursement of medicine procured by individual patients the Agency planned to spend not more than 2% out of funds made available for the reimbursement of medicine which in 2006 constituted LVL 1 264 617, actual application in the amount of LVL 357 909,29.

All in all 448 924 patients have received reimbursable medicine for LVL 63 291 457,74 (except for individual patients). At an average one patient has received reimbursable medicine for out-patient treatment in the amount of LVL 140,98 for medicine to be recompensed for outpatient medical treatment. In 2007, 4 382 353 prescriptions were written out, the average value per prescription constituted LVL 14,44. Patients have covered the non-reimbursable part of the price within the framework of medicine reimbursement system in the volume of LVL 7 524 185,73, as well as paid in addition to medicine reference price in the volume of LVL 5 141 648,83. Thereby, patient payments while receiving the medicine reimbursed by the state constituted LVL 12 665 834,56, which makes 20% out of payment funds anticipated for reimbursement of medicine from the state budget.

Most of prescriptions, that is, 2 497 473, have been written out to patients with blood circulation system diseases; 567 743 to patients with endocrine, alimentary and metabolic diseases; 306 884 to patients with mental diseases and behavioural disorders and; 269 731 to patients with respiratory system diseases which constitutes 83% out of the total number of written out prescriptions.

Most of monies have been paid for reimbursable medicine in 2007 to treat the following diseases: blood circulation system diseases (LVL 13 821 551,49), endocrine, alimentary and metabolic diseases (LVL 11 911 189,64), tumours (LVL 7 962 497,81) and mental diseases and behavioural disorders (LVL 5 050 910,51).

In the list of reimbursable medicine in 2007 the reimbursement amount was increased in respect of several groups of diseases, new general names of medicine were included, as well as provisions for writing out several types of medicine were changed, widening patient groups for their reimbursement. The above changes caused both the increase of the number of prescriptions

written out in respect of reimbursable medicine and average expenses per one prescription price, resulting, in its turn, in the increase of actual expenditures for the reimbursement of medicine procurement expenses.

In 2007 in comparison with 2006, the price of one prescription increased by 24% at an average, but the number of prescriptions in all groups of diagnosis increased by 16% at an average; actual expenditures increased by 43%.

During 12 months of 2007, the reimbursement of procurement expenses as to the medicine anticipated for out-patient treatment was executed in respect of 99 individual patients for the amount of LVL 357 909,29 (1 patient for LVL 3 615).

Dynamics of the allocation of funds for reimbursable medicine, LVL

	Funds made available			Actual application		
	2005	2006	2007	2005	2006	2007
Total	30 609 709,00	42 686 788,00	61 318 033,00	30 518 133,00	44 493 352,18	63 649 367,03

Number of written out reimbursable medicine prescriptions and the average price of one prescription, LVL

	2005		2006		2007	
	Number of written out prescriptions	Average price of one prescription (LVL)	Number of written out prescriptions	Average price of one prescription (LVL)	Number of written out prescriptions	Average price of one prescription (LVL)
	Total	3 068 536	9,86	3 779 563	11,67	4 382 353

Allocation of funds for reimbursable medicine, breakdown into diagnosis, LVL

Number of patients	2005		Number of patients	2006		Number of patients	2007	
	Utilised funds (LVL)	Funds utilised per patient (LVL)		Utilised funds (LVL)	Funds utilised per patient (LVL)		Utilised funds (LVL)	Funds utilised per patient (LVL)
Out-patient treatment of insulin-dependent diabetes mellitus patients								
6 444	1 831 050,86	284,15	6 419	2 086 593,17	325,07	6 867	2 497 971,53	363,76
Out-patient treatment of insulin-independent diabetes mellitus patients								
43 784	4 857 572,01	110,94	49 018	5 858 532,39	119,52	53 108	7 711 584,61	145,21
Out-patient treatment of oncology patients								
12 813	2 524 834,78	197,05	14 593	4 782 966,72	327,76	16 038	7 962 497,81	496,48
Out-patient treatment of patients with psychic and behavioural disorders								
17 858	3 322 325,09	186,04	17 509	4 243 376,15	242,35	18 130	5 050 910,51	282,84



3.2. Procurement of medicaments for the needs of medicare institutions

In 2007 the Agency upon carrying out the purchase of medicine, medical devices and products for the needs of medicare institutions, executed 33 procurement procedures, including 21 open tenders, 7 price inquiries and, 5 negotiation procedures. Also

- 11 contracts were concluded on the supply of medical remedies and,
- 94 general agreement based contracts were concluded with suppliers and medicare institutions.

The Agency is also the one which orders the procurement and pays for it – 5 procurement procedures (3 open tenders and 2 negotiation procedures).

The Agency also acts as the authority of centralised procurement while a medicare institution acts as a payer – 14 open tenders.

Medical remedies procured in a centralised way (the Agency acts as a payer), LVL

Procurement	Paid up funds in 2007
"Supply of vaccines, standard tuberculinum and syringes for 2007"	2 885 610,14
"Medical remedies of peritoneal dialysis supply for 2007"	1 440 935,56
"Phenylketonuria correction preparations and dietetic therapy products for 2007"	239 185,03
Total	4 565 730,73

4. Analysis of out-patient health care activity

Planned volume and actual application of funds in out-patient health care

Payment	Planned volume, LVL	Actual fulfilment within the contract, LVL
Number of health compulsory insurance participants	2 280 385	2 280 385
Total funds for out-patient care	120 905 134,00	115 600 562,55
<i>LVL per health compulsory insurance participant</i>	<i>53,02</i>	<i>50,69</i>
<i>of which</i>		
1. Services by primary health care (PHC) physicians	46 264 848,00	41 771 378,65
<i>LVL per health compulsory insurance participant</i>	<i>20,29</i>	<i>18,32</i>
<i>% out of out-patient funds</i>	<i>38,26</i>	<i>36,13</i>
2. Payment for other out-patient services (secondary out-patient health care)	70 677 093,00	69 116 815,23
<i>LVL per health compulsory insurance participant</i>	<i>30,99</i>	<i>30,31</i>
<i>% out of out-patient funds</i>	<i>58,46</i>	<i>59,79</i>
3. Patient payment reimbursement for freed categories	3 963 193,00	4 032 210,00
<i>LVL per health compulsory insurance participant</i>	<i>1,74</i>	<i>1,77</i>
<i>% out of out-patient funds</i>	<i>3,28</i>	<i>3,49</i>
4. The sum to be paid by the Agency within the amount of the contract, in accordance with paragraphs 140 and 141 of the Regulations No 1036 *		680 158,67
<i>LVL per health compulsory insurance participant</i>		<i>0,30</i>
<i>% out of out-patient funds</i>		<i>0,59</i>
Total funds for out-patient payment	120 905 133,71	x
<i>of which</i>		
Funds for out-patient health care	115 939 840,71	X
Funds paid in the end of 2006 as advance payment for 2007	4 965 293,00	X

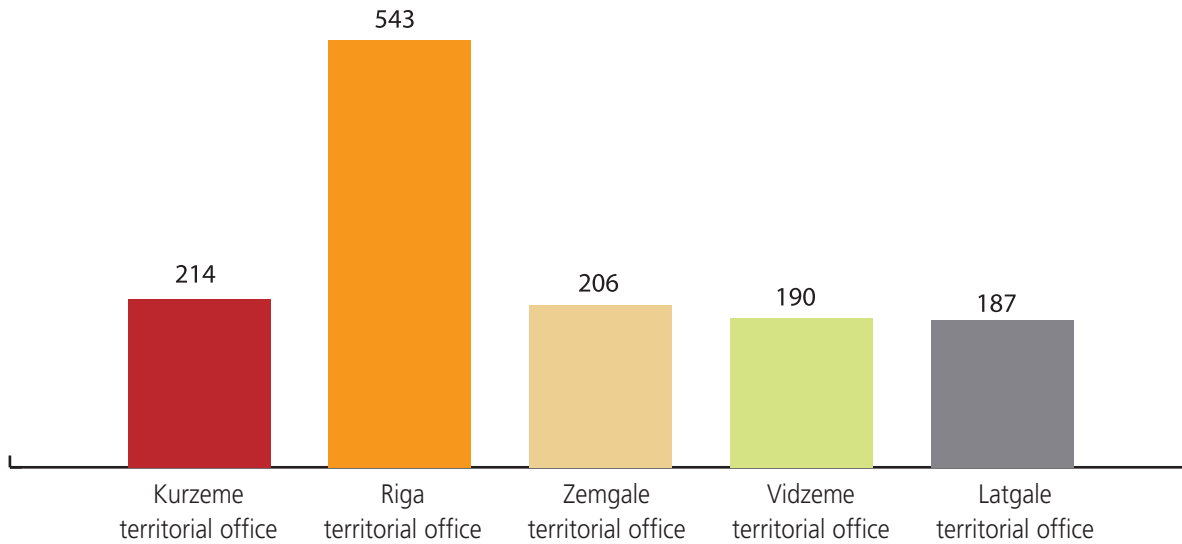
* Regulations No 1046 "Health care organization and financing procedure" issued by the Cabinet of Ministers:

* Paragraph 140. If the health care service provider fails to amount or exceeds the anticipated annual financial amount by maximum 5 % out of the anticipated annual financial amount, the Agency will pay to the service provider the entire anticipated annual financial amount;

* Paragraph 141. If the health care service provider exceeds the anticipated annual financial amount by more than 5 %, the Agency will pay to the health care service provider 25 % out of the exceeded amount.

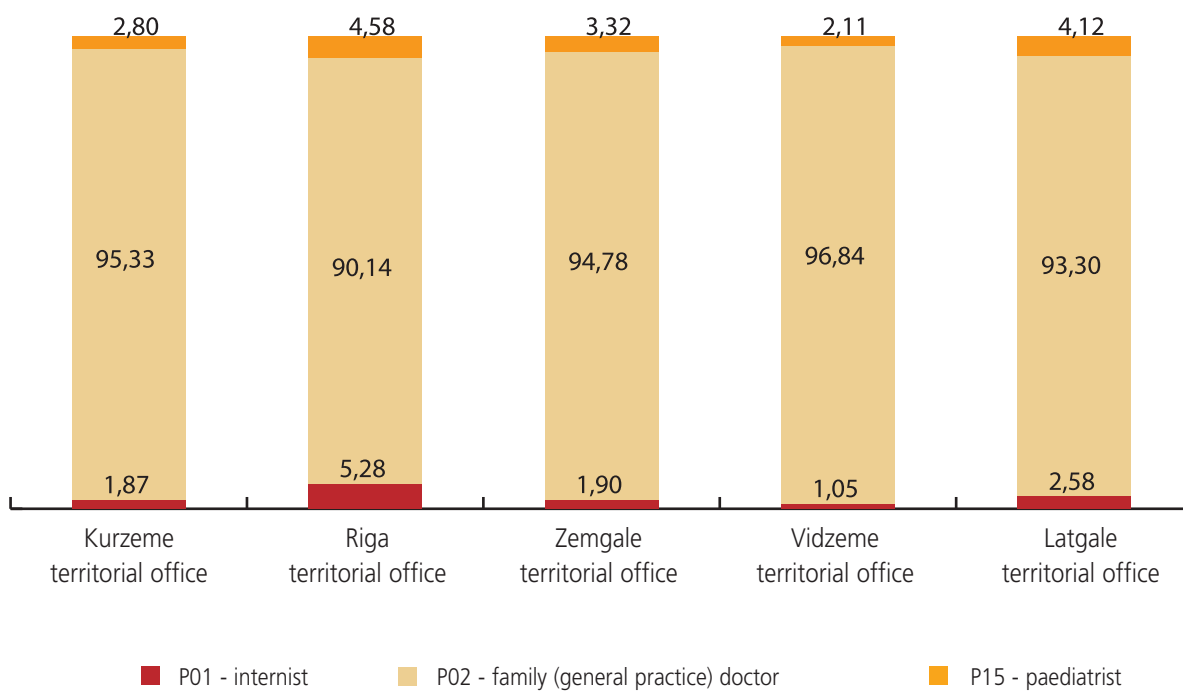


Division of family doctors by territorial offices



The above figure shows the division of family doctors by the Agency's territorial offices. Most of family doctors work in the territory of Riga where the density of population is the highest. This division of family doctors by regions is proportionate to the density of population.

Division of family doctors by specialities, %

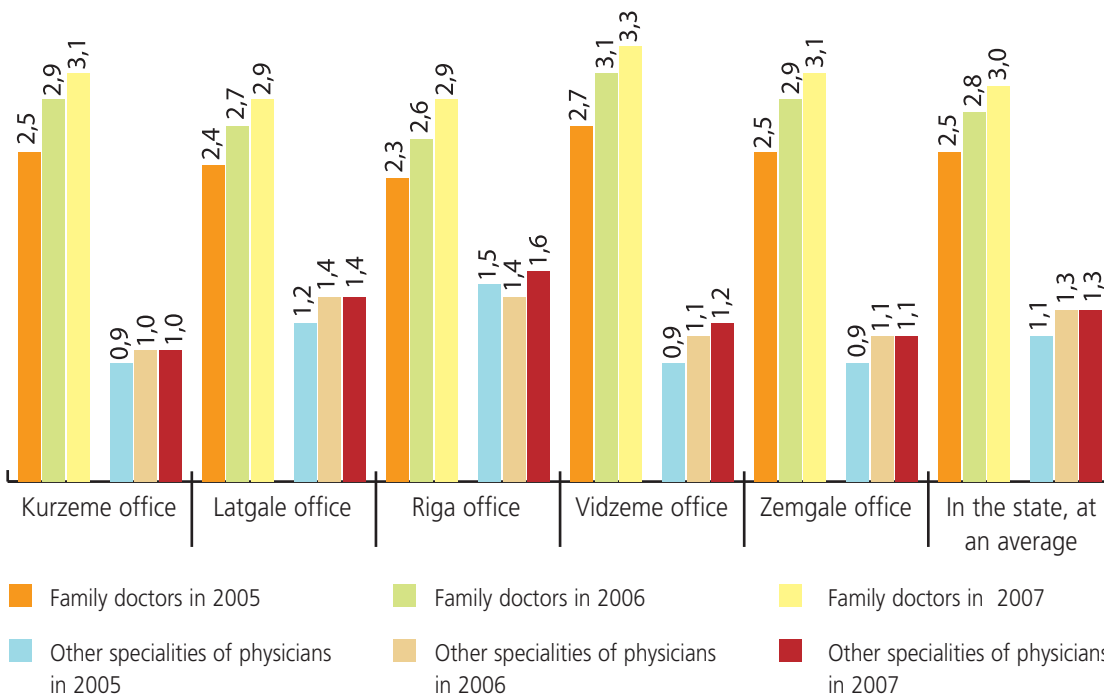


Mainly all primary health care physicians, that is 90 -96%, have a speciality of a family (general practice) doctor. This division of family doctors is proportional in all territorial offices of the Agency.

