doi:10.25143/prom-rsu_2023-04_dts

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Health Policy Reform in Latvia from 1990 to 2020 in Perspective of Historical Institutionalism

Summary of the Doctoral Thesis for obtaining the scientific degree "Doctor of Science (*PhD*)"

Sector Group – Social Sciences
Sector – Political Science
Sub-Sector – Public Administration and Governance

Riga, 2023

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The Doctoral Thesis was developed at Rīga Stradiņš University, Latvia

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Defence of the Doctoral Thesis will take place at the public session of the Doctoral Council of Political science on 23 February 2023 at 13.00 in Hippocrates Lecture Theatre, 16 Dzirciema Street, Rīga Stradiņš University

The Doctoral Thesis is available in RSU Library and on RSU website: https://www.rsu.lv/en/dissertations

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Abbreviations used in the Thesis

EU	European Union
GDP	gross domestic product
GP	general practitioner
MoH	Ministry of Health
MoW	Ministry of Welfare
NGO	non-governmental organization
USA	United States of America
USSR	Union of Soviet Socialist Republics
WHO	World Health Organization

Introduction

The most common questions to be addressed when analysing national health reforms are why the results set out in health policy documents are not achieved and what considerations should be taken into account to explain the implementation of these changes. As studies from around the world have shown, many governments have devised reforms with lofty goals, but have found that it is much more difficult to define the actions to be taken and the ways in which these lofty goals can be achieved. Gill Walt points out that there is no doubt that "most analyses of health reforms point to gap between policy intent and strategies for making policy" (Walt, 1998, 372).

The implementation of political reforms in the health care system has been a hot topic in Latvia since regaining its independence in 1990, when formation of a new state administration was launched. There are two views in public opinion on the implementation of reform in the health sector: the first is that transformations are essential to ensure more effective governance and accessible health care for the population, and the second is that changes have been taking place all along but the same problems persist as before.

The main goal of health care reforms is to improve health outcomes for patients: the number of healthy years of life lived by the population. Quality adjusted life years are closely linked to the access to timely and quality diagnosis and treatment, as well as to people's participation in maintaining and preserving their own health – health literacy and preventive action. However, these targets are difficult to achieve in many countries around the world, which is attributed to the fact that the existing incentives and structures are not set up in a way that is consistent with the stated objective.

Health policy change in the world is mainly two-pronged: the first are the structural and governance reforms, playing the crucial role in the health sector reforms of many countries to improve and streamline the health care within the

limits of available funding. The second is the mission of health care to be the safeguard of fundamental human rights ensuring universal coverage or access to health care for all. Although these two approaches are not mutually exclusive, most of the change in the health sector introduced on the basis of recommendations by the World Bank and other international organisations since the 1980s "has focused on reforms to the financing, management, and structure of health systems" (Siddigi et al., 2009, 15). Many countries are still pursuing this type of change to improve the performance of their health systems.

Successful design, adoption, and implementation of policy change and reform are among the most important functions of public administration. The biggest challenge in implementing reforms usually lies in the final phase – which is a major challenge for any public administration, especially in modern democracies. It should also be taken into account that the pace of change depends on external circumstances and events. The world experience shows that the change is more successful when it is introduced at the beginning of a new political regime, and other significant political events can "open a window" of opportunity for reforms to succeed (Reich, 1995). Thus, when making radical changes to the system, it is important to consider the most appropriate timing, while small incremental changes are less dependent on the chosen timeframe and other political events.

The difficulties faced by countries in implementing health transitions are related to the complex and paradoxical links that exist between the values and norms generally acceptable and welcome by society and the independent values and belief systems existing in parallel. Consequently, "the reform of the health care system cannot be reduced to a mechanical exercise which consists of implementing a rational plan aimed at improving the effectiveness with which resources are used." (Contandriopoulos et al., 1998, 341). Changing the health care system or introducing new approaches thus involves reinforcing or opposing

the prevailing model of values. Successful design and implementation of a particular change in health care requires an initial agreement on the dominant value model and ideological approach under which the change policy is developed. In turn, the successful implementation of any planned changes requires the promotion of a common understanding in society of the relevance of this value model for the needs of society and the rational, efficient use of funding, agreed by the majority of those actively involved in the change process.

Any transformations depend on the understanding of how the changes designed are going to be implemented, and who will be the supporters and who – the opponents. As Walt points out, the implementation of change in health care is process-oriented and it is important to look at the relationships between public and private actors, managers and policy makers, service providers and consumers when analysing it (Walt, 1998). In turn, the understanding of the nature and objectives of a reform is necessary for policy makers and promoters to be able to work together and build coalitions of support.

One of the often-cited reasons for delays in implementing change is the fact that there are competing interests in health care, represented by different actors in the field. In a simplified model, these are: 1) individuals who want to improve their health; 2) payers and providers, which are companies including both non-profit and for-profit organisations, as well as profit-oriented state enterprises; 3) political and organisational players, as well as the public administration, actually, as such, taking conflicting roles – those of the service provider and the payer (client), when acting both as the representative and the advocate for citizens, at the same time.

The health policy reform in Latvia was initiated after the restoration of independence in 1990, together with the reform of the entire public administration by approving new statutes for the Ministry of Health Defence and appointing it as the competent body for the formulation and implementation of

the health policy on September 19, 1990. In 1993, the health reform was launched in Latvia with the aim of changing the previous – planned centralised system, which was not ensuring population-oriented, modern and efficient health care. The main objective of the reform was to create a citizen-centred, effective and accessible health care system. For this purpose, the reform was set in three directions: 1) reformation of the health care financing system; 2) establishment of an effective structure of health care providers, and 3) design and implementation of public health policies.

When looking at the implementation of the reform over the 30 years from 1990 to 2020, a series of successfully implemented changes are obvious, for example, the transformation of the centralised health care model, inherited from the USSR, into a decentralised model of primary, secondary and tertiary care, and the introduction of the role of the family doctor or general practitioner (GP). Significant changes have also been effected in the network of health care institutions with a large number of institutions privatised and three forms of governance – public, municipal and private – introduced. Also, the financing model and sources of funding have seen important changes.

Changing the way health care is organised not only meant changing the way it is organised within the sector, but also required a major shift in public perceptions and habits. Historically, two sectors – health and education were fully funded by the state, and citizens believed that there was "free medicine" and "free education", but the reform, by introducing the patient co-payment, affected only one of them – the health care sector. The second major change altered the way how patients received services: the previous system involved going to a polyclinic or a hospital and seeing the specialist they needed – a cardiologist, a surgeon or a gastroenterologist. The new model, with the GP as the "gateway", meant that direct access to specialists with the state co-payment

was possible either by going to the GP initially and receiving a referral, or by paying the full fee for a visit.

With the accession of Latvia to the European Union (EU) on 1 May 2004, the situation in the health care sector has changed significantly. The accession of Latvia to EU "opened the borders" both for the free movement of medical staff within EU and for Latvian patients. The open labour market and common regulation in a number of common policy areas opened up opportunities for Latvians to take better-paid jobs in economically more developed countries. This had a socio-economic impact on the overall development of the economy, and in particular on the medical sector, with the emigration of Latvian doctors and nurses. Patients, on the other hand, were able to receive a range of services in clinics in other EU countries. The common EU market also facilitated the faster introduction of new medicines and technologies into the Latvian health care market. It provided significant improvements in the treatment options for patients, but also contributed to the significant public demand for innovative medicines and the latest technologies, thus affecting considerably the required budget. The availability of EU Structural Funds and various support programmes stimulated active investment in infrastructure and technology, which in the context of de-centralisation and de-regulation led to unplanned and nationally uncoordinated investments. The new conditions have significantly told on the treatment process and the priorities of medical institutions, with a greater emphasis on investment in new technologies and buildings, using the available EU funds for infrastructure development, and less investment in human resources due to the constraints on the use of EU funds. The lack of human resources and the use of new technologies have created new barriers for access to health services, making services substantially more expensive – a weighty cost for a population that previously had access to "free medicine" – and preventing timely access to services due to a shortage of specialists.

