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LATVIA

A HEALTHIER TOMORROW

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OECD Reviews of Public Health: Latvia

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Foreword

This report is the fourth in the OECD's series of reports reviewing public health policies across selected OECD countries. Health care systems across OECD are increasingly under pressure from social changes – including demographic changes and ageing populations – and emerging new health challenges – from a growing burden of chronic disease, to re-emerging and new communicable diseases, or a growing burden of mental ill-health – which demand a strong public health response.

The OECD Reviews of Public Health provide in-depth analysis and policy recommendations to strengthen priority areas of countries' public health systems, highlighting best practice examples that allow learning from shared experiences and the spreading of innovative approaches. In particular, this series of Reviews of Public Health builds on the OECD's long-standing programme of work on the economics of public health, applying this extensive expertise to country-specific challenges. The OECD Reviews of Public Health are a tool to help countries to strengthen their national public health systems, and help countries to develop and implement innovative public health actions.

This OECD Review of Public Health for Latvia looks the public health system in Latvia, reviews the effectiveness of existing policies and activities, and makes recommendations to improve public health. Despite noticeable improvements over the last decades, Latvia is facing a considerable public health challenge, with a high burden of non-communicable disease and unhealthy behaviours. Yet the resources available to address these challenges are limited, as Latvia operates a tight budget for health. In light of this, the review suggests ways to improve the efficient use of existing resources and to strengthen existing policies and practices. If additional financial investment in health were to be made available, this review suggests areas where these resources would be most impactful.

Latvia is prioritising public health and with good reason: public health can prevent disease and reduce future health care cost, ensuring a sustainable health system for generations to come. This report provides a path towards a healthier tomorrow.

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Acronyms and abbreviations

ACSCs	Ambulatory care sensitive conditions
AHI fees	Administration, handling and infrastructure fees [Australia]
AIDS	Acquired immunodeficiency syndrome
AMR	Antimicrobial resistance
AUD	Australian dollar
BMI	Body mass index
CCM	Comprehensive care management
CDPC	Centre for Disease Prevention and Control
CHF	Congestive heart failure
COPD	Chronic obstructive pulmonary disorder
COVID-19	Coronavirus disease 2019
CSB	Central Statistical Bureau
DDD	Defined daily dose
DMP	Disease management programmes
DTP	Diphtheria tetanus toxoid and pertussis
EDNP foods	Energy-dense, nutrient-poor foods
EHIS	European Health Interview Survey
EPR	External price referencing
EU	European Union
EU28	The 28 member states of the European Union
EUR	Euro
FFS	Fee-for-service
G20	Group of Twenty
GDP	Gross domestic product
GP	General practitioner
HFSS foods	High fat, sugar and salt foods
HIV	Human immunodeficiency virus
HPM	Health and Productivity Management
HPPs	HIV prevention points
HPV	Human papillomavirus
HTA	Health technology assessment
INN	International non-proprietary name
LBDUA	Latvian Non-Alcoholic Beverage Entrepreneurs Association
LPUF	Latvian Food Business Federation
MDR-TB	Multi-drug-resistant tuberculosis
METI	Ministry of Economy, Trade and Industry [Japan]
NCDs	Non-communicable diseases
NGOs	Non-governmental organisations
NHS	National health service
NICE	National Institute for Health and Care Excellence [England]
OECD	Organisation for Economic Cooperation and Development

OECD SPHeP NCD	OECD Strategic Public Health Planning for NCDs model
P4P	Pay-for-performance
PPP	Purchasing power parity
PPPs	Public-private partnerships
RISEBA	Riga International School of Economics and Business Administration
ROSP	Rémunération sur objectifs de santé publique [France]
RSU	Riga State University
SAM	State Agency for Medicines
SCORE	Systematic coronary risk evaluation
SDGs	Sustainable development goals
SOMC	State operational medical comity
SSBs	Sugar-sweetened beverages
TB	Tuberculosis
TSE	Tokyo Stock Exchange
UHC	Universal health coverage
USD	United States dollar
VAT	Value added tax
WHO	World Health Organization

Executive summary

Latvia is facing a dual challenge of a considerable public health burden and limited resources to address it. Latvia has high rates of smoking, harmful alcohol consumption and obesity, leading to a high burden of non-communicable diseases. These factors contribute to Latvia having the lowest life expectancy in the OECD, at 74.9 years versus the OECD average of 80.7 years. At the same time, resources for the health system are limited. Latvia has one of the lowest levels of health spending in the OECD, both in terms of per capita expenditure (USD PPP 1 924 compared to an OECD average of USD PPP 4 170) and as a percentage of GDP (6.2% in Latvia versus 8.9% in the OECD).

In this context, this review identifies scope for Latvia to improve the efficient use of existing resources, to strengthen existing policies and practices, and – if additional investment in health were made available – where the most impactful areas to direct these resources would be. It looks at the public health system as a whole, and provides an in-depth review of three priority topics: obesity, secondary and tertiary prevention, and pharmaceuticals.

Latvia's Ministry of Health has a clear strategic focus on prevention and health promotion. However, when it comes to delivering public health interventions, general practitioners (GPs) and municipalities are expected to play a key role – and both appear over-stretched and under-resourced. Allowing other health system actors to take on some GP tasks – such as pharmacists offering routine health checks – and giving more incentives to undertake prevention activities could help increase capacity. To further encourage healthy behaviours, Latvia is working on new initiatives such as more comprehensive regulation to tackle harmful alcohol consumption and a planned co-operation with industry on reformulation.

Obesity is a large public health challenge, with over a quarter (26%) of the population obese. Latvia has started to address the issue through a number of policies and interventions, but more can and should be done. First, Latvia should create a comprehensive policy package by expanding or redesigning existing policies to have maximum impact and reach a larger population. For example, the advertising regulations on energy drinks could be expanded to other unhealthy food and drinks, and the food labelling scheme should be redesigned to support consumers in making healthier choices. Second, as many initiatives currently rely on project funding, it is important to ensure their long-term sustainability through effectiveness evaluation and capacity building. Third, doctors and other medical specialists should be enabled to treat obesity through guidelines and changes in reimbursement, to prevent further complications.

In Latvia, there are some clear shortcomings when it comes to secondary and tertiary prevention: cancer screening rates are low, and complications from chronic diseases such as diabetes are common. To strengthen Latvia's secondary and tertiary prevention there is a clear need for patient and population education, covering topics such as screening, disease management, use of generics and appropriate use of antibiotics. GPs and their practice nurses could take a more active role in this. The uptake of cancer screening could also be improved by using text message invites or pre-booked appointments. For chronic conditions, there is a need to establish clearer patient pathways to improve quality of care for these patients, for example by improving gatekeeping activities to specialist care visits and by aligning the reimbursement schedule accordingly. Ultimately, to make meaningful improvements in both early disease detection and disease management, there is a need to create more capacity in primary care.

While Latvia has the building blocks in place for a robust and well-regulated pharmaceutical sector, spending on pharmaceuticals accounts for 27% of expenditure on health, compared to the OECD average of 16%. At the same time, access to medicines is not improving and Latvians still bear the costs of more than 60% of outpatient pharmaceutical expenditure out of their pockets, well above the average level of 38% in OECD countries. To reduce pharmaceutical spending, Latvia should encourage bioequivalent generics by revising the current distribution margins, ensuring that doctors and pharmacists are incentivised to prioritise the cheapest available alternative product, and educating patients and providers on the efficacy and safety of generics. To make pharmaceuticals more accessible for patients, Latvia should consider including outpatient medicine co-payments in the cap on out-of-pocket expenditure, and increasing the public sector reimbursement rate, starting with pharmaceuticals included in the lowest reimbursement category.

COVID-19

The primary research phase of this review was undertaken in late 2019, prior to the start of the major COVID-19 outbreak in Europe. The review was finalised in late 2020, as the COVID-19 crisis continued to evolve. For this reason, this review does not provide an in-depth review of the impact of or response to the COVID-19 pandemic in Latvia.

Assessments and recommendations

Despite noticeable improvements over the last decades, Latvia is facing a considerable public health challenge: life expectancy is low, the burden of non-communicable and infectious diseases is high, and risk factors such as smoking, alcohol consumption and obesity are highly prevalent. Latvia has the lowest life expectancy in the OECD, at 74.9 years versus the OECD average of 80.7 years, and the third highest level of treatable mortality in the EU, with more than half of it attributable to cardiovascular diseases.

Patterns of unhealthy behaviour in Latvia add to concerns about population health, both now and in the future. Tobacco consumption among Latvian women is around the OECD average (14.5% in 2014 in Latvia, when latest data is available, versus 13.9% in the OECD), but tobacco consumption among Latvian men is among the highest in the OECD with 36% of men smoking daily, compared to 22.3% on average in the OECD. Latvia has a relatively high alcohol consumption, at 12.6 litres per capita per year, compared to 8.8 litres in the OECD on average. This is equal to about two and a half bottles of wine per week, or ten pints of beer. Latvians are also more likely (59%) to report binge drinking than the OECD average (43% report drinking at least 60 grammes of pure alcohol at a single occasion in the 30 days prior).

In the face of these considerable public health challenges, the time to act is now. However, Latvia is operating within an extremely tight budget for health policies and services. Latvia has one of the lowest levels of health spending in the OECD, both in terms of per capita expenditure – USD 1 924 (adjusted for purchasing power parity, or PPP) in Latvia compared to the OECD average of USD PPP 4 170 – and as a percentage of GDP: 6.2% in Latvia, compared to the OECD average of 8.9% in 2019. The budget for prevention and health promotion is also lower than the OECD average: in 2018 Latvia spent 2.2% of the total health budget on prevention, compared to the OECD average of 2.7%.

In this context, this review identifies ways in which Latvia can strengthen its public health architecture, better tackle obesity, strengthen secondary prevention, and improve the effective use of pharmaceuticals. In each area, the review identifies scope for Latvia to improve the efficient use of existing resources, to strengthen existing policies and practices, and – if additional investment in health were made available – where the most impactful areas to direct these resources would be. Notably, across all areas covered by this report there appears to be scope for task shifting across health professionals, which would bring efficiency gains. For example, involving pharmacists in more health promotion activities such as health checks, as well as shifting regulations and incentives to ensure that the bulk of chronic disease care is done by General Practitioners (GPs) rather than hospital specialists. Taking steps to decrease the price of generics in Latvia – which are relatively high compared to peer countries – and remunerating pharmacists in a way that incentivises them to dispense the least expensive products, are areas for efficiency improvements in the pharmaceutical sector. In terms of increasing the effectiveness of existing policies, there is scope to expand procurement of healthier foods and drinks, and potential to increase cancer screening by sending invitation letters with a pre-filled appointment time. Finally, investing more in public health – on improving health literacy and on increasing GP primary and secondary prevention activities – and on reducing co-payments for outpatient pharmaceuticals is a better way to use scarce resources and may well turn out to be cost-saving in the long term by improving population health and disease management. OECD analysis already suggests that an effective food labelling scheme would, over the next 30 years, save 190 life years per year and save EUR 69 000 per year in health care costs in Latvia,

and expanding such a scheme to restaurant menus could save EUR 305 000 per year in health care cost and gain 384 life years.

When it comes to the overall Latvian public health system architecture, Latvia's Ministry of Health is clearly turning attention to prevention and promotion activities. When it comes to delivering public health interventions such as education and screening, however, GP and municipalities are expected to play a key role and both appear over-stretched and over-loaded. Latvia should consider allowing other health system actors to take on some GP tasks – such as pharmacists offering routine health checks – as well as looking to introduce more capacity in the system by giving additional support to GPs, especially tied to incentives for undertaking prevention activities. Municipalities, too, should be stronger public health actors through more strategic planning, especially in light of the instability of financing for programmes such as municipality-level group fitness classes or healthy eating education, which are currently mainly paid for with EU funding. This means using funding that is currently available to pay for training of staff in health promotion, so that the expertise in this area remains within the municipality beyond the horizon of the current programmes. There is also scope for Latvia to strengthen regulation around harmful alcohol consumption, continuing to pursue the tighter regulations on availability and marketing of alcoholic beverages planned for 2020-22.

Obesity is a large and growing public health challenge, where Latvia has already put in place a number of policies and interventions, acting at all levels of society. However, more can and should be done to halt the rise in obesity. Firstly, Latvia should expand or redesign existing policies to ensure they have maximum impact. For example, nutritional standards currently in place in schools and health and social care institutions could be expanded to other sectors, such as workplace canteens. The food labelling scheme should be redesigned so that it can support consumers in making healthier choices. Secondly, as many initiatives currently rely on project funding, it is important to ensure their long-term sustainability. This includes evaluating the effectiveness of different activities, as well as building capacity. Thirdly, the health system needs to be empowered to play its role in preventing and treating obesity. This can be done by using different routes to deliver counselling, or implementing pathways for the treatment of obesity – but it will also require changes to the reimbursement or financial incentives for prevention and treatment activities.

Secondary prevention aims to reduce the morbidity of a disease or injury that has already occurred through early detection, and putting in place actions to halt or slow the progress of the disease, while tertiary prevention manages the disease once it has occurred to prevent complications. In Latvia, there are some clear shortcomings when it comes to secondary and tertiary prevention, with low rates of cancer screening coverage, and high rates of complications from chronic diseases such as diabetes. Some improvements to vertical prevention programmes are needed, for example strengthening the cancer screening invitations system(s). Much of the potential to improve secondary and tertiary prevention lies in health system strengthening – investing in the health workforce, strengthening GP responsibilities and capacities, creating chronic disease management pathways for care delivery – and eliminating inefficiencies, in particular better aligning payment schedules with good practice patient pathways, for example by introducing gate keeping.

To strengthen Latvia's secondary and tertiary prevention there is a clear need for patient and population education focusing on a range of topics, including screening, disease management, use of generics and antibiotics. GPs and, especially, nurses employed in GP practices, need to take a more active role in this. Cancer screening should also be strengthened, for example using text message invites, and/or pre-booked appointments for screening included in the invitation letter. At the same time, there is a need to establish clearer patient pathways for chronic conditions, for example through gatekeeping for specialist care visits, and aligning the reimbursement schedule accordingly. Ultimately, to make meaningful improvements in both early disease detection and disease management, there is a need to create more capacity in primary care, which almost certainly involves further investment in the sector. If this investment were to be made,

we would encourage that it be focused on more patient education, active disease management, and possibly some further age/risk stratified health check-ups.

Finally, while Latvia has the building blocks in place for a robust and well-regulated pharmaceutical sector, there is clear scope to strengthen existing policies, iron out some inefficiencies, and increase access to essential medicines. In Latvia, the outpatient pharmaceutical sector is well established with a clear structure; the State Agency for Medicines is the national regulatory authority for pharmaceutical products and assesses quality, safety and efficacy of medicines, the Ministry defines pharmaceutical policy, while the National Health Service (NHS) makes decisions for inclusion of pharmaceutical products in Latvia's positive list. However, the cost of pharmaceuticals to the health budget is rising – pharmaceutical expenditure accounted for 21% of current expenditure on health in 2008 and reached 27% in 2017, compared to the OECD average of 16%. At the same time, access to medicines is not improving and Latvians still bear directly the costs of more than 60% of outpatient pharmaceutical expenditure, well above the average level of 38% in OECD countries. For patients, the current flaws of the system lead to very high levels of out-of-pocket payments to access needed medicines, resulting in high rates of catastrophic spending on health. It appears that some Latvians forgo pharmaceutical care: for cardiovascular diseases, diabetes and mental health drugs Latvia has markedly low per-capita consumption compared to OECD peers and when considering the burden of these diseases in the country.

This review identifies areas where improvements on the effective use of pharmaceuticals need to be made, some at relatively low-cost. Even though the share of generics in volume is relatively high (74%), there is still scope to increase the use of generics in Latvia. This can be achieved by revising the current distribution margins that incentivise pharmacists to sell more expensive products, and by nudging doctors and pharmacists through organisational or financial incentives to prioritise the cheapest available alternative product. More patient and provider education around the efficacy and safety of generics will be a further fruitful step. There are also ways to make pharmaceuticals more accessible for patients. To improve access and patient financial protection, Latvia should consider including outpatient medicine co-payments in the calculation of the cap on out-of-pocket expenditure, and revising the outpatient medicines reimbursement arrangements, starting with an increase of the reimbursement rate of pharmaceuticals included in the lowest reimbursement category (50% of the price of the cheapest alternative). Latvia should also make new categories of populations exempted of co-payments on outpatient medicines (low income pensioners for instance).

Box 1. Policy recommendations for improving public health in Latvia

When it comes to strengthening public health policies, tackling obesity, strengthening secondary prevention, and ensuring the effective use of pharmaceuticals to promote public health, Latvia already has some strong policies in place. However, in light of a significant burden of chronic disease, a high rate of risky health behaviours, and some notable challenges around access to care and especially pharmaceuticals, more should be done.

To strengthen the public health system, Latvia should:

- Strengthen policies to reduce harmful alcohol consumption, including regulating advertising and availability.
- Encourage the food industry to take a more active role in promoting healthier lifestyles and habits, for example to take the lead in voluntary reformulation of certain foods.
- Recognise that the primary care sector, which currently takes on a significant proportion of prevention activities, is over-stretched; and expand the involvement of other health workforce

such as nurses or pharmacists in chronic disease monitoring, health checks and patient education.

- Increase spending on public health, to provide sustainable funding support for municipalities which are taking on a growing role in health promotion activities such as diet and exercise classes, and to improve health literacy.

To more effectively tackle obesity, Latvia should create a comprehensive policy package and:

- Expand nutritional standards around calories and nutritional composition that are already in place in schools and medical institutions to other sectors, such as workplace canteens.
- Introduce a nutritional food labelling scheme so that it helps consumers make healthier choices, by showing nutritional information in a bold and readable way.
- Pursue food reformulation more actively, promoting the market opportunities for industry in developing healthier products or considering a carefully designed public-private partnership (PPP), as has been used in several other OECD countries.
- Expand some of the advertising regulations – currently only applied to the marketing of energy drinks to children – to a greater range of unhealthy food and drinks.
- Have the health system play a more active role in preventing and treating obesity, as a first priority making obesity counselling available to more Latvians, and assessing whether pharmaceutical and surgical treatments for obesity should be prescribed or reimbursed.

To strengthen secondary prevention, Latvia should:

- Include pre-filled appointment times for cancer screening invitation letters, and consider sending invitations in languages other than Latvian.
- Develop both patient-facing and physician-facing clinical guidelines or disease pathways for all major chronic diseases, and align incentive structures with these established pathways, for example clarifying the expected roles of GPs and specialists.
- Accelerate the development of chronic care management programmes led by dedicated multi-disciplinary teams, for example a diabetes management programme offering diet and exercise support, education, peer support and regular scheduled check-ups.
- In the long term, plan to move towards the development of bundled payments for chronic conditions.
- Improve patient literacy, especially for patients living with a chronic disease, through patient education, education on effective communication and patient-centred care for health care professionals, and making easy-to-understand health information broadly available.

In order to improve access to pharmaceuticals, Latvia should:

- Increase public expenditure dedicated to outpatient medicines, which would allow to expand the list of products reimbursed and contribute to more effective chronic disease management.
- Increase the utilisation of generic medicines, through increasing incentives to prescribers, and communication campaigns on the safety and efficacy of generics for patients and prescribers.
- Adjust the current pharmaceutical pricing system, including through: the establishment of a distribution mark-up system more favourable to generic medicines, the delinkage of community pharmacies' remuneration from the price of medicines, and the introduction of a ceiling to wholesalers' mark-ups.
- Improve people's access to medicines by: including co-payments on medicines in the calculation of the overall cap on out-of-pocket payments; increasing the reimbursement rate of pharmaceuticals included in the lowest reimbursement category; and including new categories

of populations (such as low-income pensioners) in the exemption mechanisms for outpatient medicines co-payments.

Latvia's public health system

Latvia faces a number of public health challenges – some similar to the other OECD countries, some more pressing. To start with, Latvia has the lowest life expectancy in the OECD, at 74.9 years versus the OECD average of 80.7 years (OECD, 2020[1]). However, Latvia has seen one of the greatest increases in life expectancy over the past 15 years. Between 2004 and 2019, life expectancy in Latvia increased by 4.1 years, while the OECD average increased by 3.1 years.

Like in other OECD countries, non-communicable diseases (NCDs) are the leading cause of mortality in Latvia. Cardiovascular disease is one of the main contributors to the disease burden in Latvia: in 2017, ischaemic heart disease and stroke were the first and second most common cause of both overall deaths and premature deaths (Institute for Health Metrics and Evaluation, 2017[2]). When compared to the OECD average, Latvia sees a higher proportion of mortality due to diseases of the circulatory system: 56% versus 35% on average. Other OECD countries see a relatively larger share of deaths due to cancers. However, in absolute terms, cancer mortality is higher in Latvia: 235.9 deaths per 100 000 population are due to cancer, compared to 197.6 per 100 000 in the OECD on average (OECD, 2020[1]).

Latvia has a higher than average incidence of acquired immunodeficiency syndrome (AIDS), at 5.1 cases per 100 000 population, compared to an OECD average of 1.4 per 100 000 in 2018. HIV/AIDs, as well as infectious diseases such as hepatitis B and C and tuberculosis, are a public health priority for Latvia, with HIV prevention promoted through 19 HIV prevention points providing information and counselling, rapid testing, and supplies (such as syringes, needles, condoms). Latvia also has one of the highest rates of mortality from suicide: the age-standardised rate in Latvia is 18.1 deaths per 100 000 population, compared to an OECD average of 12.1 per 100 000. However, this rate has decreased considerably over the last decade and a half, as it was 32.9 per 100 000 in 2000. In Latvia, mortality from road traffic accidents is also higher than in most OECD and EU countries. The mortality rate in Latvia is 10.9 per 100 000 population per year – which is about 50% higher than the averages for the EU28 (6.2 per 100 000) (OECD, 2020[1]).

In terms of behavioural health risks, tobacco consumption among Latvian women is around the OECD average (14.5% in Latvia in 2014, when latest data is available, versus 13.9% in the OECD for 2018), while tobacco consumption among Latvian men is among the highest in the OECD with 36% of men smoking daily, compared to 22.3% on average in the OECD (OECD, 2020[1]). Latvia has a relatively high alcohol consumption, at 12.6 litres per capita per year, compared to 8.8 litres in the OECD on average in 2018 (OECD, 2020[1]). This is equal to about two and a half bottles of wine per week, or ten pints of beer. In addition, Latvia has a high prevalence of heavy episodic or "binge" drinking (drinking at least 60 grammes of pure alcohol at a single occasion). In Latvia, 59% of the population reported binge drinking in the 30 days prior, compared to 43% on average in the OECD (World Health Organization, 2019[3]).

Latvia also has to manage the higher health needs that come with an aged population. Already 20.3% of the Latvian population is aged 65 years or older, higher than the OECD average of 17.6%. The next 30 years are set to bring an increase in the older population in Latvia, up to 28% by 2050, equal to the projected OECD average.

Latvia has a centralised health system with a limited role for local governments

The Ministry of Health is the leading government authority in the health sector and is responsible for public health, health care and pharmaceutical care. The Ministry of Health plays an important role in the health

system, developing national health policy, as well as coordinating and monitoring its implementation. The Ministry of Health also oversees important executive organisations, such as the NHS, the State Agency for Medicines and the CDPC. The NHS allocates state budgetary funds for health care and contracts care from providers through five territorial branches, while the Centre for Disease Prevention and Control (CDPC) implements public health policy in the areas of epidemiological safety and disease prevention, health care quality, and health promotion.

Other ministries are in charge of certain aspects of health care (Behmane et al., 2019[4]). The Ministry of Finance, through the State Treasury, is in charge of the financial flows from the state budget to the health care system. The Ministry of Welfare oversees social rehabilitation and nursing care of vulnerable, disabled and impaired individuals. The Ministry of Agriculture oversees food safety, and the Ministry of Education and Science manages several educational facilities in the health sector. The Ministry of Defence, Interior and Justice finances health services for specific population groups (e.g. armed forces, inmates).

Latvia's 119 municipal governments are responsible for ensuring geographical accessibility of health care services, and depending on budget and local priorities, they maintain hospitals and long-term social care facilities. Local governments are also charged with local health promotion activities, including promoting healthy lifestyles, controlling alcoholism, and protecting vulnerable groups. While the municipalities are in charge of health promotion, they receive support and oversight from the Ministry and the CDPC to accomplish this task. Health promotion activities in municipalities mainly fall under the Healthy Municipalities Network (CDPC, 2019[5]). This Network, a collaboration between the Ministry of Health, the CDPC and the WHO, aims to promote the exchange of best practices, experience and ideas among local governments; to provide local governments with methodological support in dealing with various public health and health promotion issues; and to improve knowledge of municipal employees on issues of public health and health promotion.

Local governments currently play a relatively small role in health policy and governance. After Latvia regained independence, a push was made towards a decentralised system that relied more on the municipalities for managing and implementing health policy (OECD, 2016[6]). However, partially due to the small size of the municipalities and the country in general, the system shifted back to a more centralised model.

Like other areas of the Latvian health system, unstable budgets limit the capacity of municipalities to deliver public health functions. For example, programmes such as municipality-level group fitness classes or healthy eating education are often funded through EU funding, which limits the sustainability of such services over the longer term. The expectation of the central government appears to have been that municipalities would receive start-up capital from these EU funds, but then be expected to cover the ongoing costs of these programmes out of local budgets from 2023. From 2017-23 overall EU funds represented 85% of overall funding for health promotion activities in municipalities. As of 2020 the projected central budget did not include provisions to continue to support municipalities, nor was there a mechanism to ensure that municipalities continued to fund public health programmes out of their own budget. While larger or richer municipalities are able to hire dedicated staff with a background in public health, in smaller municipalities the responsibilities for health promotion fall on general staff. Half of the municipalities report that they are hindered in their activities by a lack access to expertise and professionals, which translates into a lack of knowledge about how to approach the right target groups (Gobina et al., 2019[7]).

Spending on health promotion and prevention is low but increasing

Latvia's health system is, in general, stretched for resources, and the public health sector is no exception. Latvia had one of the lowest levels of health spending in the OECD in 2019, both in terms of per capita expenditure – USD 1 924 (adjusted for purchasing power parity, or PPP) in Latvia compared to the OECD average of USD PPP 4 170 – and as a percentage of GDP – 6.2% in Latvia, compared to the OECD average of 8.9% (OECD, 2020[1]). As a percentage of current expenditure on health, Latvia spends less

than the OECD average on prevention: in 2018 Latvia spent 2.2% of the total health budget on prevention, compared to the OECD average of 2.7% (OECD, 2020[1]).

When it comes to targeted health promotion and prevention programmes, for example national campaigns, efforts to support weight loss or increased physical activity, smoking cessation programmes, Latvia appears to be highly reliant upon funding from the EU. For example, Latvia's Public Health Strategy for 2014-20 has been primarily funded by EU funds (OECD, 2016[8]), and EU funding which runs until 2023 has been used to pay for municipalities to develop their own local health promotion plans, overseen by the Ministry of Health. There is a risk that too much reliance on EU funding impedes building a sustainable set of health promotion and prevention programmes, if funding in priority areas cannot be assured over the longer term.

The well-established primary care sector in Latvia is an advantage for improving public health, but the system is under-resourced and over-loaded

A strong, well-established primary care sector is one of the Latvian health system's key attributes (OECD, 2016[6]). Primary care services commissioned by the NHS are provided mostly by private GPs (OECD, 2019[9]). In recent years, Latvia has worked to improve the role of primary care in prevention and public health. The Primary Health Care Development Plan 2014-16 aimed to position primary health care as the most accessible, effective and comprehensive level of care (OECD, 2016[6]). In addition to increasing the availability of primary care, this plan aimed to increase the role of primary health care in prevention, diagnostics and treatment.

As a result, GPs now play an important role in national screening programmes for cancer, health checks, and chronic disease checks. However, there are clear challenges around this approach, as pressure on GP time is reported as being acute. Latvia has fewer practicing physicians and slightly fewer General Practitioners than the OECD average, but is not amongst the countries with the fewest physicians. However, remuneration for physicians is amongst the lowest in the OECD when compared to the national average wage, in particular for GPs. These low salaries reportedly contribute to some physicians working at least part of the time in the private sector, which reduce overall availability of physician time. As of 2019 Latvian GPs earned almost exactly the average wage, compared to GPs in neighbouring countries such as Estonia, where GPs earned between 1.6 and 2.4 times the average wage, or Lithuania, where GPs earn 20% more than the average wage.

To encourage more prevention activities in primary care, practices with more than 1 800 patients are given funding for a second practice nurse, whose primary focus is supposed to be prevention (OECD, 2016[6]). In reality though, the time of the additional practice nurse is often spent on activities other than prevention due to the heavy workload that many GP practices experience.

There is scope to strengthen policies to reduce harmful alcohol consumption

Latvia has put in place a number of policies to address tobacco and harmful alcohol consumption. Latvia has been working to reduce the rate of smoking through a range of policies, including a tobacco tax of 80% of the retail price above the WHO guide rate of 75%, banning purchase of tobacco products for under 18s, a ban on tobacco advertising and smoking in most public places, and health warnings on 50% of all tobacco products. These policies cover nearly the entire WHO Framework on Tobacco Control, but one element that had been missing was a ban on the display of tobacco products at points of sales (WHO FCTC Implementation Database, 2018[10]). This changed on 1 October 2020, as Latvian retailers are now required to put tobacco out of view of consumers.

A comprehensive policy package is required to address harmful alcohol consumption, and Latvia already has a number of policies in place. These include taxation on alcohol products, a ban on sales to people younger than 18 years, a ban on the off-trade sale of alcoholic beverages between 10pm and 8am,

educational campaigns and some advertising restrictions. However, there are important limitations to the current regulations. For example, currently beer and wine are exempt from the restrictions on television and radio advertising.

Moreover, while Latvia does have a tax on alcohol, the level of the tax has historically been low – driving alcohol tourism from nearby countries such as Finland and Estonia. The revenue from this cross-border trade means that there is a financial incentive for Latvia to keep taxes on alcohol low. When Estonia decreased the tax on alcoholic drinks by 25% in 2019, Latvia responded by reducing their tax on strong alcoholic drinks by 15% (Reuters, 2019[11]).

The Ministry of Health is in the process of exploring more extensive alcohol regulations. The National Action Plan on the Consumption of Alcoholic Beverages and Limitation of Alcoholism 2020-22 was adopted by the Cabinet of Ministers on 30 July 2020, and calls for stricter restrictions on the advertising and availability of alcoholic beverages. It includes a ban on television, radio and internet advertising of special offers (sales and discounts) for all alcohol products, and on trade promotion activities such as two-for-one sales. However, the plan does not include any changes to the tax on alcohol products, which falls under the responsibility of the Ministry of Finance.

The Latvian Government should involve the industry in supporting healthier lifestyles, for example by promoting reformulation and extending advertising regulations

Engagement between the Ministry of Health and representatives of industry, notably food, appears to be positive in Latvia. One example of engagement is a Nutrition Council, set up by the Ministry of Health in 2006, which convenes several times a year and includes the participation a range of industry actors.

In 2011, voluntary marketing regulations were introduced on soft drinks (WHO, 2011[12]). The Ministry of Health, the LPUF (Latvian Food Business Federation) and the LBDUA (Latvian Non-Alcoholic Beverage Entrepreneurs Association) signed a Cooperation Memorandum to reduce the advertising of soft drinks to children aged 12 or under. In the Memorandum, the industry committed to refrain from advertising soft drinks on television and in cinemas if more than 50% of the audience is children, and from targeting this age group on the internet. Mandatory advertising regulations currently only apply to energy drinks.

Latvia should encourage the industry to take a more active role in promoting healthier lifestyles and habits. Besides the voluntary marketing regulations on soft drinks there is currently no significant collaboration between the Latvian Government and industry – for example food and beverage, or alcohol producers – around promoting healthier lifestyles and habits. There is scope for stronger engagement of industry, following some of the practices found in other OECD countries. For example, in both Spain and the United Kingdom industry has been pushed to take the lead in voluntary reformulation of certain foods, to be followed by evaluations to assess whether a voluntary approach is delivering effective changes. Latvia is working on this, as the Ministry of Health is planning to sign a Memorandum of Cooperation with industry aiming to improve the composition of food products by implementing reformulation.

Moreover, regulations on the marketing of energy drinks should be expanded to other foods and drinks. Advertising restrictions are recommended by the WHO, and it notes that a comprehensive approach covering a wide range of unhealthy foods and advertising channels has the greatest potential to achieve the desired impact (World Health Organization, 2010[13]).

Tackling obesity

In Latvia, over a quarter (26%) of the population is obese: 28% of women and 23% of men have a body mass index (BMI) of 30 kg/m^2 or higher – the threshold endorsed by the WHO to define overweight (World Health Organization, 2017[14]). This is just above the OECD and EU28 average of 25%. In addition, 58%

of adults are overweight (BMI of 25 kg/m^2 or higher), which again is similar to the OECD average. Overweight and obesity among children has increased over recent years. In 1975, only around 1% of children were obese; by 2016, this had grown to 9% of boys and 5% of girls, with over a fifth of Latvian children overweight.

Overweight and obesity are caused by an energy imbalance between energy in (calories consumed through diet) and energy out (calories burned through physical activity) (World Health Organization, 2018[15]). In Latvia, both sides of this balance contribute to the obesity epidemic. A large proportion of the Latvian population does not get physical activity through recreational activities, sports or fitness: only 40% of the population does some form of sports at least once a week. People from lower socio-economic groups are even less likely to do this type of physical activity, with 74% of people in the lowest income quintile not engaging in sports or fitness. The frequency of physical activity decreases with age. Only 21% of 15 to 17-year-olds do not do any sports or fitness activities, compared to 50% or more in people over 30. This proportion continues to increase with age, as it reaches 70% among those aged 60 to 64 and 88% for people over 85.

On the other side of the balance, calorie availability has increased in Latvia in the last two decades. In 2000, the food supply was 2 785 calories per capita, per day. In 2017 this had increased by 14% to 3 169 calories (Food and Agriculture Organization, 2019[16]). In addition to overall calorie intake, the quality of diets also contributes to health. Only 40% of Latvians eat fruit every day, and 42% eats vegetables every day. The frequency of fruit and vegetable consumption increases with income, though it drops slightly for the highest income group. Nevertheless, in every income group less than half of Latvians eat fruit or vegetables every day.

Obesity and overweight reduce life expectancy by an estimated 3.6 years, and cost the Latvian economy around EUR 91 million a year if nothing is done

The prevalence of overweight and obesity has an impact on the population health and economy of Latvia. Using the OECD SPHeP NCD model (OECD, 2019[17]), it is calculated that, over the next 30 years, the average life expectancy in Latvia is 3.6 years lower because of overweight, if no further action is taken. This is one of the highest impacts across all countries analysed. Obesity is one of the leading risk factors contributing to the burden of non-communicable diseases (NCDs), increasing the risk of developing type 2 diabetes, cardiovascular diseases, musculoskeletal disorders, several types of cancer, and depression (WHO, 2017[18]). In Latvia, 79% of all diabetes cases can be attributed to overweight, as well as 7% of cardiovascular diseases, 4% of dementia cases and 2% of cancer cases (OECD, 2019[19]).

As a result, the prevalence of obesity contributes to an increase in health care expenditure. Over the next 30 years, Latvia will spend around 6% of its entire health care budget on treating the consequences of overweight and obesity – around EUR 91 million per year. However, compared to other countries Latvia spends relatively little. This could be due to the fact that non-obesity related conditions make up a larger part of the disease burden in Latvia, compared to other OECD countries.

While Latvia's health care expenditure on overweight and obesity is less than in other countries, obesity still has a large impact on the economy. Combining the impact of overweight on life expectancy, demographics and labour force productivity, the gross domestic product (GDP) of Latvia is 4.5% lower the next 30 years than if there had not been any overweight. This is much greater than the expected impact on GDP on average across the OECD (3.3%), which may be due to the relatively large impact of overweight on Latvia's life expectancy, as well as its impact on the productivity of the workforce.

Policies introduced by the Latvian Government mostly focus on diet rather than promoting physical activity

The Latvian central government has produced strategies and guidelines to promote healthier behaviours. The Latvian Public Health Strategy 2014-20 identifies obesity and overweight as one of the major risk factors contributing to non-communicable diseases in Latvia, and Latvia has set national guidelines for physical activity and a healthy diet, and a national physical activity roadmap. The Ministry of Health, together with the CDPC, also runs a number of campaigns to encourage healthier diets and physical activity, for example establishing health trails in five cities throughout Latvia, along with a health promotion card that offers discounts for healthy leisure services. A number of legislative policies are also used to tackle the obesity epidemic, including nutritional standards for schools, health and social care institutions, and prisons; advertising and sales restrictions on energy drinks; and a tax on sugar-sweetened beverages.

In 2006, Latvia was one of the first OECD countries to ban the sale of unhealthy foods in school, including sodas and confectionary and salted crisps. Moreover, educational institutions, medical treatment institutions, social care and rehabilitation institutions are subject to regulation on nutritional standards.

Since 2016 so-called energy drinks (soft drink with a high content of caffeine or other stimulants like taurine and guarana) cannot be sold to children under 18 years old (FAO, 2016[20]). Moreover, they are subject to specific marketing regulations, including warnings on the negative effects of energy drink overuse on any advertising materials, a ban on advertising energy drinks in schools and public buildings, and a ban on advertising to children age under 18.

Latvia has a food labelling scheme – but its primary aim is not to encourage healthier choices or reduce obesity. The National Food Quality Scheme, run by the Ministry of Agriculture, uses labels to mark “higher quality products”. A Green Spoon label is awarded to products for which at least 75% of ingredients come from one designated country (usually Latvia). There are no nutritional criteria associated with the label, and it has been awarded to products including sausages, cakes, ice cream, white bread, cheddar cheese and beer (Karotite.lv, 2020[21]).

Latvia has had a tax on sugar-sweetened beverages (SSBs) since 2000. Over the last two decades, the rate of taxation has increased from EUR 2.85 per 100 litre to EUR 7.40 per 100 litre. SSBs are currently taxed uniformly, without differentiation based on the sugar level in the drink. The SSB tax rate in Latvia is in line with other OECD countries, though some countries have higher rates for beverages with a higher sugar content. From 1 January 2022 an amendment to the excise tax will come into place, differentiating between beverages with different levels of sugar. Beverages with less than 8 grammes of sugar per 100 litres will have an excise tax of EUR 7.40, while those with more than 8g sugar per 100 litres will have an excise tax of EUR 14.00. Latvia has a reduced value-added tax rate for fresh vegetables, fruit and berries, and a reduction for fresh meat, fish, eggs and dairy is planned for the coming year.

Latvia should create a comprehensive obesity policy package by expanding or redesigning current policies

A comprehensive policy package is needed to tackle obesity and its drivers. Latvia’s current policies could have a considerable impact on diet and physical activity if they were expanded upon or redesigned. In many cases, this would require little additional investment as they are low-cost interventions, or because they build on existing structures.

