European Commission

State of Health in the EU

Latvia

Country Health Profile 2019

OECD
BETTER POLICIES FOR BETTER LIVES

European Observatory on Health Systems and Policies
a partnership hosted by WHO

The Country Health Profile series

The *State of Health in the EU*'s Country Health Profiles provide a concise and policy-relevant overview of health and health systems in the EU/European Economic Area. They emphasise the particular characteristics and challenges in each country against a backdrop of cross-country comparisons. The aim is to support policymakers and influencers with a means for mutual learning and voluntary exchange.

The 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 the Health Systems and Policy Monitor network, the OECD Health Committee and the EU Expert Group on Health Information.

Contents

1. HIGHLIGHTS 3
2. HEALTH IN LATVIA 4
3. RISK FACTORS 7
4. THE HEALTH SYSTEM 9
5. PERFORMANCE OF THE HEALTH SYSTEM 14
   5.1. Effectiveness 14
   5.2. Accessibility 17
   5.3. Resilience 20
6. KEY FINDINGS 22

Data and information sources

The data and information in the Country Health Profiles are based mainly on national official statistics provided to Eurostat and the OECD, which were validated 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. These EU averages do not include Iceland and Norway.

This profile was completed in August 2019, based on data available in July 2019.

To download the Excel spreadsheet matching all the tables and graphs in this profile, just type the following URL into your Internet browser: http://www.oecd.org/health/Country-Health-Profiles-2019-Latvia.xls

Demographic and socioeconomic context in Latvia, 2017

Demographic factors	Latvia	EU
Population size (mid-year estimates)	1 942 000	511 876 000
Share of population over age 65 (%)	19.9	19.4
Fertility rate[1]	1.7	1.6
Socioeconomic factors		
GDP per capita (EUR PPP[2])	20 000	30 000
Relative poverty rate[3] (%)	22.1	16.9
Unemployment rate (%)	8.7	7.6

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 60 % of median equivalised disposable income.
Source: Eurostat Database.

Disclaimer: The opinions expressed and arguments employed herein are solely those of the authors and do not necessarily reflect the official views of the OECD or of its member countries, or of the European Observatory on Health Systems and Policies or any of its Partners. The views expressed herein can in no way be taken to reflect the official opinion of the European Union.

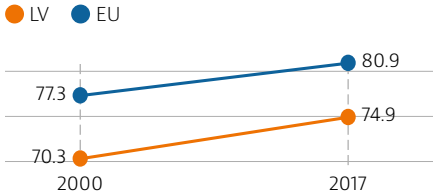
This document, as well as any data and map included herein, are without prejudice to the status of or sovereignty over any territory, to the delimitation of international frontiers and boundaries and to the name of any territory, city or area.

Additional disclaimers for WHO are visible at http://www.who.int/bulletin/disclaimer/en/

© OECD and World Health Organization (acting as the host organisation for, and secretariat of, the European Observatory on Health Systems and Policies) 2019

1 Highlights

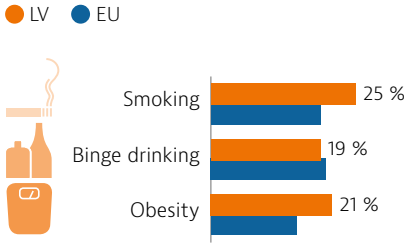
Although the life expectancy of the Latvian population has increased significantly since 2000, it remains the second lowest in the EU, and major disparities persist by gender and socioeconomic status. Poor health outcomes are largely the product of the prevalence of unhealthy behaviour, as well as low levels of health spending. Latvia also faces important challenges in the control of communicable diseases, with increasing incidence of HIV cases. The health system is underfunded and, despite recent progress, remains excessively hospital-centric. The health status of the population could be improved by reducing out-of-pocket payments and shifting the focus to prevention, primary care, home care and community-based services.



Life expectancy at birth, years

Health status

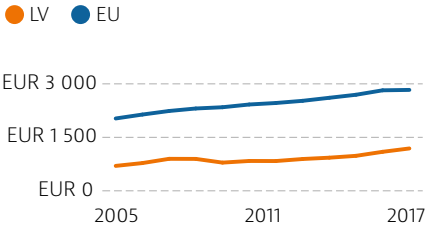
At 74.9 years, average life expectancy at birth remained six years lower than the EU average in 2017. Further, the gender gap of almost ten years in life expectancy far exceeds the EU average (5.2 years). The life expectancy of the least educated men is 11 years shorter than that of the most educated; this gap is eight years for women.



% of adults

Risk factors

Lifestyle-related risk factors account for half of all deaths in Latvia. In 2014, one in four adults smoked daily – down from one in three in 2000, but still well above the EU average. The total figure masks a large gender difference, with 37 % of men reporting smoking daily in 2014. In the same year, one in five Latvians reported engaging in heavy alcohol consumption on a regular basis – a proportion close to the EU average. The obesity rate was the second highest in the EU in 2017, with more than one in five Latvians being obese.



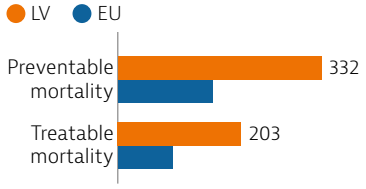
Per capita spending (EUR PPP)

Health system

Despite nominal universal health coverage, coverage gaps remain, which may be attributable in part to the system's underfunding, notwithstanding some spending growth in recent years. In 2017, per capita health expenditure in Latvia was EUR 1 213, the second lowest level in the EU. At 6 % of GDP, expenditure on health has been restored to 2008 (pre-financial crisis) levels, but remains well below the EU average of 9.8 %. In addition, only 57 % of health spending is publicly funded, compared to the EU average of 79 %, with most of the remainder paid directly out of pocket.

Effectiveness

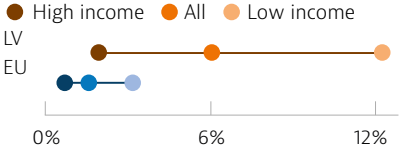
Despite declining steadily over the last decade, high mortality rates from preventable and treatable conditions indicate ample scope to improve the effectiveness of the health system. The quality of hospital care is also well below the EU average.



Age-standardised mortality rate per 100 000 population, 2016

Accessibility

Access to health care in Latvia remains limited for a sizeable proportion of the population, with large numbers of those on low incomes reporting unmet needs because of financial constraints. The uneven geographical distribution of health professionals also constitutes a significant access barrier.



% reporting unmet medical needs, 2017

Resilience

Addressing the persistent underfunding of the health system is essential to improve access to high-quality care. Key challenges to improve population health and reduce disparities in access and outcomes include the needs to strengthen prevention, continue to rationalise the hospital sector and advance the digitalisation of the health system.

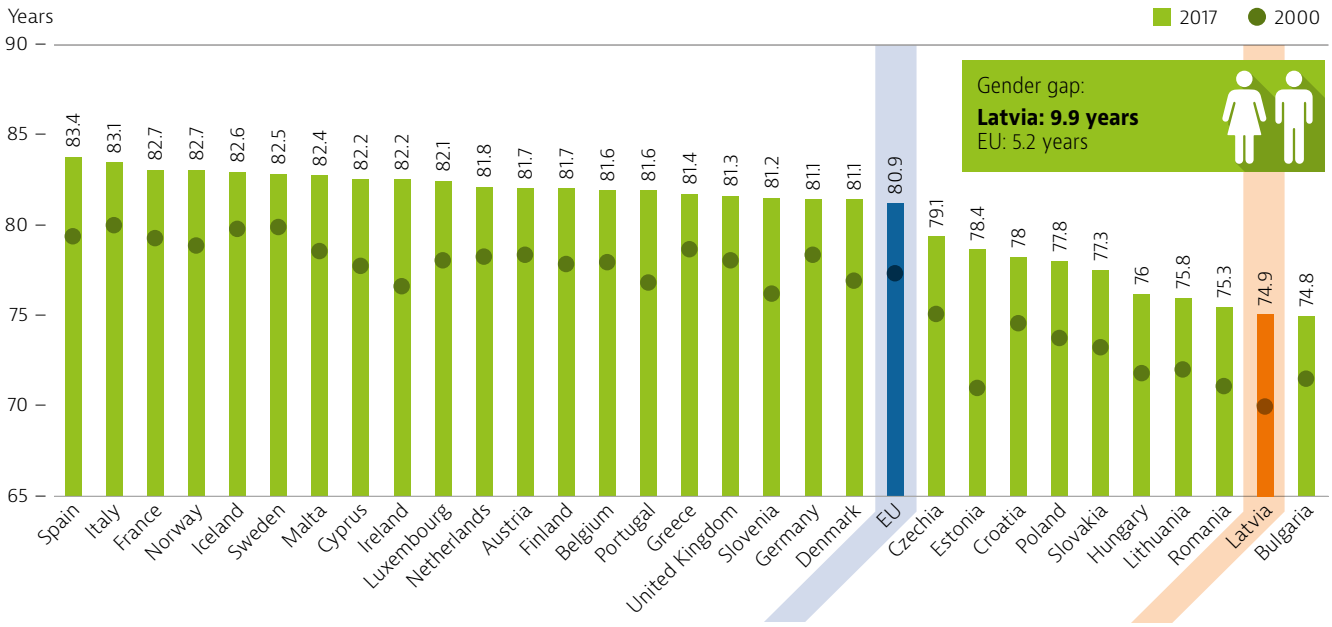
2 Health in Latvia

Latvia reports the second lowest life expectancy at birth in the EU

Latvia has achieved substantial gains in life expectancy since 2000, with a gain of almost five years (from 70.2 in 2000 to 74.9 in 2017). Yet, life expectancy remains the second lowest in the EU after Bulgaria, and six years below the EU average of 80.9 years (Figure 1).

The gender gap in life expectancy is almost ten years – the highest in the EU. On average, men lived only 69.8 years in 2017 (the lowest in the EU) compared to 79.7 years for women (the third lowest after Bulgaria and Romania). This is largely due to greater exposure to key risk factors among men.

Figure 1. Despite significant improvement, life expectancy remains six years below the EU average

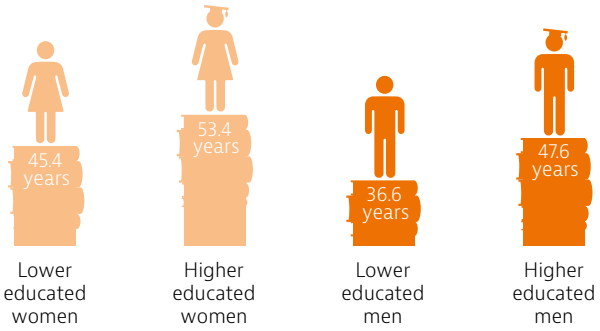


Source: Eurostat Database.

Social inequalities in life expectancy are pronounced

Inequalities in life expectancy in Latvia exist not only by gender but also by level of education. At age 30, the life expectancy of men with low educational attainment is on average 11 years lower than for men with a tertiary education, while for women the difference is eight years (Figure 2). These gaps are much greater than the EU average for both sexes and are largely explained by a greater exposure to various risk factors among the least educated. These include, for example, higher smoking rates and poorer nutritional habits (see Section 3). As people with lower levels of education also tend to have lower incomes and living standards, this may also result to greater exposure to other social and environmental risk factors and capacity to access health care.