Looking back at the health care system in the USSR and today, it is undeniable that it has changed significantly and improved in all comparable indicators, but the population is not satisfied with the health care system in Latvia. More than half of the population in the 2019 survey indicates that access to health care is insufficient, 80 % of the population indicate that it is difficult to receive basic health care services, and 73 % believe that more funding should be allocated to health care as a priority (LETA, 05.09.2019).

As Jautrīte Karaškēvica (2004, 11) points out, "A health care system reflects the political, cultural and economic values of the society in which it is developed. If the state considers health care as a public good, then health care services should be available to all citizens on equal terms, regardless of ability to pay, age, and gender." Ģirts Briģis (2016) makes a similar point when describing health policy: "Health policy in a broad sense is about values, basic settings that are dominant in the world – what is considered as values, what one wants to achieve with health policy in general".

Aim of the Thesis

The aim of the work is to evaluate the health policy reform in Latvia in the period from 1990 to 2020 from the perspective of Historical Institutionalism.

Research Questions

In order to achieve the aim of the Thesis, three research questions have been identified:

1) RQ1: What changes in health policy were implemented in the scope of health care reform in the period from 1990 to 2020? .
2) RQ2: What objectives of the reform were achieved during the health care reform in the period from 1990 to 2020?

3) RQ3: Why was there a delay in achieving the goals set for the health policy reform in Latvia in the period from 1990 to 2020?

The study was seeking to understand the process of political change over these 30 years and answer the question why the reform plans failed to achieve their objectives and why other countries of the former USSR, which were in a similar position in the 1990s, have done better. For this purpose, the Thesis analyses the design and implementation of health policy in Latvia, looking at the changes in the health sector during this period and their outcomes, and the reasons why the results of the reform were not achieved or were only partially achieved. In line with this approach, the first part of the analysis provides an overview of the changes that have taken place in the context of health policy reform in Latvia, describing the types of changes implemented and their objectives.

Given the descriptive approach of Historical Institutionalism and the fact that the review of the changes brought about by the Latvian health policy reform is based on earlier studies and information provided in briefing papers, the descriptive part is complemented by the analysis of statistical data. It provides objective evidence-based data on the outcomes of the Latvian health reform and makes it possible to assess where the reform has been successful and where the intended results have not been achieved. To determine why there is a delay in achieving the goals, the third part of the analysis provides research on the political process according to Historical Institutionalism, using the process tracing method.

Theoretical Background

The theoretical basis of the Thesis is chosen in accordance with the aim of the Thesis: analysis of the long-term phase of health policy change design and implementation as a political and institutional process, evaluation of the results

of the implemented changes and the search for an answer to the question why the planned results have not been achieved. Exploring different approaches used in health policy research, in line with the objectives of the work, the Historical Institutionalism approach has been chosen as the most appropriate theory because this approach is a meso-level theory that studies policy outcomes and is used to answer the question why the same reform or event has different outcomes in different parts of the world (Steinmo, 2013, 128). Explanations are "found in the way that institutional political and economic arrangements conflict and achieve the privileging of particular interests" (Hall and Taylor, 1996, 6), and the approach "provides a functionalist perspective by providing an explanation for why events unfolded in a particular way based on historical and institutional factors and influences" (Peters, 2005, 88).

The period chosen for the research is from 1990 onwards, which is associated with a significant change in the political course of the country, the regaining of independence by leaving the USSR, the introduction of a new political and economic system, including the establishment of a new national health care policy – the transition to a decentralised health care model. The end of the study period is set at March 2020, which is linked to the emergency situation caused by the Covid-19 epidemic.

In order to analyse and understand the process of certain reforms, it is necessary to understand why and under what circumstances they have arisen, because political processes are rooted in past decisions and the influence of historical decisions continues until radical changes occur that divert society from the course taken by historical development (Peters, 2000, 19). At the point when the government makes the initial decision on a particular policy or institutional change to be implemented, the 'patterns' established in the past continue to exist and influence any new decision (Peters, 2000, 73). In order to uncover the influence of the past and to observe how decisions made in the past influenced

the future decisions, the Thesis uses the process tracing approach. According to this approach, "a comprehensive analysis is carried out by tracing processes over time and analysing institutional configurations and contexts" (Bogason, 2013, 24), with the study of "the development of institutions over a long period of time and the associated temporal effects" (Lowndes and Roberts, 2013, 37).

Tasks

To achieve the aim of the Thesis, the following tasks have been set:

1. To assess the suitability of the theoretical approach of New Institutionalism for the analysis of long-term changes in health policy.
2. To identify the conceptual and analytical principles of Historical Institutionalism in the analysis of health policy reform.
3. To define the process tracing approach for the analysis of health policy reform.
4. To identify the data source and selection criteria to be used for the empirical study.
5. To assess the changes made in health policy within the reform and the outcomes of health policy reform.
6. To analyse the changes that occurred during the De-regulation period in the cultural-cognitive, regulatory, and normative pillars.
7. To analyse the changes that have taken place during the Regulation period in the cultural-cognitive, regulatory, and normative pillars.
8. To analyse the changes that have occurred during the Re-regulation period in the cultural-cognitive, regulatory, and normative pillars.

The objectives of the Thesis are to determine the most appropriate theoretical approach to be used in line with the research question and to identify the factors to be taken into account, when analysing the health policy reform. In

accordance with the chosen theoretical approach of Historical Institutionalism, the method used for the study – the process tracing – is defined and the aspects to be analysed that characterise each of these periods are identified. Whereas, according to Historical Institutionalism, institutions have multiple functions and influence political processes, and are influenced, in turn, by both the overall structure of government and the processes of society, each period has been analysed by looking at the cultural-cognitive, regulatory, and normative pillars.

The literature used in the Thesis includes theoretical works in political science describing New Institutionalism and Historical Institutionalism, and the studies using Historical Institutionalism to analyse the process of health care reforms or the implementation of certain health policy changes in other countries. In addition to the political science literature, public health literature has been used to provide information on different health systems, their goals and objectives, and the data used to describe national health policy outcomes and how they relate to certain types of health policy change.

The Thesis has been developed using qualitative research methods, including analysis of literature, sources, statistical data, analysis of reference information and interviews, for better understanding of the processes and to be able to describe the cultural-cognitive and normative pillars. Analysis of documents includes the study of laws, Cabinet regulations and orders, informative reports of ministries, pre-election programs of political parties and Government declarations. The study of opinions is based on literature, analysis of articles, news on certain topics and events. Publicly available official statistics on health system performance indicators, which are used in the international evaluation of a particular country's health policy, have been used to assess the achievement of the objectives and mission statements of the reform. In-depth interviews have been conducted with 16 interviewees representing the public

sector – Ministers of Health and Ministry officials, representatives of non-governmental sectors – NGOs and service providers, as well as experts in the field of public health and health economics.

The Thesis consists of an introduction, three chapters with subsections and conclusions. The first chapter of the Thesis provides a theoretical insight into the approaches used in health policy research and the rationale for the choice of Historical Institutionalism as the theoretical background in this work. The second chapter provides a contextual description, providing an insight into the characteristics of the Latvian health care system, and describes the research methodology.

The third chapter provides an analysis of the development and implementation of the Latvian health policy based on the chosen research approach. The analysis consists of two parts: the first part discusses the policy changes made within the framework of the Latvian health reform in order to answer the first research question of the work, and the results of the reform are evaluated in order to answer the second research question. According to the research and evaluation, only part of the changes have been successful and the aim of the reform has been achieved partially. The problems that were planned to be solved by changing the model of organization of health care have not been completely solved.

The process tracing method has been used for the analysis, when identifying the time periods that are associated with certain political forces in power, ideologies prevailing in society and priorities for the activities of state administration. According to the methodology of the study, three periods are distinguished: 1) the De-regulation period (1990–1997); 2) the Regulation period (1998–2005); 3) the Re-regulation period (2006–2020). For each of these time periods, three pillars have been analysed, which are related to the implementation of changes in institutions and can also be attributed to the change of the health

care model, moving from the “Semashko” to the decentralisation model – the culturally cognitive pillar, the regulatory pillar and the normative pillar. The conclusion chapter summarises the results of the analysis and observations.