Showings of out-patient care

	Total in the state
Number of out-patient care episodes, of which	7 689 353
Family doctors	5 056 676
Other physicians	2 632 677
Number of out-patient visits, of which	9 905 090
Family doctors	6 868 794
Other physicians	3 036 296

Number of out-patient visits per patient a year



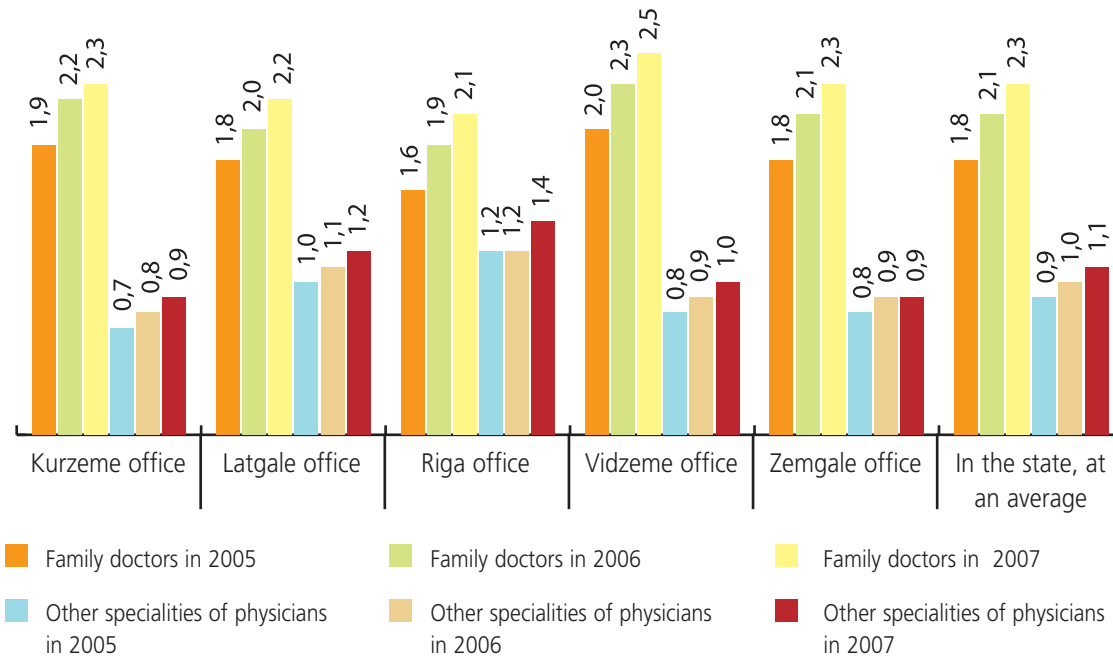
The average number of outpatient visits to family doctor in Latvia per patient has increased from 2,5 visits in 2005 to 3 visits in 2007. The number of visits to other specialists hasn't essentially changed in the time period between 2006 and 2007.

An out-patient visit is a contact of a patient with a medicare person at a certain time and in a certain place, such as out-patient medicare institution; out-patient medical aid division in a hospital, if there exists any; and admission department, if a patient doesn't need hospitalization; emergency medical aid institution, if provision of out-patient aid is organized there.

Consultation by phone, examination by laboratory and visual diagnostics, functional examination and medicare procedure is not considered as out-patient service.



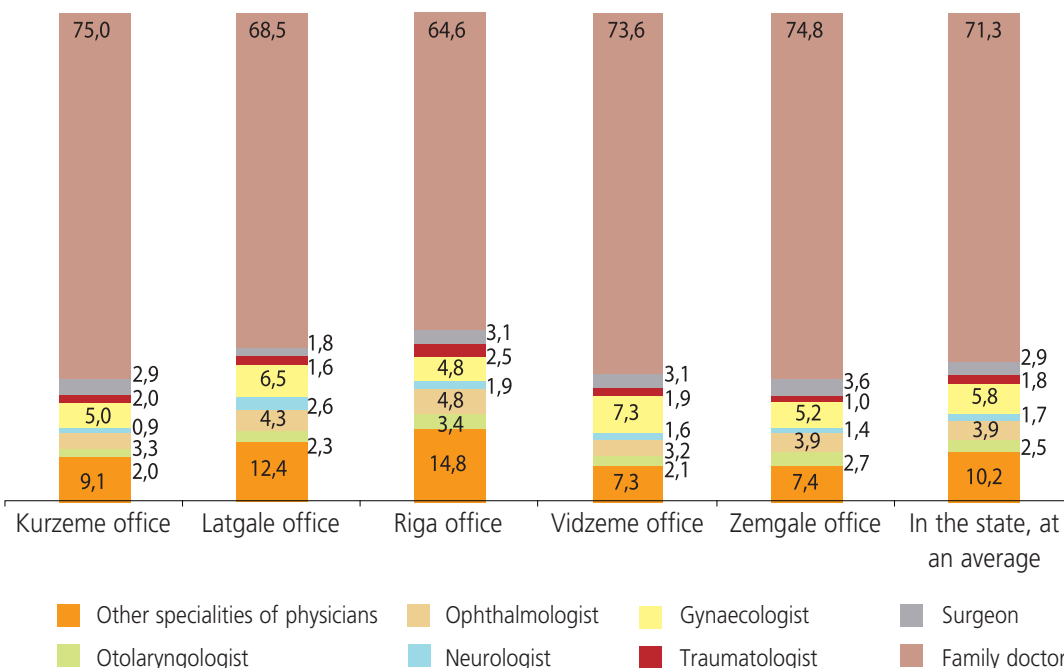
Number of health care episodes per patient a year



A health care episode is a time period which is in progress from the moment a health care service provider has met a patient's health problem (the patient's first contact with the physician) until the solution of the respective patient's problem. A health care episode can be accomplished only by one physician (PHC physician or speciality physician). One health care episode can contain several outpatient visits.

In 2007 the average number of health care episodes with a PHC physician has increased which shows that patients have visited their family doctors more frequently and have cared more for their health than before. The number of health care episodes with speciality physicians is increasing, but less then with family doctors.

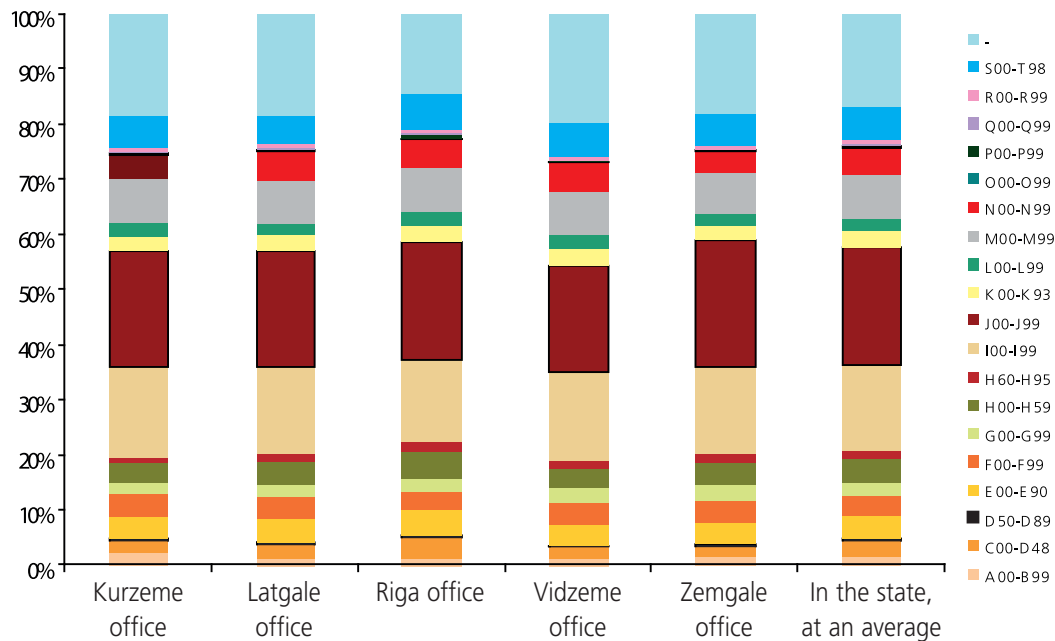
Division of out-patient visits by specialities of physicians, %



The above figure shows the division of outpatient visits by specialities of physicians assuming that the total number of outpatient visits is 100%. Number of visits to a family doctor exceeds 64% in all territorial offices of the Agency.

Consequently, family doctors perform their function of primary health care service providers and primary health care has, probably, become more comprehensive and qualitative.

Number of out-patient visits by basic diagnosis, %



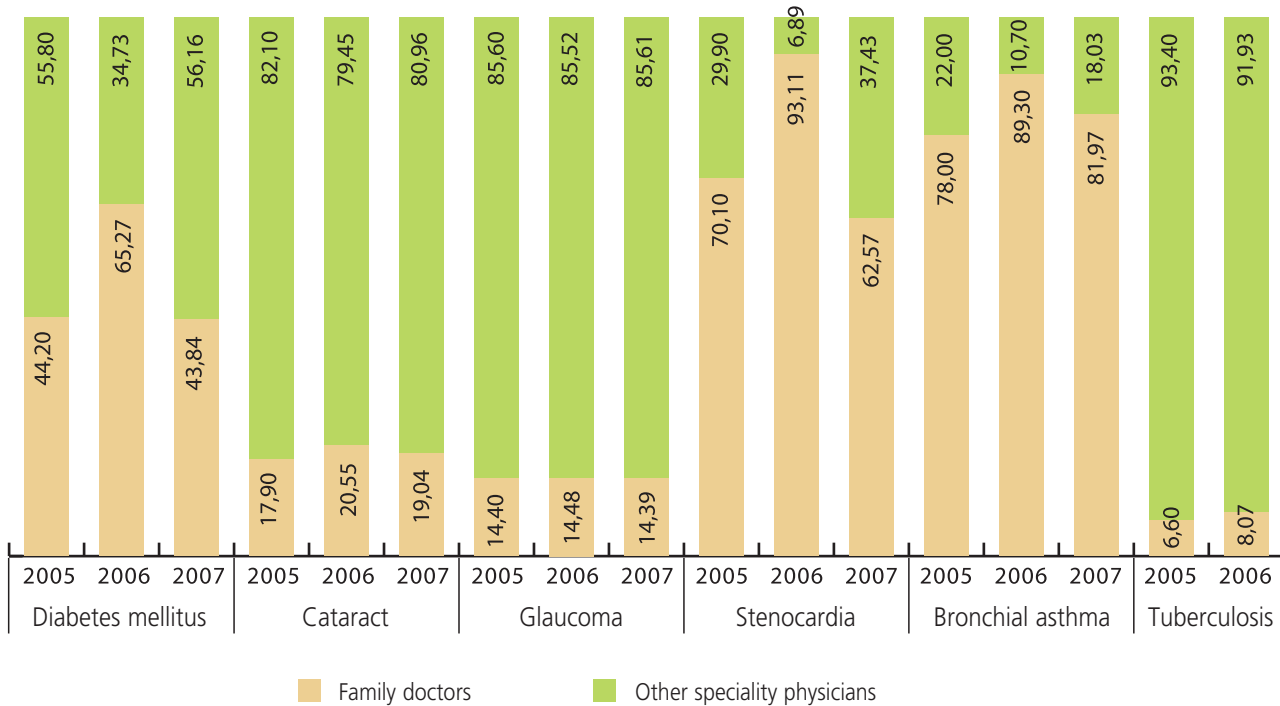
In the above figure outpatient visits are divided into groups of diagnosis, in accordance with the 10th version of the International Classification of Diseases and Related Health Problems and in each group the proportion of out-patient visits is calculated in respect of each territorial office of the Agency.

The figure shows that the highest proportion of outpatient visits is observed in respect of patients, whose basic diagnosis are diseases of respiratory system (J00-J99) – 21,2% and, diseases of circulatory system (I00-I99) – 15,4%.

The least proportion of outpatient visits – 0,2% is in certain cases of perinatal period (P00-P99) and congenital malformations, deformations and chromosomal abnormalities (Q00-Q99) (0,2%).



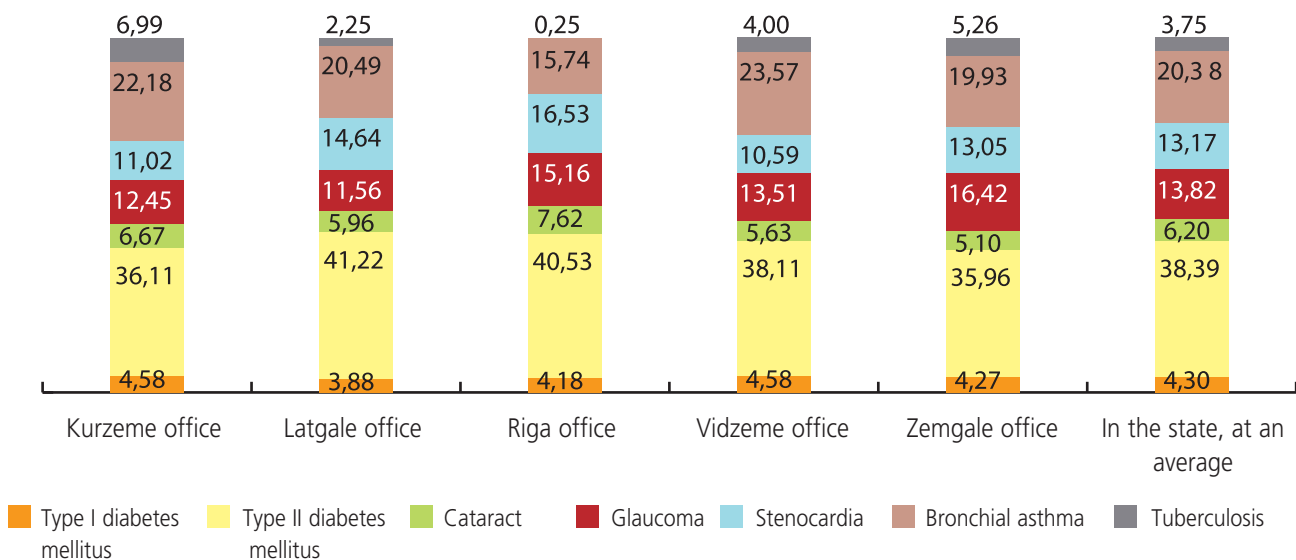
Number of out-patient visits by certain illnesses, %



The above figure analyses the number of certain diagnosis patients who visit family doctors and other speciality physicians. Alike in previous years family doctors provide medical health care for diabetes mellitus, stenocardia and bronchial asthma patients, but this proportion has a tendency to decrease in 2007 in favour of other speciality physicians. However, the number of visits has increased in absolute figures.

