Curbing system leakages:

The health sector and licensing in Latvia

A Cockcroft, S Paredes, M Roche and N Andersson

DRAFT: November 17, 2002

ACKNOWLEDGEMENTS

The most valuable contributors to this consultation are the 3439 respondents from 30 sites across Latvia who took the time to provide information on 8931 residents. Health workers interviewed at hospitals and clinics, as well as business owners and managers in each site, helped to complete the review of licensing and health services.

Responsibility for the success of the process rests with the field workers who went to each participating community to hear the opinion of the people. Special recognition is owed to Maria Krilova and the field supervisors Iveta Kešane, Kristine Pekule, Liene Ozolina, Marcis Trapencieris and Elina Osta, who played a pivotal role in identifying field workers, translating instruments, supervising and conducting focus groups discussions. Maps were generated by Steve Mitchell.

During the design phase of the project, valuable input was received from the following people who constituted the design group in Latvia: Ms. Diana Kurpniece, Managing Director of Delna (Transparency International Latvia); Dr Andris Lasmanis, President of the Latvian Association of Family Doctors; Ms. Jolanta Zalite, President of the Latvian Nurses Association; Ms. Daina Biseniece, Deputy Director of the Pharmacy Department, Ministry of Welfare; Ms. Signe Dauškane Director of the Patients' Rights Organisation; Ms Solvita Olsena, Lawyer with the Patients' Rights Organisation; and Ms. Gunita Aizstrauta, Deputy Director of Judicial Department, Department of Finance.

Other key stakeholder who provided their points of view included: Ms. Biruta Iljica, Director of the Latvian Association of Family Doctors; Ms. Lolita Cigane, Project Director, The Soros Foundation Latvia; Ms Renate Pupele, Director of the Department of Health, Ministry of Welfare; Dr Viesturs Boka, Director of the Latvian Medical Association; Erik Rozencveig, President of the Confederation of Latvian Small and Micro Enterprises; Mr Valdis Nagobads, Director of the Department of Welfare Riga City Council; Ms Fatma Fridenberga, Deputy Director, Administration of Local Self-government affairs of Latvia; Ms Ita Zalite, Head of Riga City Council Entrepreneurship Coordination Centre; Dr Gundars Prolis, President of the Latvian Hospital Association.

Special thanks to Ms. Ilze Staškevica from the Secretariat of Crime and Corruption Prevention Council who acted as the project's Latvian liaison and to Mr Rudolfs Kalnins, Executive Secretary, Head of Secretariat Crime and Corruption Prevention Council of the Republic of Latvia, for his support in all the stages of the project.

The conclusions reflected in this report are not necessarily those of the OECD or the Government of Latvia. Once cleared by the OECD, the results may be quoted and reproduced in any form provided the usual conventions on authorship are respected.

This social audit was funded by the Organisation for Economic Co-operation and Development. The Latvian counterpart was the Crime and Corruption Prevention Council of the Republic of Latvia

Riga, Latvia, 30 October 2002

CONTENTS

Acknowledgements

List of tables

List of figures

PREFACE

SUMMARY

INTRODUCTION
Background on the health sector
Background on licensing
Research on corruption in Latvia

METHODS

KEY FINDINGS
The business questionnaire
The household survey

DISCUSSION
Stakeholder workshop
Communication strategy

ANNEX ONE: Individuals and organisations consulted

ANNEXT TWO: Organisational structure of the health care system in Latvia

LIST OF TABLES

1. Information base
2. Pharmaceutical expenditures in Latvia
3. Representative sample sites for the Baltics social audit
4. Final sample for the Baltics social audit
5. Type of business interviewed
6. Biggest current problem perceived by businesses
7. The part of the way government relates with businesses that works worst
8. Year of registration and proportion giving an unofficial payment or gift for registration
9. Reasons why businesses think an unofficial payment is corruption
10. Reasons why businesses think an unofficial payment is not corruption
11. What could be done to prevent unofficial payments
12. Reasons for being willing to report officials demanding unofficial payments
13. Reasons for not being willing to report officials demanding unofficial payments
14. Suggestions to improve government involvement with businesses
15. Population surveyed by sex and age
16. Main assistance and benefits received by household members
17. Education level of main breadwinner
18. Occupation of main breadwinner
19. Indicators of household vulnerability and proportion of households in each category
20. Licence / permit applied for (of households that applied)
21. Priorities for change in licensing services
22. Mean consultation fees, among those who paid anything
23. Mean official expenditures, among those who paid anything
24. Benefits of making an unofficial payment
25. Why an unofficial payment to a health professional is corruption
26. Why an unofficial payment to a health professional is not corruption
27. Suggestions for how to prevent unofficial payments
28. Reasons people would report unofficial payments
29. Reasons people would not report unofficial payments
30. Changes suggested for government health care system
31. Changes suggested for family doctor services
32. Changes suggested for specialist doctor services
33. Summary of communication strategy

A1 Health-adjusted life expectancy in the Baltic countries, compared with Germany (2001)

LIST OF FIGURES

1. Health care expenditure per capita from state consolidated budget
2. Expenses for health care per capita per month
3. How frequently firms in Latvia have to make an unofficial payment to get things done
4. How frequently firms in Latvia have to make an unofficial payment for licences/permits
5. Location of sample sites for the household and business surveys
6. Time to complete registration process
7. Reasons for not being willing to report officials demanding unofficial payments
8. Proportion of households that speak Latvian
9. Proportion of households that have applied for a licence/permit in last 5 years
10. Proportion of households that gave an unofficial payment or gift to get a licence / permit
11. Proportion of health service users whose last contact was with government services
12. Proportion of households who do not have enough information about health care entitlements
13. Sources of information about health care entitlements
14. Preferred sources of information about health care entitlements
15. How households rated government health services
16. Proportion who rated government health services as good (of those who rated)
17. Proportion of government health service users who were satisfied with medicines prescribed or given
18. Why respondent was dissatisfied with medicines
19. Proportion of government service users who were satisfied with the overall care received
20. Why respondent was satisfied with care
21. Why respondent was dissatisfied with care
22. Proportion of government health service users who knew how to make a complaint
23. Proportion of government health service users who made an unofficial payment
24. Rating the level of corruption
25. Proportion of households who rated corruption in the government health services as high/very high
26. Proportion of households who said the level of corruption in health services has increased in the last three years
27. Proportion of households who believe an unofficial payment to a health care professional is a form of corruption
28. Proportion of households who would be willing to report a health care professional who demands an unofficial payments
29. Proportion of households who would be willing to pay to avoid a waiting list for surgery or other hospital treatment

A1. Life expectancy in Latvia, by sex and year
A2 Number of TB cases notified in Latvia, 1980-200

PREFACE

Corruption erodes confidence in political institutions and endangers public sector reforms; exacts a disproportionate cost on the poor who may be deprived of basic public services; distorts the allocation of resources; and undermines competition in the market place.
- OECD (2000)

Corruption – the use of public resources for personal gain – has long been acknowledged as an important issue. Entrenched corruption presents major barriers for achieving public service reform, limiting the capacity of States to deliver on their social objectives. According to an IMF study, after considering other factors that affect income inequality and poverty, increased corruption in a country results in a decrease in the income growth of the poor[1].

Petty corruption – petty only in the sense that it is not criminalized – increases the cost of key public services and transfers the cost to users. Petty corruption siphons off financial, technical and human resources that should be invested in maintaining and improving the system. This ***system leakage*** in the public sector limits efficient and equitable delivery of people's entitlements, and widens the gap between the goals of government reform and progress and the lived experiences of people.

Preventing corruption requires evidence of the extent and the dynamics of the practice.

A **social audit** involves ordinary people in evaluating the social objectives put forth by government.

Social audit seeks to enhance accountability, equity, effectiveness and value for money.

CIET is an international organisation dedicated to ensuring that planning is based on evidence from the communities that services aim to reach. CIET's methods for social audit have been applied globally to a range of development issues. In particular, the social audit process has provided a reliable methodology for measuring the extent and impact of corruption in public services – and, as important, identifying mechanisms to tackle corruption.

Through these social audits, hundreds of thousands of citizens and public servants have spoken up about their experiences of corruption in the police, justice, public administration, primary education, agriculture, customs, social welfare and health services. Public service providers and the public they are supposed to serve are then drawn in to making the changes necessary for increased accountability and transparency to counter corruption.

From a perspective **system leakage,** a study of corruption must be embedded in a study of the entire system, including people's opinion and experience with the system, and their recommendations for improvements and changes.

From a broad social perspective, petty corruption degrades the moral fabric and undermines the rule of law. From the state perspective, money is lost in the unofficial system

[1] Gupta, S., H. Davoodi and R. Alonso-Terme (1998) *Does corruption affect income inequality and poverty?* IMF Working Paper. http://www.imf.org

through untaxed earnings and system leakage. From the service user's perspective, it creates inequalities in access to services.

Collecting evidence on the prevalence and dynamics of corruption requires a particular sensitivity in methods employed. The CIET social audit is guided by the following seven principles:

- **Get the evidence:** Public services do not always work as expected. The easiest mistake to make in service delivery is to assume that coverage and impact are obtained, simply because the services exist. Hard evidence is needed about what works and what is needed.
- **Community participation:** When local communities are brought into the picture in an informed way, discussing the data through focus groups and stakeholder workshops, public services become part of a network of governance issues on which there is meaningful interaction with the public.
- **Impartiality:** Community-based audit by a neutral third party can help to build a culture of transparency in public services, resulting in increased accountability and good governance.
- **Partner buy-in:** Partners in governmental and non-governmental capacities are actively involved throughout the audit, from the initial stages of design to action plans based on audit results and community-led solutions.
- **No finger pointing:** A social audit is intended to focus on system flaws and to build local solutions. It is not about 'finger-pointing'. Even negative findings can be framed as a starting-point to improve.
- **Repeat audits:** Ideally, social audits are repeated at constant intervals, in order to track changes and measure the impact of the reallocation of resources. This allows for interventions to be fine-tuned or investments to be moved elsewhere.
- **Dissemination of results:** Sharing of results, and the ability to interpret them, is key to the twin principles of transparency and accountability. The public is informed about progress and public managers, nourished by fresh evidence, know about the particular mix of circumstances under which an intervention works. CIET social audit maps help to focus the attention of the public and

decision makers. Use of the mass media and more local forms of communication help to disseminate the social audit results to a wide audience.

The research CIET facilitated in the Baltic States (Estonia, Latvia and Lithuania) focused on petty corruption in the health sector and licensing processes. The Organisation for Economic Cooperation and Development (OECD) commissioned the study at the request of the countries involved. The research process took place from March to November 2002.

In each of the three countries, CIET cooperated closely with governmental and non-governmental counterparts to determine the scope of the research, to design the survey instruments and to analyse the key findings. CIET staff with experience of CIET methods in other countries trained local fieldworkers on tested techniques to collect evidence from households and institutions, code and enter the data, and hold focus groups in local communities.

In October 2002, CIET presented the key findings from the research to stakeholder meetings in each of the countries, where planners, policy makers and advocates had the opportunity to reflect on the findings and discuss the implications for continuing their efforts to curb the system leakages created by petty corruption.

This report presents key findings of the Latvian survey and the action points households, health care institutions and key stakeholders in government and civil society have identified. It proposes a communication strategy to disseminate the findings to a wider audience in order to facilitate evidence-based action.

SUMMARY

In the 2002 Corruption Perception Index (CPI), an annual 'poll of polls' produced by Transparency International, Latvia received a CPI score of 3.7 (10 being least corrupt and 0 being most corrupt). Latvia took position 52 among 102 ranked countries, the lowest ranking of the Baltic countries. Earlier corruption surveys in Latvia found that a substantial number of Latvians believed government employees accepted bribes on a frequent basis. Formal studies also found that the perception of corruption was not matched with experience.

The aim of this social audit was to measure the public perception of the social phenomenon of corruption and to document links between perception and concrete experience. The goal was to help reduce system leakages that result from petty corruption and to suggest actionable steps to improve the situation in the health and licensing sectors.

Methods

Table 1
Information base

Number of households	3439
Sample population	8926
Businesses interviewed	167
Health institutions reviewed	41
Feedback focus groups	30
Health worker focus groups	2
Business owner focus groups	1

A cross-design of methods combined quantitative and qualitative measurement tools in a way that facilitates action and builds capacities. Interviewers came from universities, NGOs and government departments, and received training to conduct the household interviews. In a second phase, teams went back to the communities and conducted focus groups on the results.

The survey sample consisted of 3439 households across the country. In order for the sample to be representative of the national population, a multistage stratification scheme was used for the selection.

Data collection instruments included

- a household survey to collect information on individual client experiences within the health and licensing sectors;
- an institutional review of health care facilities;
- interviews with businesses; and
- focus groups with communities, health workers and business owners to deepen the understanding of results and explore corrective strategies.

Main findings

Business experience with licensing

The 167 businesses interviewed rated government support for their business poorly. Only 8% rated government support as good, while 23% rated it as bad and 19% rated it as very bad. Only 12% of businesses said the level of corruption in government regulatory processes was low, while over half (55%) thought that the level of corruption was high or very high. Only 12% thought that the situation of corruption had improved in the last three years.

Despite these views about corruption, only 6% of businesses admitted to giving a gift or unofficial payment to register their businesses and 9% admitted giving a gift or unofficial payment to get a licence or permit. A higher proportion (14%) admitted ever giving a gift or an unofficial payment for an inspection. Business focus groups felt that the incidence of unofficial payments in registration and licensing was likely to be accurate. However, they felt that the rate of unofficial payments for inspections was perhaps under-estimated. They felt small businesses were not keen to admit their participation in 'paying off' an inspector.

Most business owners (88%) said they thought it was corruption if a person gives a tip or unofficial payment to facilitate business regulation. Over half (60%) said they would be willing to report an unofficial payment. Yet only three respondents claimed to have made a formal complaint about demands for unofficial payments.

Household experience with licences and permit

Some 8% of households applied for any licence or permit in the last five years. The licence mentioned most often was a driving licence.

Some 85% of service users paid officially for licences and nine out of ten got receipts. Only 7% of households said they gave an unofficial payment or gift for licences, the majority of which were given in cash. The mean value of unofficial payments was 80.5 Ls. In most cases, the payment was made to an inspector or a clerk.

No less than 85% of respondents said they were satisfied with the licensing process, and only 7% said they were

dissatisfied. The most common changes suggested for the licensing were faster service and less bureaucracy.

Information about health services

Only one quarter of household respondents felt they had all the information they needed about their health care entitlements. People would like to get information from the mail and brochures, as well as from mass media sources. Only 21% of government health service users knew how to make a complaint. There was no association between health care facilities having formal complaints procedures and the proportion of service users who knew how to make a complaint. The existence of a formal procedure for complaints does not make it effective unless service users know about it.

Contact with health services

Of the 8786 people covered by the survey, 46% had contact with health services in the first five months of 2002. Eight out of ten health service users received treatment under the government health system and about two out of ten received treatment in private facilities. Among last contacts that were through the government scheme, 64% were with family doctors and the remaining 36% were with specialists.

Rating health services and satisfaction

Only 19% of households said that health services were good or very good. The most common response (44%) was that health services were neither good nor bad, and 37% gave a rating of bad or very bad. Despite this, most people who described a contact with government health services said they were satisfied with the care they received. Some 81% said they were satisfied or very satisfied, while just 9% expressed dissatisfaction.

Official payments for health services

Among the government health service users, 12% of those seeing a family doctor and 18% of those seeing a specialist paid more than the standard consultation fee. Nevertheless, three quarters of those who paid more than the standard consultation fee got a receipt for the full amount. The average total cost of a contact with

government health services (including money spent on medicines) was 10.4 Ls.

Corruption in health services

Some 45% of respondents rated corruption in government health services as high and 50% thought it had increased in the last three years. Almost half (49%) thought that an unofficial payment to a health care professional was not corruption, with the most common reason that it was a form of gratitude. The majority (62%) said they would not be willing to report a professional who demanded an unofficial payment.

These views create an enabling environment for unofficial payments in the health sector, yet only 3% of government health service users admitted to making an unofficial payment in their last contact. The most common benefit people reported from making an unofficial payment was quicker service, mentioned by 38%. One third of those who made an unofficial payment did not perceive any benefit as a result. Patients who made unofficial payments were *less* likely to be satisfied with their care.

Community focus groups felt that the real frequency of making unofficial payments was higher than 3%. Some suggested that people were unwilling to admit they made an unofficial payment because they knew it was illegal or they got some benefit; others thought people might be afraid to admit payments; and others still said it was so universal that people would not even think of the payments as unofficial.

Some 14% of government health service users said they gave a gift during the last contact. In nearly one third of gifts were given before or during treatment, suggesting that it was given to secure preferential treatment for the patient. If gifts given before the end of treatment are counted as unofficial payments, then 6% of government health service users made unofficial payments.

Priorities for change

The most frequent change suggested for the government health care system affected the family doctor system, in particular the practice of referrals from a family doctor in order to see a specialist. Over half of the respondents were willing to pay for a change to the system.

Next steps

The most important step in the social audit process is to disseminate the findings in a way that will lead to interventions aimed at curbing unofficial payments and gifts in the health and licensing sectors. Based on the analysis of the survey findings and consultations with stakeholders, a communication strategy identifies the main actionable findings, and for each of those defines the messages to be communicated; the audiences to be addressed; and the most effective mechanisms for communicating the evidence in a way that facilitates positive changes in the sectors examined.

In the health sector, three actionable findings emerged:
- *attitudes create a supportive environment for corruption*, including widespread belief that unofficial payments are not corruption and low willingness to report unofficial payments;
- *lack of information at households level*, the majority reporting they did not have enough information about health care entitlements and few households saying they knew how to make a complaint; and
- *a gap between people's perception of the government health care system and their personal experience as users*, with very few households rating government health services as good, but most service users saying they were satisfied with their care.

In the sector of business regulation and licensing, one actionable finding was identified:
- *a high prevalence of unofficial payments for business inspections*, and a strong relationship between not having enough information about inspections and making unofficial payments.

The main target groups include the general population, service workers, the business community, and planners and policy makers. These audience segments will be targeted using the mass media (radio, newspapers and television); dissemination of posters and pamphlets; and seminars and debates. Government institutions and non-governmental organisations will take the lead on different components of the strategy. Service workers, in particular doctors, health facility administrators and government inspectors, will receive specific targeted information, as well as skills necessary to effectively communicate the information to service users.