Figure 2. The education gap in life expectancy is much greater than in the rest of the EU



Education gap in life expectancy at age 30:

Latvia: 8 years
EU21: 4.1 years

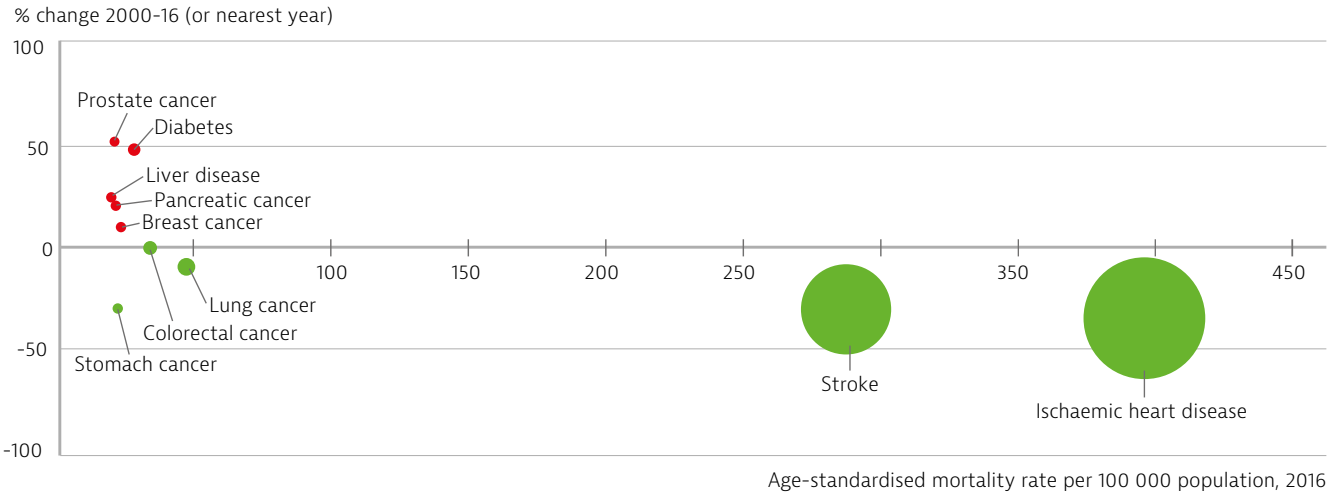
Latvia: 11 years
EU21: 7.6 years

Note: Data refer to life expectancy at age 30. High education is defined as people who have completed a tertiary education (ISCED 5-8) whereas low education is defined as people who have not completed their secondary education (ISCED 0-2).
Source: Murtin et al., OECD Statistics Working Paper N°78 (2017).

Cardiovascular diseases are the leading cause of death

Latvia's increase in life expectancy since 2000 has been driven mainly by reductions in mortality from cardiovascular diseases (Figure 3). Despite substantial reductions in the number of deaths from ischaemic heart disease (–34 %) and stroke (–30 %), however, Latvia reported the second highest mortality rate in the EU in 2016, with diseases of the circulatory system accounting for 56 % of all deaths, compared with slightly more than one-third across the EU.

Figure 3. Deaths from cardiovascular diseases have decreased but mortality from cancer is rising



Note: The size of the bubbles is proportional to the mortality rates in 2016.
Source: Eurostat Database.

In the same year, cancers accounted for 21 % of deaths (vs. 26 % in the EU), with lung cancer the leading cause, albeit showing a significant decline in mortality over the preceding decade. Mortality from other cancers such as breast and prostate cancer are, however, on the rise in Latvia, a phenomenon that can be linked in part to the low effectiveness of screening programmes in the population (see Section 5.1).

The burden of mental ill health is also significant in Latvia, with suicide a major cause of death, particularly among men. Despite some progress in suicide prevention, Latvia records the second highest suicide rate in the EU after Lithuania.

Less than half the Latvian population reports being in good health

Across all age groups, only 44 % of the Latvian population reported being in good health in 2017, a proportion substantially below the 70 % EU average. As reported in other countries, this proportion declines with age, but trends are more pronounced in Latvia than in the EU as a whole. Only about 9 % – less than a quarter of the EU average – of Latvians aged 65 and over reported being in good health, compared with 55 % among younger adults aged 16-64.

As in other countries, people on higher incomes were more likely to report being in good health. In 2017, 64 % of the Latvian population in the highest income quintile reported being in good health, compared with only 26 % of those in the lowest income quintile – one of the largest gaps in the EU.

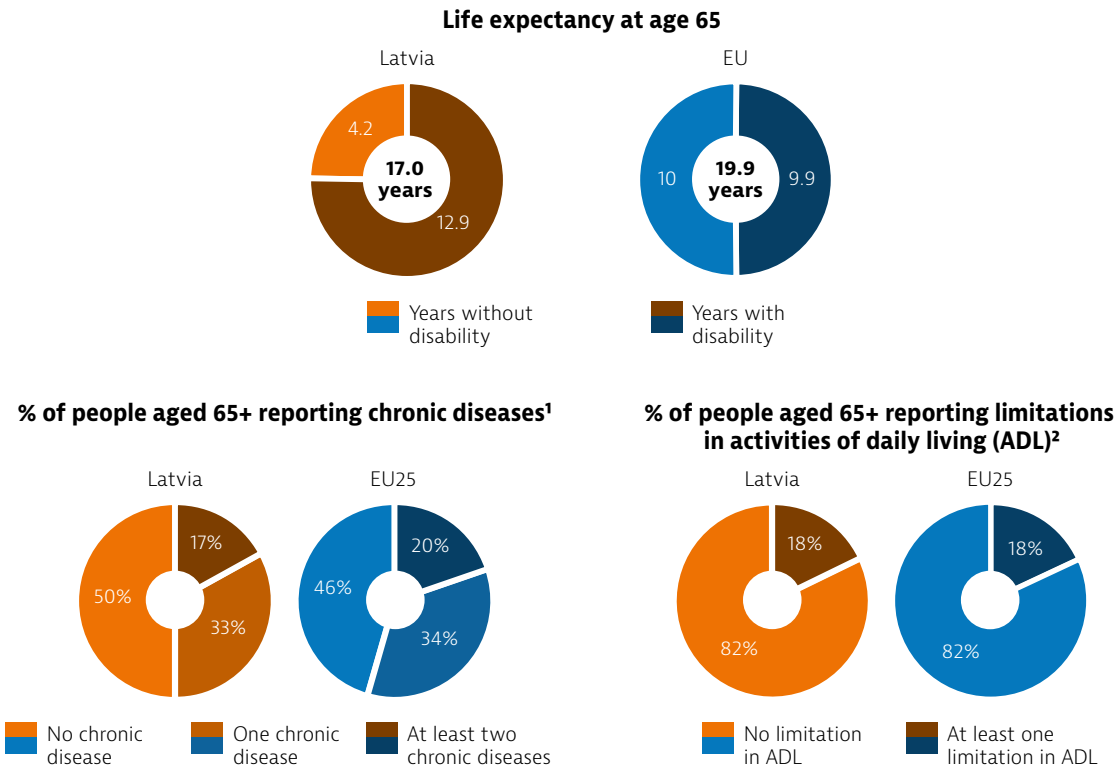
Many years of life after 65 are lived with some chronic diseases and disabilities

The general increase in life expectancy in Latvia observed in the last two decades is partly due to life expectancy gains at older ages. In 2017, Latvians at age 65 could expect to live an additional 17 years (1.9 years more than in 2000), but on average only 4.2 of those years are spent in good health (Figure 4).

Latvian women aged 65 can expect to live about five years longer than men at 19.0 years vs. 14.1 years for men. However, there is almost no difference by gender in the number of healthy life years because women tend to live a greater proportion of their lives after 65 with some chronic diseases and disabilities.

Half the population aged 65 and over report having at least one chronic condition, a proportion slightly below the EU average. Most people are able to live independently in old age, but more than one in six report some limitations in basic activities of daily living that may require long-term care, such as bathing, dressing and getting out of bed.

Figure 4. Half of Latvians aged 65 and over have at least one chronic disease



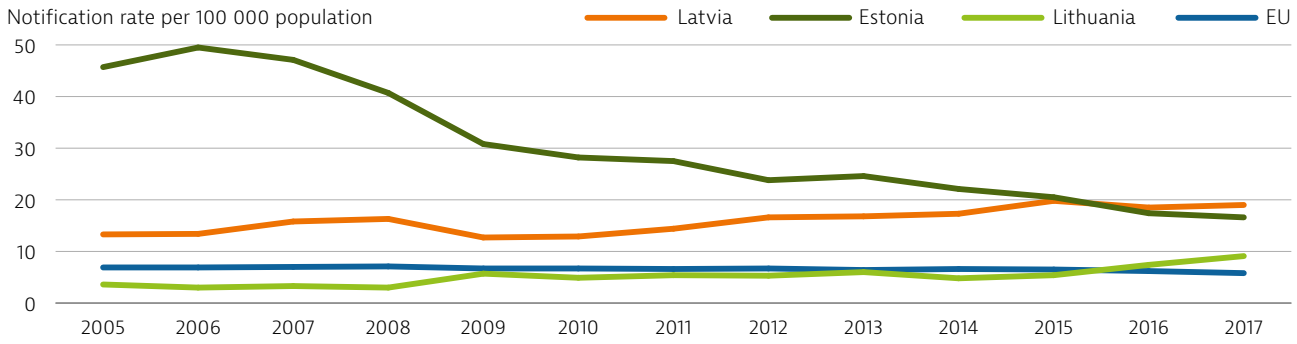
Note: 1. Chronic diseases include heart attack, stroke, diabetes, Parkinson's disease, Alzheimer's disease and rheumatoid arthritis or osteoarthritis. 2. Basic activities of daily living include dressing, walking across a room, bathing or showering, eating, getting in or out of bed and using the toilet.
Source: Eurostat Database for life expectancy and healthy life years (data refer to 2017); SHARE survey for other indicators (data refer to 2017).

Communicable diseases remain an important public health issue in Latvia

Beyond the issues of an ageing population and the rising prevalence of chronic conditions, Latvia also faces important challenges in the control of communicable diseases. The HIV epidemic is not yet under control and the notification rate remains the highest in the EU: more than three times the EU average (19/100 000 population in 2017 compared with 5.8/100 000 in the EU; Figure 5). Moreover, unlike most other EU countries, the number of new HIV cases has been increasing since 2005.

Tuberculosis is also a major public health issue in Latvia. While the notification rate has been declining since 2001, it was nevertheless nearly three times the average in the EU and European Economic Area in 2017.

Figure 5. The number of new HIV cases has increased and is now the highest in the EU



Source: ECDC/WHO Regional Office for Europe (2018), HIV/AIDS Surveillance in Europe – 2017 data.

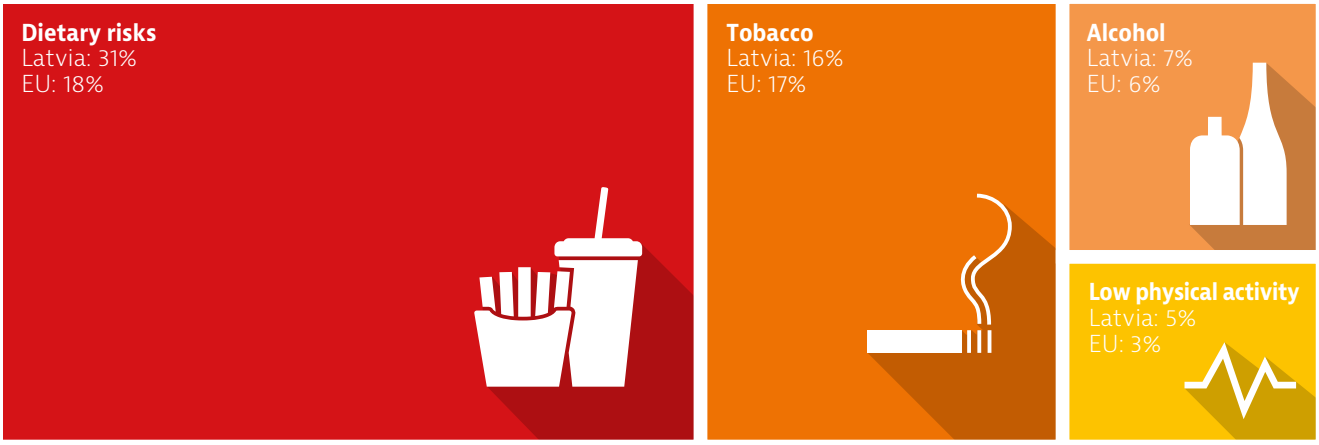
3 Risk factors

Behavioural risk factors contribute to half of all deaths in Latvia

It is estimated that 51 % of all deaths in Latvia are attributable to behavioural risk factors, including dietary habits, tobacco smoking, alcohol consumption and low levels of physical activity (IHME, 2018). This proportion is far above the 39 % EU average.

