

# State of Health in the EU

# Latvia

Country Health Profile 2017

## The Country Health Profile series

The *State of Health in the EU* profiles provide a concise and policy-relevant overview of health and health systems in the EU Member States, emphasising the particular characteristics and challenges in each country. They are designed to support the efforts of Member States in their evidence-based policy making.

The Country Health Profiles are the joint work of the OECD and the European Observatory on Health Systems and Policies, in cooperation with the European Commission. The team is grateful for the valuable comments and suggestions provided by Member States and the Health Systems and Policy Monitor network.

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## Data and information sources

The data and information in these Country Health Profiles are based mainly on national official statistics provided to Eurostat and the OECD, which were validated in June 2017 to ensure the highest standards of data comparability. The sources and methods underlying these data are available in the Eurostat Database and the OECD health database. Some additional data also come from the Institute for Health Metrics and Evaluation (IHME), the European Centre for Disease Prevention and Control (ECDC), the Health Behaviour in School-Aged Children (HBSC) surveys and the World Health Organization (WHO), as well as other national sources.

The calculated EU averages are weighted averages of the 28 Member States unless otherwise noted.

To download the Excel spreadsheet matching all the tables and graphs in this profile, just type the following StatLinks into your Internet browser:  
<http://dx.doi.org/10.1787/888933593646>

## Demographic and socioeconomic context in Latvia, 2015

	Latvia	EU
Demographic factors	Population size (thousands)	1 978
	Share of population over age 65 (%)	18.9
	Fertility rate <sup>1</sup>	1.6
Socioeconomic factors	GDP per capita (EUR PPP <sup>2</sup> )	28 900
	Relative poverty rate <sup>3</sup> (%)	10.8
	Unemployment rate (%)	9.4

1. Number of children born per woman aged 15–49.

2. Purchasing power parity (PPP) is defined as the rate of currency conversion that equalises the purchasing power of different currencies by eliminating the differences in price levels between countries.

3. Percentage of persons living with less than 50% of median equivalised disposable income.

Source: Eurostat Database.

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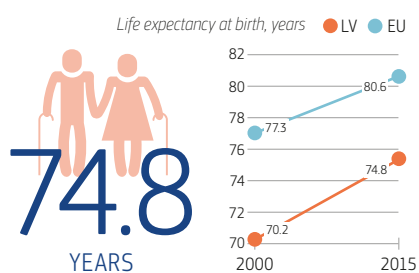
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# 1 Highlights

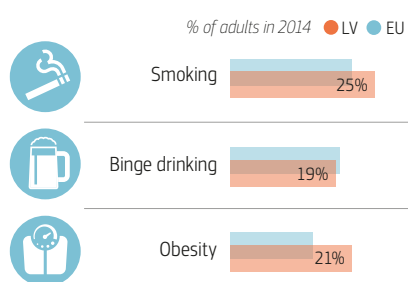
The life expectancy of Latvians improved over the past fifteen years, but still lags several years behind other EU countries. Large inequalities in life expectancy by gender and socioeconomic status exist, driven mainly by greater exposure to risk factors among men and people with low education and income, but also unequal access to health care. The Latvian health system is characterised by serious underfunding, which limits access to high quality and timely care for all.

## Health status



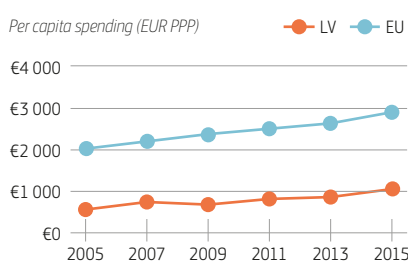
Life expectancy at birth was 74.8 years in 2015, up from 70.2 years in 2000, but still nearly six years below EU average. The gender gap in life expectancy (almost 10 years) is much greater than the EU average (5.4 years). There is also a huge gap by socioeconomic status: the life expectancy at age 25 of Latvians with low level of education is ten years lower than among those with high education. This is largely due to higher death rates from heart attack, stroke and lung cancer.

## Risk factors



In 2014, one in four Latvian adults were daily smokers, down from one in three in 2000, but still above the EU average. About one in five Latvian adults report heavy alcohol consumption on a regular basis, which is close to the EU average, but with substantial difference between men and women (33% versus 8%). Obesity rates are the second highest in the EU and on the rise: more than one in five adults in Latvia was obese in 2014 compared to one in six in 2008.

## Health system



The Latvian health system is underfunded. In 2015, Latvia spent EUR 1 071 per capita on health, the second lowest level in the EU, accounting for only 5.8% of GDP compared with an EU average of 9.9%. Only 57% of health spending is publicly funded (whereas the EU average is 79%), with most of the remaining spending paid directly out of pocket by households, raising severe accessibility issues.

## Health system performance

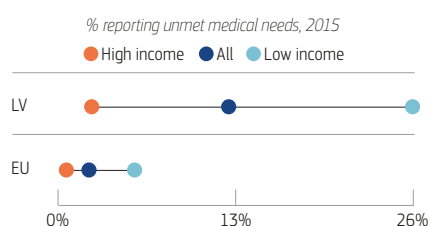
### Effectiveness

Amenable mortality in Latvia is the highest in the EU, pointing towards substantial scope for improving access to timely and effective care for life-threatening conditions.



### Access

Access to health care in Latvia is limited for a sizeable proportion of the population, with high numbers of people with low income reporting unmet needs for medical care for financial reasons, waiting times or geographic distance to access services.



### Resilience

Addressing the persistent underfunding of the Latvian health system is a prerequisite for improving access to good quality care for all the population. At the same time, the Latvian health system began to streamline the hospital sector, but the challenges are to strengthen prevention and primary care to improve population health and reduce health inequalities.



## 2 Health in Latvia

### Life expectancy in Latvia increased rapidly but remains the third shortest in the EU

Life expectancy at birth in Latvia increased by nearly five years between 2000 and 2015. Nevertheless, it remains the third lowest in the EU after Bulgaria and Lithuania (Figure 1). In 2015, life expectancy at birth of the Latvian population was 74.8 years, nearly six years lower than in the EU as a whole (80.6 years).

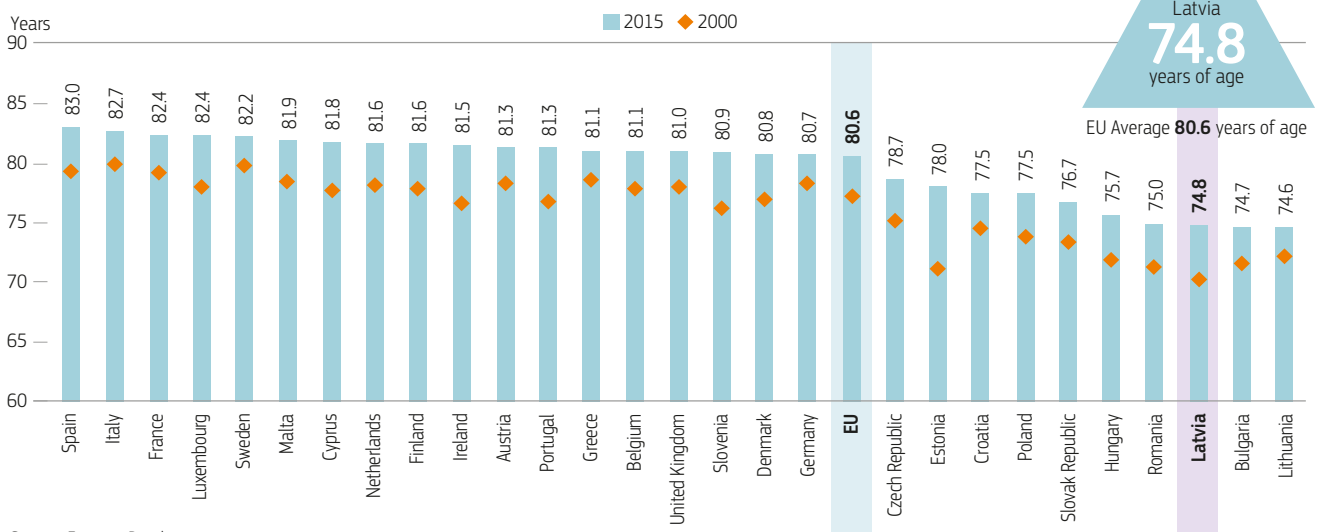
The gender gap in life expectancy in Latvia is among the largest in the EU: life expectancy at birth for men (69.7 years) is on average almost ten years shorter than for women (79.5 years). Furthermore, there is a considerable gap in life expectancy between socioeconomic groups. Life expectancy at age 25 among men and women who have not completed their secondary education is on average ten years less than those who have completed tertiary (university) education<sup>1</sup>. This is mainly due to a higher prevalence of risk factors, such as smoking, alcohol consumption and obesity,

resulting in higher death rates from cardiovascular diseases and different types of cancer (Murtin et al., 2017).

The gains in life expectancy in Latvia since 2000 have been driven to a large extent by reductions in mortality rates after the age of 65. The life expectancy of Latvian women at age 65 reached 18.9 years in 2015 (up from 16.8 in 2000), whereas the life expectancy at 65 for men reached 14.2 years (up from 12.3 in 2000). However, not all of these years gained are lived in good health. At age 65, Latvian men and women can expect to live four years of their remaining years free of disability, which corresponds to less than 30% of their remaining years. If the health and functional status of the Latvian population does not improve as they grow older, population ageing will inevitably put additional pressures on health and long-term care systems.

1. Lower education levels refer to people with less than primary, primary or lower secondary education (ISCED levels 0-2) while higher education levels refer to people with tertiary education (ISCED levels 5-8).