Table 33
Summary of communication strategy

Health sector			
Main findings & actionable facts	Target group	Channels of communication	Practical implications
Attitudes about corruption 49% of households thought an unofficial payment to a health worker was not a form of corruption and 62% were not willing to report a health worker who demanded an unofficial payment.	-General public -Health institution managers -Health care workers -Policy makers and planners	-Radio, newspapers, magazine for health care professionals -Posters and pamphlets -Seminars to health professionals -Health care workers as providers of information	-Views were more common among urban areas and non-Latvian speaking households, so these should get particular attention -Focus groups said they wanted information from trusted independent people or government authorities, so involve NGOs and Ministry
Information about entitlements 75% of households said they did not have enough information and 89% did not know how to make a complaint.	-General public	-Radios, newspapers, TV -Posters and pamphlets	-Ministry should standardise the information that is communicated in facilities -Materials should be published in both Latvian and Russian -Attention to communicating information to the elderly
Perception of government health care service Only 19% of households rated government health services as good, but 81% of users of government services said they were satisfied with the care they received.	-General public -Health care workers	-Public forums -Radio, newspapers, magazines, TV to highlight positive experiences -Meetings, internet or written feedback to foster communication between Ministry and health care workers	-Should clearly state both potential and limits of the system, being careful not to raise expectations -Closely related to the provision of information, above
Business regulation			
Main findings & actionable facts	Target group	Channels of communication	Practical implications
Unofficial payments in business inspections 14% of businesses made an unofficial payment for inspection. Over half of businesses did not have enough information about inspections.	-Businesses -Government departments that do inspections -Inspectors	-Pamphlets -Internet -Memo to inspectors -Feedback and brainstorming session with inspectors	-Should review the supervision and accountability of inspectors -Implement a mechanism for inspectors to report businesses that offer unofficial payments

INTRODUCTION

In the framework of corruption as 'system leakage', it is important to examine the context of the system – how it operates, its strengths and weaknesses, and people's experience and perceptions of it. In this section, we present a brief overview of the health and licensing sectors, followed by an overview of research on corruption in Latvia.

A health care system in transition

Health care reform has been a challenge for all transition countries. Like most of the former Soviet republics, independent Latvia inherited a health care system characterised by deteriorating hospitals and clinics with inadequate supplies; physicians who were poorly trained and underpaid (earning less than the average factory worker); and an ineffective system of quality management[2].

The Department of Health in the Ministry of Welfare is responsible for the provision of health care in Latvia. This department manages the State Compulsory Health Insurance Agency (SCHIA), which was re-established at the national level in 1997 to control and disburse funds for health care. At the sub-national level, municipalities are responsible for ensuring that people have access to health services, maintaining health facilities and consolidating large hospitals. In Riga and large towns, municipalities have ownership of some health care centres, often in partnership with the health care providers themselves. The organisational structure for the financing and management of the health care system is illustrated in Annex 2.

Primary health care is the focus of the health care reforms, making family doctors the gatekeepers of the health care system.

Primary health care was and continues to be the focus of health care reforms. This has meant a departure from a system where patients move from one specialist to another, depending on their ailment. In the new system, each person registers with a family doctor, and that family doctor serves as the 'gate-keeper' of the health care system, referring the patient to specialists as deemed appropriate.

[2] Barr, D and M Field (1996) "The current state of health care in the former Soviet Union: Implications for health care policy and reform" *American Journal of Public Health* 86(3):307-312.

The Latvian government has moved a long way in executing health care reforms, but some challenges remain. The introduction of patient fees has reportedly put basic health care out of reach for some disadvantaged groups, particularly the elderly who are in most need of health care. The incomes of health professionals are among the lowest salaries in the public services – doctors and nurses earn approximately $300 and $180 a month, respectively – and many health care workers are turning to more financially rewarding professions or seeking employment abroad[3].

In 1998, the World Bank approved a $12 million loan to assist the Government of Latvia in the implementation of a long-term strategy to restructure health services. The programme focused on health care financing reforms and the development of health care services.

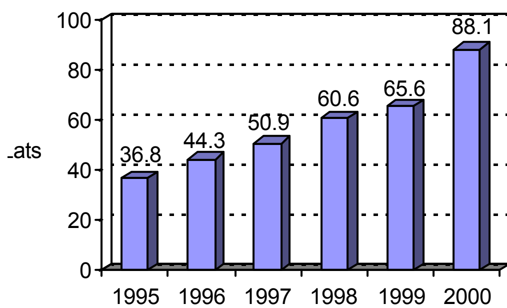
Health care finance and expenditure

A primary objective of the government's health care reform is to develop institutions and systems for appropriate health financing. Soon after independence in 1991, there was a move to decentralise health care responsibilities to a local level. Government confirmed this delegation of responsibility in the law 'On Local Self Government' (1993). However, it soon acknowledged that local municipalities did not have the financial or administrative capacity to appropriately manage health care services and in 1997 consolidated the health care budget to the state level, creating the State Compulsory Health Insurance Agency (SCHIA). The SCHIA established eight regional funds, which disburse money through contracts with local service providers.

Most hospitals are limited liability enterprises and hold contracts with the regional sick fund. The sick fund reimburses the institutions according to the number of patients it treats and the services it provides. Most family doctors operate as independent contractors with a regional sick fund, and operate within a 'capitation' model budget. Each family doctor has a determined list of patients under his or her care and is allotted a pre-determined amount per patient for all outpatient services. This system has come under severe criticism by professional doctors' association, who feel that the amount allocated is

3 Irwin J (2000) "Europe in crisis" *Nursing Standard* 15(11): 26-27.

Figure 1
Health care expenditure per capita from state consolidated budget



Source: Ministry of Welfare (2001) Public Health Analysis in Latvia, 2000

insufficient to provide adequate care to all patients and also to cover overhead and salary expenses[4].

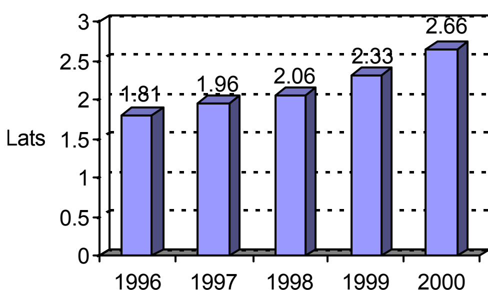
In 1999, 75% of funding for health care came through the regional sick funds, and patients paid the remainder 'out-of-pocket'[5].

Between 1995 and 2000, the health care expenditure per capita from the state consolidated budget has more than doubled (Figure 1). In 1999, the government's total expenditure on health was 4.4% of its GDP. This compares with the CEE average of 5.7% and the EU average of 8.6%[6].

Cost of health care to users

All Latvian citizens, permanent residents and those who have paid income tax for more than six months are entitled to health care services covered by the health care minimum. The government's *Basic Care Programme* describes the range of services provided and is revised annually. People receive free care only for emergency treatment, maternity treatment, if they are under 18 years of age, and if they are certified on the social register. Otherwise, visits to the clinic cost 0.50 Lats, a specialist costs 2 Lats, and procedures for non-urgent care require co-payment of 20% of care costs. Some services like dental care, joint replacement and infertility treatment are not covered at all by the Basic Care Programme and patients purchase these services directly from health care institutions (state, municipal or private).

Figure 2
Expenses for health care per capita per month (Survey on household budget of the Central Stats. Bureau)



Source: Ministry of Welfare (2001) Public Health Analysis in Latvia, 2000

The amount households spend on health care each month risen (Figure 2). A 2000 study found that 48% of those polled did not visit a doctor even when ill because they lacked the funds for treatment. One-third of those polled struggled to find the money for treatment, and only one-fifth (19%) could afford treatment without worrying about having enough money left over for other needs[7].

Prescription medications make up a significant portion of household expenditure on health care. The Cabinet of Ministers has established a list of drugs, mainly for severe

4 Based on conversations with the Latvian Association of Family Doctors and the Latvian Physicians Association.
5 European Community and World Health Organisation (2001) *Highlights on Health in Latvia.* Copenhagen: WHO Regional Office for Europe. Page 33.
6 WHO Regional Office for Europe (2000). *Health for All* database.
7 UNDP (2001) *Latvia Human Development Report 2000/2001*. Riga: UNDP.

Table 2
Pharmaceutical expenditures in Latvia

	1997	1999
Health care budget (in millions)	63 LVL 105 USD	136 LVL 226 USD
Drug expenditure	15%	10%
Domestic producers %	15%	24%
Hospital drugs %	85%	76%
Ambulatory drugs %	65%	73%
OTC drugs %	35%	27%
Drug expenditure as % of health expenditure	15.4%	16.6%
Reimbursed drug expenditure	22.5%	36.6%
Outpatient reimbursed drug expenditure	7.4%	13%

Source: European Observatory of Health Care Systems (2001) Health care systems in Transition: Latvia

and chronic illnesses, that are reimbursable by the state, and the patient must pay for all other drugs privately. Table 2 shows the structure of expenditure on pharmaceuticals in Latvia.

Private health insurance is a new phenomenon in Latvia and is growing alongside the market for private health services. Nevertheless, private insurance is out of reach for most people.

Background on licensing

Licences and permits for small and medium enterprises are not the domain of one ministry or sphere of government. The dispersed control of licences and permits creates a barrier for starting and operating a business, because it is time consuming and difficult to consolidate all of the necessary information. Businesses must first register with the national government at the Register of Enterprises and locally at State Revenue Services.

To operate, they must get the relevant licences and permits according to the "Regulations for licensing of Certain Kinds of Business Activities (Regulation of the Cabinet of Ministers No. 348, of 7 October 1997)" and "On State Fee for Special Permit (licence) to Separate Types of Entrepreneurship" (Regulations of the Cabinet of Ministries No. 48 of February 1999).[8]

Most licences and permits for small businesses are issued at the national level (see below), according to the type of business, but local governments have the power to issue certain permits and licences, according to Section 15:11 of the Law on Local Governments.[9] These include trading licences to businesses operating in public spaces; licences for public transport taxis and private buses; shooting ranges; cremation activities; and some stages of the building and construction process. In addition, small businesses must get regular certifications such as: building codes; fire safety; and environmental friendliness. All businesses are subject to a regular inspection from the State Revenue Services (local tax inspection).

A licence is needed if the business is engaged in operation of secondary and higher educational institute (issued by Ministry of Education); production of weapons and

8 Latvian Development Agency (2001) *Latvian Export and Import Directory*.
9 Government of Latvia (2001) *Law on Local Governments*.

explosives (issued by Ministry of Interior Affairs); manufacture of medicines and pharmaceuticals, and the manufacture or services of dangerous equipment (issued by Ministry of Welfare); foreign currency transactions, bank and credit activities (issued by Bank of Latvia); national or international passenger and cargo transport (issued by Ministry of Transport); radio and television broadcast (issued by National Radio and Television Council); and insurance services, production of tobacco and spirits for sale, trade of precious metals, production and import of fuel and petrol, and gambling services (all issued by Ministry of Finance).

Skilled professionals working in medicine, teaching, construction, engineering and others skilled activities require a certificate or licence issued by the relevant professional society.

The general population might require licences and permits such as: building permit for construction or renovation, driving licence, work permit, travel permit, permit to cut wood, hunting permit, trade permit, and others. Municipal departments issue most of these licences and permits.

Research on corruption in Latvia

A small variety of research studies provide a picture of the levels and perception of corruption in Latvia.

The 2000 study, *The Face of Corruption* carried out by NGO *Delna*, showed that in the categories of receiving permits and licences, medical care, and school registration, the actual bribing experience (using connections, money or gifts) was higher than the perception of bribery[10]. In the categories of customs, encounters with traffic police, settling cases in court, and encounters with national police, the perception of bribery was higher than the actual bribery experience. In this study, which surveyed 2001 inhabitant of Latvia, 55% of the respondents believed that the government of Latvia was not interested in preventing corruption and 77% thought that many officials abused their authority in order to pursue their personal interests, neglecting the needs and rights of the inhabitants.

10 Delna (2000) Delna Annual Report 2000. Riga: Delna.

Corruption in the health sector

Reports suggest that, under the Soviet administration, corruption permeated the health system. Largely as a result of low salaries, some health care personnel demanded money from patients to provide services they were supposed to provide for free. A shortage of medical supplies and basic pharmaceuticals led to the proliferation of black markets[11].

A World Bank report on health care in the region since the collapse of the Soviet Union argues that corruption still infests the system, creating "an informal market for health care within the confines of the public health care service network".[12] Although very little data exists on this informal health market in Latvia, anecdotal evidence suggests that unofficial payments to health care providers are commonplace, and almost an accepted part of the health care system[13].

The 1998 World Bank survey *Corruption in Latvia* found that health-related services were the second largest component of household bribe flows (after traffic police), both in the aggregate and for the average household[14]. Despite households' direct experience with corruption in the health sector, they gave health-related organisations relatively high marks in terms of honesty and integrity, on average above the press and local NGOs. From a list of 36 public and private institutions, households ranked the State Agency of Medicine third as the 'most honest'.

The World Bank survey found that households believed that the health sector extracts bribes from service users about 15% of the time (based on responses from households with at least annual contact with the health sector). When asked how they perceived the frequency of bribes in education and health services, households gave an average rating of 3.7 and public officials gave a rating of 3.4 (range being 1=never happens and 5=always happens).

11 Barr D and M Field (1996) "The current state of health care in the former Soviet Union: Implications for health care policy and reform" *American Journal of Public Health* 86(3): 307-312.

12 Lewis M. (2000) "Who is paying for health care in Eastern Europe and Central Asia?" Washington: World Bank.

13 Based on conversations with the Latvian Physicians Association (April 2002) and the Latvian Association of Family Doctors (April 2002).

14 World Bank. *Corruption in Latvia: Survey Evidence, 1998*. Accessed in April 2002 at: http://www.delna.lv.

When households were asked how damaging they believe different types of corruption to be, they ranked "bribery to improve quality of education or medical treatment" as the least damaging type of corruption. Respondents suggested that while bribery in education and health sectors is a frequent practice, it was necessary given the low levels of state funding.

The 2000 study, *The Face of Corruption,* had similar findings[15]. In household surveys, 18.2% of respondents reported that they believed the health clinics were corrupt. However, among those using the health services, 38.3% reported actual experience in bribing (using connections, money or gifts). The discrepancy between the number of people who *perceived* corruption and the higher number of people who have participated in official payments reflects a belief by some that gifts and unofficial payments in the health sector are not a form of corruption.

Based on discussions with key informants, both government and civil society members largely agreed that unofficial payments exist – and are possibly on the rise – in the health care system. They suggested that although unofficial payments are most organised in surgical clinics, it is also a common practice among other practicing physicians, including in the new family doctor system.

The reasons people gave for systemic corruption in the health care system were a lack of money in the health care system and low salaries of health care professionals. People pointed out particular 'opportunities' for unofficial payments, such as long waiting lines for surgeries and getting a referral to a specialist by a family doctor.

They said that patients are disinclined to openly challenge the system of corruption, because they are anxious about losing access to quality health care. For health care professionals, there are few disincentives for taking unofficial fees – no doctors have been prosecuted by the national health department and hospital administrations seem reluctant to take disciplinary action. Those individuals who benefit from the system of unofficial payments – doctors who earn money and patients who get preferential treatment – are reluctant to see changes in the system.

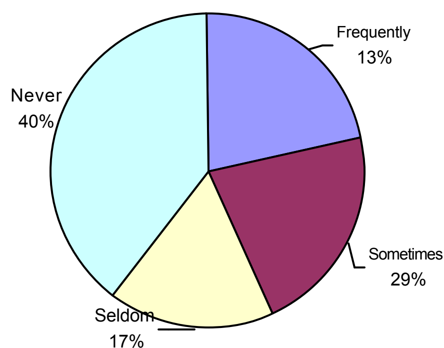
15 Delna (2000) *Delna Annual Report 2000*. Riga: Delna.

People generally agreed that 'gratuities' to doctors after a service were different from money demanded to perform a service. However, the question remains to what extent the gratuities are truly voluntary, and whether they are in fact a down-payment to get better service the next time.

Corruption in licensing

Studies about unofficial payments in the licensing and permits sectors are rare in Latvia. However, some reports indicate that corruption exists in these processes. In the World Bank survey *Corruption in Latvia* (1998), when asked to rate the frequency of corruption in the licensing and permit process, households gave an average rating of 4.0, business enterprises gave a rating of 3.8, and public officials gave a rating of 3.6 (range being 1=never happens and 5=always happens). For bribery to avoid trouble from sanitary/fire inspectors, households and enterprises gave an average rating of 3.6 and public officials gave a rating of 3.2. In the same study, when asked who most frequently extracted bribes, business enterprises named: road police 33%, customs 21%, building permits 18%, sanitary inspections 13%, fire inspectors 12%, tax or audit inspections 8%.

Figure 3
How frequently firms in Latvia have to make an unofficial payment to get things done (n=150)



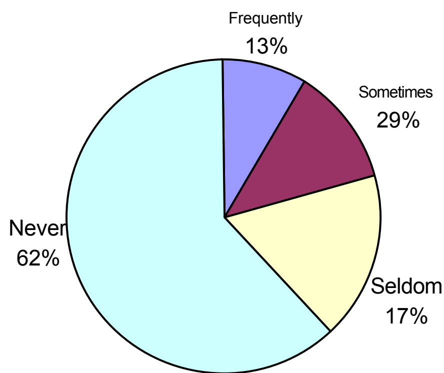
Source: Business Environment and Enterprise Performance Survey 2000, The World Bank Group

The 1998 survey also documented people's experience with corruption[16]. Thirty-seven percent of enterprises and 13 percent of households reported having made unofficial payments. On an organisation-by-organisation basis, enterprises and households that have had contact with government agencies reported that unofficial payments were required a third to a half of the time from some agencies. The average enterprise spent 2.1% of monthly turnover on bribes and the average household spent 1.2% of monthly income on bribes. Time spent on negotiating bribes was also a significant cost.

In 2000, the World Bank Group included Latvia in the Business Environment and Enterprise Performance Survey (BEEPS), which aimed to capture the private sector's perception of and experience with corruption in the business environment[17]. When questioned how frequently firms must make an unofficial payment to get things done, of the 150 firms responding, 40% said firms must never make unofficial payments (Figure 3). When asked how often firms must make unofficial payments to get licences

16 Anderson, J. (1998) *Corruption in Latvia: Survey Evidence.* Report available at http://www.delna.lv.
17 An interactive BEEPS database is accessible at http://info.worldbank.org/governance/beeps.

Figure 4
How frequently firms in Latvia have to make an unofficial payment for licences and permits (n=156)



Source: Business Environment and Enterprise Performance Survey 2000, The World Bank Group

or permits, 62% said this was never necessary (Figure 4). About 65% of the firms (n111) said that bribes to public officials have had some impact on business.

In discussions with stakeholders during the scoping phase of this project, most people suggested that opportunities for corruption were greatest in the issuing of construction permits, mainly in the big cities. People said that private individuals would be more ready to admit their experiences with unofficial payments in this sector, as established companies might fear harming their relationship with the authorities. One stakeholder said that because of the complicated procedures for procuring licences, there could be a *perception* of corruption in the process, just because there is inadequate information on the official procedures.