First, Latvia should expand the nutritional requirements for meals in schools and medical facilities to other public places, such as leisure centres, government-funded afterschool and summer programming, shelters, and vending machines on government-owned or leased property. Moreover, workplaces can be supported in their healthy food procurement efforts.

Second, a more effective food labelling scheme focused on nutritional criteria should be developed. While Latvia has a food labelling scheme in place under the Green Spoon initiative, there are no nutritional criteria associated with the label. It is important to clarify the meaning of the existing label, highlighting that it does not imply a healthier product. In addition, Latvia should consider implementing a food labelling scheme that does help consumers make healthy choices. OECD analysis suggests that an effective food labelling scheme could save 190 life years per year and save EUR 69 000 per year in health care cost in Latvia (OECD, 2019[19]). The labelling scheme should also be expanded to menus. Evidence shows that menu labelling can positively affect consumer choices, and that there is strong public support for it (Mah et al., 2013[22]; Pulos and Leng, 2010[23]; Morley et al., 2013[24]). A systematic review found that menu labelling reduced the overall energy consumed by 100 kcal on average, and that energy per order in a real-world setting decreased by 78 kcal on average (Littlewood et al., 2016[25]). In Latvia, menu labelling could save EUR 305 000 per year in health care cost and gain 384 life years (OECD, 2019[19]).

Third, Latvia should pursue food reformulation more actively. Food reformulation, where the composition of food products is changed to improve their nutritional profile, can contribute to healthier diets. Especially in Latvia, the impact of a food reformulation policy would be considerable. Compared to other countries, Latvia would see one of the largest impacts on the disease burden if calories were reduced by 20% in foods high in sugar, salt, calories and saturated fats (OECD, 2019[26]). Moreover, it would save EUR 1.3 million per year in health care cost (OECD, 2019[19]). The Ministry of Health in Latvia has already agreed with the Nutrition Council to explore ways to encourage food product reformulation (Ministry of Health, 2019[27]). One approach is a public-private partnership (PPP), as has been used in several other OECD countries. Carefully designed PPPs can be beneficial for all stakeholders, including industry, government and consumers, so long as clear objectives and accountability processes are built-in. For governments, working with the industry can mobilise additional resources and increase buy-in. There are also incentives for industry to engage with the government in creating healthier food products, which can create new market opportunities or niches.

Finally, Latvia should expand the advertising regulations that currently only apply to the marketing of energy drinks to children to a greater range of unhealthy food and drinks. Advertising restrictions are recommended by the WHO to reduce the impact of the marketing of unhealthy food and drinks on children (World Health Organization, 2010[13]), and the use of different marketing approaches targeted at children has been shown to influences food preferences, purchase requests and consumption patterns. Latvia should aim to expand mandatory regulation to other unhealthy food and beverages, to increase its impact on diet and obesity.

The health system needs to play a more significant role in preventing and treating obesity

Latvia recognises that primary care has a vital role in prevention – as shown by the introduction of primary care nurses dedicated to prevention. Moreover, the dedicated health check programmes for non-communicable diseases aim to identify individuals with risk factors such as obesity and provide them with adequate care to prevent complications. Latvia has also introduced a scheme to allow doctors to prescribe physical activity to patients. This scheme, developed together with the Centre for Sports Management, provides GPs with a handbook to create recommendations for physical activity, taking into account the patient's fitness level, health status and stage of behaviour change. However, the programme is not linked to payments or data collection, and it is unclear what its uptake and impact is. Secondary care also plays a role in obesity prevention and treatment. Children's University Hospital in Riga has run a specialised two-day weight loss programme, including consultations with an endocrinologist, rehabilitatist, physiotherapist, nutritionist and psychologist, which has seen 500 children since 2014.

Despite these initiatives, the role of the health care system in preventing and treating obesity is limited. This is due to a lack of time and resources, as well as limited treatment options under the national health

system. Primary care physicians as well as nurses experience a heavy workload, and prevention activities such as counselling on diet or physical activity – which are not directly reimbursed – are a lower priority. In addition, drug[1] or surgical treatment of obesity is not covered by the national health system. Sessions with nutritionists are not covered under the national insurance either. While some people can pay out-of-pocket for drugs, nutritionist advice or bariatric surgery in private hospitals, the public health system offers few options.

While recognising the limited health budget in Latvia, the obesity epidemic cannot be controlled without the help of the health system. Doctors and other medical specialists are uniquely placed to provide counselling and advice to high-risk individuals. Moreover, they can help treat obesity and prevent further complications or the development of non-communicable diseases. There is considerable untapped potential in the health system to support the fight against obesity. For example, even though General Practitioners are the first point of contact for patients with the health system and a trusted source of information there is no direct reimbursement associated with counselling, and few physicians can afford to make the time.

Latvia should also look to other OECD countries which have introduced obesity counselling without depending on GPs. In Chile, the Vida Sana programme in Chile includes counselling as part of a broader obesity prevention package. Though the programme is run out of primary care centres to reduce the cost of delivering the intervention, medical doctors are only involved if the patient specifically requires medical attention and most sessions are with other professionals such as a physical education teacher, physical activity therapist, or kinesiologist. In Finland the Virtual Hospital 2.0 project includes the development of Health Village – an online resource with information for patients and health care professionals (Terveyskylä.fi, 2020[28]). One of the “houses” in the village is focused on weight control and includes a 12 month weight management programme, with a virtual coach to each participant with whom they have weekly or monthly interactions. Participants also have access to 160 training sessions, 60 videos and audio tutorials, a photo food journal, group chats and research questionnaires (Pietiläinen, 2020[29]). The programme is free for patients, and they can be referred to it by primary care physicians, occupational health professionals or other specialists if they have a BMI of more than 25 kg/m^2 and are over 18 years old.

In addition to prevention activities, primary care physicians and specialists need to be able to treat obesity to prevent further complications. Currently there are no drugs or surgical treatments covered under the national health system for obesity. Instead, people have to pay out-of-pocket to undergo bariatric surgery privately. In addition to widening inequalities, this can also have a negative effect on recovery and patient well-being, as patients may not receive adequate nutritional education or decision guidance. One approach to encouraging better treatment of obesity is to develop guidelines. This can support doctors in delivering the care that is needed, and ensure a consistent and effective approach. However, this would need to be matched by changes in the reimbursement package.

Sustainable obesity prevention and reduction requires future-proofing existing public health programmes

The Healthy Municipality Network is a corner stone of Latvia’s approach to health promotion. It enables local governments to respond to the needs of their population and provide tailored interventions in the field of nutrition, physical activity and more. However, this project is strongly reliant on EU funding: around 85% of municipalities’ health promotion activities are funded by EU funds. While Latvia is currently working to secure an additional round of funding, these grants remain time limited. A considerable number of other activities and programmes in Latvia also reply on EU project-based funding. To ensure that programmes have maximum and lasting impact, they need to be sustainable without external funding.

A first step to ensuring sustainability is planning for sustainability (Shediac-Rizkallah and Bone, 1998[30]). Rather than an afterthought once funding runs out, sustainability should be a primary goal of the

programme from the beginning. As such, planning for sustainability should start as soon as possible. Most of the activities under the Networks rely strongly on human capacity. Developing capacity and expertise is therefore a crucial part of ensuring sustainability (Shediac-Rizkallah and Bone, 1998[30]). In some larger or richer municipalities, the EU funding has been used to hire or train experts in health promotion. These experts will remain in place and can continue to train new hires – thereby ensuring continuation of the programme and lasting expertise. Currently this capacity is lacking in smaller municipalities, threating the sustainability of health promotion projects there. After the planned reorganisation of the municipalities, which is expected to result in fewer municipalities with presumably more resources, capacity building around health promotion should take place in each new municipality.

In addition to human capacity, municipalities should also review other resources that their programmes require. Low-cost interventions, such as outdoor running clubs or educational lectures, can be added to the programme now to test their effectiveness. In some cases, it may also be possible to explore agreements with current facilities, educators or trainers for discounted services. Volunteers can be sought to contribute to the delivery of activities. Overall, it is important to start exploring these matters now to make the programmes future-proof. Most of these elements – the effectiveness of interventions, the expertise of programme managers and the availability of local resources – will differ from one municipality to the next. Therefore, planning for sustainability will fall on the municipalities. The Ministry and the CDPC should continue to support the municipalities' efforts by providing them with guidance materials and training sessions.

Strengthening secondary and tertiary prevention

Secondary prevention aims to reduce the morbidity of a disease or injury that has already occurred through early detection, and putting in place actions to halt or slow the progress of the disease, while tertiary prevention manages the disease once it has occurred to prevent complications. Secondary prevention interventions – screening, health checks – and tertiary prevention – disease management – can reduce the disease burden and economic impact of chronic diseases. In Latvia, non-communicable disease represent a significant and growing health and economic burden, and high levels of smoking, alcohol consumption and obesity make the population particularly vulnerable to chronic disease. Already, non-communicable diseases are the leading cause of death in Latvia, with circulatory diseases and cancers accounting for the greatest number of deaths (OECD, 2020[1]). In Latvia mortality from ischemic heart diseases, cancer, and cerebrovascular diseases was significantly higher than the OECD average; mortality from ischemic heart diseases and cerebrovascular diseases in particular was more than twice the 2019 OECD average (OECD, 2020[1]). Despite the decreasing trends in mortality rates due to cardiovascular diseases (mostly ischaemic heart disease and stroke) in Latvia are amongst the highest in the EU, and well above the OECD average (OECD, 2019[9]). Mortality from cancer has increased slightly in Latvia, but remains below the OECD average.

In this context, it is especially important that diseases are detected early and controlled effectively when they occur; the resource-tight environment in Latvia makes effective secondary prevention even more important as part of preventing higher-cost treatment of advanced disease, disease complication and co-morbid conditions and also preventing premature deaths. 'Treatable mortality' refers to deaths that could be avoided if effective health care interventions, including screening and treatment, were in place, and Latvia has the third highest rate of treatable mortality in the EU (OECD, 2019[9]). The rate of treatable mortality in Latvia was 157 per 100 000 population, more than twice the OECD average of 75 per 100 000 population in 2016. The rate of treatable mortality in Latvia was particularly high for ischaemic heart diseases and stroke; despite falling stroke and ischaemic heart disease mortality rates there is clear room for improvement if Latvia is to catch up with EU and OECD peers.

Health check-ups for chronic disease and chronic disease management falls mostly to General Practitioners

Basic health check-ups for chronic diseases, for example taking blood pressure or cholesterol, or a screening for cardiovascular disease based on age, family history, and risk factors such as body mass index (BMI), can help diagnose persons at-risk of chronic diseases, or diagnose chronic diseases in their earlier stages when they can be managed with fewer complications.

In Latvia, the main responsibility for health checks lies with GPs who carry out preventive examinations of adults and children, cardiovascular risk assessment, as well as cancer screening checks. Latvia does not have a national programme of health checks, put does have policies to incentives some specific tests. In 2018 around one-third of Latvia adults undertook preventive examinations, although it is not possible to establish which tests were in fact undertaken. GPs' second practice nurses are theoretically intended to focus on prevention tasks such as lifestyle advice and checks, but it is not clear that in reality second practice nurses are actually carrying out this role. GPs carry out cardiovascular screenings using a standardised tool, and diabetes screening, but with cardiovascular screening recommended every five years and diabetes screening ever three years the two are not well aligned, and take additional time for already over-stretched GPs. Latvia's primary care pay-for-performance scheme also has some items focused on secondary prevention – for example cancer screening, LDL cholesterol monitoring – but the scheme appears to be a weak incentive for GPs, with less than 3% of GPs achieving all eight targets in 2018.

The bulk of chronic disease management is also the responsibility of General Practitioners in Latvia. For routine care, patients are expected to visit their named GP. However, it is not always clear whether GPs or specialists should be caring for patients with chronic diseases. For example, for diabetes the main burden of care for diabetes should lie with the GP, while for chronic obstructive pulmonary disorder (COPD) a patient can visit a GP, or a specialist, can be cared for in a specialist clinic. OECD data suggests that there is room for improvement in chronic disease management in Latvia; avoidable hospital admissions were above the OECD average for Asthma (93.1 admissions per 100 000 compared to the OECD average of 41.9), and just below it for COPD (148.4 compared to 183.3) in 2017.

For diabetes management, the majority of activities – patient education, nutrition advice, some medication prescribing, foot scans – should take place at the GP level. There are a few diabetes management cabinets in Latvia, run by nurses, which give lifestyle advice, education, insulin support, and advice on disease management. However, there are limits on prescribing of some pharmaceuticals by GPs, which have to be prescribed by endocrinologists in order to be reimbursed. There are no caps on the reimbursement of visits to endocrinologists for patients with a diabetes diagnosis, and patients can self-refer to endocrinologists and have this visits reimbursed if they have a diabetes diagnosis. While data tracking the extent to which stabilised diabetic patients are making repeat specialist visits is not available, this is theoretically possible and arguably a potential source of inefficient use of specialists' time, and representing poor value-for-money. Other limits on GP prescribing, for example on medication for cardiovascular disease were also reported.

It is notable that in 2018, Latvian consumption of anti-diabetics, and cholesterol lowering drugs are the lowest and seventh lowest rates (DDD per 1 000 population) in the OECD (OECD, 2020[1]). There appear to be some gaps in reimbursement coverage for basic pharmaceuticals and medical devices for persons with chronic disease. For example, anti-coagulants are reimbursed only if a patient has previously experienced a stroke. Some pharmaceuticals for heart failure are subject to a 25% co-payment rate. Pre-diabetic drug treatment is not reimbursed.

Pre-filled appointment times for cancer screening could increase rates which remain well below the OECD average

Cancer screening stands out as an area where significant improvements should still be made in Latvia, specifically for breast and cervical screening, for which rates are amongst the lowest in the OECD despite improvement over the past decades. In Latvia, a national cancer screening programme is carried out by the National Health Service. Women between 25 and 70 years of age should receive a Papanicolaou (Pap) smear test screening for cervical cancer once every three years, women aged between 50 and 69 should receive mammography screening every second year, and the entire population between age 50 and age 74 should receive faecal immunochemical test once a year (Latvian Government/OECD, 2019[31]). Screening frequencies are well aligned with those of other European countries (Altobelli and Lattanzi, 2014[32]). While Latvia's rates of cancer screening are low compared to OECD countries, they have increased in recent years. Rates of breast cancer screening nearly doubled from 21.1% coverage in 2009, to 42.1% in 2018. Cervical cancer screening rates increased even more significantly from 14.9% to 42.8% across the same period (data age-standardised to the OECD population) (OECD, 2020[1]). This increase is likely in part due to national efforts to increase screening across the last decade. For cervical cancer, organised screening was first implemented in 2009, before which point screening was opportunistic though encouraged (Vīberga and Poljak, 2013[33]).

It is clear that considerable efforts have been made to increase both breast and cervical screening, from public campaigns to encouraging GPs to reach out to patients directly, centralising the screening invitation information system, and making mobile mammography an option in rural or under-served areas. Sending a personalised letter and following up with an individual phone call are consistent with evidence of best practice (Segura et al., 2001[34]; European Commission, 2018[35]), and Latvia has been encouraging GPs to follow up with women in the target group who have not attended screening. However, since capacity of GPs and GP practice nurses is already clearly stretched. Latvia may wish to consider whether other health professionals, for example pharmacists, could be involved in personal follow-up calls to screening invitations. At the same time Latvia should consider including a pre-arranged screening appointment time and location in invitation letters, an approach used in Denmark, Finland, Germany, Ireland, Italy, the Netherlands, Spain, Sweden and the United Kingdom (OECD, 2019[36]). Latvia can also include a fixed appointment time either in the first screening invitation or in a follow up to persons who have not responded to the first invitation. Additionally, including additional information in languages other than Latvian, alongside the invitation letter which is legally required to be sent in Latvian, would help accessibility for the large population who are not native speakers of Latvian.

Latvia should promote more proactive chronic disease management through organisational and payment incentives

To improve outcomes for people with chronic diseases in Latvia, who represent a significant proportion of the overall disease burden, it will be critical to strengthen chronic disease management. This should include coordinated and proactive interventions for people identified as at-risk of chronic diseases, for example pre-diabetic patients, comprehensive support for disease management and self-management for controlled chronic diseases, and high responsiveness in the event of disease complications.

Improving chronic disease management should also be seen as a way of improving efficiency. Timely interventions in the pre-disease period can stop the progress of a condition and reduce a patient's need for care. Effective chronic condition management can reduce complications which can be very costly, both in terms of more intensive specialist support including hospital stays, and increased disability which can take people out of the workforce earlier in their life course.

Latvia should look to strengthen chronic disease management in a three-step process that could be pursued simultaneously or incrementally depending on capacity, and on whether it is possible to undertake

some pilot projects in the country. First, Latvia should ensure that chronic disease management pathways, or clinical guidelines, are available for all high prevalence chronic diseases. Chronic disease pathways, which could be produced in both patient-facing and clinician-facing formats, should clearly establish the professional responsibilities of health professionals at different stages of disease. For example, it does not seem necessary that stable diabetes patients regularly see specialist endocrinologists, but rather they can be managed by GPs. Having established clear chronic disease management pathways, there is a need to ensure that other levers within the system are effectively aligned with the pathway. For example, when it comes to diabetes, more limits on frequency of specialist visits, or limits to reimbursement for visits without a referral, could be introduced. Second, Latvia should accelerate the development of chronic care management programmes led by dedicated multi-disciplinary teams. For example, a disease management programme for diabetes can offer diet and exercise support to help patients control their blood glucose levels and reduce their BMI, group sessions focused on education or peer support, and regular scheduled check-ups.

Third, Latvia could move towards the development of bundled payments for chronic conditions. Bundled payments for chronic conditions have been introduced in OECD countries such as Canada and France to incentivise coordination of care for chronic conditions between providers, or provide a broader set of care (for example education, regular checks, occasional specific checks) for chronic conditions (OECD, 2020[37]; OECD, 2016[38]). Bundled payments can encourage collaboration within and across care settings, contribute to greater standardisation of care for example by requiring adherence to quality criteria, and can strengthen data availability by requiring the collection of monitoring indicators or integration of data systems across care settings, and control overall costs (OECD, 2016[38]).

Improving health literacy for the population and health professionals should be a priority

Low levels of health literacy, misinformation around common medical care and pharmaceuticals, and possibly distrust of the medical system, appear to be relatively widespread in Latvia, and affect delivery of effective public health interventions across the board (OECD, 2016[8]). Low levels of health literacy appear to be affecting chronic disease management capacities too, for example reported reluctance of patients to take 'preventive' pharmaceuticals such as statins. In general, people with low overall health literacy who also have a chronic disease know less about their disease, which can complicating chronic disease management (Gazmararian et al., 2003[39]; Dunn and Conard, 2018[40]; van der Heide et al., 2018[41]; Moreira, 2018[42]). Health literacy amongst health professionals may also need to be improved, for example underscoring the efficacy of generic pharmaceuticals and insuring that inaccurate information is not being shared with patients.

In Latvia increasing health literacy through patient education, education for health care professionals, and making easy-to-understand health information broadly available should be a priority, and does not necessarily entail significant resource investments. Priorities would include: health literacy in school curricula; communication training – for example how to avoid medical jargon, encourage patient questions, and prioritise need-to-know information – for health professionals; and making easy-to-understand information available in written forms, for example brochures, websites or even phone text-message services. Health literacy programmes in schools have been found to represent good value for money (Mcdaid, 2016[43]). Improving general population health literacy can also have positive impacts for patients with chronic diseases can help individuals better manage their condition, including necessary treatment or control protocols and behaviour modification, and improve shared decision making with health care professionals (Dunn and Conard, 2018[40]; Poureslami et al., 2016[44]; van der Heide et al., 2018[41]).

Create more capacity in primary care for patient education, disease management, and disease detection

Primary care providers, and specifically General Practitioners, are at the heart of secondary and tertiary prevention in Latvia. While some interventions are managed vertically, for instance breast and cervical cancer screening, and there are a small number of chronic disease cabinets for instance for diabetes, the bulk of screening, disease risk detection, patient contact, and chronic disease management, lies with General Practitioners. To strengthen secondary and tertiary prevention capacity, and impact, Latvia should look to increase capacity in primary care.

However, that Latvian GPs are broadly agreed to already be significantly time and resource stretched increasing secondary and tertiary prevention activities in primary care would require some further investment of resources in the sector. If such resources were available, to improve secondary and tertiary prevention the priorities for increasing capacity should be focused on patient education, comprehensive disease management, and some systematic or opportunistic screening and check-ups to detect disease. Exploring whether there are ways for other health workers – for instance nurses or pharmacists – to play a role in delivering some of these key prevention activities is a possibility for Latvia to explore.

Effective use of pharmaceuticals

Ensuring access to essential medicines can make an important contribution towards improving public health. In countries where access to medicines is not guaranteed, or where high out-of-pocket payments prohibit patients from accessing care for financial reasons, patients may forego or postpone filling prescriptions and purchasing medicines. In Latvia, the pharmaceutical sector has been at the centre of attention in recent years. The sector has become costly for both patients and the public payer, impairing patients' access to needed therapeutics and generating substantial pressures on public finances.

The building blocks of an effective and efficient pharmaceutical system are in place in Latvia

Legislation and policies in the field of pharmaceuticals are clearly defined in Latvia. Under the authority of the pharmaceutical department of the Ministry of Health, the State Agency of Medicines (SAM) of Latvia and the NHS are the two main institutions responsible for the delivery of pharmaceutical-related policies. The SAM is the national regulatory authority for pharmaceutical products and assesses quality, safety and efficacy of human medicines. The NHS is responsible for making decisions regarding the reimbursement of pharmaceuticals and inclusion of products in the positive list.

The positive list of outpatient pharmaceutical publically covered consists of four groups. List A includes groups of interchangeable pharmaceutical products, for which the NHS reimburses one unique "reference" price. The groups consist of either products with the same active ingredient, or certain products pertaining to the same pharmacotherapeutic group. List B consists of reimbursed products that cannot be substituted or interchanged. List C is for high-cost pharmaceutical products with annual treatment costs exceeding EUR 4 300, and List M for pharmaceutical products for pregnant women, women up to 70 days postpartum and children under 24 months (Silins and Szkultecka-Dębek, 2017[45]).

All the medicines included in the positive list are classified into one of the three reimbursement categories (reimbursed at 100%, 75%, and 50%). The reimbursement category depends on the illnesses for which a particular product has been approved. Each reimbursement is made on the basis of a defined reference price.

In Latvia, prices of medicines are regulated by the national authorities. For medicines not included on the positive list, only the distribution chain margins (i.e. wholesalers and pharmacists) are regulated, which

means that for each non-reimbursed medicine the pharmacy prices are the same in any community pharmacy throughout the country. For medicines part of the positive list, manufacturers' prices are negotiated between the NHS and the market authorisation holder (via an External Price Referencing mechanism) and distribution margins are also regulated.

As of 1 April 2020, retail pharmacies must sell to patients the product with the lowest price (i.e. the reference price for the group). In case a patient refuses the medicine sold by the pharmacy and wishes to be given a different reference of the same medicine, the patient is not eligible for reimbursement and has to pay the full price for all the medicines listed in the prescription. In any case, a prescription fee of EUR 0.71 per item applies for medicines reimbursed at 100% (with an exemption for some patient groups, such as children and asylum seekers).

Pharmaceutical expenditure is rising, but weak financial support for outpatient medicines reduces access to care

Pharmaceuticals have represented a growing share of health spending in Latvia for more than a decade. Pharmaceutical expenditure accounted for 21% of current expenditure on health in 2008 and peaked at 27% in 2017 (as compared to 16% on average in the OECD on that year) (OECD and European Observatory on Health Systems and Policies, 2019[46]). However, the rising expenditure on pharmaceutical has not contributed to improving access to medicines for the Latvian population. In Latvia, pharmaceutical consumption is not in line with the burden of disease. Indeed, the country has the third highest level of treatable mortality in the EU, with more than half of it attributable to cardiovascular diseases. Despite this situation, Latvia reports among the lowest levels of cardiovascular drug consumption in the OECD. A similar situation is observed for diabetes or mental health drugs, with high prevalence of these diseases and comparatively lower per-capita consumption of the corresponding treatments (OECD, 2019[47]).

The current pharmaceutical pricing and reimbursement system is not protecting patients (and more particularly vulnerable populations) from the costs of ill-health. Indeed, Latvians still bear the costs of more than 60% of outpatient pharmaceutical expenditure, much above the average level in OECD countries (38% of outpatient pharmaceutical expenditure paid out-of-pocket). The limited financial support for accessing outpatient medicines contributes to the overall high level of out-of-pocket spending in Latvia, reaching 39% of total health expenditure in 2018 (second highest level in the OECD). As a result, the incidence of catastrophic health spending is very high in Latvia (in 2013, almost 13% of the population experienced catastrophic health spending), with the costs of outpatient medicines being almost exclusively responsible (OECD and European Observatory on Health Systems and Policies, 2019[46]) (WHO Regional Office for Europe, 2018[48]).

Latvia needs to improve financial protection for patients for outpatient medicines

Three key factors can explain why outpatient medicines are the most significant source of financial hardship in Latvia. First, the Latvian reimbursement system, with its percentage co-payments and absence of a cap on out-of-pocket payments, provides weak financial protection for patients. Co-payments calculated as percentage of total cost are unfair to the consumer, and ineffective for controlling health expenditure, as they shift the financial risk from the purchasing agency to the households, and expose people to any health system inefficiencies. In addition, such a system disproportionately affects vulnerable populations (e.g. persons on low-income or with chronic conditions). Strong caps on out-of-pocket payments can protect people if they are applied to all co-payments over time, rather than if they are narrowly focused on specific items or types of service. In Latvia, excluding outpatient medicines from the general calculation of the cap on out-of-pocket payments makes it less impactful since the majority of out-of-pocket payments are related to outpatient medicines.

Second, the rather limited size of the positive (reimbursement) list impairs the access to necessary therapeutics. Out of the 4 252 products registered in Latvia, 1 760 (41%) are at least partially reimbursed by the NHS (i.e. products that are part of one of the reimbursement lists). Some essential medicines such as aspirin (anticoagulant), glibenclamide (anti-diabetic), penicillin and erythromycin (antibiotics) are currently not part of the reimbursed products.

Finally, the pricing system is structured around a reference price for each molecule, which creates the possibility of an additional financial burden for patients. Patients may end up paying an extra co-payment in event the cheapest alternative is not available or if they chose not to buy it. The Ministry of Health estimates that in 2017, EUR 25 million were paid by patients because they were not provided with (or did not choose) the cheapest available alternative of a prescribed reimbursed medicine. It is expected that the reforms introduced in April 2020 will contribute to limit this issue in the near future.

Overall, a combination of the following measures should be considered in order to improve patients' financial protection: include co-payments on medicines to the calculation of the general cap on out-of-pocket payments and lower the overall threshold of this cap to make it more protective; revise the reimbursement arrangements, starting with an increase of the reimbursement rate of pharmaceuticals included in the lowest reimbursement category (50% of the price of the cheapest alternative); make new categories of populations exempted of co-payments on outpatient medicines (low-income pensioners for instance); and revising the current positive lists (list A; B, C and M) to include some current important therapeutics not yet part of it.

The efficiency of Latvia's pharmaceutical expenditure is limited

Many countries view generic and biosimilar markets as an opportunity to increase efficiency in pharmaceutical spending. In Latvia, the penetration of generic medicines is quite good. Generics represented in 2017 74% of the market in volume, which is one of the highest rates in OECD countries and some 20 percentage points above the OECD average. However, in terms of value, generic medicines accounted for 43% of the total pharmaceutical market. This level is rather high when compared to countries having similar shares in volume (Canada, the Netherlands) and could be explained at least in part by Latvia's higher relative prices of generics in comparison to all other medicines (off-patent originators and on-patent medicines).

In addition, an overall distrust of generic medicines among prescribers and patients is frequently reported in Latvia, limiting possible additional efficiency gains (Salmane Kulikovska et al., 2019[49]). There are also currently no financial incentives for doctors to prescribe more generics, nor for pharmacists to dispense cheaper alternatives, and in fact the current distribution margins nudges pharmacists to sell more expensive products.

While more public investment is needed to increase access to pharmaceuticals, efficiency gains are possible

Ultimately, improving access to critical therapeutics in Latvia requires an increase in the funds available. This is necessary in order to enlarge Latvia's positive list and ensure better financial coverage for medicines already reimbursed.

However, efficiency gains could also meaningfully complement upfront public investment (OECD, 2017[50]). Improving the knowledge of both patients and health professionals on generic medicines can contribute to this effort. New information campaigns and further efforts around initial and continuous professional education would improve understanding and trust of generics. Several countries have carried out information campaigns to promote the use of generics, explaining their equivalence to brand name drugs, including Belgium, Denmark, France, Greece, Italy, Portugal and Spain. In parallel, physicians need to be incentivised to prescribe more generics. Physicians need to be encouraged to prescribe cheaper products,

by for instance creating explicit guidelines on the prescription of the cheapest alternative as first-intention medication, or nudged by prescription software that highlights price differences for products which are therapeutically equivalent. Financial incentives can also be used to encourage generic prescription. Latvia could take inspiration from the several OECD countries already using such financial incentives to improve the efficiency of pharmaceutical spending.

Adjustments to the regulation of the distribution chain can contribute to better control over public spending on medicines

Pharmacists need to be remunerated in a way that incentivises them to dispense the least expensive products. Instead of margins that encourage pharmacists to dispense more expensive drugs, fixed fees per prescription or differentiated margins (between originators and generics for instance) can lead pharmacists to be either indifferent or willing to dispense generics, respectively. Overall, starting to disconnect community pharmacists' remuneration from the price of medicines is a critical step for Latvia. A substantial share of OECD countries have initiated reforms in this direction. In France, distribution margins represented 81% of the remuneration of community pharmacists in 2014. In 2019, with the progressive introduction of various dispensation fees they only represented 26%. Various countries have introduced distribution fees to complement the mark-up remunerations (Denmark, France), while others have in some aspects almost entirely disconnected remuneration from mark-ups (Australia, New-Zealand). Introducing a level of disconnection between medicines prices and the remuneration of community pharmacies in Latvia could facilitate the control of pharmaceutical costs while safeguarding pharmacists' remuneration.

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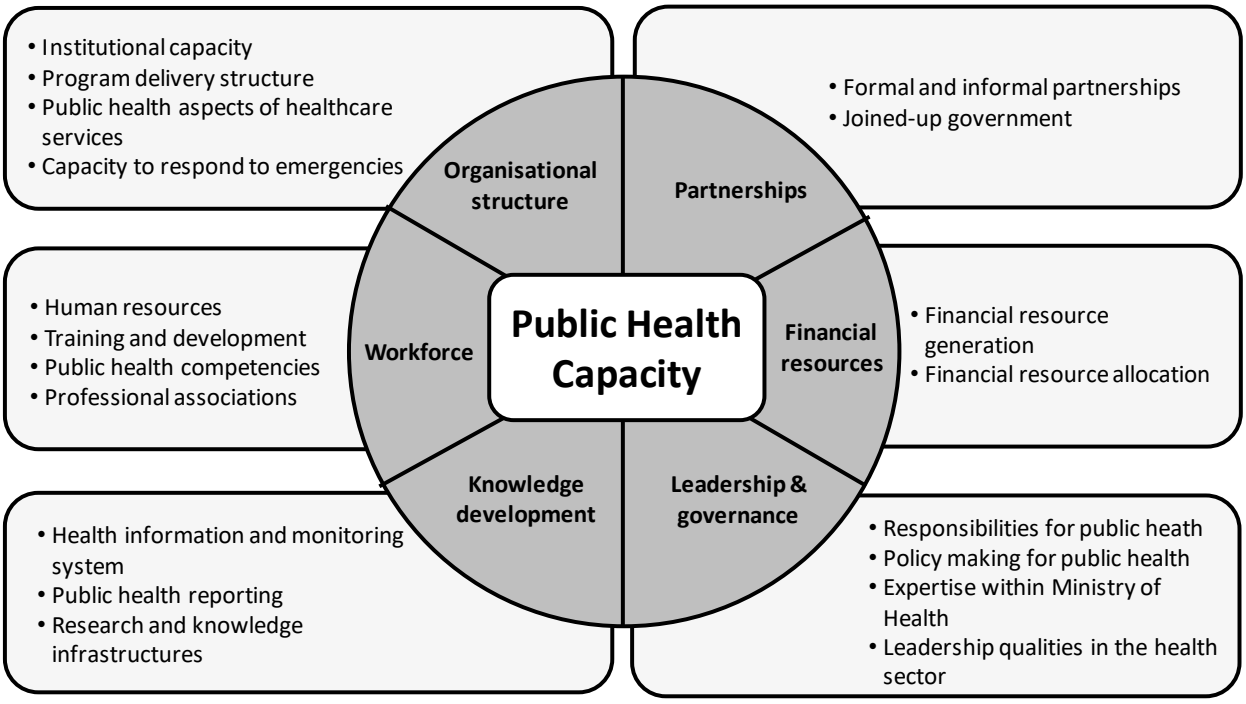
1 The Public Health System in Latvia

As Latvia is facing various health challenges while working with a limited health care budget, a well-functioning public health system is crucial. This chapter will explore the public health picture in Latvia, and describe the public health system tasked with addressing these challenges. It looks at the organisational structure, leadership and governance, partnerships and collaborations, financial resources, knowledge development and workforce.

1.1. Introduction

Public health issues have gained importance across OECD countries in recent years. Aging populations and rising prevalence of chronic diseases, combined with limited health care budgets, mean that governments are looking for ways to prevent disease and ill-health. Latvia is no exception to this trend. This chapter gives an overview of the public health picture in Latvia and the structure of the health system. It aims to provide a summary of the strengths and weaknesses of Latvia's public health system, and make recommendations to strengthen this system. The description of public health policies in this chapter is structured according to a framework for analysing public health capacity (Figure 1.1).

Figure 1.1. Appraising Latvia's public health capacity – analytical framework



Source: OECD analysis.

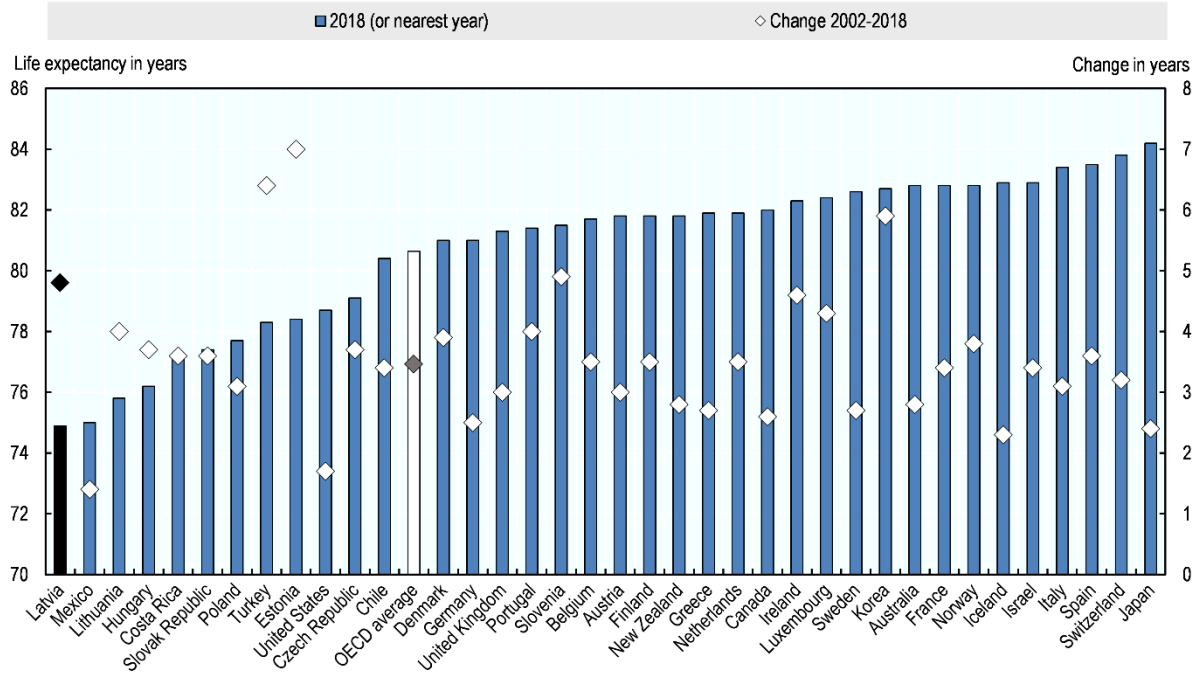
1.2. The public health picture in Latvia

1.2.1. Health status of the Latvian population

Latvia faces a number of public health challenges – some similar to the other OECD countries, some more pressing. To start with, Latvia has the lowest life expectancy in the OECD, at 74.9 years versus the OECD average of 80.6 years (Figure 1.2). However, Latvia has seen one of the greatest increases in life expectancy over the past 15 years. Between 2002 and 2018, life expectancy in Latvia increased by 4.8 years, while the OECD average increased by 3.5 years.

Figure 1.2. Life expectancy

Life expectancy at birth in 2018 or nearest year (years) and change in life expectancy between 2002 and 2018 (years)

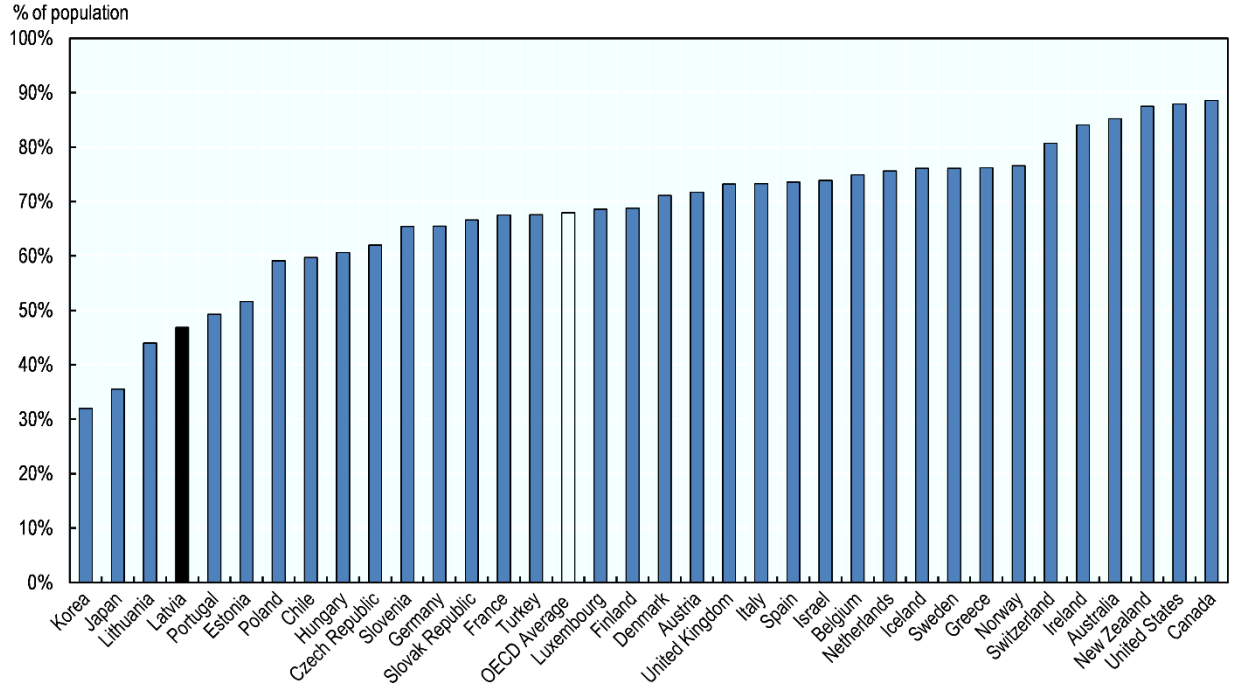


Source: OECD (2020[1]), *OECD Health Statistics 2020,* https://doi.org/10.1787/health-data-en.

