# No reforms, no staff - where is inpatient healthcare heading?

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# Audit report

No reforms, no staff - where is inpatient healthcare heading?
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Performance audit “Is inpatient healthcare planned and organised effectively?”
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The cover design includes an image from website http://depositphotos.com, *Blurred figures of with medical uniforms in hospital corridor*, author: vilevi, ID 10896568.

# Dear Readers,

The geopolitical situation dictates harsh conditions for state budget planning, where defence is inevitably the priority. Meanwhile, Latvia already has one of the lowest state budget expenditure on healthcare, that is, only 5.3% of GDP in 2023, while an average in the European Union was 7.3%. Therefore, it using every euro allocated to healthcare as efficiently as possible is more important than ever.

Every year, approximately 700 million euros or 40% of the total healthcare funding is allocated to inpatient healthcare, which is necessary for the most complicated cases of illness and is therefore the most cost-intensive form of healthcare. In addition, the number of practicing doctors and nurses per 100 thousand inhabitants in Latvia is among the lowest in the European Union and the lowest in the Baltic States. At the same time, the population is decreasing and the insufficient flow of patients, especially in the regions, does not allow to provide doctors with sufficient practice, which can affect the quality of inpatient healthcare and the health safety of patients negatively.

The basis of an effective inpatient healthcare system is a purposefully established network of medical institutions, which takes into account the number of inhabitants, travel distance, medical staff capacity and sufficient practice opportunities, including healthcare plans in crisis situations and, finally, cost-effectiveness.

The Ministry of Health supposedly implemented a reform of the network of medical institutions in 2018. Unfortunately, the audit findings confirm that no changes have occurred in essence, as a result of which money is spent, but the results are lacking and everyone is dissatisfied, both patients and medical institution staff.

For example, there are medical institutions that hospitalise only two patients a day, there are institutions that admit stroke patients, although the neurologist is available only a few hours a day, or where the patient is met by a doctor who has been working several on-call shifts in a row, or an intern who is not certified in the specialty and whose work supervision raises questions. The same thing happens in admission departments, as medical institutions of all tiers together were unable to provide as much as 53% of the specialists' on-call hours during the audit.

The state spends approximately 100 million euros per year on the operation of admission departments alone, however, there are admission departments for whose operation the state pays close to a million euros, but they are actually reception offices because they only accept planned patients and emergency medical teams do not bring even one patient there per day. The audit confirms that the existence of lower-tier medical institutions depends on the funding of admission departments, which they receive regardless of the number of patients and the services provided. In their turn, higher-tier medical institutions such as "*Rīgas Austrumu klīniskā universitātes slimnīca*" Ltd (Riga Eastern Clinical University Hospital) and state-owned "*Paula Stradiņa klīniskā universitātes slimnīca*" Ltd (Pauls Stradins Clinical University Hospital), which accept more patients in serious condition and provide more complicated healthcare services do not receive fair payment for that due to the current payment system.

These problems are known in the health sector, however, the decisions not taken indicate a long-term lack of political determination. Therefore, we hope that the audit report by the State Audit Office of Latvia will be an open and useful roadmap for urgent reforms. We would like to thank the Ministry of Health and the National Health Service for their cooperation, as well as all inpatient medical institutions for the information and opinions provided.

Respectfully
Ms Maija Āboliņa
Department Director

# Summary

## Main conclusions

**Inpatient healthcare in Latvia is not organised according to the needs of patients and in the best possible way. The Ministry of Health has not ensured effective management of the network of medical institutions and planning and payment of inpatient healthcare services. As a result, patients do not receive equivalent services in the medical institutions of the same tier and the limited funding has not been used equally efficiently.**

**We agree that the available funding affects the type of inpatient healthcare we can afford in the country significantly, however, the audit has identified a number of irregularities that the Ministry of Health has not eliminated for a long time.**

Inpatient healthcare services are provided by 41 medical institutions. Total inpatient healthcare funding has increased by an average of 8% per year from 2021 to 2024 by reaching 700.2 million euros in 2024, which is approximately 40% of total healthcare funding.