Nearly one-third of all deaths in 2017 (9 000 deaths) were attributable to dietary risks, including poor fruit and vegetable intake and high sugar and salt consumption – a proportion well above the EU average of 18 %. Tobacco consumption, including direct and second-hand smoking, was implicated in an estimated 16 % of deaths (over 4 500), while alcohol consumption contributed to around 7 % of deaths (nearly 2 000; Figure 6).

Figure 6. The majority of deaths in Latvia can be linked to lifestyle-related risk factors



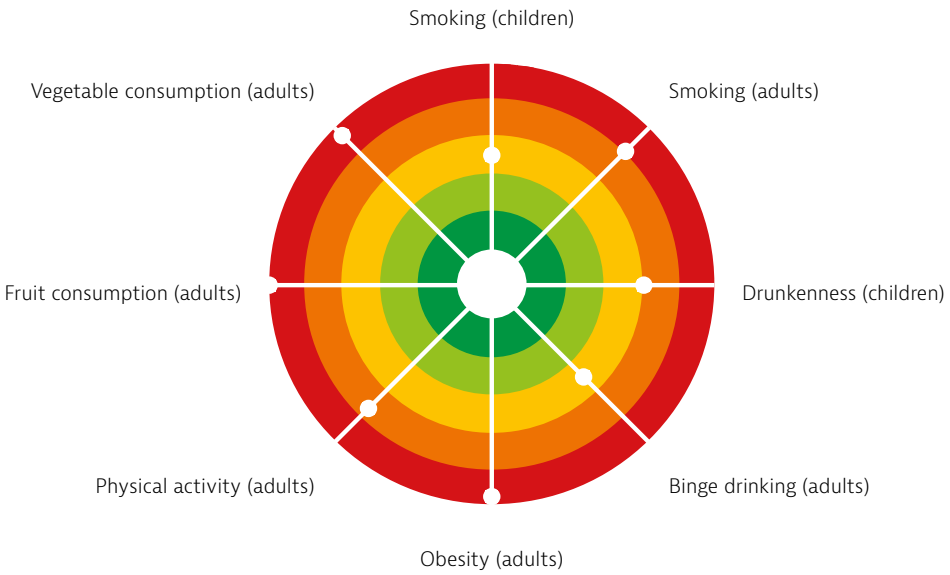
Note: The overall number of deaths related to these risk factors (14 000) is lower than the sum of each one taken individually (17 000), because the same death can be attributed to more than one risk factor. Dietary risks include 14 components such as low fruit and vegetable consumption, and high sugar-sweetened beverages and salt consumption.
Source: IHME (2018), Global Health Data Exchange (estimates refer to 2017).

Men are more likely to smoke in Latvia than in most EU countries

Smoking remains a major public health issue in Latvia. Among adults, one in four reported smoking daily in 2014, compared to one in five in the EU as a whole (Figure 7). However, the average conceals a strong gender difference, with smoking rates almost twice as high among men than women (37 % compared to 15 %). The proportion of men smoking daily is the second highest in the EU, despite having decreased by about ten percentage points since 2008.

Smoking rates among adolescents are also very high. In 2011 over 40 % of 15- and 16-year-olds reported smoking cigarettes in the preceding month – one of the highest rates of adolescent smoking in the EU at that time. Attempts to address the high smoking prevalence were made through Latvia's Public Health Strategy for 2014-20, which allocated some resources to health promotion activities targeting tobacco consumption (see Section 5.1).

Figure 7. Several behavioural risk factors are more prevalent in Latvia than in most EU countries



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 ESPAD survey 2015 and HBSC survey 2013-14 for child indicators; and EU-SILC 2017, EHIS 2014 and OECD Health Statistics 2019 for adult indicators.

Excessive alcohol consumption is an ongoing challenge in Latvia

Per capita alcohol consumption is significantly higher in Latvia than in most other EU countries, at 11.2 litres per year compared to 9.9 in the EU in 2017. In 2014 the rate of heavy episodic drinking (also called binge drinking[1]) at least once a month over the preceding year was 19 % overall, but among men it reached 33 %: five percentage points above the EU average.

Alcohol use among adolescents continues to be very common in Europe, though in recent years the percentage of teenagers aged 15-16 reporting binge drinking has declined in several countries. A similar decline has been observed in Latvia, where around 28 % of all 15-year-olds reported repeated episodes of drunkenness during the preceding month in 2013-14, down from 44 % in 2005-06. Binge drinking is of particular concern as it is associated with an increased risk of accidents and injuries, as well as having adverse effects on educational and social outcomes in adolescents.

Although a three-year alcohol strategy for Latvia was developed in 2005, lack of funding hindered its full implementation. However, some interventions aimed at restricting alcohol availability and demand – such as limited hours for off-premises sales of alcohol and substantial increases in excise taxes – were partially implemented. In 2012, an Alcohol Action Plan for 2012-14 was also adopted. More recently, in 2019 an action plan for reducing alcohol consumption and restricting alcohol addiction in 2020-22 was unveiled by the Ministry of Health (see Section 5.1).

Obesity rates are continuing to rise

The obesity rate in Latvia is well above the EU average. In 2017, more than 21 % of adults were obese, more than six percentage points above the EU average and the third highest rate in the EU. Poor nutritional habits are one factor explaining the high rate in Latvia: in 2017, almost two out of three adults (65 %) reported consuming less than one piece of fruit daily, and more than half (56 %) reported the same with respect to vegetables (Figure 7). In addition, only three in five reported engaging in at least moderate physical activity each week.

Socioeconomic inequality contributes to health risks

Many behavioural risk factors in Latvia are more common among people with lower levels of education and income. In 2014, almost a quarter of adults (24 %) who had not completed secondary education smoked daily, compared to only 14 % among those with tertiary education – an income gap much more substantial than in the EU as a whole. The obesity rate education gap is narrower: in 2017, 20 % of people without secondary education and a similar percentage (19 %) of those with higher education were obese. The higher prevalence of some risk factors among socially disadvantaged groups contributes to inequalities in health and life expectancy.

1: Binge drinking is defined as consuming six or more alcoholic drinks on a single occasion for adults, and five or more alcoholic drinks for adolescents.

4 The health system

Latvia operates a national health service health system

Latvia has a national health service (NHS) system with universal population coverage, general tax-financed health care provision, a purchaser–provider split and a mix of public and private providers. The NHS was established in 2011, succeeding 20 years of experimentation with social health insurance after Latvia regained independence.

In 2017, the government passed a law to introduce a new compulsory health insurance system, with the objective of increasing revenues for health. Under this system, entitlement to the full benefit basket would have been linked to the payment of social health insurance contributions. However, in 2019 the reform was cancelled, on the grounds that it would undermine equity and accessibility (see Box 1).

Box 1. In 2019, the Latvian government postponed a reform creating a divided health system

A health care financing law approved in December 2017 was intended to tackle the chronic underfunding of the health system and to bring the publicly funded health budget to 4 % of GDP by 2020. It stipulated that from 2019 the health benefit basket would be split in two. A minimum basket covered by the state and available to all residents would include emergency care, primary care, maternity care, psychiatric care, treatment for infectious diseases and reimbursement of medicines. The full basket of health services would be available only to those paying earmarked social security contributions.

However, in June 2019 the new Parliament adopted amendments to the law and postponed the introduction of a health financing reform to 2021, on the grounds that the two-basket system initially considered would limit access to health care services for a significant part of the population. As a result, in 2018, 2019 and 2020, all residents of Latvia, irrespective of the payment of health insurance contributions, remain entitled to health care services within the framework of state compulsory health insurance.

The new Parliament also tasked the Cabinet of Ministers with developing and submitting by March 2020 a new draft law on the introduction of a full state-paid health care package and comprehensive state compulsory health insurance.

The central government exerts strong control over the health system

The Ministry of Health is responsible for defining national health policies and regulations and for the overall organisation and functioning of the health system. The Ministry also regulates public health activities, while the Centre for Disease Prevention and Control (CDPC) coordinates and implements activities at the national and local levels in the areas of health promotion and disease prevention. Municipalities have a limited role but are responsible for ensuring access to health care services to their populations, implementing health promotion and prevention activities and organising and providing long-term care services. The NHS is the main purchaser of publicly funded health services in Latvia and is responsible for implementation of policies developed by the Ministry of Health.

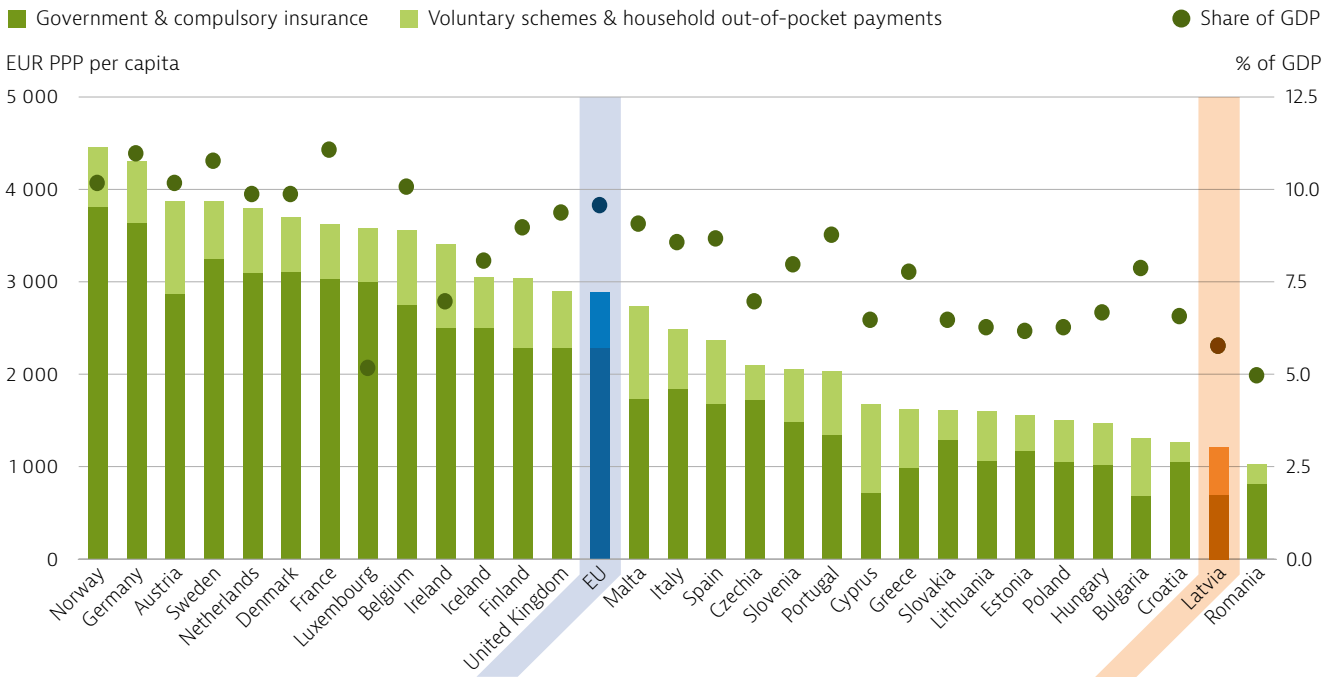
Primary care services commissioned by the NHS are provided mostly by private general practitioners (GPs) working as independent professionals. GPs are paid via a mix of capitation, fee for service, fixed practice allowances and, since 2013, a quality payments scheme. Specialist physicians practise either as independent professionals or as employees in outpatient settings and hospitals. Outpatient specialists are reimbursed at a flat rate per episode of illness.