People in Latvia have a lower perceived health status than most other OECD countries. Only 47% of people in Latvia would rate their health status as “good” or “very good”, compared to 68% of people in the OECD on average (Figure 1.3). Women are less likely to rate their health status highly, with 42% reporting “good” or “very good” health, compared to 52% of men (OECD, 2020[1]).

Figure 1.3. Perceived health status

Percentage of the population (total aged 15+) that rates their health status as “Good” or “Very good”, 2018 or nearest year



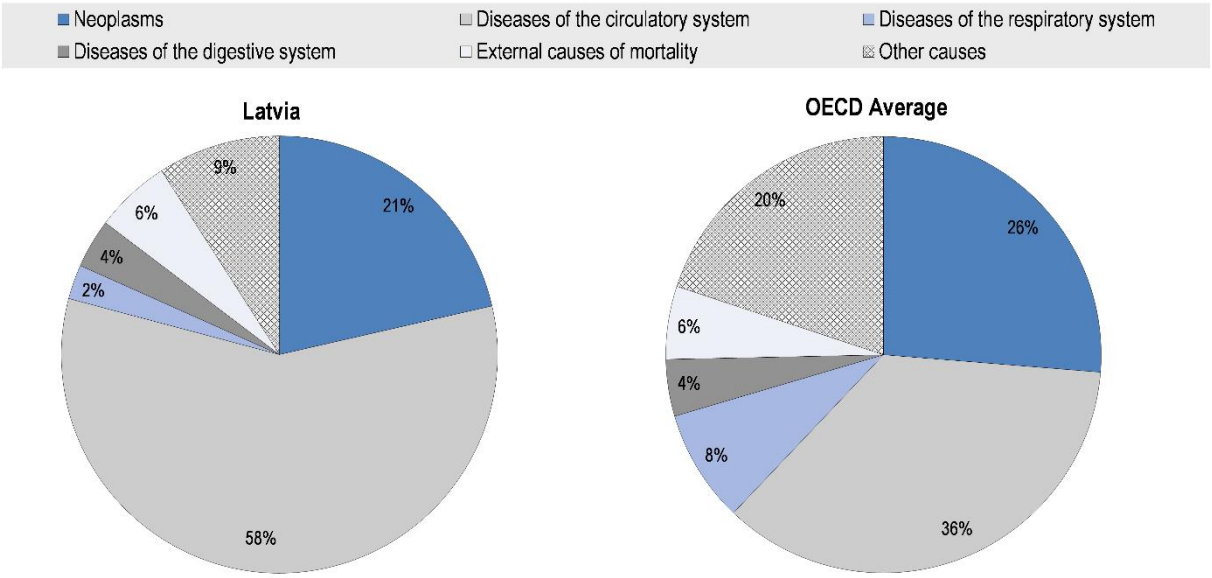
Source: OECD (2020[1]), *OECD Health Statistics 2020,* https://doi.org/10.1787/health-data-en.

1.2.2. Burden of disease

Like in other OECD countries, non-communicable diseases (NCDs) are the leading cause of mortality in Latvia. Cardiovascular disease is one of the main contributors to the disease burden in Latvia: in 2019, ischaemic heart disease and stroke were the first and second most common cause of both overall deaths and premature deaths (Institute for Health Metrics and Evaluation, 2020[2]). When compared to the OECD average, Latvia sees higher mortality due to diseases of the circulatory system: 58% versus 36% on average (Figure 1.4). Other OECD countries see a relatively larger share of deaths due to cancers. However, in absolute terms, cancer mortality is higher in Latvia: 303 deaths per 100 000 population are due to cancer, compared to 231 per 100 000 in the OECD on average (OECD, 2020[1]).

Figure 1.4. Causes of mortality in Latvia[1]

Percentage of all cause mortality, age-standardised, 2017 or nearest year



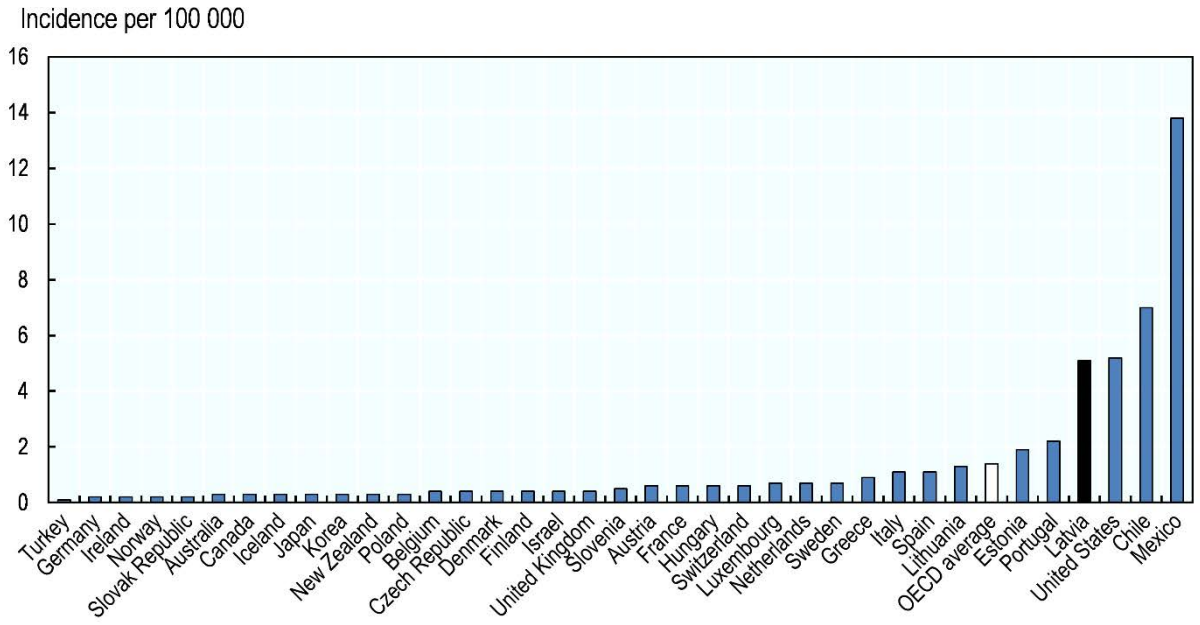
Note: [1]Data for Latvia is 2015.
Source: OECD (2020[1]), *OECD Health Statistics 2020,* https://doi.org/10.1787/health-data-en.

Latvia has a higher than average incidence of acquired immunodeficiency syndrome (AIDS) (Figure 1.5). In 2018, Latvia saw 5.1 cases per 100 000 population, compared to an OECD average of 1.4 per 100 000, based on rates age-standardised to the OECD population. Late diagnosis of human immunodeficiency virus (HIV) infection is an issue in Latvia, as approximately 30% of all new HIV cases are identified at the AIDS stage. In addition, there is a challenge around HIV and tuberculosis (TB) co-infection: according to data from the Latvian CDPC, approximately 10.8% of all TB patients also have HIV, and approximately 10% of all HIV/TB co-infections are multi-drug-resistant forms of TB (Latvia Centre for Disease Control and Prevention, 2017[3]).

HIV/AIDS, as well as other infectious diseases such as hepatitis B and C and TB, are a public health priority for Latvia, and are addressed in the Action Plan for the Prevention of HIV, Sexually Transmitted Infections and Hepatitis B and C for 2018-20. HIV prevention points (HPPs) provide information and counselling, rapid testing, and supplies (such as syringes, needles, condoms). In 2015, there were 19 HIV prevention points, of which 16 were located in cities and three mobile units that serviced seven other cities (Grāmatiņa, 2015[4]). In 2019, HPPs were visited by 7 010 people, of whom 2 466 were intravenous drug users and 4 544 non-intravenous drug users.

Figure 1.5. Incidence of acquired immunodeficiency syndrome (AIDS)

Incidence per 100 000 population, 2018 or latest year



Source: OECD (2020[1]), *OECD Health Statistics 2020,* https://doi.org/10.1787/health-data-en.

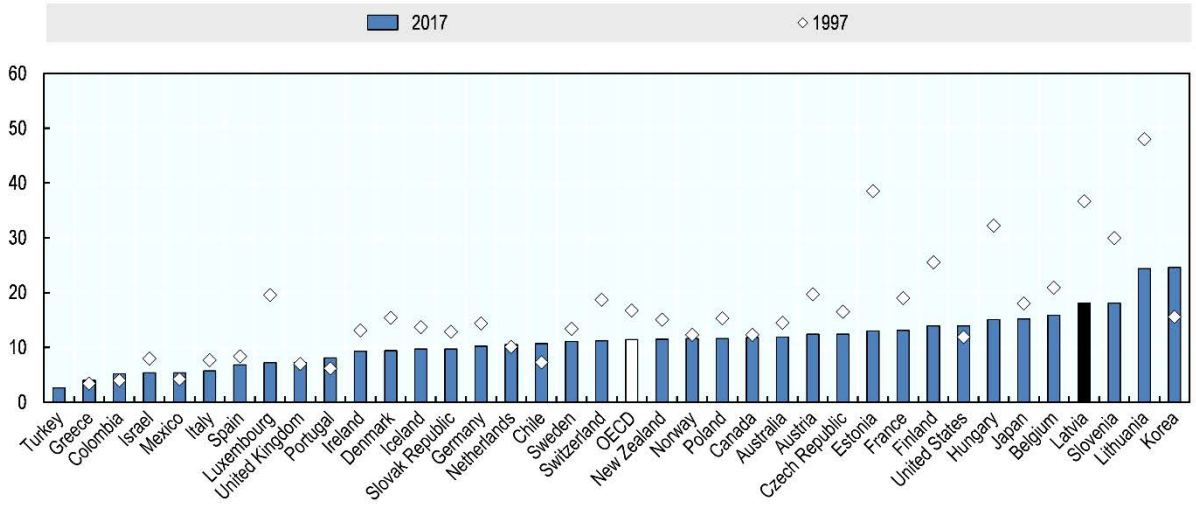
Latvia has one of the highest rates of mortality from suicide: the age-standardised rate in Latvia is 18.1 deaths per 100 000 population, compared to an OECD average of 11.5 per 100 000 (Figure 1.6). However, this rate has decreased considerably over the last two decades, as it was 36.7 per 100 000 in 1997.

The Latvian Mental Health Care Access Improvement Plan 2019-20 highlighted the importance of addressing mental health (Legislation of the Republic of Latvia, 2019[5]). The Plan identifies a number of key issues to address, including the high rate of suicide, the low rate of consultation for mental health problems in primary care settings, and high rates of bullying in schools. Particular weaknesses identified in the mental health system include under-use of multi-disciplinary teams in inpatient care, weak links between primary and specialist care, insufficient availability of psychotherapy, and shortages in human resources.

The Plan set out by Latvia to address these weaknesses aims to provide the population with evidence-based, up-to-date, high-quality and appropriate access to mental health care through mental health promotion, disease prevention programs and by promoting the early diagnosis of mental illness, early treatment and medical rehabilitation. The most important aspects of the plan are raising public awareness of mental health issues, reducing stigma against mental illness, promoting and improving help options for people with mental health problems, suicide prevention, and promoting cross-sectoral and team cooperation in the field of mental health. Increased education for family doctors and nurses, as well as medical practitioners working in prisons, is also planned. Latvia is also looking to make changes to the regulatory framework to increase the amount of funding for the multi-professional teams.

Figure 1.6. Mortality from intentional self-harm

Deaths per 100 000 population (standardised rates), 2017[1] and 1997 or nearest year

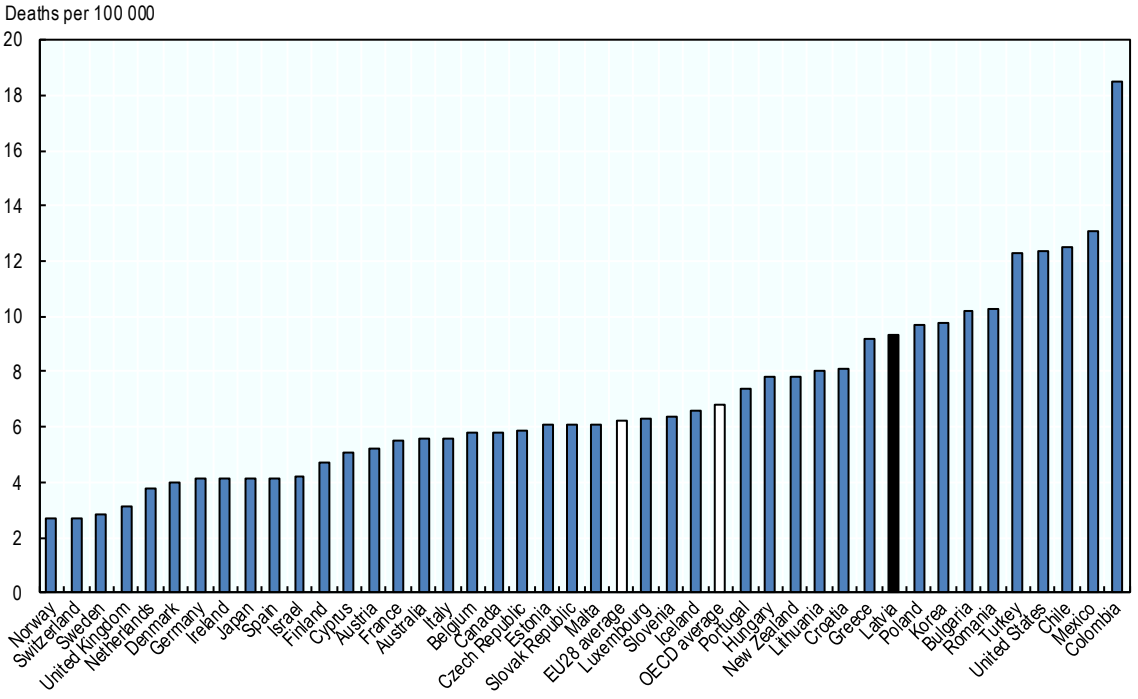


Note: [1]Most recent OECD data for Latvia is from 2015.
Source: OECD (2020[1]), *OECD Health Statistics 2020,* https://doi.org/10.1787/health-data-en.

In Latvia, mortality from road traffic accidents is also higher than in most OECD and EU countries. The mortality rate in Latvia is 9.3 per 100 000 population per year – which is about 50% higher than the averages for the EU28 (6.2 per 100 000) (Figure 1.7). The rate in Latvia is also higher than in Lithuania (8.0 per 100 000) and Estonia (6.1 per 100 000). To address this issue, Latvia has a road traffic safety programme that spans the years 2014-20, with recent activities focusing on high risk sites treatment and reduced speed limits at dangerous locations (European Road Safety Observatory, 2017[6]). Latvia's National Action Plan on the Consumption of Alcoholic Beverages and Limitation of Alcoholism 2020-22 will explore whether it is possible to reduce the legal blood alcohol concentration for all drivers from 0.5% to 0.2%.

Figure 1.7. Mortality from road traffic accidents

Estimated road traffic death rate (per 100 000 population), 2016



Source: WHO (2020[7]), *Global Health Observatory Database*, https://www.who.int/data/gho.

1.2.3. Health risk factors

While tobacco consumption among Latvian women is around the OECD average (14.5% in Latvia in 2014, when latest data is available, versus 13.9% in the OECD), tobacco consumption among Latvian men is among the highest in the OECD (Figure 1.8). In Latvia, 36.0% of men over the age of 15 smoke daily, compared to 22.3% on average in the OECD. On the other hand, smoking in men has decreased considerably in recent years (from 46% in 2008), while the smoking prevalence in women has stayed roughly the same albeit with a slight increase, up from 13% in 2008 (OECD, 2020[1]).

To reduce the smoking rate, a range of policies have been implemented. Latvia taxes tobacco products, with the tax accounting for 80% of the retail price (World Health Organization, 2019[8]). This is above the WHO recommended guideline of 75% (World Health Organization, 2014[9]). Since 2008, the affordability of cigarettes (as measured as the share of per capita GDP needed to purchase 100 packs) has not changed (World Health Organization, 2019[8]).

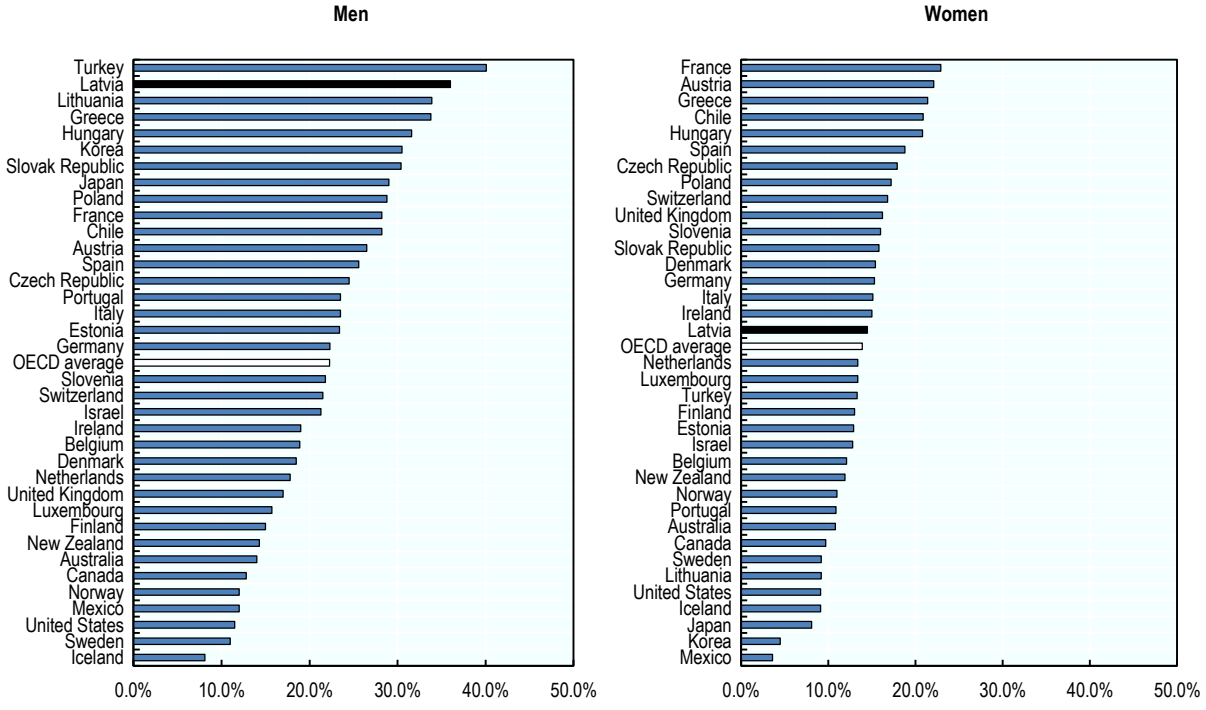
In addition to taxation, Latvia has put in place a wide range of measures: people under the age of 18 are not allowed to purchase tobacco products, all types of tobacco advertising is banned (including sponsorship) as is smoking in most public places, and products need to have a health warning that takes up 50% or more of the package. Smoking is not allowed on the balconies of apartment buildings, nor is smoking in the presence of a child.

In addition, there are public campaigns and educational activities in schools. These policies form a comprehensive package and cover nearly the entire WHO Framework on Tobacco Control, but one element that had been currently missing was a ban on the display of tobacco products at points of sales

(WHO FCTC Implementation Database, 2018[10]). This changed on 1 October 2020, as Latvian retailers are now required to put tobacco out of view of consumers.

Figure 1.8. Tobacco consumption per capita

Percentage of male/female population 15+ who are daily smokers, 2018 or nearest year

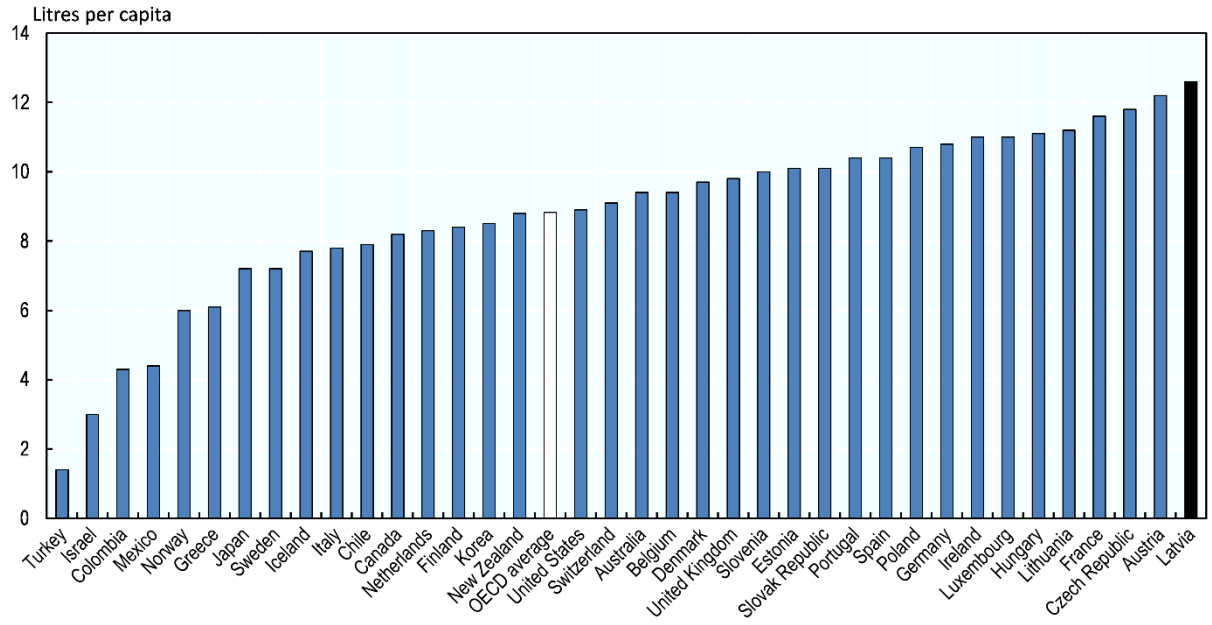


Source: OECD (2020[1]), *OECD Health Statistics 2020,* https://doi.org/10.1787/health-data-en

Latvia has a relatively high alcohol consumption, at 12.6 litres per capita per year, compared to 8.8 litres in the OECD on average in 2018 (Figure 1.9). This is equal to about two and a half bottles of wine per week, or ten pints of beer. In addition, Latvia has a high prevalence of heavy episodic or "binge" drinking (drinking at least 60 grammes of pure alcohol at a single occasion). In Latvia, 59% of the population reported binge drinking in the 30 days prior, compared to 43% on average in the OECD (World Health Organization, 2019[11]).

Figure 1.9. Alcohol consumption per capita

Recorded alcohol consumption in litres per capita (age 15+), 2018 or nearest year



Source: OECD (2020[1]), *OECD Health Statistics 2020*, https://doi.org/10.1787/health-data-en

A comprehensive policy package is needed to address harmful alcohol consumption, and Latvia already has a number of policies in place. These include taxation on alcohol products, a ban on sales to people younger than 18 years, a ban on the off-trade sale of alcoholic beverages between 10pm and 8am, educational campaigns and some advertising restrictions. Advertising restrictions include a requirement that 10% of the product is covered with a warning label. However, there are important limitations to the current regulations. For example, currently beer and wine are exempt from the restrictions on television and radio advertising.

Moreover, while Latvia does have a tax on alcohol, the level of the tax has historically been low – driving alcohol tourism from nearby countries such as Finland and Estonia. The revenue from this cross-border trade means that there is a financial incentive for Latvia to keep taxes on alcohol low. When Estonia decreased the tax on alcoholic drinks by 25% in 2019, Latvia responded by reducing their tax on strong alcoholic drinks by 15% (Reuters, 2019[12]).

The Ministry of Health is in the process of exploring more extensive regulations (Latvian Ministry of Health, 2020[13]). The National Action Plan on the Consumption of Alcoholic Beverages and Limitation of Alcoholism 2020-22 was adopted by the Cabinet of Ministers on 30 July 2020 and calls for stricter restrictions on the advertising and availability of alcoholic beverages (Box 1.1). It includes a ban on television, radio and internet advertising of special offers (sales and discounts) for all alcohol products, and on trade promotion activities such as two-for-one sales. However, the plan does not include any changes to the tax on alcohol products, which falls under the responsibility of the Ministry of Finance.

Box 1.1. National Action Plan on the Consumption of Alcoholic Beverages and Limitation of Alcoholism 2020-22

On 30 July 2020 Latvia's National Action Plan on the Consumption of Alcoholic Beverages and Limitation of Alcoholism 2020-22 was adopted by the Cabinet of Ministers. Under this plan, a number of policies will be implemented:

- Labelling of alcoholic beverages with warnings against drinking while pregnant and when driving, as well as nutrient labels that include the energy content;
- Exploring whether it is possible to reduce the legal blood alcohol concentration limit for all drivers 0.2%;
- Exploring the possibility of reviewing the sales hours of alcoholic beverages, taking into account the experience of other countries;
- Prohibiting the trade promotion activities (like discounts, sales, for buying multiple alcoholic beverages at the same time or purchase of alcoholic beverages together with other products or services with a discount);
- Prohibiting TV, radio, and internet advertising of special offers (sales and discounts) for all alcohol products;
- Exploring whether it is possible to prohibit the sale of alcoholic beverages with over 22% alcohol-by-volume packaged as a single serving intended for immediate consumption;
- The plan also suggests exploring the potential for setting up a public health promotion fund, earmarking 0.5% of excise tax revenue on alcohol, tobacco and gambling and lottery taxes.

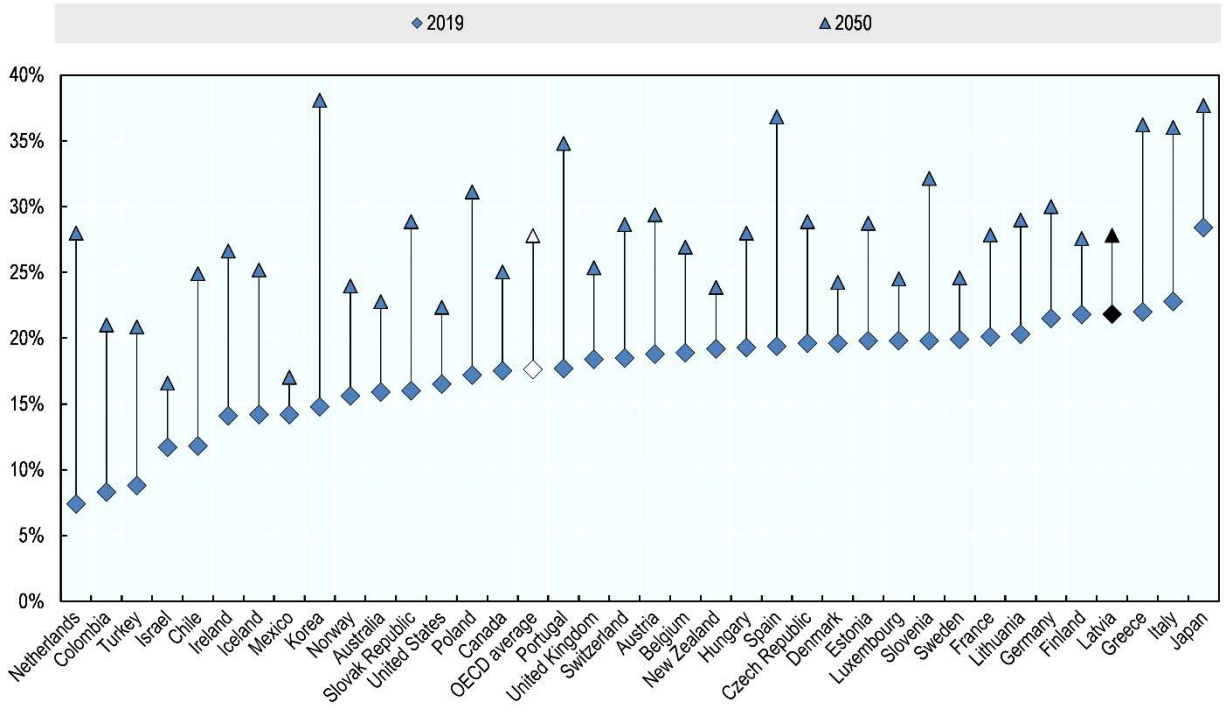
Source: Latvian Ministry of Health (2020[13]), *Order of the Cabinet of Ministers No. 412 – Action Plan for Reducing Alcohol Consumption and Limiting Alcoholism 2020-22,* https://likumi.lv/ta/id/316448-par-alkoholisko-dzerienu-paterina-mazinasanas-un-alkoholisma-ierobezosanas-ricibas-planu-20202022-gadam

Another major risk factor in Latvia is obesity and overweight: 26% of the Latvian population is obese and 58% is overweight (World Health Organization, 2020[14]). Moreover, over a fifth of children is overweight. This is driven by both diet and physical inactivity. A large proportion of the Latvian population does not get physical activity through recreational activities, sports or fitness: only 40% of the population does some form of sports at least once a week (see figure 2.4 in Chapter 2). On the other side of the energy balance, calorie availability has increased in Latvia in the last two decades. More details on obesity and the policies to tackle it can be found in Chapter 2.

Latvia also has to manage the higher health needs that come with an aged population. In Latvia, 22% of the population is currently aged 65 years or older (Figure 1.10). This is higher than the OECD average of 18%. However, Latvia will see less of an increase in the coming 30 years. As a result, by 2050 in Latvia 28%, and in the OECD on average 25%, will be 65 years old or older.

Figure 1.10. Population ageing – 2019 and 2050

Percentage of the total population that is 65 years old or over, 2019 and 2050



Source: the United Nations (2019[15]), *World Population Prospects*, https://population.un.org/wpp/Download/Standard/Population/ OECD (2020[1]), *OECD Health Statistics 2020,* https://doi.org/10.1787/health-data-en.

In terms of natural disasters that could create public health emergencies, Latvia is exposed to both (small) earthquakes and floods, with the latter posing the greatest risk (World Bank, 2016[16]). One such flooding event occurred in 2017, when heavy rain in late summer and autumn led to flash floods (European Parliament, 2018[17]). However, while there was substantial damage to crops and infrastructure, the impact on public health was very limited and there were no casualties.

1.3. Organisational structure

Since regaining independence in 1991, Latvia has undergone a number of health system reforms (OECD, 2016[18]). Currently, Latvia has single-purchaser national health system, funded by general tax revenues, which offers universal health coverage. This coverage provides access to a relatively full range of health care services, delivered by both public and private providers, although out-of-pocket payments are high. This section describes the organisation of the health system in Latvia.

1.3.1. Primary care

A strong, well-established primary care sector is one of the Latvian health system's key attributes (OECD, 2016[18]). Primary care services commissioned by the National Health Service (NHS) are provided mostly by private general practitioners (GPs) (OECD, 2019[19]). While registration is voluntary, most people are signed up with a GP practice. As in many other OECD countries, GPs act as a gatekeeper to secondary care. They are paid through a range of different mechanisms, including a capitated budget, fixed monthly

bonuses (for example for serving rural areas), payments for specific medical procedures (including vaccination and preventive check-ups) and, since 2013, a pay-for-performance scheme (Behmane et al., 2019[20]).

In recent years, Latvia has worked to improve the role of primary care in prevention and public health. The Primary Health Care Development Plan 2014-16 aimed to position primary health care as the most accessible, effective and comprehensive level of care (OECD, 2016[18]). In addition to increasing the availability of primary care, this plan aimed to increase the role of primary health care in prevention diagnostics and treatment.

As a result, GPs now play an important role in national screening programs. They inform and remind patients to use screening services, offer intestinal screening services, and perform health checks for specific chronic diseases (see Chapter 3 for more information). Patients who have not visited a GP in over a year are supposed to be contacted for a prophylactic visit, during which BMI, vision, blood pressure and vaccination coverage are checked. For this activity, doctors receive EUR 2 (for patients under 65 years of age) or EUR 1 (for patients over 65 years of age).

To encourage more prevention activities in primary care, practices with more than 1 200 patients or 600 patients under the age of 18 patients are given funding for a second practice nurse, whose primary focus is supposed to be prevention (OECD, 2016[18]). In reality though, the time of the additional practice nurse is often spent on activities other than prevention due to the heavy workload that many GP practices experience, though GP practices are left to arrange their own time and workflow arrangement.

1.3.2. Secondary care

Despite the investments in primary care, Latvia's health system remains hospital centric (OECD, 2019[19]). To remedy this, recent reforms have focused on concentrating specialised care in fewer hospitals and shifting other care to the ambulatory setting. In-hospital care is paid through a combination of fixed budgets (for emergency care and observational wards), case payments, payments for bed-days and diagnosis-related group (DRG) (Behmane et al., 2019[20]).

Most hospitals are publicly owned by the municipalities (OECD, 2016[18]). However, due to an uneven distribution of public health care services, long waiting times and high co-payment rates, the demand for private hospital care has increased in recent years. Between 2000 and 2016, the proportion of private hospital beds increased from 3% to 10% (OECD, 2019[19]).

The role of secondary care in public health and prevention is very limited. In some cases, patients will need to go to a hospital for prevention activities such as an examination of cytological smears from the cervix and posterior vault (Leishman – Nohta combined microscopy of stained preparation), further, depending on screening results women receive a human papillomavirus (HPV) test or biopsy for cervical cancer, and some tertiary prevention and disease management is done by specialists (see Chapter 3 for more information). There are also isolated examples of prevention programmes organised within hospitals, such as the weight loss programme run in the Children's University Hospital in Riga (see Chapter 2 for more information).

1.3.3. Delivery of essential public health operations in Latvia

Vaccination programmes

The vaccination programme is governed by Cabinet Regulation No.330, introduced on 26 September 2000, and last revised in March 2019 (Likumi.lv, 2000[21]) (Likumi.lv, 2019[22]). These Vaccine Regulations define a list of mandatory vaccinations. For children, these include tuberculosis, diphtheria, tetanus, pertussis, polio, measles, rubella, mumps, *Haemophilus influenzae* type b infection, hepatitis B, chickenpox, pneumococcal infection, rotavirus infection, and human papillomavirus infection. These

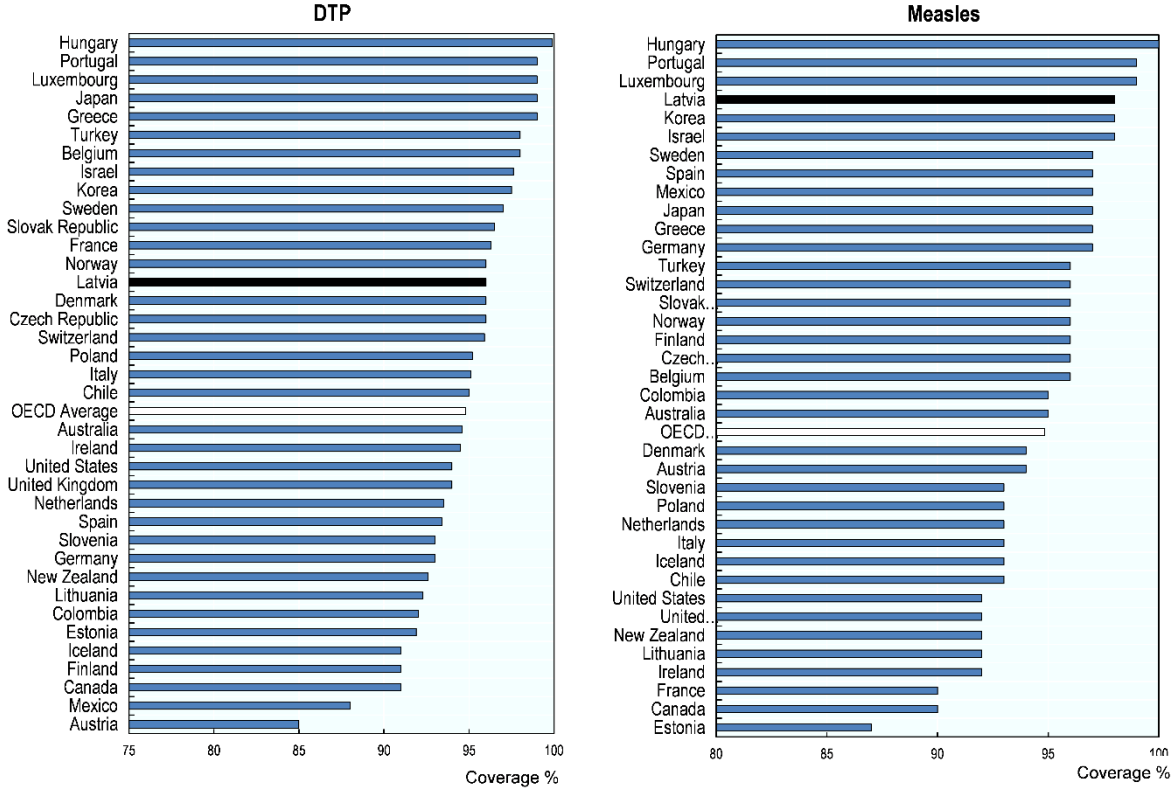
vaccines are provided free of cost for the patient. Other vaccines deemed mandatory, such as diphtheria and tetanus for adults, rabies for people who may have contracted this disease, and flu for pregnant women, tick-borne encephalitis (children from one year to 18 years declared place of residence is in a tick-borne encephalitis endemic area) are also covered in full by the state budget.

It is important to note that the term "mandatory" applies to state institutions and vaccination providers, not the public (Walkinshaw, 2011[23]). In other words, it is mandatory for the state to provide these vaccines free of cost, but people can decline vaccination. In this case, doctors are required to obtain a written and signed refusal statement.