The 2000 study, *The Face of Corruption,* conducted by the NGO Delna, reported that people's perception of frequency of bribes in licensing and permits is higher than actual bribing experience. [18] In the surveys, 59% of service users thought bribing associated with receiving a licence or permit was common. However, when they reported actual experience (using connections or giving money or gifts), only 47% had some experience. The report does not discriminate what proportion of bribes were linked to using connections, money or gifts.

A stakeholder reported that businesses commonly felt that for most processes, one can pay a bribe to make things go faster or to have the inspector 'look the other way'. With the tax inspector, for example, the stakeholder suggested that it is cheaper to pay a bribe to the inspector than to go through a long process of challenging the inspector's decision. According to this person, owners of small business have the perception that it will not do much good for them to challenge corruption. Most of them are constantly struggling to survive in their small businesses, and they are willing to pay bribes just to make sure that they can keep operating.

[18] Delna (2000) *Delna Annual Report 2000*. Riga: Delna.

METHODS

To initiate the process in April 2002, a series of interviews with planners and decision makers clarified the objectives and set the limits of the enquiry. The government counterparts identified the sectors of health and licensing. Further meetings with key individuals and organisations attempted to tease out the main concerns for investigation and the components of service delivery that would benefit from community-based information.

In consultations during the design phase, representatives of government, health care professionals and civil society all agreed that unofficial payments were present in the current health care system, but they disagreed about the extent of the problem. Asked about the reasons for corruption, the informants generally pointed to under-funding and low salaries of health professionals.

People interviewed during the design phase expressed the opinion that patients were reluctant to openly challenge the system of corruption, because they felt anxious about losing access to quality health care. Many expressed the opinion that unofficial payments were not given to obtain better treatment but were given to express gratitude to the physician. Informants agreed that 'gratuities' to doctors after a service were different from money demanded to perform a service. The extent to which gratuities are truly voluntary or a down payment to get better service the next time, however, remained to be established.

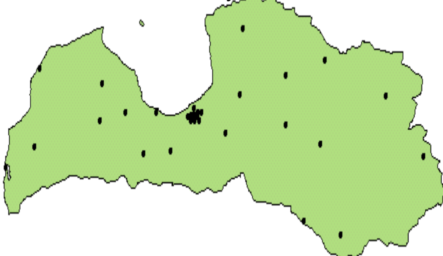
Table 3
Representative sample sites for the Baltics social audit

	Capital sites	Other urban sites	Rural sites	Total
Estonia	10	10	10	30
Latvia	15	7	8	30
Lithuania	8	12	10	30
TOTAL	33	29	28	90

The government counterparts formed a design committee that contributed to the content of the survey instruments. With the input of this committee, in cooperation with local partners, CIET followed its established research methodology for a social audit.

Sample and sampling

Figure 5
Location of sample sites for the household and business surveys



The Baltic Study Centre (BSC) at the University of Latvia performed the sample selection, relying on the most recent government census data.

The national sample consisted of representative sentinel sites (Table 3 and Figure 5). In order for the sample to represent the national population, the BSC stratified the sample frame by size of settlement and location, and randomly selected a number of sites from the list of

Table 4
Final sample for the Baltics social audit

	Households interviewed	People represented	Health institutions reviewed	Businesses interviewed	Community focus groups	Health worker focus groups
Estonia	3,388	7,526	33	-	30	2
Latvia	3,439	8,926	41	167	30	2
Lithuania	3,493	8,541	30	150	30	2
TOTAL	10,320	24,993	104	317	90	6

candidate communities in each stratum, in proportion to the population.

In each site, approximately 100 contiguous households were interviewed. The final sample size in Latvia was 3,439 households, representing almost 9,000 people (Table 4).

Data collection instruments

Data collection instruments:

- Household survey
- Institutional review for health care facilities
- Interview format for small- and medium-sized businesses
- Focus group format for community members
- Focus group format for health care professionals

The data collection methods included a household survey to collect information on individual client experiences with the health and licensing sector; institutional reviews of health care facilities; and community focus groups to deepen the understanding of results and to explore corrective strategies. The CIET team selected and trained interviewers, piloted and adjusted the instruments to local conditions, supervised the household surveys and double-data entry, facilitated the institutional reviews and focus groups, analysed the data and produced the report over nine months.

Household Survey

Following a standards-based approach, CIET reviewed questionnaires used in and outside the Baltic region as a starting point for the questionnaires, and used pre-validated questions whenever possible. The design committee reviewed the questionnaire and interviewers piloted it in communities in order to test clarity and appropriateness. The 79 questions on the household survey covered six different areas:

-*General household questions* collected information about the household structure, including age, sex, breadwinner data, education level, occupation, social assistance and household income level.

-*Questions about licensing* were asked only to those households that reported applying for a licence or permit in the last five years. This section included questions about

the type of licence, time spent in dealing with the application, official payments and receipts, unofficial payments and gifts, overall satisfaction with the process and suggestions for change.

-*Questions about people's perceptions of the health sector* included a rating of the health services, suggested changes about health services, willingness to pay for changes, and where people would like to get information about free health services.

-*Questions about people's attitudes and perceptions of corruption in the health sector* included questions about willingness to pay to avoid a waiting list, willingness to report a doctor that demands an unofficial payment, whether an unofficial payment is corruption, the acceptable value of a gift to a health professional, rating and time trends of corruption, and suggestions for preventing unofficial payments in health services.

-*Questions about people's direct experiences with the health sector* were asked for each member of the household. For household members that had visited health services in the last five months (since the beginning of 2002), information was collected about that person's contact: whether it was private or public, where the person was treated and by what type of doctor, whether the visit was an emergency, whether the person was admitted to the hospital, time spent on a waiting list, satisfaction with care and medicine, and whether the person made or knows how to make a complaint about services. The respondent estimated the amount spent on the person's care, including consultation fee, medicines, investigations, bed and other charges.

-*Questions about people's experience making unofficial payments in the health sector* were asked only about those household members that had contact with health services in the last five months. The household respondent provided information, for that last contact, about whether the person made any unofficial payment, and if so, whether it was of their own initiative or at the request of the health professional, when the payment was made, the amount of the payment, who received the money, and the benefit gained for making the payment. Similar questions were asked with regards to gifts. If the patient did not make an unofficial payment, the respondent was asked whether a health care worker requested an unofficial

payment, and if the patient had refused, what affect that had on the care received.

Institutional review of health care facilities

Interviews were conducted in person or over the telephone with the main health centres that people reported attending. An interview with a respondent from the institution elicited information on staff and staff shortages, employee salaries, absenteeism, contracts with the sick fund, budget and expenses, patient load, fees charged and medicines provided. It also collected information about how the facility informed patients about policies and practices and a series of questions about complaints procedures. With regards to unofficial payments, the review inquired about the institutional position on unofficial payments and gifts, whether the facility has received any complaints about unofficial payments, where opportunities for unofficial payments might exist, and what the facility does and thinks should be done to prevent unofficial payments. Further, the institution provided suggestions for changes in the health system and the family doctor system specifically.

Focus groups

In each of the sample sites, interviewers invited community members to join focus groups to discuss the findings and discuss corrective actions. To facilitate the discussion, the research team developed focus group guides, which presented key findings from the household questionnaires and institutional reviews and guided discussion into areas useful for programme planning. In addition to community focus groups in each of the sample sites, trained facilitators conducted two focus groups with health care workers in each of the countries.

Business interviews

A total of 167 businesses participated in the business survey in Latvia. In most cases, the interview was with the proprietor, who was asked initial questions regarding the number of employees, the year of establishment, and perceptions of the level of support received by government.

Sections of the questionnaire dealt with business regulation processes, namely registration of new

businesses, procurement of business licences, and official inspections. For each of these, the business respondent answered questions regarding time required, difficulties, and official and unofficial costs. A final section of the questionnaire dealt with general aspects of corruption, assessing the perceptions of the business community.

Following the initial analysis of the business interviews, a number of business owners participated in a focus group, providing feedback on findings.

Data collection

Household interviews and reviews of health care facilities took place during May and June 2002. In each country, local interviewers participated in a one-day training session, which provided a background of the project and standardised administration of the interviews. The trainees practiced conducting the questionnaire in the community and were given feedback on their performance. The training also reiterated the issues of confidentiality, quality control and logistics.

Interviewers clustered themselves in multiple teams, each with a team supervisor. Teams travelled to a site and interviewed all households in a designated cluster in a single day, with no sub-sampling.

Following the household survey, interviewers conducted reviews of the health institutions that household members reported attending. Only institutions that at least 20 people reported visiting participated in the institutional review. CIET fieldworkers contacted the institutions primarily by telephone, with a trained interviewer speaking to the director of the facility or another senior administrator.

After the initial analysis of the household and institutional data, the interviewers returned to each of the sites in September 2002 to conduct focus groups. Only those individuals who had participated in the household interviews participated in the focus group meetings. Up to ten people participated in each focus group, and a trained facilitator and a recorder guided the session. In addition, facilitators held two focus groups with health care workers (one of doctors and one of nurses), randomly chosen among the institutions that had been reviewed.

Data entry, validation and analysis

Prior to data entry, the research team coded open-ended answers conducted logical checks. Using public domain software (EpiInfo), they entered data twice. They checked discordant data with the source questionnaire, in order to eliminate all keystroke error, and further cleaned data to exclude logical errors.

In the analysis of data (also using Epi Info), researchers linked the institutional review data with the individuals who reported using a given institution. This process is known as *meso-analysis*, by which data from the individuals can be interpreted in a local context[19]. Meso-analysis deals with factors operating in the community or institution by linking them to the behaviour and attitudes of the individuals in that community.

Formal epidemiological analysis probed behind the indicators to get a deeper understanding of vulnerability to particular attitudes and practices. CIET analysed promising associations indicating possible vulnerability using standard epidemiological techniques to identify potentially confounding effects of age, sex of respondent, education, residential area and other factors. Risk analysis used the Mantel-Haenszel procedure[20 21]. Contrasts are reported as the odds ratio, and exact confidence intervals (CI) are those of Cornfield. Heterogeneity between strata was tested using the procedure of Woolf.

CIET researchers tested differences between averages (for example, unofficial cost of services and willingness to pay) using standard procedures: where the variances of the two groups were homogenous (95% confidence), the t-test was used. Where the variances were heterogenous, the Kruskal Wallis test for two samples was used. Only those associations that are significant at the 5% level are reported. Most other associations will have been tested and found to be easily explicable by chance alone.

[19] Andersson, N. (1996) “Meso-analysis: Quantifying qualitative data from communities and services” in *Evidence based planning: the philosophy and methods of sentinel community surveillance*. Washington: EDI/World Bank.
[20] Mantel, N, W. Haenszel (1959) “Statistical aspects of the analysis of data from retrospective studies of disease” *Journal of the National Cancer Institute* 222: 719-748.
[21] Mantel, N. (1963) “Chi-square tests with one degree of freedom: extensions of the Mantel Haenszel procedure” *Journal of American Statistical Association* 58: 690-700.

Maps and their interpretation

Key findings from community-based questionnaires are represented in population weighted raster maps. These maps are made by draping a surface – as one might do a tent – over a matrix of 'tent-poles', one located in each sentinel site. The height of the tent-pole reflects the height of the indicator in question.

As the surface of the tent rises and falls over tent poles of different heights, the colour changes to reflect the different level of the indicator. An important characteristic of the CIETmap geomatic package is that it permits weighting of where the colour changes between tent poles of different heights. As the value of each sentinel site is related across to all other sentinel sites through the shared surface, the population each site represents weights the interpolation.

The interpretation of maps is straightforward, not unlike a weather map. Darker colours on the map represent higher levels of the indicator being mapped, as if the population represented by each sentinel site were 'spread out' on the geographic surface. Population weighting thus transforms the geographic space into population space. For example, if 30% of the map falls into a given range of the indicator, then – because of the way the sample was chosen and interpolation weighted by population – 30% of the population of the country falls within that range. Much like a standard weather map, trends are much more accurate than the exact location of any contour gradient.

Darker areas on the map represent the need for attention or investment. Sufficient class ranges are used to ensure that individual communities are not easily identified. Each colour set represents the different CIET levels of indicators. For example, a green palette represents coverage and a brown palette represents impact.

KEY FINDINGS

The Latvian business questionnaire

In total, 167 businesses participated in the survey. Table 5 presents the types of businesses interviewed. In more than half of the cases (93/167) the interview was with the director or manager of the business and in a quarter (39/167) it was with the owner. A quarter of the respondents (26%, 43/167) were male.

Table 5
Types of business interviewed (n167)

Food trader	20%
Professional / IT	19%
Beauty / pharmacy	17%
Restaurant	11%
Construction	11%
Clothing	10%
Agriculture /flowers	5%
Hotel / tourism	5%
Other	2%
Total	100%

Most businesses were small. Around half (48%, 80/167) employed 5 people or less, 40% (69/167) employed 6-20 people, and only 11% (18/167) employed more than 20 people. The greatest number of employees in a business was 250. A few businesses (13%, 21/166) were registered between 1986 and 1991, and 19% (32/166) were registered in 2001 or 2002.

The most common complaint by businesses was of low profits or lack of financial resources, followed by a related complaint that customers did not have enough money to spend (Table 6).

Table 6
Biggest current problem perceived by businesses (n= 163)

Low profit	29%
Lack of clients/people don't have money	24%
No problems	15%
Low quality of personnel	8%
Taxes too high	7%
Too much competition	7%
No government support	4%
Other	5%
Total	100%

Respondents generally rated government support and facilitation for their business poorly. Only 8% (14/166) rated the support as good, while 23% (38/166) rated it as bad and 19% (32/166) rated it as very bad. The remainder (47%, 78/166) rated government support as neither good nor bad. The focus group of business managers also complained about lack of government support for businesses, suggesting that there was effectively no support given to small businesses.

Table 7
The part of the way government relates with businesses that works worst (n=163)

Tax system and inspections	17%
Various parts of bureaucracy	17%
Nothing	15%
Everything is bad	6%
Legislation and regulations	2%
Other	7%
Could not say	36%
Total	100%

Asked which part of the government relationship with businesses worked *best*, almost half (46%, 74/161) could not say which worked best and nearly one fifth (18%, 29/161) said “nothing works best”. Some 21% (34/161) thought the tax and financial arrangements were the best, while sanitary or veterinary inspections were mentioned by 7% (11/161). Table 7 presents responses to a question about which aspect of the government relationship with their business worked *worst*. The most common specific response was the tax system and inspections.

“You can only get support from business state institutions if you are acquainted with some officials personally”.
-Business owner in focus group

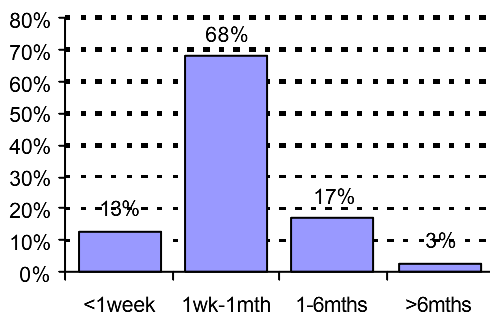
Some 60% (99/165) of businesses thought they had enough information about state regulations in the business sector.

Business registration

Two thirds of businesses said it was easy to get the business registration.

Only 14% (22/160) of businesses said it was difficult or very difficult to get their registration. Some 67% (108/160) said it was easy or very easy, and the remaining 19% (30/160) said it was neither difficult nor easy. By far the most common reason that businesses mentioned for registration being hard was that it was too bureaucratic (16/21). Among those who found the process easy, 65% (65/99) said they did not have any difficulty at all, and the most common specific reason for being easy was that it was fast (12%, 12/99).

Figure 6
Time to complete registration process (n=108)



Among those who were able to give information about the official charge for registration, the average charge was 133 Ls (n78, median 100 Ls). The average time reported to get the registration was 4.9 months (n108, median 4.0 months). Only 13% (14/108) of respondents said they got the registration in a week or less (Figure 6).

Most respondents (73%, 114/157) said they went in person to get their business registration. The remaining 26% (41/157) used an agent and 1% (2/157) did it by mail. Among those who reported how much they paid the agent, the mean amount was 78 Ls (n26, median 50 Ls).

Only 3% (4/146) of respondents admitted that they made an unofficial payment to get their registration. The mean amount was 52 Ls (n3, median 30 Ls). Three out of the four businesses said they got quicker registration by making an unofficial payment. One half (2/4) of those who gave an unofficial payment for registration said they offered it, the others said the service provider asked for the payment.

6% of business respondents admitted to giving an unofficial payment or gift to get their business registration.

In response to a separate question, 3% (4/146) of respondents said they gave a gift to an official when getting their business registration. The mean value of the gift was reported as 20 Ls (n=3, median 5 Ls). Combining unofficial payments and gifts, in total 6% (8/140) of respondents gave either an unofficial payment or a 'gift' in order to get their registration.

When this finding was discussed in the focus group of business managers, they were not surprised to hear that not many businesses made an unofficial payment for registration, pointing out that registration has clear regulations and structure, leaving less room for latitude in

decision making and hence little room for businesses to make unofficial payments to get the system to work in their favour.

Table 8
Year of registration and proportion giving an unofficial payment or gift for registration

1986 – 1991 (n=9)	0
1992 - 1995 (n=42	3%
1996 - 2000 (n=69)	8%
2001 - 2002 (n=14)	11%

There was no detectible relationship between type of business or size of business and giving an unofficial payment or gift for registration. There was some evidence of a trend for more unofficial payments and gifts for more recent registrations (Table 8), although this could have been due to chance (the number of observations was small) (Chi square 3.16, df 3, p0.37).

There was no evidence that giving an unofficial payment or gift actually shortened the delay in getting a business registration. In fact, those who gave an unofficial payment or gift reported somewhat longer waiting to get the registration than those who did not pay.

Licences

Nearly all respondents (88%, 142/161) felt they had enough information about the licences required for their businesses. Most (85%, 135/159) who responded about the licences required for carrying on their business said they required at least one licence or permission. Among these, 16% (22/135) said they needed only one licence; 31% (42/135) needed two licences; 23% (31/135) needed three licences; 14% (19/135) needed four licences; and 15% (21/135) said they needed five or more licences. Two respondents said they required ten licences.

Of the 408 licences businesses considered necessary for their operation, 110 related to health and safety, such as sanitary inspections, fire security, work protection and environment; 92 were for business or tax registration, 66 for alcohol or tobacco, 57 special licences for the type of business, 20 professional certificates, 11 patents or copyrights, and 11 other miscellaneous licences.

74% of respondents said it was easy to get their last licence.

The average time since the business last applied for a licence was 10.1 months (n=113, median 6 months). Most (99/113) had applied within the last year.