Most hospitals are publicly owned. Transparency of the payment system in hospitals is rather limited; a diagnosis-related group-based hospital payment system was introduced in 2015, but its implementation has been delayed, and the system is currently only used to inform the global budget setting process.

Despite recent increases in spending, the Latvian health system remains underfunded

Despite a 45 % increase since 2010, health expenditure per capita in Latvia remains the second lowest in the EU after Romania, at EUR 1 213 in 2017 (Figure 8). The proportion of GDP spent on health has also increased since 2014, but at 6.0 % in 2017 it remains very low compared to the EU average (9.8 %) and 0.5 percentage points below that of the other Baltic states. Moreover, only 57.3 % of health expenditure came from public funding sources in 2017 – the third lowest proportion in the EU and considerably below that of neighbouring countries (66.5 % in Lithuania and 74.7 % in Estonia).

Figure 8. Health expenditure has increased in Latvia but remains among the lowest in the EU



Source: OECD Health Statistics 2019 (data refer to 2017).

Despite spending shifts to outpatient care, over-reliance on the hospital sector persists

While several European countries have announced plans to shift care provision away from inpatient care, Latvia is one of the few that has increased the proportion of spending on outpatient care – by almost 20 % since 2010: from 27 % to 32 % of total spending. The overall number of hospitals of all sizes has been reduced substantially in recent years (from 156 in 1997 to 63 in 2017) and this has had an impact on the number of hospital beds per 1 000 population. Between 2005 and 2016, this rate declined more rapidly in Latvia than in the EU as a whole – from 7.9 in 2005 to 5.6 in 2017 – but remained above the EU average of 5.0 in 2017.

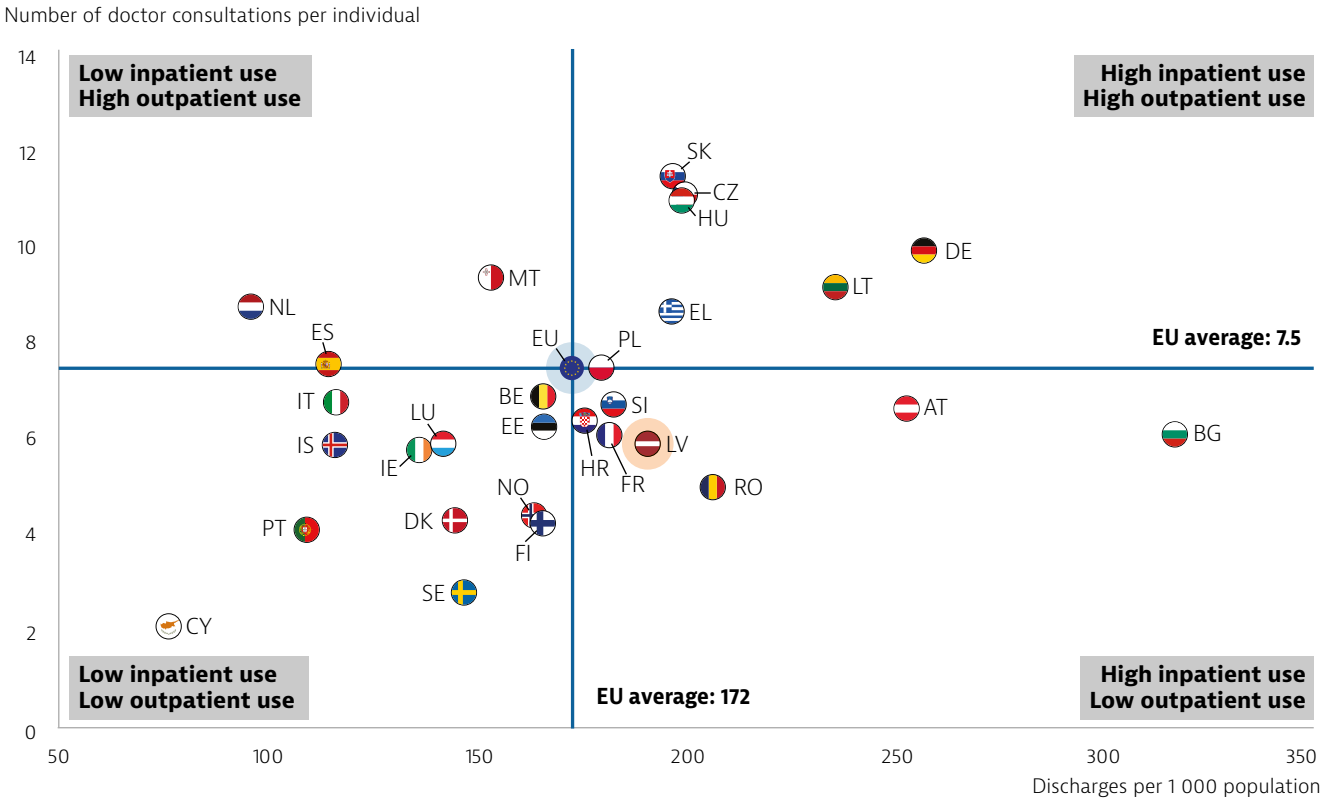
Recent reforms have aimed at concentrating specialised care in fewer hospitals, by creating a 'tiered' system under which the NHS contracts fewer hospital services in order to promote a shift in use from inpatient to outpatient or day care settings. Over the same period, the health services offered in primary care grew substantially: the number of health care institutions providing outpatient services increased from 1 127 to 3 667, the number of primary care practices (GP, paediatricians, internists) grew from 361 to 1 239, and the number of other outpatient health care institutions grew from 75 to 956.

Yet despite these changes, the Latvian health system remains very hospital-centric. In 2017, the bed occupancy rate (71 %) was lower than the EU average (77 %), pointing to persistent hospital overcapacity. The number of discharges also remained higher than the EU average (Figure 9), indicating opportunities to improve disease management in the community (see Section 5.3), and the average length of stay was 8.4 days – slightly longer than the EU average of 7.9 days – having not declined since 2012.

A high proportion of health care resources are spent on medicines and medical devices

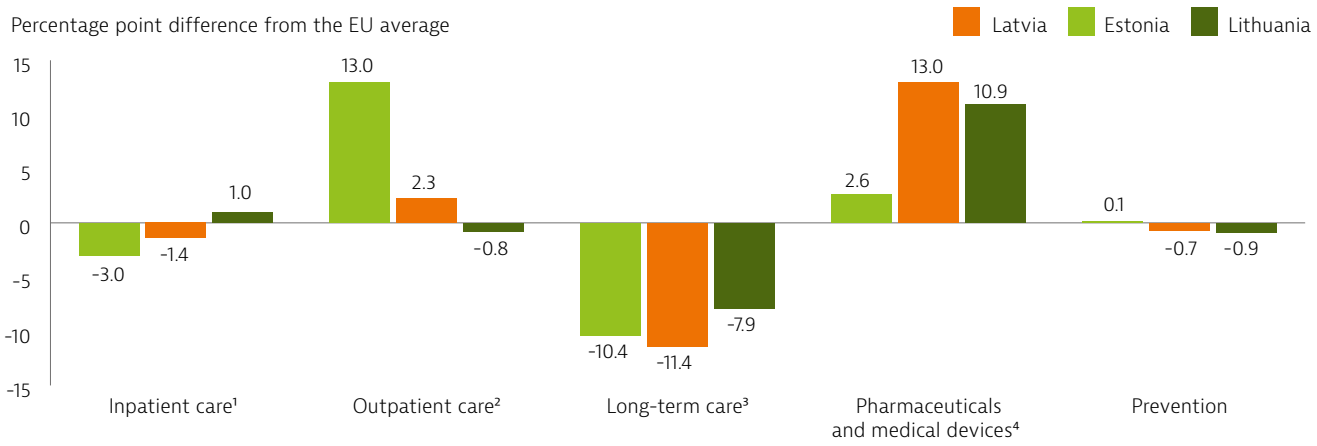
In 2017, about 31 % of Latvia's health care budget was absorbed by the cost of medicines and medical devices – a proportion much higher than the EU average of 18 %. However, in absolute terms, pharmaceutical spending in Latvia was one-third below the EU average (EUR 378 per person compared with EUR 522 in the EU). While the shares of health expenditure devoted to inpatient and outpatient care were similar to EU averages (close to 30 % each in 2017), the proportion spent on long-term care was significantly lower (5 % vs. 16 % in the EU; Figure 10).

Figure 9. Despite progress, the Latvian health system remains very hospital-centric



Note: Data for doctor consultations are estimated for Greece and Malta.
Source: Eurostat Database; OECD Health Statistics (data refer to 2016 or the nearest year).

Figure 10. Latvia's health resource allocation differs from the EU average and other Baltic states



Note: Administration costs are not included. 1. Includes curative-rehabilitative care in hospital and other settings; 2. Includes home care; 3. Includes only the health component; 4. Includes only the outpatient market.
Sources: OECD Health Statistics 2019, Eurostat Database (data refer to 2017).

Out-of-pocket spending on health is the third highest in the EU

Out-of-pocket (OOP) spending[2] on health is very high in Latvia, accounting for 41.8 % of total health expenditure in 2017 – almost three times the EU average. This relatively high reliance on OOP expenditure for the health system's financing can be explained by its significant underfunding, as well as the limited scope of the benefit package. While most hospital spending is publicly funded, public coverage for outpatient medical care, pharmaceuticals, medical devices and dental care is much more limited than in other EU countries (OECD/EU, 2018). As a result, patients have to contribute a substantial proportion of the costs of the health services, including specialist visits, hospital stays and prescription medicines (see Section 5.2).

Shortages of health care personnel are aggravated by uneven geographical distribution

In Latvia, health workers are highly concentrated in urban areas, which gives rise to equity and accessibility issues for residents living in rural areas (see Figure 11 and Section 5.2). Moreover, while the number of practising doctors in Latvia is slightly below the EU average, at 3.2 doctors per 1 000 population, the number of nurses is less than half the EU average.

During the 2008-09 economic crisis, severe budget constraints led to cuts in health workers' salaries and reductions in employment of doctors and nurses (Figure 12). In recent years, the authorities have taken steps to reduce these shortages. These include an increase in the wages of medical practitioners in 2018 and an additional 20 % increase each year for 2019-21. Additional measures planned include support for continuing medical education to enable non-practising medical practitioners to return to the workforce and additional compensation for the extended working hours of health care personnel (European Commission, 2019a). Also, since 2018 an EU-funded project has provided financial incentives to attract medical practitioners to work in regions outside Riga. As of July 2019, 315 medical practitioners have received such financial support. Beneficiaries include doctors of various specialties, as well as medical assistants, nurses, nursing assistants, midwives and physiotherapists.