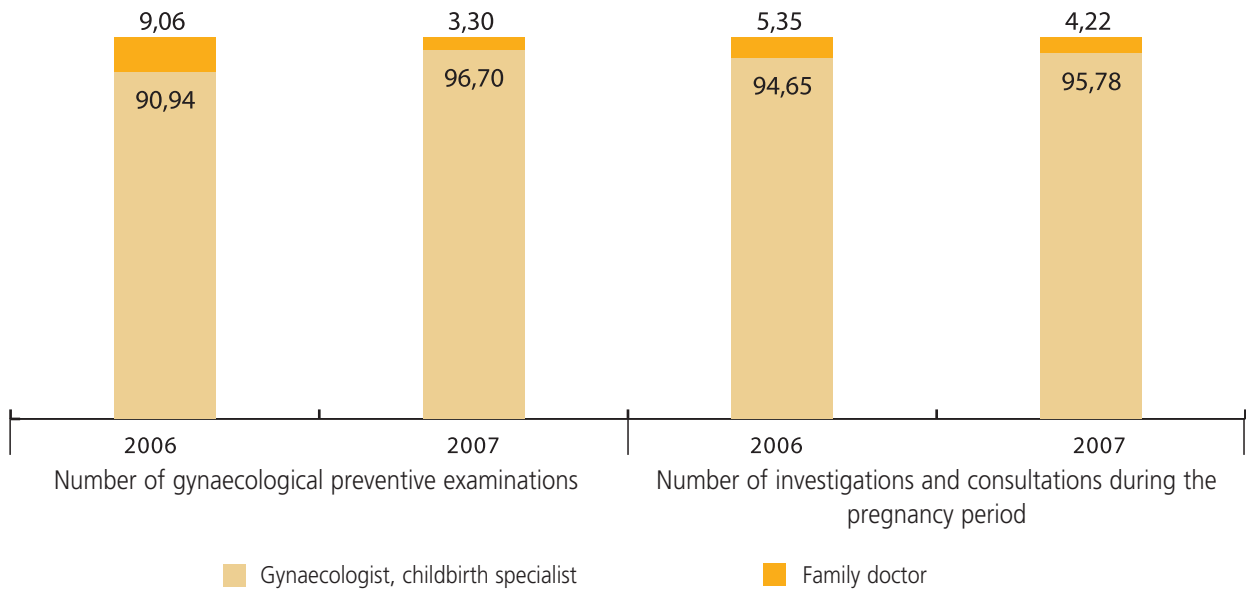
Also speciality physicians are the ones who make a greater contribution to the treatment of cataract and glaucoma.

Number of out-patient visits by certain diagnosis, %



The above figure analyses the proportion of outpatient visits by certain diagnosis. The indicated types of diagnosis at an average constitute 8,9% of the total number of outpatient visits. Out of these 8,9%, patients of type II diabetes mellitus constitute the largest number of visits in all offices of the Agency – 34,54% at an average.

Ratio between the preventive work carried out by gynaecologists, childbirth specialists and, family doctors, as well as health care of pregnant women, %

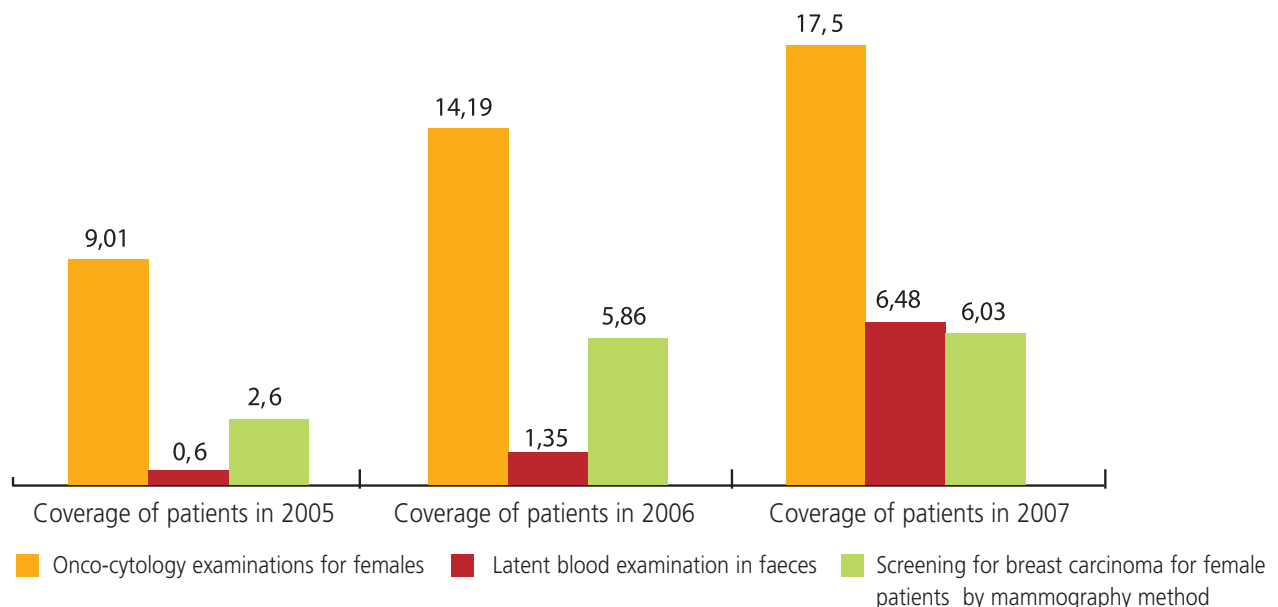


The above figure reflects the ratio between the work performed by family doctors and, gynaecologists and childbirth specialists while providing health care services in cases when the competence of both these specialists is equal.

Both the specialists perform both the gynaecological preventive examination within the preventive program and the investigation and consulting of pregnant women during the pregnancy period. Gynaecological preventive examination and health care of pregnant women is included in the number of manipulations for which a family doctor gets paid in addition. However, family doctors perform only a small part out of all gynaecological preventive examinations.

In 2007 the dynamics in comparison with 2006 has even decreased from 9.06% to 3.3%. The contribution of family doctors to the health care of pregnant women is also rather small. In 2006 only in 5.35% cases, but in 2007 only in 4.22% cases the health care of pregnant women was performed by family doctors. Family doctors can only supervise a pregnancy which passes off normally.

Dynamics of carcinoma screening examination showings, %





The above figure reflects showings on the coverage of cancer screening included in the preventive examination program. In 2007 three screening examinations of early carcinoma diagnostics were included in the preventive examination program.

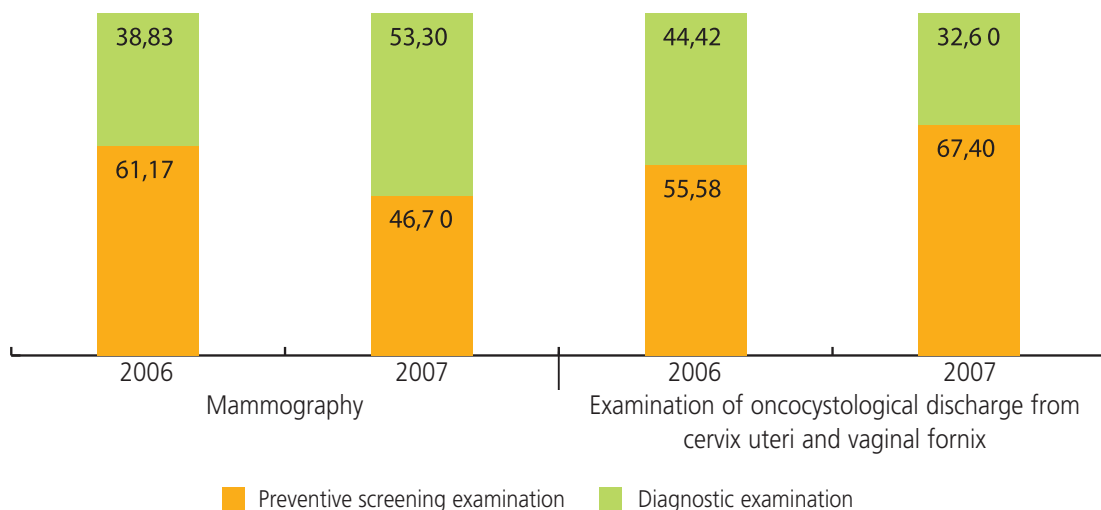
Within the preventive program screening examination of cervix uteri carcinoma (oncocytoplogical vaginal discharge from cervix uteri) was performed in respect of 116 195 women.

18 323 women were examined by mammography method within the framework of breast carcinoma screening prophylactic program. Early diagnostics of intestinal carcinomas by latent blood examination in faeces were carried out for 53 589 patients.

The frequency for carcinoma screening examinations paid from the state budget (not oftener than once a year with several repetition intervals), age of persons to be examined, manipulations to be carried out and defined conditions, which have to be observed upon filling in the check of an outpatient health care patient, are set. Basic data on number of patients, who have received carcinoma screening examinations, are procured from data basis of outpatient health care services selecting information according to above stated conditions. Basic data on the number of patients, who have received carcinoma screening examinations, are procured from data base of outpatient health care services, by selecting information according to above stated conditions.

Information included in the figure shows the proportion of the number of patients having received carcinoma screening examinations, against the number of population in the respective age group. The showings of carcinoma screening examinations are not high. However, upon comparing of showings of 2007 with showings of 2005 and showings procured in 2006, a positive dynamics can be observed.

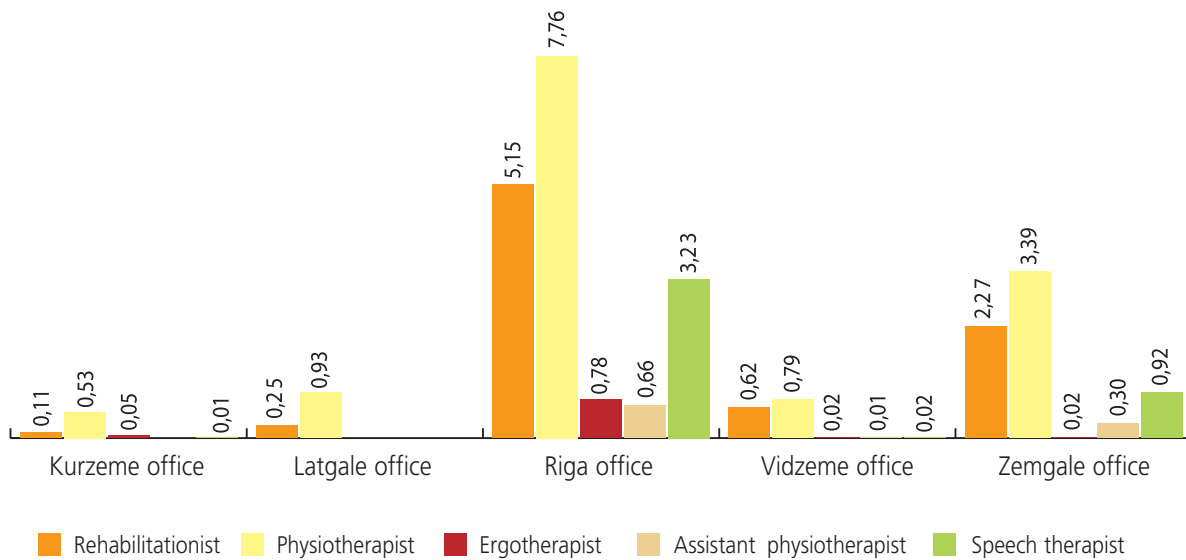
Breakdown of examinations by mammography method and oncocytoplogical examinations into diagnostic and preventive examinations for women whose age conforms to the requirements of the preventive examination, %



The above figure shows the proportion of examinations by mammography method and oncocytoplogical examinations made in 2007 and 2006, with breakdown into diagnostic and preventive examinations for women whose age conforms to the requirements of the preventive examination. The same diagnostic methods are used for both preventive and diagnostic examinations made as a result of clinical indications and complaints by patients.

Upon the analysis of data on examinations made by mammography method and oncocytoplogical examinations for women whose age conforms to the age limits prescribed in the preventive program in which screening examinations shall be made, it can be seen that oncocytoplogical examinations both in 2006 and in 2007 were mostly made as preventive examinations. In 2007 examinations by mammography method unlike in 2006 were mostly made on a diagnostic basis.

Number of visits to rehabilitation speciality physicians per 1 000 patients annually



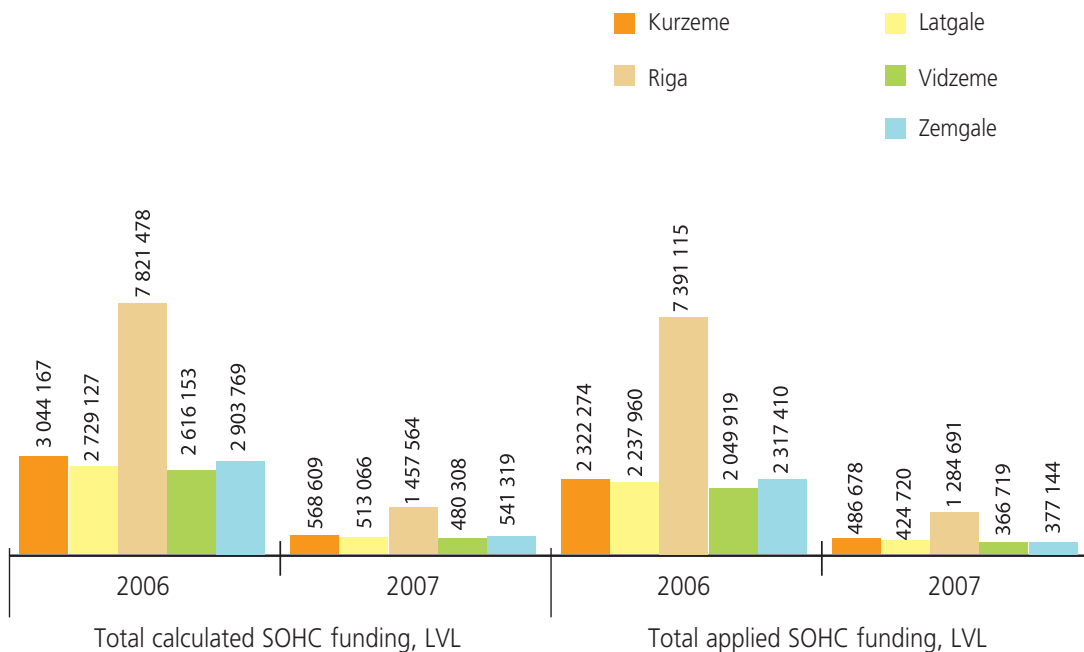
In 2007 the Agency had contractual relations with 5 748 physicians, of which 326 (5,67%) are rehabilitation physicians.