### I. The Ministry of Health is not acting in the public interest when managing the network of medical institutions

The Ministry of Health of Latvia and the National Health Service of Latvia began cooperation with the World Bank more than 10 years ago. As a result, the World Bank recommended how to optimise the network of medical institutions in 2016 taking into account the number of inhabitants, travel distance and other criteria. The most optimal scenario: to maintain 20 acute healthcare institutions and divide them into four tiers by differentiating the available inpatient healthcare services, while transforming some of the remaining institutions into daycare or long-term care institutions. Such optimization of the inpatient healthcare network provided significant benefits like saving funding, improving the quality and accessibility of services and increasing the satisfaction of population.

Although the Ministry of Health implemented a reform of the network of medical institutions in 2018 and divided medical institutions into tiers, the goal of the reform to eliminate disparities in inpatient healthcare in different parts of Latvia and to use available resources rationally has not been achieved. The number of medical institutions has not changed overall. In their turn, the differentiated service groups or profiles that must be provided in medical institutions of the same tier differ, as they are adapted to the actual capabilities of each institution.

There were 40 medical institutions before the reform in 2018, and the number changed to 39 after the reform and to already 41 medical institutions in 2025. In addition, medical institutions were divided into five tiers instead of four while the recommendation to transform the lower-tier medical institutions into daycare or long-term care institutions was not implemented. During the audit, the Ministry of Health did not provide an opinion on the reasons why the reform resulted in the creation of a network

of medical institutions that differed from that recommended by the World Bank and indicated in the 2017 Conceptual Report on the Reform of the Healthcare System.

Depending on the tier, medical institutions must provide a total of 29 different profiles (e.g., therapy, surgery, paediatrics, stroke unit). The mandatory profiles determine which tier the medical institution corresponds to while the specified tier also affects the funding available to the institution. However, the legal framework already provides for exceptions when a medical institution does not have to provide a mandatory profile. For example, two IV-tier medical institutions, "*Jelgavas pilsētas slimnīca*" Ltd (Jelgava City Hospital) and "*Jēkabpils reģionālā slimnīca*" Ltd (Jēkabpils Regional Hospital), and one I-tier medical institution, "*Limbažu slimnīca*" Ltd (Limbaži Hospital) do not have to provide a mandatory care profile.

In addition to the division of profiles according to their tier, medical institutions can also provide certain service programs within each profile, which can be very specific, but they may not be provided for all medical institutions that provide the relevant profile. It means that if a medical institution does not have a service program corresponding to the profile, the profile can be implemented within the framework of other profiles, for example, in the therapy profile service program "Other therapeutic services". The data also shows that in 2024, the majority of hospitalizations in medical institutions of all tiers fall under two profiles, that is, therapy and surgery, although, for example, in IV-tier medical institutions, a total of 17 mandatory and 11 optional profiles have been established.

Consequently, the distribution of profiles and their service programs by tier of medical institutions does not work in practice and is not traceable. Therefore, the country as a whole does not have complete information on what service profiles each medical institution provides in order to make data-based decisions.

The quality of inpatient healthcare services is related to the volume of services provided. Therefore, re-profiling of medical institutions not only concentrates services in medical institutions of the appropriate tier to optimise resources but also ensures sufficient volume to maintain the quality level.

Although the reform of the network of medical institutions envisaged setting requirements (staff, material and technical support, volume) for medical institutions at each tier in order for them to be allowed to provide services of the specified profile, the Ministry of Health has not set them to this day. Therefore, medical institutions provide inpatient healthcare services with the resources available to them or do not provide them at all, and the volume and quality of services vary, and the actual availability is not what was intended as a result of the levelling of medical institutions.