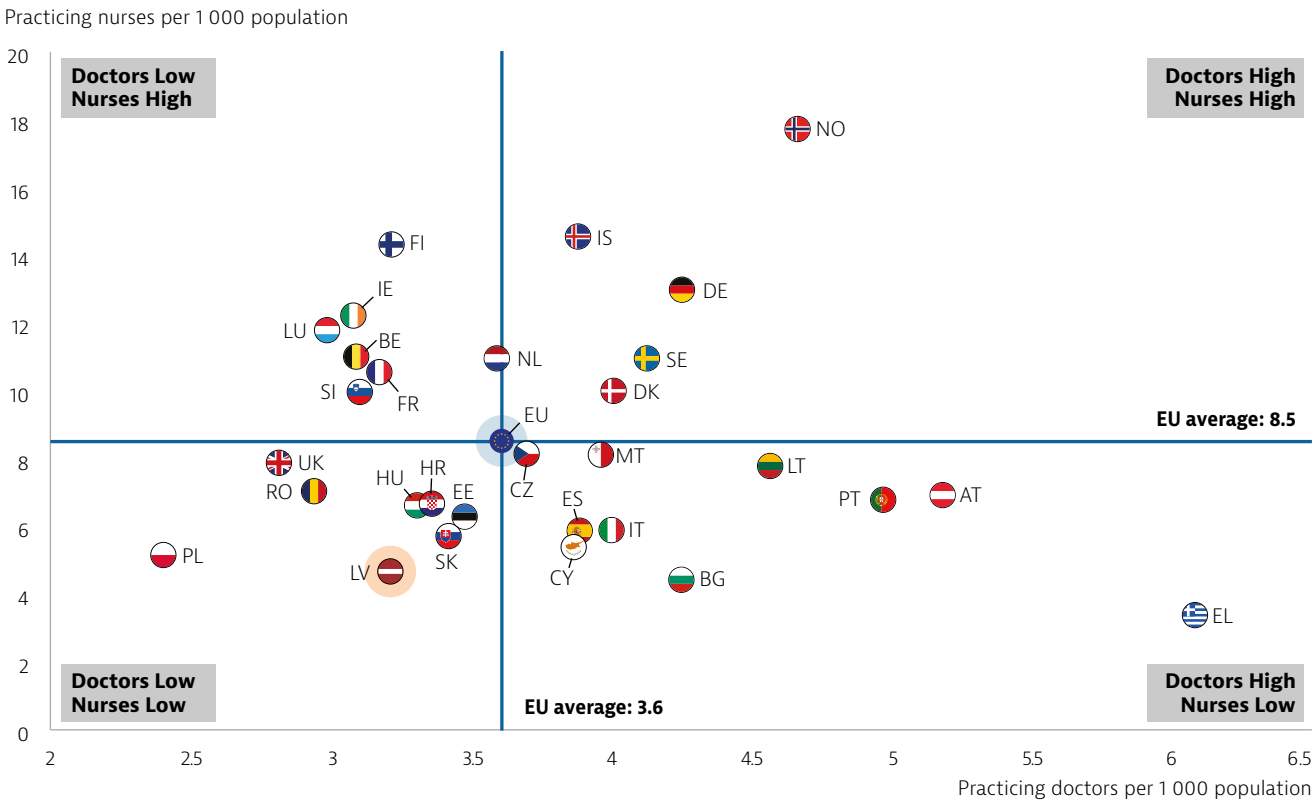
The private sector is growing in response to bottlenecks in access to the public system

Provision of general health services is regulated mainly through contracts signed between health care providers and the NHS. For inpatient care, the NHS has a quota system, purchasing only a certain number of services per year, depending on the available budget. There is a partial gatekeeping system, with patients requiring referrals from GPs to access most secondary ambulatory and hospital care services, with some exceptions (e.g. for gynaecology).

Significant geographical imbalances in the distribution of public health care services, long waiting times and high co-payment rates have led to a substantial expansion of a parallel private health care sector. The number of private, for-profit hospital beds grew from 3.3 % to 10 % of the total number between 2000 and 2016.

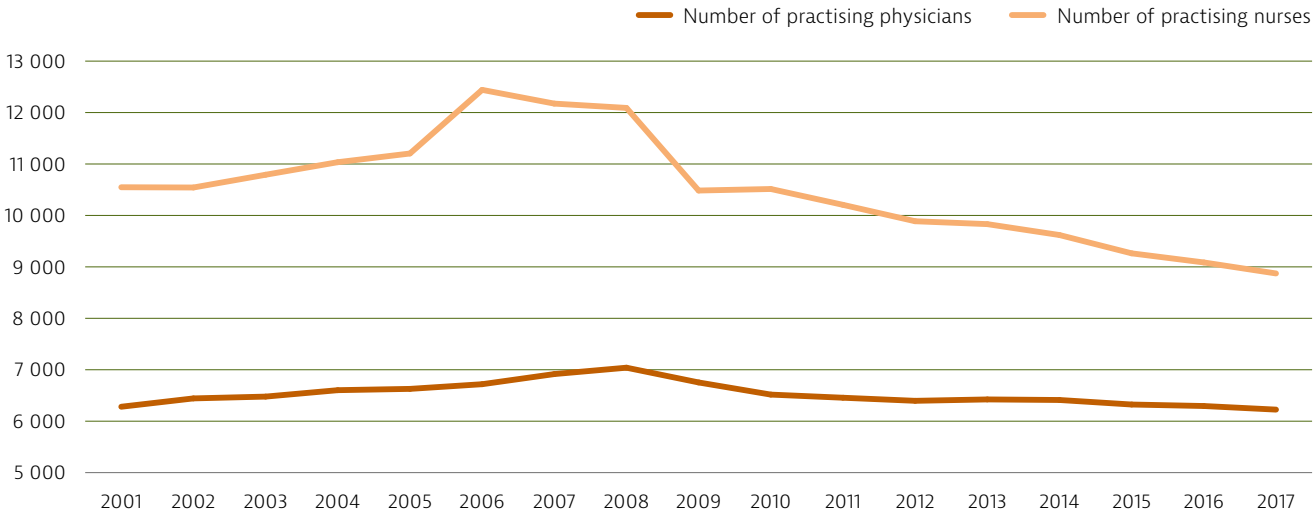
2: OOP payments include direct payments, cost-sharing for services outside the benefit package and informal payments.

Figure 11. Health workforce shortages are a major concern for the Latvian health system



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 (data refer to 2017 or the nearest year).

Figure 12. The 2008-09 economic crisis led to reductions in employment of doctors and nurses



Source: OECD Health Statistics 2019.

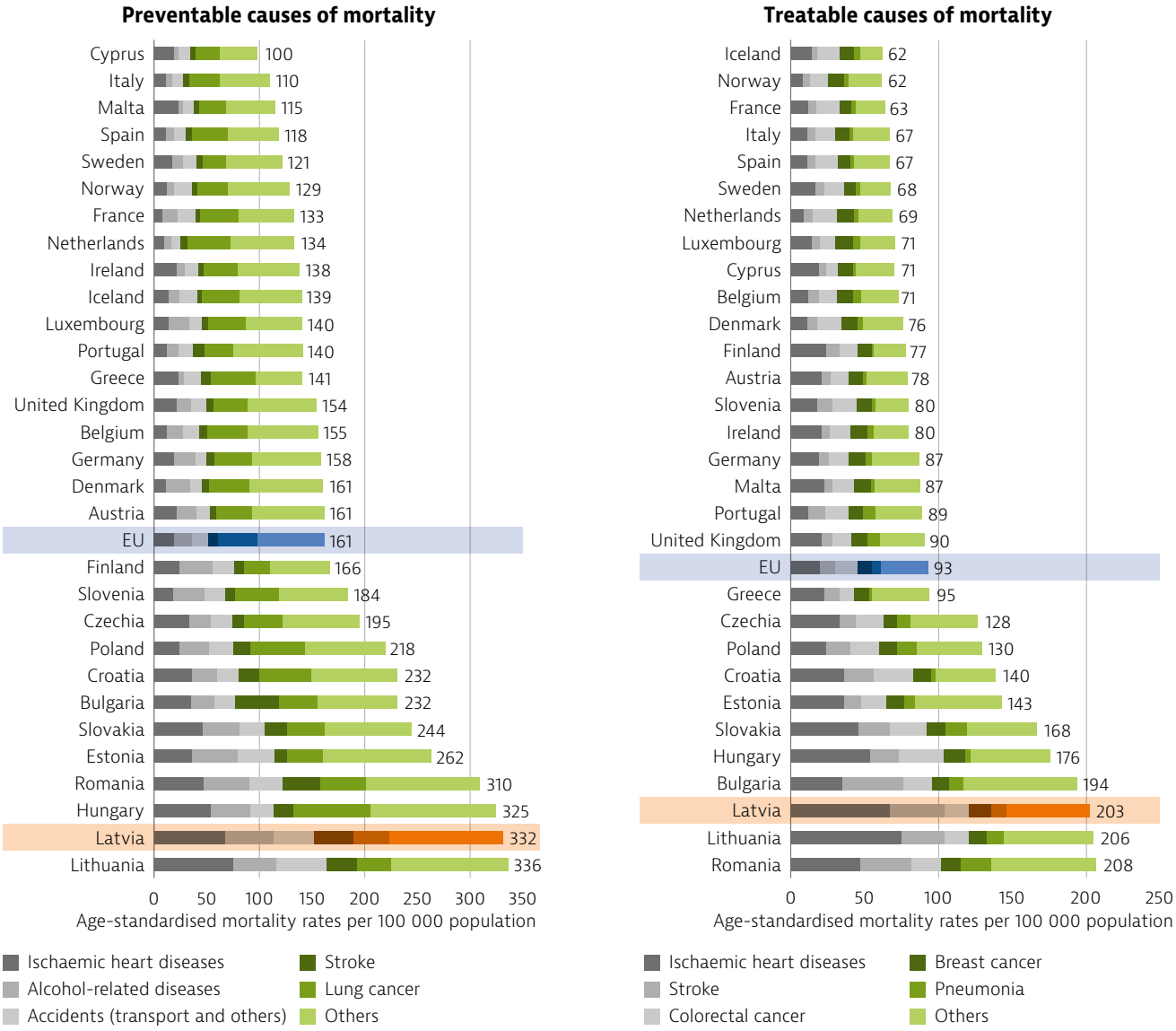
5 Performance of the health system

5.1. Effectiveness

Many deaths in Latvia could be avoided through better prevention and health care

Latvia had the second highest preventable mortality rate and third highest mortality rate from treatable causes in the EU in 2017 (Figure 13). Nearly 6 000 deaths could have been avoided in 2017 through effective public health and prevention interventions, and a further 3 500 deaths through more appropriate and timely health care. This highlights a substantial need to develop more effective public health policies and to reform and invest in improving the quality of the health care system.

Figure 13. Latvia reports among the highest rates of preventable and treatable mortality in the EU



Note: Preventable mortality is defined as death that can be mainly avoided through public health and primary prevention interventions. Mortality from treatable (or amenable) causes is defined as death that can be mainly avoided through health care interventions, including screening and treatment. Both indicators refer to premature mortality (under age 75). The data are based on the revised OECD/Eurostat lists.
Source: Eurostat Database (data refer to 2016).

Latvia is attempting to tackle the disease burden driven by behavioural risks

Diseases of the circulatory system remain the leading cause of death in Latvia, and behavioural risk factors – alcohol, smoking, poor nutrition and physical inactivity – are implicated in over 50 % of deaths (see Sections 2 and 3).

Latvia currently spends 2.4 % of its health care budget on public health and prevention, a lower proportion than the EU average of 3.1 %, but considerably higher than in several other European countries. To address the disease burden attributable to behavioural risk factors, Latvia's Public Health Strategy for 2014-2020 allocated resources to health promotion activities targeting substance abuse reduction, healthy diet and physical activity – including diet and nutritional awareness in schools – and sexual and reproductive health. Fruit, vegetables and milk were provided in participating kindergartens and in schools for the first to ninth grades (ages 6-14). In addition, anti-smoking campaigns and a public awareness campaign on cardiovascular disease risk factors began in 2013 and continued throughout 2017.

More recently, several pieces of legislation have been enacted prohibiting the sale of energy drinks to people under 18; setting the maximum permissible content of trans fatty acids in foodstuffs, and maximum volumes of alcoholic beverages; and prohibiting smoking in the presence of children or pregnant women, as well as in state and local government buildings. In other anti-smoking measures, the Tobacco Law regulates tobacco advertising and sales of tobacco, and sets out requirements for health warnings on tobacco packaging.

In July 2019, the Ministry of Health presented the draft of a three-year action plan to reduce alcohol consumption and alcohol addiction. The plan envisages a complete ban on the advertising of alcohol on television, radio and the internet, as well as on the sale of alcoholic beverages in gas stations. It also plans to improve alcohol addiction treatment and rehabilitation services.