The above figure shows the number of visits to rehabilitation physicians per 100 patients. Most of arrangements have been made with physiotherapists (from 0,53 to 7,76) due to specifics of received services (services shall be received as a course of treatment). Least of arrangements have been made with ergotherapists (up to 0,78).

According to the division of the amount of work by doctors, per regions, it can be concluded that speciality physicians are mostly available in Riga, but relatively seldom in regions. In regions, speciality physicians work in the largest cities and towns. Patients, taking into account the general socioeconomic situation in the state, might have problems with the receipt of necessary medical rehabilitation services.



Secondary out-patient health care (SOHC) funding under the control of family doctors



In 2007 a new calculation principle and utilization accounting methodology of the basket under the control of family doctors was prescribed, which was different from the one used in 2006. In 2007 the volume of SOHC service payment basket for a family doctor was calculated every month, multiplying the number of registered patients by the payment amount per patient prescribed in Regulations No 1046.

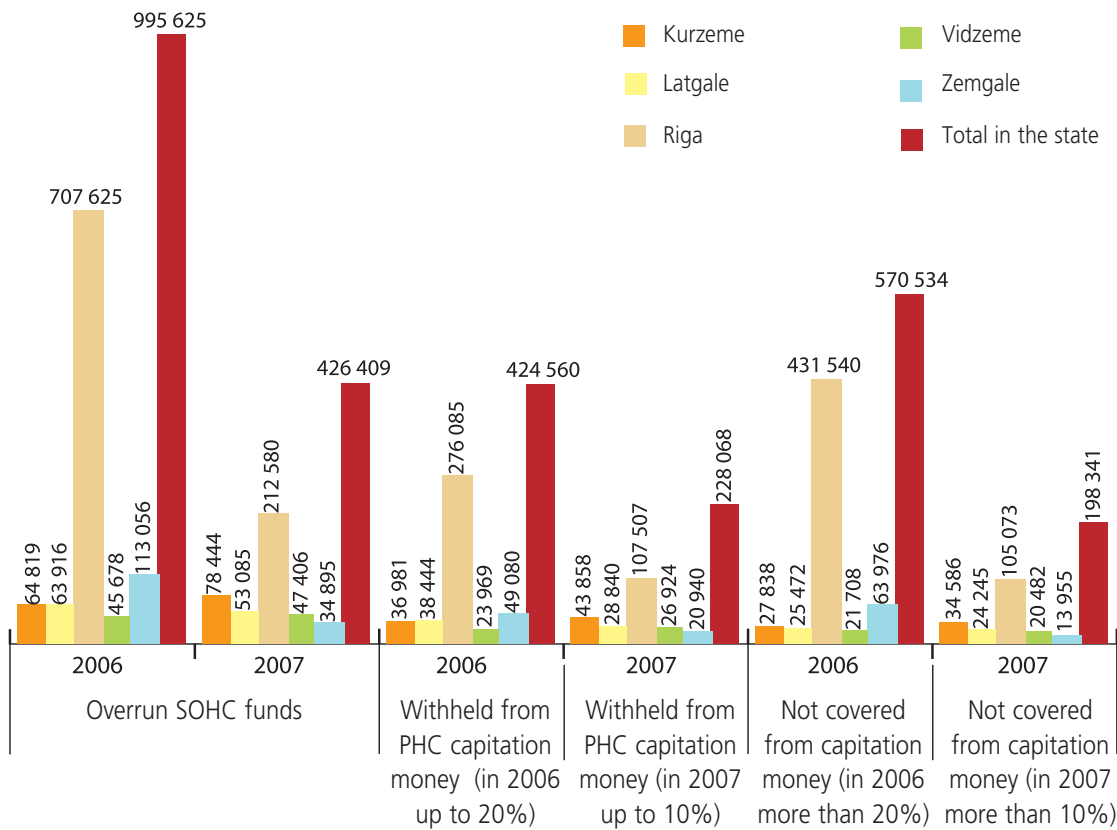
When a patient saw a SOHC physician, depending on the prescribed diagnosis, in accordance with Annex 13 of Regulations No 1046 "Diagnoses, in which cases provided health care services are paid up from secondary outpatient health care funds under the control of family doctors", the payment was made from the SOHC service payment basket under the control of family doctors. The Agency performs the calculation of the utilization of SOHC payment funds under the control of family doctors and the payment of the remaining amount to family doctors in respect of each quarter, taking into account the following conditions:

- If the remaining amount of the above funds constitutes 30 % or less out of the calculated quarterly volume, a family doctor is paid 75 % out of the remaining amount;
- If the remaining amount constitutes more than 30 % out of the calculated quarterly volume, a family doctor is paid the amount which constitutes 75 % out of the 30 % of the calculated quarterly volume of funds.

If a family doctor has spent all calculated SOHC basket funds within a quarter, the overrun can be withheld from capitation money, but not exceeding 10% of it.

Conditions of SOHC basket calculation, which were essentially modified in 2007, show great differences between years 2006 and 2007. It can be seen from the figure that none of primary health care (PHC) physicians in territorial offices in 2007 has overrun the volume of calculated SOHC basket, equally with 2006.

Overrun SOHC funds



If a family doctor has spent all calculated SOHC basket funds within a quarter, the overrun could be withheld from capitation money. In 2006 the withheld amount could not exceed 20%, but in 2007 – 10% of the capitation money.

Showings of dentistry care

Dentistry care for children under age of 18, first time consultation on orthodontal treatment for children under age of 18 and in cases of congenital –face-jaws clefts for persons under age of 22 are paid from the state health care budget. Dentistry assistance expenditures for participants of Chernobyl atomic power plant emergency consequences and persons suffered due to Chernobyl atomic power plant emergency set by the paragraph No 14 of the social protection law of 9 September 1999 “The law on social protection of participants of Chernobyl atomic power plant emergency consequences and persons suffered due to Chernobyl atomic power plant emergency”, are covered in the volume of 50% , but expenditures for prosthesis of teeth with removable plastics prosthesis – in full value.

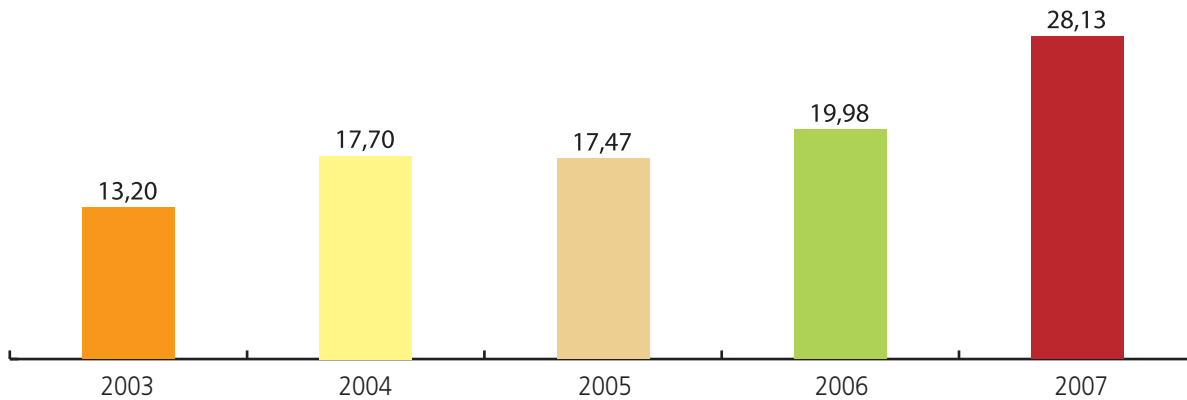
Fulfilment of dentistry contracts for provision of dentistry services, LVL

The Agency's territorial offices	Sum of contract	Amount of work within account period	Overfulfilment (above sum of contract)	Non-fulfilment of contract
Total	6 561 732,38	5 797 533,88	10 336,08	774 534,58



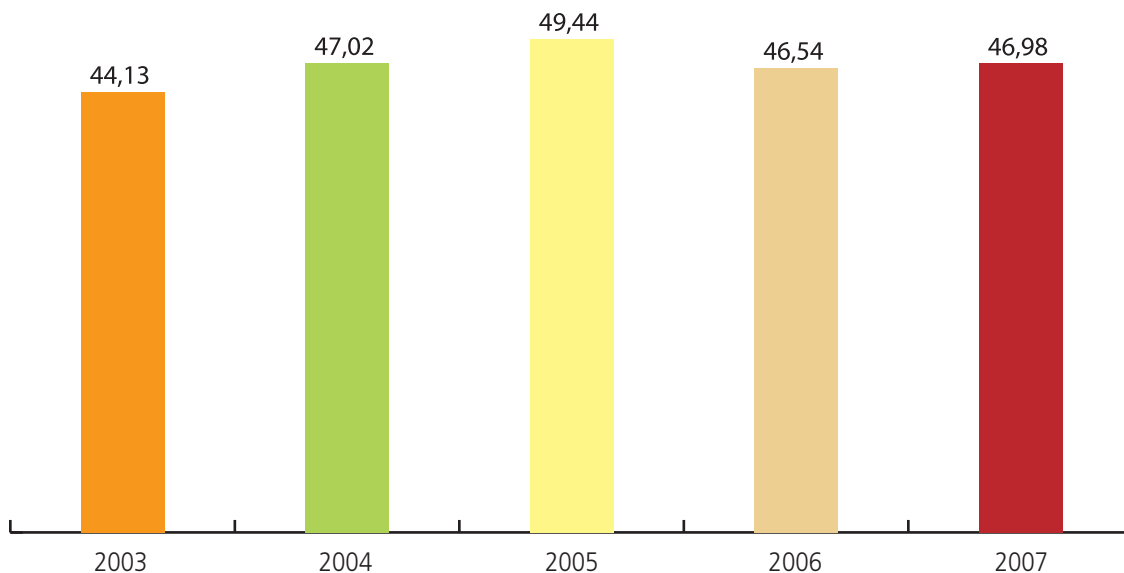
Showings of dentistry assistance to children

Dynamics of expenditures per child having received treatment, LVL



The above figure shows expenditures in lats per child who has received treatment, by years. In 2007 expenditures of dentistry services per one child who has received treatment at the national level increased by 40,79%. It is due to the increase of the average salary of medicare employees in the state and the increase of dentistry service rates.

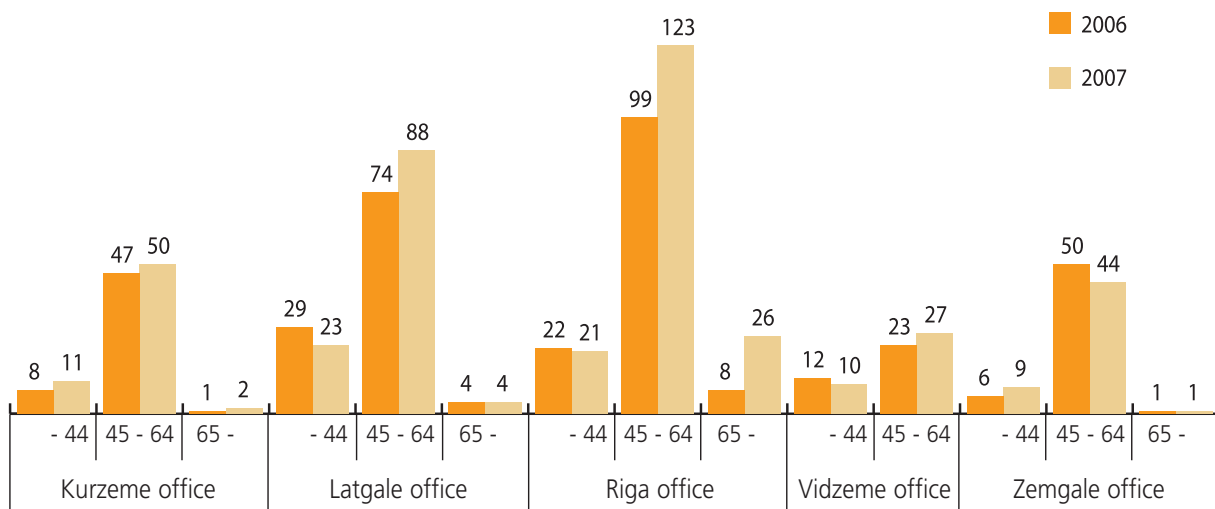
Dynamics of coverage, %



The above figure shows the percentage of children under age of 18 who have received dentistry services, by last five years. In 2006 there was a fall observed in the showing of dentistry coverage of children. It was mostly justified by the increase of paid services. In 2007 dentistry rates were increased. As a result the dentistry coverage of children did not become worse, but also has not increased to the level of 2005.

Showings as to the provision of dentistry services to persons who have participated in the liquidation of Chernobyl atomic power plant emergency consequences

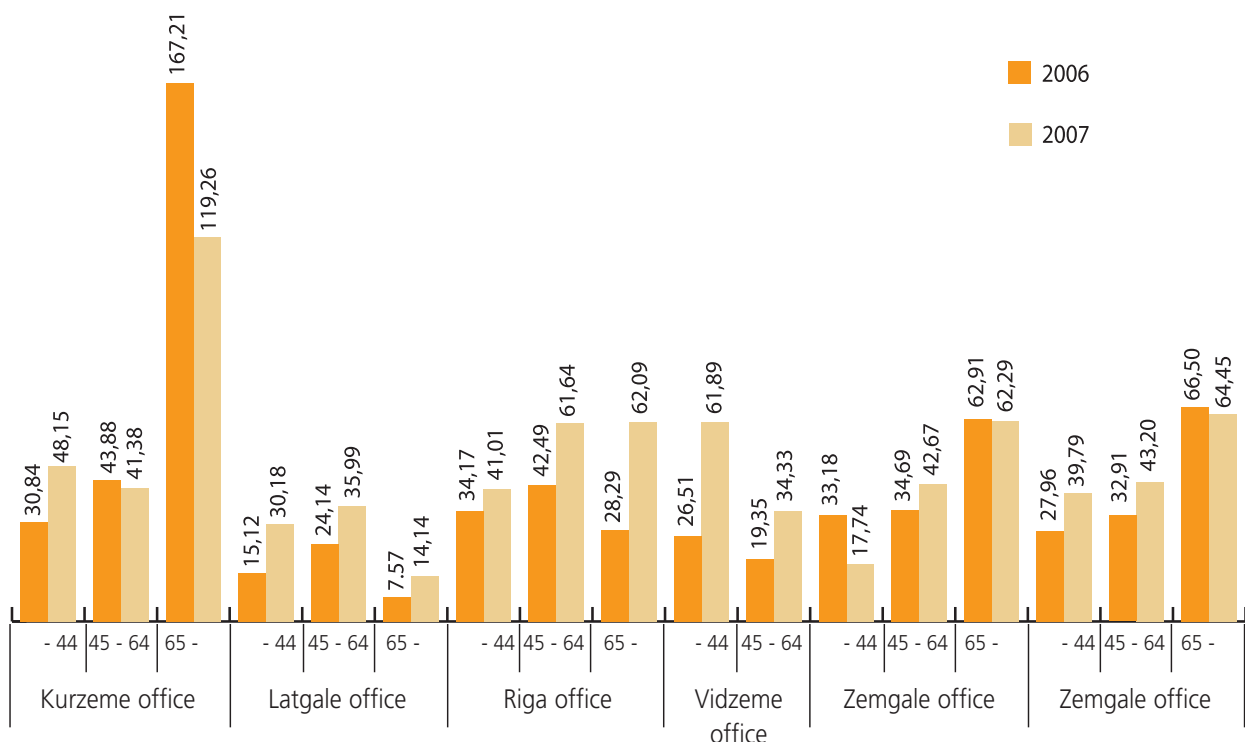
Number of persons having received dentistry services



The above figure shows the number of persons who have participated in the liquidation of Chernobyl atomic power plant emergency consequences and who have received dentistry services, divided by the Agency's territorial offices and age groups.