**Figure 1. Latvia has the third lowest life expectancy among all EU countries**



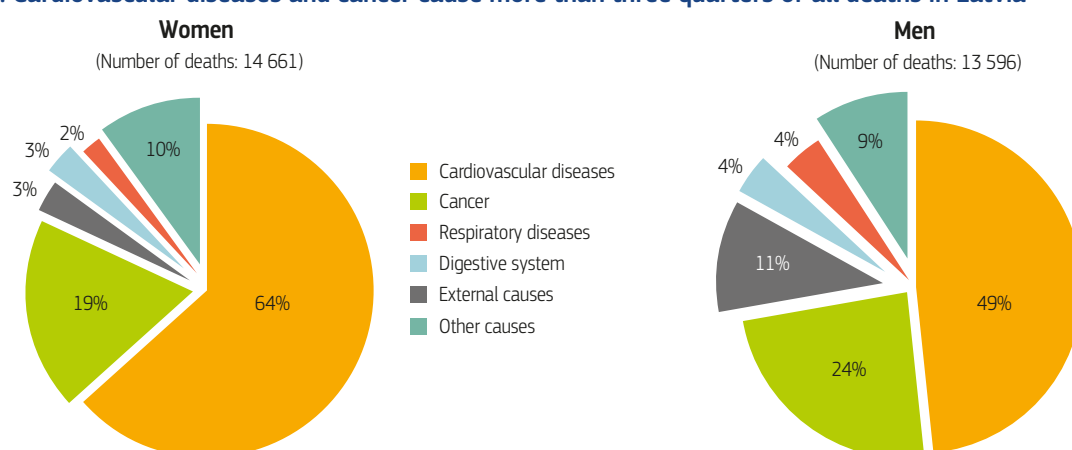
Source: Eurostat Database.

### The leading causes of death in Latvia are cardiovascular diseases followed by cancer

Cardiovascular diseases remain the leading cause of death for both women and men, and accounted for 16 100 deaths in 2014 (64% of all deaths among women and 49% among men). Cancer was the second leading cause of death in Latvia in 2014 (Figure 2). Nearly 6 000 people died from cancer, corresponding to 19% of deaths among women and 24% among men, while deaths due to external causes accounted for more deaths among men than women (11% among men and 3% among women).

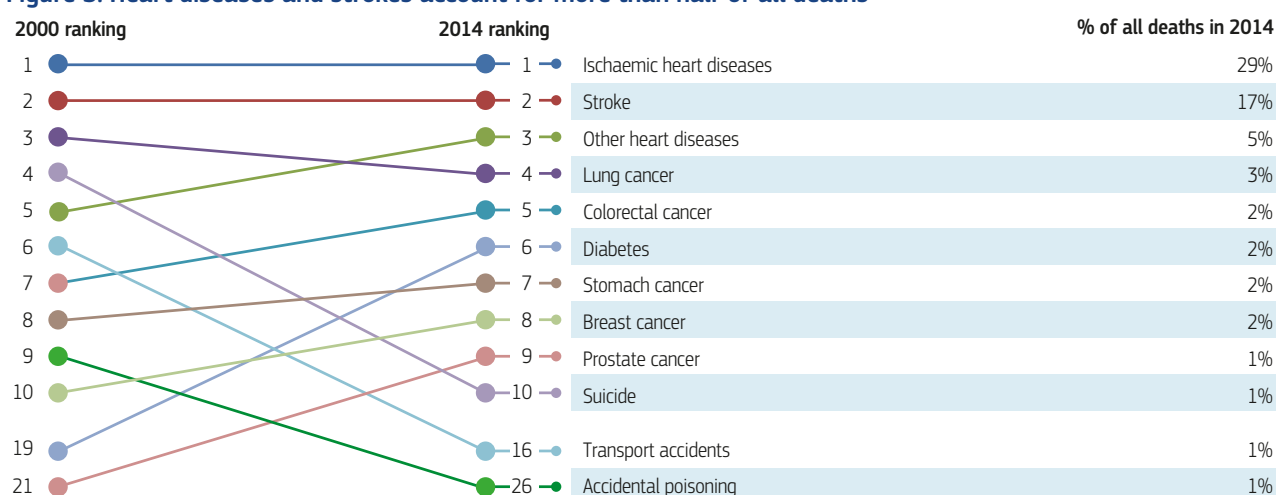
Looking at trends in specific causes of death, heart diseases and stroke have remained the two most common causes in Latvia since 2000 accounting for half of all deaths in 2014 (Figure 3). Lung cancer continues to be the main cause of cancer death, reflecting the long-term consequences of high smoking rates (Section 3). While five of the ten main causes of death in 2014 were due to different types of cancer, deaths caused by diabetes increased drastically between 2000 and 2014.

Death rates from suicides and traffic accidents have come down since 2000 but still remain important public health challenges in Latvia (Section 5.1).

**Figure 2. Cardiovascular diseases and cancer cause more than three quarters of all deaths in Latvia**

**Note:** The data are presented by broad ICD chapter. Dementia was added to the nervous system diseases' chapter to include it with Alzheimer's disease (the main form of dementia).

**Source:** Eurostat Database (data refer to 2014).

**Figure 3. Heart diseases and strokes account for more than half of all deaths**

**Source:** Eurostat Database.

## Musculoskeletal problems, mental health problems and diabetes are important contributors to disease burden

In addition to the burden of disease caused by cardiovascular diseases and cancers, musculoskeletal problems (including low back and neck pain), poor mental health and diabetes are also some of the leading contributors to disability-adjusted life years<sup>2</sup> (DALYs) lost in Latvia (IHME, 2016).

Based on self-reported data from the European Health Interview Survey (EHIS), nearly one in three Latvians live with hypertension, and one in twenty-nine lived with asthma. Wide inequalities persist in the prevalence of these chronic diseases by education and income level. People with the lowest level of education are over 50% more likely to live with asthma and more than twice as likely to live with diabetes as those with the highest level of education.<sup>3</sup>

2. DALY is an indicator used to estimate the total number of years lost due to specific diseases and risk factors. One DALY equals one year of healthy life lost (IHME).

## Latvia also faces challenges with various infectious diseases

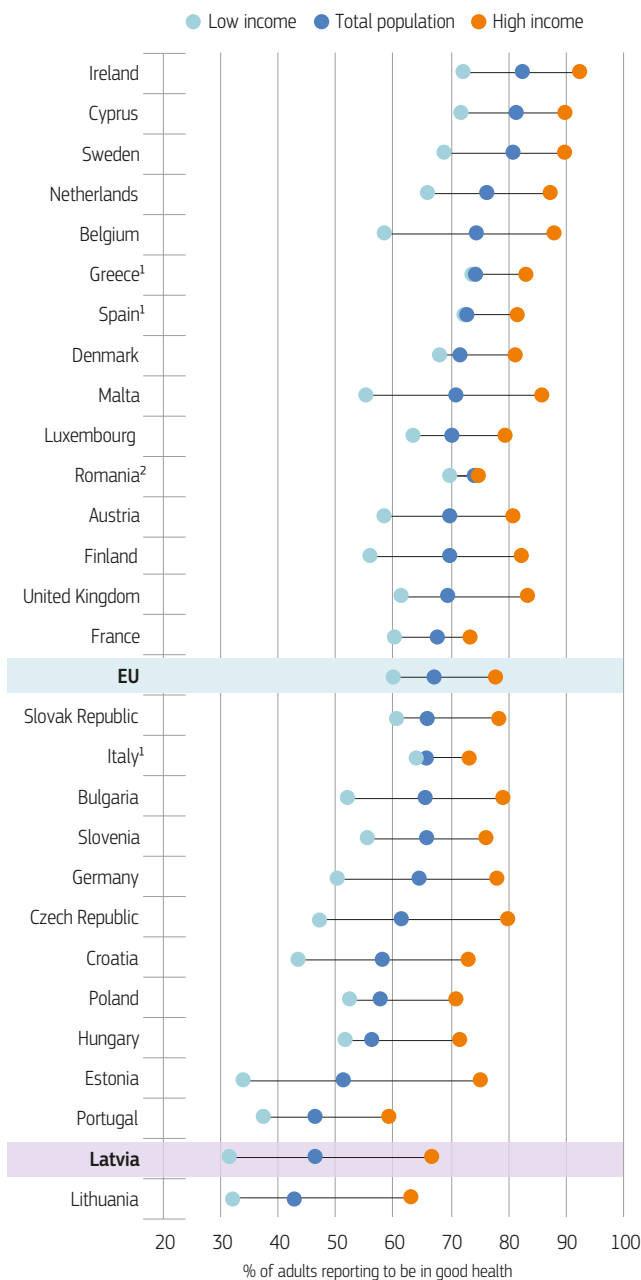
Latvia has higher levels of infectious diseases than most other EU countries with several communicable diseases still posing major threats to public health. While the number of new tuberculosis cases has decreased since 2010, the number of new HIV and hepatitis C cases has grown steadily. In 2015, Latvia reported the highest hepatitis C notification rate in the EU (79.1 per 100 000 population compared with the EU average of 8.6) (ECDC, 2017). The reported HIV rate was more than three times the EU average (19.8 per 100 000 population compared with the EU average of 5.8) (ECDC/WHO, 2016). The Latvian Ministry of Health has developed an action plan to reduce the risk of contracting a communicable disease, promoting early intervention and diagnosis, which was submitted to the Cabinet of Ministers for approval in 2017.

3. Inequalities by education may partially be attributed to the higher proportion of older people with lower educational levels; however, this alone does not account for all socioeconomic disparities.

### Less than half of Latvians consider themselves to be in good health

In 2015, only 46% of Latvians reported to be in good health, the second lowest level in the EU (Figure 4). Latvian men tend to perceive their health as being better than women with 51% reporting to be in good health compared to only 42% of women. There are also large disparities by income group: only about one in three Latvians in low-income households report to be in good health, compared to two in three in high-income households.

**Figure 4. Large disparities by socioeconomic status in self-perceived health in Latvia**



1. The shares for the total population and the low-income population are roughly the same.  
 2. The shares for the total population and the high-income population are roughly the same.