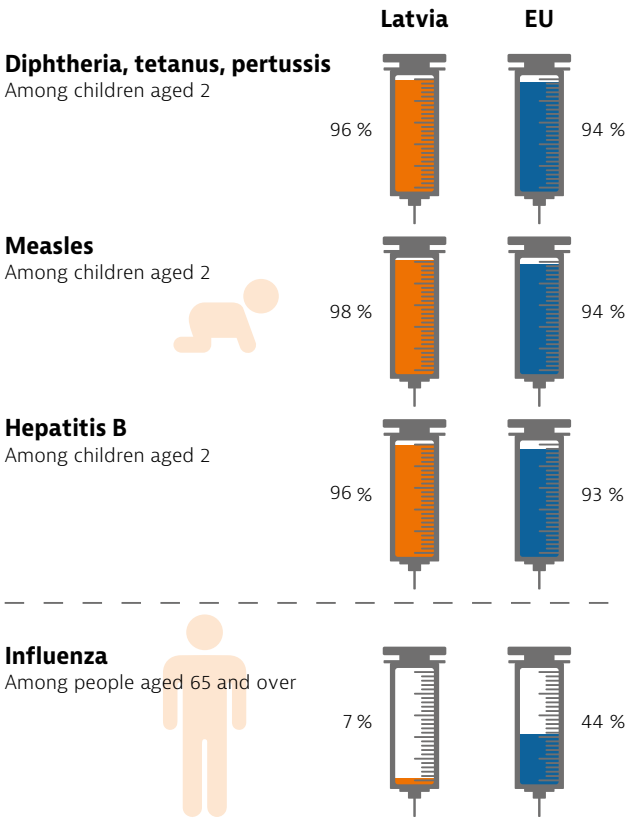
Childhood vaccination coverage is very high in Latvia

Despite not being mandatory, immunisation rates for routine childhood vaccinations in Latvia are very high and above the 95 % coverage target suggested by WHO (Figure 14). Routine childhood vaccinations included in the benefit package are provided free of charge by the state. For people classified as belonging to a list of nominated risk groups – for instance, those suffering from chronic respiratory disease and chronic kidney disease – the NHS also covers 50 % of the cost of seasonal influenza vaccine. The remaining cost and the fee for administration must be paid out of pocket (Rechel, Richardson & McKee, 2018).

By contrast, seasonal influenza vaccination coverage for people over 65 remains very low, with only 7 % of people vaccinated in 2017, well below the EU average of 44 %, and even further from the WHO target of 75 %. This may be related to the financial burden of vaccine purchase and administration costs, but the lack of awareness concerning the health threats posed by influenza and misconceptions about vaccine safety may also be a contributing factor.

The CDPC is responsible for planning, coordinating and monitoring the implementation of the state immunisation programme. It also estimates the quantity of vaccines necessary for implementation of the vaccination schedule. The State Immunisation Advisory Council has been established to evaluate and respond to issues related to vaccination and to recommend new vaccines.

Figure 14. Immunisation rates among children are high, but coverage among elderly people is low



Note: Data refer to the third dose for diphtheria, tetanus, pertussis and hepatitis B, and the first dose for measles.
Source: WHO/UNICEF Global Health Observatory Data Repository for children (data refer to 2018); OECD Health Statistics 2019 and Eurostat Database for people aged 65 and over (data refer to 2017 or the nearest year).

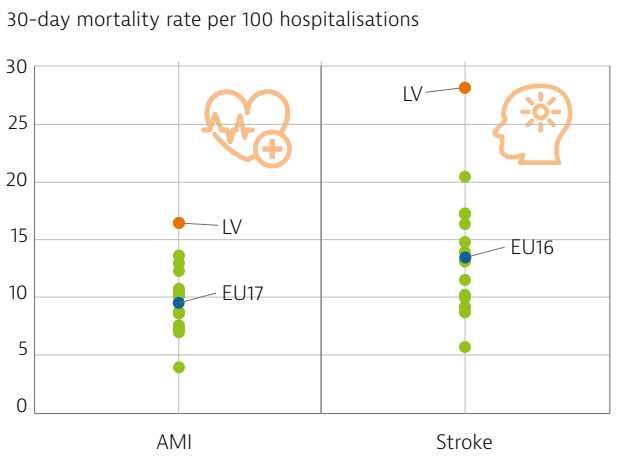
30-day mortality from acute myocardial infarction and stroke is the highest in the EU

Mortality after hospitalisation for acute conditions is a common indicator of hospital care quality. The 30-day mortality rate following hospital admission for acute myocardial infarction (AMI) or stroke reflects the processes of care, including timely transport of patients to hospital and effective medical and surgical interventions. The rates for these two conditions are the highest reported in the EU (Figure 15).

Cancer care outcomes are improving despite very low levels of screening

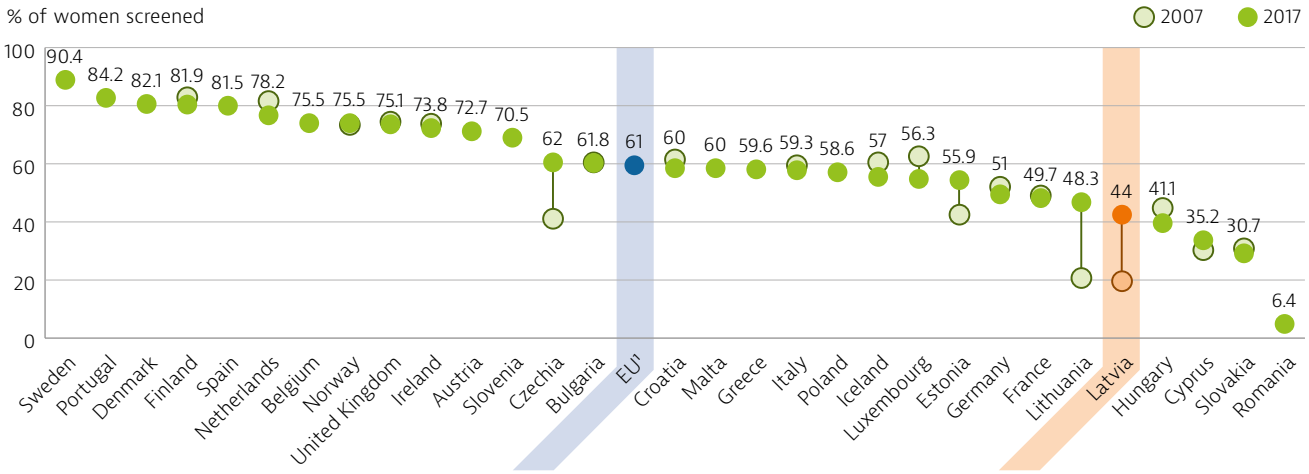
Although some cancer screening rates in Latvia are improving, they remain low by EU standards. In 2017, only around 44 % of women aged 50-69 had been screened for breast cancer within the preceding two years (Figure 16) and only 39 % had been screened for cervical cancer over the same period, compared with an EU average of more than 60 % in both cases.

Figure 15. The 30-day mortality rates for acute conditions in Latvia are the highest in Europe



Note: Figures are based on patient data and have been age-sex standardised to the 2010 OECD population aged 45+ admitted to hospital for AMI and ischaemic stroke.
Source: OECD Health Statistics 2019 (data refer to 2017 or nearest year).

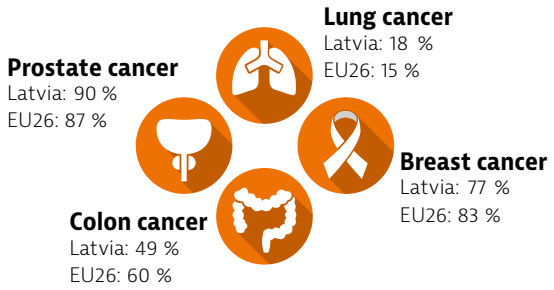
Figure 16. Screening rate for breast cancer has improved but remains among the lowest in the EU



Note: 1. The EU weighted average has been calculated by the OECD.
Source: OECD Health Statistics 2019 and Eurostat Database (Joint questionnaire on non-monetary health care statistics).

However, the quality of cancer care has improved over the past decade and is now comparable to that in most EU countries, with five-year survival rates after diagnosis for most forms of cancer approaching – and in some cases even slightly exceeding – those elsewhere in the EU (Figure 17).

Figure 17. Five-year cancer survival rates in Latvia are comparable with EU averages



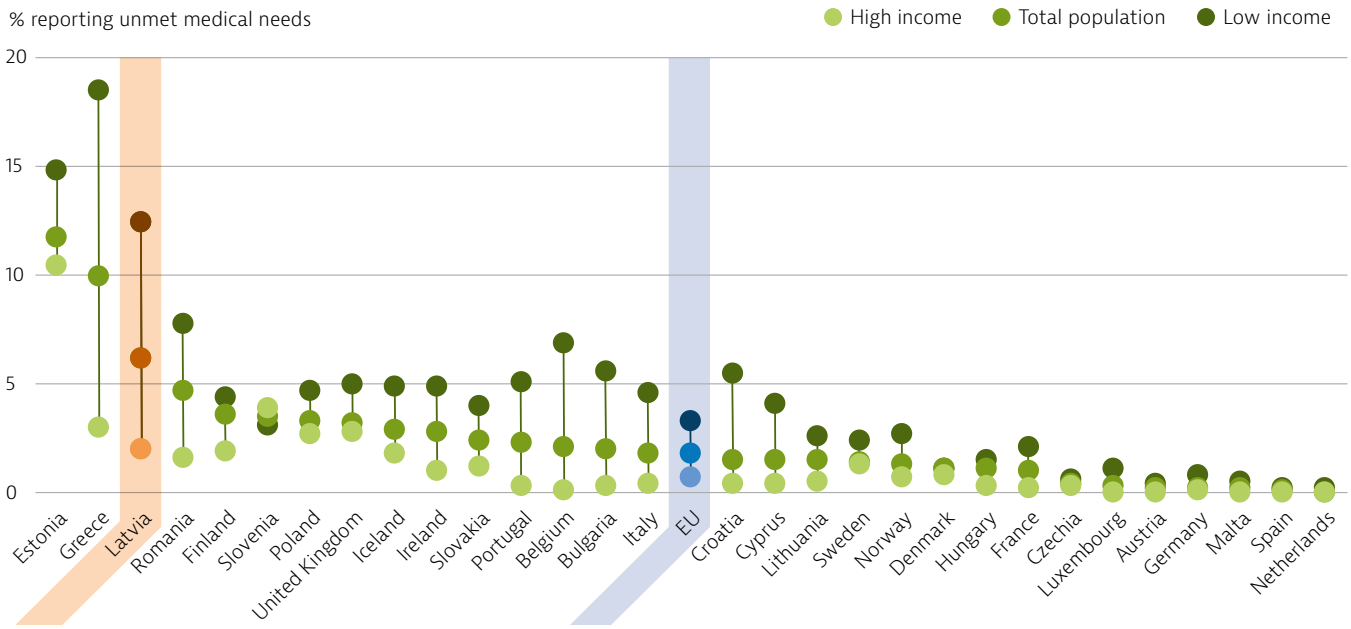
Note: Data refer to people diagnosed between 2010 and 2014.
Source: CONCORD programme, London School of Hygiene and Tropical Medicine.

5.2. Accessibility

A substantial share of the population cannot access the care they need

The proportion of the Latvian population reporting unmet needs for medical treatment is among the highest in Europe. In 2017, 6.2 % of the population reported having foregone medical care due to costs, distance to travel or waiting times – well above the EU average of 1.7 % (Figure 18). Moreover, financial barriers to access disproportionately affect lower income groups. In 2017, Latvians in the lowest income quintile reported much higher levels of unmet needs for medical and dental care due to cost (9.9 % and 25.5 % respectively) than those in the highest income quintile (0.9 % and 3.3 % respectively).