In 2007 the number of persons who wanted to receive state paid dentistry assistance, increased by 14,32%. Most of services to participants of Chernobyl atomic power plant emergency consequences and persons suffered due to Chernobyl atomic power plant emergency were provided in Riga and Latgale, less in Vidzeme. Upon the analysis of persons who had received services within three age groups, it was established that most of patients who have applied for assistance have been aged between 44 and 65.

Costs per person, LVL





The above figure shows treatment costs in LVL per person suffered in the liquidation of Chernobyl atomic power plant emergency consequences, divided by territorial offices of the Agency, by age groups. In 2007 treatment costs in LVL per person suffered in the liquidation of Chernobyl atomic power plant emergency consequences up to the age of 44 increased by 42,31%, between the age of 45 and 64 increased by 31,27%, but for those aged above 65 even decreased by 3,08%.

5. Operation of in-patient institutions

On 1 January 2007 the Agency concluded contracts on the national provision of in-patient health care services with 82 in-patient medicare institutions.

Upon comparison of the number of unique patients in 2006 (327 172) and in 2007 (335 617) it can be seen that in 2007 it increased by 8 445 patients. From the number of unique patients and hospitalization cases we can conclude that each patient has been in the hospital 1,4 times at an average, both in 2006 and 2007.

Day and night in-patient hospital	Total / at an average in 2007	Total / at an average in 2006	Total / at an average in 2005
Number of unique patients	335 617	327 172	321 518
Number of in-patient hospitalization cases	480 508	464 769	448 752
Number of bed days	4 527 812	4 334 763	4 294 628
Average duration of treatment	9,4	9,3	9,6
Average costs by the state per one in-patient hospitalization case	412	311	245
Average costs by the state per one bed day	43,68	33,31	25,62

The number of in-patient hospitalization cases in 2007 increased by 3,39% in comparison with 2006 (from 464 769 patients in 2006 to 480 508 patients in 2007).

The number of bed days in 2007 increased by 4,45% in comparison with 2006 (from 4 334 763 bed days in 2006 to 4 527 812 bed days in 2007).

The average duration of treatment in 2007 is very similar to the average duration of treatment in 2006 (9,30 days in 2006 and 9,40 days in 2007).

Average costs by the state per one in-patient hospitalization case and per one bed day include costs for the provided in-patient service and costs for the patient payment for categories of the population released from the patient payment. In 2007 in comparison with 2006 average costs by the state per one in-patient hospitalization case increased by 32,51%, and average costs by the state per one bed day increased by 31,13%.

Actual fulfilment of in-patient contracts on the provision of health care services in 2007

The figure below reflects the information on the planned financial volume and actual fulfilment of the contract signed by in-patient institutions "On provision of in-patient health care services".

The analysis on the work performed in fact shows that the actual joint work performed by medicare institutions in 2007 exceeds financing by LVL 392 217, (0,20% against the contract sum), but non-fulfilment constitutes LVL 3 714 900 - (0,191% against the contract sum).

The patient payment for population categories freed from the patient payments is covered in accordance with the Regulations No 1046, in total LVL 7 225 731, which is 3,78% out of the joint actual fulfilment within the framework of contract.

Planned financial volumes and actual fulfilment in respect of the “Provision of in-patient health care services”.

Medicare institution	Contract sum for 2007, LVL	Actual fulfilment, LVL	Actual fulfilment within the contract, LVL	Over-fulfilment (above the contract sum)		Non-fulfilment of contract		Patient payment for released population categories, LVL	
				LVL	% against the accounting period	LVL	% against the accounting period	Within the contract	Non-paid up patient payment taking into account over Fulfilment
1	2	3	4	5=3-4	6	7=3-2	8	9	10
1. Regional multiprofile hospitals	106 038 594	104 714 285	104 576 886	137 399	0,13	-1 461 708	1,38	3 610 205	6 877
2. Local multiprofile hospitals	48 947 628	48 086 537	47 977 576	108 961	0,22	-970 052	1,98	1 287 514	3 163
3. Specialized centres	13 565 002	13 325 650	13 221 794	103 856	0,77	-343 208	2,53	791 346	1 049
4. Specialized hospitals	24 245 056	23 432 631	23 396 835	35 796	0,15	-848 221	3,50	1 471 529	1 341
5. Other	1 958 281	1 872 775	1 866 570	6 205	0,32	-91 711	4,68	65 137	212
Total	194 754 561	191 431 878	191 039 661	392 217	0,20	-3 714 900	1,91	7 225 731	12 642
% out of actual fulfilment within the contract								3,78%	0,01%
Patient payment for released population categories, actual fulfilment								7 238 373	

Financing of in-patient medicare institutions and actual fulfilment by programs of services in 2007

In accordance with the effective legislation hospitals are divided into several levels:

- Regional multiprofile hospitals;
- Local multiprofile hospitals;
- Specialized centres and state agencies;
- Other hospitals and health centres.

44 programs of specialized services and 1 program of other services included within the minimum of service (therapeutic and surgery services) were introduced into basic contracts with in-patient medicare institutions and paid up in 2007.

Application of funds for payment of therapeutic and surgery services included within the minimum of services constitute LVL 103 517 776 (respectively 62% for therapeutic and 38% for surgery services out of funds made available within this program), which were utilized for the treatment of 377 890 patients in in-patient medicare institutions.

Application of funds for specialized programs constitutes 46% (LVL 87 453 418) out of the total funding; the number of treated patients constitutes 22% (103 480 patients) out of the total number of patients.



Programs of specialized services with the largest funding are as follows:

- Invasive cardiology that constitutes 9,48% (LVL 17 976 239) out of the total volume of funds and, 1,71% out of the total number of patients treated in in-patient hospitals;
- Psychiatry that constitutes 8,68% (LVL 16 459 137) out of the total volume of funds and, 3,77% out of the total number of patients treated in in-patient hospitals;
- Haematology and oncology; Beam therapy and chemotherapy (inter alia, neuro-oncology) of oncology patients, that constitute 6,49% (LVL 12 297 434) of the total volume of funds and, 5,11% out of the total number of patients treated in in-patient hospitals;

Fulfilment of programs by all level hospitals, LVL

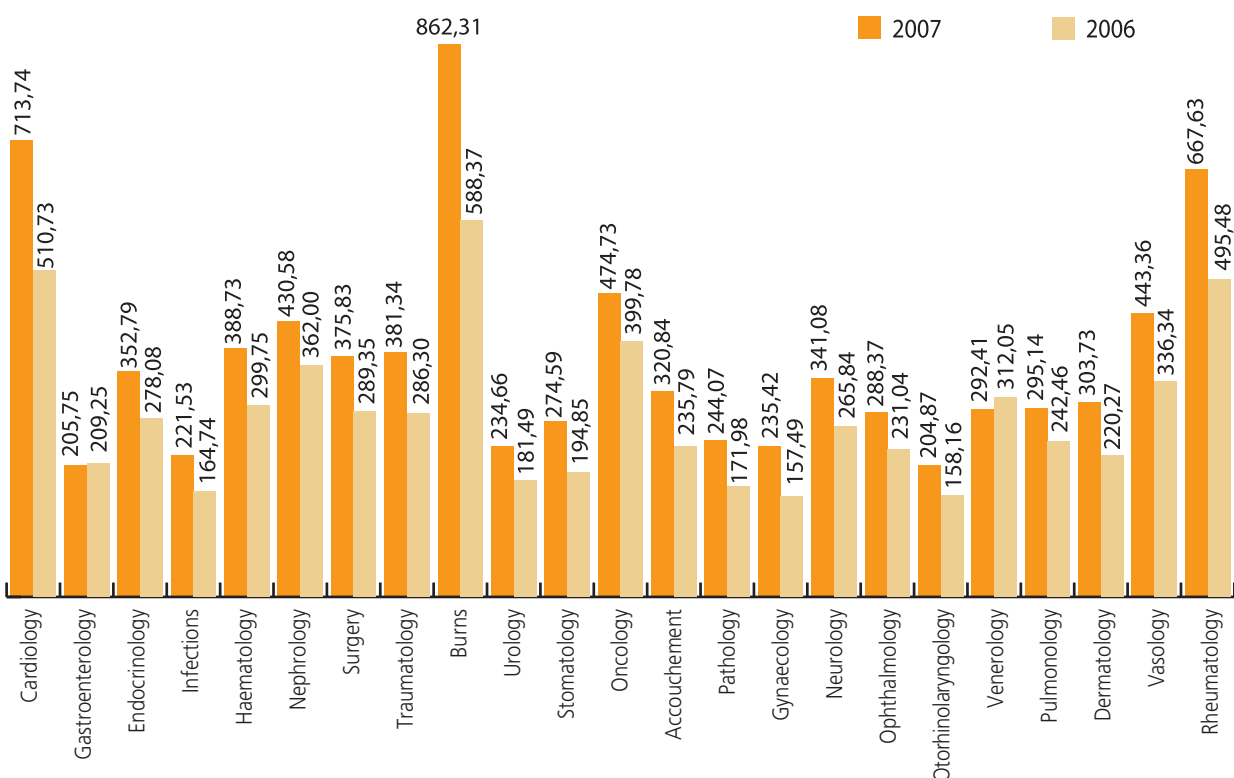
Title of program	Actual fulfilment in 2007	
	Scope of work actually accomplished, LVL	Number of patients treated
Regional multiprofile hospitals	104 714 285	239 185
Surgery of blood-vessels	1 083 733	838
Cardiosurgery, cardiosurgery for children	8 665 434	1 414
Thoracic surgery	321 795	262
Microsurgery	2 870 643	2 384
Neuroangiology, functional neurosurgery	1 223 746	660
In-patient psychiatrist assistance to children	514 176	1 525
Hepatobiliar surgery	68 178	57
Toxicology	208 479	1 583
Nephrosurgery	1 171 131	296
Invasive cardiology	17 976 239	8 255
Narcology	157 629	1 339
In-patient treatment of Chernobyl atomic power station crash liquidators and patients of industrial diseases	369 349	1 188
Medical rehabilitation in in-patient medicare institution	278 484	661
Haematology and oncology	572 107	553
Oncology (oncology, neuro-oncology, beam and chemotherapy)	1 171 229	1 308
Extragenital pathology of pregnant women	204 730	688
Intensive therapy and reanimation of new-borns (up to 7th day of life)	1 435 923	1 129
Neuro-oncology	321 895	632
Planned endoprosthesis of big joints	890 861	610
Palliative care	95 247	243
Syphilis, gonorrhoea of children. Mycosis.	194 317	297
Implantation of cochlear implants for children	206 791	20
Prevention of tuberculosis and chronic lungs diseases	647 833	417
Electrocardiostimulation, ECS implantation	1 634 064	1 097
Cystic fibrosis	14 962	30
Services included within the minimum of service, of which:	62 415 310	211 699
<i>Surgical services</i>	<i>24 328 748</i>	
<i>Therapeutic services</i>	<i>38 086 562</i>	

Title of program	Actual fulfilment in 2007	
	Scope of work actually accomplished, LVL	Number of patients treated
Local multiprofile hospitals	48 086 537	161 203
Transplantation of parent cells	207 694	59
Burns	1 174 339	558
Microsurgery treatment of bedsores	535 373	34
Osteomyelitis	98 802	96
Rehabilitation of persons suffered from national-socialist regime	74 495	162
Endoprosthetics of revision endoprosthesis	65 504	27
Planned endoprosthetics of big joints	1 111 650	760
Inpatient medical assistance in haematology, oncology. Beam and chemotherapy of oncology patients	9 669 517	18 441
Multiple sclerosis	190 293	726
Children surdology (temporary or constant disorders of hearing and speech). In-patient assistance. Rehabilitation.	126 678	213
In-patient treatment of adult frostbites	103 030	54
Palliative care	185 798	579
Services included within the minimum of service, of which:	34 543 364	139 494
<i>Surgical services</i>	<i>11 434 121</i>	
<i>Therapeutic services</i>	<i>23 109 243</i>	
Specialized centres	13 325 650	22 599
Osteomyelitis. Microsurgery (planned type). Vertebral column traumas and their after-effects. Oncology	463 968	334
Specialized treatment of mouth, face and jaw diseases in cases of congenital pathologies and neoplasms	19 262	88
Medical rehabilitation in in-patient institution	2 232 866	3 455
Psychiatry	3 434 302	4 925
Narcology	484 347	3 192
Rehabilitation of drugs addicted persons	55 428	43
Planned endoprosthetics of big joints	1 875 253	1 198
Endoprosthetics of revision endoprosthesis	417 732	152
Scoliosis operations	167 185	54
Services included within the minimum of service, of which:	3 714 623	9 158
<i>Surgical services</i>	<i>3 252 391</i>	
<i>Therapeutic services</i>	<i>462 232</i>	
Estimated funding	460 684	
Specialized hospitals	23 432 631	45 559
Palliative care	482 711	1 608
Medical rehabilitation in in-patient institution	2 440 307	5 728
Psychiatry	12 684 190	11 526
Inpatient medical assistance in haematology, oncology. Beam and chemotherapy of oncology patients	1 733 915	5 012
Tuberculosis (psychiatric patients)	444 728	232