Source: Eurostat Database, based on EU-SILC (data refer to 2015).

## 3 Risk factors

### Behavioural risk factors are major public health issues in Latvia

The relatively poor health status of the population in Latvia is linked to a number of health determinants, including more difficult living and working conditions and behavioural risk factors. Based on the Institute of Health Metrics and Evaluation (IHME) estimations, about 40% of the overall burden of disease in Latvia in 2015 measured in terms of DALYs was attributable to behavioural risks, with smoking (11.5%), alcohol (5.7%) and high body mass index (11.0%) contributing to most of this burden (IHME, 2016).

### One in five adults smoke on a daily basis

Although the share of adults who smoke daily in Latvia has decreased since 2000 (from 33% in 2000 to 25% in 2014), it still remains higher than the average across EU countries (21%) and sixth-highest overall (Figure 5). Smoking is much more common among men (37%) than among women (15%). On a slightly more positive note, there have been substantial reductions in regular smoking among 15-year-old Latvians, so that the smoking rate among these adolescents (14% in 2013-14) is now about equal to the EU average.



## Alcohol consumption is on the rise in Latvia

In contrast to most EU countries, alcohol consumption among Latvian adults has increased since 2000, rising from 7.1 litres per adult in 2000 to 10.8 litres in 2015. It is estimated that as many as one in eight Latvian adults have some form of alcohol dependency (CDPC, 2012). Nearly one in five Latvian adults report heavy alcohol consumption on a regular basis (binge drinking<sup>4</sup>), which is close to the EU average. Binge drinking is much more frequent among men (33%) than among women (8%). Heavy alcohol consumption is also a problem among Latvian adolescents, with one in three 15-year-old boys and one in four girls reporting to have been drunk more than once in their life. This is a greater proportion than in most EU countries.

## Obesity is a growing problem among adults

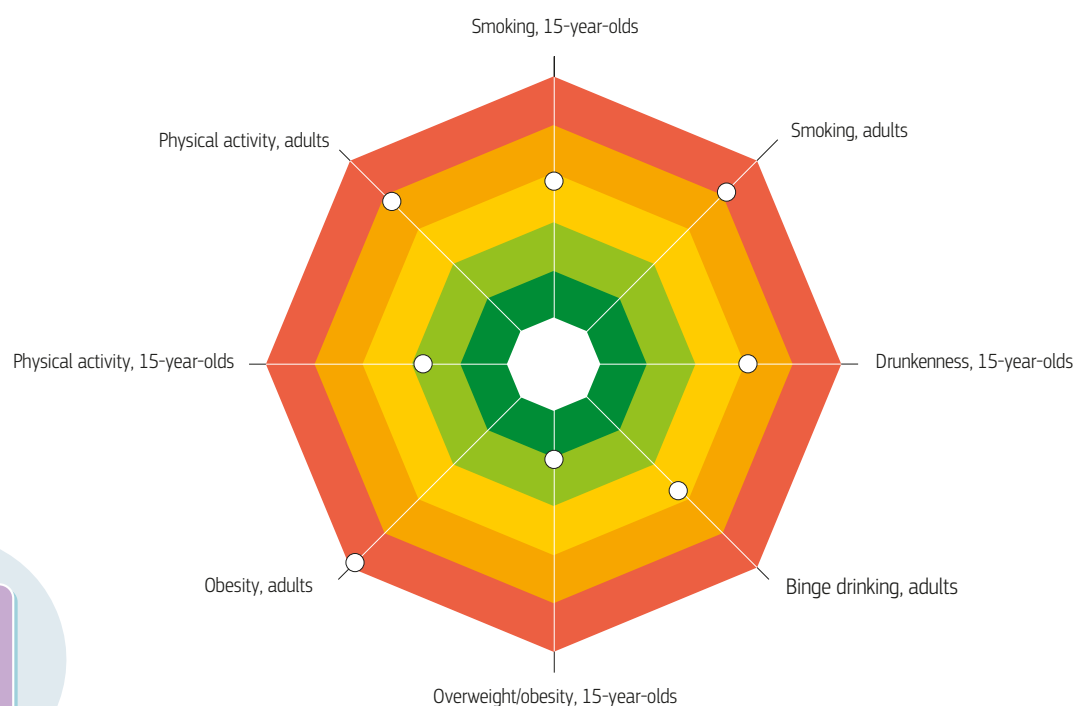
Increasing rates of obesity are a growing public health issue in Latvia. More than one in five adults (21%) were obese in 2014, an increase from one in six in 2008 (17%), and the third highest rate in the EU. In contrast with other risk factors, the obesity rate

in Latvia is higher among women (23%) than men (19%). It is also higher among people that have not completed their secondary education (23%) compared to those with tertiary education (18%).

Although overweight and obesity rates among adolescents remain below the EU average, they have increased sharply in Latvia, from 6% in 2001-02 to 15% in 2013-14. Twice as many boys as girls were overweight or obese in 2013-14. This trend is worrisome as being overweight or obese in childhood and adolescence increases greatly the risk of being overweight and obese in adulthood.

The level of physical activity among adults in Latvia is relatively low, with only six out of ten adults reporting that they practice at least moderate physical activity each week. This is below the EU average (64%). However, seven out of ten Latvian men exercise weekly, compared to just over half (54%) of Latvian women. Latvia fares better compared to other EU countries in physical activity among adolescents, but still only 14% of 15-year-old girls and 21% of 15-year-old boys report doing the required level of physical activity each day.

**Figure 5. Smoking and obesity are public health concerns in Latvia**



**Note:** The closer the dot is to the centre the better the country performs compared to other EU countries. No country is in the white 'target area' as there is room for progress in all countries in all areas.

**Source:** OECD calculations based on Eurostat Database (EHIS in or around 2014), OECD Health Statistics and HBSC survey in 2013-14. (Chart design: Laboratorio MeS).

4. Binge drinking behaviour is defined as consuming six or more alcoholic drinks on a single occasion, at least once a month over the past year.



## 4 The health system

### Latvia has an NHS-type health system with a purchaser-provider split

The Latvian health care system is characterised by tax-financed statutory health care provision, a purchaser-provider split and a mix of public and private providers. The system is the result of more than 25 years of transformation since the independence of the country in 1991. After undergoing several reforms, a National Health Service (NHS) type system was established in 2011.

The two main actors in the health system are the Ministry of Health, which is responsible for developing national health policies and for the overall organisation and functioning of the health system, and the NHS, which implements health policies and purchases of publicly financed health services.

Providers contracting with the NHS tend to be predominantly private in the case of primary care; public and private in the case of secondary care, with public ownership concentrated mainly at the municipal level; and predominantly public in the case of tertiary care, with ownership concentrated at the national level.

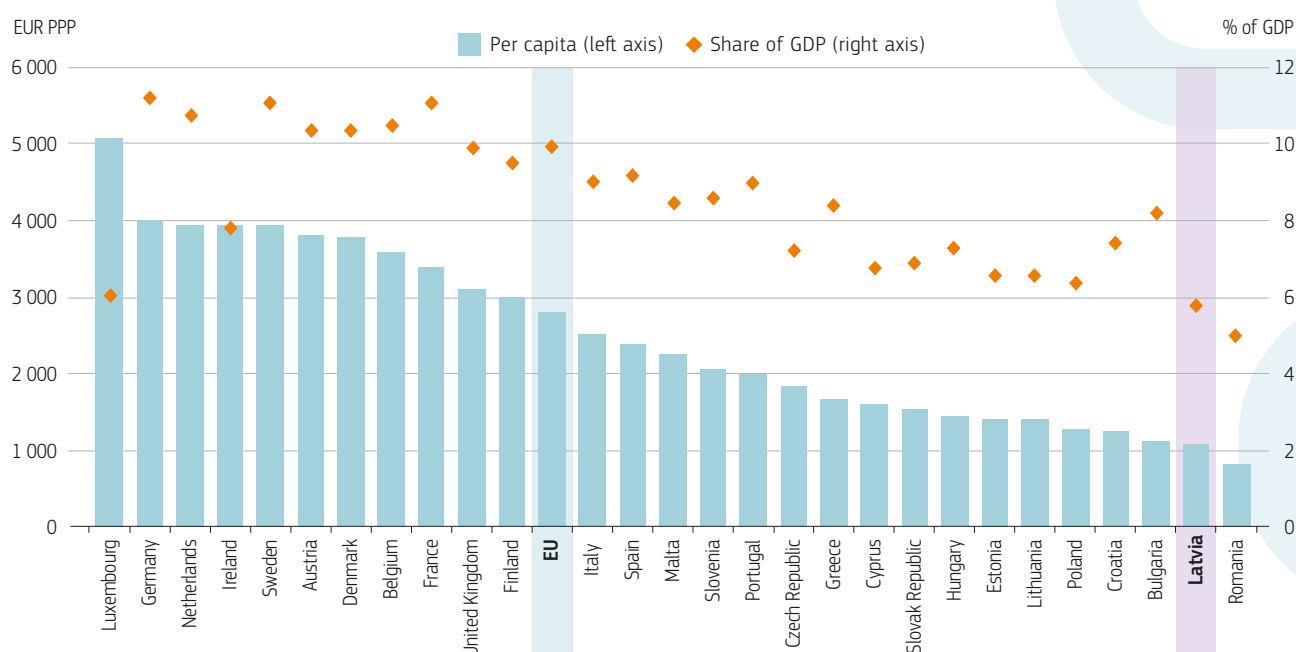
### Public coverage is limited by severe budget constraints

Spending on health in Latvia is very low by EU standards. In 2015, health expenditure per capita was EUR 1 071 (adjusted for differences in purchasing power), less than 40% of the EU average (EUR 2 797) and the second lowest in the EU after Romania (Figure 6). The share of GDP spent on health declined in recent years, from 6.2% in 2009 to 5.8% in 2015. This is because health expenditure grew more slowly (3% per year) than the economy (4% per year).