Only in 2021, a working group established by the Ministry of Health developed requirements for the provision of certain profiles (chronic patient care, surgery, paediatrics, pregnancy and maternity care, treatment of COVID-19 patients); however, inter-institutional coordination was not achieved. Also in 2025, the Ministry of Health continues to develop requirements, which it plans to implement from 1 January 2026. Still, the informative report planned by 1 April 2025 was not submitted to the Cabinet of Ministers. In addition, the auditors draw attention to the fact that 10 years will have passed in 2026

since the World Bank recommended that one also assessed the fulfillment of minimum quality criteria in medical institutions, which was postponed several times, and they are also planned to be applied from 1 January 2026.

To assess whether medical institutions provide inpatient healthcare services that are appropriate and equivalent to their tier, the audit analysed the provision of four service profiles randomly such as therapy, surgery, paediatrics, and stroke units in all relevant I to IV tier medical institutions.

In fact, medical institutions of the same tier do not provide equivalent inpatient healthcare services, and these differences not only create inequality in patient care but also affect the fact that funding is not spent equally efficiently but with different returns.

The number of hospitalizations differs significantly in medical institutions of the same tier. This indicates a different flow of patients and the volume of services, which affects quality. For example, in the therapy profile, the number of hospitalizations in the I-tier medical institution, "*Līvānu slimnīca*" Ltd (Līvāni Hospital) is more than 90% lower than in other medical institutions of this tier, as less than two patients are hospitalized per month in this profile one patient per day on average is hospitalise in other profiles.
The number of specialists is not sufficient to ensure their continuous availability. For instance, the total number of neurologists in the stroke unit is less than three loads in three medical institutions while it does not even reach one load in "*Jēkabpils reģionālā slimnīca*" Ltd, therefore, it is not possible to have a doctor available 24 hours a day, seven days a week. The number of hospitalisations on average per month per load of the relevant specialist differs significantly in medical institutions of the same tier. For example, in the paediatric profile, the IV-tier medical institution, "*Rēzeknes slimnīca*" Ltd (Rēzekne Hospital) has 106 hospitalizations per paediatrician load, but "*Daugavpils reģionālā slimnīca*" Ltd (Daugavpils Regional Hospital) has 23 hospitalisations. The number of profile beds and load in medical institutions of the same tier also differ. For instance, all II-tier medical institutions have from 9 to 21 surgical profile beds, but the average bed load is from 3% to 54% in three medical institutions although the optimal bed load is considered to be 75%.

The intensity and variety of inpatient healthcare services provided in medical institutions differ much. For example, in the surgical profile of the IV-tier medical institution "*Ziemeļkurzemes reģionālā slimnīca*" Ltd (North Kurzeme Regional Hospital), the number of major surgical operations per month per surgeon is 75 while it is 25 in "*Jelgavas pilsētas slimnīca*" Ltd. In the opinion of the Ministry of Health, low surgical activity also does not allow to provide a medical practitioner with sufficient experience.

After the reform, the Health Inspectorate assessed the compliance of inpatient healthcare services with the tiers of medical institutions on behalf of the Ministry of Health in 2019, 2020 and 2024 and found significant discrepancies that even posed a risk to the health safety of patients. For instance, some medical institutions do not provide various types of services at all (endoscopy, neurology, traumatology, etc.) because they lack specialists and are unable to provide specialists on duty 24 hours a day in emergency medicine and patient admission departments.

Although the inspections by the Health Inspectorate have identified significant problems in inpatient healthcare, no changes have been made. The information in the informative reports forwarded to the

Cabinet of Ministers is selective, as all the most significant problems are not included at all or are not reflected clearly enough. In addition, the Ministry of Health withdrew some of them because, for example, it did not achieve inter-institutional coordination or did not receive a decision from the Prime Minister on further action. All this indicates a lack of support from both the health sector and other ministries in making unpopular, yet important decisions for the public.