Vaccines are generally provided by the GPs, who also monitor the childhood vaccination schedule for their patients. Coverage in Latvia is high compared to the OECD average: 96% of children receive their diphtheria tetanus toxoid and pertussis (DTP) vaccination, compared to 95% on average in the OECD (Figure 1.11). The coverage of the first dose of measles vaccine is even higher, at 98%, compared to an OECD average of 95%.

Figure 1.11. Childhood immunisation rates

Immunization coverage by the nationally recommended age (%), for diphtheria tetanus toxoid and pertussis (DTP) vaccine, and first dose of measles vaccine, 2018



Source: OECD (2020[1]), *OECD Health Statistics 2020*, https://doi.org/10.1787/health-data-en.

The Centre for Disease Prevention and Control (CDPC) is in charge of planning, coordinating and monitoring the implementation of the state immunisation programme. In 2017, the CDPC launched a programme of educational activities for medical professionals about HPV vaccination. Seminars were organised in five regions of Latvia and in total 360 medical practitioners were trained. This was followed-

up in 2018 with a public awareness campaign to explain the need to vaccinate girls against HPV infection, aimed at the parents of girls aged 12 to 18.

Tackling Antimicrobial resistance (AMR)

Systematic surveillance of AMR was introduced in Latvia in 2006. More recently, the Ministry of Health has developed a short-term policy planning document – the Antimicrobial Resistance Limiting and Proper Antibiotic Use Action Plan "One Health" for 2019-20 – which is the first policy document in Latvia that has defined the problem of AMR (Ministry of Health, 2019[24]) (see Box 1.2). This "one health" approach was developed together with the Ministry of Agriculture.

Box 1.2. Antimicrobial Resistance Limiting and Proper Antibiotic Use Action Plan "One Health" for 2019-20

The Latvian action plan on AMR covers several different areas (Ministry of Health, 2019[24]):

- Improving AMR monitoring
- Improving the use and tracking of antimicrobials
- Improving surveillance, control and prevention of communicable diseases
- Limiting the spread of multi-drug-resistant tuberculosis (MDR-TB)
- Strengthening inter-institutional cooperation on AMR
- Promoting science and research in AMR
- Building the capacity of laboratories
- Improving specialist education, training and public awareness on AMR in public health
- Improving education and public awareness on AMR in animal health

Source: Ministry of Health (2019[24]), *On the Antimicrobial Resistance Control and Precautionary Antibiotic Use Plan "One Health" 2019-20,* https://likumi.lv/ta/id/308758-par-antimikrobialas-rezistences-ierobezosanas-un-piesardzigas-antibiotiku-lietosanas-planu-viena-veseliba-2019-2020-gadam

To raise awareness, the CDPC runs public education initiatives about the prudent use of antibiotics each year on European Antibiotic Awareness Day. The CDPC disseminates information for the general public, for health care specialists and other stakeholders about the AMR threat to public health and the importance of prudent antibiotic use.

The largest university hospitals have implemented stewardship programmes to encourage better prescription of antibiotics. The Ministry of Health is now working on the implementation of an EU Structural Reform Support programme in collaboration with the Swedish Public Health Agency, to facilitate the development of stewardship programmes in other hospitals and health care institutions.

Food safety

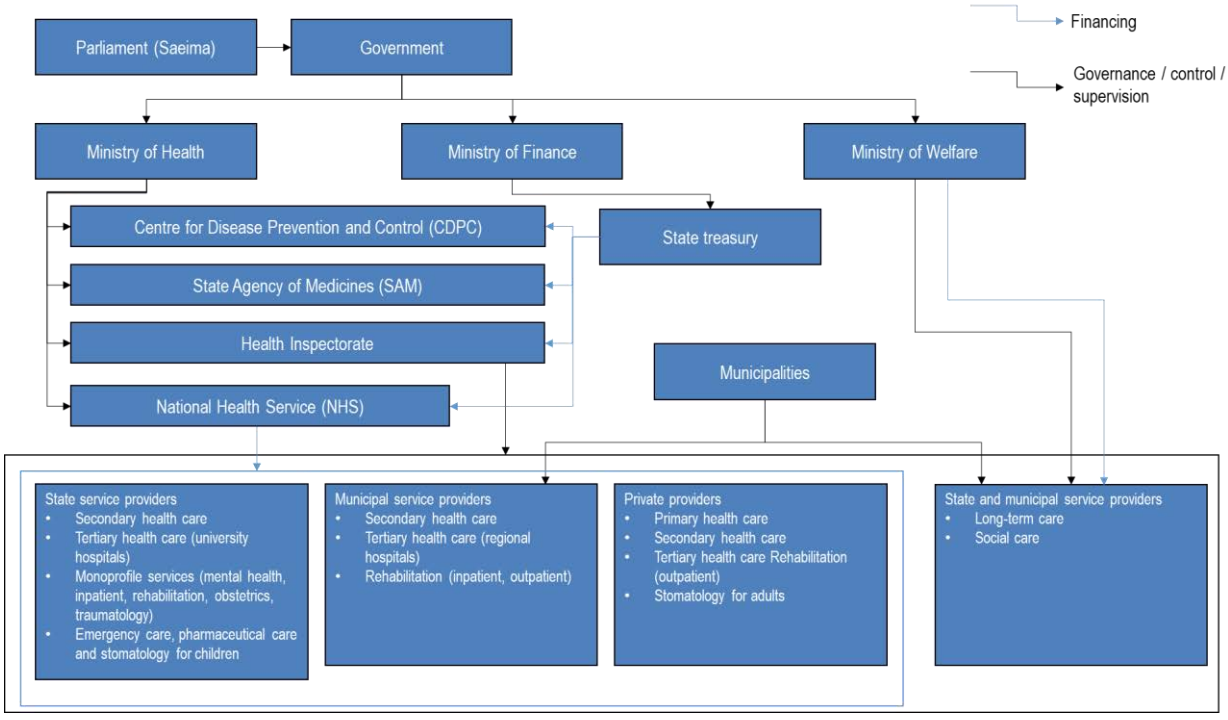
The Food and Veterinary Service, which falls under the Ministry of Agriculture, is responsible for food safety in Latvia (Behmane et al., 2019[20]). The Food and Veterinary Service carries out control of compliance with safety, quality, and other specific requirements for food products, and they are in charge of food labelling activities, including the Bordeaux and Green Spoon front-of-pack labels (see Chapter 2 for more details). Eleven regional boards provide veterinary surveillance and food control throughout Latvia, while the central office is in charge of strategic planning and providing methodological assistance to regional boards. (Ministry of Agriculture, 2020[25]).

1.4. Leadership and governance

1.4.1. Key actors in the Latvian health system

The Ministry of Health is the leading government authority in the health sector and is responsible for public health, health care and pharmaceutical care. The Ministry of Health plays an important role in the health system, as it develops the national health policy, as well as coordinating and monitoring its implementation. The Ministry of Health also oversees important executive organisations, such as the NHS, the State Agency for Medicines and the CDPC. The Ministry's budget, as well as that of the NHS, are approved by the parliament (Saeima) (Figure 1.12).

Figure 1.12. The Latvian Health System (simplified)



Source: Adapted from Behmane et al. (2019[20]), *Latvia: Health system review. Health Systems in Transition*, https://apps.who.int/iris/bitstream/handle/10665/331419/HiT-21-4-2019-eng.pdf.

Other ministries are in charge of certain aspects of health (Behmane et al., 2019[20]). The Ministry of Finance, through the State Treasury, is in charge of the financial flows from the state budget to the health care system. The Ministry of Welfare oversees social rehabilitation and home help (for instance hygiene support, help with household tasks, in the home or in institutional settings), disabled and impaired individuals. The Ministry of Agriculture oversees food safety, and the Ministry of Education and Science manages several educational facilities in the health sector. The Ministry of Defence, Interior and Justice finances health services for specific population groups (e.g. armed forces, inmates).

The National Health Service (NHS) is an administrative institution subordinate to the Ministry of Health. The aim of the NHS is to allocate the state budgetary funds for health care and to contract care from providers (Behmane et al., 2019[20]). The NHS agrees contracts with providers, determining the range of services, number of patients and funding. It is also tasked with implementing the state policy for the planning of health care services and ensuring rational and effective use of the state budget for health. The NHS has five territorial branches that contract health care providers for their populations.

The Centre for Disease Prevention and Control (CDPC), also an administrative institution subordinate to the Ministry of Health, implements public health policy in the areas of epidemiological safety and disease prevention, health care quality, and health promotion. In addition to disease monitoring, it also implements various policies of the Ministry. For example, the CDPC is main coordinator and budget holder of HIV prevention points (HPP) network; it produces and disseminates health information campaigns; and it works with municipalities to support them in their health promotion and disease prevention activities (see Chapter 2 for more information).

Local municipal governments are responsible for ensuring accessibility of health care services and health promotion, and depending on budget and local priorities, they maintain hospitals and long-term social care facilities. They also are also charged with local health promotion activities, including promoting healthy lifestyles, controlling alcoholism, and protecting vulnerable groups. While the municipalities are in charge of health promotion, they receive support and oversight from the Ministry and the CDPC to accomplish this task (Box 1.3).

Box 1.3. Balancing local and central government

After Latvia regained independence, a push was made towards a decentralised system that relied more on the municipalities for managing and implementing health policy (OECD, 2016[18]). However, partially due to the small size of the municipalities and the country in general, the system shifted back to a more centralised model.

Local Governments do still participate in health policy and governance. The Union of Local Governments of Latvia has a separate Health and Social Affairs Committee, which actively operates and solves various issues related to the health sector and often participates in the Ministry's discussions. Section 15 of Part 2 of the Local Government Law stipulates that the Local Administration is to ensure the availability of health care, as well as to promote a healthy lifestyle and sports for the population.

Currently there are 119 municipalities, with populations ranging from just over 1 000-36 000 people (Centrālā statistikas pārvalde, 2011[26]). The expertise and capabilities of these municipalities are equally variable, resulting in inequalities in access to health services and health promotion (Behmane et al., 2019[20]). To address this, the system is being reorganised, and a reduction to 43 larger municipalities is expected in 2021.

The State Agency for Medicines is in charge of registering medical drugs, devices and treatment methods. While until recently health technology assessment (HTA) was under the remit of the NHS, it has recently moved to the State Agency for Medicines (see Chapter 4 for more information).

The Health Inspectorate performs audits of health care providers to ensure compliance with the conditions of service provision determined in NHS contracts, as well as adherence to the mandatory requirements of health care institutions (Behmane et al., 2019[20]).

The State Emergency Medical Service implements a unified national policy for emergency and disaster medicine, organises and provides pre-hospital emergency medical care, stores state medical stockpiles and organises trainings in first aid.

Voluntary private health insurance accounts for a minor share of financing of health care in Latvia, and the role of private insurers therefore is limited (Behmane et al., 2019[20]).

1.4.2. Management of public health emergencies and the COVID-19 crisis

In a case of a public health emergency, the State Disaster Medicine Plan (SDMP) and the Hospital Disaster Medicine Plans are activated to manage and coordinate the disaster response. Both were developed according regulation of Cabinet of Ministers No. 948 “Roles of organisation of Disaster medical system”. The SDMP describes coordination mechanism for emergencies caused by biological, chemical, radioactive agents, climatic impact on health, mass casualties and pandemic preparedness. Based on the type of threat each SDMP annex consists of the list of points of contact relevant to exchange and receive information (including health and non-health sectors, for example, police, fire and rescue service, environmental health services). Each annex also describes key functions and tasks attributed to all involved actors. At the level of Ministry of Health emergency situations are coordinated and leading decisions are accepted by State Operational Medical comity (SOMC).

The CDPC is responsible for the monitoring and prevention of communicable and noncommunicable diseases. Its nine regional offices, in Rīga, Daugavpils, Rēzekne, Valmiera, Gulbene, Jelgava, Jēkabpils, Liepāja and Ventspils, are responsible for epidemiological surveillance and monitoring, outbreak investigation of infectious diseases, and emergency management of epidemics (Behmane et al., 2019[20]).

Like all other OECD countries, in the Spring of 2020 Latvia was confronted with the outbreak of the new coronavirus COVID-19 which demanded a whole-of-government response. At the time of writing in early September 2020, Latvia recorded a peak of COVID-19 cases in March 2020 with a daily high of 71 cases (Our World in Data, 2020[27]). Since June daily recorded cases have fluctuated around 0-19 per day. As of the week of 8 September 2020 new daily confirmed cases were at 2.5 per million population, well below the European Union average of 51.95. As of early September 2020 Latvia had recorded 35 deaths from COVID-19, a rate of 18.56 per million population, significantly below both the European Union average of 317.42 per million population and below neighbouring Estonia (48.25 per million population) and Lithuania (31.59 per million population) (Our World in Data, 2020[27]).

Latvia recorded its first case of COVID-19 in March 2020, and begun introducing a series of containment measures from mid-March. Containment measures included limits on public gatherings, closure of schools, limits to international travel, and a requirement that Latvians practice social distancing both inside and outside (OECD, 2020[28]). After initial boarder closures, from May free movement was allowed between Latvia, Lithuania and Estonia as part of a so-called “Baltic Bubble”. At the beginning of September 2020, as average daily cases in Estonia (16.91 per million population) and Lithuania (10.18 per million population) were rising Latvia was considering tightening travel restrictions on these countries (BBC News, 2020[29]; Our World in Data, 2020[27]).

Like other OECD countries, at the beginning of the crisis Latvia also took steps to prepare for the health system impact of the COVID-19 outbreak. In Latvia this included using medical equipment from the private sector, stockpiling and procuring additional protective equipment and pharmaceuticals (OECD, 2020[28]). Special new structures include mobile testing points of the Emergency medical service and drive-throughs (public and private) were set up, and the capacity of COVID-19 laboratory testing capacity was increased. To increase health care capacity overtime working hours are allowed in excess of the maximum overtime hours prescribed by the Labor Law, but not exceeding 60 hours per week for medical practitioners working in the Emergency medical service, in-patient institutions, as well as for epidemiologists working in the CDPC. the government also increased a financial bonus for health workers, amounting to an additional 20-50% of the monthly salary for March, April and May (OECD, 2020[28]).

The primary research phase of this review was undertaken in late 2019, prior to the start of the major COVID-19 outbreak in Europe. The review was finalised in late 2020, as the COVID-19 crisis continued to evolve.

1.5. Partnerships and collaboration

1.5.1. Ministries that have a role in public health policy

Along with the Ministry of Health, which leads public health governance and policy setting in Latvia, numerous other Ministries contribute to the delivery of health promotion and disease prevention efforts in different ways. The Ministries of Welfare, of Agriculture, and of Environmental Protection and Regional Development in particular play a role in public health activities.

The Ministry of Welfare is the leading institution of the state administration in the areas of labour, social security, children's and family rights as well as equal rights for people with disability and gender equality. The Ministry of Welfare has responsibility for vulnerable populations, nursing care and social care services – although these are usually organised by local authorities – and promoting healthy work places. In addition, the Ministry of Welfare is implementing a 'healthy aging' project with the support of the European Union, which aims to extend and improve the working life of the population, and identify evidence-based strategies to promote active ageing.

Latvia's Ministry of Agriculture is the main governmental institution responsible for the sector of agriculture, food, forestry and fisheries. The Ministry's main responsibilities are to assure sustainable systems in these areas, including assuring food safety and animal welfare. In addition, the Ministry of Agriculture, in collaboration with the Ministry of Health, works on the topic of antimicrobial resistance in order to improve the quality and analysis of data on antimicrobial resistance and antibiotic use, to improve the prevention and monitoring of communicable diseases in both public and animal health, and to raise awareness among professionals and the general public of responsible and prudent use of antibiotics in humans and animals.

The Ministry of Agriculture, in collaboration with the Ministry of Health, is responsible for the food nutrition labelling and food safety. The Ministry of Education and Science is the main governmental institution responsible for education, sports, youth, state language policies. It is also involved in the anti-doping policy implementation in cooperation with the Ministry of Health and the National Anti-Doping Agency. The Ministry of Education and Science in collaboration with the Ministry of Health and other organisations have established the draft of The Sports Policy Guidelines 2021–2027. This draft aims to promote physical activity for all, including youth, paralympic and elite sports, including the preparation of athletes within the competitive programmes; improve disabled people`s access to sports; and promote the development of the sports infrastructure. The policy of the Ministry of Education and Science of Latvia has developed the Education Development Guidelines 2020–2030, which addresses the integration of physical activity in education. This includes general (primary and secondary) education, along with higher education, and focuses on ethnic minorities, low socio-economic groups, and children and youth. Health education in Latvia has been integrated in the general education programmes for all education levels (preschool, primary and secondary, as well as vocational) and the Ministry of Health was involved in the development of the content of subjects like biology, chemistry, natural science, social sciences, sports, where health themes are included.

More broadly, there is ongoing collaboration across Ministries for issues related to health. This includes co-operation of the Ministry of Health with the Ministry of Welfare around agreements for prescribing and paying for sick-leave certificates, or collaboration with the Ministry of Education and Science on, for instance, issues such as exempting students from state tests because of health; first aid and health care in educational institutions; requirements for children's camps; integration of children with disabilities in educational institutions, and so on.

1.5.2. Public involvement in policy making for public health

Latvia takes some steps to involve the public in health care planning, both through general public consultation or through engagement with Non-Governmental Organisations, some of which are required

by law. The 2013 'Procedures for the Public Participation in the Development Planning Process' requires that certain procedures for public participation in the development planning process of the government and state institutions are followed (Republic of Latvia, 2013[30]). Opportunities for public participation includes participation in the planning of legal acts, opportunities to review planning documents, participation in inter-institutional working groups and advisory councils, and involvement in public discussions and consultations.

The Ministry of Health has established long-term cooperation with various Non-Governmental Organisations (NGOs), involving them in the development and implementation of health care policy. NGOs are also involved in several commissions and councils established in public administration. Inter-sectoral policies affecting the health sector are dealt with in ad-hoc inter-ministerial working groups where NGOs are also involved. Interdisciplinary commissions within the Ministry of Health in which NGOs are engaged include the Anti-microbial Resistance Limitation Commission, the National Anti-Smoking Committee and the Nutrition Council and others (see Chapter 2). Advisory groups on specific topics bring in expertise from a range of Ministries, as well as stakeholders from outside of government. A Human Biomonitoring Council established in 2016, for example, brings together expertise from the Ministry of Health and related public health institutions, from the Ministries of Environmental Protection and Regional Development, of Agriculture, of Education and Science, of Welfare, as well as input from Riga Stradiņš University, the Latvian Medical Association and the Environmental Consultative Council.

There is also active engagement with a range of professional associations, for example the Latvian Public Health Association, Latvian Physicians' Association, the Health Care Employers' Association, the Latvian Family Physicians' Association, the Latvian Midwives' Association, the Latvian Nurses' Association, and the Latvian Pharmacists' Association. Some professional groups have been assigned regulatory tasks, for example around licensing and education.

There is also engagement between the Latvian Ministry of Health and a number of patient groups. For example, with the Latvian Haemophilia Society, Latvian Cystic Fibrosis Society, or the Oncological Patient Support Association 'Tree of Life'. Some patient associations receive EU funding to support their activities, and some associations receive funding from pharmaceutical companies.

Overall the relationship between the Ministry of Health and patient representatives seemed to be a positive one. It appeared that patient groups were regularly consulted with, even if their demands are not always met, and there are frustrations with the capacity of the current Latvian health system.

1.5.3. Engagement with representatives of industry

Engagement between the Ministry of Health and representatives of industry, notably food, appears to be positive in Latvia. Voluntary marketing regulations on soft drinks were introduced in 2011, notably a voluntary commitment from industry to limit advertising of soft drinks to children. The Nutrition Council, set up by the Ministry of Health, convenes several times a year and includes the participation of the Latvian Food Business Federation, Latvian Hotel and Restaurant Association (for more information see also Chapter 2). The Latvian Confederation of Employers – the largest employers organisation of Latvia, representing 42% of all employees in Latvia – and the Foreign Investors Council in Latvia – a non-governmental organisation that brings together the largest companies from various countries and sectors that have made significant investments in Latvia – also engage with the government in policy discussions.

As Chapter 2 sets out, there is scope for stronger engagement of industry with promoting healthier lifestyles for Latvians, following some of the practices that can be found in other OECD countries. For example, as detailed in the Chapter 2, both in Spain and the United Kingdom the food and beverage industry has been pushed to take the lead in voluntary reformulation of certain foods, followed by evaluations to assess whether a voluntary approach is delivering effective changes. Latvia is working on this, as the Ministry of

Health of Latvia is planning to sign a Memorandum of Cooperation with industry aiming to improve the composition of food products by implementing reformulation.

1.6. Financial resources

1.6.1. The case for investing in health promotion and disease prevention

When invested in the right way, spending on public health and prevention activities can be highly cost-effective, reducing health care expenditure, reducing years of life lost, and increasing participation in the labour market. A 2014 analysis of investment in public health services and capacity at the European level found that spending on prevention can be cost-effective and provide good value-for-money in both the short and longer term (World Health Organization, 2014[31]). National analyses, for example from England, have found that many public health interventions are either cost-saving or cost-effective (Owen et al., 2012[32]; Owen and Fischer, 2019[33]). The OECD's economics of public health analysis has identified interventions across a range of public health areas, and in particular with regards to reducing non-communicable diseases, which are represent excellent investments in population health.

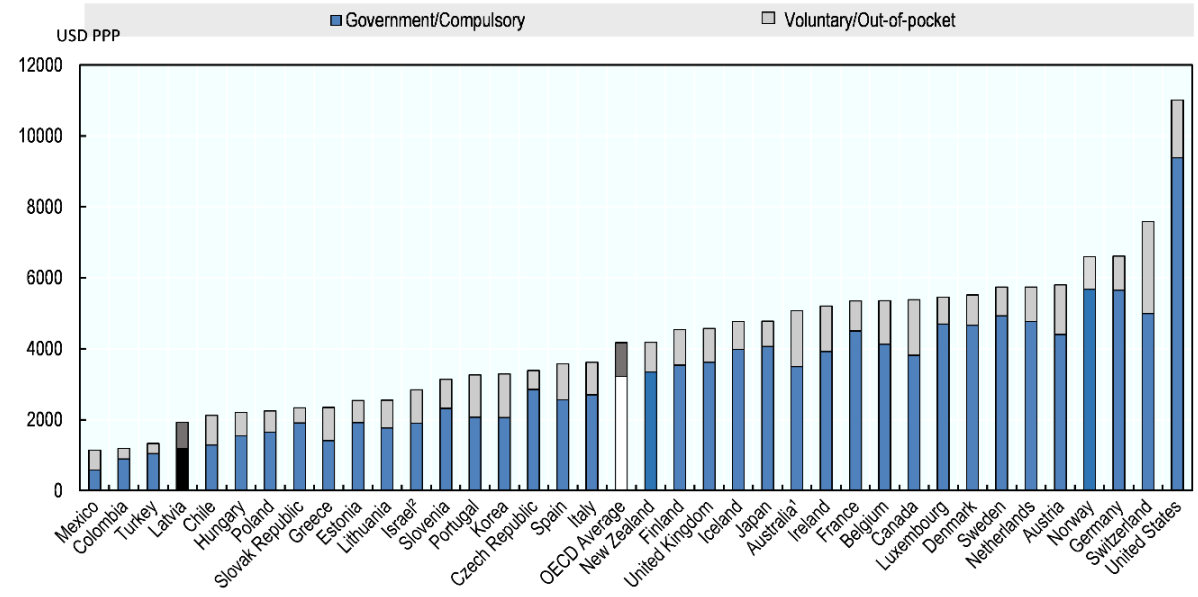
The effectiveness of spending on public health depends on the policies and interventions where investments are made. Many of the interventions that represent the best value-for-money are population-level investments that target broad health improvements, for example reducing obesity or harmful alcohol consumption. The WHO 'best buy' interventions also includes several 'prevention' interventions that are highly cost effective, including tobacco and alcohol legislation, reducing salt, and increasing physical activity (World Health Organization, 2014[31]; World Health Organization, 2011[34]). A significant number of interventions – including vaccinations, mental health promotion, violence prevention, and road traffic injury prevention – are investments that can give returns on investment within 1-2 years (World Health Organization, 2014[31]). Other public health interventions – including those discussed in the other chapters of this Review – are also be cost-effective when well-implemented, for example cancer screening or chronic disease management programmes as discussed in Chapter 3.

OECD analysis has identified cost-effective public health policies and policy packages, in particular in terms of reducing the burden of obesity and reducing harmful alcohol consumption (OECD, 2019[35]; OECD, 2015[36]). For example, across OECD countries, each USD 1 invested in reducing overweight and obesity, up to USD 5.6 will be returned in economic benefits through reduced health care costs, and increased labour market participation. By helping to tackle overweight and obesity regulation of advertising, and menu labelling, would save USD 5.6 and USD 4.8 respectively in GDP benefits, for each dollar invested (OECD, 2019[35]).

1.6.2. Latvia had one of the lowest levels of health spending in the OECD

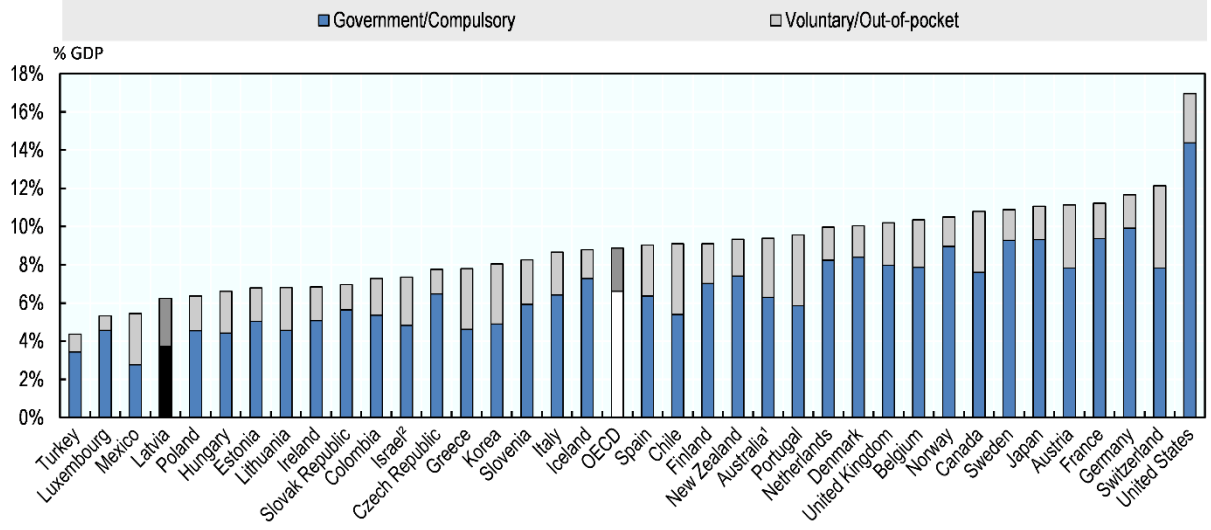
Latvia had one of the lowest levels of health spending in the OECD in 2019, both in terms of per capita expenditure – USD 1 924 (adjusted for purchasing power parity, or PPP) in Latvia compared to the OECD average of USD PPP 4 170– and as a percentage of GDP – 6.2% in Latvia, compared to the OECD average of 8.9% (OECD, 2020[1]) (Figure 1.13, Figure 1.14).

Figure 1.13. Health expenditure per capita, 2019 (or nearest year)



Note: 1. Australian expenditure estimates exclude all expenditure for residential aged care facilities in welfare (social) services.
2. Includes investments.
Source: OECD (2020[1]), *OECD Health Statistics 2020,* https://doi.org/10.1787/health-data-en, World Health Organization (2020[37]) *Global Health Expenditure Database,* https://apps.who.int/nha/database.

Figure 1.14. Health expenditure as a share of GDP, 2019 (or nearest year)



Note: Expenditure excludes investments, unless otherwise stated. 1. Australian expenditure estimates exclude all expenditure for residential aged care facilities in welfare (social) services. 2. Includes investments.
Source: OECD (2020[1]), *OECD Health Statistics 2020,* https://doi.org/10.1787/health-data-en, World Health Organization (2020[37]) *Global Health Expenditure Database,* https://apps.who.int/nha/database.

However, in recent years the Latvian Government has been looking to increase health spending. Additional funding of EUR 190.07 million was allocated in 2018 compared to 2017, followed by EUR 142.51 million in 2019 compared to 2018, and additional EUR 78.19 million in 2020 compared to 2019. This additional investment had been initially financed from a mix of budget reallocation, a budget deficit increase allowed by the European Commission, and revenues raised by an increase in social contributions.

1.6.3. High levels of cost-sharing reduces access to health care

Household out-of-pocket payments represented 39.2% of total health spending in Latvia in 2018, compared to the OECD average of 20.1% (OECD, 2019[38]; OECD, 2019[19]). In 2014, 34.7% of Latvians reported having foregone care because of affordability, and in 2013 15.2% of Latvian households experienced catastrophic health spending (households spending 40% or more of total household resources on health care) (OECD, 2019[38]). In 2017 out-of-pocked spending represented 4.2% of Latvian household spending on average, higher than the OECD average of 3.3%, and higher than neighbouring countries such as Lithuania (3.3%), Estonia (3.1%), and Poland (2.6%) (ibid.). Some key public health functions – for example breast and cervical cancer screening, and vaccinations – are available with no out-of-pocket payments. However, if Latvians are foregoing health care for cost reasons it may be making the population less likely to proactively seek health care, consult early in the case of health concerns, or even engage actively in the management of a chronic disease.

Additionally, Latvia has relatively limited mechanisms in place to protect the population from catastrophic health spending and/or protecting poorer populations from foregoing health care due to cost. During the financial crisis period from 2008-10 Latvia introduced exemptions for cost-sharing for vulnerable and low-income groups, and in 2016 the OECD encouraged Latvia to consider re-introducing some or all of these exemptions (OECD, 2016[39]). Exemptions to co-payments remain extremely limited. For example, co-payment exemptions for financial need are applied only if an individual's average monthly income during the last three months does not exceed a set threshold, and if the individual does not own monetary accumulations, securities or property. The total annual contribution for inpatient and outpatient treatment is also relatively high (excluding the purchasing of outpatient medicines, spectacles and dental services) (WHO, 2017[40]) (see also Chapter 4).

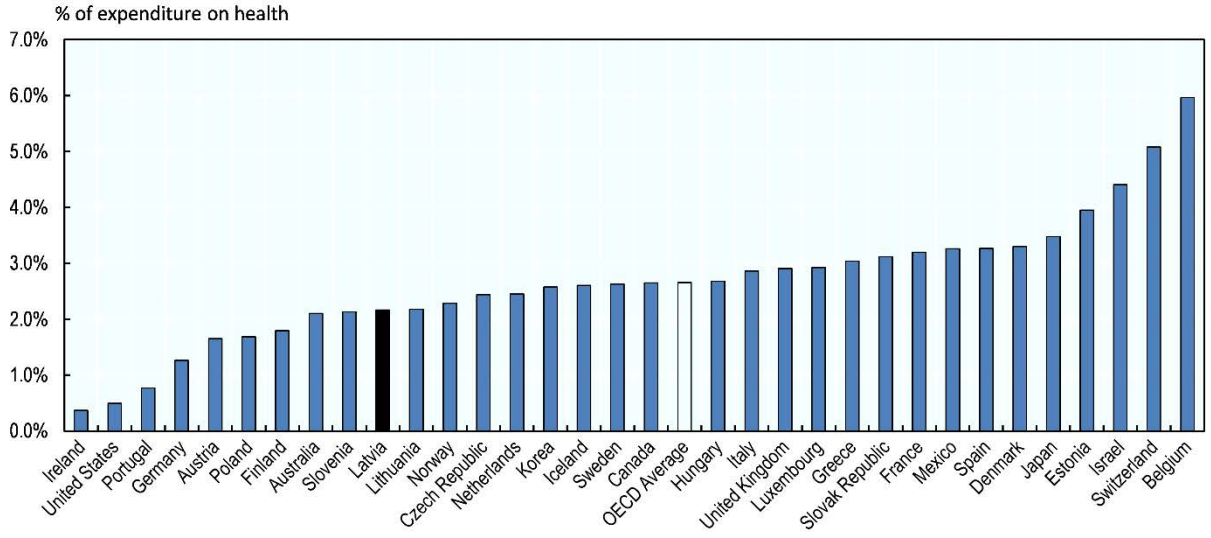
As of 2020 Latvia introduced changes to co-payment for different health care services and patient categories, primarily to protect elderly persons over age 65 from risk of catastrophic health expenditure, which is a welcome development. Children under age 18 are already exempt from co-payments for general practitioner visits, and all Latvians can attend a GP visit once a year for a general preventive health check-up. Mandatory vaccines are purchased centrally and provided free of charge. Employees whose workplace means that they need additional vaccinations, for example yellow fever or hepatitis B, should have the cost of this vaccine borne by their employer. Additional vaccines for patients with chronic or acute disease are compensated at 50% by State budget resources. Flu vaccines are also covered in full for children aged 6-23 months, for children up to the age of 18 with health risks, and at 50% for people aged over 65 and adults with certain health risks. During 2020 flu vaccinations were fully covered (100%) for over 65s and adults with certain health risks, as part of efforts to reduce pressure on the health system given the COVID-19 outbreak.

1.6.4. Spending on health promotion and prevention is low but increasing, but funding sources may not be sustainable

Latvia's health system is, in general, stretched for resources, and the public health sector is no exception. As a percentage of current expenditure on health, Latvia spends less than the OECD average on prevention; in 2018 Latvia spent 2.2% of the total health budget on prevention, compared to the OECD average of 2.7% (OECD, 2020[1]) (see Figure 1.15). Latvia also spent less on prevention as a percentage

of GDP than the OECD average; in 2018 Latvia spent 0.16% of GDP on prevention, compared to the OECD average of 0.25% (OECD, 2020[1]).

Figure 1.15. Spending on prevention as a percentage of current expenditure on health, 2018 (or nearest year)



Source: OECD (2020[1]), *OECD Health Statistics 2020,* https://doi.org/10.1787/health-data-en, World Health Organization (2020[37]) *Global Health Expenditure Database,* https://apps.who.int/nha/database.

Spending on public health is spread across a range of different functions in Latvia, for example centralised purchasing of vaccines, funding for cancer and newborn screening, and prevention activities in primary care delivered by General Practitioners. In 2018, total government spending on prevention was 44.7 EUR million (excluding municipal spending and EU funds) was split across health condition monitoring programmes (49%), immunisation programmes (21%), early disease detection programmes (15%), epidemiological surveillance and risk and disease control programmes (8%), information, education and counselling programmes (7%) (Central Statistical Bureau of Latvia, 2018[41]). A further EUR 3.4 million was spent on health promotion with multi-sectoral approach (ibid.).

However, when it comes to targeted health promotion and prevention programmes, for example national campaigns, efforts to support weight loss or increased physical activity, smoking cessation programmes, Latvia appears to be highly reliant upon funding from the European Union. For example, Latvia's Public Health Strategy for 2014-20 has been primarily funded by EU funds (OECD, 2016[39]), and EU funding which runs until 2023 has been used to pay for municipalities to develop their own local health promotion plans, overseen by the Ministry of Health. There is a risk that too much reliance on EU funding for impedes building a sustainable set of health promotion and prevention programmes, if funding in priority areas cannot be assured over the longer term.

In terms of municipal public health programmes, these local efforts should be tailored to local needs, but focus on areas such as physical activity, nutrition, alcohol, tobacco, mental health, and sexual and reproductive health. The expectation of the central government appears to have been that municipalities would receive start-up capital from these EU funds, but then be expected to cover the ongoing costs of these programmes out of local budgets from 2023. As of 2020 the projected central budget did not include provisions to continue to support municipalities, nor was there a mechanism to ensure that municipalities continued to fund public health programmes out of their own budget.

1.7. Knowledge development

1.7.1. Most public health information is centralised and analysed by the CDPC

The principal institutions responsible for health data collection in Latvia are the CDPC, the NHS, and the Central Statistical Bureau (CSB). The CDPC is responsible for collecting and summarising all health-related statistical data in Latvia, including data collected by the NHS and the CSB. The CDPC is also responsible for complying with international obligations by submitting certain data to WHO and Eurostat.

All statistical reports consist of aggregated data and do not include personal identifiers. The CDPC collects cause of death statistics and the NHS all data related to state-paid health services, service provision and payment information received from all contracted providers (such as for instance hospitals, health centres or GPs). The NHS data system also contains information on all services provided for individual patients, including patient personal data, diagnoses, procedure codes (according to a national coding system), and a provider identifier. The CSB collects statistical information on some key health indicators, for example, the use of emergency medical services or population morbidity. The CSB is in charge of communications with the OECD and also Eurostat for some indicators (Behmane et al., 2019[20]).

1.7.2. Latvia is developing its eHealth system but further progress is needed

The current eHealth system intents to provide a secure system to record and exchange medical and patient information. The use of the central electronic system is voluntary for medical institutions; however, since January 2018 electronic sick leave certificates and prescriptions for outpatient pharmaceuticals reimbursed by the NHS have been mandatory.

In practice, the eHealth system consists of two parts, one for the public and one for authorised health care professionals. The public section, accessible through the eHealth portal, provides information on the health care system, healthy lifestyles, databases, etc. After authentication, patients can view their basic health data, check current prescriptions or sick leave certificates. Health care professionals are able to enter and process patient data and prescribe medications, as well as sick leave certificates, while pharmacists can access prescriptions for the patient and mark their delivery to the pharmacy.

The NHS is responsible for the implementation of the national eHealth strategy and the establishment of the necessary infrastructure and running of the eHealth support service. However, it is up to health care providers to equip themselves with the necessary IT material (Behmane et al., 2019[20]).

Latvia could still stand to increase use of real-world health care data to inform biomedical research and evaluation. A “learning health care system” based on electronic health records and other routinely collected data holds large promises for facilitating medical research and improving effective and efficient use of medicines, is at an early stage in Latvia, although mechanisms for data access for research are in place (OECD, 2021 (forthcoming)[42]). The Centre for Disease Prevention and Control evaluates researchers’ and research institutions’ applications for the use of identifiable patient data recorded in the medical documents in specific research under Cabinet Regulation No. 446 which covers cases where it is not possible to obtain informed consent from the patient. If approved, data for research from different sources is provided/available on a person level with a direct identifier (personal ID, etc.). Requests for a data extraction from the public monitoring system for health care quality and efficiency are approved by a special project council consisting of representatives from the Centre for Disease Prevention and Control, National Health Service, State Emergency Medical Service and Health Inspectorate. In this case, approved applicants’ access pseudonymised data (OECD, 2019[43]).

Latvia has developed a Health System Performance Assessment Framework (including health care quality, patient safety and efficiency indicators). Within this framework, principles and procedures for data provision, data linkage, health data protection, and access for research are set out (OECD, 2019[43]).