Novelty

The Latvian health care system and the changes it has undergone have been described and analysed in a number of studies and reports. Some of these include Jautrīte Karaškēvica's doctoral thesis in public health, which describes the health sector in Latvia in the period 1993–2003 (Karaškēvica, 2004). Maija Bušmane's (2007) research in health management analyses changes and outcomes in the health sector in the period 1990–2007 and assesses the introduction of entrepreneurship principles in the health sector and its impact on health management and access to services. There is also a series of studies “Health Systems in Transition” by the World Health Organisation including the Latvian health care system in the light of a defined methodology of analysis. One of the studies was published in 2008, describing the Latvian health care system, the results and outcomes of the reform in the period up to 2008, by Olga Avdeeva, Ellie Tragakes, Ģirts Briģis, Jautrīte Karaškēvica, Aiga Rūrāne, Artis Stuburs, Evita Zušmane (European Observatory, 2008). A similar report was published in 2012 by Uldis Mitenbergs, Māris Taube, Jānis Misiņš, Ēriks Miķītis, Atis Martinsons, Aiga Rūrāne, Wilm Quentin (European Observatory, 2012). The latest report was prepared in 2019 by Daiga Behmane, Alīna Dūdele, Anita Villeruša, Jānis Misiņš, Kristīne Kļaviņa, Dzintars Mozgis, Giada Scarpetto (European Observatory, 2019). The Latvian health care system has also been described in the reviews by the Organisation for Economic Co-operation and Development: “Reviews on Health Systems: Latvia” in 2016 (OECD, 2016) and “Country Health Profile: Latvia” in 2017, 2019, and 2021 (OECD, 2017, 2019, 2021).

These studies and reports characterize the health sector over time and point out some of the changes introduced in the past, but none of them analyse the health policy in view of the political aspects, in particular, the political forces in power and prevailing values in society, the normative and regulatory process. None of them answer the questions of why the intended results have not been achieved and what have been the barriers to the successful implementation of the reform.

The novelty of the Thesis is the long-term study of the Latvian health policy-making, for the first time examining the Latvian health reform and policy in the long term using the Historical Institutionalism approach to health reform analysis. Compared to the short-term studies and reports mentioned above, this study provides an analysis of the long-term changes in health care reform by looking at health policy changes and their outcomes in macro-level quantitative indicators, and for the first time develops a health policy thesis in the discipline of political science.

As a novelty in the study of social fields, the work has developed an analytical model, for the analysis of the culturally cognitive, regulatory and normative pillars of institutions, and determines the aspects to be analysed in each of the pillars, as well as identifies the sources to be studied.

The empirical novelty of the work is an important contribution in the field of public administration research in Latvia, analysing the political aspects of health reform, revealing the impact of past decisions on changes in future periods and identifying the long-term influencing factors. A novelty is also the introduction of the periodisation of the Latvian health sector, according to the Historical Institutionalism approach, distinguishing specific periods: De-regulation, Regulation, and Re-regulation.

1 Theoretical aspects of health policy analysis

In reviewing the literature on implementation of health policy reform and the theoretical approaches used for looking at the experiences of different countries in health policy implementation, it was concluded that there is no single theory or model that can be considered appropriate for the analysis of such processes in any of the areas, including the analysis of the implementation of health system reforms. Consequently, several approaches have been used in health care research, distinguishing different strategies depending on the policy area, context, leadership, stakeholders and organisational capability (Cerna, 2013).

Different approaches and methods can be used to analyse individual changes, which are a relatively fragmented process and can be characterised by an initiation phase, a characterisation and detailed study of the drivers, the implementers, their relationships, and interactions. The theoretical approach chosen to study individual changes is linked to the research question and may use one of the New Institutionalism approaches: Sociological or Rational Choice Institutionalism, if the focus is on certain actors and their influence on the reform process. On the other hand, if the research question is more concerned with influences and interactions, the management and implementation of reform progress, then Multilevel Governance or Network Governance approaches may be more appropriate (Cerna, 2013; Walt, 1998; Sabatier, 1988). If the object of the analysis is the implementation of a reform borrowed from another country, then comparative political theory approaches may be appropriate (Cerna, 2013).

On the other hand, Historical Institutionalism is used as the only appropriate theoretical approach analysing incremental long-term health policy change if the object of the study is large, touches on profound and fundamental issues related to broad societal interests. It is used analysing the process of

implementing such change in the long term, analysing macro-level contexts and describing system transformations over a longer period of time.

The Historical Institutionalism approach is characterised by the following three features: 1) the approach is used to study large, substantive issues of broad public interest; 2) the approach produces explanatory arguments about important outcomes or ambiguous events, because Historical Institutionalism gives importance to time and to particular sequences of change and transformation; 3) it analyses macro-level contexts and puts forward hypotheses about combined phases of institutions and processes rather than single institutions or processes over time (Pierson and Skocpol, 2002, 696).

On the basis of these three aspects, i.e., the essential order of things, the time argument, and an increased focus on context and configurations, Historical Institutionalism makes an important contribution to political science in the study of governance processes, policy-making and public policy and order. The approach is used primarily to explain significant deviations in important or surprising patterns, events or orders of things, rather than focusing on the behaviour of particular individuals, without taking into account global processes and events at a given time and place. The Historical Institutionalism analyses the course of certain events and explains why certain choices were made. The approach is based on an analysis of certain phases – looking at the patterns that existed during that period.

Given that this study is an investigation of health policy as a long-term process of policy-making and its implementation, rather than a case study of a single change or actor analysis, as the most appropriate theory was chosen new institutionalism, which is described in the first section – 1.1 "New Institutionalism as a framework for long-term policy research". The subsection describes the new institutionalism on the basis of conclusions by A. Lecor, G. Peter, S. Steinmo, J. March, J. Olsen, W. Lowndes, M. Roberts,

M. Örnerheim, E. Wilborg. P. Bogason and E. Immergut (Lecours, 2011; Peters, 2005; 2012; 2013; Steinmo, 2013; March and Olsen, 2009; Lowndes and Roberts, 2013; Örnerheim and Wihlborg, 2014, Bogason, 2013, Immergut 1998; 2002). It assesses the suitability of the new institutionalist theoretical approach for the analysis of long-term health policy change.

The second section 1.2 "Historical Institutionalism – an approach to studying socially significant change" is devoted to the approach of Historical Institutionalism, which uses the method of tracing certain sequential processes to explain processes, events and their interactions. It is chosen as the most appropriate approach for such long-term policy research. The section identifies the conceptual and analytical principles of Historical Institutionalism for the analysis of health policy reform. Given the theme of the Thesis, the implementation of long-term reform, the following aspects are examined and described in depth: the definitions of the institution and the characteristics of the likelihood of change, as well as the interactions and mutual influence of actors in political processes. The conceptual and analytical aspects summarised in the subsection are based on the work of the following authors: Peters, 2005; 2012; Judge 2013; Hall and Taylor, 1996; Lecours, 2011; Immergut, 1998; 2002; Pierson 2000; Cerna, 2013; Lowndes and Roberts, 2013.

2 Approach to analysis of Latvian health policy

The Historical Institutionalism is the theoretical approach chosen for the Dissertation on the implementation of health policy reform in Latvia over a thirty-year period, starting with the restoration of Latvia's independence and including significant change in health policy. As described in the previous chapter, this approach is used to investigate large, grounded, and relevant issues of broad public interest, providing explanations of major events with long-term implications, analysing time, and certain sequences of events, explaining change and transformation. Analysis using the Historical Institutionalism approach provides explanations and justifications for the differences between the outcomes of different national policies and the inequalities that point to these outcomes. These explanations are found in the way in which institutional political and economic structures conflict and achieve the privileging of some interests over others. Historical Institutionalism is a theoretical approach that has macroscopic inclinations and thus studies overarching and interacting contexts, rather than examining individuals at a microscopic level as is typical of Rational Choice approaches.