Decisions not made in time affect both the quality of inpatient healthcare services and patient health safety, and funding. For example, if a III-tier was assigned to a IV-tier medical institution, the fixed surcharge for the operation of the emergency medical care and patient admission department, and patient observation for up to 24 hours would be reduced by 40%. Moreover, the Ministry of Health increased the funding of emergency medical care and patient admission departments from 1 May 2024 although the Health Inspectorate recommended discontinuing their funding in lower-tier medical institutions after the inspections in 2019 and 2020. If a decision had been made not to finance the 24-hour emergency medical care and patient admission departments of I-tier and II-tier medical institutions from 2020, then an average of 10 million euros per year would not have been allocated to their operation.

The auditors are critical of the monitoring mechanism for inpatient healthcare services, as the practical possibilities of the National Health Service of Latvia to implement it comprehensively and systematically in an objective manner are limited. Thus, the provision of inpatient healthcare services depends primarily on the good faith of the medical institution, rather than on the inspections by the Service.

## II. Inpatient healthcare services are planned and paid for without taking into account the patient needs and without spending resources optimally

Limited funding for inpatient healthcare is a key factor that prevents services from being planned in line with patient needs. In its turn, the use of existing inpatient healthcare funding, influenced by historically formed and outdated calculations, is not optimal, as it does not balance either resource consumption or the quality and complexity of the inpatient healthcare service provided fairly.

The main payment methods for inpatient healthcare services are fee for DRG services according to the diagnosis-related group (DRG) payment system and designated services according to single-patient treatment tariffs. However, there are also a number of other payment methods that create an administrative burden for medical institutions and reduce the ability of the National Health Service to ensure sufficient monitoring of the spending.

### Services are paid for using a poorly implemented system and outdated tariffs

DRG is an internationally recognized classification system for recording inpatient healthcare services, as it groups patient treatment cases into groups related to diagnoses taking into account the age, gender, duration of treatment, diagnosis and manipulations performed. In 2024, the National Health Service paid 294.6 million euros or 43% of the total inpatient healthcare funding to medical institutions for DRG services.

The DRG service payment system has been implemented only partially for more than 10 years and does not achieve the goal of cost-effectiveness and fairer payment of inpatient healthcare services taking into account the complexity of patient treatment cases.

Medical institutions do not have sufficient understanding of the appropriate coding of patient treatment cases in the DRG service payment system, and this affects the planned financing of the medical institution. Although the availability of actual costs of inpatient healthcare services is an important prerequisite for the DRG service payment system, such data is still not collected centrally. Also, the payment of atypical (expensive) patient treatment cases is not separated, and the diagnosis groups are not always homogeneous. This contributes to the fact that the state overpays medical institutions for simple patient treatment cases but it underpays for complicated ones in such an incompletely implemented DRG system. Due to the aforementioned shortcomings, it is precisely the V-tier medical institutions, namely, "*Rīgas Austrumu klīniska universitātes slimnīca*" Ltd and state-owned "*Paula Stradiņa klīniska universitātes slimnīca*" Ltd where 40% of patients are hospitalized. Although they provide inpatient healthcare services that are not available elsewhere, they are not adequately compensated for atypical (expensive) patient treatment cases. Furthermore, to fit into the 2025 budget, the funding for DRG services of these two medical institutions was mathematically reduced the most compared to the 2024 funding and the reduction for other medical institutions, thus not implementing an equal approach towards all medical institutions.
Contrary to the DRG service payment system, the designated services are paid for in the same way to all medical institutions according to the tariffs for the treatment of one patient regardless of the complexity of each patient treatment case. The tariff for the treatment of one patient is set for 63 designated service programs, for which the National Health Service paid 129.8 million euros or 18.9% of the total inpatient healthcare funding to medical institutions in 2024. The tariffs for the treatment of one patient for the majority of designated service programs have not been updated for more than 10 years. On the other hand, if some of them were updated, it is possible that funding savings could also be found. However, the National Health Service plans to make changes to the tariffs for the treatment of one patient when the bed-day tariff used in the calculation of these tariffs is also updated, and one will be able not only to reduce tariffs but also increase them.