1.7.3. Heath information to citizens increased substantially in recent years but health literacy remains low

Public health information available to citizens has increased in Latvia. The Ministry of Health developed a portal called “Your Health”, where citizens may obtain information on their rights and responsibilities, health care organisation, how to apply for health care services, health prevention, healthy lifestyle, special recommendations for specific patient groups etc. The Ministry of Health uses this support to also inform patients about regulatory issues, planned reforms and provides links to other national and international institutions.

Other public institutions share online information regarding their activities and responsibilities: the NHS for instance provides information on the financing of health services, tariffs and access to contracted health care providers; the CDPC information on health promotion, infectious disease control, epidemiological data and other health statistics; and the SAM on responsible medicines utilisation and medicines shortages (among others) (Behmane et al., 2019[20]).

Yet, despite these recent improvements the health literacy of the Latvian population appears to be rather limited; there have been no recent studies of health literacy in Latvia, although in 2020 “Study on the knowledge and skills of the Latvian population in the field of health or health literacy” has been put out for procurement. Digital Transformation Guidelines are currently being developed in Latvia, which also includes health literacy, and health education is promoted through the Public Health Guidelines, while the education sector promotes children’s health education. However, given how important good health literacy is for person-centredness in health systems, for supporting chronic disease management, and for promoting healthy habits in the population, Latvia could still follow other OECD countries in introducing targeted efforts to increase health literacy (see Box 1.4).

Box 1.4. Increasing health literacy

Health literacy supports individuals become partners in the co-production of health. When individuals are educated and empowered on health information, they will be able to make informed decisions about the care that they, or others, receive. It also encourages individuals to take more responsibility for own health. It is thus a key element in the move towards people-centred health systems. Evidence shows it can improve patient experience, support self-care practices and may contribute to improve certain health outcomes.

The proportion of a population seeking health information in the internet is one of the indicators used to measure health literacy. Half of all EU residents sought health information on line in 2017, a figure that has almost doubled since 2008. The highest proportions were in the Netherlands and Finland (about 70%). Latvia reported among the lowest levels, with only 43% of people seeking health information on line in 2017.

Austria, Australia, Germany or New-Zealand have all developed health literacy programmes. In Austria for instance, the national government has structured its health literacy approach into three areas of intervention: (i) improving the organisational health literacy of the health care system, i.e. health literacy becomes a quality dimension of health care organisations and of the health system, (ii) improve personal health literacy with a focus on information, education and training, and (iii) improve health literacy in the consumer and service sector with specific attention to the quality of information that supports decision on product purchasing or service utilisation. For each sub-goal, a number of interventions has been defined and are subject to a monitoring process focusing on progress of interventions. Another area of future action focus digital health literacy which is slowly gaining relevance.

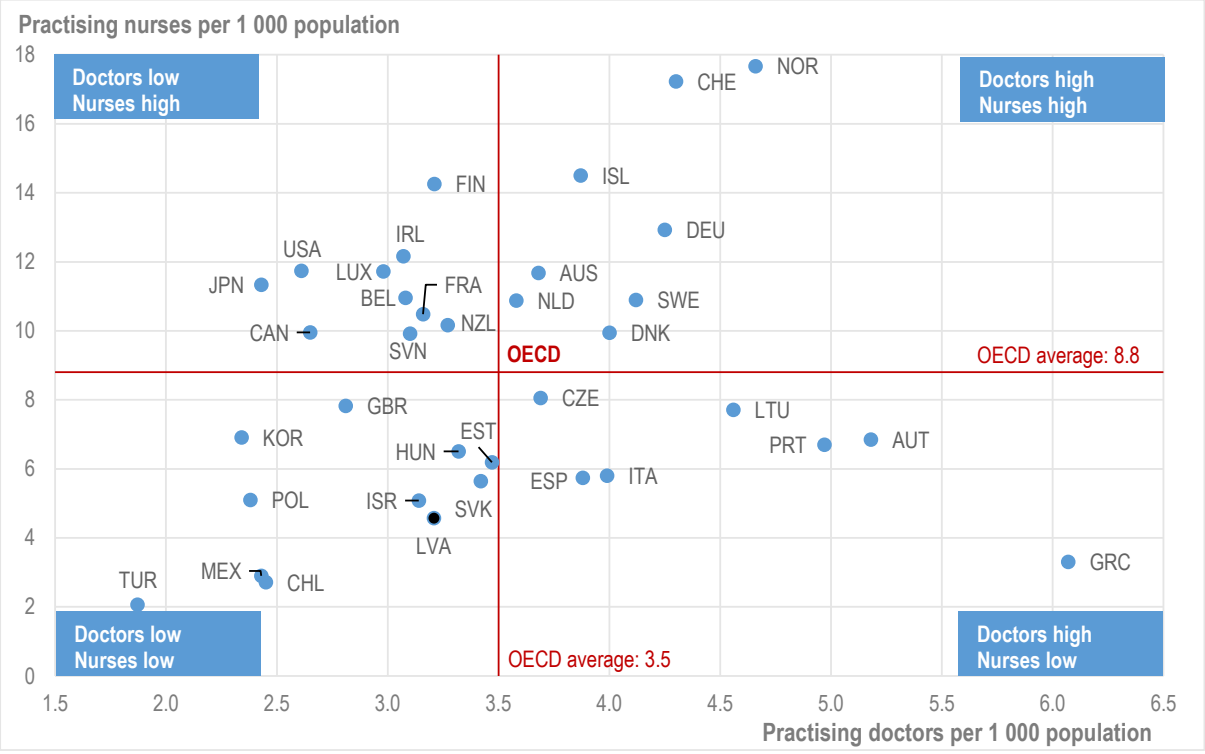
Source: Moreira (2018[44]), *Health Literacy for People-Centred Care: Where do OECD countries stand?,* http://www.oecd.org/els/health-systems/health-working-papers.htm, OECD (2018[45]), *Health at a Glance: Europe 2018,* https://ec.europa.eu/health/sites/health/files/state/docs/2018_healthatglance_rep_en.pdf.

1.8. Workforce

1.8.1. Latvia reports fewer health professionals than the OECD average

While the number of practising doctors in Latvia is slightly below the OECD average, at 3.2 doctors per 1 000 population (3.5 in OECD countries), the number of nurses is nearly half the OECD average (4.6 per 1 000 vs. 8.8, see Figure 1.16). While the number of doctors per 1 000 population has been continuously increasing since 2001, the number of nurses has been decreasing since 2010 and the nurse-to-population ratio is currently one of the lowest among OECD countries (1.4 nurses per physician in 2016) (Behmane et al., 2019[20]).

Figure 1.16. Doctors and nurses numbers in OECD countries, 2017 or nearest year



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: OECD (2020[1]), *OECD Health Statistics 2019,* https://doi.org/10.1787/health-data-en.

Since 2000, Latvia has witnessed an increase in the overall number of graduates of health-related study and training. In particular, the number of medical graduates increased more than four times between 2000 and 2015 (Behmane et al., 2019[20]). However, many of them choose to work in different professions or move abroad and consequently the health authorities continue to grapple with important health workforce shortages, more particularly in rural areas.

1.8.2. The regional repartition of the health workforce is very imbalanced

There is considerable variation in the distribution of doctors across regions in Latvia. Physician density across the country reveals a clear divide between urban and rural areas that constitutes an important access barrier for many Latvians living outside major urban centres. In 2018, the ratio of practising medical doctors per population was more than three times higher in the Riga area than in rural regions such as Zemgale or Kurzeme. (OECD, 2019[19]). While population density is far higher in Riga and other cities than rural areas of Latvia, securing geographical access to health care can nonetheless be a concern in less populated 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, foreshadowing the development of additional shortages of primary care physicians.

In light of these issues, the Latvian authorities have begun taking steps to increase the supply of physicians in rural areas. For example, 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. Also, since 2018 an EU-funded project has provided financial incentives to attract medical

practitioners to work in regions outside Riga. In 2020, EU funding will also be used to try to attract physicians to public health care services in Riga, in parallel with these measures to attract practitioners to rural areas. As of July 2019, 315 medical practitioners have received such financial support. Beneficiaries include doctors of various specialties, as well as medical assistants, nurses, midwives and physiotherapists (OECD, 2019[19]).

1.8.3. GPs are a strong feature of the Latvian primary health care system

Primary care is provided by a network of GP practices, mostly private entrepreneurs, and few employed by health centres. Registration with a family doctor is voluntary but most Latvians choose to sign up with one practice.

GPs act as health-system gatekeepers, providing referrals for patients to visit most specialists (some specialists such as gynaecologists do not require to be referred to by a GP though). Most GPs work in solo practices, conversely to what has been reported in many OECD countries where there has been a shift towards larger teams in recognition of the economic and communal benefits of working with peers (OECD, 2016[18]). GPs are paid using a mix of capitation, fee for service, fixed practice allowances (capitation) and, since 2013, payments on quality indicators. The family medicine curricula was introduced as a new specialty in 1990 in Latvia (Behmane et al., 2019[20]).

Continuous medical education is offered and organised by universities and medical professional associations, under different formats. Proof of having participated and validated a certain number of continuous medical courses (credits) is required for recertification every 5 years, regardless of the type of health care institution in which doctors work (Behmane et al., 2019[20]).

1.8.4. Training of public health professionals in Latvia is well-established

Since 1997, Riga State University has offered a 4-year Bachelor programme in public health, training approximately 20 students every year. After their Bachelor's degree, graduates as well as other health professionals (physicians, nurses, etc.) can engage in a 2-year Master's programme in Public Health, after which they may pursue a doctoral degree (Behmane et al., 2019[20]). From 2020 the University of Latvia is offering a Master's Programme in Epidemiology and Statistics.

In 2014, RSU and Riga International School of Economics and Business Administration (RISEBA) established a joint full-time Professional Master's degree in Health Management and a professional Business Establishment Executive, which lasts 1.5-2 years (Behmane et al., 2019[20]).

Other public health professionals include:

- Public health physicians: these are physicians who undertook a 4 years residency specialisation in public health (the other medical specialties that include a substantial amount of training in public health are general medicine, infectiology and sport medicine).
- Nutritionists, who receive a four-years dedicated training.

In addition, nurses' training has been revised in 2019 and the curricula now includes more focus on public health matters (environmental health, prevention, social determinants of health, etc.) and the possibility for them to further specialise. Also, as mentioned previously, to encourage more prevention activities in primary care, practices with more than 1 200 adult patients or 600 patients under the age of 18 on their patient list are given funding for a second practice nurse, whose primary focus is supposed to be more on prevention.

1.9. Conclusion

When it comes to the overall Latvian public health system architecture, Latvia's Ministry of Health is clearly turning attention to prevention and promotion activities. However, despite noticeable improvements over the last decades, Latvia is facing a considerable public health challenge: life expectancy is low, the burden of non-communicable and infectious diseases is high, and risk factors such as smoking, alcohol consumption and obesity are prevalent.

To address these issues, Latvia has a centralised health system controlled by the Ministry of Health. The role of local governments in public health is limited, but this may change after the municipalities are reorganised, and the local government role in public health has grown in recent years. Most preventive care falls under the remit of primary care, however this sector is under-resourced and overloaded. GP and municipalities are expected to play a key role and both appear over-stretched and over-loaded. Latvia should consider allowing other health system actors to take on some GP tasks – such as pharmacists offering routine health checks – as well as looking to introduce more capacity in the system by giving additional support to GPs, especially tied to incentives to undertake prevention activity. Municipalities, too, could likely be stronger public health actors through more strategic planning, especially in light of the instability of financing for programmes such as municipality-level group fitness classes or healthy eating education, which are currently mainly paid for with EU funding. This could mean using funding that is currently available to pay for training for staff in health promotion, so that the expertise in this area remains within the municipality beyond the horizon of the current programmes. There is also scope for Latvia to strengthen regulation around harmful alcohol consumption, continuing to pursue the tighter regulations on availability and marketing of alcoholic beverages planned for 2020-22.

There is scope for Latvia to make better use of existing resources, such giving pharmacists a more significant role in public health education and prevention activities, but it remains that Latvia has one of the lowest levels of health spending in the OECD, and high levels of cost-sharing reduces access to health care. While spending on health promotion and prevention is low but increasing, funding sources may not be sustainable. Latvia would be well-placed to maintain the commitment made in recent years to increasing health spending, and focus on investing in public health interventions that represent good value-for-money, including those examples given in this chapter which include a comprehensive policy package to reduce harmful alcohol consumption, strengthening the health information infrastructure, and promoting health literacy.

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2 Tackling obesity in Latvia

Obesity is a growing public health issue in Latvia, despite efforts at different levels of society to improve diet and physical activity. To tackle the rise in obesity, Latvia has implemented a range of policies, including local health promotion programmes, restrictions on the food and drinks sold in schools, and a tax on sugar-sweetened beverages. To further step up the response, three recommendations are made. Firstly, Latvia should expand or redesign a number of its obesity policies, to ensure they have maximum impact. Secondly, it is important to ensure the long-term sustainability of the large number of initiatives that are funded on a project-basis. Thirdly, while there are some quick-wins to empower the health system to deliver prevention and treatment activities, adequate reimbursement or other financial incentives need to be put in place.

2.1. Introduction

Obesity is a growing concern for most OECD countries – Latvia included (see Box 2.1). As a major risk factor for many non-communicable diseases, obesity has considerable consequences for both population health and the economy. To curb the rise of obesity, a wide range of policy options are available to encourage healthier diets and increase physical activity.

This chapter looks at how the obesity epidemic can be tackled in Latvia. It starts with an overview of the prevalence and distribution of obesity in Latvia, as well as its main risk factors. Then the policies and initiatives currently in place in Latvia are reviewed, covering different levels of society, including the central government, municipalities, schools, the healthy system and industry. Finally, recommendations are made to improve Latvia's obesity strategy.

Box 2.1. The Heavy Burden of Obesity

Almost one in four people in OECD countries are currently obese. This epidemic has far-reaching consequences for individuals, society and the economy. In its recent report on The Heavy Burden of Obesity, the OECD used microsimulation modelling to explore and quantify the burden of obesity and overweight in 52 countries (including OECD, European Union and G20 countries).

The report shows how obesity and overweight reduce life expectancy, increase health care costs, decrease workers' productivity and lower GDP. It also explores different interventions that can help to tackle the epidemic by supporting a healthy lifestyle. These interventions can improve health whilst at the same time reducing health care cost and aiding the economy. As such, they are an excellent investment.

The Public Health Review of Latvia draws on some of the results of the Heavy Burden of Obesity report – to make the economic case for investing in the prevention and treatment of obesity and overweight. More details for Latvia can be found in the main report, as well as the technical country notes (OECD, 2019[1]).

Source: OECD: The Heavy Burden of Obesity, 2019 (OECD, 2019[2]).

2.2. Obesity in Latvia

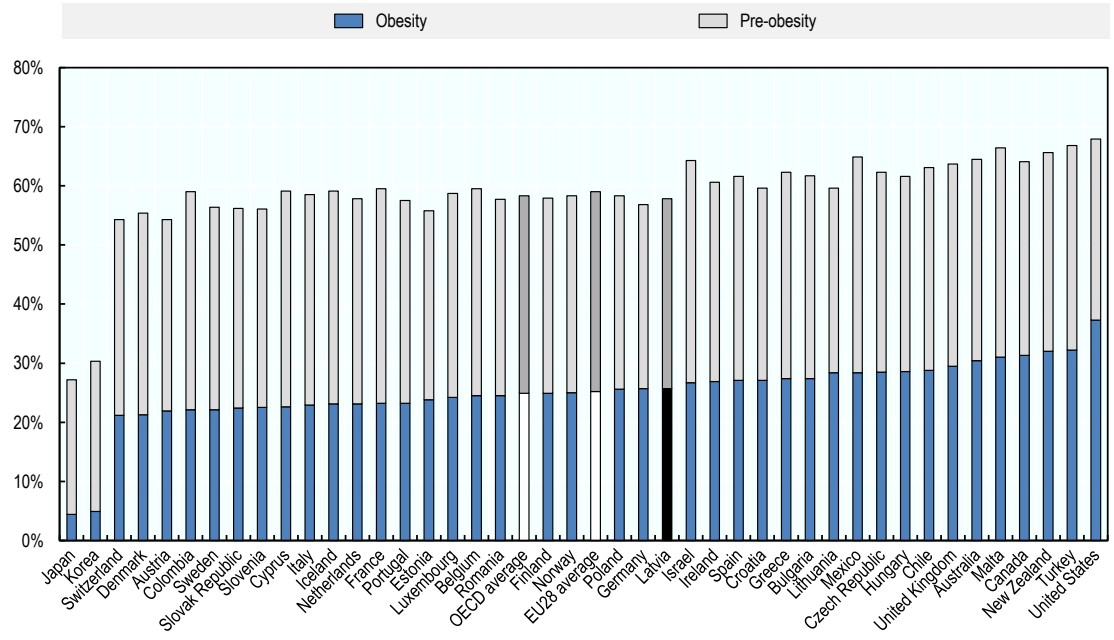
This section provides an overview of the obesity epidemic in Latvia. It looks at the prevalence of obesity and overweight, which are around the OECD average but increasing over time – especially in children. It also explores two of the main drivers of obesity: diet and physical activity. Finally, this section shows the considerable impact that obesity and overweight have on life expectancy, health care expenditure and the economy.

2.2.1. Over a quarter of the Latvian population is obese, and more than half is overweight

In Latvia, over a quarter (26%) of the population is obese: 28% of women and 23% of men have a body mass index (BMI) of 30 kg/m^2 or higher – the threshold endorsed by the WHO to define overweight (World Health Organization, n.d.[3])(Annex Figure 2.A.1). This is just above the OECD and EU28 average of 25%. In addition, 58% of adults are overweight (BMI of 25 kg/m^2 or higher), which again is similar to the OECD average.

Figure 2.1. Prevalence of obesity and overweight in OECD countries

Prevalence of obesity and pre-obesity among the adult population (2016)

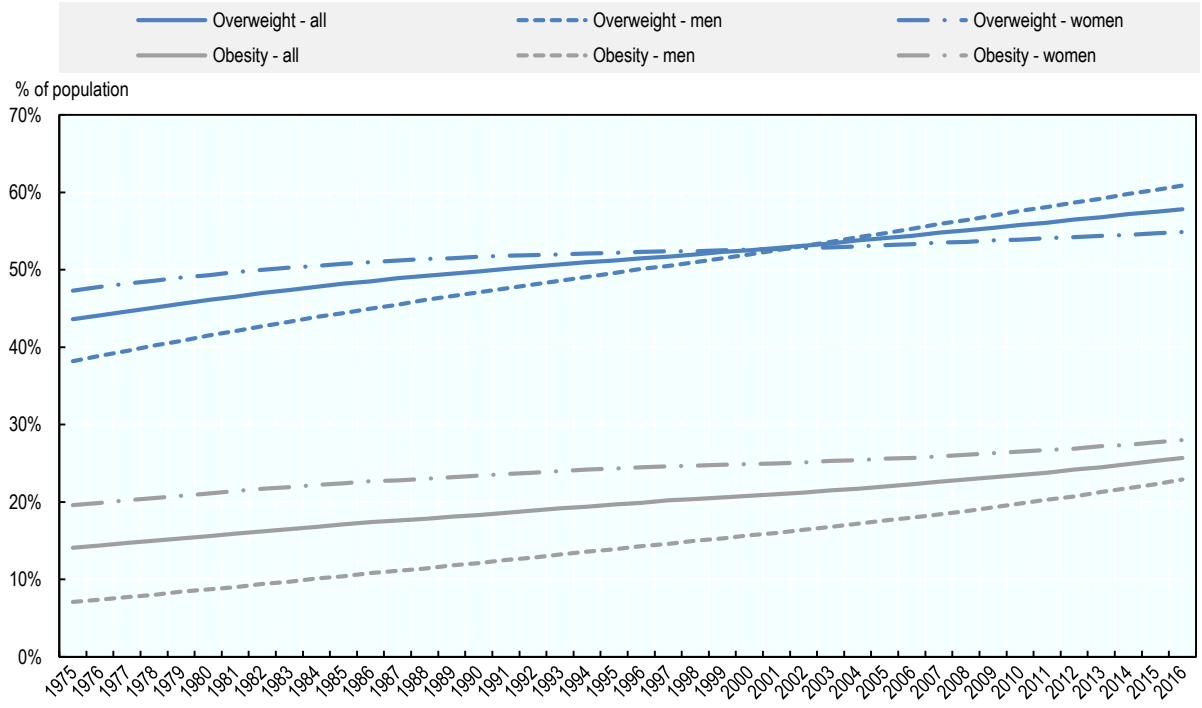


Note: Obesity is defined as BMI>=30 kg/m^2; overweight as BMI>=25 kg/m^2. Pre-obesity is a BMI between 25 and 30 kg/m^2.
Source: World Health Organization Global Health Observatory, 2017. For details on the comparability of OECD and WHO obesity and overweight data, please refer to Annex 2.A.

Over the past 40 years, the prevalence of obesity in Latvia has increased drastically (Figure 2.2). While in 1975 only 7% of men and 20% of women were obese, in 2016 this had increased to 23% of men and 28% of women. In 1975, more women than men were overweight, but in the intervening decades, men have overtaken women.

Figure 2.2. Prevalence of obesity and overweight in Latvia over time

Prevalence of obesity and overweight (including obesity) by sex among adult population, crude estimate

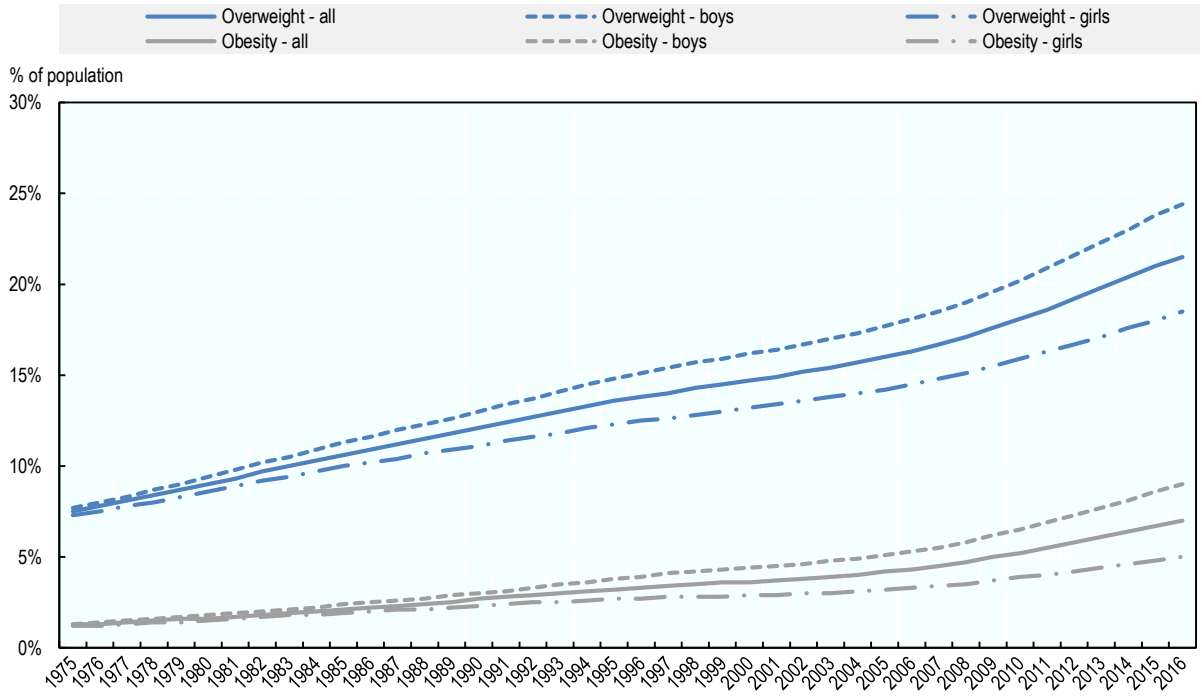


Note: Obesity is defined as BMI>=30 kg/m^2; overweight as BMI>=25 kg/m^2
Source: World Health Organization Global Health Observatory, 2017. For details on the comparability of OECD and WHO obesity and overweight data, please refer to Annex 2.A.

Overweight and obesity among children has also increased over recent years (Figure 2.3). In 1975, only around 1% of children were obese. In 2016, this had grown to 9% of boys and 5% of girls. In addition, over a fifth of children is now overweight.

Figure 2.3. Prevalence of childhood obesity and overweight in Latvia over time

Prevalence of obesity and overweight (including obesity) by sex among the population aged 5-19, crude estimate



Note: For children, overweight is defined as a BMI > +1 standard deviations above the median, and obesity as BMI > +2 standard deviations above the median.
Source: World Health Organization Global Health Observatory, 2017. For details on the comparability of OECD and WHO obesity and overweight data, please refer to Annex 2.A.

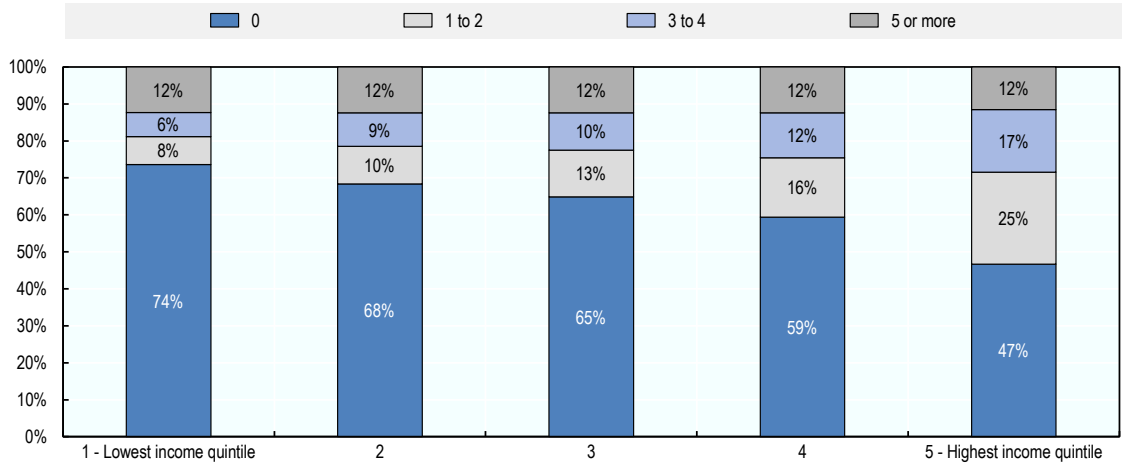
2.2.2. Both diet and physical inactivity contribute to the obesity epidemic in Latvia

Overweight and obesity are caused by an energy imbalance between energy in (calories consumed through diet) and energy out (calories burned through physical activity) (World Health Organization, 2018[4]). In Latvia, both sides of this balance contribute to the obesity epidemic.

A large proportion of the Latvian population does not get physical activity through recreational activities, sports or fitness: only 40% of the population does some form of sports at least once a week. People from lower socio-economic groups are even less likely to do this type of physical activity, with 74% of people in the lowest income quintile not engaging in sports or fitness (Figure 2.4). The frequency of physical activity decreases with age (Figure 2.5). Only 21% of 15 to 17-year-olds do not do any sports or fitness activities, compared to 50% or more in people over 30. This proportion continues to increase with age, as it reaches 70% among those aged 60 to 64 and 88% for people over 85.

Figure 2.4. Prevalence of physical activity frequency in Latvia, by income quintile

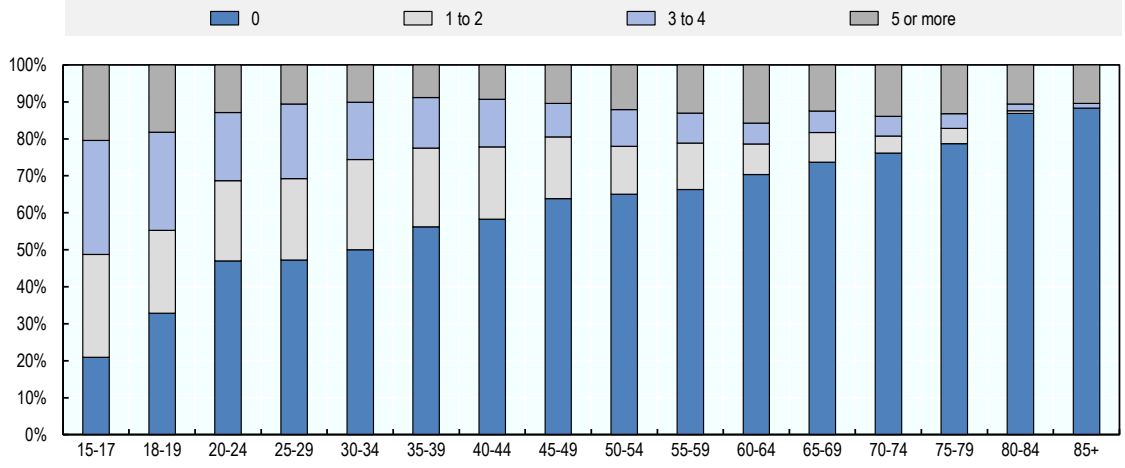
Number of days in a typical week doing sports, fitness or recreational (leisure) physical activities that cause at least a small increase in breathing or heart rate for at least 10 minutes continuously, by income quintile from 1 (lowest incomes) to 5 (highest incomes)



Source: European Health Interview Survey (EHIS) wave 2, 2014.

Figure 2.5. Prevalence of physical activity frequency in Latvia, by age group

Number of days in a typical week doing sports, fitness or recreational (leisure) physical activities that cause at least a small increase in breathing or heart rate for at least 10 minutes continuously, by age group



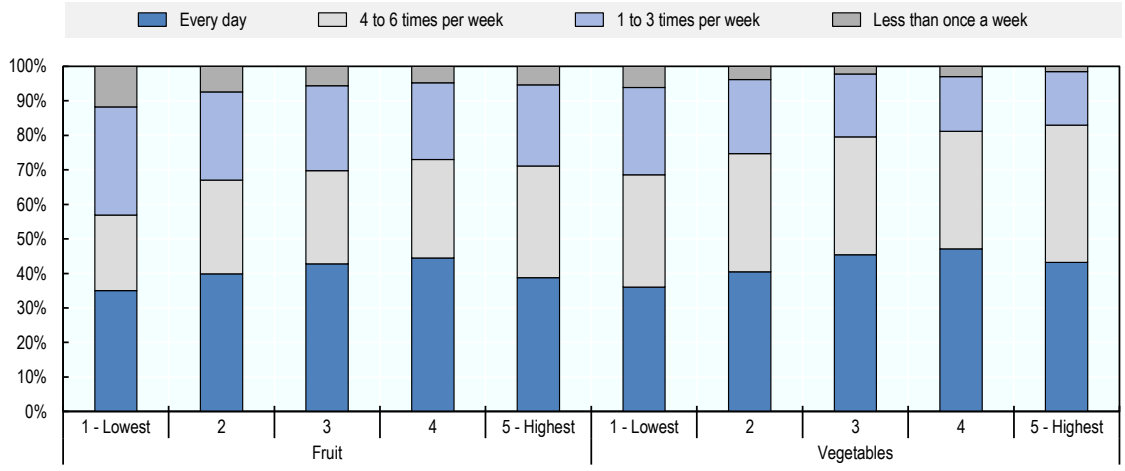
Source: European Health Interview Survey (EHIS) wave 2, 2014.

On the other side of the balance, calorie availability has increased in Latvia in the last two decades. In 2000, the food supply was 2 785 calories per capita, per day. In 2017 this had increased by 14% to 3 169 calories (Food and Agriculture Organization, 2019[5]).

In addition to overall calorie intake, the quality of diets also contributes to health. Only 40% of Latvians eat fruit every day, and 42% eats vegetables every day. The frequency of fruit and vegetable consumption increases with income, though it drops slightly for the highest income group (Figure 2.6). Nevertheless, in every income group less than half of Latvians eat fruit or vegetables every day.

Figure 2.6. Prevalence of fruit and vegetable consumption frequency, by income quintile

Frequency of eating fruit, or of eating vegetables or salad; income quintiles from 1 (lowest income) to 5 (highest income)



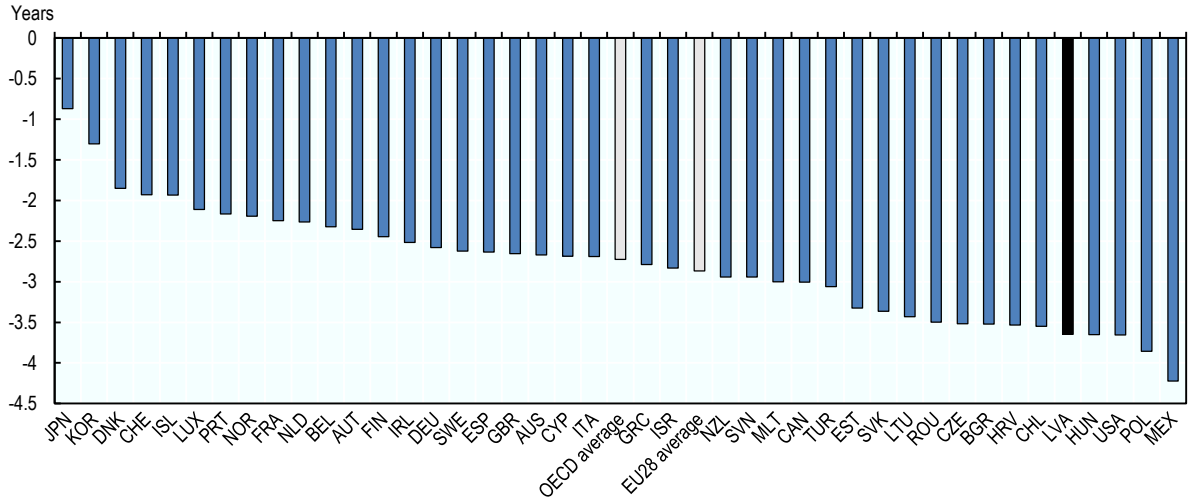
Source: European Health Interview Survey (EHIS) wave 2, 2014.

2.2.3. Obesity has a considerable impact on health and the economy

The prevalence of overweight and obesity has an impact on the population health and economy of Latvia. Using the OECD SPHeP NCD model (OECD, 2019[6]), it is calculated that, over the next 30 years, the average life expectancy in Latvia is 3.6 years lower because of overweight (Figure 2.7). This is one of the highest impacts across all countries analysed.

Figure 2.7. The impact of overweight on life expectancy

The impact of overweight on the average life expectancy in years, average 2020-50



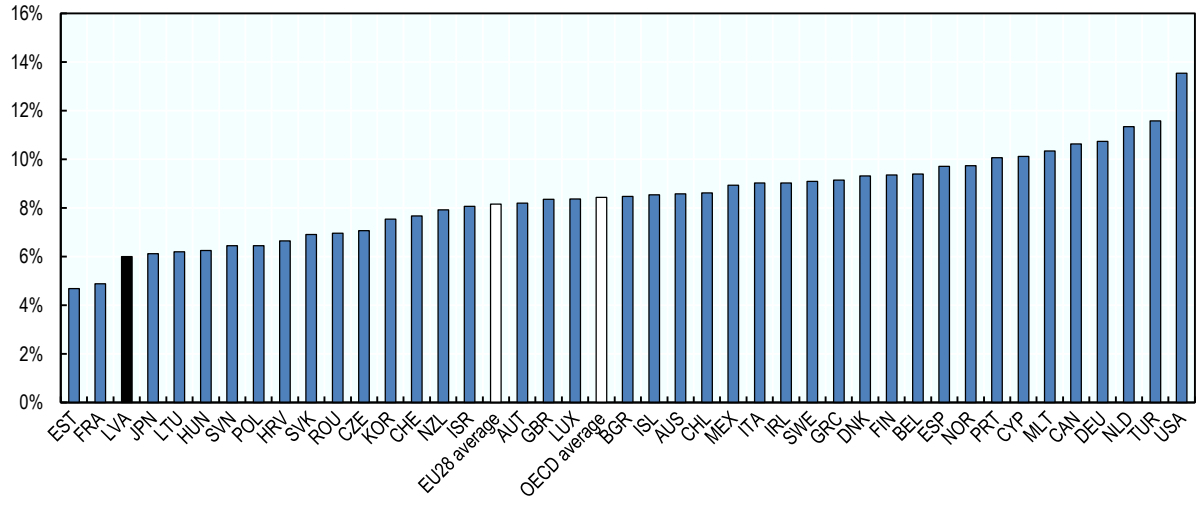
Source: OECD (2019[2]), *The Heavy Burden of Obesity*, https://www.oecd.org/health/the-heavy-burden-of-obesity-67450d67-en.htm.

Obesity is one of the leading risk factors contributing to the burden of non-communicable diseases (NCDs), increasing the risk of developing type 2 diabetes, cardiovascular diseases, musculoskeletal disorders, several types of cancer, and depression (WHO, 2017[7]). In Latvia, 79% of all diabetes cases can be attributed to overweight, as well as 7% of cardiovascular diseases, 4% of dementia cases and 2% of cancer cases (OECD, 2019[1]).

As a result, the prevalence of obesity contributes to an increase in health care expenditure. Over the next 30 years, Latvia will spend around 6% of its entire health care budget on treating the consequences of overweight and obesity – around EUR 91 million per year (Figure 2.8). However, compared to other countries Latvia spends relatively little. This could be due to the fact that non-obesity related conditions make up a larger part of the disease burden in Latvia, compared to other OECD countries.

Figure 2.8. Health expenditure associated with overweight

Health expenditure due to overweight per year, as a percentage of total health expenditure, average 2020-50

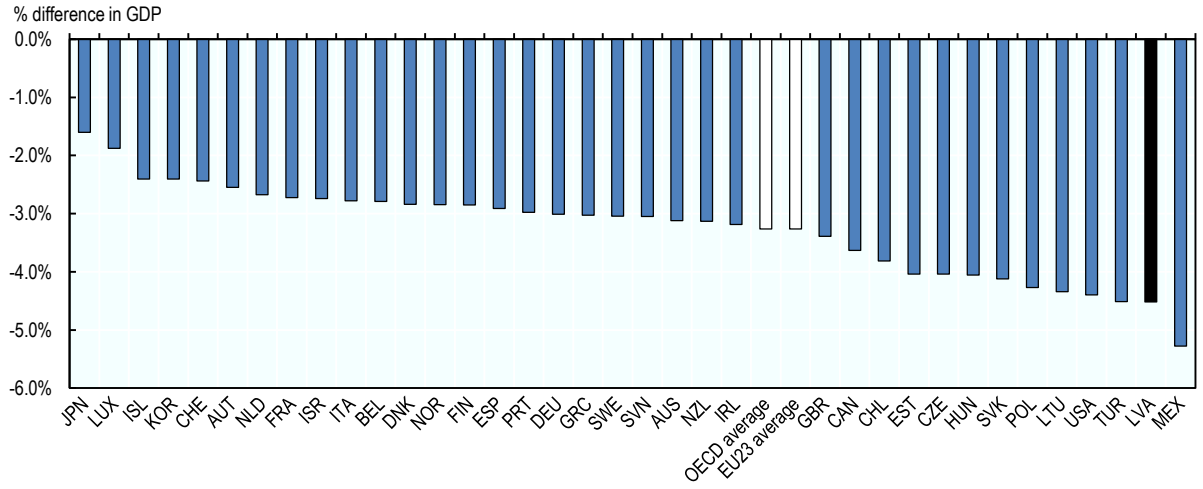


Source: OECD (2019[2]), *The Heavy Burden of Obesity*, https://www.oecd.org/health/the-heavy-burden-of-obesity-67450d67-en.htm.