This approach is based on historical analysis and has three main focuses: 1) to explain significant events; 2) to analyse overarching social contexts; and 3) to trace historical processes. In turn, the analysis is based on the three pillars that underpin each institution: cultural-cognitive, regulatory, and normative. According to Örnerheim and Wihlborg, the cognitive-cultural pillar covers the existence of cognitive functions in organisations, the structures, and context of how the institution is perceived by society, and how the organisation fits into this context. The regulatory pillar describes legislative and constitutional arrangements, while the normative pillar describes informal cultural norms, structures, and principles that exist alongside formalised practices (Örnerheim and Wihlborg, 2014).

The chapter consists of four subsections. The first subsection – 2.1 “Historical challenges of Latvian health care” provides a description of the object of study, summarising the world experience and practice, looking at the experience of the former USSR countries that have undergone a similar health policy reform as Latvia when changing their health care model. The chapter presents a description of the earlier model, highlights its fundamental shortcomings, as well as insights into the preconditions for successful implementation of the reform, building on the experiences of countries that transformed their health care systems when leaving the USSR and developing their own decentralised health care policies.

The second subsection – 2.2 “Methodological approach”, provides a description of the methodological approach of the study, based on the use of the chosen theoretical approach – Historical Institutionalism, describing the ontological aspects of Historical Institutionalism, and the social constructivism approach used in the study. The approach used in the Thesis represents the view of social constructionism of the ontological approach, which, according to the philosophy of science, includes the issue of scientific veracity, which is directly related to concerns about the objectivity of facts. The social constructivism approach assumes that the historical explanation of science starts from social processes and proceeds to theoretical and experimental facts, and not vice versa. An ontological position has been chosen for the research work, since the research task is to understand the course of specific events tied to history and their long-term results. Historical analysis, according to Historical Institutionalism, involves three basic focal points: (a) to explain significant events; (b) to analyse overarching social contexts; and (c) to trace historical processes. In turn, in order to address the shortcomings of the ontological position and to ensure factual objectivity, the inductively conducted descriptive research is complemented by objective quantitative data describing the process outcomes of the changes made.

The third subsection – 2.3 “The role of past dependence and process tracing in its detection” describes the process tracing approach used in the analysis process. Historical Institutionalism has an inductive approach, based on an analysis of existing patterns and events at specific stages. The approach is able to reveal the factor of past dependence, which is one of the key factors in the use of Historical Institutionalism. Using a process tracing approach, Historical Institutionalism uncovers and explains cross-temporal contexts and interacting processes that influence states, policies and legislation (Pierson and Skocpol, 2002, 693). Unlike empirical approaches where events are analysed independently of time and place, Historical Institutionalism considers all variables in the light of the relevant context (Hall and Taylor, 1996, 13-17).

The last subsection – 2.4 “Study design and data selection” describes the study design according to the chosen process tracing method and justifies the selection of data. The selection of the objects to be studied is in line with the ontological position of universalisation, which assumes that although the world is composed of individual objects and they have their own properties and relations, objects undeniably share common properties. The analysis bases on documentary research – analysis of normative documents: laws, regulations, guidelines, by-laws, as well as documents related to these formalised processes. They include results of the parliamentary elections, elected political parties and their pre-election programmes, composition of the coalition formed from elected parties, commitments to health reforms included in government declarations, as well as briefing reports on the implementation of reforms.

Characterising the power relations between the legislators, the executive and the reformer, publicly expressed views and interviews were analysed. The selection of interviewees was made according to the following criteria: 1) the interviewee represents one of the actors in the health sector – public sector, non-governmental sector (service provider, service recipient,

service payer); 2) the interviewee is a professional in the relevant field, holding a relevant position at the time of the interview or in the past, or is an expert in the field and has participated in international reports on health in Latvia, or has authored international publications on this topic. In-depth expert interviews were conducted with 15 representatives from both the public and non-governmental sectors.

3 Analysis of Latvian health policy

Any change in public administration, including health, should be seen as a political process for the following five reasons: 1) it reflects the values expressed by certain sections of society; 2) reform brings about significant changes and impacts on society because it redistributes resources and costs; 3) change triggers competition between certain groups in society who want to create favourable impacts and outcomes for themselves; 4) the adoption or rejection of reform is in most cases linked to certain political events or political crises; 5) change can have a significant impact on the stability of the political regime. Thus, for intended health policy change to be successful, policy makers need to choose appropriate and effective methods to use to assess the conditions of the political environment and to facilitate the development of political factors that create a favourable breeding ground for change (Reich, 1995).

The research chapter consists of two parts. The first section 3.1 ”Health policy reform in 1990–2020” – according to the first research question: *“RQ1: What changes in health policy were implemented in the scope of health care reform in the period from 1990 to 2020?”* – examines the policy changes made in the context of the Latvian health reform, expanding their description, in particular, in the subsections 3.1.1 ”Changes in the health financing model”, 3.1.2 “Changes in the organisation of health services”, 3.1.3 “Changes in human resource policy”, and 3.1.4 “Introduction of electronic health record” that took place during this period.

In response to the second research question: “*RQ2: What objectives of the reform were achieved during the health care reform in the period from 1990 to 2020?*” – the changes have been objectively assessed, drawing conclusions on the success of the reform and evaluating the quantitative indicators of the health system.

The evaluation is based on studies of other authors and quantitative statistical data used in reporting by international organizations in the comparative analysis of certain aspects of health care systems. The subsection 3.1.5 "Outcome of the changes implemented as part of the health reform" analyses the following quantitative indicators of the health system and their changes: indicators characterising the hospital sector (number of hospitals, beds, average length of stay in hospital, number of hospital admissions and emergency services), indicators characterising the outpatient sector (number of ambulatory facilities, number of medical practices, number of outpatient visits), indicators characterising the medical personnel (number of doctors, number of general practitioners, number of nurses, number of physician assistants and midwives) and indicators of access to health care (the rate of people struggling the lack of treatment or examination and reasons for this).

The second subsection answers the third research question *"RQ3: Why was there a delay in achieving the goals set for the health policy reform in Latvia in the period from 1990 to 2020?"* by a political analysis of the reform process in order to identify the factors that have facilitated or hindered the implementation of the reform. As the experience of other countries shows, in order to achieve the desired improvements through decentralisation of the health system, it is necessary to create certain social, cultural, and environmental conditions, as well as to ensure sufficient management and administrative capacity of the local administration.

The study analyses the conditions for successful de-centralisation: social, cultural, and environmental conditions, administrative management and capacity, as well as the prevailing ideological trends in politics and economics. To study these processes, the Historical Institutionalism approach has been used, applying the method of process tracing and identifying certain periods characterised by common ideological features.

In line with this approach, the entire reform period 1990–2020 has been analysed dividing it into three sub-periods when certain common predominant features can be observed The first period is described in the first subsection – 3.2.1. “The period of De-regulation of Latvian health care” characterised by an active shift from the former centrally planned economic system to a decentralised system when the essential values are: free market and competition, which is seen as a kind of panacea that will be able to solve all the problems of the past. The period highlights the trend towards a radical change in the system, mainly in the form of ownership, the privatisation of health institutions, and the abolition of centralised management in the field of health care, replacing it by free market principles. The prevailing assumption is that self-organisation will take place in the unregulated sector, with competition leading to improved quality and value for money. The period covered is 1990–1997. As this is a period of change in the system of government, it can also be seen as a period in which the window of opportunity for reform has opened and, from a theoretical point of view, the conditions for successful change have been created.

The next is the “Regulatory Period”, described in the subsection 3.2.2 ”Regulatory period in Latvian health care”, starting from 1998 onwards, when changes were taking place on the political level linked to the 7th parliamentary elections, which saw the change of parties in power. The parties' pre-election programmes, government declarations and other documents show a shift in values and priorities in the health sector. The reform path chosen and changes made on the bases of the free market principle, as it was understood at the time, and de-regulating the sector did not bring the desired results: quality improvement, access to health services, significant investment inflows and the desired growth of the sector. The reforms did not improve access to health care, but created new problems. The chaotic changes had led to a situation where citizens were not guaranteed the rights and equality before

the law as laid down in the Constitution of the Republic of Latvia (1922). The health services available depended on the administrative territory where the resident was registered, with services varying in quality and price, but this variation was not determined by quality. Faced with reforms in the first period that failed to achieve their objectives, solutions were sought to improve the access to health care and to promote the development of health sector by returning an increasing role and influence to the public administration. The year 2005 was chosen as the end of this period, linked to the accession of Latvia to EU in May 2004, followed by the period until the next parliamentary elections. During that period, active work is being done to incorporate common EU norms and values into Latvian regulatory framework and public administration models of operation.