The health system provides coverage of the entire population and pays for a publicly funded benefit package. However, patients are exposed to substantial user charges and direct payments, in particular for pharmaceuticals and inpatient procedures (Section 5.2).

Health services are purchased by the NHS. Primary health care providers are paid using a mix of capitation, fee-for-service, fixed practice allowances, bonuses and a voluntary pay-for-performance scheme. Secondary ambulatory (or outpatient) providers are

**Figure 6. Health expenditure per capita in Latvia is the second lowest of all EU countries**



Source: OECD Health Statistics, Eurostat Database, WHO Global Health Expenditure Database (data refer to 2015).



primarily paid by flat rate fees for defined episodes of illness, with additional fee-for-service payments for preventive, diagnostic and therapeutic interventions. Global budgets adjusted for numbers and types of patients treated were introduced for hospitals in 2010 to control expenditure. The implementation of a new hospital payment based on diagnostic-related groups (DRGs) began in 2015.

## General practitioners are the cornerstone of primary care

Almost all Latvians are registered with a general practitioner (GP), who acts as the main point of entry to the health care system and as the gatekeeper to secondary, specialist services. In rural areas (where about a third of the population lives), physician assistants (feldshers) or midwives still provide a considerable share of primary care services. A patient with a referral from the GP can freely choose any specialist or hospital that has a contract with the NHS. Some specialists can be accessed directly (e.g. paediatricians, gynaecologists and ophthalmologists) and patients diagnosed with certain conditions have direct access to relevant specialists (e.g. oncologists, psychiatrists and endocrinologists). In 2016, a requirement that only specialists can issue referrals for certain highly specialised diagnostic and laboratory examinations was introduced as an attempt to rationalise expenditure.

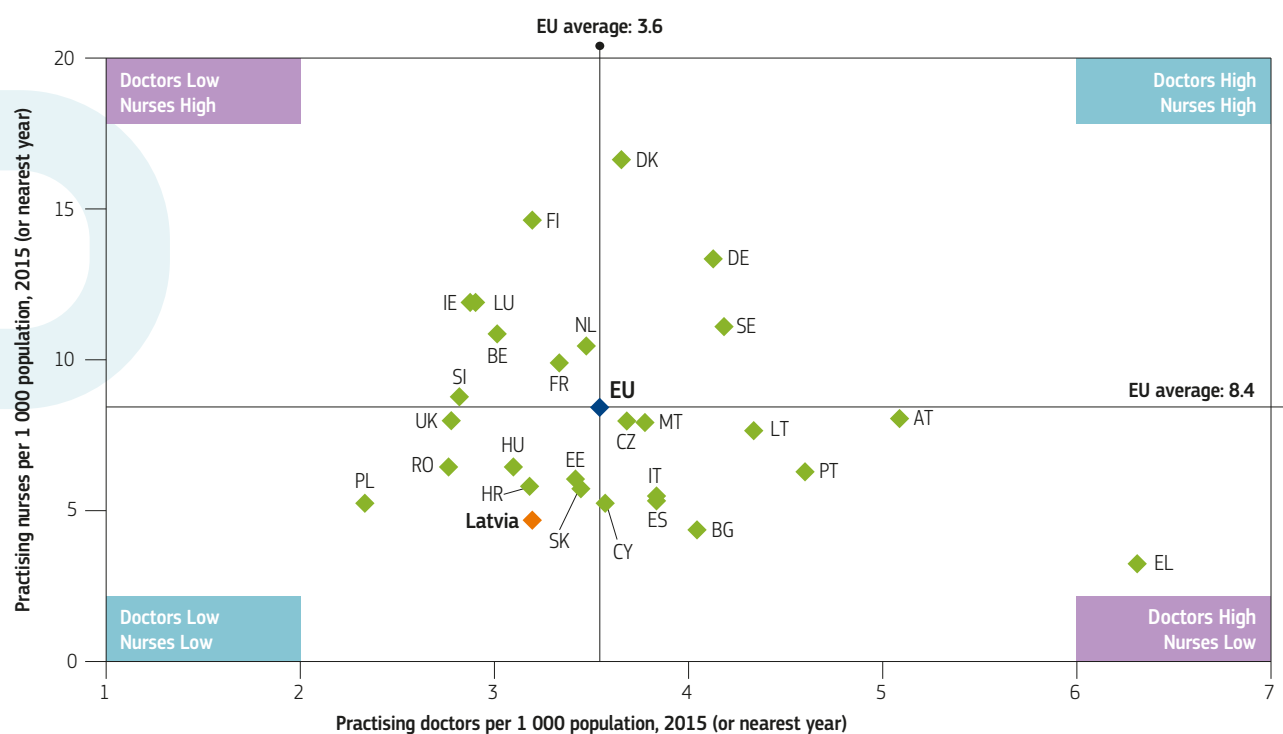
## The health workforce is under pressure

The number of physicians per population in Latvia is below the EU average (3.2 per 1 000 population compared to 3.6 for the EU average), and the number of nurses per capita is very low (4.7 per 1 000 population), the third lowest number among EU countries after Bulgaria and Greece (Figure 7). Low salaries and difficult working conditions make it difficult to recruit and retain a sufficient number of skilled health workers. Since Latvian doctors and nurses are generally considered well-trained and highly competent, many of them have found employment elsewhere in Europe, particularly after the financial crisis (Section 5.2).

## Budget constraints have encouraged a downsizing of the hospital sector

The overall number of hospital beds per population in Latvia has declined by more than one-third since 2000, coming down from 8.8 per 1 000 population in 2000 to 5.7 in 2015, but still remains above the EU average (5.2). This reduction has been driven by a sharp reduction in the number of acute care beds (which dropped from 6.1 per 1 000 population in 2000 to 3.4 in 2015). However, the number of discharges remains slightly above the EU average. Latvian patients stay on average 8.3 days in the hospital, which also is slightly above the EU average of 8.0 days.

Figure 7. Latvia has among the lowest numbers of practising doctors and nurses



**Note:** In Portugal and Greece, data refer to all doctors licensed to practice, resulting in a large overestimation of the number of practising doctors (e.g. of around 30% in Portugal). In Austria and Greece, the number of nurses is underestimated as it only includes those working in hospital.

**Source:** Eurostat Database.

## 5 Assessment of the health system

### 5.1 EFFECTIVENESS

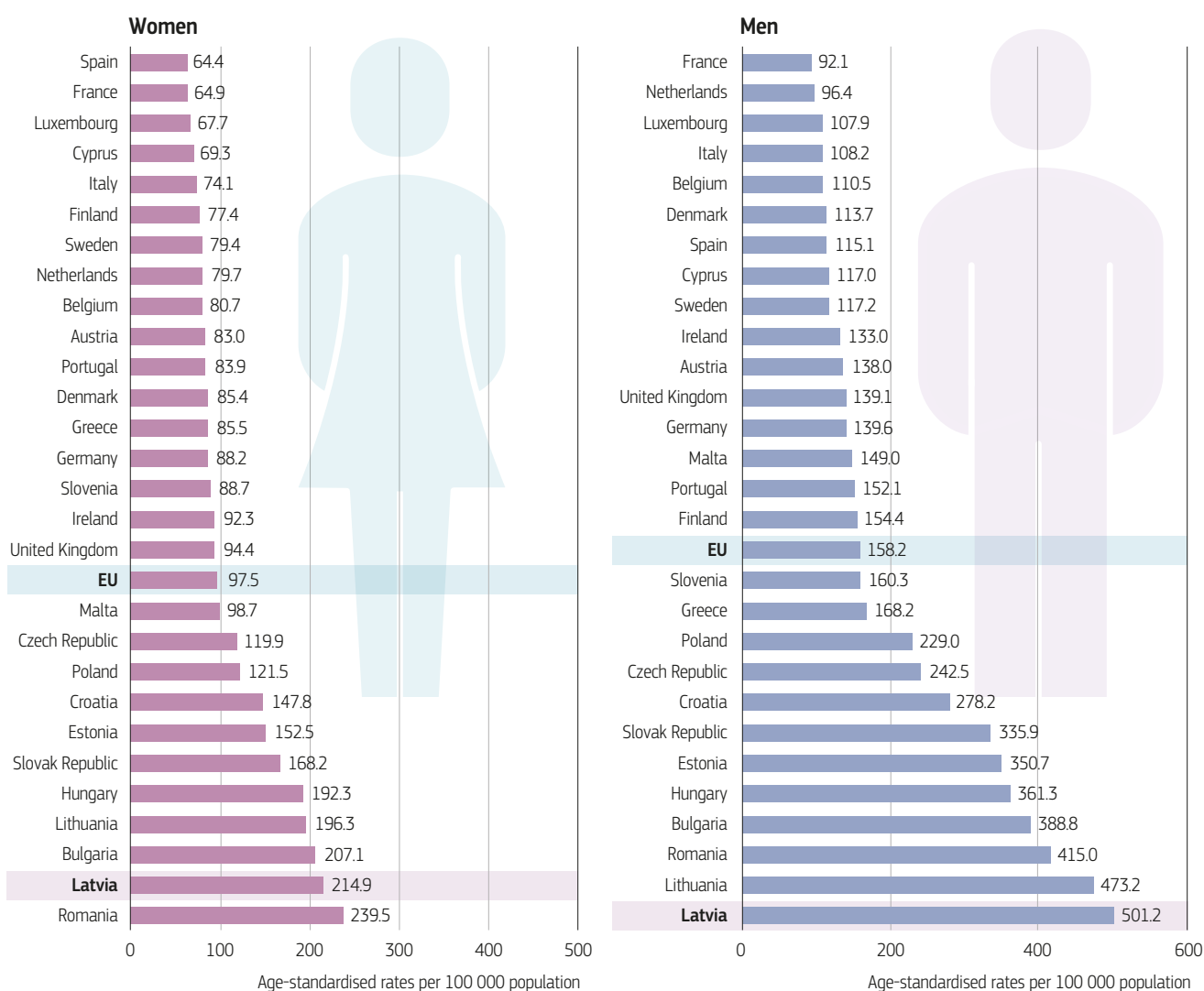
#### Avoidable mortality rates in Latvia are among the highest in the EU

Mortality amenable to health care<sup>5</sup> provides a general indication of the effectiveness of the Latvian health care system in treating people with life-threatening conditions. In 2014, Latvia had the highest rate of amenable mortality for men and the second highest for women (Figure 8). Ischaemic heart diseases accounted for a very large proportion (44%) of amenable deaths. Other important causes of amenable deaths were stroke (22% of the total) and hypertensive diseases (6%).