While Latvia's health care expenditure on overweight and obesity may be less than in other countries, obesity still has a large impact on the economy. Combining the impact of overweight on life expectancy, demographics and labour force productivity, the gross domestic product (GDP) of Latvia is 4.5% below trend over the next 30 years (Figure 2.9). This is much greater than the OECD average of 3.3%, which may be due to the relatively large impact of overweight on Latvia's life expectancy, as well as its impact on the productivity of the workforce.

Figure 2.9. The impact of overweight on GDP

Percentage difference in GDP due to overweight, average 2020-50



Source: OECD (2019[2]), *The Heavy Burden of Obesity*, https://www.oecd.org/health/the-heavy-burden-of-obesity-67450d67-en.htm.

2.3. Latvia's approach to tackling obesity

In an attempt to tackle some of the key social and environmental determinants of obesity, countries around the world have significantly up-scaled their policy actions (OECD, 2019[2]). These policies generally focus on education and information; increasing the availability of healthy choices; changing the price of health-related choices; and regulating or restricting the promotion of unhealthy choices. While some policies may be very effective, none of them is sufficient in isolation. Instead, multi-component obesity strategies are needed.

Latvia has also implemented a number of policies and programmes to tackle the rise in unhealthy diets and physical inactivity. This section will discuss these policies, covering different levels of society. At the central level, the government has put in place various population-level policies to encourage healthier lifestyles. Schools and municipalities have implemented programmes to reduce risk factors at the local level. The health system, including GPs, specialists and nutritionists, is tasked with prevention and treatment of individual patients. Finally, the private sector – in particular the food sector – also has a role to play in tackling the obesity epidemic.

2.3.1. The government has implemented a range of population-level policies to encourage healthier behaviours

The central government has produced strategies and guidelines to promote healthier behaviours. The Latvian Public Health Strategy 2014-20 identifies obesity and overweight as one of the major risk factors contributing to non-communicable diseases in Latvia. The Latvian Public Health Strategy 2021-27 is currently being developed, and includes various activities to tackle obesity, including:

- educating society about healthy nutrition (promoting fruit and vegetable consumption, reducing consumption of products that have high content of salt, sugar and fats);
- implementing food reformulation in cooperation with food industry;

- exploring the possibility to design a consumer friendly front-of-pack labelling to promote healthier products;
- updating nutrition recommendations for specific age groups;
- exploring the possibility to develop weight loss programmes for adults and promoting health care professional involvement in obesity prevention and treatment.

To promote physical activity, a national physical activity roadmap was developed in cooperation with the WHO Regional Office, Ministry of Health, the Centre for Disease Prevention and Control (CDPC) and Ministry of Education and Science. This roadmap provides recommendations for policy makers and implementers on how to promote physical activity. For example, includes recommendations on educating health care professionals to promote physical activity around pregnancy, and the inclusion of physical activity in workplace safety and health protection policies.

Latvia has also set national guidelines for physical activity and a healthy diet. The Ministry of Health updated their nutritional recommendations in 2017, and they include recommendations for different population groups, including adults, children, seniors, vegetarians, pregnant women, and infants.

The Ministry of Health, together with the CDPC, also runs a number of campaigns to encourage healthier diets and physical activity. One such campaign was the 2015 “Active Lifestyle” programme. This included the establishment of health trails in five cities throughout Latvia (Jūrmala, Tukums, Ogre, Cēsis and Varakļāni). Health trails were 2-3 km long tracks with eight to ten posters explaining different exercises along the way. In 2019, as part of the Movement campaign (“Kustinācija”), Movement Ambassadors were trained to provide free group exercise classes in the municipalities.

In addition to education and information, Latvia has also introduced a number of legislative policies to tackle the obesity epidemic. These include nutritional standards for schools and health care institutions; advertising and sales restrictions on energy drinks; a tax on sugar-sweetened beverages and a reduced value-added tax rate for fresh vegetables, fruit and berries.

In 2006, Latvia was one of the first OECD countries to ban the sale of unhealthy foods in school, including sodas and confectionary and salted crisps. Moreover, educational institutions, medical treatment institutions, social care and rehabilitation institutions are subject to regulation on nutritional standards (Likumi.lv, 2018[8]). The regulations set the daily nutritional requirements of meals, including the calories they must provide and their composition. For example, meals for primary and secondary school students need to provide 700 grammes of vegetables, fruit and berries per week (Likumi.lv, 2018[8]). The regulations also prohibit serving certain food products such as fried potatoes, mechanically separated meats[1], and soft drinks with caffeine.

The latter product is subject to wider restrictions. In Latvia, so-called energy drinks (soft drink with a high content of caffeine or other stimulants like taurine and guarana) cannot be sold to children under 18 years old since 2016 (FAO, 2016[9]). Moreover, they are subject to specific marketing regulations:

- Advertisements need to include warnings on the negative effects of energy drink overuse, covering at least 10% of the advertisement.
- Advertisement of energy drinks on walls of educational establishments, public buildings and structures in not allowed.
- Advertisements cannot associate energy drinks with sports, or suggest that energy drinks can quench thirst or can/should be consumed with alcohol.
- Advertisements are prohibited before, during and after TV programmes targeting children under the age of 18, or in print media targeting this group.
- At the point of sale, warning signs need to be shown with the text: “High caffeine content. Not recommended for children and pregnant and breastfeeding women.”
- Promotions offering energy drinks for free to children under the age of 18 are not allowed.

Other than the restrictions on the advertisement of energy drinks, Latvia does not have any regulation on the advertising of other unhealthy food and beverages.

Latvia does have a food labelling scheme – but its primary aim is not to encourage healthier choices. The National Food Quality Scheme, run by the Ministry of Agriculture, uses labels to mark "higher quality products" (Ministry of Agriculture, n.d.[10]). The Green Spoon label is awarded to products for which at least 75% of ingredients come from one designated country (usually Latvia), while the Bordeaux Spoon label is awarded to products that were produced in one designated country (again, usually Latvia) (Figure 2.10).

Figure 2.10. Green and Bordeaux Spoon label

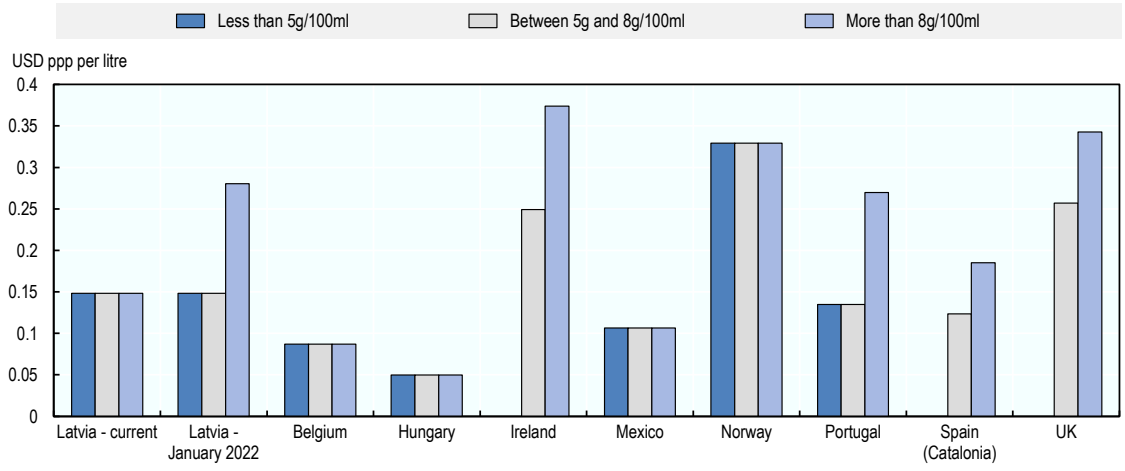
Source: (Karotite.lv, n.d.[11]).

While there are quality criteria associated with the scheme, these focus on production and processing quality issues, such as animal welfare, environmental protection, the use of genetically modified organisms and synthetic dyes. There are no nutritional criteria associated with the label, and it has been awarded to products including sausages, cakes, ice cream, white bread, cheddar cheese and beer (Karotite.lv, n.d.[11]). The labels have a high degree of recognition, with 92% of consumers recognising the Green Spoon label and 67% of consumers trusting the label (Karotite.lv, 2019[12]).

Latvia also has had a tax on sugar-sweetened beverages (SSBs) since 2000. Over the last two decades, the rate of taxation has increased from EUR 2.85 per 100 litre to EUR 7.40 per 100 litre. SSBs are taxed uniformly, without differentiation based on the sugar level in the drink. The SSB tax rate in Latvia is in line with other OECD countries when adjusted to purchasing power parities, though some countries have higher rates for beverages with a higher sugar content (Figure 2.11). From 1 January 2022 an amendment to the excise tax will come into place, differentiating between beverages with different levels of sugar. Beverages with less than 8 grammes of sugar per 100 litres will have an excise tax of EUR 7.40, while those with more than 8g sugar per 100 litres will have an excise tax of EUR 14.00. Latvia also has a reduced value-added tax rate for fresh vegetables, fruit and berries, and a reduction for fresh meat, fish, eggs and dairy is planned for the coming year.

Figure 2.11. SSB tax rates in selected OECD countries

Tax rate by sugar content, expressed in USD per litre, adjusted for purchasing power parities (PPP)



Source: OECD analysis of the NOURISHING database, 2019, World Cancer Research Fund International.

2.3.2. Local governments promote healthy lifestyles under the Healthy Municipalities Network, but have limited resources and expertise

According to the Law on Local Governments, one of the functions of local governments is to promote a healthy lifestyle and sports activities for their local population (Likumi.lv, 1994[13]). Activities are expected to be financed from the budget of the municipality.

Health promotion activities in municipalities mainly fall under the Healthy Municipalities Network (CDPC, n.d.[14]). This Network, a collaboration between the Ministry of Health, the CDPC and the WHO, aims to promote the exchange of best practices, experience and ideas among local governments; to provide local governments with methodological support in dealing with various public health and health promotion issues; and to improve knowledge of municipal employees on issues of public health and health promotion. Currently, 114 out of 119 municipalities are part of this Network.

While the Healthy Municipalities Network is aimed at overall health, diet and physical inactivity are the primary focus in many municipalities. A survey among 42 municipalities that are part of the Network found that physical inactivity was the most common target behaviour followed by nutrition, with 95% and 77% of municipalities reporting initiatives in these areas, respectively (Gobina et al., 2019[15]). These activities include nutrition lectures, cooking courses, ice skating, cardio fitness classes, swimming, Nordic walking and running groups.

To deliver these activities and recruit participants, municipalities work with local stakeholders such as schools, doctors and gyms. This happens at an ad-hoc basis, and coordination with the health system seems limited. Municipalities also use social media and local newspapers to notify people of the activities taking place, but anecdotal evidence suggests that they struggle to reach lower socio-economic groups. If confirmed, this may increase health inequalities across population groups, affecting the overall impact of the intervention

Oversight and coordination of the programme is in the hands of the Ministry of Health and the CDPC. Once a year, the municipalities submit a report to the CDPC detailing the activities that were carried out. The CDPC organises meetings and seminars for coordinators to provide training and exchange knowledge. In 24 municipalities the CDPC is in charge of running the activities that are financed through EU structural

funds. Among these 24 municipalities are those that are not part of the Network and those that have decided not to receive the money from EU structural funds (mainly due to administrative reasons)

To pay for trainers, facilities and programme coordinators, the municipalities are supposed to use their own budget (in line with the Law on Local Government). However, currently, most health promotion activities undertaken by the municipalities as part of the Network are funded through EU structural funds. For the period from 2017 to 2023, overall funding for health promotion activities in municipalities is around EUR 32 million, of which EUR 27 million (around 85%) comes from EU funds.

The effectiveness of the programme is often dependent on the human resources and expertise available within the municipality. While larger or richer municipalities are able to hire dedicated staff with a background in public health, in smaller municipalities the responsibilities for health promotion fall on general staff. Half of the municipalities report that they are hindered in their activities by a lack access to expertise and professionals (Gobina et al., 2019[15]).

This also translates into a lack of knowledge about how to approach the right target groups, reported by half of the municipalities (Gobina et al., 2019[15]). Municipalities are expected to identify and target specific population groups, like the elderly, mums and babies, or children, as well as difficult to reach groups such as people on lower incomes. Whether these target groups are reached and how effective the programmes are is not currently being evaluated.

2.3.3. Schools will soon teach health education as part of a new curriculum, and some have additional health promotion activities

There are a number of health promotion programmes and policies in Latvian schools that can help to improve nutrition and increase physical activity. In addition to the nutritional standards, the ban on the sale of unhealthy foods and the restrictions on the sale and advertisement of energy drinks (see the section on central government policies), the curriculum is being reformed to include health education, and various health promotion activities take place as part of the Healthy Schools Network.

To address changes in society, such as globalisation and the increase in information technology, Latvia is reshaping its educational curriculum (Skola2030.lv, 2019[16]). The aim is to create a curriculum that is more integrated, enables children to act on unprecedented and complex situations, and to provide them with resources that are more closely linked to real life. Part of the new curriculum is a subject called “Health and physical activity”. The Ministry of Health was involved in developing the new material for this subject (through the CDPC was not).

In elementary school, the new “Health and physical activity” subject will include physical activities, as well as education about lifestyle, its relation to health, and safety issues (Skola2030.lv, 2019[17]). In high school, schools are required to offer a wide range of physical activities – ranging from team sports and individual competitive sports to dance and outdoor activities. Students are required to choose at least five different physical activities across four modules, with the aim of finding an activity they enjoy and would like to continue doing in their spare time.

Similar to the programme for municipalities, schools in Latvia can become part of the Healthy Schools Network. Also managed by the CDPC, the Healthy Schools Network currently includes 103 primary, secondary and pre-schools across Latvia (about 10% of all schools). Some of the activities that school organise include sport days, mental health promotion, and healthy breakfast days. These activities take place during school hours and as extra-curricular activities.

Schools do not directly receive EU funding for health promotion activities, but as they are municipal organisations, many of the activities in schools are carried out by municipalities (which can use EU funding) or in close cooperation with them. The CDPC provides materials and information for schools, for example on hand washing or related to world health days. Every year the CDPC also organises educational health

promoting activities (hand washing, water safety, breast self-exam for girls, etc.). The CDPC organises meetings and seminars for Healthy Schools Network coordinators to receive training and exchange knowledge. Like the municipalities, the schools report to the CDPC once a year on their activities.

As there is no funding associated, the success of this programme is greatly dependent on the motivation of the school personnel. The support that CDPC can give to schools is also limited as only one part-time resource is dedicated to the Network. 64% of schools reported that funding is one of the main issues associated with running health promotion activities (Gobina et al., 2019[15]).

2.3.4. The health system should play a more significant role in preventing and treating obesity

Latvia recognises that primary care has a vital role in prevention – as shown by the introduction of primary care nurses dedicated to prevention. Every patient in a GP practice is supposed to receive an annual prophylactic examination, where BMI is evaluated and recommendations for physical activity and nutrition are provided. Moreover, the dedicated health check programmes for non-communicable diseases aim to identify individuals with risk factors such as obesity and provide them with adequate care to prevent complications (discussed in more detail in Chapter 3 on secondary and tertiary prevention).

Latvia has also introduced a scheme to allow doctors to prescribe physical activity to patients. This scheme provides GPs with a handbook to create recommendations for physical activity, taking into account the patient's fitness level, health status and stage of behaviour change. The programme is not linked to payments or data collection, and it is unclear what its uptake and impact is.

Secondary care also plays a role in obesity prevention and treatment. Since 2014, the Children's University Hospital in Riga has run a specialised weight loss programme. This two-day programme consists of an individual consultation on day one with a multi-disciplinary team (including an endocrinologist, rehabilitologist, physiotherapist, nutritionist and psychologist); and a cooking class with a nutritionist and the child's parents, and physical activity session with a physiotherapist on day two. Patients need to be referred by an endocrinologist or paediatrician within the hospital, and currently there is a two to three month waiting list. About 500 children have gone through the programme. It is paid for by the state, but only available in the one hospital.

In secondary care, nutritionist consultations are funded by the NHS if the patient received specific care (e.g. medical rehabilitation in multi-professional team; health care services for rare diseases; enteral and parenteral nutrition), but not for obesity.

Despite these initiatives, the role of the health care system in preventing and treating obesity is limited. This is due to a lack of time and resources, as well as limited treatment options under the national health system. Primary care physicians as well as nurses experience a heavy workload, and prevention activities such as counselling on diet or physical activity – which are not reimbursed separately – may not be carried out systematically. In addition, drug[2] or surgical treatment of obesity is not covered by the national health system. Sessions with nutritionists are not covered under the national insurance either. While some people can pay out-of-pocket for drugs, nutritionist advice or bariatric surgery in private hospitals, the public health system offers few options.

2.3.5. The industry has committed to voluntary advertising regulations and engages with the Ministry on food policy

The private sector can potentially play a significant role in promoting healthier diets and increasing physical activity. As many people spend a large part of their waking hours in office buildings, it is important to create a health-promoting working environment as the example of Japan shows (OECD, 2019[18]). In addition, the private sector – in particular the food and drinks sector – has a direct influence on Latvian diets through

the products they produce, sell and market. Therefore, incentives to produce more nutritionally balanced products may, in principle, significantly improve people's diets (OECD, 2019[2]).

The CDPC organises seminars and creates materials to promote healthy behaviours in the workplace. Leaflets and videos provide ideas about exercises that can be done in the workplace (CDPC, n.d.[19]). These materials were sent to municipalities and made available through the CDPC website as well as social networks. It is unclear what the uptake and impact of these materials is. The CDPC also closely collaborates with other institutions, such as the State Labour Inspectorate and Institute of Occupational Safety and Environmental Health of Riga Stradiņš University, to provide for example joint seminars on health promotion in workplaces.

In 2011, voluntary marketing regulations were introduced on soft drinks (WHO, 2011[20]). The Ministry of Health, the LPUF (Latvian Food Business Federation) and the LBDUA (Latvian Non-Alcoholic Beverage Entrepreneurs Association) signed a Cooperation Memorandum to reduce the advertising of soft drinks to children aged 12 or under. In the Memorandum, the industry committed to refrain from advertising soft drinks on television and in cinemas if more than 50% of the audience is children, and from targeting this age group on the internet.

To engage with the food industry, as well as various other stakeholders involved in the food chain and nutrition, the Ministry of Health set up the Nutrition Council in 2006. The main aim of the Council is to analyse diet-related public health problems, develop proposals to tackle diet-related issues, and encourage nutrition policy implementation. The Council usually convenes once or twice a year.

The Council is chaired by the health minister, and participants include representatives from the CDPC, other ministries (the Ministry of Agriculture, Ministry of Education and Science, Ministry of Welfare), industry (Latvian Food Business Federation, Latvian Hotel and Restaurant Association), academia (Riga Stradinš University, University of Latvia, Latvia University of Life Sciences and Technologies), and professional organisations (Latvian Diet Physicians Association, Latvian Association of Local and Regional Governments, Latvian Association of Paediatricians).

During meetings of the Council, there are presentations on the latest news in the field of nutrition, and proposed policies or regulations are discussed. For example, the Council discussed amendments to the nutritional guidelines, and draft regulation on the permissible amount of trans-fats in food. This approach enables the Ministry to gather feedback on proposed policies, as well as get buy-in from key stakeholders, including the industry.

In the latest meeting of the Council, which took place in December 2019, the members of the Council discussed ways to improve the composition of food products through reformulation. They agreed to set up a separate meeting with industry stakeholders to discuss a voluntary approach to reformulation, and explore the signing of a Memorandum of Cooperation (Ministry of Health, 2019[21]).

2.4. Recommendations

While Latvia has implemented a range of policies that help curb the rise of obesity, more can be done. In this section, recommendations to improve the obesity strategy are provided. Firstly, it is recommended that, to create a comprehensive policy package, a number of existing activities and policies are expanded or redesigned to increase their impact. Secondly, it is important that Latvia takes steps to ensure the long-term sustainability of the many project-funded activities. Finally, the health system needs to be empowered to play its important role in preventing and treating obesity.

2.4.1. Expand or redesign existing activities and policies to create a comprehensive policy package

A comprehensive policy package is needed to tackle obesity and its drivers (OECD, 2019[2]). Latvia's current policies could have a considerable impact on diet and physical activity if they were expanded upon or redesigned. In many cases, this would require little additional investment as they are low-cost interventions, or because they build on existing structures.

Healthy food procurement

A systematic review found that healthy food procurement programmes in a variety of locations (schools, worksites, hospitals, care homes, correctional facilities, government institutions, and remote communities) contribute to the increased purchases of healthier foods and lower purchases of food high in fat, sodium and sugar (Niebylski et al., 2014[22]). While Latvia already has a comprehensive regulations covering health and educational institutions (including social care, social rehabilitation institutions and prisons), the nutritional requirements can be expanded to other places.

The city of Philadelphia (United States) has set Comprehensive Nutrition Standards for all food and beverages purchased, prepared or served by all city agencies, including city-funded afterschool and summer programming, shelters and vending machines on city-owned or leased property (Philadelphia Department of Public Health, 2018[23]). The local public health team of Blackpool Council (United Kingdom) developed nutritional guidelines which are now in place in council-run leisure centres; and the council is encouraging its partners, local organisations and businesses to follow suit (Local Government Assocation, 2016[24]). The Norwegian Directorate of Health and the Norwegian Food Safety Authority have developed an online Diet Planner, which workplace canteens can use to create weekly healthy menus (www.kostholdsplanleggeren.no).

Food and menu labelling

While Latvia has a food labelling scheme in place, there are no nutritional criteria associated with the label (other than on the use of food colouring). In practice, it has been awarded to less-healthy products including sausages, cakes, ice cream, white bread, cheddar cheese and beer (Karotite.lv, n.d.[11]). Yet the label's high consumer trust, its green colours and its focus on "quality" products may mislead consumers to believe that Green Spoon products are also a healthier choice.

It is important to clarify the meaning of the existing label, highlighting that it does not imply a healthier product. In addition, Latvia should consider implementing a food labelling scheme that does help consumers make healthy choices. An effective food labelling scheme could save 190 life years per year and save EUR 69 000 per year in health care cost in Latvia (OECD, 2019[1]). Several other OECD countries have already implemented such schemes (see Box 2.2).

Box 2.2. Food labels in other OECD countries

Many countries have introduced voluntary labelling schemes for producers of healthy or healthier products (OECD, 2019[2]). The label provides at-a-glance information for consumers, as well as an incentive for producers to formulate healthier products. It can be used to signpost products that are considered healthy (e.g. where the nutrient content meets specific requirements), healthier than other products of a similar type (e.g. products with a significant reduction in salt content) or to give easy-to-interpret information on the nutritional composition of products. Mandatory label are less common, and generally take the form of warning labels for products that are less healthy.

One example of a voluntary scheme is the "Keyhole" logo (Figure 2.12), which has been used since 2009 in Denmark, Norway and Sweden, and more recently in Iceland, Lithuania and Macedonia (Öhrvik and Lagestrand Sjölin, 2018[25]). The criteria for food to be allowed to carry the logo are set by the national authorities, and favour food lower in fat, sugar or salt, or higher in healthy fat, fibre or wholegrain, compared to other food products in the same category. This allows consumers to select the healthiest option within a category, for example meat, oils or ready meals. Soft drinks, candy and cakes, or foods with artificial sweeteners, are not eligible for the label. The use of the logo by food producers is voluntary and free of charge.

Figure 2.12. The Keyhole logo

Source: (Öhrvik and Lagestrand Sjölin, 2018[25]).

Some countries have introduced warning labels for foods high in salt, sugar, fat or calories. Contrary to the voluntary healthy food labels, these types of schemes need to be mandated. In 2016, Chile introduced a mandatory food labelling system that uses four black labels to indicate whether a certain foodstuff is high in calories, salt, sugar or fat (Figure 2.13) (Taillie et al., 2020[26]). The thresholds for the labels are universal rather than per food category. An evaluation of the scheme found that purchase volume of "high in" beverages decreased by 22.8 mL per capita per day, or 23.7%, after the regulation was implemented (Taillie et al., 2020[26]). Similar labelling schemes have since been adopted in Peru, Mexico, and Israel.

Figure 2.13. Chile's food labels

Source: Chile Ministry of Health.

The labelling scheme can also be expanded to menus. Evidence shows that menu labelling can positively affect consumer choices, and that there is strong public support for it (Mah et al., 2013[27]; Pulos and Leng, 2010[28]; Morley et al., 2013[29]). A systematic review found that menu labelling reduced the overall energy consumed by 100 kcal on average, and that energy per order in a real-world setting decreased by 78 kcal on average (Littlewood et al., 2016[30]). Some OECD countries or regions have already implemented mandatory menu labelling regulations (see Box 2.3). In Latvia, menu labelling could save EUR 305 000 per year in health care cost and gain 384 life years (OECD, 2019[1]).

Box 2.3. Menu labelling in other OECD countries

United States: Since 2018, all chain restaurants in the United States with at least 20 locations are required to disclose the number of calories contained in standard items on menus and menu boards (FDA, 2018[31]). In addition, two statements must be displayed: one saying that written nutritional information is available upon request and one about daily calorie intake. The latter must say that 2 000 calories a day is recommended, but that calorie needs vary.

Ontario, Canada: From 2017 onwards, the "Healthy Menu Choices Act, 2015"" requires restaurants and other food outlets with 20 or more locations in Ontario to display calories on menus for standard food items (Ontario.ca, 2019[32]). In addition to the number of calories, the menu must also include contextual information to help educate customers about their daily caloric requirements, stating that "Adults and youth (ages 13 and older) need an average of 2 000 calories a day, and children (ages 4 to 12) need an average of 1 500 calories a day. However, individual needs vary."

Australia: Four states in Australia require chain restaurants with more than 20 locations in the state (or more than 50 across Australia) to display the kilojoule content of menu items. In addition, a statement recommending a daily energy intake of 9 700 kilojoule (ca. 2 300 calories) per adult must be included. The Australian Capital Territory has similar regulation for any chain with more than seven locations (World Cancer Research Fund International, 2019[33]).

Reformulation

Food reformulation, where the composition of food products is changed to improve their nutritional profile, can contribute to healthier diets. Especially in Latvia, the impact of a food reformulation policy would be considerable. Compared to other countries, Latvia would see one of the largest impacts on the disease burden if calories were reduced by 20% in foods high in sugar, salt, calories and saturated fats (OECD, 2019[2]). Moreover, it would save EUR 1.3 million per year in health care cost (OECD, 2019[1]).

The Ministry of Health in Latvia has already agreed with the Nutrition Council to explore ways to encourage food product reformulation (Ministry of Health, 2019[21]), and is planning to sign a Memorandum of Cooperation with industry aiming to improve the composition of food products by implementing reformulation.

One approach is a public-private partnership (PPP), as has been used in several other OECD countries (see Box 2.4). Carefully designed PPPs can be beneficial for all stakeholders, including industry, government and consumers. For governments, working with the industry can mobilise additional resources and increase buy-in.

There are several reasons why the industry may be willing to engage with national governments to create healthier food products. Firstly, engaging with the government to develop healthier products can create new opportunities and market niches for the industry. In the soft drinks industry there has been a diversification of producers' product portfolios, introducing products that consumers perceive as a healthier choice (Daniel B. Kline, 2018[34]). This may help offset losses in less healthy products. Secondly, the

industry may also be willing to work with government to prevent stronger legislative action. The United Kingdom's sugar reduction programme specifically states that if the voluntary reformulation programme does not result in sufficient progress, alternative levers would be introduced (Department of Health & Social Care, 2016[35]). Lastly, collaborating with the government can improve the public image of producers, and support their corporate social responsibility efforts. In Spain, the government has introduced the NAOS Strategy Awards (Strategy for Nutrition, Physical Activity and Obesity Prevention), which are awarded to food and beverage producers for their initiatives on obesity prevention (Aecosan, 2019[36]).

To ensure the success of the PPP, it is important to minimise the potential for conflicts of interest, by setting clear objectives and accountability processes. Governments should also be wary of PPPs being used as a promotional tool only without real impact. As with any intervention, a PPP programme should include a monitoring and evaluation plan. This should be done under the responsibility of the government. A first step would be to conduct a baseline measurement of the nutritional composition and sales of different food groups, to inform both the development of targets and to use as a reference for progress made.

Box 2.4. Public-private partnerships in food reformulation in other OECD countries

Spain

Spain has set up a reformulation initiative, described in "The collaboration plan for the improvement of food and beverage composition and other measures, 2020" (AECOSAN, 2018[37]). This initiative was the result of cooperation between the Spanish Food Safety and Nutrition Agency and a number of food sector associations, representing almost 400 companies. This aims was to reduce the amount of added sugar, salt and saturated fat in processed food and to increase the availability of healthier options in a number of different retail settings. Reduction targets for subcategories of food and beverages were developed and agreed with the industry.

To allow companies enough time to develop and introduce the newly reformulated products, a timeframe of three years was set, from 2017 to 2020" (AECOSAN, 2018[37]). At the end of this period an evaluation will take place, which will compare the nutritional composition of food products to the baseline measurement that was done in 2016.

England

As part of its strategy on childhood obesity, "Childhood obesity: A plan for action", England set up a voluntary sugar reduction programme in 2016 (Public Health England, 2018[38]). The target was to reduce the amount of sugar coming from foods that children consume the most by 20% by 2020. In 2017, the programme was extended to other food groups. This calorie reduction programme challenged the food industry to achieve a 20% reduction in calories by 2024. Public Health England, an executive agency of the Department of Health and Social Care, worked with industry organisations to develop the plans for this calorie reduction programme.

Public Health England is also in charge of evaluating progress made against the targets (Public Health England, 2019[39]). For progress on sugar reduction, a baseline measurement was done in 2015. In 2018, there had been a 2.9% reduction in average sugar content (based on the sales weighted average in grammes per 100 grammes) for retail and manufacturer branded products (in-home sector). For the out-of-home sector, for which the baseline measurement took place in 2017, the reduction in average sugar content was 4.9%. However, the average calorie content of single serve products in the out-of-home sector increased by 1.8%.

Marketing restrictions

Advertising restrictions are recommended by the WHO to reduce the impact of the marketing of unhealthy food and drinks on children (World Health Organization, 2010[40]). The use of different marketing approaches targeted at children has been shown to influence food preferences, purchase requests and consumption patterns. In addition to regulating advertising in mass media, policy makers are advised to make settings where children gather (e.g. nurseries, schools, playgrounds) free from all forms of marketing of unhealthy foods. Regulation generally concerns advertising to children, as they do not recognise the persuasive intent of advertising, nor do they have the capacity to critically evaluate commercial messages (Graff, Kunkel and Mermin, 2012[41]).

Latvia has introduced relatively extensive regulations on the marketing of energy drinks to children, covering both traditional mass media advertising as well as promotions and display advertising in schools. In addition, there are some voluntary restrictions on the advertisement of soft drinks. However, soft drinks and energy drinks make up only a small part of children's' diet. Latvia should aim to expand mandatory regulation to other unhealthy food and beverages, to increase its impact on diet and obesity (see Box 2.5).

Box 2.5. Marketing regulations on unhealthy food and drinks in other OECD countries

Chile

In Chile, the mandatory "high in" labels (see Box 2.2) are used as the basis for marketing restrictions. Products that carry a warning label cannot be sold or advertised in schools, nor can they be advertised to children under 14. They cannot be given away for free, or accompanied by presents such as toys or games. This regulation is complemented by a second law, prohibiting marketing to all audiences of food with labels between 6am and 10pm on TV and in cinemas. The definition of marketing directed at children includes advertisement with children, with the voices of children, with music for children, or depicting a place for children (e.g. schools); or when a television audience consists of more than 20% children (OECD, 2019[42]).

Ireland

The Irish Children's Commercial Communications Code restricts the advertising of high fat, sugar and salt (HFSS) foods to children (Broadcast Authority of Ireland, n.d.[43]). HFSS foods are designated in accordance with the Nutrient Profiling Model developed by the UK Food Standards Agency. Advertisements for HFSS foods cannot air during children's programmes (defined as programmes with an audience profile of which over 50% are under 18 years of age); and they cannot include licensed characters (such as characters from movies or video games), health and nutrition claims or promotional offers.

Korea

Since 2010, Korea restriction the advertisement of energy-dense, nutrient-poor (EDNP) foods targeting children (Lee et al., 2017[44]). These regulations forbid television advertising of EDNP foods before, during, and after all TV programs broadcast between 5pm and 7pm The EDNP foods subject to the regulations include snacks and meal substitutes favoured by children that do not meet nutritional standards set by the Korean Food and Drug Administration. These standards include threshold levels for energy, sugar, saturated fat, sodium and minimum levels of protein per single serving size.

Workplace programmes

The CDPC has developed materials for companies that they can use to encourage physical exercise in the workplace. However, there are many more things that can be done by companies and organisations to create a health-promoting workplace, including providing facilities such as showers and bike racks to encourage active transport, promoting the use of stairs, providing healthy options in canteens and vending machines, and organising physical activity classes.

The Ministry of Welfare is also involved in healthy workplace programmes. The Ministry provides information on promoting health in the workplace on its public information website www.stradavesels.lv. It also participates in the Healthy Workplaces campaign of European Agency for Safety and Health at Work (EU-OSHA), and developed an active ageing strategy which emphasises the importance of healthy ageing and includes activities that prevent obesity and other health risk factors.

To promote the implementation of such interventions, Latvia should consider setting up a network similar to the one for schools and municipalities. This would allow companies to exchange ideas and get motivation. As an incentive, an awards scheme could be considered, as has been used in Japan (see Box 2.6). Programmes to target workplace sedentary behaviour could save EUR 256 000 in health care expenditure per year; while workplace wellness programmes could save EUR 93 000 (OECD, 2019[1]).

Box 2.6. Workplace health promotion award schemes in Japan

The government of Japan has set up a number of awards schemes to reward companies who invest in health promotion, and to encourage others to follow their example.

The Smart Life Project, run by the Ministry of Health, Labour and Welfare, was started in 2011 and aims to get companies to engage in health promotion around four themes:

- Smart Walk: "Plus 10", promotes an additional 10 minutes of daily exercise, for example brisk walking during the commute, cleaning or gardening
- Smart Eat: "Plus one dish every day", promotes including an additional portion of vegetables each day
- Smart Breath: "Eradication of tobacco smoke", focuses of smoking cessation
- Smart Check: "Regularly knowing your body condition", promotes the participation in medical check-ups and screening

To encourage participation, the Ministry rewards the most inventive or successful interventions. Companies, organisations and local governments can self-nominate for an excellence award.

Similar to the Ministry of Health, Labour and Welfare encouraging and its Smart Life Project, the Ministry of Economy, Trade and Industry (METI) promotes its Health and Productivity Management (HPM) through an awards scheme. HPM tries to incorporate investment in employees' health as a corporate philosophy, which can benefit the company as a whole.

To highlight best practices in HPM, the METI, together with the Tokyo Stock Exchange (TSE), established the Health & Productivity Stock Selection for TSE-listed enterprises in 2014. Companies are selected through a METI-run Survey on Health and Productivity Management. Programmes are evaluated based on five criteria:

- the positioning of health and productivity management in management philosophy and policies;
- the existence of frameworks for tackling health and productivity management issues;
- the establishment and implementation of systems for ensuring health-conscious management;
- the presence of measures for assessing and improving health and productivity management;
- and adherence to laws and regulations and risk management.

In 2016, the METI also established an awards programme Program for large organisations and small and medium-sized enterprises (SMEs) that are not TSE-listed: the Certified Health and Productivity Management Organization Recognition. This award programme is administered by the Nippon Kenko Kaigi, an organisation collaborating with communities and workplaces to improve health.

Source: (OECD, 2019[18]).

2.4.2. Ensure the long-term sustainability of project-funded programmes

The EU-funded health promotion activities in municipalities, often as part of the Healthy Municipality Network, are a corner stone of Latvia's approach to health promotion. It enables local governments to respond to the needs of their population, and provide tailored interventions in the field of nutrition, physical activity and more. However, these activities is strongly reliant on EU funding. While Latvia is currently working to secure an additional round of funding, these grants remain time limited. A considerable number of other activities and programmes in Latvia also reply on EU project-based finding, such as projects to

train and attract doctors and develop health technology. To ensure that programmes have maximum and lasting impact, they need to be sustainable without external funding.

A first step to ensuring sustainability is planning for sustainability (Shediac-Rizkallah and Bone, 1998[45]). Rather than an afterthought once funding runs out, sustainability should be a primary goal of the programme from the beginning. As such, planning for sustainability should start as soon as possible.

An evaluation of the effectiveness of different interventions in the programme is needed to prioritise for the future (see Box 2.7). When funding becomes more limited, efforts and resources should focus on interventions that are effective, that have the greatest impact across the population, and that are most likely to be successful in the future. To be part of the Healthy Municipality Network, municipalities are required to develop a health promotion plan. In this plan, they should plan ahead for when EU funding runs out, selecting and prioritising those interventions that are most cost-effective.

Box 2.7. Evaluating public health interventions

To help countries identify, implement and evaluate best practice interventions, the OECD Public Health is working on a new project on best practices. As part of this project, the OECD will publish a handbook, which provides guidelines on evaluating existing interventions. It will cover the entire process from developing a logic model, identifying the best evaluation metrics, collecting and analysing data, and disseminating the results.

In addition to identifying priority interventions that should be continued in the long-term, evaluation can help in many ways:

- To understand whether the programme is delivering its intended outcomes, for the intended population
- To determine the best way to design and deliver the programme, to improve the programme
- To ensure the optimal use of time and resources
- To justify continued funding
- To ensure services are equitable and accessible
- To satisfy questions of accountability
- To advance health promotion by sharing knowledge about effective programmes

Source: (Louise O'Connor-Fleming et al., 2006[46]; Lobo, Petrich and Burns, 2014[47]; Public Health Ontario, 2016[48]).