The last period of the study is the "Re-regulation period", which is described in subsection 3.2.3 "Re-regulation period in Latvian health care" and covers the period starting in 2006, which is related to the next parliamentary elections that took place after the accession of Latvia to EU. Following the previous reform period, the country had established Ministry of Health, managed to develop a reform plan, launched a model of primary, secondary and tertiary care facilities and services, and created a single financing model for primary care. However, the accession to EU significantly changed the pre-established practices in drafting of planning documents and provided new opportunities for the take-up of EU funding programmes. One of the pressing issues during this period of EU influence was the development of a civically active society. The promotion of public participation and involvement in policy processes created new challenges and different types of regulatory mechanisms for the state to cooperate with society. March 2020 was set as the end of the research phase, due to the emergency situation caused by the Covid-19 epidemic, under which various types of restrictions were introduced. They affected the organisation of

the political process, the understanding of democracy and individual freedom, as well as health threats that require different reactions than in “peace times”.

According to Historical Institutionalism, institutions have cognitive, regulatory, and normative functions (Örnerheim and Wihlborg, 2014), so the research analyses the pillars related to these three functions: cognitive, regulatory and normative. Historical Institutionalism “takes into account the entire institutional apparatus of the state and the building blocks of the national level” (Lowndes and Roberts, 2013, 37) and includes different types of institutions: formal rules, compliance procedures, standards of practice that structure and regulate relations between individuals (Thelen and Steinmo, 1992, 2). However, institutions are formalised and analysis needs to identify existing arrangements, whether viewed through policy or in structural terms (Peters, 2013, 13). Hence, the research has covered not only the process of health policy-making, but also the overall state administration and its changes: the Parliament and the Cabinet in power during the period in question, as well as the regulation of how legislation is promoted and adopted in the Parliament and the Cabinet. When investigating a particular reform, the Historical Institutionalism analyses the political process, but does not analyse the nature and values of the policy, i.e., it assesses “not how good and relevant the policy is, but how well designed and sustainable it is” (Peters, 2012, 85).

For each period, by an in-depth analysis, three pillars have been assessed: 1) cultural-cognitive – analysing and describing the values and ideologies prevailing in society during this period, the major problems facing the country and the perception of the value of health; 2) regulatory – analysing the state system, legislation in force during this period, the structure of public administration and the procedural arrangements for driving political change;

3) normative – analysing the pre-election programmes of political parties, government declarations and health-related actions of the executive responsible for the health care sphere.

Conclusions

The changes in Latvian health policy that took place in the period 1990–2020, linked to the change in the political and economic order after the restoration of independence, are part of a significant overall change in the regime and state order of the country. The overall course of national development, changing the political and economic order from a planned centralised economy to one based on free market principles, was a major challenge for all countries of the former USSR, including Latvia. In Latvia, the health reform was launched immediately after the restoration of independence in 1990 aiming to change the model of health care organisation, abandon the "Semashko" model of the USSR and introduce a new de-centralised and de-regulated model. In this model, entrepreneurship is encouraged and free market and competition principles are introduced in the health care sector. The implementation of the reform was targeted to the improvement of the health care system by providing modern and up-to-date services to meet the needs of the population at appropriate prices and quality.

In order to achieve the aim of the Thesis – "*to evaluate the health policy reform in Latvia in the period from 1990 to 2020 from the perspective of Historical Institutionalism*" – the long-term changes in the health care system have been analysed. The first part of the research dealing with the changes in health policy of the period is based on the study of documents and other researchers' work on health policy making and its outcomes. The sequential characterisation of health policy change, in line with the Historical Institutionalism approach, allows for tracing the changes ensuring, hence, the necessary analytical clarity. The disadvantage of such a descriptive approach is the dependence on interpretation and the influence of other authors in providing explanations, as well as the lack of objectivity. To compensate for this lack of objectivity, the Author discusses the quantitative indicators, which describe the

state of public health, characterise health systems and are used for international comparison.

The research revealed that, within the framework of the health reform, the changes were implemented in the following aspects of health care: 1) changes in the health care financing model with the first changes taking place already in 1993; 2) changes in the health service delivery model, where the first changes started in 1996 with the introduction of changes in primary, secondary, and tertiary health care. In addition to the changes in these two key ways of financing health care and providing services to the population there are two other major changes that are specific to the Latvian health care sector, namely, changes in human resource policies and the introduction of the electronic health record. Although 30 years have passed since the reform was launched, the problem of access to health care and the need for change in the health sector have not lost their relevance at the end of the period under review.

The analysis of changes in the health care model revealed that changes in the financing model have been made several times during the reform period, especially in the first 10 years of the reform. Health financing in absolute monetary terms has increased substantially over time. However, when considered as a share of total government expenditure or as a share of GDP, even in the years with the highest levels of financing, it amounts to only 11 % of total government expenditure and just over 4 % of GDP. It is significantly lower than EU average. Underfunding is one of the most frequently cited reasons in virtually all reports and reviews of Latvian health sector for not achieving the goal of providing affordable health care to the population and significantly improving public health indicators.

The underfunding is directly linked to a number of problems in healthcare: very limited possibilities to review and set tariffs for health care services in line with real costs; to increase quotas for state-funded services, thus

reducing queues; to include new medicines in the list of state of reimbursable medicines and expand the diagnoses for which they are covered; to include new diagnostic and treatment services in the scope of state-funded services. Insufficient funding is also a major obstacle to increase the remuneration of medical practitioners, which in turn hinders solving the problem of sufficient provision of medical staff and the replacement of generations.

The analysis of changes in the organisation of health care revealed that one of the most significant changes implemented in the Latvian reform process started in 1996 with the introduction of primary, secondary, tertiary and emergency care, and general practitioner (GP) practices. Changes in this area were very gradual and there was no significant increase in primary health care providers at the beginning of the reform. Due to the lack of a general surveillance over the sector, there was no centralised management of the sector and no coherent development plan, resulting in problems in attracting investment depending on the type of facility. In subsequent periods, when investments were available, they were absorbed without a common national plan, leading to inefficient allocation of services and cost-ineffective investments. Midway through the reform, a Master Plan for service providers was developed in 2004 and, with its approval, a state-led planned service development was launched for the period 2005–2010. According to quantitative data, the reform has seen significant changes in outpatient and inpatient services: the number of hospitals and beds has been reduced by two thirds, the number of outpatient facilities has increased tenfold, practices of GP have been introduced, and the emergency medical services have been reformed. The reform has been successful in terms of the reform of service providers, as it has succeeded in creating a cost-effective network of hospitals and outpatient services providing geographically accessible services to the population.

Changes in service delivery have succeeded in achieving the reform objective of modern and efficient health care, whereas the average length of hospital stay halved. While changes ensuring the network of providers have been successful – as evidenced by the health sector reports and data on hospital admissions and outpatient visits – the implementation has not been successful, since the population is visiting fewer doctors on the outpatient basis and the proportion of hospitalised patients remains high As the reports and data analysed in the study show, the problems of access to health care are related to three factors: 1) insufficient financing of health care, which results in limited access to services due to quotas and long waiting lists; 2) the inability of providers to render services according to the established national tariff, since it is inconsistent with the actual cost of the service; 3) lack of human resources, which means that a service is not provided because the necessary medical staff to provide the service is not available in sufficient numbers.

A major problem in the Latvian health care sector throughout the period under review has been the problem of human resources. As the analysis shows, certain changes have been implemented though they have been addressed in a piecemeal fashion, both by increasing salaries within the limits of restricted funding in years when this was possible, and by using various specialised EU funding programmes to address problems in the regions. Nevertheless, as the overall figures show at the end of the period, despite the fact that the number of doctors has increased, the number of nurses has continued to fall each year regardless of the changes implemented and has reduced by two thirds since 1990. Compared to EU average, Latvia has half the number of nurses it needs for its population. Given the important role of medical staff in the provision of health services, it can be concluded that the shortage of human resources and the continuing decline in the nursing workforce in particular is a major threat to the

provision of health services, even if the funding issue were resolved and the possibility found to increase the health funding substantially.