Responding about their last licence application, 10% (11/116) said it was difficult or very difficult to get the licence, while 74% (86/116) said it was easy or very easy. Almost half (47%, 46/97) said they did not pay at all for the licence. For those who paid, the mean official charge

for the licence was 76 Ls (n=51, median 20 Ls).

About one in ten businesses admitted to making an unofficial payment for a licence.

Three respondents (out of 114) admitted to giving an unofficial payment for their last licence. A further eight (out of 115) respondents said they had ever given an unofficial payment for a licence. Combining those who paid on the last occasion with those who paid on some previous occasion, 9% (11/118) admitted to having made an unofficial payment for a licence at some time.

"Some people do pay unofficially in order to get the licence issued faster; these payments should be made official"
-Business owner in focus group

Participants in the business focus group felt that the proportion of businesses that reported making an unofficial payment for a licence could be accurate as it is quite possible to get a licence without paying unofficially.

On average, the last time that an unofficial payment for a licence was made was about 21 months ago. However, six of the events happened within the last year.

There was no association between type, size or date of registration of the business and making an unofficial payment for a licence. Men seemed more likely to have made an unofficial payment for a licence than women (5/28 vs 6/90) but the difference could easily have occurred by chance. Those who found getting a licence difficult were no more or less likely to have made an unofficial payment than those who did not find it difficult.

A business requiring less than four licences was over twelve times *less* likely to make an unofficial payment for a licence, compared with a business requiring four or more licences.

There was a strong association between the number of licences required for the business and unofficial payments for a licence. Among those businesses requiring less than four licences, only 2% (2/81) reported an unofficial payment, compared with 25% (9/36) of those requiring four or more licences. A business requiring less than four licences was over twelve times less likely to give an unofficial payment for a licence, compared with a business requiring four or more licences (OR 0.08, 95%CI 0.01-0.42, 2/81, 9/36).

A small number of respondents gave answers to questions about the last time they made an unofficial payment for a licence. No striking patterns emerged. In five out of eight cases the unofficial payment was in cash and in three cases in kind. The average amount paid, or equivalent value of an in-kind payment, was 39 Ls (n=8, median 30 Ls). Three out of the eight said they offered the payment themselves. Seven out of nine mentioned personal satisfaction as the benefit from making the unofficial payment, one person

said there was no benefit, and one mentioned faster service.

Inspections

Almost half of the respondents (48%, 79/164) felt they had enough information about the inspections required for their businesses. Most who responded (93%, 149/160) said they needed one or more inspections for their businesses. In total, the 149 respondents mentioned 460 inspections they needed: 135 were related to tax, finance and audit; 220 were related to health and safety and the environment such as safety, fire, sanitary, workers protection, health and environment, consumer protection, food and veterinary, and trade inspections; 51 were municipal police inspections; 27 were language inspections; and 27 were other miscellaneous inspections.

42% of businesses said their last inspection was easy to pass.

The last inspection was on average 6.7 months ago (n=140, median 3 months). Nearly all (91%, 128/140) of the businesses that gave the information had an inspection within the last year, mostly a tax or financial inspection (40%, 56/140), a health and safety related inspection (43%, 60/140), or an inspection by municipal police (9%, 13/140). Some 27% (37/138) of respondents said this last inspection was difficult or very difficult to pass, and 42% (58/138) reported it as easy or very easy to pass.

Only 27% (36/133) of inspections involved an official charge. Among these, the average charge was 122 Ls (n=36, median 40 Ls).

14% of businesses admitted to giving an unofficial payment or gift for an inspection.

Some 4% (5/137) of respondents admitted to giving an unofficial payment for the inspection. A further 11% (14/130) said they had ever given an unofficial payment for an inspection. Combining these, 14% (19/135) of businesses reported they had given an unofficial payment for an inspection on the last occasion or on a previous occasion. The most recent incident of an unofficial payment happened an average of 20 months ago (median 12 months ago). Ten out 16 cases were within the last year. Respondents were asked how many times they had made an unofficial payment for an inspection in the last five years. Among those 13 who responded, the average number of times was 3.6 (median 2).

Three out of 13 unofficial payments were for a tax inspection, three for alcohol or tobacco inspection, two for

fire and security inspection, two for work protection inspection, two for municipal police inspection, and one for audit inspection. For the rest of the events the respondent did not want to mention the type of inspection concerned.

"It is very true that unofficial payments, in cash or kind, do work with inspectors. Most businesses and common people as well have experienced giving a bribe to an inspector".
-Business owner in focus group

Business managers participating in the focus group discussion confirmed that corruption was frequent in relation to inspectors' visits. In fact, they felt that 14% was an underestimate of the proportion of small businesses that pay bribes to pass inspections. They suggested that businesses might not have admitted to making these payments, either because they knew it was wrong to give bribes and they did not trust the anonymity of the survey, or because they did not believe that these payments were really a form of corruption.

There were no associations between size, type and year of registration of the business, and unofficial payments for inspections. However, sex of the respondent was associated with disclosure of unofficial payments in inspections. More males reported making an unofficial payment for an inspection (31%, 11/35) than females (8%, 8/100). A male respondent was more than five times more likely to make an unofficial payment during a inspection, compared with a female respondent (OR 5.27, 95%CI 1.71-16.6, 11/35, 8/100).

Those who said the most recent inspection was difficult to pass were apparently *more* likely to have made an unofficial payment for an inspection at any time than those who did not find the inspection difficult to pass (7/36 vs 11/96). The association could have occurred by chance (the numbers are small) but this could be some suggestive evidence that difficult inspections may be associated with unofficial payments.

A business with enough information about inspections was over four times *less* likely to make an unofficial payment for an inspection compared with a business without enough information.

There was a strong association between businesses having enough information about required inspections and unofficial payments for inspections. Among those who felt they had enough information, only 6% (4/66) reported an unofficial payment for inspections, compared with 22% (15/67) of those who did not have enough information. A business with enough information was over four times less likely to make an unofficial payment, compared with a business without enough information (OR 0.22, 95%CI 0.06-0.79, 4/66, 15/67).

A business requiring less than five inspections was over eight times *less* likely to be involved in an unofficial payment compared with a business requiring five or more inspections.

There was also a strong association between the number of different inspections required for the business and unofficial payments for inspections. Among those businesses requiring less than five inspections, only 7% (8/107) reported an unofficial payment for inspections, compared with 41% (11/27) of those requiring five or more different inspections. A business requiring less than five inspections was over eight times less likely to make an unofficial payment, compared with a business requiring five or more inspections (OR 0.12, 95%CI 0.06-0.79, 8/107, 11/27).

Participants in the business focus group stressed that information could be protective. They suggested that some inspections should be planned, and businesses informed in advance, but not all. They complained that for some types of inspection, particularly those carried out by the municipal police, inspectors see fining and penalties as their primary task, rather than educating and warning people about infringements and then fining only against those who remain in breach of regulations despite information and warnings.

Those respondents who admitted having made an unofficial payment for an inspection were asked some questions about the last time it happened. Among the 14 who responded, 11 said that the inspection in question had been unexpected rather than a planned inspection.

Table 9
Reasons why businesses think an unofficial payment is corruption (n=127)

Reason	%
It is unofficial /bribery	48%
Officers are already paid	24%
State loses money	8%
Money was asked	6%
Corruption is everywhere	4%
Those who pay get a benefit	4%
It depends of circumstances	6%
Total	100%

Most of the unofficial payments were in cash (9/14). The mean amount of the cash or equivalent in-kind value was 70 Ls (median 25 Ls). Nine out of 15 respondents said they themselves offered the unofficial payment. The perceived benefits of making the unofficial payment were: to ‘get what they wanted’ (6/15), to save money (3/15), to avoid a fine (1/15), and ‘no more inspections’ (1/15). Some reported ‘no benefit’ (4/15).

Business perceptions about corruption

Table 10
Reasons why businesses think an unofficial payment is not corruption (n=17)

Reason	%
Presents are not corruption	53%
It depends on the circumstances	24%
You get a benefit	18%
Corruption is everywhere	6%
Total	100%

Most business respondents who expressed an opinion (88%, 142/161) said they thought it was corruption if a person gives a tip or unofficial payment for a licence or permit or to pass an inspection. Table 9 shows the reasons given by those who thought these unofficial payments were corruption. Table 10 shows the reasons given by those who did not think these unofficial payments were corruption.

The focus group participants made a distinction between small payments to municipal police or sanitary inspectors – of 5 or 10 Ls or an equivalent in-kind payment – and larger payments for getting a tender or winning a state competition, where the level of the payment is much higher as the anticipated profits are also much higher.

"When I know that something is wrong with my taxes or I am late with a declaration, I prefer to take a box of chocolates with me because then I feel myself more comfortable."
-Business owner in focus group

The small payments to officials are often not perceived as corruption, according to focus group participants. As in the business interviews, they suggested that giving presents or small payments was more like an expression of gratitude or a way to establish personal relations. The business owners also suggested that making payments was not corruption, but rather payment for the job.

"Officials are paid, but they are indifferent towards you, so in order to buy their positive attitude and attention you pay unofficially or bring a gift."
-Business owner in focus group

Table 11 shows the suggestions from businesses for what should be done to prevent people giving tips or unofficial payments for licences and permits. The most common suggestions were to improve the business legislation, to check inspectors, and to educate people and persuade them not to give bribes.

Table 11
What could be done to prevent unofficial payments (n=162)

Improve legislation	24%
Check inspectors	14%
Educate/ persuade people	13%
Increase salaries	9%
Nothing should be done	6%
Punish people	4%
Cheaper fines	3%
Hard to say/ do not know	26%
Total	100%

Focus group participants explained the problem with the attitude of state officials:
"They perceive their work as temporary, saying: I am not paid well, my job is not prestigious, and why should I care? People in private business, both owners and employees, care for their jobs because they see them as long-term, as a livelihood, and they are interested in development. State officials are not, they do not understand that everything is interconnected, that their well-being depends on the well-being of enterprises, but not in terms of immediate bribes, in terms of longer relations. They do not respect themselves, they do not respect businessmen, that is why they think it is fine to break laws made by the state, because they think the state does not take proper care of them."

Only three respondents (of 164 who gave information) mentioned making a formal complaint about unofficial payments for licences and permits.

Table 12
Reasons for being willing to report officials demanding unofficial payments (n= 93)

It is not fair	34%
Depends on the situation	32%
It is illegal	23%
Have no experience	7%
Other	4%
Total	100%

Some 60% (100/166) of respondents said they would be *willing* to report officials who demanded unofficial payments from them. A quarter of respondents (44/166) said they would not report and 13% (22/166) said they did not know if they would report or not.

Table 12 shows the reasons among those who said they would be willing to report, while Table 13 shows the reasons among those who would not be willing to report.

Table 13
Reasons for not being willing to report officials demanding unofficial payments (n=43)

Do not want problems /don't want to complain	31%
It depends on the situation	16%
Have no experience	12%
It is hopeless	9%
I'm getting a benefit	7%
Other	2%
Total	100%

The focus group participants echoed the sentiments from the business interviews, noting that business people may not report because of concern that it could be bad for their business, or because they themselves got a benefit from the transaction and so would not want to report it. They suggested that one thing that could help encourage businesses to report demands for unofficial payments would be to publicise examples of successful reporting: where a business has reported, the corrupt officials have been prosecuted, and the business has continued to thrive. Other participants felt it would be very difficult to persuade businesses to report, despite the fact that 60% claimed they would be willing to report.

Figure 7
Rating of corruption in the business sector (n=146)

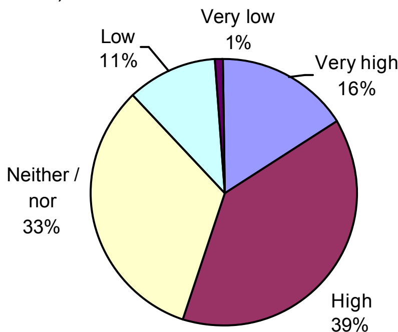


Figure 7 shows the overall business ratings of corruption in the regulation of the business sector. Some 12% (20/167) said they did not know how to rate corruption. Of those that responded with a definitive rating, 55% (80/146) rated it as high or very high.

Opinions were divided on whether the corruption has got better, stayed the same or got worse in the last three years. A quarter of respondents (25%, 41/167) did not know how to rate the trend in corruption. Of those who responded with a definitive answer, 40% (49/123) said that it had got worse and 48% (59/123) said it had stayed the same. Only 12% (15/123) said corruption had got better in the last three years. In the focus group discussion, business owners felt that the level of corruption had not changed much over the last three years, but that people might feel the problem has increased because there has been more media attention to the issue.

Table 14
Suggestions to improve government involvement with businesses (n=165)

Decreased taxes	38%
More support to SMEs / easier credit system	19%
Improve tax policy	18%
Decrease bureaucracy	5%
Other	3%
Hard to say / Do not know	17%
Total	100%

Finally, the respondents were asked about what would be the most important thing that would make government involvement in their business work better. Table 14 presents their suggestions. Focus group participants stressed the urgent need to reform legislation and regulations, which they felt were far too complex, especially in the tax area.

In focus groups, businesses praised the idea of the so called "one stop agencies" – a new from of cooperation

between state and businesses. These agencies can provide qualified help and assistance for reaching solutions to problems. State officials working in these agencies assist, for instance, with getting licences or permits. The advantage of these agencies is that it saves time and hassle of having to go from one agency to the next.

The household survey

Population characteristics

The national household survey covered 3439 households in 30 representative sample sites. Household respondents answered on behalf of all members of the household, some 8931 people in total (average of 2.6 people per household). The geographic distribution of households in the sample approximately reflects the national population distribution. Some 74% (2532/3439) of households were from urban areas. The age and sex structure of the sample population is shown in Table 15.

Table 15
Population surveyed by sex and age

	Male	Female	Total
Less than 5 years	163	168	331
5 - 14 years	511	500	1011
15- 49 years	1966	2180	4246
50- 64	634	908	1542
64 +	552	1197	1749
Total	3826	4953	8779

The household member responding to the interview on behalf of the household was male in 27% (927/3439) of the households. In 46% (1579/3438) of households the respondent was younger than 50 years old.

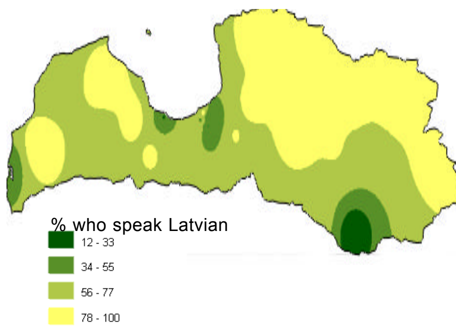
Education level of the adult population

Among household members aged 18 and above, 2% (117/6961) had an education level lower than grade four; 4% (305/6961) had only elementary education; and 16% (1146/6961) had basic education. Some 31% (2184/6961) had secondary general level education; 28% (1982/6961) had secondary specialist education; and 18% (1227/6961) had attained higher education.

Employment

Under half the adults in the households (46%, 3205/6980) were in paid employment. Nearly one in ten (8%, 568/6980) were unemployed; 33% (2279/6980) were pensioners or retired; 1% (108/6980) were disabled; 7% (495/6980) were students; and 5% (325/6980) were homemakers.

Figure 8
Proportion of households who speak Latvian



Language

Some 70% (6134/8757) of households reported Latvian as the main language spoken at home, with another main language (mostly Russian) in the remaining 30% (2623/8757). Figure 8 shows the spatial distribution.

Income and social assistance

One out of ten households (388/3439) did not give an estimate of their monthly household income. Among those who reported, considering the incomes of all the household members, the estimated average monthly total income was 177 Ls (n=3051, standard error = 9.5, median 120 Ls). The 25th centile value for total monthly household income (25% of the households have an income below this level) was 70 Lats. Only 22% (737/3337) of respondents said their monthly household income was sufficient to meet their expenditure needs.

Table 16
Main assistance and benefits received by household members (n=8675)

None	59%
Child assistance	19%
Retirement pension	14%
Disablement benefit	2%
Social insurance	2%
Studies credit	2%
Unemployment benefit	1%
Other assistance & benefits	1%
Total	100%

Some 59% (5085/8675) of household members did not receive any form of social assistance from government. The most common assistance that household members received was children's assistance, reported among 19% (1667/8675). Pension followed with 13% (1175/8675). Other types of assistance reported are in Table 16.

Only about a third of households (36%, 1212/3396) were not in receipt of any assistance or benefits from government, including pensions, for any of their members.

Main breadwinner's education and occupation

Respondents were asked to identify the main breadwinner in the household. In almost half of the households (45%, 1537/3421) a female was reported as the main breadwinner. Also in almost half of the households (47%, 1616/3419) the breadwinner was less than 50 years old. Only 7% (226/3357) of the breadwinners had lower than basic education (Table 17). Some 55% (1850/3356) of household breadwinners were in paid employment and 5% (157/3356) were unemployed (Table 18).

Table 17
Education level of main breadwinner (n=3357)

Less than basic	7%
Basic	14%
Secondary general	28%
Secondary specialist	30%
Higher	21%
Total	100%

Table 18
Occupation of main breadwinner (n=3356)

Paid employment	55%
Pensioner / retired	36%
Unemployed	5%
Disabled	2%
Student	1%
Homemaker	1%
Total	100%

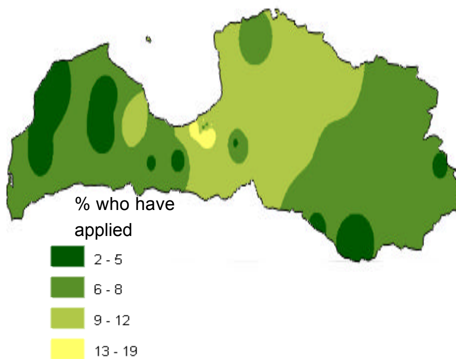
Vulnerable households

Information about several possible indicators of vulnerability was collected from household respondents and combined to give a composite indicator of household

Table 19
Indicators of household vulnerability and proportion of households in each category

At least one unemployed adult	15% (503/3389)
Breadwinner unemployed	6% (203/3356)
At least one child under the age of five	9% (305/3439)
Elderly people (over 65) living alone	22% (762/3439)
Someone receiving government assistance	64% (2184/3396)
Household monthly income below 25th centile	24% (730/3049)
At least two of the criteria above	42% (1257/2993)

Figure 9
Proportion of households that have applied for a licence/permit in last 5 years



vulnerability. The possible vulnerability criteria were: someone in the household unemployed; a household with only people over 65 years; total monthly household income below the 25th centile (for the sample); children under five years old; someone receiving assistance; and breadwinner unemployed. The proportion of households in each of these categories is shown in Table 19. For the purposes of analysis here, households were categorized as vulnerable if any two of the factors were present. By this means, 42% (1257/2993) of the households were categorized as vulnerable.