The National Health Service has still not developed and introduced the principle of actual costs or at least current tariffs in the payment of inpatient healthcare services. Therefore, a solid basis has not been established that would allow for a comprehensive analysis of the use of funding and a reasonable determination of the amount of missing funding. This is also evidenced by the fact that the total funding received by medical institutions for both outpatient and inpatient healthcare services even exceeds its use by 2.9 million euros.

## The justification of salary costs cannot be traced; the number of inpatient healthcare staff is unknown

Both in the bed-day tariff and in the total expenditure of medical institutions, salaries constitute more than half of all expenses. The bed-day tariff, which is used to calculate the payment for both DRG and designated services, calculates the amount of salaries included by multiplying a historically determined number of minutes by the average salary for one minute. However, the National Health Service could not distinguish accurately what part of the total number of minutes was actually required for the provision of inpatient healthcare services and what part was an element of the tariff calculation, which gave the medical institution the basis to receive payment for additional payments since they were also expressed in abstract minutes.

The validity of the remuneration included in the bed-day tariff cannot be traced. Moreover, it is not known at the national level what kind of staff actually provide inpatient healthcare. Consequently, it is

impossible to ascertain whether the staff of medical institutions spend as much working time on providing services as is included and paid for in the bed-day tariff, and how this affects the quality of the service.

### Patient and funding planning is not transparent, needs-based and equitable

The volume of designated and DRG service programs is generally planned in accordance with statutory provisions, yet making various exceptions for individual medical institutions at the same time.

The National Health Service should determine the number of patients planned for DRG service programs in medical institutions by assessing the fulfillment of the specified quality indicators. However, they are currently being assessed only in state-owned *"Bērnu klīniskā universitātes slimnīca"* Ltd (Children's Clinical University Hospital) while one plans to begin assessing in other medical institutions only in 2026. When planning the number of patients for DRG services from 2023 to 2025, the National Health Service has applied different terms and conditions each year by adapting to the available funding and increasing or decreasing the planned number of patients for individual medical institutions as an exception.

Since there is no complete information at the national level about what profiles of inpatient healthcare services are actually provided by medical institutions, and the quality of services is still not assessed, there is no mechanism created to plan services more purposefully and strengthen those medical institutions that work more effectively, rather than maintaining all medical institutions under the same conditions of limited funding. Due to the aforementioned irregularities, the National Health Service also allows cases where the number of patients is planned according to the individual request of medical institutions, thus creating an unequal approach and making planning difficult to trace.

There are also certain exceptions to the patient planning procedure for designated service programs, namely, if an actual number of patients is less than planned, then it is determined in the previously planned amount. For instance, state-owned "*Bērnu klīniskā universitātes slimnīca*" Ltd plans 39 patients in the designated service program "Tuberculosis diagnostics and treatment in children" every year, although the services were actually provided to 11 patients in 2023 and to 6 patients in 2024. As a result, the medical institution is allocated an average of 473,884 euros more funding per year for the aforementioned program, which is later redistributed to other service programs.

The audit was not able to determine to which service or medical institution the funding obtained as a result of the replanning was directed because the funding went into the general budget reserve, from which it was redistributed according to the actual needs throughout the inpatient healthcare system. It is directed primarily to emergency and acute inpatient healthcare services and only then, to the extent possible, other medical institutions and their service programs are assessed. In fact, the total funding for inpatient healthcare services has been increased for all medical institutions included in the audit sample and the unused funding has been redistributed among service programs within the same medical institution. This practice does not allow for an impartial assessment of whether the reprogrammed funding is directed towards national priorities or priorities of individual medical institution.

## III. Inpatient emergency medical care is not planned and organised effectively and efficiently

36 out of 41 medical institutions also provide emergency medicine and patient admission departments, for which the National Health Service paid 96.2 million euros in 2024, or 14% of the total funding for inpatient healthcare.