Figure 18. The level of reported unmet medical needs is high in Latvia

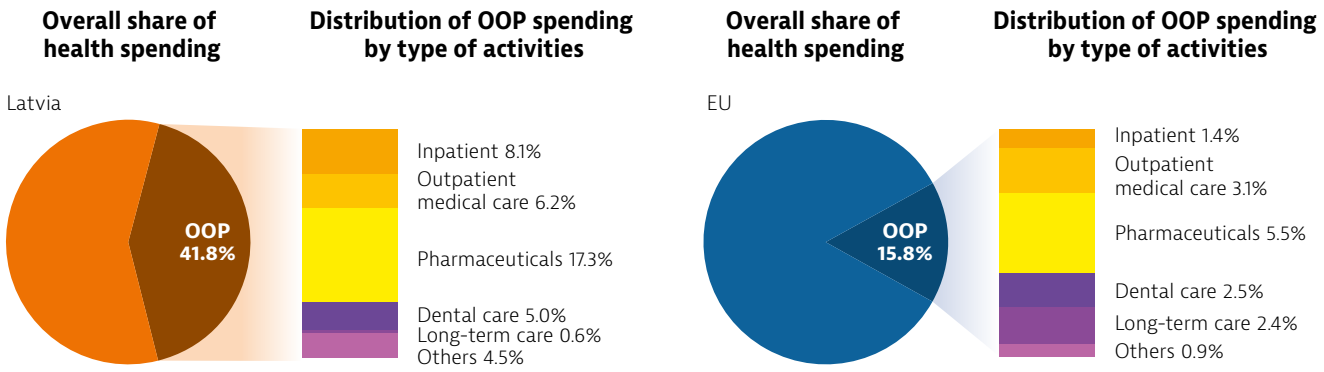


Note: Data refer to unmet needs for a medical examination or treatment due to costs, distance to travel or waiting times. Caution is required in comparing the data across countries, as there are some variations in the survey instrument used.
Source: Eurostat Database based on EU-SILC (data refer to 2017).

Many Latvians report difficulties in affording health care services

In 2017, 61.9 % of the Latvian population and 72.8 % of Latvian households on low incomes reported using health care services, but having some, moderate or great difficulty in affording them. This is probably due to the high level of OOP spending in Latvia: at 42 %, this was the third highest level in the EU (average 16 %; Figure 19), and had increased significantly from around 35 % in the mid-2000s.

Figure 19. The proportion of out-of-pocket health spending in Latvia is nearly three times the EU average



Source: OECD Health Statistics 2019 (data refer to 2017).

In Latvia, OOP spending is mainly driven by pharmaceuticals and medical devices. The list of medicines covered by the NHS is relatively limited, and a percentage reimbursement system applies (100 %, 75 % or 50 % of the defined reference price), as well as a prescription fee of EUR 0.71 for medicines reimbursed at 100 %. Some exemptions have been defined (e.g. for children and people on low income), but recent reforms have removed some of the waivers introduced in recent years (WHO Regional Office for Europe, 2018a). In 2019 the authorities have planned the introduction of new measures to improve financial access to medicines through more stringent price regulation (see Box 2).

These high levels of OOP payments create barriers to access, especially for people on low incomes. OOP medical spending accounted for more than 4 % of final household consumption in Latvia in 2017, nearly twice as high as the EU average. In 2013, almost 13 % of the Latvian population experienced catastrophic health spending[3] (Figure 20), a major increase from the 2010 level of 10.6 % and the second highest proportion documented in the EU. The incidence of catastrophic health spending is also heavily concentrated among the poorest quintile of the population. The costs of outpatient medicines were almost exclusively responsible for catastrophic spending in all quintiles (WHO Regional Office for Europe, 2018b).

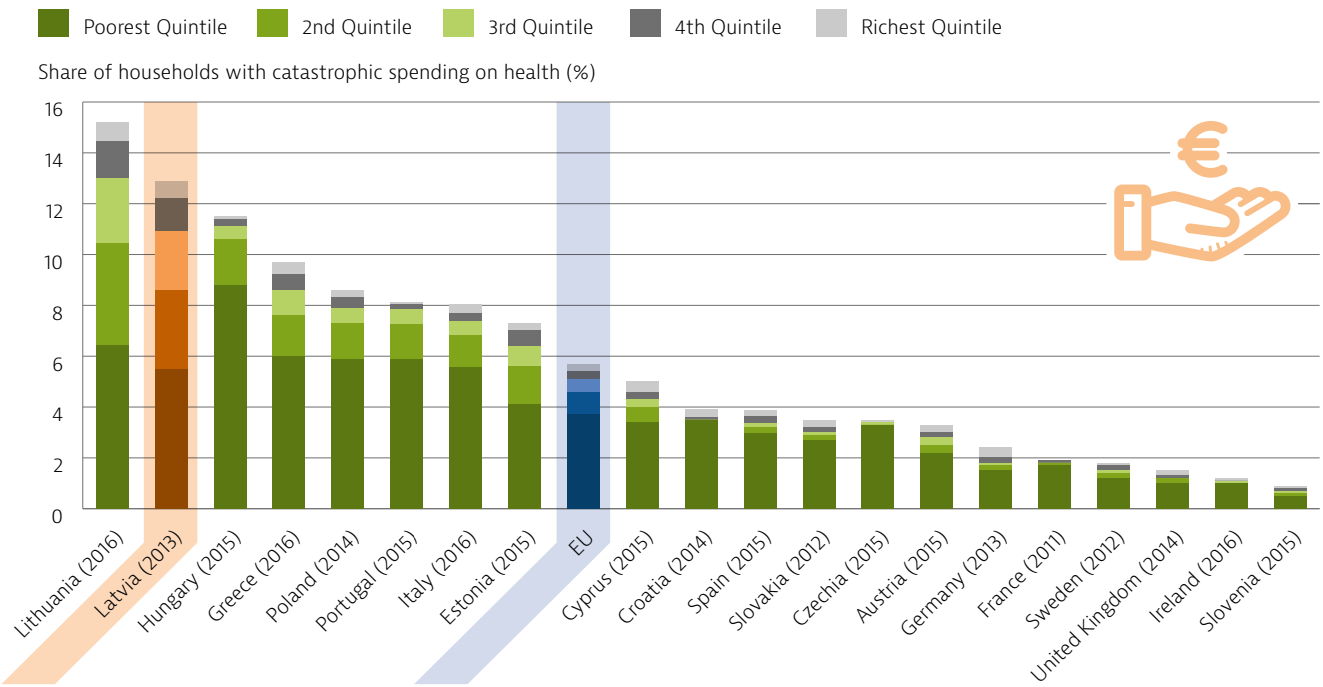
Box 2. Further control of outpatient medicines prices will be introduced in 2020

To improve the availability of reimbursable medicines, in July 2019 the Latvian government approved amendments to regulations on the reimbursement of medicines and medical devices. The purpose of the legal text is to reduce the cost of medicines and patient co-payments for reimbursable medicines via better price control.

In accordance with this new regulation, as of April 2020, the following measures will be enforced:

- the external reference pricing system will be revised and the basket of reference countries changed;
- a price ceiling for medicines subject to internal reference pricing will be introduced (the most expensive alternative will have to be less than double the price of the cheapest one);
- prescription by international non-proprietary name will have to be made for at least 70 % of doctors' yearly prescriptions;
- for medicines subject to internal reference pricing, it will be mandatory for pharmacies to keep stocks of the cheapest alternative.

Figure 20. A substantial share of the population reports catastrophic expenditure on health



Source: WHO Regional Office for Europe, 2019.

3: 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).

The benefit package is comparatively narrow and limited by a quota system

The NHS benefit package is defined by a number of explicit inclusions and exclusions, and is less comprehensive than in most other EU countries (OECD/EU, 2018). Services explicitly excluded from coverage include dental care for adults, some rehabilitative and physiotherapy services, sight correction, hearing aids for elderly people, spa treatments and termination of pregnancy, if there are no medical or social grounds (WHO Regional Office for Europe, 2018b).

Moreover, despite nominal inclusion in the benefit package, in practice access to specialist and hospital outpatient and inpatient services is restricted as a result of annual volume caps or quotas. Once providers' annual quotas with the NHS have been reached, patients must wait until the following year when the quota is renewed, which can lead to long waiting times. Patients who wish to avoid waiting, or to receive services excluded from NHS coverage, must cover all costs out of pocket or through voluntary health insurance. While waiting-time guarantees have not been established thus far, in 2018 the government allocated an additional EUR 194 million to improve access to health care services, including reducing waiting times.

The uneven geographical distribution of health professionals creates barriers to access

Access to care is particularly limited in rural areas. While the number of practising doctors in Latvia is close to the EU average (see Section 4), there is considerable variation in their distribution across regions. An analysis of physician density across the country reveals a clear divide between urban and rural areas that constitutes an access barrier for many Latvians living outside major urban centres. In 2018, the density of practising medical doctors was more than three times higher in the Riga area than in Zemgale or Kurzeme (Figure 21), an imbalance that has been exacerbated by internal and external migration of young health workers unwilling to work in rural areas. The age composition of the currently practising GP workforce is a further concern, as the retirement of substantial numbers of GPs is anticipated in the next few years (OECD, 2017), foreshadowing the development of additional shortages and regional imbalances in the distribution of primary care physicians.

In light of these issues, the Latvian authorities have begun taking steps to ensure an adequate supply of health professionals in rural areas. The capitation rate[4] for primary health care in rural areas, for example, is higher than in urban areas. In addition, since April 2015 medical universities are required to give priority to applicants who have agreed to practise in a rural area on completion of their training. The government has also raised salaries for all groups of health professionals and increased the number of student places in nursing schools. While these actions may mitigate some of the workforce challenges, Latvia could consider other innovative solutions to reduce geographical barriers to access, including making better use of existing health resources for rural populations (such as pharmacists, practising nurses and feldshers[5]/medical assistants; OECD, 2017).

Figure 21. The distribution of doctors across regions is severely unbalanced

Source: Statistical yearbook of health care in Latvia, 2018.

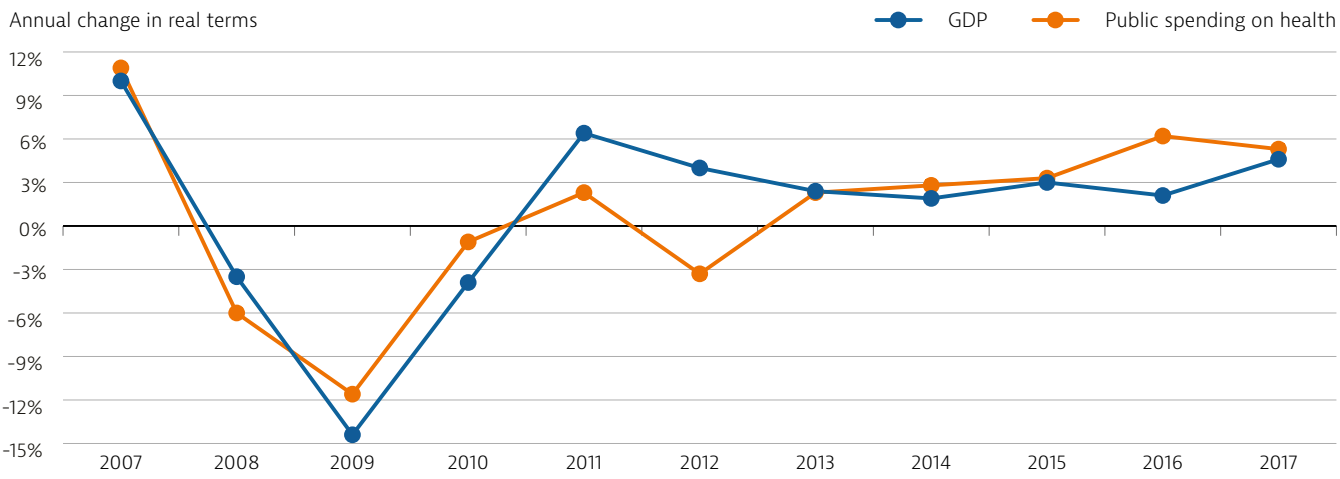
4: *Capitation is a type of a health care payment system in which a doctor is paid a fixed amount per patient for a defined period of time.*
5: *A feldsher is a health care worker with limited training who provides various medical services limited to emergency treatment and ambulance practice.*

5.3. Resilience[6]

Public spending on health was affected by the economic crisis

In the aftermath of the European sovereign debt crisis of 2008-09, public spending on health declined in Latvia (Figure 22), both in real terms and as a share of GDP: from 6.2 % of GDP in 2009 to 5.4 % in 2012. It was not until 2013 that the growth of public health expenditure caught up with economic growth, leading to an increased share of GDP devoted to health.