Licences and permits

Only 8% (283/3439) of households applied for a licence or permit in the last five years (Figure 9). Of those, 46% (127/277) applied for the licence in the last year, 40% (111/227) more than one year ago, and a few did not specify when they applied during the five years (14%, 39/227).

The most common licence households requested was a driving licence (Table 20). Consequently, most households submitted the application at the traffic department (56%, 142/256), followed by the municipality (23%, 59/256), the business registry (5%, 14/256), the building department (4%, 10/256), and the police (3%, 7/256).

Table 20
Licence / permit applied for (of households that applied) n=281

Driving	54%
Construction	11%
Trade	10%
Permission to work	5%
Permission to cut wood	4%
Business registration	3%
Residence/travel permit	3%
Other	10%
Total	100%

The applicant obtained the licence in 90% (252/279) of the cases. While 46% (103/225) of households reported that the application took less than a month, 38% (85/225) took between one and three months, and 16% (37/225) took more than three months.

Cost of licences

Some 15% of the applicants (31/204) did not pay anything officially for the licence. The reported amount paid ranged between 0.25 Ls and 650 Ls, with an average of 99.5 Ls (n=173, standard error= 6.6, median 100 Ls). Among those who paid, 90% (141/156) received an official receipt for the amount paid.

7% of households said they made an *unofficial payment* or *gift* to get a licence.

Unofficial payments for licences

Of the 283 households that applied for licences or permits, 7% (20/283) reported making an unofficial payment or giving a gift to obtain the licence or permit. Of the 20

Figure 10
Proportion of households that made an unofficial payment or gave a gift to get a licence / permit*

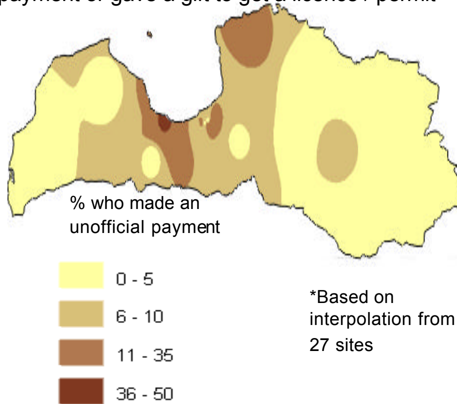


Table 21
Priorities for change in licensing services (n= 236)

Nothing should be changed	56%
Less delay/faster service	14%
Less bureaucracy/documents	13%
Cheaper services	7%
Change the whole system	3%
Other	6%
Total	100%

people who made unofficial payments, 73% (11/15) reported giving cash and 27% (4/15) reported giving a gift. The value of the gift or cash ranged from 3 Ls to 500 Ls, with an average of 80.5 Ls (standard error= 33.5, median 25 Ls). When asked to whom the unofficial payment was given, households reported: inspector (n= 6), clerk (n=6), administrative personnel (n=2), municipality (n=1) and intermediary agent (n=1) (Figure 10).

Household satisfaction with licensing services

Most households (85%, 228/268) reported they were satisfied with the licensing services. Some 20 households said they were neither satisfied nor dissatisfied and 20 reported frank dissatisfaction with the services.

When asked for their priorities for change to the licensing services, over half of the households (132/236) said that nothing should be changed. Of those that suggested changes, the most common were for faster services and less bureaucracy (Table 21).

Health services

Of the 8786 people providing information about use of health services, some 46% (4742/8786) visited a health facility at least once in the five months prior to the survey.

Private health insurance

A few household members (17%, 1441/8633) had private health insurance cover. Some people were more likely to have private insurance:

- People living in urban locations were more likely to have private health insurance (18%, 1089/6104), compared with people living in rural locations (14%, 352/2529) (OR 1.34, 95%CI 1.17-1.54).
- People living in households not categorized as vulnerable were more likely to have private health insurance (19%, 854/4625), compared with those living in households in the vulnerable category (14%, 403/2835) (OR 1.37, 95%CI 1.20-1.56).

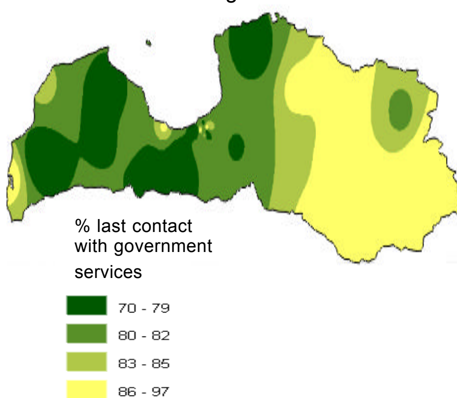
Contact with health services

For each of the household members, the respondent provided information about how many times the person

had contact with the health services since the beginning of the year. Since the survey took place in June, this information corresponds to the first five months of 2002. Over half of the population (54%, 4742/8786) did not have any contact with health services in this period of time. Some 46% (4044/8786) had at least one contact.

- Female household members were more likely to have contacted health services in the last five months (52%, 2567/4953), compared with male household members (39%, 1474/3826) (OR 1.72, 95%CI 1.57-1.87). This higher use of services by females was more marked when only adults over the age of 18 were considered: 50% (1998/3976) of women had a contact, compared with 33% (964/2883) of men (OR 2.01, 95%CI 1.82-2.23).
- People aged over 50 years were more likely to have had contact with health services (50%, 1634/3290), compared with younger people (44%, 2406/5488) (OR 1.26, 95%CI 1.16-1.38).
- Members of households in the vulnerable category were somewhat more likely to have contacted health services (49%, 1404/2865), compared with members of non-vulnerable households (46%, 2145/4702) (OR 1.15, 95%CI 1.04-1.26).

Figure 11
Proportion of health service users whose last contact was with government services



In a few of those who had at least one contact, the actual number of contacts in the period was not clear (11%, 457/4044). Among those who specified the number of contacts, the average number of contacts in the five month period (January to May 2002) was 3.36 (n= 3587, standard error= 0.06).

Last contact with health services

Further information was collected about the last contact with health services in the five months since the beginning of 2002, for each household member with contact. Figure 11 shows the spatial concentration of these contacts in the east of the country.

27% of specialist consultations and 11% of family doctor consultations were private.

In 18% (694/3953) of reported contacts, the patient received treatment in a private facility. Private health service contacts were clustered around Riga and nearby urban areas and were rare outside this area (Figure 14).

Patient used private services less for family doctor consultations (11%, 244/2294), compared with specialist

consultations (27%, 440/1614) (OR 0.32, 95%CI 0.27-0.38).

Among last contacts that were through the government scheme, 64% (2050/3224) of patients visited family doctors, and the remaining 36% (1174/3224) visited specialists.

The most common specialists that patients in the government system contacted were surgeons (16% of contacts with specialists), followed by gynaecologists (11%) and dentists (11%).

Most service users under the government scheme attended a polyclinic or health centre for treatment (73%, 2312/3151). Some 10% (320/3151) of the patients were treated in a doctor's office, 13% (414/3151) were treated in a hospital and 3% (105/3151) were treated at home.

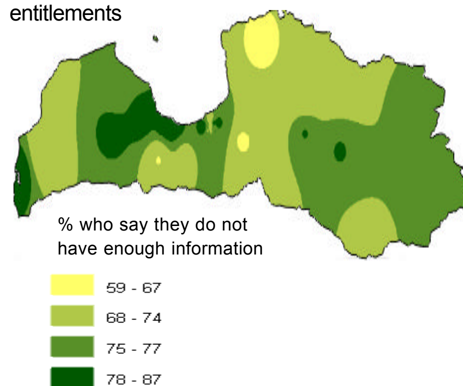
Respondents described over a third (39%, 1258/3198) of the contacts under the government scheme as emergencies. Just 11% (358/3162) of patients were admitted to hospital, and the remainder were treated as outpatients.

Information about health services

Three out of four households said they did not have enough information about their health care entitlements.

Just a quarter of household respondents (25%, 869/3423) said they had all the information they needed about free health services or compensated medicines to which they were entitled. There was no difference between male and female respondents, nor between households in urban and rural communities. Figure 12 shows the spatial aspects.

Figure 12
Proportion of households who do not have enough information about health care entitlements



Several factors were related to household perceptions of having enough information about their entitlements:

- Latvian speaking households were more likely to think they had all the information they needed (28%, 651/2370), compared with non-Latvian speaking households (21%, 215/1039) (OR 1.45, 95%CI 1.21–1.74).
- Respondents under age fifty were less likely to say they had all the information they needed (20%, 319/1573), compared with older respondents (30%, 550/1849) (OR 0.60, 95%CI 0.51-0.71).
- Respondents from households in the vulnerable category were somewhat more likely to say they had all the information they needed about their

Figure 13
Sources of information about health care entitlements (n=2773)

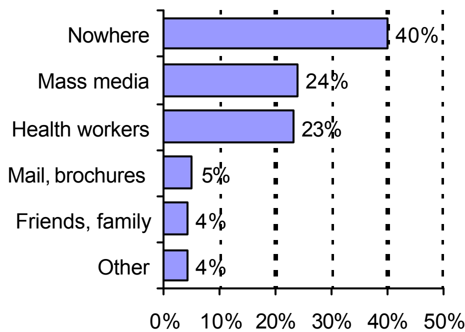


Figure 14
Preferred sources of information about health care entitlements (n=3025)

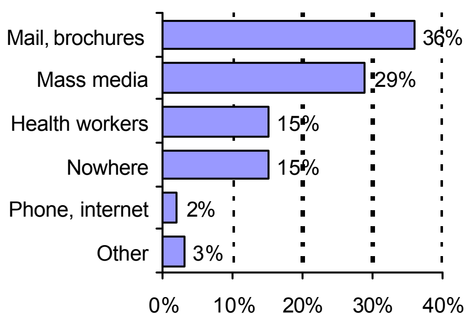
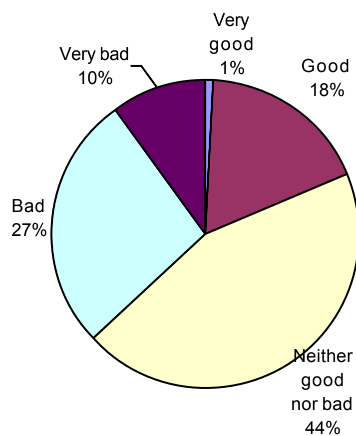


Figure 15
How households rated government health services (n=3419)



entitlements (27%, 367/1354), compared with those from households not in the vulnerable category (24%, 502/2069) (OR 1.16, 95%CI 0.99-1.36).

- On the other hand, respondents who reported that the household income was sufficient for their expenditure needs were more likely to say they had all the information they needed (31%, 229/732), compared with those who reported the income was not sufficient (24%, 610/2591) (OR 1.48, 95%CI 1.23-1.78).

This provides some evidence of the need to target information to those who most need it, such as the elderly and vulnerable households, but not necessarily towards those with perceived insufficient income (bearing in mind that 78% of households considered their income insufficient for their needs). Having "all the information you need" is subjective. Some may be more demanding about the information they receive.

Sources of information

Asked where they currently received information about free services and compensated medicines, four in ten household respondents (40%, 1115/2773) replied "nowhere", implying that they just gleaned information from various places, but had no specific sources. The present sources of information are shown in Figure 13. The mass media and health professionals are the most common specific sources.

Preferred sources of information

While only 5% (139/2773) got information through the mail or in brochures and advertisements, 36% (1080/3025) said they would like to get information by this means. Mass media and health professionals feature prominently both as current sources and as preferred sources. However, health professionals are not cited as often as preferred sources as they are as present sources (Figure 14).

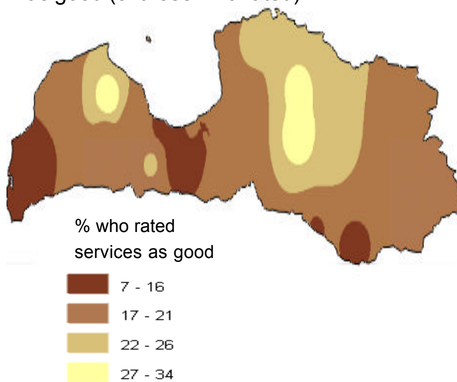
Rating of government health services

A small proportion of respondents (6%, 204/3419) said they did not know how to rate government health services. Of those that provided a response, the most common was that health services were neither good nor bad (44%, 1406/3215). Only 19% (606/3215) of households said that health services were good or very good (Figure 15).

There was no difference in rating of government health services between Latvian and non-Latvian speaking households. Nor was there a difference in rating by age of the respondent. Figure 16 shows the spatial heterogeneity.

There were several factors related to the rating of government health services as good or very good:

Figure 16
Proportion who rated government health services as good (of those who rated)



- Male household respondents were less likely to rate the services as good or very good (17%,143/868), compared with female respondents (20%, 463/2347) (OR 0.80, 95% CI 0.65–0.99)
- Respondents from urban areas were less likely to rate the service as good or very good (17%, 408/2363), compared with respondents from rural areas (23%, 198/852) (OR 0.69, 95%CI 0.57–0.84).
- Respondents who said they had all the information they needed about free services and compensated medicines were more likely to rate the services as good or very good (26%, 209/814), compared with those who did not feel they had all the information they needed (17%, 394/2390) (OR1.74, 95%CI 1.44-2.13).
- Respondents who rated the corruption in the services as high or very high (see below) were less likely to rate the services overall as good or very good (12%,122/1038), compared with those who rated corruption lower (21%, 271/1281) (OR 0.50, 95%CI 0.39-0.63).

A person who rated corruption in government health services as high or very high *was 50% less likely* to rate government health services as *good* or *very good,* compared with someone rating corruption less highly.

While the direction of the association with perceived corruption is not clear, it is possible that decreasing the perception of high levels of corruption in government health services could improve the overall rating of government health services.

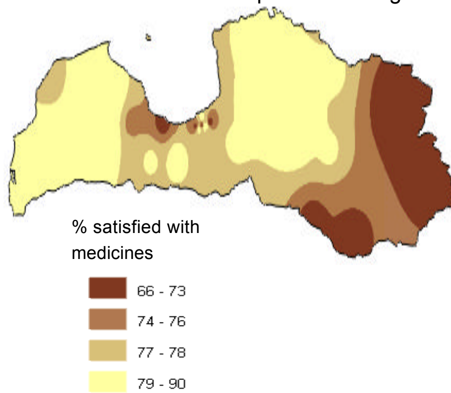
Satisfaction and complaints

Satisfaction with medicines

76% of patients were satisfied with the medicines they were prescribed or given.

Most of those who had contact with health services under the government scheme were satisfied with the medicines they were prescribed or given. Excluding those who could not give an answer, 76% (2052/2697) of government service users were satisfied with the medicines they received.

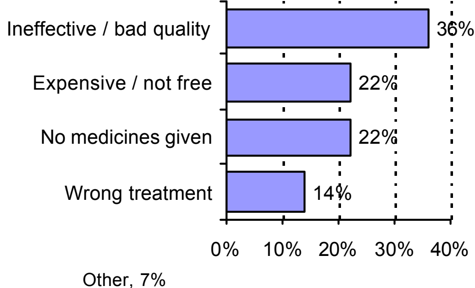
Figure 17
Proportion of government health service users who were satisfied with medicines prescribed or given



Satisfaction with medicines was slightly higher among people whose contact was private. Excluding those who could not give an answer, 79% (396/500) of private service users were satisfied with the medicines they were prescribed or given (Figure 17)

The overwhelming reason that respondents gave for satisfaction with medicines was that they were effective or good quality. Among those dissatisfied with medicines, the most common reason was that they were ineffective or bad (36%, 114/320) (Figure 18).

Figure 18
Why respondent was dissatisfied with medicines (n=320)

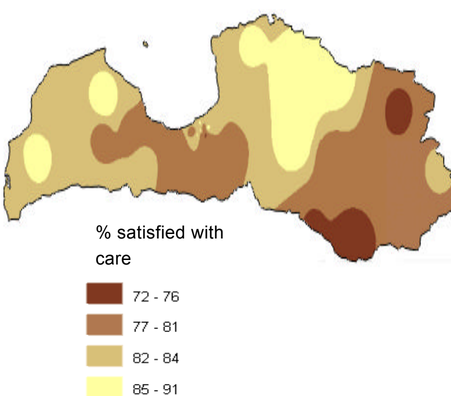


Satisfaction with medicines among users of government services did not differ by age or sex of the user, between urban and rural residents, or by language spoken. People whose contact was with a family doctor were more likely to be satisfied with the medicines (79%, 1400/1784), compared with people whose contact was with a specialist (71%, 635/889). (OR 1.46, 95%CI 1.21-1.76).

Satisfaction with overall care

Most people who described a contact with health services under the government scheme reported they were satisfied with the overall care they received (Figure 19). Of those who answered, 81% (2561/3151) were satisfied or very satisfied, and just 9% (276/3151) were dissatisfied or very dissatisfied.

Figure 19
Proportion of government service users who were satisfied with the overall care received



Satisfaction with private care was slightly higher: 90% (603/667) of private service users were satisfied or very satisfied and just 5% (34/667) were dissatisfied or very dissatisfied.

This high level of satisfaction with the care received on an individual contact with the government health services contrasts with the relatively low rating of government health services made by households (see above). Only 19% of households rated government health services as good or very good, but 81% of service users were satisfied or very satisfied with their individual experience.

81% of patients were satisfied with the care they received.

The main reasons given for being satisfied or dissatisfied with the overall care under the government scheme are shown in Figures 20 and 21.

Figure 20
Why respondent was satisfied with care (n=2080)

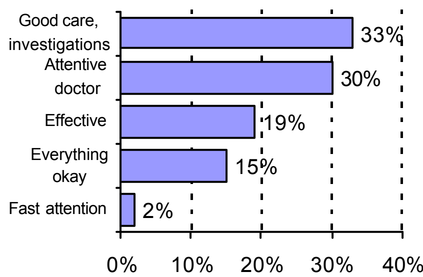


Figure 21
Why respondent was dissatisfied with care (n=263)

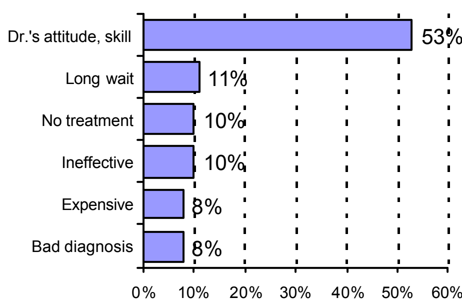
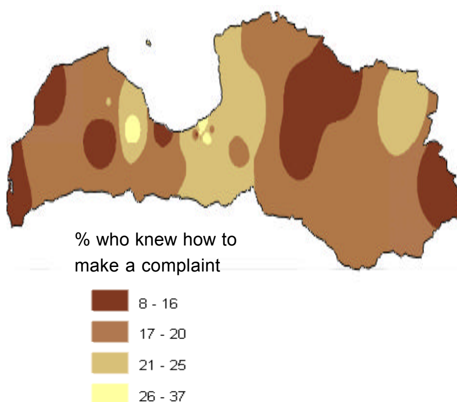


Figure 22
Proportion of government health service users who knew how to make a complaint



Only 21% of government health service users knew how to make a complaint.