The network of emergency medicine and patient admission departments lacks justification, as it was created without taking the actual flow of patients into consideration, and therefore does not operate equally effectively. Also, medical institutions do not provide equivalent services within the same tier, and there are significant differences in the efficiency of funding spent.

In 2024, 37% of the total number of patients in emergency medicine and patient admission departments were admitted to V-tier medical institutions, 32% to IV-tier medical institutions, 12% to III-tier medical institutions, and 3% to I-tier and II-tier medical institutions each while the remaining patients were admitted to other medical institutions. In their turn, it is the lower-tier medical institutions that are more dependent on the funding of the emergency medicine and patient admission department, which they receive regardless of the number of patients and the services provided. Higher-tier medical institutions receive the majority of the funding for inpatient healthcare services of various profiles.

The audit identified such I-tier and II-tier medical institutions where the number of patients transported by emergency medical teams was from one patient in twenty days to five patients in two days in 2024. Meanwhile, for instance, the number of such patients was from 16 to 36 patients per day in IV-tier medical institutions. The volume of services provided in the emergency medicine and patient admission departments of medical institutions of the same tier also differs significantly. The average costs per patient in emergency medicine and patient admission departments also differ significantly. For example, these were 350 euros in a II-tier medical institution in 2024 while these were 130 euros, or two and a half times less in a IV-tier medical institution. We agree that the average costs per patient cannot be the only indicator in the evaluation of the network of emergency medicine and patient admission departments, yet they are also an important indicator, especially in conditions of limited funding.

The need to evaluate the network of emergency medicine and patient admission departments is also evidenced by the medical institutions identified in the audit where no patient has been hospitalized for emergency treatment and the emergency medical team has not delivered any patient to this institution as a result of a call still the institution receives funding for the emergency medicine and patient admission department. On the other hand, there are also medical institutions that do not receive such funding but hospitalise patients for emergency treatment including those brought by an emergency medical team.

The establishment of emergency medicine and patient admission departments in I-tier medical institutions has not been assessed and justified sufficiently. Despite the World Bank's recommendations to transform these institutions into daycare centres, the existing emergency medical care points in them have been transformed into emergency medical care and patient admission departments as part of the reform. In addition, the six emergency medical aid points that still exist today have provided assistance to a total number of patients, which is 42% of the total number of patients in the emergency medicine and patient admission departments of I-tier medical institutions. These points provide a more diverse range of healthcare services, and the funding for maintaining one

point is on average 40% less than the funding for one emergency medical care and patient admission department. If emergency medical aid points were maintained in I-tier medical institutions, they would cost 2.5 million euros less per year than the existing emergency medical care and patient admission departments.

The requirements for the provision of specialists in the emergency medicine and patient admission department have not been carefully considered, are not adapted to the flow of patients and are not practically feasible. Therefore, the Ministry of Health has not achieved the set goal, to ensure that patients in the emergency medicine and patient admission department of any medical institution of any tier are met by a team of specialists who provide the necessary assistance.

In 2024, the Ministry of Health began to strengthen emergency medicine and patient admission departments of medical institutions at all tiers and increased their funding. Almost all designated specialists must be constantly present in the emergency medicine and patient admission department, and they may not be employed simultaneously in other structural units during their on-call time, such as inpatient or outpatient departments.

The existing requirements for specialists in emergency medicine and patient admission departments have not been considered thoroughly because they cannot be met in full in the existing network of departments due to either a lack of specialists or the low average salary set in the law. Apart from that, medical institutions consider that planning the work of all specialists on a 24-hour basis is not necessary. Publicly available data show that the average actual salary in inpatient medical institutions from state budget funds exceeds the average salary included in the payment for healthcare services by an average of 40%. This is also explained by the audit finding that medical institutions were unable to provide all the necessary specialists in the emergency medicine and patient admission departments and they directed a part of the received funding to finance the motivation and work intensity of existing specialists. As mentioned above, there are also no specific requirements and it is not known at the national level which staff provide inpatient healthcare outside the emergency medicine and patient admission departments and to what extent. This makes tracking the provision of staff difficult and leaves the organisation of work to the medical institutions according to their capacity.