Changes in the principles of financing and organising health care introduced the principle “money follows the patient”. That made it possible for patients to receive services in any of the facilities that provide them, rather than only within their own administrative area, thus increasing the mobility of the population. This also raised the issue of the availability of a patient's medical records, when he/she goes to receive services in a different institution from the one where his/her “patient card” is located, and the need for an electronic health record. The results of the study show that the implementation of these changes has not been successful, which is attributed to several factors: insufficient funding at the initial stage, leading to work on the implementation of the changes only starting in 2008, when EU funding became available. A second inhibiting factor was the lack of administrative capacity to manage the project and the lack of expertise, which resulted in a lack of successful project management, as evidenced by the views expressed in interviews and other studies on eHealth implementation.

Answering the second research question: *“RQ2: What objectives of the reform were achieved during the health care reform in the period from 1990 to 2020?”* – according to the overview and results of the changes made as part of the reform, it can be concluded that the reform was successful in some aspects, such as increase in efficiency in hospital services and medical technology, declining the number of hospitals and beds, and the average number of days a patient spends in hospital. The more efficient and modern medicine, created by the reform, in terms of diagnosis and treatment, has undeniably improved overall health care in the country, as evidenced by the increase in life expectancy, with the average life expectancy of new-born rising from 69.5 to 75.1 years between 1990 and 2020. Thus, it can be concluded that one part of the main objective of

the reform launched in 1993 – "creation of an effective structure of health care providers" – has been achieved.

However, the other part of the objective "introduction of a patient-oriented, effective and accessible health care reform", providing for improvements to ensure timely access to publicly funded services, has not been achieved. It is shown by a number of indicators: the high rate of hospitalisation and the low number of outpatient appointments, and people's perception of the cases when they have not been treated or examined, when the predominant reason is related to the cost of services. Access to health care in primary care is difficult, which is directly related to the availability of services: human resources, tariffs and quotas, as well as high patient out-of-pocket payments.

The second part of the analysis focuses on the health reform process, in order to answer the third research question: *"RQ3: Why was there a delay in achieving the goals set for the health policy reform in Latvia in the period from 1990 to 2020?"*, explains why the reform has failed to achieve its objectives of improving access to health care. The study follows the approach of Historical Institutionalism and process tracing, analysing the cognitive, regulatory, and normative pillars of each period to uncover the factors that facilitated or hindered the implementation of the reform.

According to the theory, the most favourable period for major reforms is when a window of opportunity opens up, either as a result of international events or major national-level changes or shocks, most often crises, changes in power following democratic elections or social conflicts. Such a window of opportunity, with a change of political system and regime, was in the early 1990s when Latvia regained its independence. As the study concluded, it was in those early years that reforms in public administration were most active. As the study revealed, the perception in Latvia in the early 1990s that the role of the state in economic processes needed to be radically changed away from centralisation and

regulation was linked to the policies implemented during the Soviet occupation, which had had a negative impact on agriculture and production. This prevailing view has been used globally and applied in all areas and policies, including health. The overall objective of moving away from the regulatory role of the state towards decentralised services in the health field took two forms: firstly, by delegating to local municipalities the responsibility for organising and providing health care for the population and, secondly, by abolishing the institution of the Ministry of Health (MoH). In 1991, under the influence of these prevailing ideas, the tasks of the MoH and the Ministry of Social Security were reviewed and, after giving up their regulatory tasks, these institutions were merged to form the Ministry of Welfare (MoW). According to the statutes of the newly created MoW, a number of tasks that had previously been the responsibility of the MoH were no longer carried out under the new administrative model.

As a result, the state administration abandoned a number of regulatory functions. They included developing and implementing the main directions for the improving of the health system, providing medical treatment and assistance to the population, training of medical personnel, researching medical achievements and promoting their implementation in the practical activities of health institutions, developing standards for medical assistance and recommended tariffs for services, ascertaining and meeting the needs of health institutions and the population for medical services, and receiving and distributing centralised limits for equipment.

The decisions taken at the beginning of the period were due to the application to the health sector of the principles of classical free market economics. They based on a demand and supply mechanism borrowed from the production sector, in which the main factor in regulating the market – the buyer – evaluates supply and makes a choice when, from whom and at what price to buy a good or service, or not to buy it at all. This change, with the state abdicating

the above-mentioned tasks, was in line with the political objective set at the time, to remove the state regulatory mechanisms that were possibly interfering with the self-organisation of the sector. There was the hope that the free market and competition would lead to self-regulating processes and that these sectors would regulate themselves according to the needs and demands of the population, identical to the production of household goods or agriculture.

At the same time, health economics as a separate discipline was developing rapidly in the USA in the 1970s. This occurred due to the conclusion that the blind application of classical free market laws to health care was impossible, and that the state needed to regulate these issues more, because the health of an individual does not just affect the individual, but has a major impact on society and economic development as a whole. In the area of health services, supply and demand do not depend solely on the consumer's free will and free choice – when, how much and which services to buy, and for how long to delay buying a service, as is the case with buying new shoes or a car. In the area of medical assistance or health care, these free market mechanisms do not work. In addition, as health economists point out – it is important to consider that the health of an individual is an important determinant of the value and choice of all other goods and commodities. It affects not only the individual, but also, in the case of illness, the individual's family and the social and economic growth potential of the economy as a whole (Palmer, 2007, 28).

Such decisions were made due to a lack of understanding of the role of the state in providing health care, the impact of population health on the overall economy, and a too narrow view of the right of the state to intervene in health regulation. On the other hand, according to the Historical Institutionalism approach and the past dependency factor, institutions continue to operate according to pre-existing practices until they are significantly dislocated from their current equilibrium state or their existence is threatened. This may also

explain the inertia that existed in the health sector after the adoption of these changes "on paper". Since such a framework did not impose new responsibilities, but on the contrary decentralised the responsibility for providing health care to the municipalities, and abandoned the monitoring, development planning and management of the sector, there was consequently no change agent or implementer to promote this entrepreneurial development and self-organisation of the sector. These changes, which were implemented in Latvia in 1991, contradicted the WHO recommendations on the role of the state and the principles of regulation that should be implemented in changing the health care model from a centralised to a de-centralised, entrepreneurial model.

The study found that, as a result of these prevailing ideas of self-regulating mechanisms for free markets, the institutional changes implemented by abandoning the tasks of monitoring, development planning and ensuring sustainability, significantly weakened the capacity of institutions and, consequently, the ability to implement reform. The abolition of the MoH and the non-transfer of the state tasks formerly under its responsibility to the newly created MoW, thereby depriving the state of a number of health regulatory activities, created significant long-term problems for the further development of the sector and the successful implementation of the reform. As the only essential regulatory function of the state, left to the newly created MoW, was the distribution and channelling of funding from the State budget through the municipalities to service providers, the most important reforms were implemented in this respect. During the period when the MoW was responsible for this area, the conditions for the distribution of funding and payment for services were changed several times, leading in the long term to the conclusion that centralised management of health funding was necessary, with the creation of a single national health insurance agency. However, the gradual introduction of these reforms and the continuing series of changes have created instability and

unpredictability as well as uncertainty in access to services, thus worsening the overall situation of access to health care.

Analysis of the changes implemented during this period, when the state's regulatory role in the health sector was abandoned, leaving only a funding distribution function and some control functions, showed the emergence of significant new challenges in the health sector. The quantitative data from the study shows that, during the first six years of the reform, the abandonment of the state's task of “training medical staff” had a negative impact on the availability of medical staff. Both the number of doctors and nurses was declining to such an important extent that service delivery was compromised and this problem, particularly with the supply of nurses, continues to threaten service delivery.