#### More people die after being admitted to hospital for heart attack or stroke in Latvia than in other EU countries

Mortality following hospital admission for an acute myocardial infarction (AMI or heart attack) and stroke provides a good indication of the quality of acute care, capturing important processes of care, such as timely transport of patients and the delivery of effective and appropriate treatment in dedicated stroke or cardiac units. Deaths following admission for AMI and stroke are higher in Latvia than in any other EU country reporting these data (Figure 9).

Figure 8. Latvia lags far behind other EU countries in terms of amenable mortality

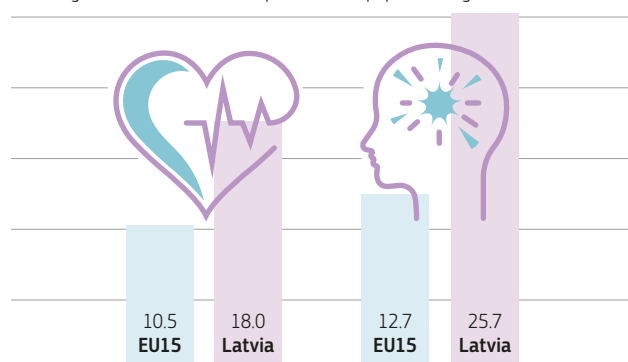


Source: Eurostat Database.(data refer to 2014).

5. Amenable mortality is defined as premature deaths that could have been avoided through timely and effective health care.

**Figure 9. Latvia has the EU's highest death rates from heart attacks and stroke**

Age-sex standardised rate per 100 000 population aged 45 and over



**Note:** These data refer to mortality rates within 30 days following a hospital admission for AMI and ischaemic stroke, including deaths both in the hospital where the patient was initially admitted and deaths in other settings.

**Source:** OECD Health Statistics (data refer to 2015).

However, there are important variations across hospitals in Latvia in mortality rates following admission for AMI. Mortality rates in some hospitals are up to two times higher than in other hospitals. This indicates opportunities to improve overall hospital system performance by focusing policy action on greater consistency of care across all hospitals (OECD, 2017).

## Poor cancer outcomes drive new reforms to improve cancer care

Survival after a diagnosis from breast cancer, cervical cancer and colon cancer has increased slightly in Latvia over the past decade, but the gap has nonetheless widened compared to many other countries. The relatively low survival from treatable cancers is partly due to low screening rates. This means that a high share of cancer patients is diagnosed at a later stage. In 2015, only one quarter of Latvian women in the target group (20-69 years) were screened for cervical cancer during the last three years, while only about one-third of women in the target group (50-69 years) had mammography screening during the last two years<sup>6</sup>.

Latvia intensified efforts in recent years to improve cancer care. In addition to introducing national cancer control strategies in 2009, cancer care delivery has been centralised and expertise concentrated in specialised institutions to improve both quality and efficiency of care delivery. A national plan was adopted in 2017 aiming to improve cancer care in Latvia. It includes reducing the prevalence of risk factors and improving access to early diagnosis and treatment, as well as rehabilitation and palliative care. This initiative, called the 'Green Corridor' pathway, specifically targets early diagnosis of cancer (Box 1).

### BOX 1. RECENT REFORM AIMING TO PROMOTE EARLY DETECTION OF CANCER AND IMPROVE QUALITY OF CARE

A new streamlined pathway to ensure effective and timely diagnosis and treatment of cancer was introduced on 1 October 2016. According to this so-called 'Green Corridor', family doctors with a medically reasonable suspicion of cancer in a patient have to refer this patient for primary diagnostic examinations within 10 working days. If the suspicion of cancer is confirmed, the family doctor has to request an appointment at a specialised cancer centre for a specialist consultation and secondary diagnostic tests within another 10 working days. A first treatment decision has to be taken no later than one month after the first specialist consultation. During the period from 14 November to 31 December 2016 according to the 'Green corridor' pathway, 926 patients received such accelerated oncological consultations.

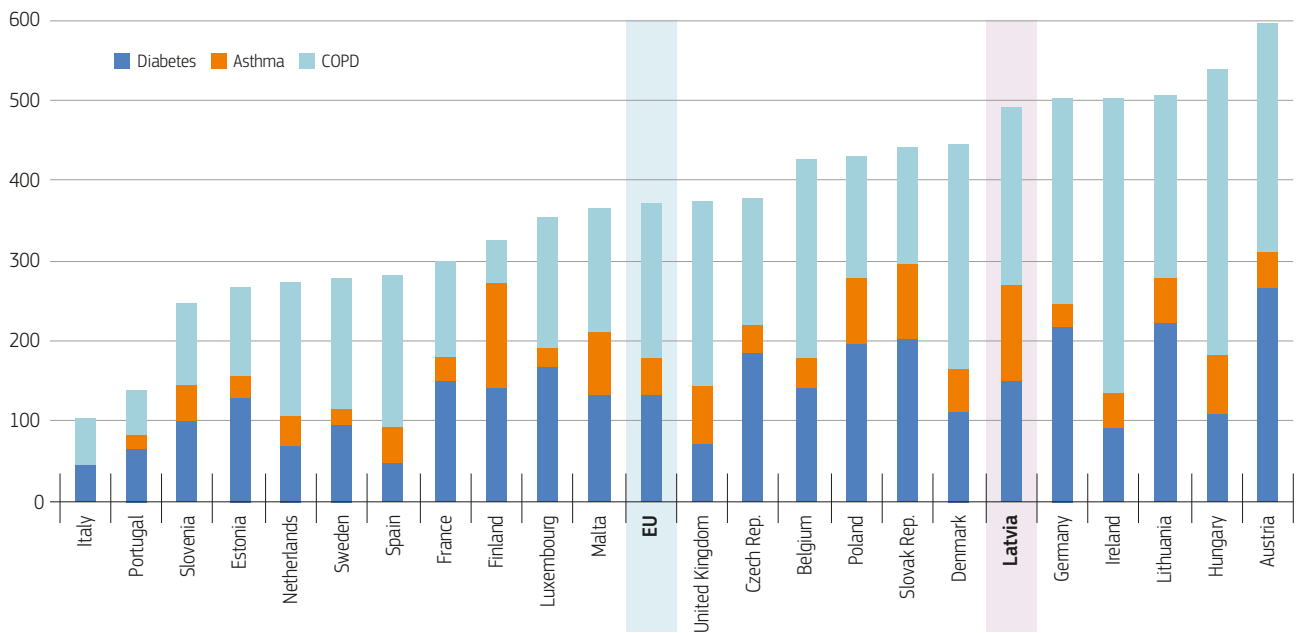
## Potentially avoidable hospitalisations can be reduced by strengthening primary care

Hospitalisations for chronic conditions, such as asthma, chronic obstructive respiratory disease (COPD) and diabetes, provide an indication of the quality of primary care as these hospitalisations may be prevented if well-managed in primary care. Latvia has a high rate of hospitalisations for asthma, which is more than double the EU average (119 per 100 000 population versus 52 per 100 000 population). On the other hand, Latvia fares better when it comes to hospitalisation for diabetes with the rate closer to the EU average (Figure 10).

Latvia has undertaken several initiatives in recent years to strengthen the quality of its primary care. A new pay-for-performance scheme was introduced in 2013 to reward GPs who are meeting defined targets for prevention, chronic disease management, increased diversity and efficiency of services.

The impact of these initiatives has not yet been evident, as shown by the high hospital admission rates for chronic diseases and the persistently low survival from cancer. However, it is still too early to assess either the changes in physician behaviour or the health impacts. The increasing prevalence of some key risk factors and consistently low cancer screening rates nonetheless signal the challenges for prevention and early detection, and most indicators in the pay-for-performance scheme have not been met by most GPs since the scheme was implemented (OECD, 2016).

6. However, in addition to the organised cervical cancer screening in Latvia, opportunistic screening is still widely applied, meaning that the proportion of patients undergoing screening may be higher.

**Figure 10. High hospital admissions raise questions over quality of chronic disease management**

**Note:** Rates are not adjusted by health care needs or health risk factors.

**Source:** OECD Health Statistics 2017 (data refer to 2015).

## Preventable deaths are high in Latvia, particularly among men

Preventable mortality, such as deaths from traffic accidents, lung cancer and alcohol-related conditions, shows that Latvia struggles to reduce the number of premature deaths. While alcohol-related death rates are the second highest in the EU, traffic accidents caused more deaths in Latvia than in any other EU country. In fact, four times as many men as women died in road traffic accidents in 2014. Latvian men are also at substantially higher risk of dying from lung cancer, with death rates more than seven times higher for men than women.

These premature deaths could be reduced if appropriate and effective prevention policies and strategies were in place, specifically targeting high risk groups. Although a series of tobacco control policies contributed to a reduction in smoking rates among adolescents and adults in Latvia over the past decade, the smoking rates among adults nonetheless remain higher than in most other EU countries, particularly among men and people with lower levels of education.

Latvia's low spending on prevention raises concerns. Spending on prevention represents only 2% of current health spending in Latvia compared to the EU average of 3%. Investment in public health and prevention in Latvia is also heavily reliant on funding from the EU and the international community more broadly. One of these EU-

funded initiatives is the Public Health Strategy for 2014-20, which allocates considerable financial resources for health promotion and prevention activities.