A number of factors were examined for their relationship to the satisfaction of people who had care under the government scheme:

- There was no relationship between sex or age of the service user and satisfaction with the service
- Service users from urban areas were less likely to be satisfied with the service (80%, 1753/2200), compared with service users from rural areas (85%, 808/951) (OR 0.69, 95%CI 0.56-0.86).
- Service users from Latvian speaking households were more likely to be satisfied with the service (83%, 1836/2200), compared with service users from non-Latvian speaking households (77%, 718/929) (OR 1.43, 95%CI 1.18-1.75).
- Service users from households which rated the government health services generally as good or very good were more likley to be satisfied with the service for an individual visit (91%, 519/573), compared with service users from households rating the services less positively (79%, 1915/2424) (OR 2.55, 95%CI 1.88-3.49).
- Among service users who paid a consultation fee (see below), those who got a receipt were more likely to be satisfied with their care (83%, 1058/1279), compared with those who did not get a receipt (70%, 216/307) (OR 2.02, 95%CI 1.50-2.72).

Making complaints

Only 2% (57/2696) of government health service users said they made a formal complaint. Including these, just 21% (548/2586) of government health service users knew how to make a complaint (Figure 22).

There was no relationship between knowing how to complain and sex of the service user, nor with age of the service user, nor urban or rural residence. But there were some factors related to knowing how to make a complaint:

- Government health service users from Latvian speaking households were more likely to know how to make a complaint (23%, 413/1778), compared with those from non-Latvian households (17%, 134/797). (OR 1.50, 95%CI 1.20-1.87).
- Service users from households that had enough information about free services and compensated medicines were more likely to know how to make a

complaint (30%, 189/629), compared with those from households without enough information (18%, 359/1950). (OR 1.90, 95%CI 1.54-2.35). Their source of information about services may have included also information about making a complaint.

Among service users whose experience could be linked to a specific institution visited and reviewed as part of the survey, there was no association between the institution having a formal complaints procedure and the proportion of service users who knew how to make a complaint. An institution may have a formal procedure for complaints, but this will not be effective unless it is communicated to the service users.

Payments for health services

Table 22
Mean consultation fees, among those who paid anything (Lats)

	Family Doctor	Specialist
Private	1.5	7.8
Government	1.1	3.1

Among the 2643 government health service users who reported about paying a consultation fee, about a third (37%, 964) said they did not pay anything for a consultation fee. Table 22 presents the fees paid by service users for family doctor and specialist visits in private and government facilities.

The standard consultation fee under the government scheme for a visit to a family doctor is 0.5 Ls and for a visit to a specialist is 2.0 Ls. Some 12% (211/1754) of those who visited a family doctor paid more than the standard consultation fee. A higher proportion of those who visited a specialist (18%, 152/869) paid more than the standard consultation fee. Overall, of those who gave information about the consultation fee they paid, 14% (363/2623) paid more than the standard fee.

Among government health service users, 12% of those seeing a family doctor and 18% of those seeing a specialist paid more than the standard consultation fee.

Among government service users who reported paying a consultation fee, most (81%, 1306/1623) said they got a receipt for the full amount they paid. Service users who paid a consultation fee within the standard were more likely to get a receipt for the amount paid (82%, 1027/1250), compared with those who paid more than the standard (74%, 247/336) (OR 1.66, 95%CI 1.24-2.23). Nevertheless, three quarters of those who paid more than the standard consultation fee got a receipt for the full amount.

Users of government health services reported on other expenditures:

- 22% (534/2401) said they paid nothing for medicines.

Table 23
Mean official expenditures, among those who paid anything (Lats)

	Private	Government
Medicines	11.4	9.1
Investigation	8.9	3.5
Bed charges	14.9	13.7

- 74% (1570/2111) said they paid nothing for investigations.
- 52% (108/206) said they paid nothing for bed charges.

Table 23 presents the average expenditures among service users who reported payments for medicines, investigations and bed charges.

The mean total official cost of a contact with government health services was 10.4 Lats.

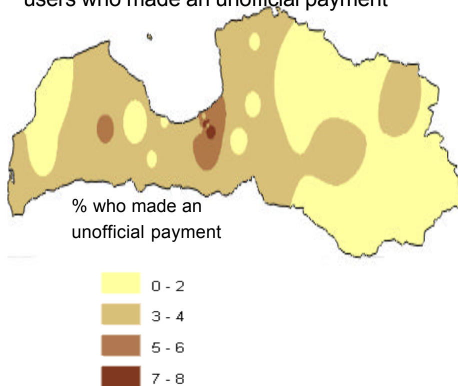
The total cost of the consultation was either calculated by adding up the individual costs of medicines, investigations, etc., or recorded directly if the user could not give the cost breakdown. Among 3139 government health service users, 14% (433) made no payment at all. The overall mean total payment (including those who paid nothing) was 10.4 Ls (median 5 Ls). Excluding those who paid nothing, the mean total payment was 12.1 Ls (median 5.5 Ls.

3% of users of government health services admitted an unofficial payment.

Unofficial payments

Some 3% (96/3177) of users of government health services admitted to making an unofficial payment in the course of their contact with the service (Figure 23).

Figure 23
Proportion of government health service users who made an unofficial payment



Most (83%, 77/93) of those who admitted to making an unofficial payment said they offered the payment. Only 69 provided the amount of the payment. Among these, the mean amount was 25.7 Ls (standard error=6.6, median 5 Ls).

Most (76%, 66/87) of those who gave details said they gave the unofficial payment to a doctor (including some who mentioned 'family doctor' or 'specialist'), 8% (7/87) paid a surgeon, 13% (11/87) paid a nurse. A few others paid laboratory personnel, other health personnel or a receptionist.

Almost half the unofficial payments (47%, 42/89) were made before or during the treatment.

Benefits from unofficial payments

Table 24
Benefits of making an unofficial payment (n=79)

Quicker service	38%
None	33%
Easier future service	10%
Gratitude of doctor	6%
Better service	6%
Personal satisfaction	5%

The most common benefit people reported from making an unofficial payment was quicker service, mentioned by 38% (30/79) (Table 24). However, a third of those who made an unofficial payment (26/79) did not perceive any benefit as a result of the payment. Indeed, those users of government health services who did *not* make an

Service users who did *not* make an unofficial payment were more satisfied with their care than those who made an unofficial payment.

unofficial payment were more likely to be satisfied with their care (82%, 244/2993), compared with those who did make an unofficial payment (73%, 69/95) (OR 1.67, 95%CI 1.02-2.71). (See section above on satisfaction with care.)

Among the 3067 government health service users who said they did not make any unofficial payment, 12 (0.4%) said that they were asked for an unofficial payment but refused. The effects of refusing to make an unofficial payment included: not getting the service (3) and poor quality of service (3).

Is there under-reporting of unofficial payments?

"Maybe 3 out of 100 are not making unofficial payments"
-Community focus group

Community focus groups discussed some of the findings from the household survey. Many participants thought the real frequency of making unofficial payments was higher than 3%. Some suggested that people were unwilling to admit they made an unofficial payment because they knew it was illegal or were getting a benefit; others thought people might be afraid to admit to the payments; and others suggested it was so universal that people would not even think of the payments as unofficial.

"People did not want to admit they had paid because they were getting something back as a benefit from [unofficial] payment"
-Community focus group

Gifts

Some 14% (436/3186) of government health service users said they gave a gift during their last contact with the health services. In nearly a third of cases (30%, 128/423), the gift was given before or during the treatment.

Nearly all (95%, 402/425) the reported gifts were presents rather than cash. In 4% (15/425) the gift was cash, and in 1% (6/425) money and a present together. Among the 380 who gave information about the value of the gift, the mean value was 4.4 Ls (standard error = 0.38, median 2). The presents were mainly things such as flowers, chocolates or alcohol.

Nine out of ten times (89%, 362/406) the service user gave the gift to a doctor. In 12% (47/406) of cases, the service user gave the gift to a nurse. Some people gave a gift to more than one health professional.

People who reported giving a gift were much more likely also to report making an unofficial payment (9%, 39/425),

compared with those who did not give a gift (2%, 56/2715) (OR 4.80, 95%CI 3.06-7.50).

When is a gift an unofficial payment?

There is clearly a grey area between giving gifts and making unofficial payments. Many respondents in the household interviews thought that unofficial payments to health professionals were not corruption (see above) and were equivalent to gifts to show gratitude for the service. In community focus group discussions some participants pointed out that Latvia had a strong tradition of giving gifts to people such as doctors and teachers. The timing of the gift was important in people's perceptions: most thought small gifts after treatment were fine and simply a way of showing gratitude, but a good number of people considered that a gift given "in advance" was less innocent and was effectively a sort of unofficial payment, given with a view to getting some benefit, such as a faster service or better attention.

Associations with unofficial payments and gifts

Considering both those who admitted unofficial payments and those who gave gifts *before* service, 6% of government health service users made an unofficial payment in their last contact.

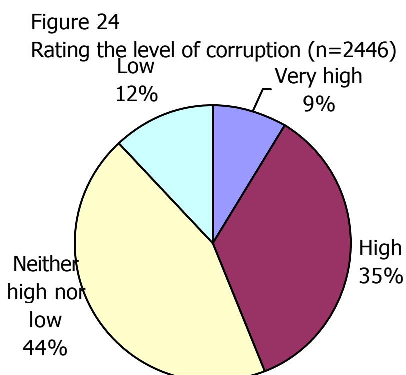
Clearly not all gifts are any sort of corruption. However, given the discussion about timing of gifts, it seems reasonable to consider gifts given *before the end of the treatment* as a form of unofficial payment. If one counts gifts given before the end of treatment as unofficial payments, then 6% (195/3149) of government health service users made an unofficial payment.

Both personal and service factors were associated with government health service users giving an unofficial payment (including gifts given before the end of treatment):

- Those over 50 years old were more likely to make give an unofficial payment (7%, 93/1358), compared with those who were younger (5%, 88/1779) (OR 1.41, 95%CI 1.03-1.93).
- Females were more likely to make unofficial payments (7%, 133/2008), compared with males (4%, 48/1130) (OR 1.60, 95%CI 1.12-2.28).
- Those from non-Latvian speaking households were slightly more likely to make unofficial payments (7%, 61/917), compared with those from Latvian speaking households (6%, 121/2211) (OR 1.23, 95%CI 0.88-1.72).

- Those from urban areas were more likely to make unofficial payments (7%, 155/2183), compared with those from rural areas (3%, 27/957) (OR 2.63, 95%CI 1.70-4.10).
- Those from households categorised as vulnerable were less likely to make unofficial payments (5%, 55/1156), compared with those from households not in the vulnerable category (7%, 107/1619) (OR 0.71, 95%CI 0.50-1.00).
- Those from households who did not believe unofficial payments are corruption were more likely to make unofficial payments (7%, 92/1346), compared with those from households who believed unofficial payments are corruption (5%, 76/1446) (OR 1.32, 95%CI 0.95-1.84).
- Those who saw a specialist were more likely to make unofficial payments (8%, 88/1127), compared with those who saw a family doctor (5%, 91/1979) (OR 1.76, 95%CI 1.28-2.41).
- Those treated in a hospital were more likely to make unofficial payments (12%, 48/394), compared with those treated in other types of health facilities (5%, 131/2645). (OR 2.66, 95%CI 1.84-3.84).
- There was no apparent relationship with knowledge about entitlements, but those who knew how to make a complaint were more likely to make unofficial payments (8%, 43/538), compared with those who did not know how to make a complaint (5%, 105/1979) (OR 1.55, 95%CI 1.05-2.28).
- Those treated in a facility where not all the family doctors had a contract with the sick fund were more likely to make unofficial payments (9%, 39/427), compared with those treated in a facility where all the family doctors had a contract with the sick fund (4%, 41/1001) (OR 2.35, 95%CI 1.45-3.81).

Figure 24
Rating the level of corruption (n=2446)

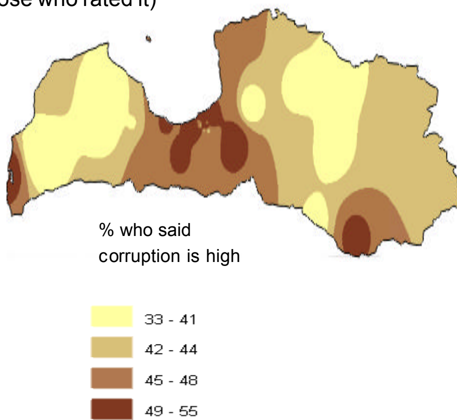


Perceptions and attitudes about corruption in health services

Rating the corruption

Asked about the level of corruption in government health services, about one in four respondents (28%, 935/3381) said they did not know how to rate it. Among those who gave an opinion, 45% (1092/2446) rated corruption in government health services as high or very high (Figure 24).

Figure 25
Proportion of households who rated corruption in the government health services as high/very high (of those who rated it)



The rating of corruption was no different between male and female respondents, nor between older (more than 50 years) and younger respondents (Figure 25).

Several factors were related to household ratings of corruption in government health services:

- Non-Latvian speaking households were more likely to rate corruption as high or very high (50%, 344/683), compared with Latvian speaking households (42%, 744/1756) (OR 1.38, 95%CI 1.15–1.66).
- Respondents in urban areas were more likely to rate corruption as high or very high (46%, 842/1815), compared with those in rural areas (40%, 250/631) (OR 1.32, 95%CI 1.09–1.60).
- Respondents who did not feel they had enough information about free services and compensated medicines were more likely to rate corruption as high or very high (46%, 844/1840), compared with those who did feel they had enough information (41%, 244/597) (OR 1.23, 95%CI 1.01-1.49).

Discussions in focus groups:

"Corruption exists in big cities like Riga but not in this place."

"As far as I have heard everybody is paying something unofficially."

"If you don't give a bribe, the doctor looks dissatisfied."

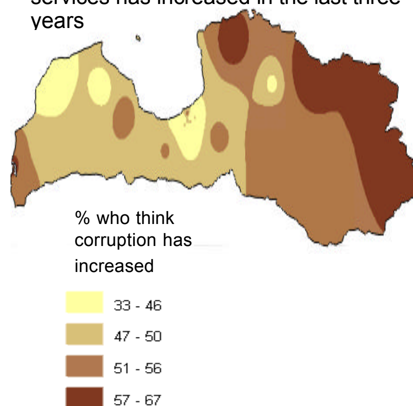
"The waiting is artificially created, so people are forced to look for a way out and it is usually unofficial payment."

"Health professionals have low salaries. If people can pay extra money, they do that and it is normal."

Focus group discussions explored the reasons behind the common perception of a lot of corruption in government health services. Many participants mentioned indirect or hearsay evidence of widespread corruption, while others noted more direct experience of the problem. They suggested several reasons for the frequency of corruption, including: the way the system worked (with waiting times and a desire to avoid this), a desire by doctors to make money (sometimes viewed sympathetically because of their low salaries), and a cultural norm of giving presents to health professionals.

The trend of corruption

Figure 26
Proportion who said corruption in health services has increased in the last three years



Over a third (39%, 1321/3374) of households said they did not know how to rate the change in level of corruption over the last three years (Figure 26). Considering only those who gave an opinion, 7% (146/2053) thought corruption had decreased, 43% (875/2053) thought it had stayed the same, and 50% (1032/2053) thought it had increased.

Age of the respondents was not related to their perception of change in the level of corruption. Several factors were related:

- Males were less likely to think corruption had increased (46%, 273/593), compared with females (52%, 759/1460) (OR 0.79, 95%CI 0.64–0.96).
- Latvian speaking households were more likely to think corruption had increased (53%, 750/1421), compared with non-Latvian speaking households (45%, 278/625) (OR 1.4, 95%CI 1.15–1.7).
- Households in urban areas were *less* likely to think corruption had increased (48%,745/1547), compared with households in rural areas (57%, 287/506) (OR 0.71, 95%CI 0.57–0.87).

50% of household respondents who gave an opinion believed corruption had *increased* in the last three years.

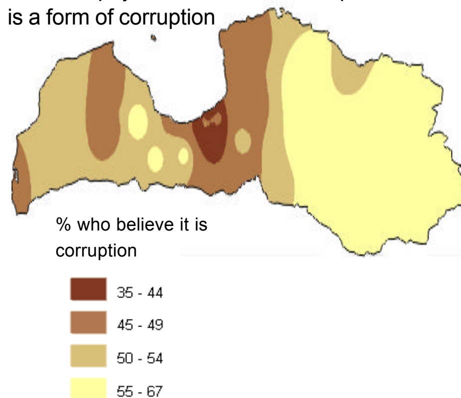
The perception of absolute level of corruption differed from the perception of the trend in the level of corruption. In rural areas people were less likely to rate the level of corruption as high, but they were also more likely to think that corruption had increased over the last three years.

Household perception of unofficial payments

Only half of the household respondents thought unofficial payments to health professionals are a form of corruption.

Public opinion was divided about the status of unofficial payments to health professionals. When the respondent was asked whether an unofficial payment was a form of corruption, about 12% (407/3422) did not know what to answer. Of those who provided an answer, 51% (1529/3015) thought that an unofficial payment to a health professional was corruption and 49% (1486/3015) thought that an unofficial payment was not corruption (Figure 27).

Figure 27
Proportion of households who believe an unofficial payment to a health care professional is a form of corruption



When asked why the person thought an unofficial payment *was* corruption, the most common answer was that it was illegal or wrong (43%, 601/1393) (Table 25). Among those who said it *was not* corruption, the most common answer was that it was an act of gratitude (50%, 690/1369) (Table 26).

Table 25
Why an unofficial payment to a health professional is corruption (n=1393)

It is illegal / wrong	43%
Doctors are already paid	19%
Payments should be official	11%
Not all can afford / it's unfair	9%
Depends on the timing/intention	5%
Those who pay get better treatment	4%

There was no difference between older and younger respondents in the proportion who thought an unofficial payment to a health professional was corruption. But some factors were related to the perception of unofficial payments to health professionals as corruption:

Table X
Why an unofficial payment to a health professional is not corruption (n=1369)

It is an act of gratitude	50%
Doctors have low salaries	19%
Simply not corruption	8%
It depends on timing/ intention	6%
Patients get better attention	5%
Doctors do good and important work	4%
It is something normal	4%

- Male respondents were somewhat less likely to consider unofficial payments as corruption (48%, 399/840), compared with female respondents (52%, 1130/2175) (OR 0.84, 95%CI 0.71–0.99).
- Respondents from Latvian speaking households were more likely to think unofficial payments were

"Unofficial payments are not corruption because both sides, doctor and patient, skip state taxes, which are too big and unfair."
-Community focus group

corruption (53%, 1098/2075), compared with respondents from non-Latvian speaking households (45%, 420/927) (OR 1.36, 95%CI 1.16–1.59).