Title of program	Actual fulfilment in 2007	
	Scope of work actually accomplished, LVL	Number of patients treated
Pregnancy, childbirth and intensive therapy and reanimation of new-borns (up to 7th day of life)	2 795 430	9 298
Prevention of tuberculosis and chronic lungs diseases	279 459	143
Narcology	858 813	5 135
Rehabilitation of drugs addicted persons	125 331	77
In-patient treatment of inherited vices: face clefts and face jaws, lips and occlusion related anomalies	181 339	190
Services included within the minimum of service, of which:	1 406 408	6 610
<i>Surgical services</i>	451 184	
<i>Therapeutic services</i>	955 224	
Other	1 872 775	12 824
In-patient treatment of skin and sexually transmitted diseases in in-patient institution	39 684	133
Psychiatry	340 645	1 677
Narcology	42 101	70
Rehabilitation of drugs addicted persons	12 274	15
Services included within the minimum of service, of which:	1 438 071	10 929
<i>Surgical services</i>	0	
<i>Surgical services</i>	1 438 071	

Costs covered by the state per patient at an average, by profiles of illnesses in 2006 and 2007, LVL



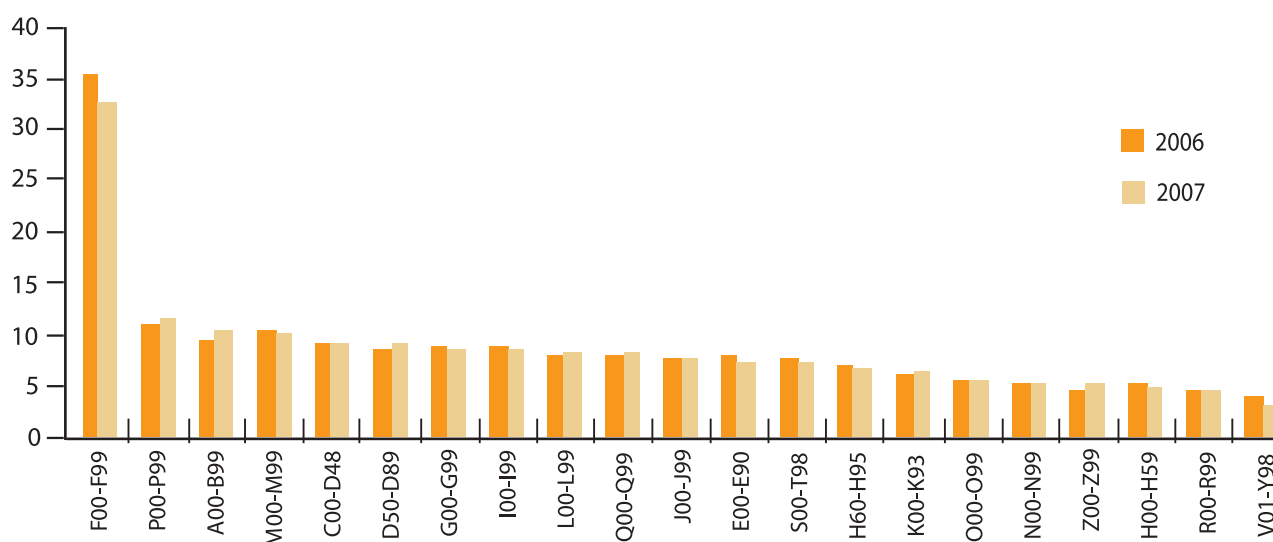
The above figure shows data on average costs covered by the state, per patient, in 2007 and 2006 by profiles of illnesses. The costs contain both state costs for the service provided and reimbursed patient payments for categories of the population released from the patient payment.

The lowest costs in 2007 just as in 2006 were in the profile of otorhinolaryngology (LVL 158,16 in 2006 and LVL 204,87 in 2007). It is connected with a short duration of treatment (5,00 days in 2006 and 4,80 days in 2007) and a low application of curative manipulations.

The most expensive treatment profiles in 2007 just as in 2006 were the profiles of burns and cardiology. It is connected with a long duration of treatment (in the profile of burns 12,0 days in 2006 and 11,7 days in 2007 at an average) and a complicated and expensive application of curative manipulations.

The highest rise in costs in 2007, in comparison with 2006 was observed in the profiles of gynaecology, burns and pathology of pregnancy.

Average treatment showings, breakdown into SSK-10 diagnoses groups



The above figure shows that both in 2006 and in 2007 the longest duration of treatment was applied to patients, whose basic diagnosis is F00-F99 "Psychic and behavioural disorders" – 35,20 days in 2006 and, 32,50 days in 2007.

The durations of treatment for this kind of diagnosis is connected with permanent patients in mental hospitals who stay there for a very long time.

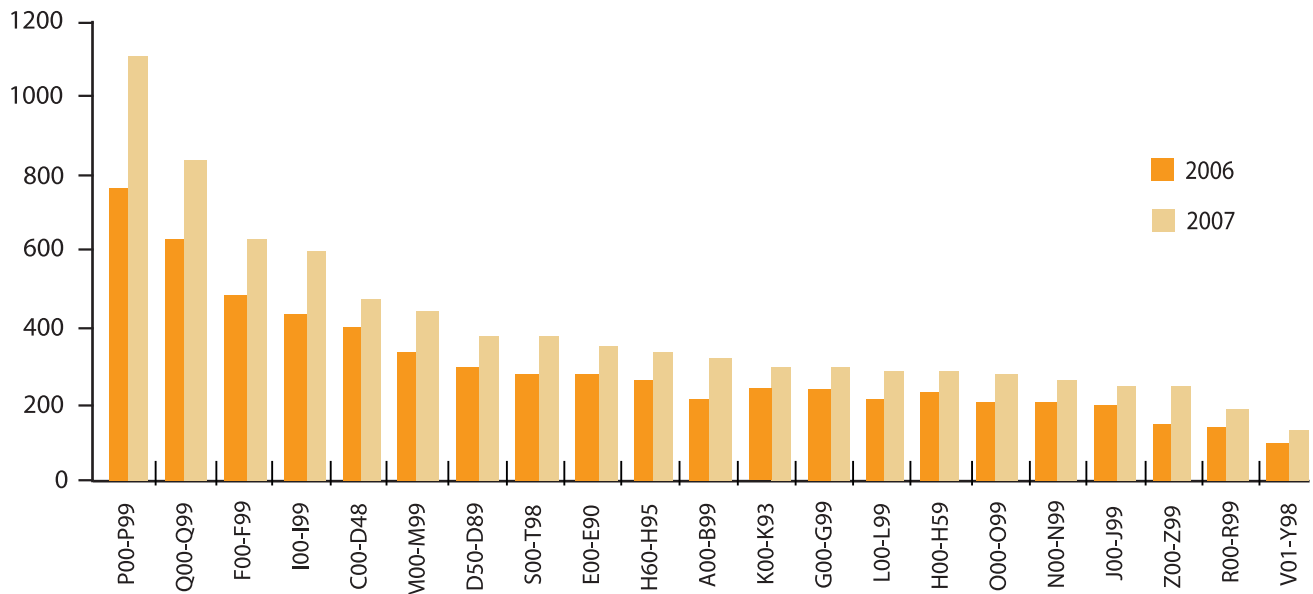
Both in 2006 and in 2007 the durations of treatment was also relatively long for patients with diagnoses included in the below mentioned groups:

- P00-P99 "Specific conditions of the perinatal period", 11,50 days in 2007 and, 10,90 days in 2006;
- A00-B99 "Infection and parasitic diseases", 10,40 days in 2007 and, 9,40 days in 2006;
- M00-M99 "Diseases of skeleton, muscles and connective tissues", 10,00 days in 2007 and, 10,20 days in 2006.

The highest increase of the average duration of treatment was observed in the treatment of patients with the diagnosis A00-B99 "Infection and parasitic diseases"; in 2007 the duration of treatment grew by 1 day in comparison with 2006.



Average costs covered by the state per patient, breakdown into SSK-10 diagnoses groups, LVL



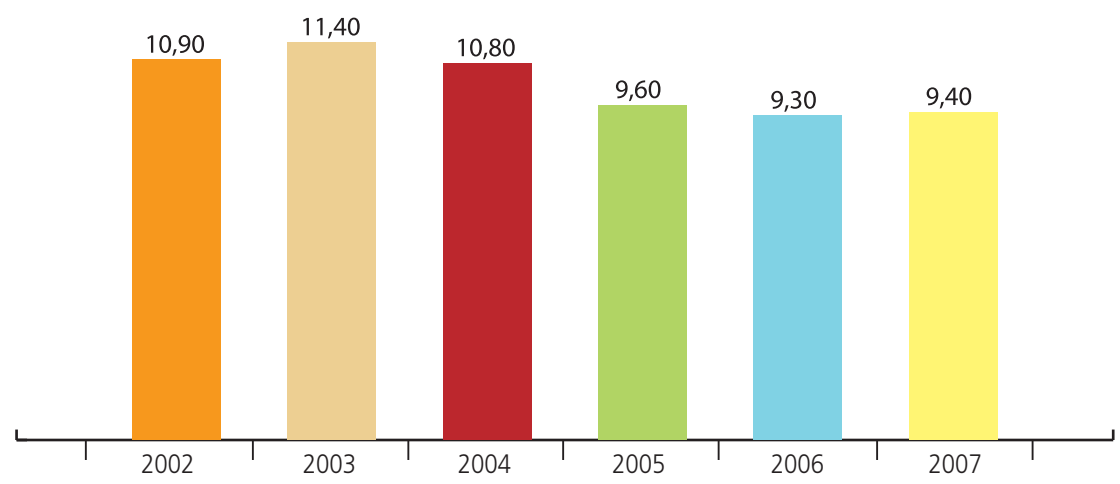
The above figure shows the average hospitalization costs covered by the state, in each group of diagnoses. It can be seen that both in 2006 and 2007 the most expensive treatment was applied to patients with the following diagnoses:

- P00-P99 "Specific conditions of the perinatal period"; LVL 765,16 in 2006 and LVL 1 106,91 in 2007, which is by 44,66% more than in 2006. The rise in costs in this group of diagnoses is not only connected with costs, but also with the increase of the average duration of treatment;
- Q00-Q99 "Anomalies of inborn monstrosity, distortion and chromosomes"; LVL 629,85 in 2006 and, LVL 836,29 in 2007, which is by 32,78% more than in 2006.

The largest increase of costs which is directly connected with the largest increase of the average duration of treatment was observed in the treatment of patients with the diagnosis A00-B99 "Infection and parasitic diseases". In 2007, in comparison with 2006, costs increased by 48,30% (in 2007, at an average, LVL 322,01 were paid from the state budget for the treatment per patient of this group of diagnoses while in 2006 only LVL 217,13).

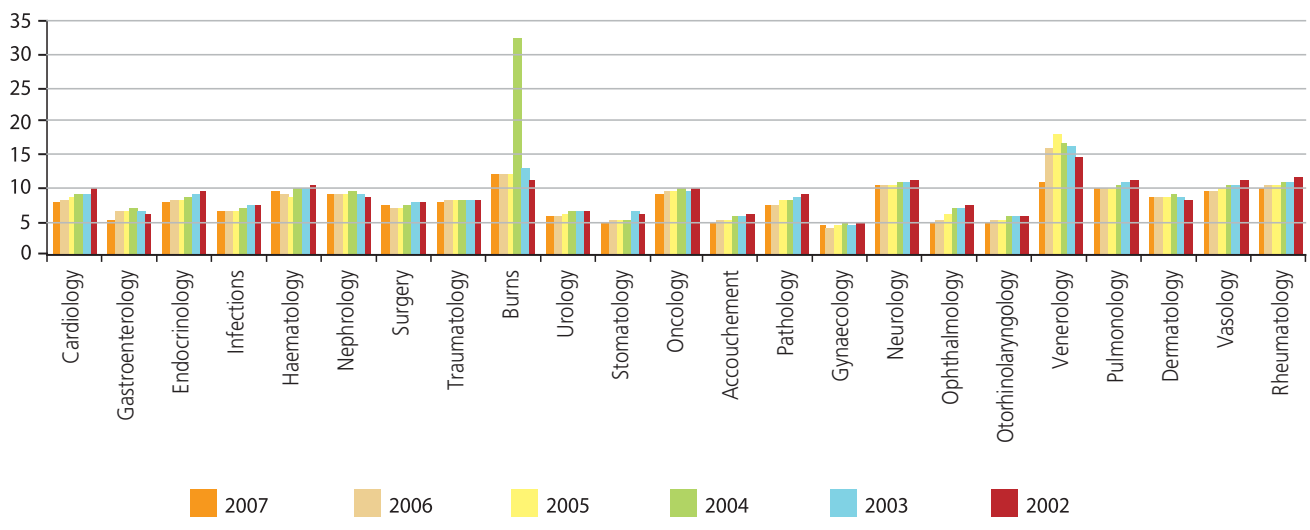
Average modifications of treatment duration in the time period between 2002 and 2007

Average treatment duration in the period between 2002 and 2007, in days



In 2007, in comparison with previous years the average duration of treatment by profiles of illnesses has not essentially changed. The largest modifications in the average duration of treatment can be observed in the profile of venerology (from 15,70 days in 2006 to 10,70 days in 2007) and in the profile of un gastroenterology (from 6,40 days in 2006 to 5,20 days in 2007).

Average duration of treatment, breakdown into illness profiles in the period between 2002 and 2007, in days





6. Activity of emergency medical aid teams

In the beginning of 2007 the Agency concluded contracts with 42 institutions which provided emergency medical aid (hereinafter referred to as "EMA") in the state, but in the end of the year there were contracts concluded with only 39 EMA institutions since by March 2007 Aizpute EMA institution and Kuldiga EMA institution merged, but by 1 July 2007, EMA of Riga District Hospital and EMA of Saulkrasti Hospital were incorporated into Riga First Medical Aid Station.

In the beginning of 2007 there were 174,5 EMA teams, but in the end of the year there were 176,5 EMA teams. By February a new intensive therapy team Riga First Medical Aid Station (hereinafter referred to as "Riga FMAS") was additionally established, but by March 2007, a new doctor assistant's team EMA of Kuldiga Hospital was additionally formed with a view to improve the provision of EMA in Aizpute area.

EMA in the state was provided by 60,6 intensive therapy teams and 116 doctor assistant's teams.

The estimation of the volume of funding was based on Regulations No 1046 and Regulations No 980 "Regulations on the work pay for medicare personnel" issued by the Cabinet of Ministers on 30 November 2006. In accordance with the above mentioned regulations the payment for EMC work was performed due to estimate financing principles, pursuant to actual expenditures divided by types of expenditures.