The abandonment of quality of service and tariff setting led to a situation where service providers offered services of different quality and price, while the price was not linked to the quality of the service. In turn, the abandonment of the task of ensuring access to health care services for the population by delegating it to municipalities led to a situation where the possibilities for the population to receive a certain service were very limited and depended on the place of residence of the citizen. In turn, the abandonment of planning the provision of medical equipment at the national level and planning the availability of services at the national level led to availability of investments. As a result, medical institutions purchased equipment in an uncoordinated manner and unrelated to the needs of service provision, which, in turn, led to inefficient use of funds available for improving health care services.

Despite the fact that the Ministry of Welfare (MoW) was not obliged by its regulations to implement the strategic development of the health care system such ideas were still on the table in the executive branch. The possible reasons for it might be institutional inertia, customary practices, as well as the fact that

positions in the newly created MoW were occupied by people who had previously worked in the Ministry of Health (MoH).

As early as in 1995, amendments to the Statutes of the MoW were adopted, assigning new functions and tasks, which essentially restored the tasks of the previously abolished MoH, and "on paper" restored the regulatory role of the MoW. This in turn was followed by the first reforms to the planning of health service providers, as evidenced by the work initiated in 1996 in collaboration with World Bank experts to develop a reform of health service providers.

Although the regulatory functions in the health sector have been restored "on paper" since 1995 with the changes to the MoW's Statute, the results of the analysis show that the capacity of civil servants was not sufficient to implement these tasks and to adopt certain amendments to the regulatory framework. The change towards a renewed management and regulation of health development has only been observed since the establishment of the MoH, as evidenced by a series of changes adopted and initiated in 2004 and 2005. This confirms, in line with Institutionalism theory, that executive institutions have significant inertia and that previously established patterns continue to operate in the face of political change. By contrast, the reforms that the executive continues to push for and work on, regardless of the political setting, are those that are directly linked to the values, ethos and existence of the existing institution.

During this period of time, according to the study of the cultural - cognitive pillar, there was a desire to move towards the principles of the free market, and a mixed system of financing and provision of services was established. Analysing the dominant values model, it corresponded to a technocratic model, according to which the governance is based on reliance on officials who carry out monitoring and evaluation of the system, but in comparison with the earlier technocratic model of the time of the USSR, significantly reducing the role and functions of the state.

The significant difference that can be observed between the period when the MoW and the MoH are responsible for the sector is precisely in the administrative capacity: how much change is promoted, implemented, and enforced, which is largely due to the different scope of tasks set for each institution in the statutes establishing the institution. The problems created by the abandonment of the regulatory role of the State in the health sector in 1991 had a severe negative impact on the development of the sector because it was not centrally managed. It led to a series of problems that were undeniably linked to the underfunding of the health sector, but just as importantly to the absence of development and management of the sector, as, according to Institutionalism theory, is evidenced by the decision to create the MoH. With the creation of the new institution, the MoH, in 2004, one can see that the tasks that were removed in 1991 have been returned to the public administration – thus, in a sense, leaving the sector without development planning and management, supervision and regulation for 13 years.

In the following periods, when the regulatory role of the State was re-established under the MoH, the health sector was reformed and the long-standing problems of the previous period were addressed: development plans were drawn up for service provision, human resources and the implementation of information systems. However, for all these strategies, concepts, guidelines and plans, health financing was an essential prerequisite. Although health funding has increased substantially in absolute terms, when health expenditure is compared as a share of total budget expenditure or as a share of GDP, there has not been a significant increase in health funding. This, in turn, is due to the historical dependence of institutionalism and the past, which determines that past practices and patterns continue to exist until times of crisis. This also explains the fact that health funding is only increased at times of crisis, when there are significant problems in society with access to health services and civil society takes certain types of

action – calling strikes, protest actions and other activities that, in a sense, force politicians to respond to public pressure.

In addition to these basic observations on the lack of institutional capacity and the underfunding of the sector, the research process has made a number of observations on the implementation and enforcement of health policies in Latvia. The analysis of the pre-election programmes of political parties and their comparison with the political changes in health policy that have been promoted and implemented shows that the political parties elected to the Parliament do not influence or play a significant role in the implementation of health policy. This is evidenced by the "disappearance" of the priorities written into the election programmes of political parties from the political agenda when the government and the government declaration are formed and approved.

Despite the fact that in Latvia the Parliament has the decision-making power, all reforms implemented in the health sector in the period 1990–2020 have been initiated, promoted and implemented through the executive branch – the MoH (or the MoW until the establishment of the MoH), which is both the writer and promoter of the draft law, and the implementer. Given that the leading driver of legislative change in the health sector is the public administration – initially the MoW, later the MoH – as public organisations, they tend to make their activities a routine and create standard procedures. This, in turn, creates inertia that has a significant impact on the work of government but a disabling effect on the implementation of any change. The past dependence tendencies may not only manifest themselves in this primitively inhibiting way, but are also sometimes observed in another way: by creating a new rule to compensate for the effects of another rule, but not by deciding to repeal the previously created imperfect rule or law.

When analysing the political process of reform in the health sector, the established Parliamentary commissions in charge of the sector are also failing to

play their full role. For example, the opinions expressed in the Social and Labour Affairs Commission are basically informative and do not influence the adoption of bills in the Parliament as the votes in the Parliament are motivated by the leading coalition and the opposition. Even if the representatives of the respective political parties oppose a bill in the debates in the commissions, once it reaches the Parliament, the vote bases on the political affiliation and support of the submitter and the promoter in the coalition, not on the merits. This phenomenon can be explained according to the Rational Choice Institutionalism and the fact that votes in Parliament do not reflect the personal attitudes and preferences of particular politicians, but should be seen as strategic decisions, taken on the basis of the strategic decisions of a particular group and in the light of shared fundamental values and agreements. This observation, when the opinion expressed in the commissions differs from the vote in the Parliament, can be explained by the common understanding of the coalition or political party alliance and the coalition's agreement to support strategic issues. Another important condition for the adoption of reforms is the timeframe and proximity to the next elections, especially in the case of changes involving not only amendments to cabinet regulations but also amendments to laws.

Long-term process studies have shown that not only the political party affiliation of a minister in a given area, but also the support for the reform from the Prime Minister and the Minister of Finance, play a crucial role in driving a reform forward. Even in cases where the minister is initially a non-partisan person, but is nominated by a particular party and enjoys its political support. This is clearly illustrated by the analysis of the implementation of the reforms and the periods when the health sector was recognised as a common political priority of the ruling coalition, with the necessary funding being allocated to it, due to the existence of the “iron triangle” – where one political force is represented by the Minister for Health, the Minister for Finance and the Prime

Minister. This observation, based on the theory of Institutionalism, can be explained by normative predominance, where ministers from one party are endowed with significantly more power and resources based on normative preferences; they have institutionally more influence on resource reallocation issues, which gives them a significant advantage compared to other cases where a minister represents another political force. This normative predominance of power also indicates that the institution within which the minister is located is much more important than the abilities of the individual minister, and although the formally delegated power and rights of all health ministers are the same, being part of this institution significantly increases the influence of the individual.

Analysing the factors that influence the design and implementation of health policies from a cultural-cognitive perspective, over time there has been a regular change of ideological course. It has hindered the implementation of policy changes between right-liberal and social-democratic orientations. Since independence in 1990, there has been a conviction among the ruling political forces that health is a distinctly free market commodity. It has led to a rejection of the approach to regulation and common budget financing, calling for free market and competition principles to be introduced, but responsibility for individual's health and health problems to be left entirely to the individual. However, in the face of the consequences of such changes – inequalities and problems of access to services, as well as the desire to approach the level of European welfare states and social democratic values – the ideological course is changing, with the promotion of increased health financing. However, in the context of the economic crisis, the same free-marketers are again gaining the upper hand as the dominant forces, thus changing and confusing the direction of European social democracy once again. Such ideological vacillation and the absence of a single recognised clear model of values create a situation where

changes are made but the necessary funding is not provided to implement the changes and therefore the objectives of the reform are not achieved.