- Respondents from urban areas were less likely to perceive unofficial payments as corruption (48%, 1083/2221), compared with respondents from rural areas (58%, 446/794) (OR 0.74, 95%CI 0.63–0.88).
- Respondents who felt they had enough information about their health care entitlements were less likely to perceive unofficial payments as corruption (47%, 360/768), compared with respondents who did not think they had enough information (52%, 1165/2237) (OR 0.81, 95%CI 0.69-0.96).

Table 27
Suggestions for how to prevent unofficial payments (n=2639)

Suggestion	%
Higher salaries for doctors	51%
Nothing will change	10%
Better inspection / supervision	9%
Change the entire system	8%
Nothing should change	5%
Increase health budget	4%
Government should act	4%
Improve morality of doctors	3%
Patients should stop paying	3%
Makes services free/cheaper	2%
Other	1%

When asked what should be done to prevent unofficial payments in government health services, 22% (735/3370) said they did not know what could be done. Of those who provided a suggestion, the most common response was to provide higher salaries for doctors, mentioned by over half the households that named something (51%, 1349/2635) (Table 27).

"It is impossible to convince people not to pay unofficially. It's human logic: it's necessary to pay doctors because they need a wealthy lifestyle."
-Community focus group

Focus groups discussed what could be done to convince people that making unofficial payments to health professionals is a form of corruption and to persuade people not to make such payments. People expressed some pessimism about the possibility of convincing people. Others had a more positive view, and suggested that if people believed that the money they paid in taxes came back to the health care system, then they would not feel they had to make unofficial payments.

Acceptable value for a gift to a health professional

Nearly a third of households said there was NO acceptable value for a gift to a health professional.

A third of household respondents would be willing to report a health professional who demanded an unofficial payment.

The practice of giving small gifts to thank health professionals for care is common in Latvia (see below), and there is a grey area between a gift and an unofficial payment. Household respondents were asked about what maximum value they would consider acceptable for a gift from a patient to a health professional. Nearly a third of respondents who gave an answer (31%, 683/2177) said that no gift of any value was acceptable. Considering all responding households (including those that said zero) the average acceptable maximum value was 15.9 Ls (standard error=1.46, median 2 Ls). Among those households that named some acceptable value for a gift, the average amount mentioned was 23.1 Ls (standard error=2.10, median 5 Ls).

Figure 28
Proportion of households who would be willing to report a health care professional who demands an unofficial payments

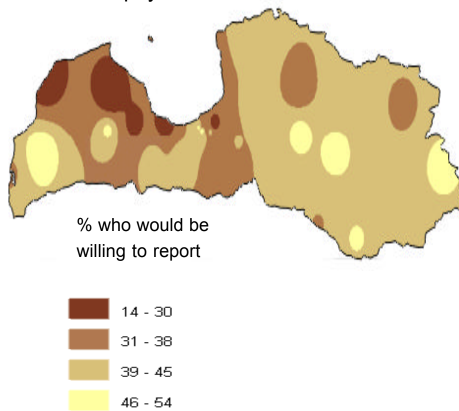


Table 28
Reasons people would report unofficial payments (n=972)

It is unethical / unprofessional	30%
It is a crime	24%
Depends on timing / intention	9%
People already pay too much	8%
No experience of this	6%
Might change behaviour	4%
Should be official payments	4%

Table 29
Reasons people would not report unofficial payments (n=1444)

No experience of this	30%
Fear of reporting	13%
Not my business	8%
I get a benefit	6%
Depends on timing / intention	6%
It is useless	5%
I will go to another doctor	5%
Don't know how to report	4%

Willingness to report unofficial payments

When asked whether they would be willing to report a health professional who demanded an unofficial payment, 16% (523/3375) said they were unsure whether they would report. Of those who responded with a definitive position, 38% (1094/2852) said they would be willing to report and 62% (1758/2852) said they would not be willing to report (Figure 28).

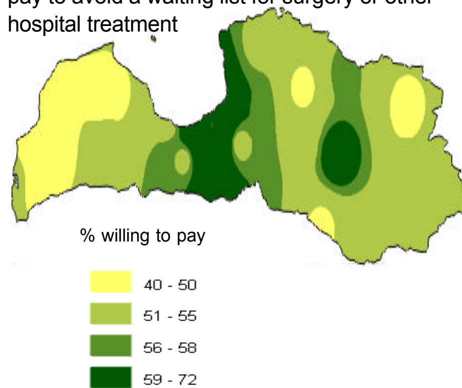
Among those who said they were willing to report, the most common reason was that unofficial payments were unethical or a crime (Table 28). Among those who said they were not willing to report, the most common reason was that the respondent had no experience of the problem, followed by a fear of reporting (Table 29).

Several factors were related to willingness to report a health professional asking for an unofficial payment:

- Respondents less than fifty years old were more likely to be willing to report (47%, 649/1396), compared with respondents aged fifty or above (31%, 445/1455) (OR 1.97, 95%CI 1.68–2.31).
- Male respondents were more willing to report (42%, 329/784), compared with female respondents (37%, 765/2068) (OR 1.23, 95%CI 1.04–1.46).
- Latvian speaking households were more willing to report (42%, 824/1953), compared with non-Latvian speaking households (30%, 268/887) (OR 1.69, 95%CI 1.42–2.01).
- Respondents from urban areas were less likely to be willing to report (37%, 787/2136), compared with respondents from rural areas (43%, 307/716) (OR 0.78, 95%CI 0.65–0.93.
- Respondents who felt they had enough information about free services and compensated medicines were less willing to report (34%, 235/685), compared with respondents who did not feel they hade enough information about services (40%, 855/2154) (OR 0.79, 95%CI 0.66-0.96).

Over half of household respondents would be willing to pay to avoid a waiting list for surgery or other hospital treatment.

Figure 29
Proportion of households who would be willing to pay to avoid a waiting list for surgery or other hospital treatment



Willingness to pay to avoid a waiting list

Almost one in ten (9%, 323/3409) respondents could not decide if they would be willing to pay to avoid a waiting list for surgery or other hospital treatment (Figure 29). Of those that gave a definitive response, over half (56%, 1730/3086) said they would be willing to pay and the remainder (44%, 1356/3086) said they would not be willing to pay.

Willingness to pay to avoid a waiting list was related to several factors:

- Respondents under age fifty years were five times more likely to be willing to pay (77%, 1098/1429), compared with older respondents (38%, 632/1656) (OR 5.37, 95%CI 4.57–6.32).
- Respondents from households in the vulnerable category were less likely to be willing to pay (43%, 527/1213), compared with respondents from non-vulnerable households (64%, 1203/1873). (OR 0.43, 95%CI 0.37-0.50).

Discussions in focus groups:

"I would pay to get treated immediately. At least there should be a procedure to shorten waiting time for those whose disease is progressing."

"That is the system, the way it happens; if somebody has money, why shouldn't he or she pay?"

"For poor people this situation is tragic and hopeless."

"That is discrimination; pensioners cannot pay but they need surgery most as they are old."

Ability to afford to pay seems to be the main consideration for being willing to pay to avoid a waiting list. Younger people have more disposable income than older people and perhaps cannot afford the time to wait. Vulnerable households are essentially those with poorer economic status. In focus group discussions, participants confirmed that many people who could afford it would be willing to pay to avoid a waiting list. They made little distinction between official and unofficial payments in this situation. Some participants felt that it was perfectly acceptable for people to pay to "jump the queue". On the other hand, others said this leads to an unfair situation, disadvantaging the elderly and the poorest members of society.

Priorities for changes in government health services

When asked to name the one thing they would most like to change about government health services, 6% (216/3399) suggested completely free services and 17% (587/3399) wanted cheaper services. Some others (6%, 212/3399) requested free or cheaper services for special groups, such as pensioners, students or children. In 18% (607/3399) of households the respondent could not say one thing they wanted changed.

Table 30
Changes suggested for government health care system (n=2137)

Change family doctor system	28%
Nothing should change	16%
Availability/cheaper medicines	13%
See specialist directly	11%
Shorter waiting times	11%
Better attitude of doctors	9%
Higher salaries	7%
Better quality of services	4%
More personnel	3%
Other	5%

Focus group discussions:

"The family doctor system in Latvia is not working because of finances."

"The family doctor avoids sending you to a specialist because is not profitable for him."

"Family doctors are so busy that they don't pay proper attention to patients and don't have time to educate themselves further."

"People are not stupid; they can decide themselves which doctor to visit."

If the respondent suggested free or cheaper services as the first thing they would like to change about health services, the interviewer prompted for an additional response. A variety of responses emerged among those who had a suggestion other than free or cheaper services (Table 30). About one in four respondents (28%, 597/2137) said their priority was to change the family doctor system. Related to this, 11% (246/2137) said they wanted to be able to see specialists directly. Some 13% (274/2137) wanted cheaper medicines. There were 16% (350/2137) who thought nothing should change.

Focus group discussions confirmed widespread dissatisfaction with the family doctor system. Participants said they thought this system was responsible for delays; they suggested it was the cause of corruption as people were eager to find ways so see a specialist directly; they criticised the skills and attitudes of family doctors; and they voiced the opinion that the system should be scrapped to allow direct access to specialists 'as before'.

Willingness to pay for a change in government health services

Nearly half the households (44%) suggesting a specific change to government health services said they would be willing to pay to see this change.

Of those suggesting a change a specific change, some 44% (685/1538) said they would be willing to pay for the change they suggested. The most commonly requested changes among those willing to pay were: 36% (245/685) abolish the family doctor system; 15% (102/685) shorter waiting times; 10% (71/685) better attitude of health workers; and 7% (54/685) improved availability of medicines.

Services from family doctors

Asked for their priority change to family doctor services, only 1% of the respondents (48/3387) mentioned free services and 4% (118/3387) mentioned wanted cheaper services. In 21% of the cases (715/3387) the respondent could not make any suggestion for change. If the respondent suggested free or cheaper services as the priority for change to the family doctor system, the interviewer prompted for another suggestion. The most frequent answer was that nothing should be changed, mentioned by 40% (1028/2590), followed by 20% (529/2590) who said they would like to revamp the family doctor system and 13% (346/2590) who said they would like to be allowed to go directly to specialists (Table 31).

Table 31
Changes suggested for family doctor services (n=2590)

Nothing should change	40%
Change family doctor system	20%
See specialist without referral	13%
Shorter wait times	12%
Attitude of doctors	8%
Better quality service	5%
Qualification of doctors	5%
Better access to services	3%
Prescribe cheaper medicines	2%
Other	4%

Over half the households (55%) suggesting a specific change to family doctor services said they would be willing to pay to see this change.

Willingness to pay for changes to family doctor services

Among those who named a specific change that they would like to see from family doctor services, more than half (55%, 776/1417) said they were willing to pay in order to have that change. The average maximum amount people were willing to pay for a consultation with a family doctor was 1.98 Ls (standard error=0.21, median 1 Ls). Among those willing to pay for change, their priorities for change were: 32% (245/776) re-organise the family doctor system (allowing direct referrals to specialists); 23% (175/776) shorten waiting times; and 14% (105/776) improve the attitude of the doctors.

Services from specialists

Table 32
Changes suggested for specialist doctor services (n=2166)

Nothing should change	42%
Change referral system	14%
Attitude of doctors	11%
Better quality service	8%
Qualification of doctors	8%
Shorter wait times	5%
Better access to services	3%
Prescribe cheaper medicines	1%
Other	5%

Asked to name a desired change to the services from specialist doctors, just 1% (42/3385) mentioned free services and 7% (231/3385) mentioned cheaper services. Almost a third of the respondents (1050/3385) said they did not know what should be changed. As before, if the respondent first mentioned free or cheaper service, the interviewer prompted to provide another suggestion. Some 42% (908/2166) of households said that nothing should be changed; 14% (304/2166) wanted to change the referral system, and 11% (246/2166) wanted an improvement in the specialists' attitudes (Table 32).

The majority of households (71%) suggesting a specific change to specialist services said they would be willing to pay to see this change.

Willingness to pay for changes to specialist services

Among those who named a specific change that they would like to see in specialist services, some 71% (607/855) said they were willing to pay in order to have that change. The average maximum amount people were willing to pay for a consultation with a specialist was 4.8 Ls (standard error=0.49, median 2 Ls). Among those willing to pay for a change, some 23% (138/607) wanted to see specialists without referral, 21% (126/607) wanted a better attitude of specialist doctors, 16% (97/607) wanted better qualified doctors, and 11% (66/607) wanted shorter waiting times.

DISCUSSION

The final and most important step in the social audit process is the dissemination and application of findings in ways that will lead to multiple interventions for preventing corruption.

Stakeholder workshop

On 22 October 2002, the Secretariat of the Crime and Corruption Prevention Council hosted a workshop to discuss the survey findings and to identify actionable factors to curb the incidence of unofficial payments, bribes and system leakages. Representatives of the Ministry of Welfare, the Family Doctors Association and the Patients Rights Association attended the meeting. After a presentation by CIET on the key findings of the household survey, focus group discussions and business interviews in Latvia, the workshop participants discussed the findings and their implications.

Discussion of findings

Participants noted that while most households were satisfied with individual visits to health care facilities, they rated the overall health services less positively. This could represent a difference between people's negative perception of the health care system and their more positive personal experience within the system. The representative from the Ministry of Welfare said that although not everyone was satisfied with their experience of health services, it was encouraging to see that a good amount of people did express satisfaction. The challenge will be to make improvements so that more people are satisfied with their experiences.

Some people were surprised that household respondents expressed a willingness to pay for changes in the health care system, given patients' resentment about user fees. It was noted that respondents were willing to pay *if* they could get the service improvements they requested, and that these changes would need to be palpable to the users.

People were also surprised at the low incidence of unofficial payments in the health care system. Most people felt that there was probably underreporting. The representative from the Patients Rights Association said

that from her experience with patients, the true level of unofficial payments is much greater than 3%.

The underreporting may be a reflection of people's definition of corruption, because focus groups participants made it clear that people only think it is corruption when the doctor demands a payment, not if the patient offers a payment. The survey evidence also reflected this - only one in two households thought that unofficial payments to doctors were a form of corruption.

Suggestions for action

One workshop participant suggested that patients should have more options to pay officially for additional services and privileges. This would create a mechanism to capture payments and reinvest them in the system, instead of losing the resources to the unofficial market.

Someone made a point that the legal position on unofficial payments in the health sector should be clarified. The Law on Corruption deals with state officials accepting unofficial payments, but doctors are not technically state officials. Some lawyers interpret that they are covered by the spirit of the law because of the work they do for the state, but others are more rigid about the letter of the law, and many prosecutors will not take cases even if they are reported. This is a point that needs clarification and communication to both the legal community and citizens.

People agreed that the findings of the survey need to be disseminated to a larger audience in order to influence attitudes and behaviours. The Crime and Corruption Prevention Council agreed to convene a larger seminar before the end of the year, in order to give experts and stakeholders a forum to discuss the findings and identify actions to be taken.
The representative from the Ministry of Welfare noted that the results of the survey should be communicated to municipalities, so that they might use the information to guide their planning and programming.

Communication strategy

The stakeholder workshops discussed the need to promote public information and education. Sharing the findings to stimulate discussion and action, they concluded, could

alter inappropriate perceptions of corruption and laissez-faire attitudes about corruption.

At the stakeholder workshop, participants identified three events where the findings of the survey will be presented and discussed among decision makers:

- The Corruption Prevention and Enforcement Bureau will present the findings at its first seminar in Riga on 9 December 2002[22].
- The Latvian Nurses' Association will present the results at its annual meeting on 28 November 2002.
- The Patients' Rights Organisation will host an international conference in May 2003 and will present the findings, alongside the results of the patient survey they are currently conducting.

In addition to these high-profile events, participants agreed that a multi-prong communication strategy was necessary to target service users and service providers. Four actionable facts from the survey will make up the framework for a communication strategy.

1. Attitudes about corruption

As a top priority, a strategy must address the population's *laissez-faire* attitudes about corruption. Despite relatively low levels of unofficial payments in the last contact with health services, inappropriate attitudes create an environment in which corruption can flourish.

Almost one half (49%) of households that responded thought that an unofficial payment to a health care professional was *not* a form of corruption. This view was more common in urban areas and among non-Latvian speaking households. These groups should therefore be targeted in a communication strategy on this issue.

Asked if they were willing to report a health professional who demanded an unofficial payment, 62% of respondents said they were *not* willing to report. This view was again more common in urban areas and among non-Latvian speaking households. In addition, respondents over the age of 50 were less likely to be willing to report.

[22] The Bureau was conformed by the Latvian Government on 1st of May 2002, replacing the Crime and Corruption Prevention Council of the Republic of Latvia

Managers of health institutions will need to know about these findings in order to develop tools and policies that will change attitudes among the general population. Publishing the findings in the magazine *Doctus*, popular among health professionals, would help to get the word out. In addition, the strategy should inform health workers directly of the findings in the early stage of the process, engaging them as advocates and ensuring them that the process aims to foster their participation and not place blame. Actively involving administrators, doctors and nurses in health care facilities will contribute to the creation of an environment in which unofficial payments are considered unacceptable.

In line with how service users said they would like to receive information, written material will be the primary way to communicate an anti-corruption message to service users. Posters in health care facilities will communicate the message that an unofficial payment to a health care worker *is* a form of corruption. Pamphlets and brochures with the same information can be sent in the mail to the general population and also made available in health care facilities.

Almost half of the community focus groups said they would like to receive information from doctors. One intervention must be for health worker to distribute these pamphlets directly to their patients. This not only ensures that patients receive the information, but it may also dispel the perception that corruption in health services is high and rising.

Some focus groups said they would like to get information about corruption from trusted independent people or organisations, or from government authorities. NGOs such as *Delna* and the Patients' Rights Organisation might be enlisted to do public service announcements on the radio or television, or to publish columns in local newspapers. To inform policy makers and planners, conferences and debates can be held in the capital and in the regions, and the report of the study should be distributed widely.

2. Information about services and health care entitlements

The survey findings clearly point to the need to give patients better information about their health care entitlements. Three out of four households said they did not have enough information about free health services or

compensated medicines to which they were entitled. In addition, 89% of government health service users did not know how to make a complaint about health services.

Households that felt well informed about their health care entitlements had a more positive view of health services in general and were also less likely to think that health services were corrupt. Therefore, giving patients more information about their health care entitlements can help to improve people's perceptions about the health care system.