The total number of EMA calls in 2007 decreased by 0,8% in comparison with 2006. The largest number of calls was observed in the first and second quarters, which could be explained by the increase of the number of acute infection illnesses in autumn-winter months.

In 2007 intensive therapy teams served 38% out of all EMA calls in the state which is by 1,9% less than in 2006 due to the decrease of physicians as EMA personnel. The number of primary calls in 2007 has increased by 2% (from 87% to 89%) in the state.

In the state the average number of calls a day per team constituted 5 calls.

Regulations No 1046 prescribe that in 75% of cases EMA teams shall provide medical assistance within 15 minutes, but in rural territories within 25 minutes from receipt of the call.

The average number of mileage per call is larger in EMA institutions, which are located in more distant district areas from where patients need to be taken to the nearest regional hospital. At the national level this showing is 22,99 km per call (in 2006 – 23,1 km per call).

In 2007 the average number of hospitalized patients constituted 41% out of all executed calls which is at the same level as in 2006.

Work accomplished by emergency medical aid teams in 2007

N	Name of institution	Number of teams	Anticipated volume of contract yearly, LVL	Costs per call, LVL	Number of EMA calls			Total mileage (km)	Level of urgency				Average arrival time per call, min.		Number of hospitalized patients	Number of hospitalized patients, %	Average number of calls per day	Average number of calls a day, per team	Mileage per call (km)	
					Total number of calls, of which	Intensive therapy calls	Doctor assistants' teams		I	II	III	IV	City or town	Country						
		175,5	23 175 978,65	65,29	479 147	173 043	305 853	11 015 307	32 854	81 148	274 618	36 124	7,9	20,7	195 917	41	32	5	23,0	
	Total																			



7. Waiting lists for scheduled health care services

A centralized waiting list for pretenders to receive scheduled health care services is formed

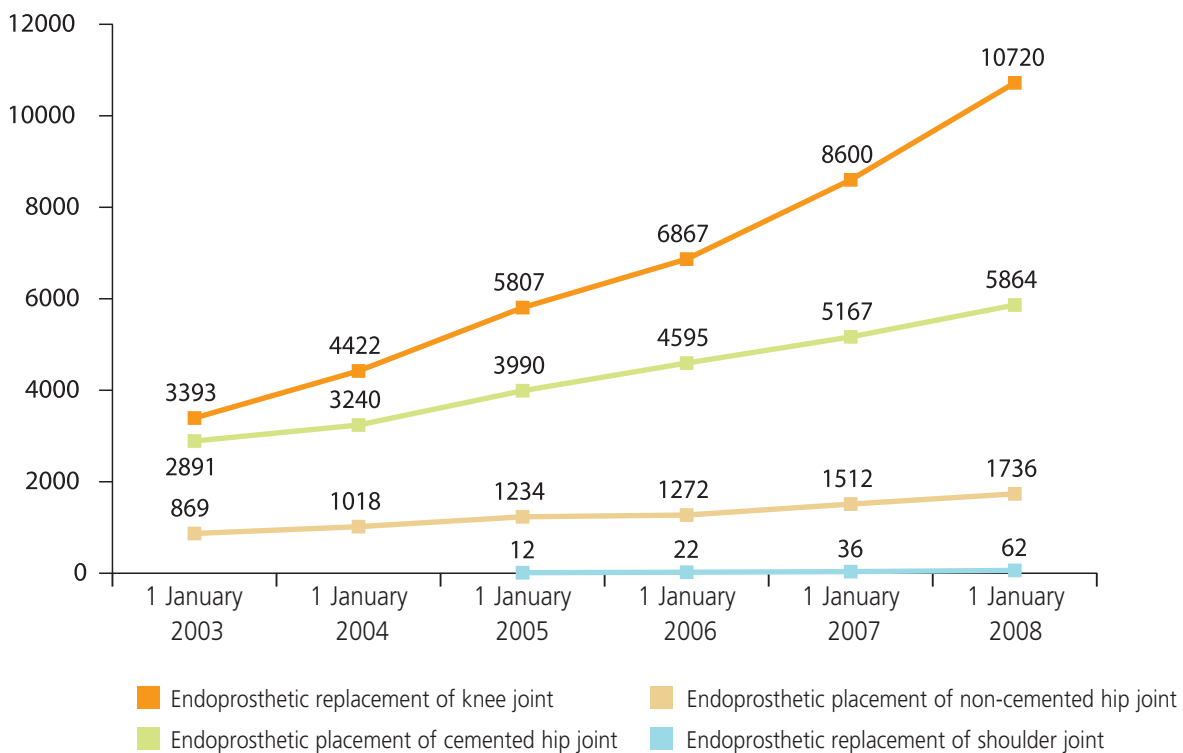
- In orthopaedy: endoprosthesis replacement of hip joints, knee joints and shoulder joints as follows:
 - Common waiting list in orthopaedy;
 - Waiting list where health care service is provided on an urgent basis, on the ground of a conclusion by the council of physicians (the service is provided within a year since the day of adoption of the conclusion by the council of physicians);
 - Waiting list where a patient covers 50% out of the tariff fixed for health care services (the service is provided within 3-6 months from the day of receipt of the application).
- In otorhinolaryngology (implantation of cochlear implants for children);
- And haematology (transplantation of autologous cells).

The number of patients waiting for endoprosthesis large joint replacement operations has increased by 3 002 (+20%) and reached 18 382 within a year. In 2007 there were 6 418 patients registered in the waiting list, which is by 512 (+9%) more than registered a year ago.

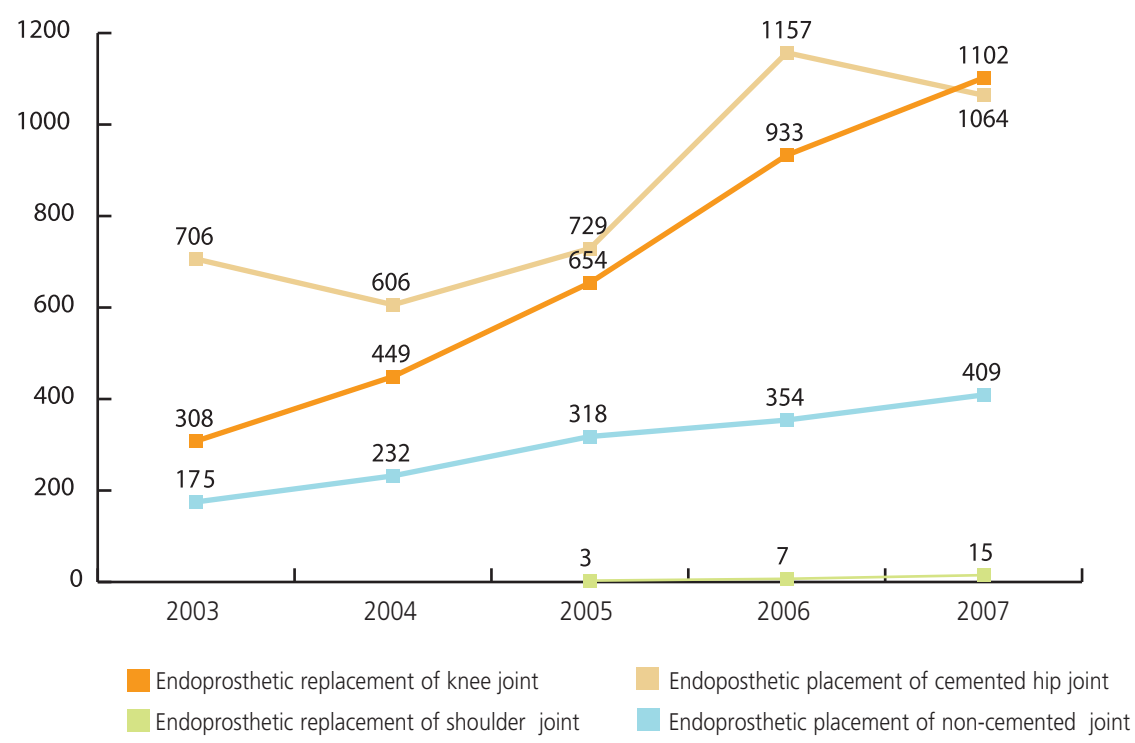
2 590 endoprosthesis replacements of large joints were carried out in 2007, which is by 139 (+5,7%) more than in 2006. From the waiting list where the patient covers 50% out of the tariff fixed for health care services, 990 patients underwent an operation, but from the waiting list where health care service shall be provided on an urgent basis, on the ground of a conclusion by the council of large joint speciality physicians, 981 patients underwent an operation. 619 patients from the common waiting list underwent an operation.

In 2007 there were 10 patients registered in the waiting list for implantation of cochlear implants to children. 17 operations of this kind were carried out within a year, but 27 patients were registered in the waiting list for transplantation of autologous cells.

Number of patients in the waiting list for scheduled endoprosthetic replacement of large joints in the time period from 1 January 2003 until 1 January 2008



Number of performed scheduled endoprosthetic operations in the time period from 2003 until 2007





Movement in the waiting list for scheduled endoprosthesis replacement of large joints and implantation of cochlear implants for children in 2007

Waiting list	Number of patients registered in the waiting list as at 1 January 2007	Number of patients who have entered the waiting list	Number of patients who have received scheduled health care services	of which			Withdrawn from the waiting list due to other reasons	Number of patients registered in the waiting list as at 1 January 2008
				Common waiting list	Urgency waiting list	50% patient coverage waiting list		
Orthopaedy	15380	6418	2590	619	981	990	826	18382
<i>of which</i>								
Non-cemented hip joint	1512	699	409	95	216	98	66	1736
Knee joint	8665	3510	1102	299	482	321	353	10720
Cemented hip joint	5167	2157	1064	211	283	570	396	5864
Shoulder joint	36	52	15	14		1	11	62
Implantation of cochlear implants for children	15	10	17				0	8

8. Control and monitoring to provide the fulfilment of contractual provisions

In 2007 the Agency carried out regular controls in medicare institutions and pharmacies on the observance of contractual provisions, of which scheduled controls affirmed by the Agency's order per each quarter and unscheduled controls on the following ground:

- Complaints by physical persons and legal entities;
- Information summarized by the Agency, such as surveys, reports, showings, etc.,
- Recommendations by Ministry of Health or other authorities (such as Health Inspection, Disaster Medical Centre, etc.);
- Medicare institution defect statements;
- Suggestions by the Agency's management and structural units;
- Improper accounting data or specially selected information has been established in the management information system (hereinafter referred to MIS);
- Other cases.

In total 2 761 controls affirmed by control statements were conducted in 2007.

Survey on the control of medicare institutions and pharmacies

Accounting period: 2007

No	Outcome of controls	Total
1.1.	Number of controls performed	2 761
1.2.	Deductions made (LVL)	180 052,92
1.3.	Fines imposed (LVL)	111 537,27
1.4.	Sum returned to patients (LVL)	1 682,31
1.5.	<i>of which: with control statements</i>	<i>1 323,51</i>
1.6.	<i>of which: without control statements</i>	<i>3 58,80</i>
1.7.	Number of reviewed complaints	327

Upon the assessment of control results the following most frequently detected clusters of violations were identified:

Violations in the accounting of services:

- Medicare institutions enter their accounting data inaccurately and without any ground, as well as perform incorrect information coding;
- There are more manipulations accounted than performed in fact;
- Entered accounting data do not conform with entries in medical documentation;
- Both out-patient's coupons and in-patient's cards are accounted for payment within one hospital at the same time;
- Manipulations are accounted which do not conform with diagnoses, etc.

Violations in the availability of services:

- Insufficient, superficial information for patients in medicare institutions, in areas accessible to public;
- Failing to issue payment documents to patients;
- Unprofessional and unfriendly attitude;
- Ungrounded issue or non-issue of prescriptions;
- Refusals within a specific period to provide services paid up by the state;
- Paid services are offered instead of services paid up by the state without any ground, etc.

In 2007 controls as to family doctors' practises were defined as the priority in control and monitoring. The following facts were established in respect of the work accomplished by family doctors:

- Family doctors are not accessible within all 5 week days;
- There are no substitute doctors during the absence of family doctors;
- Premises of family doctors' practises are closed during working hours;
- Medical documentation is filled in incompletely and illegibly;
- In-patient medical cards are not filled in for short time health care patients;
- Patient groups are incorrectly encoded in out-patient coupons;
- Medicine to be reimbursed by the state has been written out without observing reimbursement provisions;
- Home visits are rejected without any reasonable ground, etc.



Summary of control results on the observance of PHC contractual provisions in the time period from 1 April* 2007 until 31 December 2007

Region	Number of family doctors in respect of which violations of contractual provisions have been detected	Number of detected violations:								Imposed sanctions			
		Accessibility and work organization of family doctors	Existence and filling in medical and accounting documentation	Information for patients in publicly accessible areas	Preventive work and planning and performance of vaccination	Collection of payments from patients	Nonconformity of VIS APANS information with information in out-patient card	Ensuring the minimum of medicaments and medical appliances necessary for the provision of emergency medical aid	Observance of regulations as to writing out reimbursable medicine and medical appliances	Deductions (LVL)	Fine (LVL)	Including the value of medicine (III and IV quarter)	Warning
Total	454	79	396	121	145	12	173	11	262	4323,98	16144,5	5185,06	150

* Summarization of control results on the observance of PHC contractual provisions was started only from 1 April 2007

In respect of complaints by the population, the Agency has examined 327 oral and written complaints. The nature of complaints is indicative of essential violations in family doctors' practises and health care organizations; nearly every received complaint is followed by control in a medicare institution.

9. Recovering of reverse claims

Recovery of financial resources in accordance with the reverse procedure is one of the directions of the Agency's activities. It means recovery of the state budget resources for treatment of persons, whose treatment is necessary due to after-effects of illegitimate activities, inaction or crime.

The agency in accordance with its strategy in 2007 planned within the reverse procedure to recover LVL 270 000 (plan A) and LVL 320 000 (plan B). During 2007 the Agency within the reverse procedure has recovered **LVL 538 692,38**. The above sum constitutes 168,34% out of the sum anticipated within the strategy for 2007 (plan B). Recovered funds will be channelled as extra funds for the health care program "Medicare".