According to the auditors' estimate, medical institutions of I-tier to V-tier have not provided 53% of all the specialist on-call hours required in the emergency medicine and patient admission departments in September 2024, for which they received 3.1 million euros. In addition to the necessary specialist doctors, services in this department are actually also provided by residents, interns and medical staff of other specialties, and specialists combine work in the department with work in another structural unit of the medical institution or even in another medical institution simultaneously or sequentially. Similarly, medical institutions are also unable to provide all the nurses and nursing assistants required in the emergency medicine and patient admission departments. In addition, the National Health Service also found in 2023 that the necessary specialist on-call hours were not provided in the emergency medicine and patient admission departments for a total amount of 286,000 euros, which was withheld from the medical institutions. However, deductions for unsecured on-call hours in 2024 were not made at the time of the audit.

Moreover, the Ministry of Health set more general requirements for the replacement of specialists assigned to emergency medicine and patient admission departments at the suggestion of medical institutions during the audit. With these changes, the Ministry of Health adapts to the actual capabilities

of medical institutions to ensure the operation of emergency medicine and patient admission departments, and they are not related to a strategic vision of which specialists are actually needed in these departments on a 24-hour basis.

The Ministry of Health has implemented the patient observation service for up to 24 hours incompletely, as the observation criteria were developed late and patient observation is not provided as intended, thus the cost-effectiveness of observation has not been achieved.

Patient observation for up to 24 hours belongs to the emergency medicine and patient admission department, and its main goal is to avoid unnecessary hospitalisations. 28 out of 36 medical institutions provide patient observation for up to 24 hours and receive a fixed supplement for it. In 2024, the National Health Service paid 11.5 million euros to the medical institutions for patient observation for up to 24 hours, or 1.7% of the total inpatient healthcare funding.

The calculation of the payment for patient observation includes the remuneration of nurses and nursing assistants, the costs of catering and medical consumables. However, in almost all medical institutions, not additional but the existing specialists of the emergency medicine and patient admission department provide the patient observation, although medical institutions are unable to provide them in full even in these departments in most cases. Consequently, the National Health Service paid 4.3 million euros to 19 medical institutions for planned but unprovided nurses and nursing assistants on duty to ensure patient observation in 2024. In addition, not all medical institutions provide patient catering despite the fact that they receive funding for that.

In addition to the fact that the proportion of patients observed varies significantly across healthcare institutions, which is influenced by the late development of observation criteria, half of healthcare institutions refer less than 70% of patients to outpatient treatment after observation. It means that a fairly large proportion of patients are hospitalized after observation anyway, thus not ensuring the cost-effectiveness of observation.

## Key recommendations

Based on the audit findings, five recommendations have been made to the Ministry of Health by calling for a series of actions that will improve state-provided inpatient healthcare so that it is planned and organised in accordance with the needs and in the best possible way. It is expected that implementation of the recommendations shall:

- ✓ Optimise the network of medical institutions by reviewing the distribution of hospital healthcare service profiles and monitor that medical institutions provide service profiles that meet the requirements;
- ✓ Result in planning hospital healthcare services by linking available funding to the achievement of certain quality indicators taking into account the established national priorities and patient needs in the field of healthcare;
- ✓ Ensure that medical institutions receive fair and adequate funding for inpatient healthcare services;
- ✓ Optimise the network of emergency medicine and patient admission departments of medical

institutions by balancing the actual patient flow, costs, the requirements of the necessary specialists and the capacity of the medical institution to provide emergency care;

- ✓ Ensure an effective patient observation service for up to 24 hours by introducing clear criteria and monitoring that the service is provided according to the established requirements.