In the long term, the New Institutionalism insights about the influence of the past and the preservation of institutional balance in the form of institutional inertia are clearly observable in the characterisation of health policy-making and implementation in Latvia. The early phase of reform in the early 1990s, marked by a global shift in political and ideological course, positioned as the complete opposite of the existing order, and associated with a return to the pre-occupation growth phase, is a window of opportunity for rapid and significant reform, building a completely new system from the ground up. In the period when a complete change of values, practices, and culture is taking place, there are no major constraining factors that would contribute to institutional inertia. In contrast, at a later stage, when certain institutional practices, norms, and values have already been established, it is not possible to make significant changes – for example, by reversing the earlier and unsuccessful course towards free market principles – and only small incremental changes to improve and refine existing practices take place in the next stages.

Institutional inertia and the influence of the past can also be observed in the change of the governance model, which, according to the results of the study, only took place in 2016 with the full involvement of the public (both representatives of the sector and patients' representatives) in health policy, as indicated by the interviewed representatives of the non-governmental (NGO) sector. In contrast, in previous periods, cooperation was not described as participation and involvement of partners, but the NGO sector was rather seen as one of the potential performers to whom a certain task or function can be delegated.

This observation does not match the practice described in other countries, where doctors are credited with vetoing many political issues and introducing

reforms or delaying their implementation. As the study of the health policy reform shows, in Latvia associations and trade unions representing medical practitioners, patients, and service providers have begun to identify their role and impact and actively use their participation only in recent years. Although organizations representing medical practitioners have carried out various activities, including protest actions and strikes, the right of veto in the political decision-making of certain issues has not been not observed so far. Thus, it can be concluded that the representation and influence of the sector in political decision-making is relatively small and insufficient.

From this, it can be concluded that in the Latvian health policy field, in order to achieve the principles of good governance that have been in place in Europe since the 1990s, it took 25 years to break free from the institutional patterns of the past and to be able to change policy-making and implementation practices in an incremental way.

Summarising the results of the analysis, it can be concluded that the health system in Latvia has undergone a fundamental change and political course reversal in 30 years – from a highly centralised planned economy, through a period of de-centralisation and de-regulation guided by a free market approach, and finally to a new type of re-regulation approach. These processes have not only seen a change in the practices implemented – through certain types of policy decisions – but also a change in society and in perceptions of the role of health in the overall economy and a shift in views: from health care as a service to health care as part of human rights.

The approach used in the study, analysing not only the health sector in isolation, but also public policy-making and implementation practices in general, analysing the cultural-cognitive, regulatory and normative pillars, revealed broader concepts prevailing in society, priority directions for national development. It also highlighted the different perceptions between the

legislative, executive and the sector's own views on health policy and its values. The approach of Historical Institutionalism and tracing processes, in addition to the previously known reasons of underfunding of the sector, revealed the impact of past events on the decisions taken, namely: the lack of knowledge in the 1990s about the differences between the health economy and the production economy, the negative aspects of the free market and de-regulation on the development of the health sector. The analysis of the regulatory pillar, on the other hand, revealed and helped to explain the global national objectives and priorities in the legislative and executive organisation, which explained why health was not identified as a priority and its development was not targeted. The analysis of the normative pillar revealed differences between the legislative and executive perceptions of the development of the field, its challenges, and the issues to be addressed. The event tracing approach and a systemic view of all three pillars, complemented by quantitative data analysis, further revealed gaps between the tasks and outcomes for the executive, which revealed a lack of institutional capacity.

The interviews conducted with various staff involved in the health sector revealed gaps between the theoretical, legislative role and tasks of governance "on paper" and the actual governance of the sector. The views expressed on cooperation and its characteristics revealed different perspectives on the role and tasks of public administration in cooperation with the NGO sector, as well as the fact that it takes a long period of change and possibly generations to translate the regulatory norm into institutional practice. Thus, one can conclude that the implementation of health reforms cannot be seen as a technical process of change, but primarily as a political process, influenced by many different political aspects, as well as by the ecosystem in which these changes are implemented, and by external conditions.

The model used in this study, applying a Historical Institutionalism and a process tracing approach, analysing the cultural-cognitive, regulatory and normative pillars, can be used to analyse not only health policy, but also other socially relevant policy processes and changes – for example, changes in social security (pensions, benefit systems) or education. Such a broad and comprehensive field study would not be useful for the areas that generate funding – the so-called "profit sectors". However, it could provide explanations and justifications for decisions on why a significant share of the budget is or is not allocated to a particular social function – as such an approach reveals general concepts that are long-term and have a global impact on society, its prevailing values, ideologies and priorities.

Publications

The results of the dissertation have been published in the following scientific publications:

1. Bikava, I., Kreituse, I., Skride, A. 02.12.2020. The voice of Society in Healthcare politics in Latvia. Proceedings of Conference "Society. Health. Welfare 2018". DOI: https://doi.org/10.1051/shsconf/20208501001.
2. Bikava, I., Kreituse, I. 25.11.2019. How will Future Health Policy Impact Regional Disparities and Healthcare in Latvia. Proceedings of Conference "Society. Health. Welfare 2018". DOI: https://doi.org/10.1051/shsconf/20196802001.
3. Bikava, I., Skride, A. 25.11.2019. Healthcare Accessibility and Disparities in Medical Staff Availability in Latvia. Proceedings of Conference "Society. Health. Welfare 2018". DOI: https://doi.org/10.1051/shsconf/20196802003.
4. Bikava, I., Kreituse, I. 2019. Cooperation and Collaboration Impact on Policy Development: HIV/AIDS Policy in Latvia. Sociology Study, March 2019, Vol. 9, No. 3, doi: 10.17265/2159-5526/2019.03.001.
5. Bikava, I., Kreituse, I. 2018. Governance – the key factor of E-health implementation in Latvia. 5th International Multidisciplinary Scientific Conference on Social Science and Arts SGEM Vienna 2018. Volume 5. Political science. DOI: 10.5593/SGEMSOCIAL2018H/11/S01.002.
6. Bikava, I., Kreituse, I. 31.01.2018. Interest group impact on E-health implementation in Latvia. SHS Web of Conferences 40, 02001 (2018) International Conference SOCIETY. HEALTH. WELFARE 2016. DOI: https://doi.org/ 10.1051/shsconf/20184002001.
7. Bikava, I., Skride, A. 31.01.2018. Evaluation of healthcare policy in Latvia. SHS Web of Conferences 40, 02002 (2018) Int. Conf. Society. Health. Welfare 2016. DOI: https://doi.org/10.1051/shsconf/20184002002.
8. Bikava, I., Skride, A. 2017. Latvijas veselības aprūpes finansēšanas modeļa maiņas lietderības novērtējums (Utility Assessment of Healthcare Financing Model Change in Latvia). RSU Zinātniskie raksti 2016 sociālo zinātņu nozares pētnieciskā darba publikācijas. Politika, Rīga, RSU, 2017, 5–12.

The results of the dissertation have been presented in the following abstracts on scientific conferences:

1. Bikava, I., Kreituse, I. 03.2021. Path Dependency and Institutional Inertia in Health Politics in Latvia. The 63rd International Scientific Conference of Daugavpils University.
2. Bikava, I., Kreituse, I. 04.2019. Cooperation and Collaboration impact on Policy Development: HIV/AIDS policy in Latvia. PLACES in Knowledge for Use in Practice. Rīga Stradiņš University, Riga.

3. Bikava, I., Skride, A. 10.–12.10.2018. Healthcare Accessibility and Disparities in Medical Staff Availability in Regions of Latvia. 7th International Interdisciplinary Scientific Conference “Health, Society, Welfare”, Riga.

4. Bikava, I., Kreituse, I. 10.–12.10.2018. How Strong is the Voice of Society in Healthcare Politics in Latvia? 7th International Interdisciplinary Scientific Conference “Health, Society, Welfare”, Riga.

5. Bikava, I., Kreituse, 10.–12.10.2018. I. How Will Future Health Policy Impact Regional Disparities and Healthcare in Latvia? 7th International Interdisciplinary Scientific Conference “Health, Society, Welfare”, Riga.

6. Bikava, I., Kreituse, I. 22.03.2018. Programmas nozīme Latvijas politisko partiju mērķu noteikšanā (The meaning of the Programme in the Process of setting the Goals of the Political Parties in Latvia). RSU Scientific Conference.

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