Information about fees is particularly important given that the survey found that a significant proportion of patients paid more than the official fee for a health care visit. Among government health service users, 12% of patients seeing a family doctor and 18% of patients seeing a specialist paid more than the standard consultation fee.

The need to communicate information to patients is clear. The challenge is to determine what information should be communicated and what are the most effective channels and mechanisms of communication. Experience has shown that information is absorbed best in controlled doses, focusing on consistent and persistent messages. A press release can draw attention to an issue, but it is repetitive delivery of that message that is the most effective over time.

Three out of four health care facilities said they informed patients about fees through displays. The ministry should standardise information that must be displayed in health care facilities and additional information about official fees should be communicated directly to service users through clearly written pamphlets.

In addition to providing information at the place of care, the mass media can be a good mechanism for getting information to a broad population and stimulating debate and discussion. A weekly segment in newspapers such as *Diena*, *Neatkariga rita avize*, *? ? ?* , *? ? ? ? ? ? ? ? ? ? ? ? ?,* and various regional papers would provide a consistent flow of manageable information. The articles should cover only one concept at a time and should appear consistently in the same section of the newspaper. It could be authored by the Patients' Rights Organisation or the Ministry of Welfare. A debate in a news-oriented television

programme, such as *Panorama* on channel LTV1, would stimulate debate on the issue.

Particularly given the fact that non-Latvian speakers are less likely to have all the information that they need, special care should be taken to ensure that all written material is communicated in both Latvian and Russian.

A communication strategy must give special attention to the elderly population. The elderly are frequent users of health services and the least able to absorb the frequent changes in the system. Information posted in clinics is not always accessible. An alternative for communicating changes in health services and entitlements to the elderly is by radio. A weekly segment on an appropriate radio programme, such as *Karl Strips* on Radio One, would provide manageable doses of information on a consistent basis.

3. Perception of government health care services

The survey found a gap between people's perception of the government health care system and their personal experience as users of the system. Only 19% of households rated government health services as good, but 81% of users of government services said they were satisfied with the care they received in the system. Evidence of people's personal experience with care in the system should be harnessed to change the perception of the system.

When interviewers asked respondents to name the most important change for the government health system, the most frequent response was to change the family doctor system, followed closely by a related desire to see a specialist directly. Changing the family doctor and referral system were also mentioned as the primary changes desired when people were asked about family doctor and specialist services.
Changing people's perception about government health care services requires that people have adequate information about services and their rights; a sense of ownership and engagement; and trust for the system. If people have positive experiences but still rate the overall services poorly, then clearly one of these is missing.

In addition to providing general information about government health services and fees (as highlighted in

point two above), specific information should be provided about the family doctor system. People's dissatisfaction about the family doctor system may simply be a result of their not understanding how the system works and the benefits it offers. Brochures should be delivered to all households that outline the nature of the family doctor system, answering potential concerns and frustrations, and highlighting family doctor-patient relationships that are working as they should. It should clearly and honestly state both the *potential* as well as the *limits* of the government health service, being careful not to raise people's expectations.

At the same time, forums should be held with both family doctors and patients to discuss the survey results. People may ask questions, voice their concerns about the system, and brainstorm about ways to address those concerns within the current legislative framework and resource allocations. This will foster not only more information, but also a sense of ownership and trust in the system.

Mass media can be used to highlight the positive aspects of the government health services. Public interest stories can provide interviews with patients who have had positive interactions with health services and doctors who are working with integrity in their profession, despite the obvious constraints of the system. Media outlets can include newspapers, magazines and radios, and would ideally also include television programs to give a real 'human face' to the message.

In addition, a communication strategy around this finding should aim to foster a stronger relationship between health workers and government. Doctors, nurses and health care administrators should have a forum to voice their concerns, so that they feel engaged in the process of health care reform, rather than victims of those changes. This forum for engagement could be in the form of regional meetings, an Internet site, or a written feedback request sent out by the Ministry to health care workers. If health care workers feel more engaged and invested in the system, they will be better advocates for that system in their local institutions.

4. Incidence of unofficial payment in business inspections

Most unofficial payments in business regulation happened during inspections. Some 14% of businesses admitted to

giving an unofficial payment or gift for an inspection, either on the last occasion or on a previous occasion. Many respondents had made multiple unofficial payments for inspections. Business owners in focus groups confirmed that inspections were the area with the greatest opportunity for making an unofficial payment. In fact, they felt that 14% was an underestimate of the proportion of businesses that had made unofficial payments in order to pass inspections.

Over half of the businesses respondents said they did not have enough information about inspections required for their businesses. A business with enough information was significantly *less likely* to make an unofficial payment for an inspection. An obvious intervention would therefore be to provide more information about inspections required for businesses.

Information about inspections should be provided in pamphlets to businesses upon registration. This would not only include the inspections that must be passed, but also the exact requirements for passing inspection. Upon registering, businesses might get a schedule of inspections for their particular business area. There should also be easily accessible information on the Internet, as well as a phone number or email address that businesses can use to contact someone regarding questions they might have about inspections. More information will not only decrease the incidence of unofficial payments, but it will also increase the compliance to inspection criteria.

In addition to targeting business owners and managers, a communication strategy on this piece of evidence should clearly target the government departments that are responsible for inspections. These departments, in their various levels of government, need the information in order to design training and supervisory systems for reducing the incidence of unofficial payments. Business owners in the focus group suggested that the reason unofficial payments are rare in the registration process is because there are clear regulations and administrative structures in place. Inspection services should use this as an example to institute similar structures.

Inspectors themselves should be targeted with the information and should be involved in designing strategies to reduce the frequency of unofficial payments. If inspectors suggest that they are frequently offered bribes

by businesses in order to give a favourable inspection, they should have a mechanism to report those businesses.

ANNEX ONE:
INDIVIDUALS AND ORGANISATIONS CONSULTED

Members of the design team

Mr. Rudolfs Kalnins (Chair)
Executive Secretary, Head of Secretariat
Crime and Corruption Prevention Council

Ms. Ilze Staškevica
Communication expert
Crime and Corruption Prevention Council

Ms. Daina Biseniece
Deputy Director
Ministry of Welfare, Pharmacy Department

Ms. Gunita Aizstrauta,
Deputy Director
Ministry of Finance, Judicial Department

Ms. Diana Kurpniece
Managing Director
Delna (Transparency International Latvia)

Ms. Lolita Cigane
Project Director
Soros Foundation

Ms. Signe Dauškane
Director
Patients' Rights Organisation

Dr Andris Lasmanis
President
Latvian Association of Family Doctors

Ms. Jolanta Zalite
President
Latvian Nurses Association

Additional government officials consulted

Ms Renate Pupele
Director
Ministry of Welfare, Department of Health

Ms Ita Zalite
Head
Riga City Council Entrepreneurship Coordination Centre

Mr Valdis Nagobads
Director
Ministry of Welfare, Riga City Council

Ms Fatma Fridenberga
Deputy Director
Administration of Local Self-government affairs of Latvia

Additional non-governmental officials consulted

Dr Viesturs Boka
Director
Latvian Medical Association

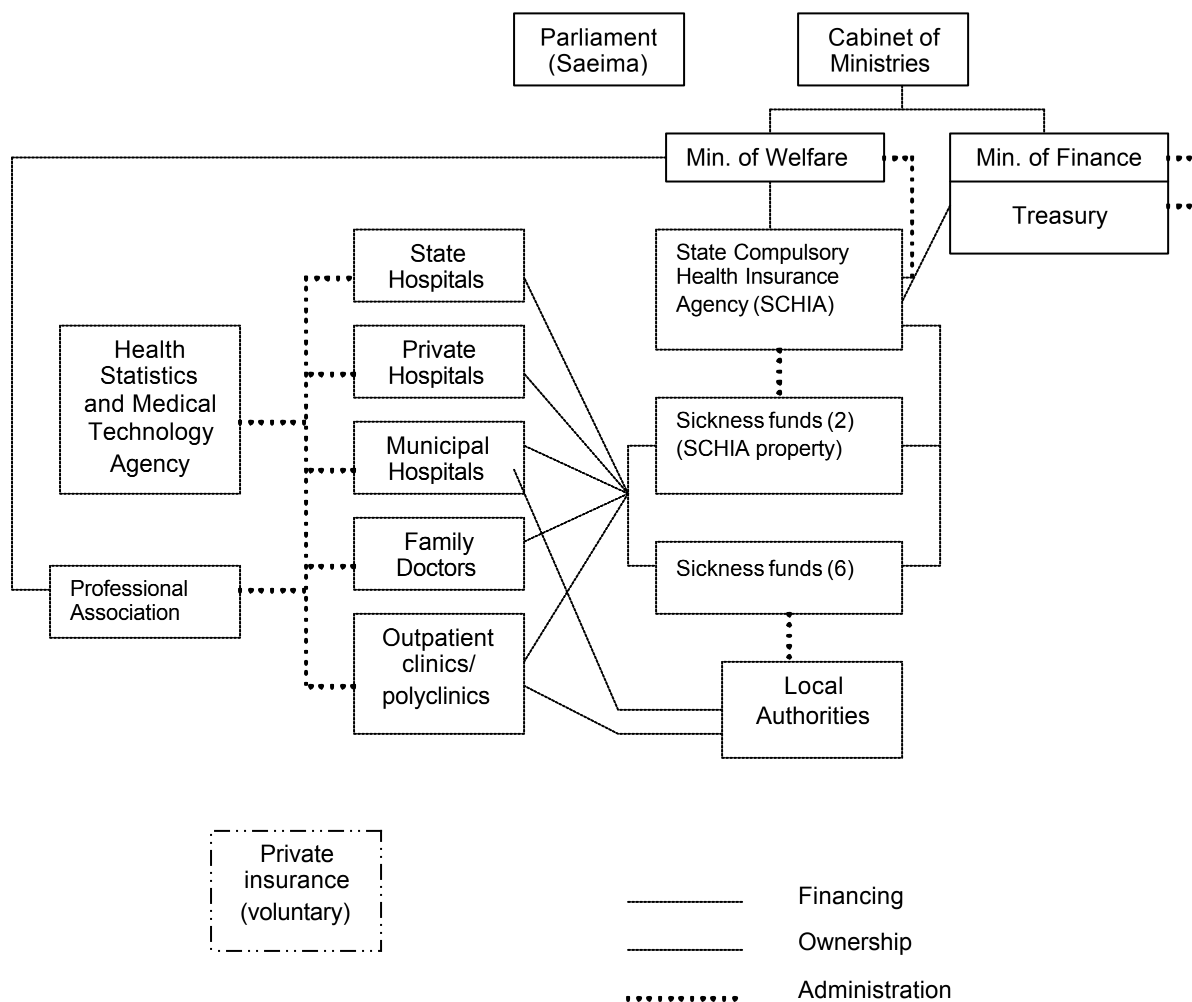
Erik Rozencveig
President
Confederation of Latvian Small and Micro Enterprises

Mr Dominic Haazen
Senior Health Specialist
World Bank, Europe and Central Asia Region

Mr Aivars Tabuns
Associate Professor
University of Latvia, Department of Sociology

Dr Gundars Prolis
President
Latvian Hospital Association

ANNEX TWO: ORGANISATIONAL STRUCTURE OF THE HEALTH CARE SYSTEM IN LATVIA



Adapted from European Observatory on Health Care Systems (2001). *Health Care Systems in Transition: Latvia*. Available online at http://www.observatory.dk.

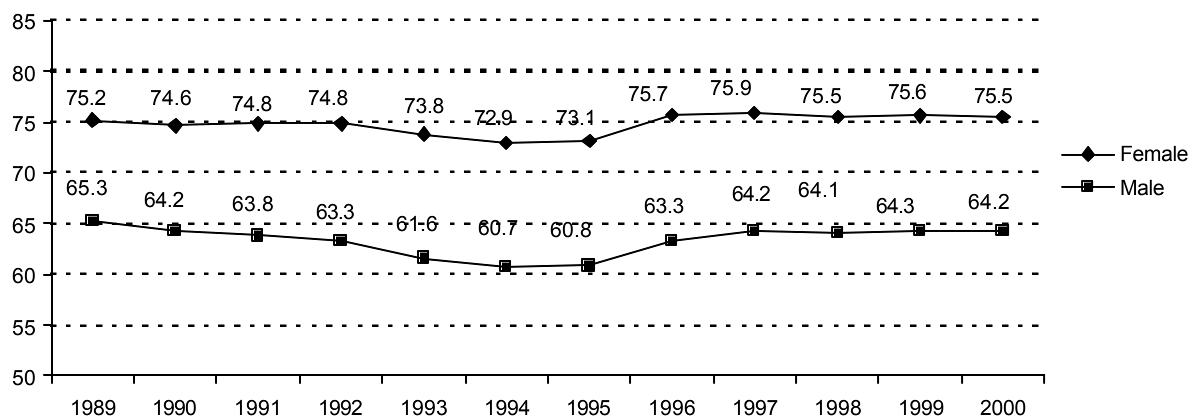
Annex 3

Background on the health sector

In the period of Soviet occupation, between 1945 and 1991, health care in Latvia was centrally planned and delivered. The health care strategy was oriented towards construction of large facilities, high-level specialisation and scientific advancement. Although all services were free of charge and generally accessible to the whole population, preventive medicine and primary health care were almost non-existent.

The disintegration of the Soviet Union also meant the breakdown of the entire public service infrastructure. The disruption of the health system, combined with the social and economic pressures of the external environment, resulted in a deteriorating health status of the population. Life expectancy in Latvia declined significantly in the period of and after political transition[23] (Figure A1). Between 1987 and 1994, life expectancy decreased by more than seven years, mostly due to an increase in mortality from cardiovascular diseases and external causes (alcohol related injuries, drug use and suicides). The life expectancy for men in 2000 was 64.2, lower than in the early 1970s. Life expectancy for women has stagnated since the 1970s and in 2000 was at 75.5[24]. These figures are considerably lower than the average life expectancy for the European Union (approximately 10 years lower for men and 6 years for women)[25].

Figure A1
Life expectancy in Latvia, by sex and year



Source: World Bank Statistical Database

23 European Communities and World Health Organisation (2001) *Highlights on Health in Latvia*. Copenhagen: WHO Regional Office for Europe. Page 9.
24 World Health Organisation (2001) *World Health Report 2001*. Geneva: WHO. Page 139.
25 United Nations (2000) *Putting People First: A Common Country Assessment*. Riga: United Nations.

Table A1
Health-adjusted life expectancy in the Baltic countries, compared to Germany (2001)

	Expectation of lost healthy years at birth (years)		Percentage of total life expectancy lost	
	Male	Female	Male	Female
Latvia	12.8	11.6	19.9%	15.3%
Estonia	9.3	11.0	14.2%	14.4%
Lithuania	13.3	14.0	19.8%	18.2%
Germany	*6.9*	*9.2*	*9.3%*	*11.4%*

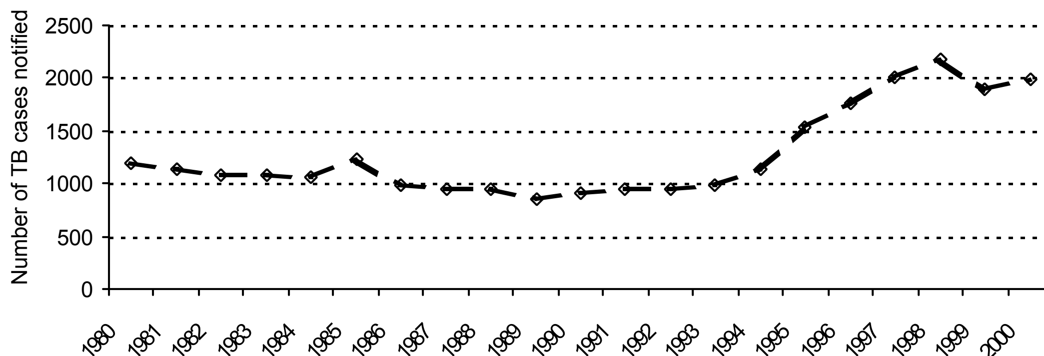
Source: WHO 2001 World Health Report

The World Health Organisation, using a methodology of health-adjusted life expectancy (HALE), estimates that a man in Latvia will spend an average of 12.8 years in poor health, and a woman will spend an average of 11.6 years in poor health. This can be compared to Germany, with male and female estimates of 6.9 and 9.2 years, respectively[26] (Table A1).

The main causes of mortality in Latvia are cardiovascular diseases (mortality rate, 753 per 100,000 inhabitants), malignant cancers (mortality rate, 237 per 100,000 inhabitants) and external causes (mortality rate, 159 per 100,000 inhabitants). The rate of death due to cardiovascular disease is more than three times the EU average.[27] Reasons for this include high alcohol consumption, smoking, poor diet and lack of exercise. The suicide rate, often registered among external causes of deaths, climbed by 95% between 1998 and 1999.[28] Men in the Baltic countries are between 3.4 and 4.2 times as likely to die from external deaths than women, a fact attributable to social stress and alcohol use.[29]

Public health trends elucidate the challenges facing the health care system in Latvia. The National Public Health Department of the Ministry of Welfare reports high, and often rising, incidence rates of infectious diseases, including acute intestinal diseases, diphtheria, hepatitis B and C, and sexually transmitted diseases[30].

Figure A2
Number of TB cases notified in Latvia, 1980-200



26 World Health Organisation (2001) *World Health Report 2001*. Geneva: WHO. Page 157.

27 European Communities and World Health Organisation (2001) Highlights on Health in Latvia. Copenhagen: WHO Regional Office for Europe. Page 13.

28 Ciment, J (1999) "Life Expectancy of Russian Men Falls to 58" *British Medical Journal* 319(7208): 468.

29 Varnik, A, D. Wasserman, E Palo and L Tooding (2001) "Registration of External Causes of Death in the Baltic States 1970-1997" *European Journal of Public Health* 11(1): 84-88.

30 Unless otherwise stated, all the statistics in this section are from Ministry of Welfare of the Republic of Latvia (2001) *Public Health Analysis in Latvia*. Riga: Ministry of Welfare Health Statistics Department.

The re-emergence of communicable diseases, most notably tuberculosis (TB), is an indicator for a deteriorating health situation in Latvia. The incidence of TB increased from 25.1 cases per 100,000 inhabitants in 1991 to 67.5 cases in 2000 (Figure A2). Outbreak of TB is related to poverty, poor living conditions and life style. About one-half of TB patients are marginalised individuals (homeless, alcoholics, drug abusers or ex-prisoners). During the last years, the number of new TB patients who are unemployed has increased 4.3 times. Particularly alarming is the fact that one-third of TB patients have multi-resistant forms of TB, making it very difficult to treat and contain the disease[31].

31 Ministry of Welfare of the Republic of Latvia (2001) *Public Health Analysis in Latvia*. Riga: Ministry of Welfare Health Statistics Department.