Drawing on experiences from other EU countries in reducing harmful alcohol consumption, the Latvian government increased excise taxes on alcoholic beverages and tobacco products in 2015 and 2017. A national action plan is currently under preparation, including activities aimed at reducing harmful alcohol consumption and alcoholism, as well as strengthening regulations around the marketing of alcoholic drinks.

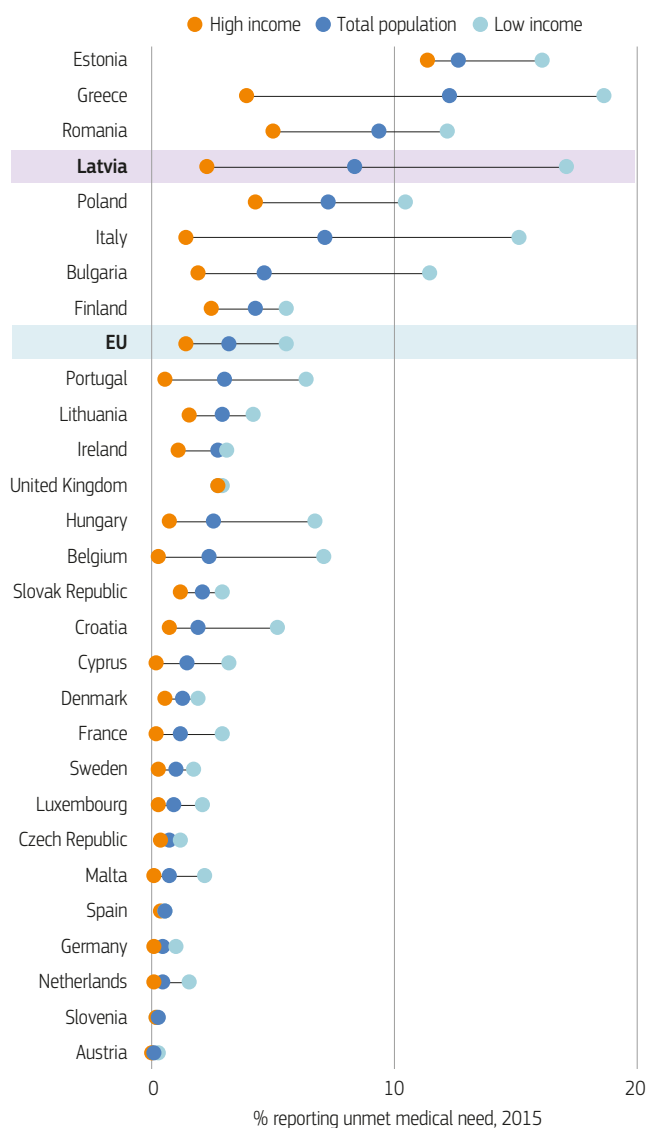
## 5.2 ACCESSIBILITY

### Despite universal health coverage, many Latvians cannot access the care they need

Latvia has universal health coverage, although the breadth and depth of coverage is more limited than in most other EU countries. As a result, a large share of people reports problems in obtaining care mainly because of financial barriers, but also because of geographic reasons or long waiting times.

In 2015, 8.4% of Latvians reported unmet medical care needs, the fourth highest share among all EU countries (Figure 11). Unmet medical care needs are mainly reported by people in low-income groups: one in six Latvians (17.1%) from low-income households

**Figure 11. Latvians report the fourth highest level of unmet needs for medical care in the EU**



**Note:** The data refer to unmet needs for a medical examination or treatment due to costs, distance to travel or waiting times. Caution is required in comparing the data across countries as there are some variations in the survey instrument used.

**Source:** Eurostat Database, based on EU-SILC (data refer to 2015).

reported to having forgone medical appointment or treatment due to financial or other reasons, a share that is three times greater than the EU average (5.5%). In contrast, only 2.5% of high-income households in Latvia reported such unmet needs.

Latvians also report the highest level of unmet needs for dental care among EU countries with almost 14% of the population reporting unmet dental care needs in 2015. This is over three times higher than the EU average (4.4%). Here as well, there is a large disparity by income group: 27% of people with low income reported unmet needs for dental care compared to about 4% only for people in the highest income group.

## The publicly-funded benefits package is limited in scope

Publicly-funded health benefits cover only services provided by physicians and institutions that have contractual agreements with the NHS. The benefit package is defined by 'positive lists' (for pharmaceuticals and for certain preventive, diagnostic and therapeutic interventions) and 'negative lists' (exclusion of certain services, such as dental care for adults, rehabilitation with exceptions, as well as sight and hearing correction aids).

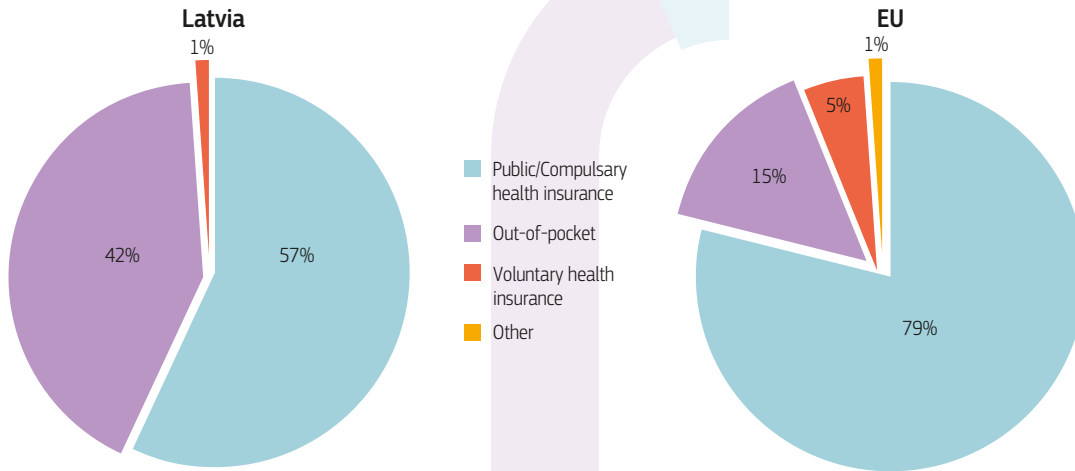
The scope of the benefit package is relatively limited, and it was reduced after the economic crisis in 2008 to contain health spending during the period of fiscal consolidation. Some clear gaps exist between recommended clinical practice and the publicly-funded benefits package. For example, thrombolysis for ischaemic stroke is excluded from the benefit package, running against clinical evidence on international best practice. Furthermore, procedures that might be expected to be covered, such as thoracic surgery and some neurological procedures are not included. A failure to make such services systematically available limits access to good quality care.

## Barriers to care are exacerbated by high user charges and the annual 'quota' system

All health services in Latvia, including GP visits, specialist visits, hospital stays and pharmaceuticals, require cost-sharing in the form of user charges. Public funding only accounted for 57% of health spending in 2015, the second lowest share in the EU after Bulgaria (Figure 12). Nearly all of the rest (42%) is paid out of pocket by patients themselves. This is the third highest share in the EU after Cyprus and Bulgaria, and nearly three times the EU average of 15%. These large out-of-pocket payments constitute a substantial barrier to accessing medical care for many Latvians, as reflected in the high levels of unmet medical and dental care needs.

The organisation of health services is based on an annual 'quota' system, which constitutes an additional barrier to accessing care for Latvians. Service providers are given annual quotas for the volume of services that will be covered by the NHS. When these service quota limits are reached, patients must either wait for the following year and the renewal of the quota or pay for the services out of pocket. Therefore, access has been reported to worsen in the last months of the year. However, the 'quota' system's impact on waiting times is seen throughout the year. To avoid long waits for services, many people choose to pay out of pocket, contributing to Latvia's high shares of out-of-pocket payments.

**Figure 12. Out-of-pocket payments account for a large share of health spending in Latvia**



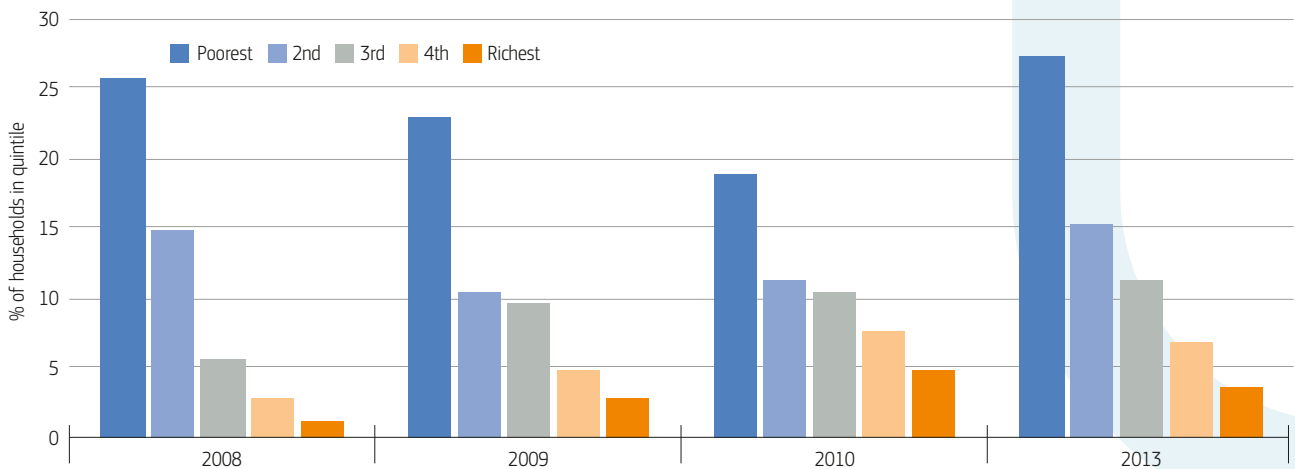
Source: OECD Health Statistics, Eurostat Database (data refer to 2015).