Figure 22. Public spending on health decreased following the economic crisis

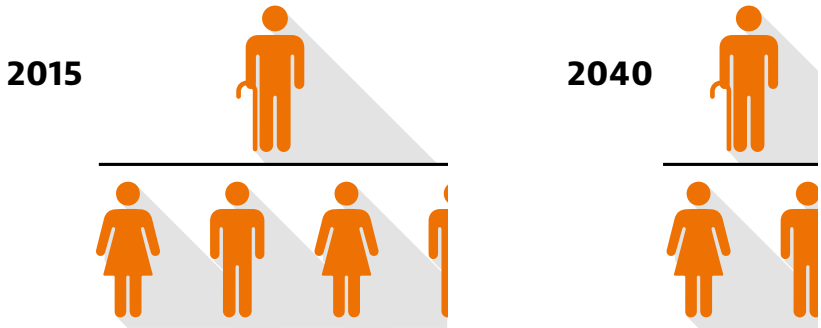


Source: OECD Health Statistics 2019, Eurostat Database.

Population ageing is projected to put pressure on health and long-term care spending

Population ageing is expected to increase the demand for health and long-term care, and at the same time fewer working-age people will be financing and delivering those services (Figure 23). Health care expenditure is projected to increase by 0.6 percentage points of GDP between 2016 and 2070, below the average growth expected for the EU of 0.9. Overall, for Latvia no significant short-term risks of fiscal stress appear on the horizon, although some macro-financial indicators point to possible short-term challenges (European Commission, 2019b). The twin challenges of increasing demand driven by an ageing population and population expectations of higher standards of care call for an improvement of the health system in terms of both efficiency and public investment. In its 2019 European Semester Country Specific Recommendations, the European Commission called for such actions to be taken[7] (Council of the European Union, 2019).

Figure 23. The number of working-age people per person aged over 65 will almost halve by 2040



Note: This graphic shows the number of people aged 20-64 (denominator) per person aged 65+ (numerator).
Source: UN Population Projections.

6: Resilience refers to health systems' capacity to adapt effectively to changing environments, sudden shocks or crises.
7: In July 2019 the Council of the European Union issued Latvia a country-specific recommendation to 'increase the accessibility, quality and cost-effectiveness of the healthcare system.

Efforts to overhaul the hospital sector could result in more efficient use of resources

While Latvia has made progress towards improving the efficiency of its health system by concentrating services in fewer higher-quality hospitals and reducing excess bed capacity (see Section 4), a series of further reforms would enable the system to reduce waste and improve value for money. The Latvian hospital sector has two types of public ownership with different regulatory conditions. Central government-owned hospitals operate within strict financial constraints and cannot carry deficits at the end of the fiscal year. By contrast, municipal hospitals have less stringent operating conditions and make autonomous procurement and capital investment decisions. Unfortunately, this system creates incentives for municipal hospitals to buy expensive pieces of equipment such as MRIs and CT scanners, the use of which is then financed by the NHS. This may in part explain why Latvia reports one of the highest rates of CT scans per million population in the EU (36 vs. 22 in the EU as a whole) – well above the rates reported in the other Baltic states. Moving the ownership and functional governance of all hospitals to the central level could reduce such inefficiencies (OECD, 2017).

The recent introduction of diagnosis-related groups is another step towards promoting more efficient use of hospital resources. However, hospitals do not have sufficient incentives to promote quality of services. The NHS could consider more strategic contracting arrangements to incentivise quality and efficiency. It could, for example, strengthen monitoring and evaluation of hospital activities and contract selectively with better-performing hospitals to drive quality improvement (OECD, 2017). In addition, as the majority of services are still reimbursed on a fee for service basis, alternative payment mechanisms could reduce the incentives for volume rather than quality of services.

Better use of health data can drive quality of care improvements

Establishing a more thorough collection of high-quality information to measure, compare and improve the performance of health care provision is essential to improve the efficiency of the Latvian health care system. In recent years, Latvia has strengthened its health information infrastructure, and has set up instruments to access to high-quality health system data. Several national institutions, including the CDPC, the Central Bureau of Statistics and the NHS collect and report health system information relating expenditure, health care activities and quality in primary and secondary care. Latvia also introduced an eHealth system in 2015. All providers and patients are expected to share data on diagnoses, health care services and treatments.

Over the long term, the introduction of the eHealth system should contribute to enhancing care quality and efficiency, and reducing duplication of diagnostic tests (OECD, 2017). At the present time, however, important gaps in information on health care quality in primary and secondary care persist. Overall, more systematic monitoring and assessment of health provider performance and patient outcomes is warranted. To that end, a framework of indicators for health system performance assessment has been drawn up, and will eventually support benchmarking at health provider, regional and international levels. Early measures taken so far include educating health care staff in patient safety issues, and better application and assessment of clinical guidelines (European Commission, 2019a)

Currently, the use of health technology assessment (HTA) is focused mainly on the evaluation of medicines and some medical devices. The expansion of HTA to support pricing and procurement, the selection of non-drug technologies, the development of clinical guidelines and the evaluation of public health interventions could contribute to attaining greater efficiency in several important areas of expenditure.

Increased public investment is required to improve health outcomes and quality of care

Latvia spends much less on health per capita and as a share of GDP than most other EU countries. Such low levels of public spending on health reflect the relatively small size of government (public spending represents 37 % of GDP) but also the relatively low priority given to health, as less than 9 % of overall public spending is allocated to this sector compared with an average of 16 % in the EU as a whole.

Significant progress across the areas outlined in Section 5 will remain extremely difficult given the current level of resources in the system. While some improvements may bring efficiency gains, most will involve at least a certain level of upfront investment. To achieve health outcomes closer to EU averages and make real inroads into problems of access and quality, Latvia may need to increase health spending per capita to a level closer to the EU average, and will almost certainly have to raise the share of GDP spent on health.

6 Key findings

- While the health of Latvians has improved since 2000, life expectancy remains six years below the EU average and the second lowest in Europe. Moreover, substantial inequalities persist by gender and socioeconomic status. On average, Latvians aged 65 can expect to live an additional 17 years, but three-quarters of this time is likely to be spent with chronic disease and disability.

- More than half of all deaths in Latvia are attributable to behavioural risk factors, including poor nutrition, tobacco smoking, alcohol consumption and low physical activity. While one in four adults reported smoking daily, the average conceals a strong gender difference, with Latvian men being among the heaviest smokers in the EU. Alcohol consumption per capita is higher than in most other EU countries, at 11.2 litres compared to 9.9 in the EU, and has risen in the past decade. The obesity rate is also above the EU average: one in four women and one in six men in Latvia are obese.

- Latvia has the second highest preventable mortality rate in the EU after Lithuania. A number of steps have been taken to deliver preventive care more effectively, but given the substantial impact of behavioural risk factors, further attention to prevention could greatly improve the health of the population. Mortality from treatable causes is also substantially higher than the EU average. These indicators suggest that the general effectiveness of the health system could be improved.

- Latvia has a national health service system with universal population coverage and general tax-financed health care provision. However, with a relatively small share of government spending allocated to health, the health system remains significantly underfunded. Despite recent increases in spending, the share of GDP spent on health was 6.0 % in 2017, well below the EU average (9.8 %) and 0.5 percentage points less than the other Baltic states.

- Latvia is one of the few countries that has increased the proportion of spending on outpatient care – by almost 20 % since 2010 – but over-reliance on the hospital sector persists. The publicly funded benefit package is relatively limited, and the Latvian population is not well protected from the costs of poor health. The uneven distribution of health services across the country is a further barrier to health care accessibility.

- The proportion of the Latvian population reporting unmet medical needs is among the highest in Europe, with 6.2 % of Latvians reporting having foregone medical care. One of the major barriers to access is the level of out-of-pocket payments, which represent 41.8 % of total health spending (the third highest level in the EU and mainly driven by the costs of medicines). This means that significant numbers of households incur catastrophic expenditure.

- Substantial improvement in accessibility to care will remain difficult given the current level of resources in the Latvian health system. While some improvements may bring efficiency gains, most may require at least some upfront investment. To achieve health outcomes closer to EU averages, while making real inroads into problems of access and quality, dedicating a higher share of public budget to health will be needed.

Key sources

Mitenbergs U, Taube M, Misins J, Mikitis E, Martinsons A, Rurane A, Quentin W (2012). *Latvia: Health System Review.* Health Systems in Transition, 14(8):1–191.

OECD/EU (2018), *Health at a Glance: Europe 2018 – State of Health in the EU Cycle.* OECD Publishing, Paris, https://doi.org/10.1787/health_glance_eur-2018-en.

References

Council of the European Union (2019), *Council Recommendation on the 2019 National Reform Programme of Latvia*. Brussels, http://data.consilium.europa.eu/doc/document/ST-10167-2019-INIT/en/pdf

European Commission (2019a), *Country Report Latvia 2019. 2019 European Semester*. Brussels, https://ec.europa.eu/info/sites/info/files/file_import/2019-european-semester-country-report-latvia_en.pdf

European Commission (2019b), *Fiscal Sustainability Report 2018.* Institutional Paper 094. Brussels.

OECD (2017), *OECD Reviews of Health Systems: Latvia 2017.* OECD Reviews of Health Systems, OECD Publishing, Paris, https://doi.org/10.1787/9789264262782-en

Rechel B, Richardson E, McKee M, eds. (2018), *The Organization and Delivery of Vaccination Services in the European Union,* European Observatory on Health Systems and Policies and European Commission, Brussels.

WHO Regional Office for Europe (2018a), *Medicines Reimbursement Policies in Europe.* WHO Regional Office for Europe, Copenhagen.

WHO Regional Office for Europe (2018b), *Can people afford to pay for health care? New evidence on financial protection in Latvia.* WHO Regional Office for Europe, Copenhagen.

Country abbreviations

Austria	AT	Denmark	DK	Hungary	HU	Luxembourg	LU	Romania	RO
Belgium	BE	Estonia	EE	Iceland	IS	Malta	MT	Slovakia	SK
Bulgaria	BG	Finland	FI	Ireland	IE	Netherlands	NL	Slovenia	SI
Croatia	HR	France	FR	Italy	IT	Norway	NO	Spain	ES
Cyprus	CY	Germany	DE	Latvia	LV	Poland	PL	Sweden	SE
Czechia	CZ	Greece	EL	Lithuania	LT	Portugal	PT	United Kingdom	UK

European Commission

State of Health in the EU
Country Health Profile 2019

The Country Health Profiles are an important step in the European Commission's ongoing *State of Health in the EU* cycle of knowledge brokering, produced with the financial assistance of the European Union. The profiles 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, in cooperation with the European Commission.

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/EEA country. The aim is to create a means for mutual learning and voluntary exchange that can be used by policymakers and policy influencers alike.

Each country profile provides a short synthesis of:

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

The Commission is complementing the key findings of these country profiles with a Companion Report.

For more information see: ec.europa.eu/health/state

Please cite this publication as: OECD/European Observatory on Health Systems and Policies (2019), *Latvia: Country Health Profile 2019, State of Health in the EU*, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels.

ISBN 9789264647657 (PDF)
Series: State of Health in the EU
SSN 25227041 (online)

OECD
BETTER POLICIES FOR BETTER LIVES

European Observatory on Health Systems and Policies
a partnership hosted by WHO