Most of the activities under both Networks rely strongly on human capacity. Developing capacity and expertise is therefore a crucial part of ensuring sustainability (Shediac-Rizkallah and Bone, 1998[45]). To this end, the CDPC organises educational meetings for local health promotion coordinators of Healthy Municipalities Network. In some larger or richer municipalities, the Healthy Municipalities funding has been used to hire or train experts in health promotion. These experts will remain in place and can continue to train new hires – thereby ensuring continuation of the programme and lasting expertise. Currently this capacity is lacking in smaller municipalities, threatening the sustainability of health promotion projects there. After the planned reorganisation of the municipalities, which is expected to result in fewer municipalities with presumably more resources, capacity building around health promotion should take place in each new municipality (see Box 2.8).

Box 2.8. Capacity building in local governments through a National Training Strategy

Training is an important part of capacity building. A National Training Strategy can help to raise the standards of training through standardised materials and accreditation. To develop a National Training Strategy, it is important to conduct a training needs analysis. This analysis is based on the views of the municipalities as well as other stakeholders, and should take into account:

- The existing knowledge and experience of local government staff;
- The scope and type of training needed for improved knowledge and professional skills;
- Municipalities' willingness to participate in training and their ability to pay;
- Any external constraints threatening the successful implementation.

Based on this needs analysis, a curriculum can be developed.

In addition, the Strategy should identify the best way to deliver training. This can include "training the trainer" (for example training managers to train their staff), internships or exchanges, self-learning through distance learning materials, or training events by a team of professional trainers.

The Strategy should also cover a potential accreditation process, best practice awards and a communications programme.

Source: (Council of Europe, 2005[49]).

In addition to human capacity, municipalities should also review other resources that their programmes require. Low-cost interventions, such as outdoor running clubs or educational lectures, can be added to the programme now to test their effectiveness. In some cases, it may also be possible to explore agreements with current facilities, educators or trainers for discounted services. Volunteers can be sought to contribute to the delivery of activities. Overall, it is important to start exploring these matters now to make the programmes future-proof.

Most of these elements – the effectiveness of interventions, the expertise of programme managers and the availability of local resources – will differ from one municipality to the next. Therefore, planning for sustainability will fall on the municipalities. The Ministry and the CDPC should continue to support the municipalities' efforts by providing them with guidance materials and training sessions.

2.4.3. Empower the health system to play its part in obesity prevention and treatment

While recognising the limited health budget in Latvia, the obesity epidemic cannot be controlled without the help of the health system. Doctors and other medical specialists across all levels of care are uniquely placed to provide counselling and advice to high-risk individuals. Moreover, they can help treat obesity and prevent further complications or the development of non-communicable diseases. There is considerable untapped potential in the Latvian health system that can be used in the fight against obesity.

As general practitioners are the first point of contact for patients with the health system and a trusted source of information (Sassi, 2010[50]), they play an important role in counselling on diet and physical activity for patients with a high BMI. However, as there is no dedicated reimbursement associated with counselling and resources are limited, few physicians can afford to make the time. In addition to putting in place adequate payment mechanisms, other medical professionals and e-health solutions can help reduce the burden on already-overloaded primary care physicians (see Box 2.9).

Box 2.9. Diet and physical activity counselling in other OECD countries

Chile

The Vida Sana counselling and physical activity programme has been part of the national prevention package in Chile since 2014. This one-year programme targets patient with obesity, or overweight with other risk factors, and provides them with individual and group counselling sessions with nutritionists and psychologists.

The programme consists of eight individual care appointments (one with a medical doctor, five with a nutritionist, two with a psychologist); five group interventions (Nutritionist-Psychologist workshops) and physical activity sessions three times a week for 12 months, guided by a physical education teacher (Ministerio de Salud, n.d.[51]).

To reduce the cost of delivering the intervention, medical doctors are only involved if the patient specifically requires medical attention, for example for specific diseases. The 144 hours of physical activity classes are guided by a physical education teacher, physical activity therapist, or kinesiologist. While the sessions take place in primary care centres, the programme is completely independent and run by dedicated councillors (OECD, 2019[42]).

Finland

As part of the Virtual Hospital 2.0 project, the Finnish Ministry of Social Affairs and Health has supported hospitals in developing Health Village – an online resource with information for patients and health care professionals (Terveyskylä.fi, 2020[52]). One of the "houses" in the village is focused on weight control. The HealthyWeightHub.fi (Painonhallintatalo.fi) provides both public information on weight loss, as well as a referral-based weight management programme and a bariatric surgery programme.

The weight management programme is 12 months long, and provides a virtual coach to each participant with whom they have weekly or monthly interactions. Participants also have access to 160 training sessions, 60 videos and audio tutorials, a photo food journal, group chats and research questionnaires (Pietiläinen, 2020[53]). The programme is free for patients, and they can be referred to it by primary care physicians, occupational health professionals or other specialists if they have a BMI of more than 25 kg/m^2 and are over 18 years old.

The bariatric surgery programme starts two months before the surgery and continues 12 months after (Pietiläinen, 2020[53]). In Helsinki University Hospital, this digital programme is now part of the standard care pathway, and over 85% of patients who underwent weight loss surgery have used it. In a sample of 100 patients, the hospital saw the number of surgery-related contacts decrease by 30% and the number of emergency visits to the hospital by more than 50% (DigitalHealthVillage.com, n.d.[54]).

Latvia has introduced a programme to facilitate the prescription of physical activity. However, due to the limited information available about the uptake and effectiveness of this programme, it is difficult to say whether it is having a positive impact. The fact that there are no financial incentives linked to the programme is likely to limit the uptake in an already overstretched primary care system. Nevertheless, other countries with physical activity programmes have shown promising results (see Box 2.10).

Box 2.10. Prescribing physical activity in other OECD countries

Sweden

In the Swedish physical activity prescription programme patients at risk of developing non-communicable diseases receive written, individualised prescriptions for physical activity. These prescriptions can be written by any qualified, licensed health care practitioner, and not necessarily a medical doctor. The prescription includes recommendations for both everyday physical activities as well as cardio, strength and flexibility training. The prescription also specifies duration, frequency and intensity of the exercise, and can be tailored to specific diseases.

An evaluation concluded that the programme significantly increased self-reported moderate physical activity level, with the proportion of patients reporting doing hardly any exercise decreasing from 35% to 16% (Kallings et al., 2008[55]).

Netherlands

The Netherlands has had a physical activity prescription programme since 2002 ("bewegen op recept"), targeting physically inactive patients at higher risk of cardiovascular diseases, hypertension or type two diabetes. Patients enrol in the programme through an evaluation with their GP and pay a one-off fee of EUR 100 to ensure their commitment. GPs can then write the prescription, which enables patients to access exercise clinics or classes for free or for a reduced fee, where they receive training and counselling

An evaluation of the programme in one city found that after the 18 week programme the proportion of participants that met the Dutch physical activity guidelines had increased from 33% to 49% (Versteeg and Walraven, 2014[56]). Moreover, of those participants that had never done sports before, 37% still participated in group sports a year later.

In addition to prevention activities, primary care physicians and specialists need to be able to treat obesity to prevent further complications. Currently there are no drugs or surgical treatments for obesity covered under the national health system. Instead, people have to pay out-of-pocket to undergo bariatric surgery privately. In addition to widening inequalities, this can also have a negative effect on recovery and patient well-being, as patients may not receive adequate nutritional education or decision guidance.

One approach to encouraging better treatment of obesity is to develop guidelines (see Box 2.11). This can support doctors in delivering the care that is needed, and ensure a consistent and effective approach across all levels of health care. However, this would need to be matched by changes in the reimbursement package. To make the case for this additional investment, Latvia can use modelling exercises to compare the cost of the intervention to the cost of inactivity on obesity. For example, the OECD SPHeP model could be used to compare the cost of covering certain treatments with its impact on health care expenditure, labour force productivity and GDP.

Box 2.11. Obesity treatment guidelines in other OECD countries

Iceland has recently introduced guidelines for the treatment of obesity by physicians, which include amongst others (Directorate of Health, 2020[57]):

- Identify obesity based on BMI and an assessment of abdominal fat accumulation with waist circumcision
- Recommend a diverse, well-composed and energy-deficient diet
- Recommend physical activity focusing on both cardio and strengthening
- Diagnose and treat any mental illness and distress
- Diagnose and treat any sleep disorders
- Cognitive behavioural therapy can be recommended, covering the aspects of behaviour that need to be adjusted to achieve and maintain weight loss
- Surgery should be considered for individuals aged 18-65 years with a BMI ≥ 40 kg/m2 or those with a BMI ≥ 35 kg/m2 and obesity-related adverse events (diabetes 2 and other metabolic disorders, cardiovascular disease, sleep apnoea, serious sleep disorders)
- Ensure that facilities are suitable for obese individuals.

In the **United Kingdom**, the National Institute for Health and Care Excellence (NICE) provides guidelines to improve health and social care. Their guidelines on obesity include (NICE, 2014[58]):

- Equip health care settings for treating people who are severely obese
- Identify obesity based on BMI but to interpret with caution, and considerer waist circumference
- Encourage adults to do at least 30 minutes of physical activity on five or more days a week
- Not to recommend unduly restrictive and nutritionally unbalanced diets, because they are ineffective in the long term and can be harmful
- Consider pharmacological treatment only after dietary, exercise and behavioural approaches have been started and evaluated
- Weight-loss surgery can be considered for people with a BMI of 40 kg/m2 or more, or between 35 kg/m2 and 40 kg/m2 and other significant disease.

In the **Netherlands**, guidelines for the identification and treatment of obesity in primary care have been developed, and include (Van Binsbergen JJ et al., 2010[59]):

- Identify obesity based on BMI and waist circumference
- Explain the drivers and potential consequences of obesity
- Aim to reduce weight by 5% to10% (more is unrealistic) and focus on health improvement rather than becoming skinny
- Provide advice on diet and exercise
- Recommend behavioural therapy for emotional and external eaters
- Drug treatment is not recommended
- Weight-loss surgery is recommended for people with a BMI of 40 kg/m2 or more, or a BMI between 35 kg/m2 and 40 kg/m2 and a comorbidity.

2.5. Conclusion

Obesity is a large and growing public health challenge in Latvia. To address this issue, Latvia has put in place a number of policies and interventions, acting at all levels of society. However, more can and should be done to halt the rise in obesity. Firstly, Latvia should expand or redesign existing policies to ensure they have maximum impact. For example, nutritional standards for schools and medical institutions can be expanded to other sectors, and the food labelling scheme should be redesigned so that it can support consumers in making healthier choices. Secondly, as many initiatives currently rely on project funding, it is important to ensure their long-term sustainability. This includes evaluating the effectiveness of different activities, as well as building capacity. Thirdly, the health system needs to be empowered to play its role in preventing and treating obesity. This can be done by using different routes to deliver counselling, or implementing pathways for the treatment of obesity – but will also require changes to the reimbursement or financial incentives for prevention and treatment activities.

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Annex 2.A. Data on obesity and overweight

As part of the Health Statistics, the OECD collects data on overweight and obesity prevalence (Annex Figure 2.A.1). This data comes from national surveys, and is presented without any adjustment by age group, and split by measured and self-reported estimates.

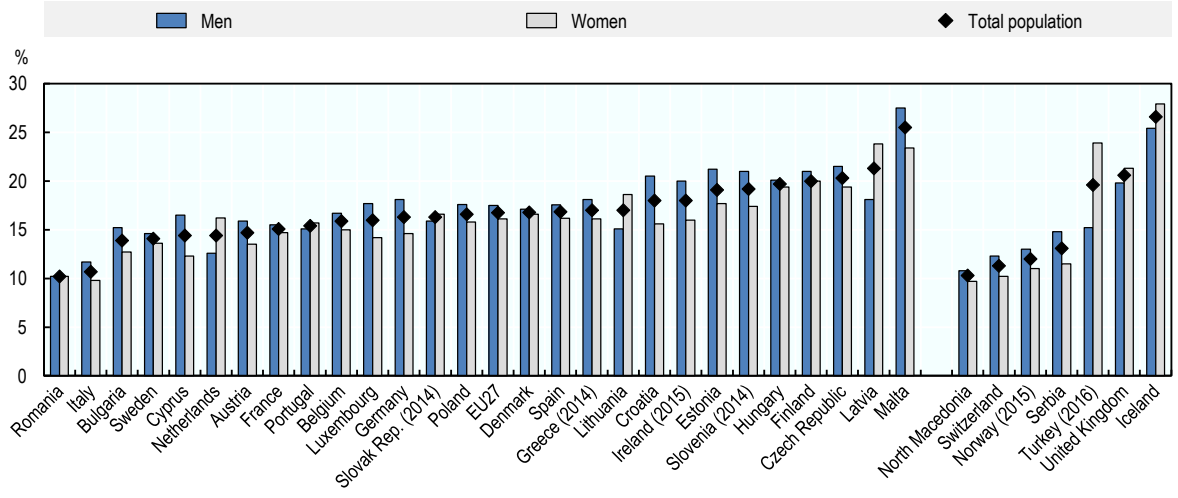
The World Health Organization (WHO) also reports overweight and obesity prevalence data as part of the WHO Global Health Observatory (2018[60]). This dataset provides both crude and age-standardised estimates based on a range of data sources. Age standardization is a technique used to increase the cross-country comparability of data when the age profiles of the populations included in the analysis are different and when there are significant differences in the age group-specific prevalence rates of the dimension under consideration – as it is the case for overweight and obesity rates.

Due to the difference in data sources, and adjustments such as age-standardisation, the prevalence values of the OECD and WHO datasets can be different.

In this report, the WHO data was used as it has more comprehensive country and historical coverage.

Annex Figure 2.A.1. Prevalence of obesity

Self-reported prevalence of obesity (BMI>=30 kg/m^2) by sex among population aged 15 and over, 2018 (or latest year)



Note: OECD Health Statistics 2020 are based on EU-SILC 2017 and EHIS 2014 for several countries.
Source: OECD (2020[61]), *Heath at a Glance: Europe 2020*, http://oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-europe-2020_82129230-en.

Notes

[1] Mechanically separated meat is derived from the meat left on animal carcasses once the main cuts have been removed. The resultant product generally has the appearance of a smooth paste, and is used as an ingredient for food products.

[2] Liraglutide is only reimbursed for diabetic patients, with weight loss being a side effect.

3 Strengthening Latvia's secondary and tertiary prevention policies

Secondary prevention aims to reduce the morbidity of a disease or injury that has already occurred through early detection, and putting in place actions to halt or slow the progress of the disease, while tertiary prevention manages the disease once it has occurred to prevent complications. In Latvia, there are some clear shortcomings when it comes to secondary and tertiary prevention, with low rates of cancer screening coverage, and high rates of complications from chronic diseases such as diabetes. Some improvements should be made to vertical prevention programmes, for example strengthening the cancer screening invitations system(s). Much of the potential to improve secondary and tertiary prevention lies in health system strengthening – investing in the health workforce, strengthening GP responsibilities and capacities, creating chronic disease management pathways for care delivery – and eliminating inefficiencies, in particular better aligning payment schedules with best practice patient pathways and chronic disease care.

3.1. Introduction

Secondary prevention aims to reduce the morbidity of a disease or injury that has already occurred through early detection, and putting in place actions to halt, slow or treat the progress of the disease, while tertiary prevention manages the disease once it has occurred to prevent complications or disease progression. In Latvia, there are some clear shortcomings when it comes to secondary and tertiary prevention, with low rates of cancer screening coverage, and high rates of complications from chronic diseases such as diabetes, high cholesterol or hypertension. Some improvements should be made to vertical prevention programmes, for example strengthening the cancer screening invitations system(s). Much of the potential to improve secondary and tertiary prevention lies in health system strengthening – investing in the health workforce, strengthening primary care responsibilities and capacities, creating chronic disease management pathways for care delivery – and eliminating inefficiencies, in particular better aligning payment schedules with best practice patient pathways and chronic disease care.

This chapter begins by examining the total burden of disease in Latvia, focusing in particular on high burden diseases that are known to be amenable to secondary prevention strategies such as screening and health check-ups (notably cancer, heart disease, and diabetes). Secondly, the chapter describes the existing secondary and tertiary prevention systems in place in Latvia, including both vertical screening programmes such as for breast and cancer care, and screening, health check-ups and disease management delivered through primary care settings. Finally, the chapter highlights key areas for strengthening Latvia's secondary and tertiary prevention approach, giving recommendations for policies that represent good value-for-money, and will have a positive impact on the health outcomes of the Latvian population.

Box 3.1. What are secondary and tertiary prevention?

There are a range of different ways that secondary and tertiary prevention can be defined and distinguished, and this chapter follows the definitions set out here. Secondary prevention is considered as covering all forms of early detection and screening, while tertiary prevention includes disease management and early treatment to prevent poorer health outcomes.

Secondary prevention aims to reduce the morbidity of a disease or injury that has already occurred (Baumann and Ylinen, 2017[1]). This is done through an early detection, when its detrimental effects are still limited, to be followed up with treatment to halt or slow its progress. Secondary prevention includes activities such as screening programmes for specific diseases (e.g. mammograms to detect breast cancer or colonoscopies to detect colorectal cancers) and health checks covering a range of risk factors and morbidities. Robust secondary prevention, when well joined-up with other health system processes, can help funnel patients towards effective disease management approaches. Interventions to control risk factors for chronic diseases, for example daily, low-dose aspirins and/or diet and exercise programs to reduce risk of heart attack or stroke for patients with hypertension, are sometimes included as part of secondary prevention strategies.

Tertiary prevention aims to lessen the impact of illness on a person's life and functioning, prevent worsening of symptoms or development of secondary complications. Tertiary prevention is usually focused on helping people to manage long-term, often complex health problems or injuries, such as chronic diseases or permanent impairments, to maximise daily functioning, quality of life, and life expectancy. Tertiary prevention covers interventions put in place to treat, halt or slow down progress of a disease, including programmes such as cardiac or stroke rehabilitation programmes, chronic disease management programmes, or support groups to support quality of life.

For lifestyle diseases such as diabetes and heart disease effective tertiary prevention or 'disease management', following detection, can slow the progression of the disease (Baumann and Ylinen, 2017[1]). Interventions to prevent the onset of disease once warning signs are observed, for example weight loss support for pre-diabetic patients or pharmaceutical management of risk factors such as high blood pressure, can also be considered to be part of tertiary prevention efforts. Disease management is also included as part of effective tertiary prevention, such as diabetes disease management which can avoid complications of the disease, for example vascular complications of diabetes. Slowing disease progression is an advantage to the patient, but also to the health system; effective disease management in primary care or dedicated programmes can avoid costly admissions to hospital (Van Loenen et al., 2016[2]; OECD, 2017[3]; OECD, 2019[4]). Ambulatory Care Sensitive Conditions (ACSCs) are conditions for which effective and accessible primary care can generally prevent the need for hospitalisation, and include diabetes and COPD.

3.2. Burden of chronic disease in Latvia

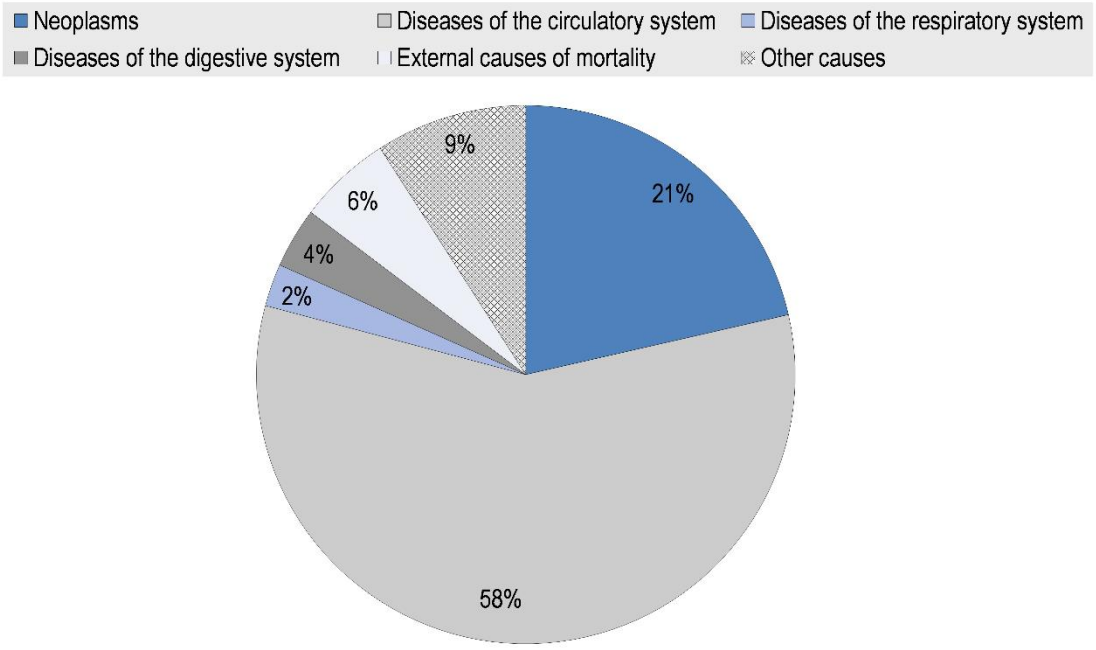
Non-communicable diseases are the leading cause of death in Latvia, in particular ischemic heart diseases, cancer, and cerebrovascular diseases. Additionally, the rate of treatable mortality in Latvia is twice the EU average. This burden of disease points to a need to improve primary prevention efforts, as detailed in Chapters 1 and 2, but also scope to scale-up chronic disease management and early intervention.

3.2.1. Non-communicable diseases are the leading cause of death in Latvia

Non-communicable diseases are the leading cause of death in Latvia, with circulatory diseases (56%) and cancers (21%) accounting for the greatest number of deaths in 2015 (OECD, 2020[5]) (Figure 3.1). In Latvia mortality from ischemic heart diseases, cancer, and cerebrovascular diseases was significantly higher than the OECD average (Figure 3.1); mortality from ischemic heart diseases and cerebrovascular diseases in particular was more than twice the OECD average (OECD, 2020[5]).

Figure 3.1. Main Causes of Mortality in Latvia, 2015

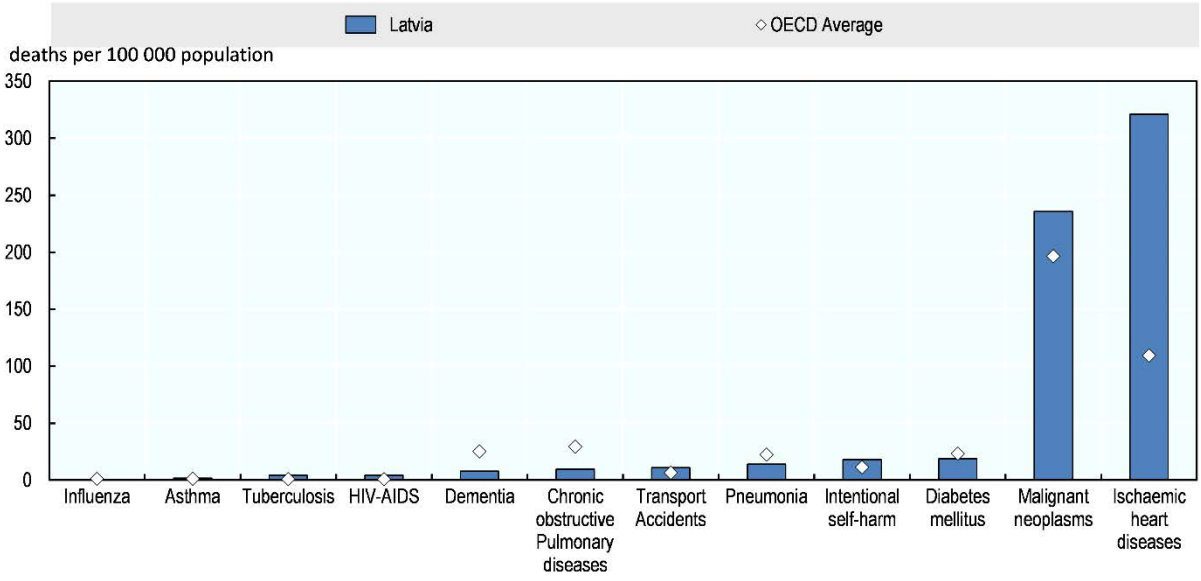
Causes of mortality, age standardised (% total deaths)



Source: OECD (2020[6]), *OECD Health Statistics 2020,* https://doi.org/10.1787/health-data-en.

Figure 3.2. Main Causes of Mortality, Latvia and OECD Average, 2017 or latest year[1]

Deaths per 100 000 by cause of mortality, age standardised Latvia and OECD Average

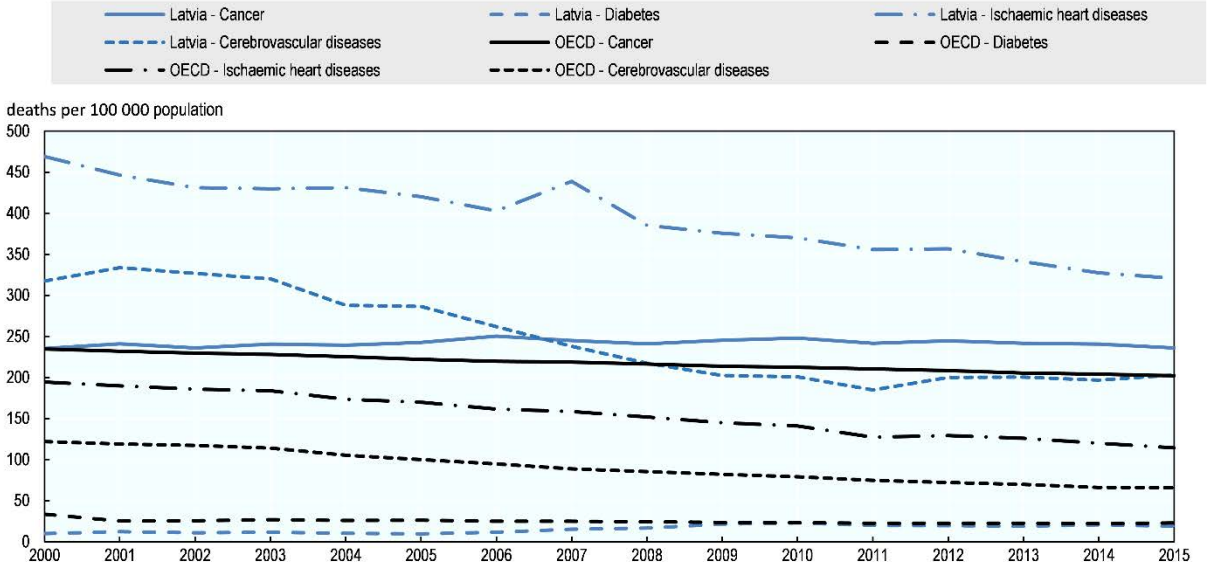


Note: [1]Data for Latvia is 2015.
Source: OECD (2020[6]), *OECD Health Statistics 2020,* https://doi.org/10.1787/health-data-en.

Despite the decreasing trends mortality rates due to cardiovascular diseases (mostly ischaemic heart disease and stroke) in Latvia are amongst the highest in the EU, and well above the OECD average (OECD, 2019[7]; OECD, 2020[5]). Mortality from cancer has increased slightly in Latvia, but remain below the OECD average (Figure 3.3).

Figure 3.3. Main causes of mortality over time in Latvia and the OECD average, 2000-15

Mortality rates per 100 000 population for leading causes of mortality in Latvia and in OECD countries, 2000 to 2015



Source: OECD (2020[6]), *OECD Health Statistics 2020,* https://doi.org/10.1787/health-data-en.

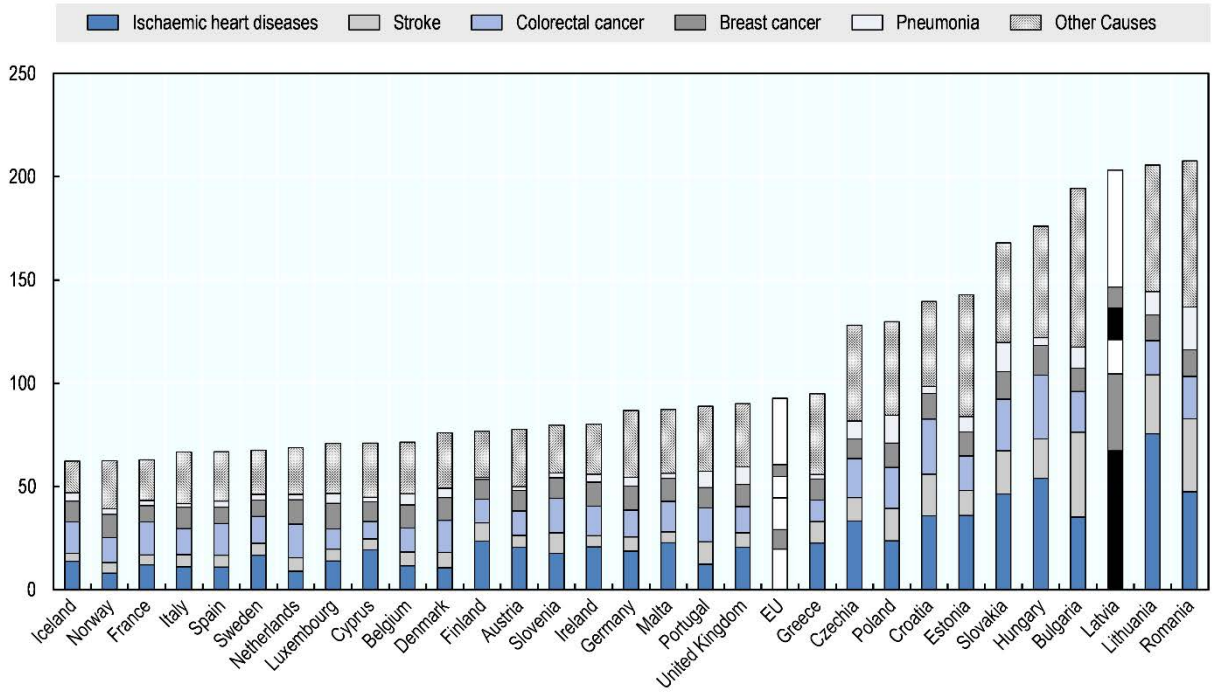
3.2.2. Treatable mortality in Latvia is amongst the highest in the EU

'Preventable mortality' are deaths that could mostly be avoided if effective public health and primary prevention interventions are in place; 'treatable mortality' refers to deaths that could be avoided if effective health care interventions, including screening and treatment, were in place. Latvia has high rates of both preventable mortality (second highest in the EU) and treatable mortality (third highest in EU) (OECD, 2019[7]). Compared to OECD peers in 2015, Latvia has the second highest rate of treatable mortality (157.0 deaths per 100 000 in Latvia, compared to the OECD average of 77.2) and the second highest rate of preventable mortality (157.0 deaths per 100 000 in Latvia compared to the OECD average of 77.2) (OECD, 2020[5]).

The rate of treatable mortality in Latvia was 203 per 100 000 population, more than twice the EU average of 93 per 100 000 population in 2016 (Figure 3.4). The rate of treatable mortality in Latvia was particularly high for ischaemic heart diseases and stroke; despite falling stroke and ischaemic heart disease mortality rates there is clear room for improvement if Latvia is to catch up with EU and OECD peers.

Figure 3.4. Rates of treatable mortality in the EU, 2016

Rate per 100 000 population under age 75



Note: Mortality from treatable (or amenable) causes is defined as death that can be mainly avoided through health care interventions, including screening and treatment. This indicators refers to premature mortality (under age 75).
Source: OECD/European Observatory on Health Systems and Policies (2019[7]), *Latvia: Country Health Profile 2019, State of Health in the EU, OECD Publishing*, https://dx.doi.org/10.1787/b9e65517-en.

3.3. Screening, health checks, and disease management approaches in Latvia

This chapter focuses on secondary prevention interventions – screening, health checks – and tertiary prevention – disease management – for chronic conditions that are both amenable to secondary and tertiary prevention, and represent a high burden of disease in Latvia. In particular, this chapter focuses on

preventive care and early intervention for cancer, preventive care, early intervention and disease management for cardiovascular disease, and disease management for some chronic conditions that are well amenable to management in primary care, notably diabetes.

This section describes the screening, health checks, and disease management approaches that are already in place in Latvia, focusing on cancer, cardiovascular disease, and diabetes.

3.3.1. Cancer screening and detection in Latvia

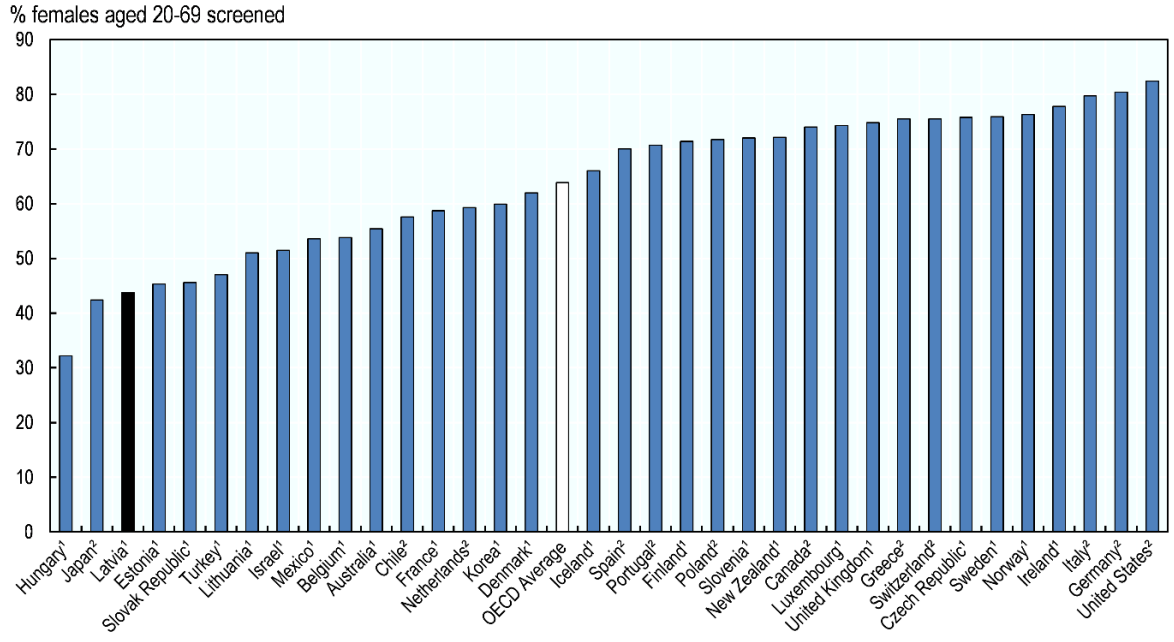
In Latvia, a national cancer screening programme is carried out by the National Health Service, in line with Cabinet Regulation No. 555 of 28 August 2018, Procedures for the Organization and Payment of Health Care Services. Women between 25 and 70 years of age should receive an examination of cytological smears from the cervix and posterior vault (Leishman – Nohta combined microscopy of stained preparation). Further, depending on screening results women receive HPV test or biopsy for cervical cancer once every three years, women aged between 50 and 69 should receive mammography screening every second year, and the entire population between age 50 and age 74 should receive faecal immunochemical test once a year (Latvian Government/OECD, 2019[8]). Screening frequencies are well aligned with those of other European countries (Altobelli and Lattanzi, 2014[9]). For breast and cervical screening, invitation letters are sent out to eligible females by the National Health Service, while colorectal screening is left to General Practitioners (GPs) to encourage or deliver opportunistically. Cervical cancer, breast cancer are fully funded, with no co-payment; for colorectal cancer screening tests there is a co-payment for the GP visit unless the screening is undertaken during the specified annual preventive visit.

According to Latvian data, in 2018 43.8% of women in the target group participated in cervical cancer screening, 42.1% of women in the target group participated in breast cancer screening and 16% of target population participated in colorectal cancer screening (Latvian Government/OECD, 2019[8]) (data available from survey “Health Behaviour Among the Latvian Adult Population”, (Latvian Government, 2018[10]).

Compared to OECD peers, Latvia does not perform well when it comes to rates of cancer screening. Screening rates for cervical (Figure 3.5) and breast screening (Figure 3.6) were in the bottom third of OECD countries. Latvia’s colon cancer screening rates, based on rates of lifetime faecal occult blood test, were above the OECD average based on the latest available 2014 data (Figure 3.7).

Figure 3.5. Cervical cancer screening coverage, 2018 or nearest year

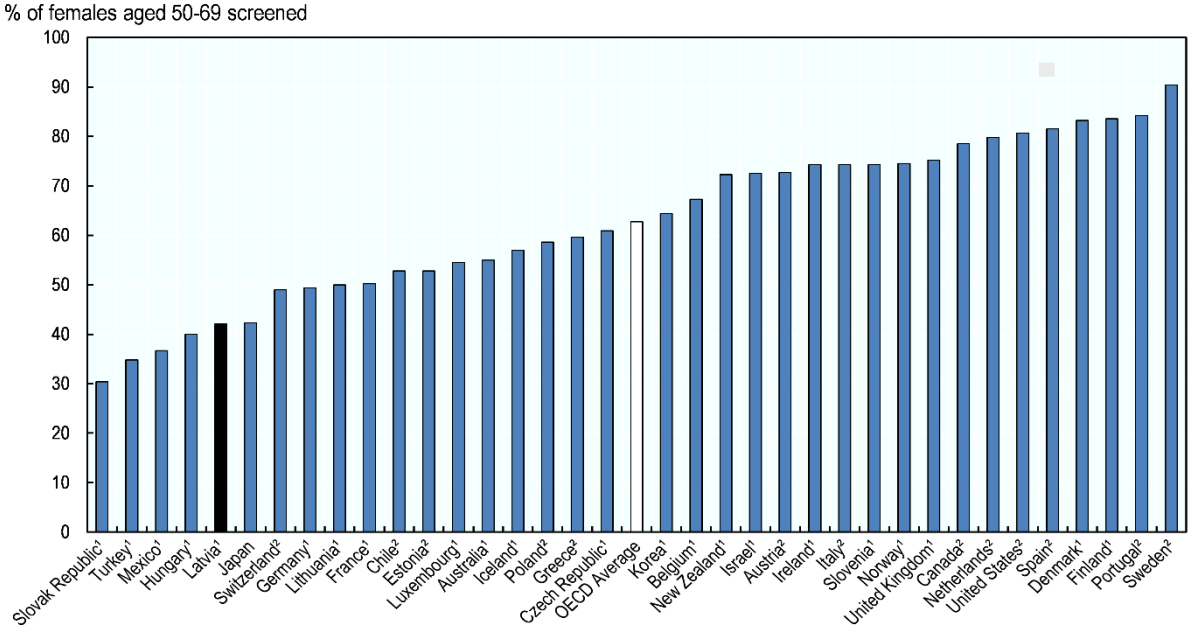
Share (%) of females aged 20-69 screened



Note: ¹Programme data ²Survey data.
Source: Source: OECD (2020[6]), *OECD Health Statistics 2020,* https://doi.org/10.1787/health-data-en.