### High cost-sharing puts low-income households at risk of facing catastrophic out-of-pocket payments

The limited coverage of health services and pharmaceuticals outside hospital is reflected in the structure of out-of-pocket spending. In 2015, spending on pharmaceuticals and curative care represented 80% of total out-of-pocket spending, with dental care accounting for another 10%. As a consequence, many Latvian households face catastrophic out-of-pocket payments.<sup>7</sup> This is particularly the case among low-income households, with over 25% of them facing catastrophic out-of-pocket payments in 2013 (Figure 13).

The reduction in the share of low-income households facing catastrophic out-of-pocket payments between 2008 and 2010 was partly due to the implementation of the Safety Net and Social Sector Reform Programme. This scheme, which was implemented from 2009-11, aimed to protect the poorest people from financial risk in the event of illness by exempting certain households from co-payments and subsidising pharmaceuticals. While the scheme is still covering some specific patient groups, it was discontinued for low-income households in 2011. After discontinuation, the share of households in the lowest income groups (1st and 2nd income quintile) facing catastrophic of-pocket payments increased sharply, going back to their 2008 level.

**Figure 13. Catastrophic out-of-pocket payments affect mostly low-income households**



Source: Taube et al (2017, forthcoming) (data refer to 2013).

7. Catastrophic expenditure is defined as household out-of-pocket spending exceeding 40% of total household spending net of subsistence needs (i.e. food, housing and utilities).

## Steps were taken to address shortages of health professionals

Although the number of practising doctors has slowly increased, it remains below the EU average. The number of practising nurses causes even greater concern. Not only are the numbers below the EU average, but the numbers of new graduates have dropped sharply since 2011. Furthermore, low salaries and difficult working conditions have led many nurse graduates to choose not to pursue a nursing career and rather seek employment in other sectors in Latvia. Many nurses have also decided to migrate to other EU countries.

Latvia also faces growing challenges with the geographic distribution of health workers. Due to declining population, GPs are leaving rural areas or are reaching retirement without being replaced. Geographic distribution of secondary and tertiary services throughout the country also poses a problem with many services concentrated in urban areas, particularly in or around Riga. The introduction of free hotel-type accommodation for low-income groups when they have to travel for treatment (typically for day surgery) is designed to mitigate these additional travel costs.

With the support from EU funding, several measures are underway to attract health workers to work in rural areas, thereby reducing the shortage of specialists and health workers in regions outside of Riga. The Ministry of Health has taken steps since April 2015 to address the geographic maldistribution of doctors by requiring medical universities to give priority residency positions to applicants who have agreed to practice in a rural area after completing their training. Some 43 residents were accepted in this new 'regional arrangement' programme during the second year of implementation (2016-17).

### 5.3 RESILIENCE

## Latvia has taken steps to improve efficiency in the hospital sector

Latvia's health system is structurally underfunded. Increasing efficiency to optimise the use of limited resources has been, and continues to be, a major priority – and progress has been made. In response to the economic crisis and budgetary pressures, Latvia closed a number of hospitals and 18 emergency departments in order to improve quality and contain costs. Simultaneously, efforts were made to move care out of hospitals to community settings to reduce admissions and lengths of stay in hospitals.

Latvia's push to reduce the size of the hospital sector and move more care into the community started before the economic crisis but was accelerated afterwards. The 'Development Programme for Outpatient and Inpatient Healthcare Service Providers' (adopted

in 2004 with an implementation plan in 2005) aimed to further develop an integrated health care system through optimising the number and distribution of service providers. The programme and implementation plan stipulated that, as of 2005, the number of hospital beds providing state-paid services would gradually be decreased. Furthermore, a home care programme was put in place to promote earlier discharge for frail patients. Services provided comprise close follow-up of chronically ill patients, post-surgery care and rehabilitation for stroke patients.

By 2015, there were 6 435 fewer hospital beds than in 2005, a reduction of 36%. However, most of this reduction occurred in 2009-10. The number of hospitals providing state-funded services also decreased by more than half with the closure of some institutions and the transformation of others from inpatient to outpatient settings exclusively. At the same time, there was a decrease of nearly 20% in average length of stay in hospital, coming down from 10 days in 2005 to 8.3 days in 2015, with most of the reduction occurring after 2008 (Figure 14).

While Latvia has already reduced hospital beds to a level close to the EU average and closed a number of hospitals and emergency departments, its level of psychiatric care beds remain high. There may be scope for functional changes to help secure higher quality care and greater efficiency. It is important, however, that such efficiency measures are part of a broader plan to strengthen mental health care and expand the scope of services provided outside of hospitals. The Mental Health Care Policy Action Plan implemented in 2013-14 included measures to improve the availability and quality of mental health care services.

## Latvia implemented measures to increase the use of generics

Latvia's relatively low public spending coupled with the high share of out-of-pocket spending for pharmaceuticals create financial barriers to pharmaceutical drugs for many people, particularly those in low-income groups. Latvia has encouraged the use of generic medicines by obliging pharmacists to offer the cheapest version of prescribed pharmaceutical products that are included in the publicly funded benefit package. For other prescriptions, pharmacists are allowed to substitute unless the prescribing doctor has forbidden this option. These measures led to a high share of the generics market, in terms of value and volume.

## Increasing efforts to strengthen health information infrastructure in Latvia

To support greater care coordination, Latvia has begun to strengthen its health information infrastructure in recent years with the introduction of an eHealth system and eHealth portal started in 2016. The availability and use of health information should increase further in the years ahead. The introduction of the eHealth system is expected to increase the quality of health care as well as system efficiency. For instance, health care providers can issue ePrescriptions so that patients can purchase their medications at any pharmacy in the country. This will also enable providers to monitor medication safety when multiple drugs are prescribed for patients. Likewise, coordination across providers is expected to improve by avoiding, for example, duplicated diagnostic tests and informing GPs when their patient is discharged from hospital.

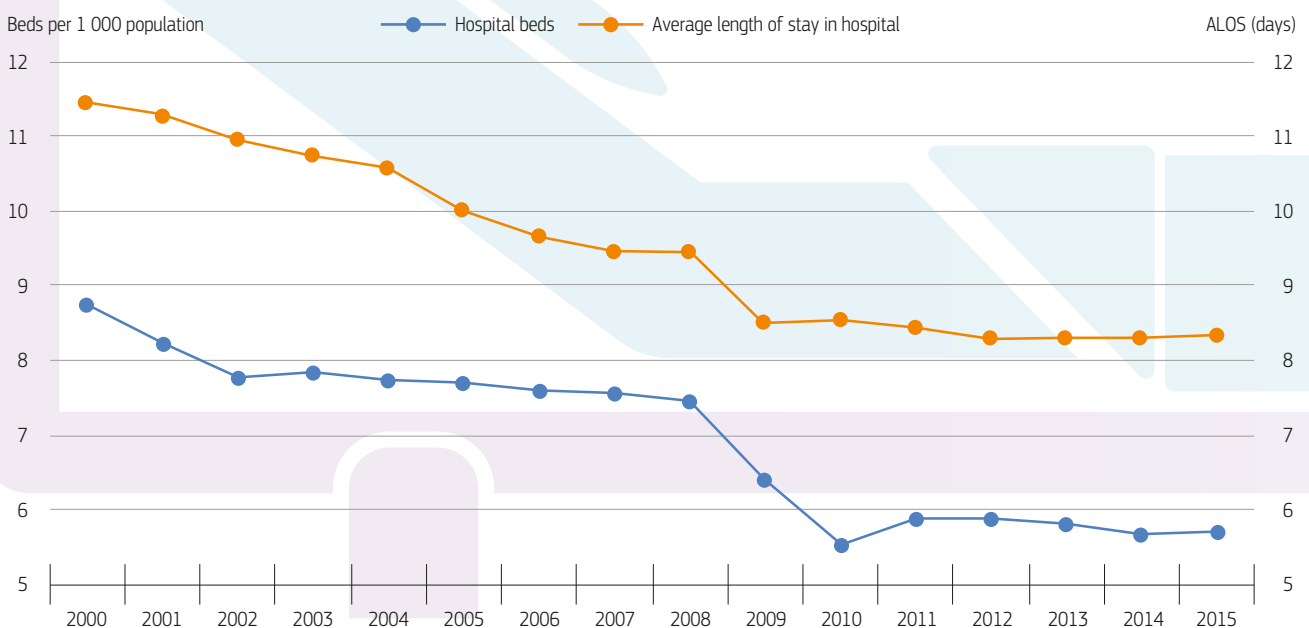
## Securing long-term financial resources for health care services while preparing for future challenges

Latvia's shrinking population, low birth rate and ageing population will challenge the health system's ability to meet future health care needs – on mainly two fronts.

First, health needs can be expected to increase. With an ageing population, Latvia – as other countries – can expect multiple additional challenges, such as higher burden of chronic diseases, additional long-term care needs, changing needs in terms of access to care, and increased risk around discharging frail elderly patients from hospital.

Second, a shrinking working-age population may put additional pressure on revenue sources and put health budgets under strain given fiscal pressures generated by other age-related care expenditures. According to Eurostat projections, the Latvian population will decline drastically in the coming decades, from about 2.0 million in 2015 to 1.4 million in 2060. This 31% drop is very different from the EU average population which is expected to increase by 3%. With a growing old-age dependency ratio, fiscal pressures beyond the health system can be expected to include increased long-term care needs and pressures on pension systems. Following a 'no-policy change' scenario, expenditure on health care and long-term care is projected to remain fiscally sustainable, the adequacy of health care provision would continue to be very poor (European Commission and Economic Policy Committee, 2015).