Showings of reverse claims in 2007

	Number	Amount, LVL	Number	Amount, LVL
	2006	2006	2007	2007
Submitted claims, total	1 308	543 447,28	1768	638 901,10
<i>of which</i>				
For the treatment of road accident casualties	1 233	471 374,18	1 734	594 119,25
<i>of which</i>				
to insurance companies	1 008	1602	1 602	524 729,93
to Latvian Bureau of Vehicle Insurers	223	132	132	69 389,32
to persons who caused accidents	2	0	0	0
For the treatment of other casualties	75	72 073,1	34	44 781,85
<i>of which</i>				
illegal and criminal acts	19	0	0	0
accidents at work	56	34	34	44 781,85
Paid up claims, total	1 185	449 160,78	1 430	538 692,38
<i>of which</i>				
Partially paid up claims			5	7 062,83
For the treatment of road accident casualties	1 062	402 747,6	1390	507 486,41
<i>of which</i>				
from insurance companies	914		1304	464 820,21
from Latvian Bureau of Vehicle Insurers	139	1304	86	42 666,20
from persons who caused accidents	9	86	0	0
For the treatment of other casualties	123	46 413,18	40	24143,14
<i>of which</i>				
illegal and criminal acts	87		12	1 033,97
accidents at work	36	12	28	23 109,17

Number of reverse claims submitted to the Agency has increased for 35% in comparison with the previous year, but the common sum of reverse claims has increased for 18%. Analysing submitted reverse claims by positions, the biggest rise in claims and sums was observed by insurance companies and claims submitted to Bureau of Latvian vehicle Insurers.

The Agency in 2007 recovered a sum that was by 20% larger than in 2006. The total amount of paid up reverse claims against the total amount of submitted reverse claims constituted approximately 84% in 2007. Taking into account the offset in time of the payment of reverse claims, this proportion shows only an approximate return of the reverse recovery in the definite time period.

Essential increase of the amount of reverse claims was not possible in 2007 since the matter on the receipt of electronic information from law enforcement institutions necessary for advising of reverse claims was not settled yet. In this connection the Agency has started talks with Information Centre, Ministry of the Interior on the receipt of information from Road Police Register and Criminal Acts Register.

Problems of the reverse process are based on the application of normative act issues, changes in normative acts and consequences caused by them co-operating with other state administration institutions, insurers and Bureau of Latvian Vehicle Insurers.



10. Ensuring health care in member states of the European Union and the European Economic Zone

As soon as Latvia obtained a full-scale status of an EU member state, also residents of Latvia were entitled to receive health care in EU, as well as EU citizens have the right to undergo treatment in Latvia under the same conditions. The above rights to receive services of this health care are certified in special e-forms which the competent institutions of each state (in Latvia – the Agency) issue to “insured persons”.

Pursuant to Article 17 of the Medicare law, the amount of treatment services paid up from the state basic budget and funds of service receivers, in accordance with the procedure established by the Cabinet, shall be provided to the following:

- Citizens of Latvia;
- Non-citizens of Latvia;
- Citizens of the European Union member states (hereinafter referred to as the EU), the European Economic Zone (hereinafter referred to as the EEZ) states and Confederation of Switzerland, who stay in Latvia due to employment or as self-employed; as well as their family members; foreigners, who have permanent residence permits in Latvia;
- Refugees and person with alternative residence status; as well as detained and arrested persons, and persons sentenced to imprisonment.

Moreover, children of the above mentioned persons are entitled to receive free medicare services paid up from the state basic budget and funds of service receivers.

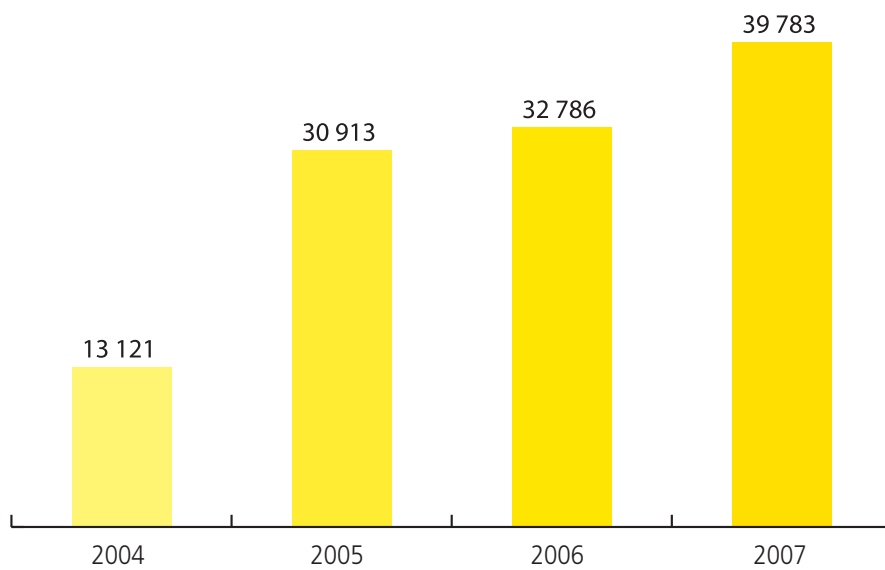
It is important to note that one of the tasks of the Agency is to administrate the receipt of and payment for health care services provided to residents of the Republic of Latvia while staying in EU and EEZ member states or Confederation of Switzerland, as well as to administrate the provision of and payment for health care services provided to ensured persons of EU and EEZ member states or Confederation of Switzerland while staying in the Republic of Latvia.

Consequently, the Agency accepts from residents of the Republic of Latvia applications for the receipt of E-forms, European Health Insurance Card (hereinafter referred to as EHIC) or substitute certificate for EHIC (hereinafter referred to as SC EHIC), examines received applications, prepares and issues E-forms, EHIC or SC EHIC, as well as examines claims submitted by residents of the Republic of Latvia on the reimbursement of expenses for health care services received in other EU and EEZ member states. The Agency performs interstate payment for health care services.

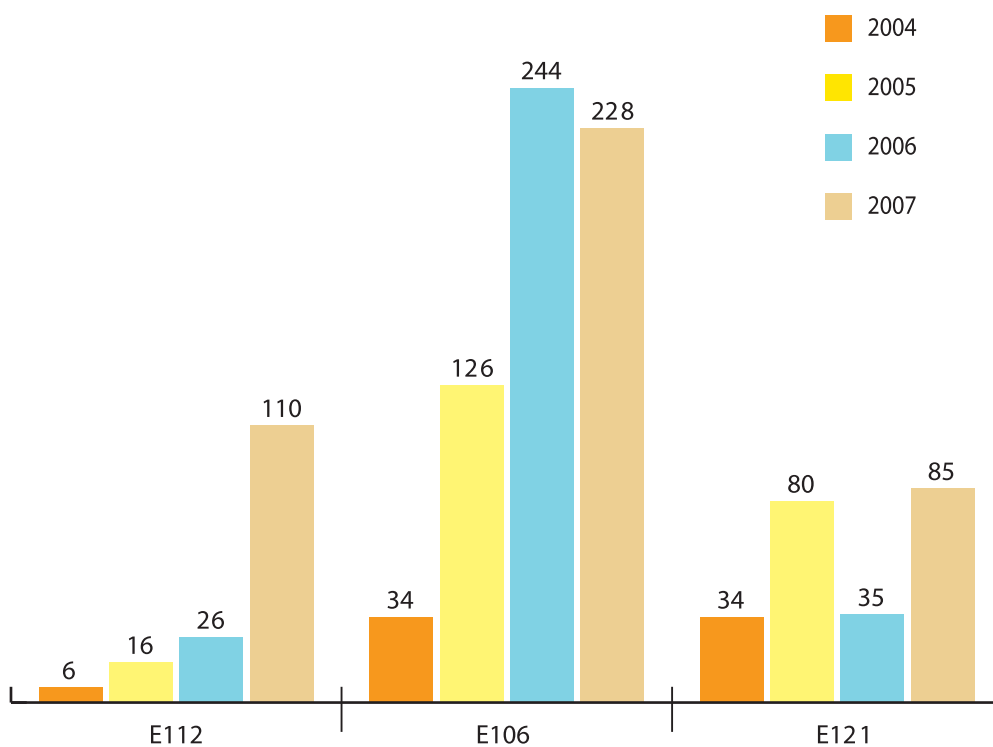
Types of E-forms are as follows:

- Certificates which verify that residents are entitled to receive the prescribed benefit in terms service.
- EHIC and SC EHIC verify that a person is "insured" in his/her state and is entitled to receive guaranteed emergency or necessary medical aid in accordance with the effective legislation of the state where the person is having a short-term stay.

Issued EHIC / SC EHIC



Dynamics of issued E-forms



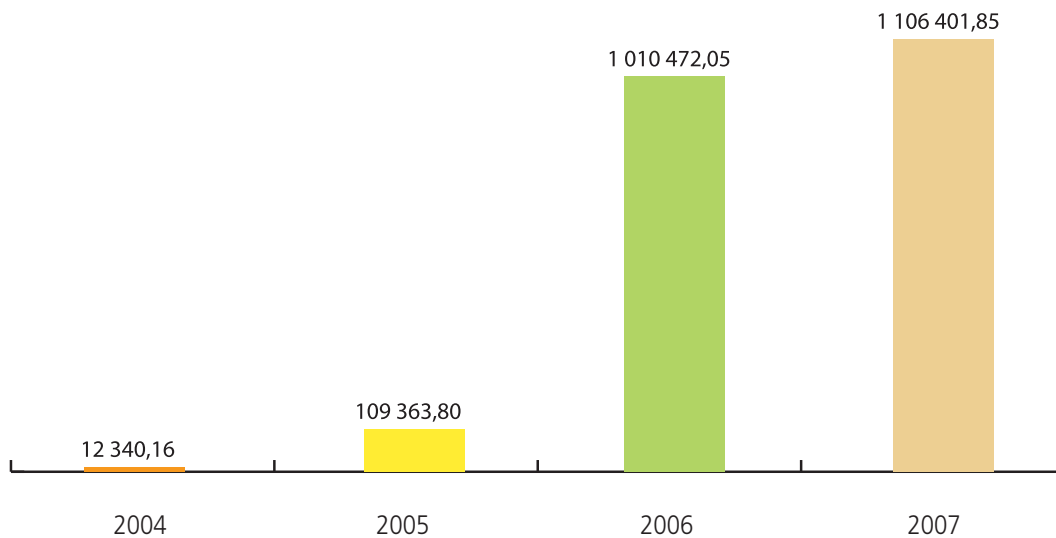


- Forms for execution of payments, ie. invoices for health care services.
 - Form E125 is an invoice for received health care services. The competent state reimburses actual expenses for health care services.

Costs of emergency and necessary medical aid rendered to residents of Latvia in EU, EEZ member states and Confederation of Switzerland in 2007

State	Received invoices (E125), LVL	Paid up invoices (E125), LVL
Austria	22 352,33	22 161,41
Belgium	10 083,55	7 126,43
Denmark	414,68	415,56
France	216 074,72	216 100,02
Estonia	50 129,17	50 129,18
Italy	34 433,94	34 433,94
Cyprus	1 666,85	1 666,85
Lithuania	116 242,41	114 315,83
Luxemburg	4 005,67	4 005,67
Malta	65,48	65,48
The Netherlands	1 118,21	1 118,21
Norway	13 846,87	14 431,95
Poland	6 584,03	6 226,61
Portugal	694,09	694,09
Slovakia	2 207,8	2 303,28
Slovenia	904,73	167,72
Spain	7 411,41	3 438,68
Hungary	15 454,21	15 454,21
Germany	489 359,57	499 765,75
Sweden	81 694,87	79 603,35
The Czech Republic	4 065,37	3 935,6
Confederation of Switzerland	87,12	2 626,49
Sum total paid against E125 forms, LVL		1 080 186,31
Payments for year 2006		8169,13
Sum paid up to physical persons, LVL		18 046,41
Sum total paid up by the Agency in 2007, LVL		1 106 401,85

Payment executed for health care services provided to residents of Latvia in EU, EEZ member states and Confederation of Switzerland, LVL



Costs of emergency and necessary medical aid rendered to residents of EU, EEZ member states and Confederation of Switzerland in 2007

State	Written out invoices E 125, LVL
France	15,90
Estonia	2 190,25
Italy	166,11
Lithuania	2 127,58
Norway	130,28
Poland	379,78
Portugal	79,09
Finland	1 491,86
Germany	79,1
Sweden	2 072,24
Total	8 732,19

- Form E126 represents reimbursement rates for benefits received in terms of services. Form E126 is used in cases when a physical person has not taken out EHIC or Form E 112, which the E112 issue commission has decided to issue, and has paid for received (emergency or necessary and delegated scheduled) health care services in EU, EEZ or Switzerland on his/her expense.

By the help of Form E126 the Agency finds out how large amount out of the sum paid by the person shall be reimbursed in accordance with regulations of the state where health care services have been received.



Reimbursement of expenses to physical persons for health care received in other EU, EEZ member states and Confederation of Switzerland in 2007

State	E126 Number of applications in 2007	of which			Amounts reimbursed by the Agency (year 2007), LVL
		paid up	refused	in process	
Austria	5	2		3	137,42
Belgium	2	2			291,8
Bulgaria	1			1	
France	5	2	1	2	175,82
Estonia	2	1		1	582,22
United Kingdom of Great Britain and Northern Ireland	1	1			19 804,56
Lithuania	2	1		1	540,13
The Netherlands	2	1	1		258,75
Norway	2		1	1	
Poland	1			1	
Spain	1		1		
Germany	20	15	1	4	13 320,22
Sweden	4	2		2	196,57
Switzerland	2	2			70,67
Total	50	27	5	16	35 307,49

11. The Agency's activities in informing the public

In accordance with its main tasks the Agency performed various activities also in 2007, in order to increase the level of awareness of the public on health care and service availability related issues.

In 2007 several informative materials were published and distributed, such as the brochure "How to receive state guaranteed health care services. Patient payments"; fact sheets "Health care in the hospital"; the brochure "If you are planning to go on a foreign trip, you have a chance to receive EHIC; the brochure "Health care for children" and, the brochure "What has to be known about the system of reimbursable medicaments", thereby informing the population of Latvia about the availability of health care services and the procedure of their receipt.

In order to contribute to the mutual communication between the population and medical employees in 2007 there were several informative video-clips prepared and broadcasted on the LNT television channel, such as "Listen in your patient, doctor!" and "Say Yes to your health!". This year cooperation was also started with other Latvian TV broadcasting stations, such as "Valmieras TV", program "Vidzemes televīzija", and Latvian television program "1".

The Agency ensures its feedback with the public by the help of its free informative telephone hotline 80001234. When using this hotline, residents ask questions on health care services paid up by the state, as well as try to find solutions to various problems they have had while receiving health care services.

Moreover, in order to find out what is the opinion by residents of the following two issues: "How often do you see your family doctor?" and "Who do you call for a home visit when you are sick: a family doctor or an emergency medical aid team?", two telephone campaigns were performed in 2007.



Information prepared by **Ministry of Health, Health Compulsory Insurance State Agency**, reports submitted by **medicare institutions**, as well as laws and regulations of the **Cabinet of Ministers** and **Ministry of Health** were put to use in preparation of this edition.



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