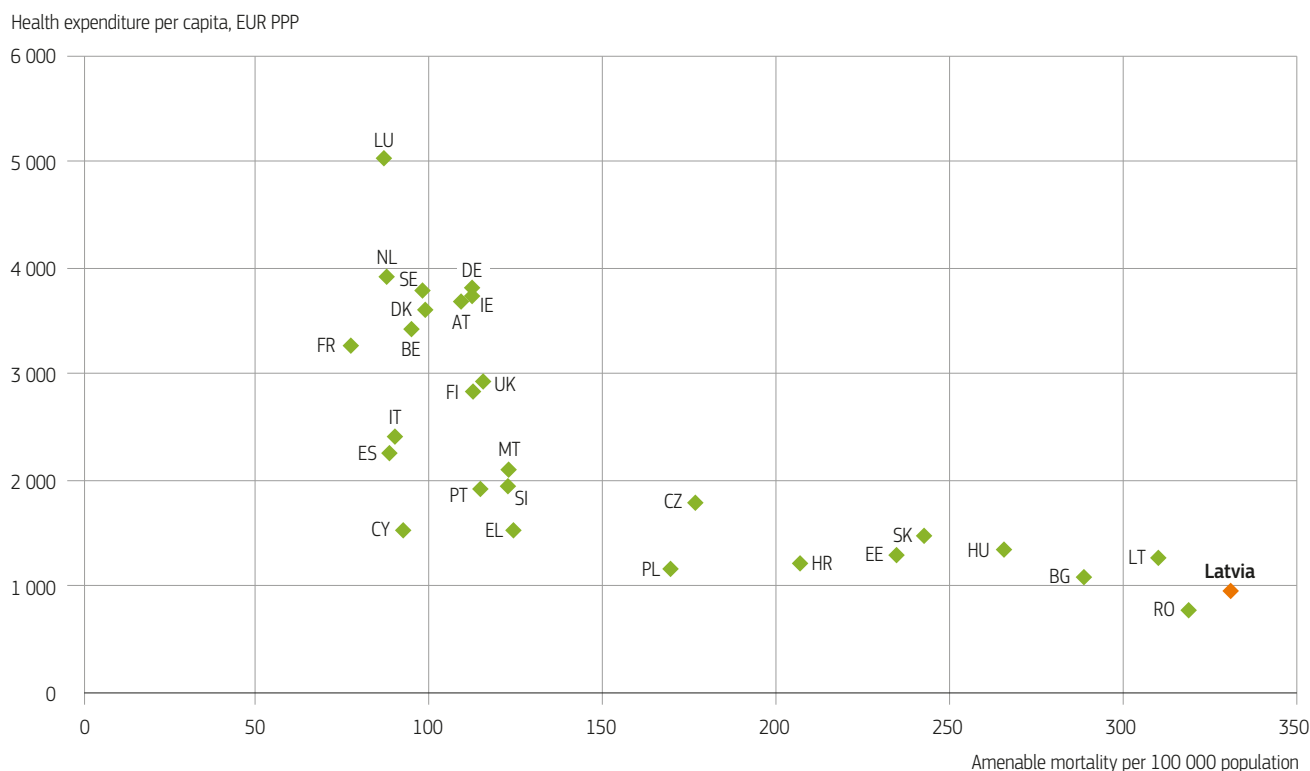
**Figure 14. The number of hospital beds and average length of stay has been reduced**



Source: Eurostat Database.

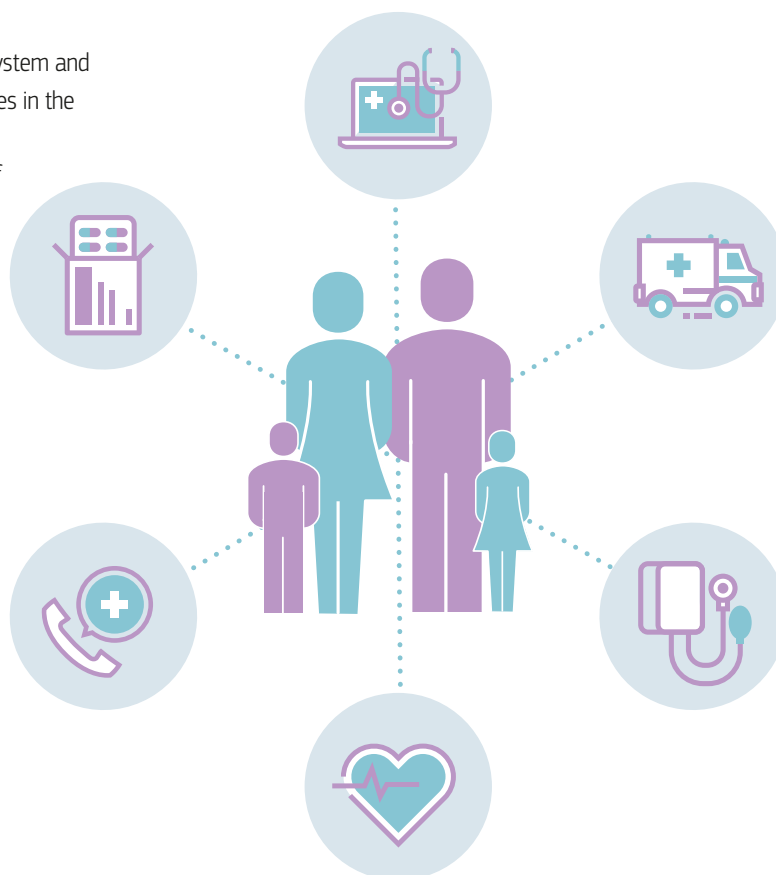


**Figure 15. Very low spending is associated with poor health outcomes in Latvia**



Sources: OECD Health Statistics, Eurostat Database, WHO Global Health Expenditure Database (data refer to 2014).

As Latvia looks to strengthen and improve its health system and the health status of its population, the level of resources in the system will undoubtedly be a major challenge. By 2018-20, health spending is expected to reach 12% of the government budget, up from 8.9% in 2015. Still, Latvia spends less on health per capita and as a share of GDP than any other EU country except Romania. The current low level of expenditure on health is associated with relatively poor health outcomes (Figure 15). If properly spent, additional expenditure on health should contribute to a gradual reduction in amenable mortality in Latvia.



## 6 Key findings

- The life expectancy of the Latvian population increased quite rapidly over the past fifteen years, but still lags about six years behind the EU average, and is the third lowest in the EU after Lithuania and Bulgaria. There are huge gaps in life expectancy by sex and socioeconomic status. Latvian men can expect to live on average nearly ten years less than women. The gap in life expectancy at age 25 between Latvians with the lowest and highest level of education is also ten years. These health inequalities are mainly due to higher prevalence of risk factors, particularly smoking and harmful alcohol consumption, among men and people with low education or income.
- Strengthening efforts to prevent non-communicable diseases has been recognised as a priority in Latvia, with policies designed to control tobacco smoking, alcohol abuse and obesity. The Public Health Strategy for 2014-20 allocates considerable financial resources for health promotion and prevention activities, using EU funds and state budget, to address key risk factors related to cardiovascular diseases and cancer, as well as perinatal, neonatal and mental health.
- The performance of the Latvian health care system must be considered in the light of the limited resources available. Health spending in Latvia is among the lowest in the EU, resulting in considerable resource constraints within the health system. The low level of health spending is a challenge to sustainable improvements in population health and health system performance. Recent government plans to increase public spending on health should produce real inroads into problems with access and quality of care and contribute to improving health outcomes for the population.
- Given the limited resources that have been allocated so far to health, it is not surprising to see that the Latvian health system does not perform well in terms of quality or access. Regarding the quality of acute care, Latvia has the highest case fatality rates for heart attack and stroke among all the EU countries reporting these data. Early detection and timely access to treatment are also challenges in cancer care with both screening rates and net survival for breast and cervical cancer among the lowest in the EU.
- Access to quality primary care can be assessed by looking at hospitalisations for chronic conditions that could have been avoided if patients were well-managed in primary care. The Latvian data indicate that there is scope for improving chronic disease management outside of hospitals. While hospitalisation rates for diabetes in Latvia is close to the EU average, it is much higher for asthma and chronic obstructive pulmonary disease.
- Given the low levels of public spending on health, the health system is highly reliant on private spending in the form of direct out-of-pocket payments by households. Cost-sharing requirements are applied to nearly all health services, resulting in severe financial barriers to accessing care, particularly for low-income households. The lack of financial protection mechanisms for people with low incomes limits access to care. More than one in four low-income households face catastrophic out-of-pocket spending.



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## Country abbreviations

Austria	AT	Denmark	DK	Hungary	HU	Malta	MT	Slovenia	SI
Belgium	BE	Estonia	EE	Ireland	IE	Netherlands	NL	Spain	ES
Bulgaria	BG	Finland	FI	Italy	IT	Poland	PL	Sweden	SE
Croatia	HR	France	FR	Latvia	LV	Portugal	PT	United Kingdom	UK
Cyprus	CY	Germany	DE	Lithuania	LT	Romania	RO		
Czech Republic	CZ	Greece	EL	Luxembourg	LU	Slovak Republic	SK		



# State of Health in the EU

## Country Health Profile 2017

The Country Health Profiles are an important step in the European Commission's two-year *State of Health in the EU* cycle and are the result of joint work between the Organisation for Economic Co-operation and Development (OECD) and the European Observatory on Health Systems and Policies. This series was co-ordinated by the Commission and produced with the financial assistance of the European Union.

The concise, policy relevant profiles are based on a transparent, consistent methodology, using both quantitative and qualitative data, yet flexibly adapted to the context of each EU Member State. The aim is to create a means for mutual learning and voluntary exchange that supports the efforts of Member States in their evidence-based policy making.

Each Country Health Profile provides a short synthesis of:

- health status
- the determinants of health, focussing on behavioural risk factors
- the organisation of the health system
- the effectiveness, accessibility and resilience of the health system

This is the first series of biennial country profiles, published in November 2017. The Commission is complementing the key findings of these country profiles with a Companion Report.

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