Figure 3.6. Breast cancer screening coverage, 2018 or nearest year

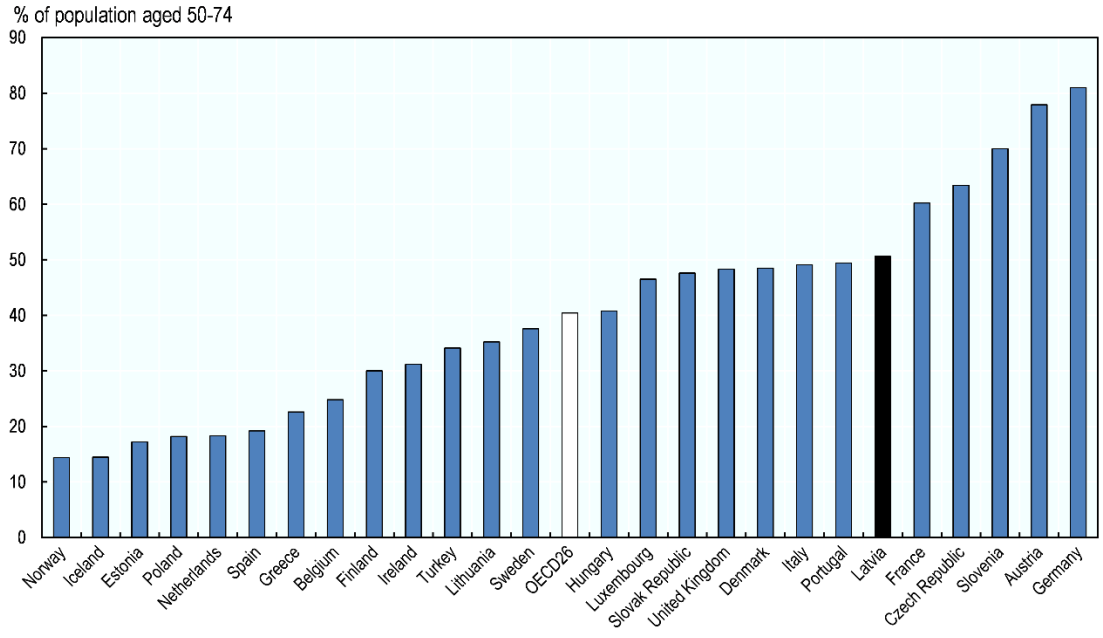
Share (%) of females aged 50 – 69 screened



Note: ¹Programme data ²Survey data.
Source: OECD (2020[6]), *OECD Health Statistics 2020,* https://doi.org/10.1787/health-data-en.

Figure 3.7. Rates of lifetime screening for colon cancer, 2014

Share (%) of people aged 50-74 years who have had faecal occult blood test at least once in their life



Source: OECD (2019[4]), *Health at a Glance 2019: OECD Indicators,* OECD Publishing, Paris https://dx.doi.org/10.1787/4dd50c09-en.

Though rates of cancer screening in Latvia are low compared to OECD peers, they have been increasing. In Latvia rates of breast cancer screening nearly doubled from 21.1% coverage in 2009, to 42.1% in 2018. Cervical cancer screening rates increased even more significantly from 14.9% to 42.8% across the same period (data age-sex standardised to the OECD population) (OECD, 2020[5]).

This increase is likely in part due to national efforts to increase screening across the last decade. For cervical cancer, organised screening was first implemented in 2009, before which point screening was opportunistic though encouraged (Vīberga and Poljak, 2013[11]). Since 2011, the National Health Service has sent invitation letters to all women aged 25 to 69 years, identifying the target population through a central screening database to which General Practitioners also have access (ibid). Since 2010 the HPV vaccination has been available to girls aged 12-14 in Latvia (Patel et al., 2017[12]).

In theory, General Practitioners (GPs) and nurses in GP practices and practice assistants should have access to the screening database, be able to see which of their patients have received screening invitations but not followed up. However, it is not clear how often this occurs, with GPs reporting that their existing patient lists and appointment demands are too intense to make time for proactive screening follow-up (Vīberga and Poljak, 2013[11]). GPs can undertake cervical screening, but few do; an estimated 1% of GP`s take the cytological material by themselves and send it to laboratory). Latvia has been experimenting with ways to increase engagement of GPs with cancer screening activities, including cervical screening.

A population-based mammography screening programme was also launched in 2009 in Latvia, offering biennial mammography to women aged between 50 and 69, through around 25 radiology units across the country (Hegmane and Eglitis, 2011[13]). Again, invitations to screening are sent through the National Health Service, and GPs can access information on whether their patients have had a mammography. It is unclear how many GPs are actively following up with eligible patients or even opportunistically encouraging patients to get a mammography; the only available data on GP engagement comes from those GPs who participated in a pilot project which awarded a fee for increasing the rate of cancer

screening amongst their registered patients. This pilot, intended to improve the responsiveness of the population to cancer screening invitations and thus early diagnosis of cancer, was launched in 2018. GPs were given an additional fee for increasing the response to cancer screening among their registered patients. In 2018, 424 (approximately one-third of all Latvian GPs) applied for the pilot project, of whom 50% met the set criteria for the implementation of cervical cancer preventive examinations. In 2019 483 GPs applied, of whom 37% met the set criteria for the implementation of cervical cancer preventive examinations.

For at least a decade, since the introduction of three national cancer screening programmes (breast, cervical, colorectal) in 2009, the Latvian Government has been seeking to improve participation in screening programmes (see Box 3.2). Despite increases in participation rate, the rate of screening for breast and cervical cancer still remains well below the OECD average, and well below the target rate set by Latvia.

Box 3.2. Efforts to improve cancer screening rates in Latvia

Latvia has taken some steps to increase cancer screening coverage, notably introducing information campaigns, educational seminars, and a pilot programme incentivising GPs to follow-up their patient's involvement of their patient in screening programs. While the increase in screening rate between 2009 and 2018 for breast and cervical cancer has been impressive, these programmes have not been evaluated for their direct impact on screening.

Information campaigns

Public awareness campaign around cancer screening have been organised twice, in 2017 and in 2019, organised by The Centre of Disease Prevention and Control, The Ministry of Health and The National Health Service. The purpose of both campaigns was to improve cancer awareness and screening rates in country.

During the information campaigns several activities aimed at people aged 25 to 74 were carried out. These activities included in-person events, such as lectures in workplaces, and distribution of educational materials on 'frequently asked questions' to health professionals and in medical institutions. Other activities were focused on different forms of media impact, for example online expert discussions, collaborations with cultural 'influencers', celebrities, and cancer survivors, and advertising on TV, cinema, public transport, radio and internet portals, communication in social networks, educational articles in the printed and electronic media.

Educational seminars

From 2017 to 2019 The Centre of Disease Prevention and Control has been organising educational seminars in workplaces. The seminars are designed to raise awareness of cancer screening and to motivate them to attend preventive health check-ups. Since 2017, more than 1 000 people have attended these seminars, which include discussion of common oncological diseases, symptoms, risk factors, screening programmes, and the 'myths' about cancer.

Source: Latvian Government/OECD (2019[8]), *Latvian Responses to the OECD Public Health Review Questionnaire.*

3.3.2. Health check-ups for chronic disease and chronic disease risks

Basic health check-ups for chronic diseases, for example taking blood pressure or cholesterol, or a screening for cardiovascular disease based on age, family history, and risk factors such as body mass

index (BMI), can help diagnose persons at-risk of chronic diseases, or diagnose chronic diseases in their earlier stages when they can be managed with fewer complications.

Several OECD countries have health check-ups for chronic conditions, usually targeted at particular populations, undertaken periodically for example every five years, and sometimes provided by health care professionals other than doctors. In Australia, for example, primary health physician can provide health assessment for people who are at risk of developing a chronic disease. This assessment is provided to people aged between 45 and 49 once if they have at least one risk factor (lifestyle habits or a family history) for developing a chronic disease such as type 2 diabetes or heart disease. The assessment is also provided to people aged 75 and over with an interval of 12 months or longer (Australian Government, 2014[14]; Australian Government, 2016[15]). In Estonia, health check ups and guidance are provided by family nurses for people aged between 40 and 60 with hypertension or diabetes (Habicht et al., 2018[16]), and in 2007, Korea introduced the National Screening Program for Transitional Ages, targeting people at age 40 and 66 (Kim et al., 2012[14]). In England, the NHS Health Check was introduced for people aged between 40 and 74 in 2009 and an invitation letter is sent every five years to those who do not already have diabetes, heart disease, or kidney disease or have not had a stroke, in order to screen them for the risk of developing chronic conditions including heart disease, stroke, kidney disease, type 2 diabetes, or dementia (available only for those above 65 and above). This check-up is often undertaken by a nurse or health care assistant ((Gmeinder, Morgan and Mueller, 2017[18]; NHS, 2019[19]).

While too much screening can be an inefficient use of resources, and does not appear to improve equity of health outcomes, well-targeted screening can be an effective way to identify and manage chronic disease (see Box 3.3).

Box 3.3. Basic health checks for chronic diseases – costs and benefits

General health check-ups targeting the adult population aim to detect risky health behaviours and try to assess whether people are at risk of developing chronic conditions, such as cardiovascular diseases or diabetes. Activities carried out as part of these health check-ups can involve the establishment of the medical history of the patient, clinical examination, laboratory tests of blood (e.g. for cholesterol and glucose levels) and urine (e.g. for protein, erythrocytes, leukocytes, nitrite) and subsequent counselling based on examination and test results. Across the OECD, healthy condition monitoring programmes account for nearly half of all prevention spending (Gmeinder, Morgan and Mueller, 2017[14]).

Health check-ups are intended to identify people at risk of or suffering from disease, and intervene to prevent, manage, or treat disease. Some evaluations of national or regional health check-up programmes have found that they are effective at identifying disease risks: in an evaluation in the North of England two cases of high cardiovascular risk and a further case of hypertension were identified for every ten health checks performed (Lambert, 2016[15]); the introduction of the NHS Health Check in England was associated to significant but modest reductions in cardiovascular risk amongst high-risk individuals who were screened (Artac et al., 2013[16]; Robson et al., 2016[17])

However, there are some questions about the efficacy of health check-ups. A number of studies conducted in other countries suggest that population-based routine general health check-ups were not effective. A systematic review of 16 studies conducted in Denmark, Sweden, the United Kingdom and the United States found that general health check-ups did not reduce morbidity or mortality among adults while they increased the number of newly diagnosed cases. This systematic review also highlighted the problems such as false-positive result, which causes anxiety and leads to unnecessary follow-up tests, over-diagnosis and overtreatment, suggesting that a general health check-up could be harmful (Krogsbøll et al., 2012[18]). Some argued that studies in the review were too old, based on examples between the 1960s and 1990s, and the effectiveness of contemporary health check-ups may be different due to progress in medical technologies (Lauritzen, Sandbaek and Borch-Johnsen, 2014[19]). Nonetheless, based on these findings, Denmark put an implementation of health check-ups on hold (Krogsbøll et al., 2012[18]). A Cochrane Review including 17 trails that covered 251 891 participants found that general health checks were unlikely to be beneficial, and may lead to unnecessary tests and treatments (Krogsbøll, Jørgensen and Gøtzsche, 2019[20]).

Questions have also been raised about the cost-effectiveness of generalised health check-ups, i.e. those that do not target individuals with existing risk factors such as high BMI or family history of particular diseases (Si et al., 2018[21]). England's NHS Health Check programme for all adults aged 40-74 every five years, for example, has had mixed evaluation. Some analysis finding that the way the checks were implemented was neither equitable nor cost-effective (Kypridemos et al., 2018[22]; Abdalrahman and Soljak, 2015[23]), and that optimal targeted implementation could improve both equity and cost-effectiveness, and adding other structural policies targeting cardiovascular risk could make a more substantial difference. Other analysis has suggested that while the NHS Health Checks were associated with only modest changes, for example a small reduction in BMI, this was sufficient to justify its costs in terms of QALYs gained and reduction in disease-related care costs (Hinde et al., 2017[24]). Economic modelling by the Public Health England suggested that the policy was both clinically and cost-effective (Public Health England, 2013[25]).

In addition, several studies suggest that population-based health check-ups may potentially increase health inequality. A study in Germany found that those with high risk factors and low socio-economic background are less likely to participate in population-based health check-ups than others, and the study suggested a need to develop a targeted health check-up (Hoebel et al., 2014[26]), and a similar trend was found in the Danish 'Check Your Health Preventive Program' (Bjerregaard et al., 2017[27]), and England's NHS Health Check (Kypridemos et al., 2018[22]; Collins et al., 2020[28]). A systematic

review of studies conducted in different OECD countries also found that uptake is low among those with clinical need and higher risk factors, suggesting that population-based health check-ups may in fact increase health inequality and a tailored and targeted approach is needed (Dryden et al., 2012[29]).

In Latvia, the main responsibility for health checks lies with GPs. GPs carry out preventive examinations of adults and children, cardiovascular risk assessment, as well as the cancer screening checks detailed in the previous section. Latvia does not have a national programme of health checks, put does have policies to incentives some specific tests; GPs should encourage all patients to perform the same test or screening in the same way, given that tests are not mandatory and are left to patient choice. An exception is preventive examinations for children under the age of 1, where the GP performs the compulsory examinations, and if the child fails to attend the prescribed exam, the GP or practicing nurse or assistant performs a home visit to the child. In 2018 around one-third of Latvia adults undertook preventive examinations, although it is not possible to establish which tests were in fact undertaken (Self-reported free of charge preventive health check-ups, data from survey "Health Behaviour among Latvian Adult Population"). GPs are able to recruit a second practice nurse if they have more than 1 200 adult patients or 600 patients under the age of 18 on their patient list, and these nurses are theoretically intended to focus on prevention tasks such as lifestyle advice and checks. In reality though, while GP practices can organise their own time and team working practices, the time of the additional practice nurse is often spent on activities other than prevention due to the heavy workload that many GP practices experience. Of course, it depends on how general practitioner organise his own and his team members' work.

An internationally recognised cardiovascular risk assessment tool Systematic Coronary Risk Evaluation (SCORE) was introduced in Latvia in 2018, after development along with the Latvian Cardiologist's Association. SCORE is administered by GPs for a small fee-for-service (FFS) payment for EUR 6.40 in 2019 (around five times the basic FFS payment for a GP visit, which is EUR 1.42), with the target of screening patients aged 40 to 65 every five years. GPs are able to calculate the risk of cardiovascular diseases using the SCORE method, which includes items on lifestyle, family history, medical history, age, blood pressure, and total cholesterol. Patients with existing cardiovascular conditions are excluded. The patient should then be provided with appropriate information on health management, for instance nutrition, and/or given a referral for further testing or care. 13 000 people were screened in 2019, and around 70-80% of GPs were estimated to have done at least one risk assessment as of 2019. Currently no reliable data on uptake of SCORE or how effective it is at identifying at-risk patients is available (use of SCORE began in mid-2018). However, anecdotal reports suggest that this risk assessment is a very burdensome process for GPs, and the FFS payment may not make the assessment worthwhile.

Diabetes screening should be carried out every three years for 'at-risk groups' aged 10 years and older, and every three years for persons aged 40 years and older even without additional risk factors. Again, screening is carried out by General Practitioners, but the fact that the screening is every 3 years means that it is not well-aligned with the SCORE screening for cardiovascular risk. Latvia also has a pay-for-performance scheme for General Practitioners, which includes some items on preventive activities (Box 3.4).

Box 3.4. General Practitioner pay-for-performance quality scheme

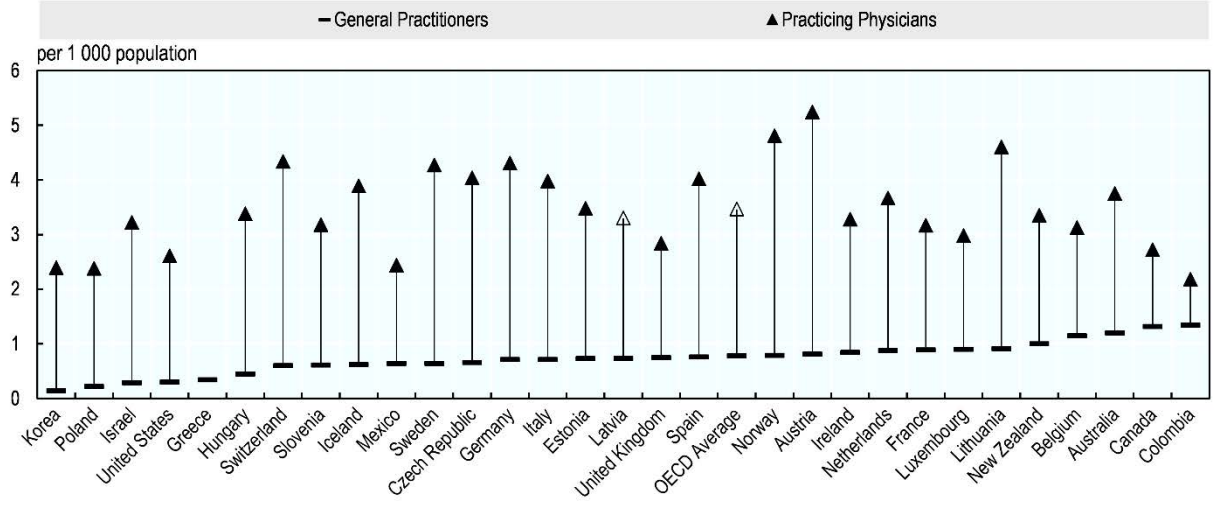
Latvia also has a pay-for-performance scheme focused on 'quality criteria' for General Practitioners, which includes some items on preventive activities. This compulsory scheme, which was introduced in 2013, includes annual targets in the domains of prevention, care for chronic conditions, and some routine services (OECD, 2016[30]). Originally established with 14 targets, this was since reduced to eight criteria. For example, cancer screening, and taking LDL cholesterol to monitor cardiovascular disease, were included as part of the pay-for-performance incentives for GPs in 2018.

However, there appear to be some limits to the extent that this pay-for-performance scheme is an effective mechanism for incentivising particular activities or performance. In the last two years less than 4% of GPs have achieved all eight of the targets – 52 GPs in 2018, and 46 GPs in 2019. Reports during the OECD research interviews in Latvia in 2019 suggested that the financial reward for achieving the quality criteria was insufficient given the extra effort that it demanded, and especially given that it would require a either additional hours or concerted shift away from other activities for GPs, who already report being under considerable strain (see Figure 3.8).

Overall, basic health checks and risk screening for chronic disease relies on General Practitioners, and predominantly on opportunistic screenings. However, there are clear challenges around this approach, as pressure on GP time is reported as being acute. Latvia has fewer practicing physicians and slightly more General Practitioners than the OECD average (see Figure 3.8), but is not amongst the countries with the fewest physicians. However, it should be pointed out that remuneration for physicians is amongst the lowest in the OECD when compared to the national average wage, in particular for GPs (see Figure 3.9). These low salaries reportedly contribute to some physicians working at least part of the time in the private sector, which reduce overall availability of physician time. Based on most recently available data, in 2014 Latvian GPs earned exactly the average wage, compared to GPs in neighbouring countries such as Estonia, where GPs earned between 1.6 and 2.4 times the average wage, or Lithuania, where GPs earn 20% more than the average wage. These higher wages in neighbouring countries, and in EU countries, have also led to high rates of out-migration of Latvian health professionals (OECD, 2016[30]). Nurses working in Latvian hospitals earned 80% of the average national wage, the second lowest rate in the OECD (Figure 3.9), and nurses in GP practices are reported to earn less.

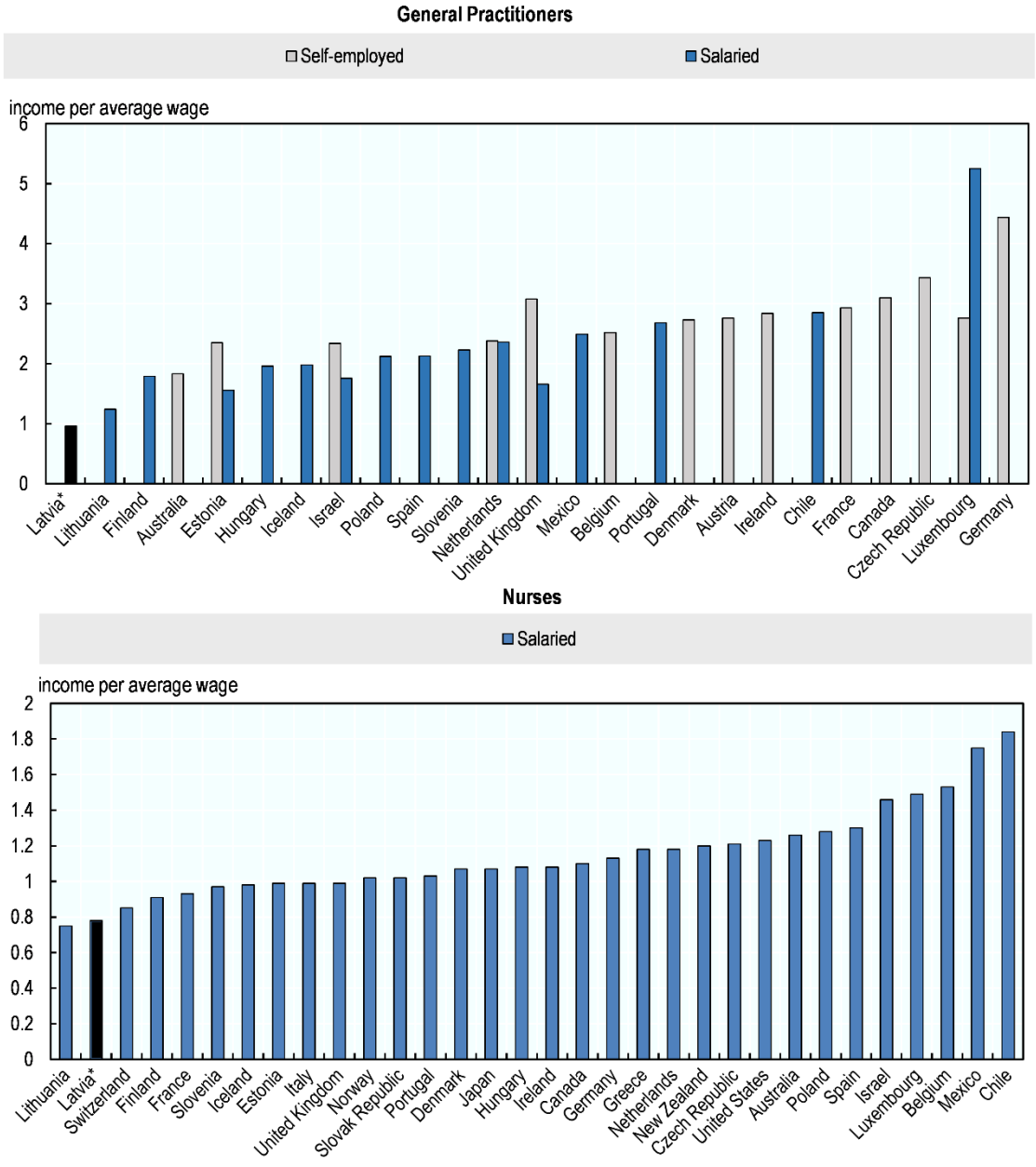
Figure 3.8. Practicing Physicians and General Practitioners, 2018 or nearest year

Number of practicing physicians and General Practitioners per 1 000 population



Note: *Data for Latvia is from 2014.
Source: OECD (2020[6]), *OECD Health Statistics 2020,* https://doi.org/10.1787/health-data-en.

Figure 3.9. Remuneration of General Practitioners and Nurses ratio to average wage, 2018 (or nearest year)



Note: *Data for Latvia is from 2014.
Source: OECD (2020[6]), *OECD Health Statistics 2020,* https://doi.org/10.1787/health-data-en.

Proactive interventions for high-risk patients, for example nutrition advice for pre-diabetic persons, or lifestyle support for persons at risk for cardiovascular disease, do not appear to be widely available in Latvia.

The Latvian Pharmacists' Association in cooperation with the Latvian Cardiology Association has developed a training programme for pharmacists about cardiovascular risk identification, self-monitoring measurements, documentation and guidelines (OECD, 2018[31]). Training was started in September 2015, and by 2017, 172 certificates had been issued to pharmacists for the successful completion of a training

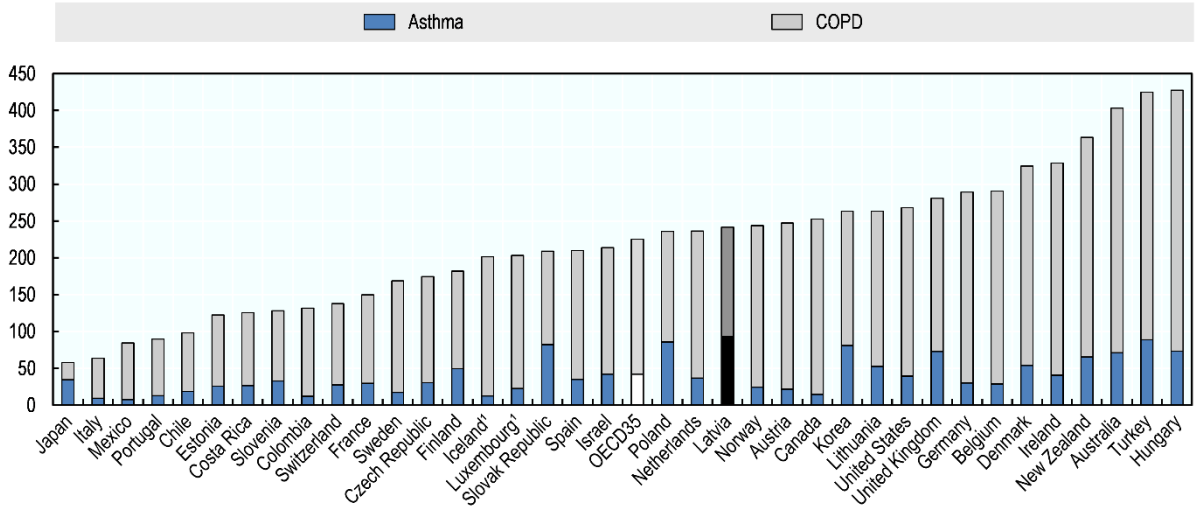
programme, which would suggest about 10% of Latvia's pharmacists had received training (OECD, 2020[5]). The impact of training on the improvement of patient coverage will be evaluated in due course.

3.3.3. Chronic disease management in Latvia

The bulk of chronic disease management is the responsibility of General Practitioners in Latvia, and some of the challenges previously outline around workforce capacity likely also impact upon disease management capabilities. For routine care patients are expected to visit their named GP. However, it is not always clear whether GPs or specialists should be caring for patients with chronic diseases. For example, for diabetes the main burden of care for diabetes should lie with the GP, while for chronic obstructive pulmonary disorder (COPD) a patient can visit a GP, or a specialist, can be cared for in a specialist clinic. A cardiovascular disease pathway was introduced in 2019, and a diabetes pathway was introduced in 2020 which is a positive step forwards (National Health Service, 2020[32]).

OECD data suggests that there is room for improvement in chronic disease management in Latvia; avoidable hospital admissions for Asthma and COPD were well above the OECD average in 2017 (Figure 3.10). There is room for improvement still, too, when it comes to management of diabetes (wand reducing both admissions to hospital and amputation from complications).

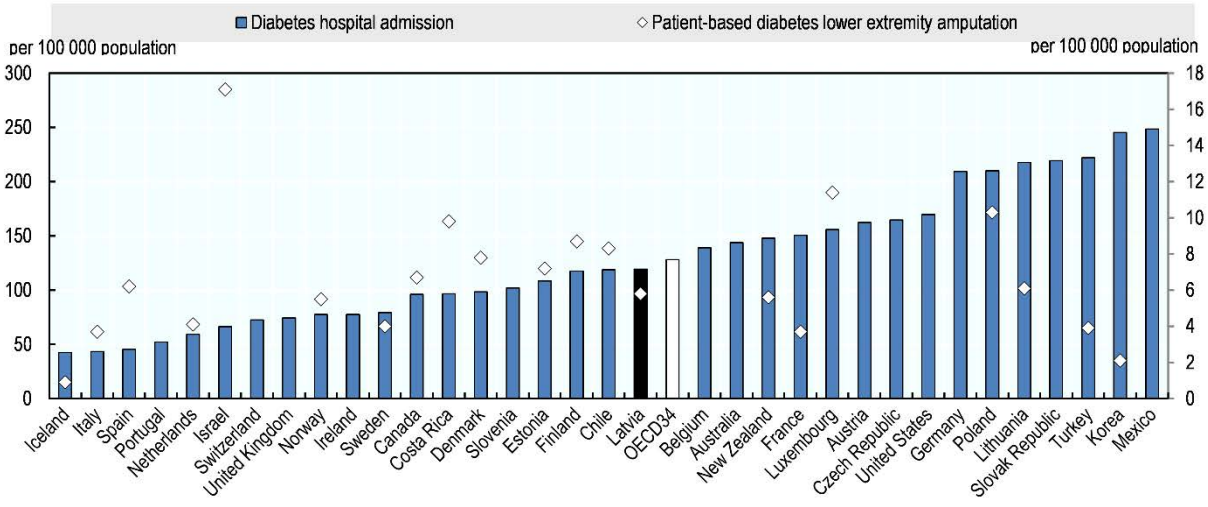
Figure 3.10. Asthma and COPD hospital admission in adults, 2017 (or nearest year)



Note: 1. Three-year average.
Source: OECD (2020[6]), *OECD Health Statistics 2020,* https://doi.org/10.1787/health-data-en.

Figure 3.11. Quality of diabetes care, 2017 or nearest year

Diabetes hospital admissions and lower-extremity amputation, age-sex standardised per 100 000 population



Source: OECD (2020[5]), OECD Health Statistics 2019.

For diabetes management, the majority of activities – patient education, nutrition advice, some medication prescribing, foot scan – should take place at the GP level. There are 17 diabetes management cabinets in Latvia and 31 diabetes foot care cabinets, run by nurses, which give lifestyle advice, education, insulin support, and advice on disease management.

There are no caps on the reimbursement of visits to endocrinologists for patients with a diabetes diagnosis, and patients can self-refer to endocrinologists and have this visits reimbursed if they have a diabetes diagnosis. While data tracking the extent to which stabilised diabetic patients are making repeat specialist visits is not available, this is theoretically possible and arguably a potential source of inefficient use of specialists' time, and representing poor value-for-money. There are limits on GP prescribing, although some of these for instance for on-patent drugs are not necessarily unusual as compared to other OECD countries. GPs can only prescribe metforminum and sulfonylurea group medicines, other medicines for Type 2 diabetes have to be prescribed or approved by endocrinologists in order to be reimbursed. Other limits on GP prescribing, for example on medication for cardiovascular disease were also reported.

It is notable that in 2017, Latvian consumption of anti-diabetics, anti-hypertensive, and cholesterol lowering drugs are the lowest, third lowest, and fifth lowest rates (DDD per 1 000 population) in the OECD (OECD, 2020[5]). There appear to be some gaps in reimbursement coverage for basic pharmaceuticals and medical devices for persons with chronic disease. For example, anti-coagulants are reimbursed only if a patient has previously experienced a stroke. Some pharmaceuticals for heart failure are subject to a 25% co-payment rate. Pre-diabetic drug treatment is not reimbursed.

Reports to the OECD during their research interviews in Latvia in 2019 suggested that patient compliance with pharmaceutical regimens was also a major challenge. For example, doctors report hearing fears of side effects from common medications such as statins, with a lot of information coming from a widely read magazine falsely warning of risks from medical treatments and pharmaceuticals.

3.4. Strengthening secondary and tertiary prevention

3.4.1. Improving health literacy for the population and health professionals should be a priority

Low levels of health literacy, misinformation around common medical care and pharmaceuticals, and possibly distrust of the medical system, appear to be relatively widespread in Latvia, and affect delivery of effective public health interventions across the board (see Chapter 1, 2, 4) (OECD, 2016[30]). Low levels of health literacy appear to be affecting chronic disease management capacities too, for example reported reluctance of patients to take 'preventive' pharmaceuticals such as statins. In general, people with low overall health literacy who also have a chronic disease also appear to know less about their disease, likely complicating chronic disease management (Gazmararian et al., 2003[33]; Dunn and Conard, 2018[34]; van der Heide et al., 2018[35]; Moreira, 2018[36]). Health literacy amongst health professionals may also need to be improved, for example underscoring the efficacy of generic pharmaceuticals and insuring that inaccurate information is not being shared with patients.

In Latvia increasing health literacy through patient education, education for health care professionals (see also Chapter 4), and making easy-to-understand health information broadly available should be a priority, and does not necessarily entail significant resource investments (see Box 3.5). Indeed, health literacy programmes in schools have been found to represent good value for money (Mcdaid, 2016[37]). Improving general population health literacy can also have positive impacts for patients with chronic diseases can help individuals better manage their condition, including necessary treatment or control protocols and behaviour modification, and improve shared decision making with health care professionals (Dunn and Conard, 2018[34]; Poureslami et al., 2016[38]; van der Heide et al., 2018[35]).

Box 3.5. Promoting population health literacy

Three approaches can be taken to improving health literacy, all of which are complementary: improving individuals' health literacy; improving health professionals' health literacy and communication skills; and making generally available health information easier to access and understand.

There is a strong relationship between good general literacy and numeracy, and good health literacy, so strong education systems and health education for children are a key starting point for good health literacy in later life. Many OECD countries, including Latvia, include health education as part of the school curricula, and evidence suggests that targeting younger population helps build healthy habits and skills. Health literacy training can also be targeted as part of disease self-management skill building. For example, the Evivo international programme "Devenir acteur de sa santé" (i.e. To become an actor of its own health), is based on Stanfords's Chronic Disease Self-Management Programme. It consists on a standardised course programme that teaches basic skills to manage the challenges related to disease and health. This programme has been successful in supporting individuals' autonomy in managing their own health and has been adapted and used in countries including Austria, Switzerland, France, Ireland, and Finland.

Improving health professionals' health literacy and communication skills can include training health professionals to avoid medical jargon in oral and written communications with patients, eliciting questions from patients, asking after patient's concerns, prioritising 'need-to-know' information and insuring that the patient has understood these key points, and recommending the use of medical interpreter services in the case of linguistic barriers. Some countries have introduced communication toolkits to help health professionals adapt their communication to patients' health literacy level. In Canada, the "Easy Does It! Plain Language and Clear Verbal Communication", is a training manual developed for health providers carrying advice and stories on how to communicate with patients to improve the quality of care.

Finally, making easy-to-understand information available in written forms, for example brochures, websites or even phone text-message services, is one of the most common ways to increase knowledge around health issues. Web-based interventions provide vast amounts of information, which can be easily updated, and easy for the information consumer to tailor their search for information. Ensuring that accurate information is the most easily available is also key, for example that government-created information is easily found when conducting a search online and that populations are not led towards false or misleading information. One study in 18 Latin American and Caribbean countries – including Mexico, Chile, Colombia, Costa Rica, Mexico and Peru – found the probability of finding information of national health authorities among the top ten results on Google was less than 7%. Additionally, for more than half of the countries, information was not a top result in Google. Several countries also have developed guidelines and distribute written information including infographics and posters (e.g. Australia) or comics (e.g. France, i.e. SanteBD) that provide easily readable health related information to different stakeholders, including disabled individuals.

Source: Moreira (2018[39]), "Health Literacy for People-Centred Care: Where do OECD countries stand?", *OECD Health Working Papers*, No. 107, OECD Publishing, Paris, https://doi.org/10.1787/d8494d3a-en

3.4.2. Latvia should strengthen cancer screening with pre-filled appointment times

Cancer screening stands out as an area where significant improvements shuold still be made in Latvia, specifically for breast and cervical screening, for which rates are amongst the lowest in the OECD despite improvement over the past decades.

It is clear that considerable efforts have been made to increase both breast and cervical screening, from public campaigns to encouraging GPs to reach out to patients directly, centralising the screening invitation information system, and making mobile mammography an option in rural or under-served areas. Sending a personalised letter and following up with an individual phone call are consistent with evidence of best practice (Segura et al., 2001[40]; European Commission, 2018[41]), and Latvia has been encouraging GPs to follow up with women in the target group who have not attended screening. However, capacity of GPs and GP practice nurses is already clearly stretched. Latvia may wish to consider whether other health professionals, for example pharmacists, could be involved in personal follow-up calls to screening invitations. At the same time Latvia should consider including a pre-arranged screening appointment time and location in invitation letters, an approach some other OECD countries have found successful (Box 3.2), either in the first screening invitation or in a follow up to persons who have not responded to the first invitation.

Additionally, including additional information in languages other than Latvian, alongside the invitation letter which is legally required to be sent in Latvian, would help accessibility for the large population who are not native speakers of Latvian.

Box 3.6. Increasing response rates to breast cancer screening invitations using pre-arranged appointments

In countries including Denmark, Finland, Germany, Ireland, Italy, the Netherlands, Spain, Sweden and the United Kingdom, mammography screening invitation letters include a fixed appointment date (OECD, 2019[42]). In these countries women in the breast cancer screening target group received a letter, or a follow up letter after a first missed appointment, with a pre-arranged date, time and location for screening already filled out. This approach is also consistent with European Commission Initiative on Breast Cancer Guidelines, which recommend that women are invited to breast cancer screening with a letter including a fixed appointment, followed by a phone or written reminder (European Commission Initiative on Breast Cancer, 2019[43]).

A randomised control trial in England found that women who did not attend their first offered appointment and were invited again for breast cancer screening with a letter with a pre-arranged time were nearly twice as likely to attend screening than women in a control group who received an invitation letter with a telephone number to call to book their new screening appointment (Allgood et al., 2017[44]).

3.4.3. Promote chronic disease management through organisational and payment incentives

To improve outcomes for people with chronic diseases in Latvia, who represent a significant proportion of the overall disease burden, it will be critical to strengthen chronic disease management. This should include coordinated and proactive interventions for people identified as at-risk of chronic diseases, for example pre-diabetic patients, comprehensive support for disease management and self-management for controlled chronic diseases, and high responsiveness in the event of disease complications. Improving chronic disease management should also be seen as a way of improving efficiency. Timely interventions in the pre-disease period can stop the progress of a condition and reduce a patient's need for care. Effective chronic condition management can reduce complications which can be very costly, both in terms of more intensive specialist support including hospital stays, and increased disability which can take people out of the workforce earlier in their life course.

Latvia can look to strengthen chronic disease management in a three-step process, that could be pursued simultaneously or incrementally depending on capacity, and whether it is possible to undertake some pilot projects in the country:

- Development of clinical guidelines or disease management pathways;
- Development of chronic care management programmes led by dedicated multi-disciplinary teams;
- Development of bundled payments for chronic conditions.

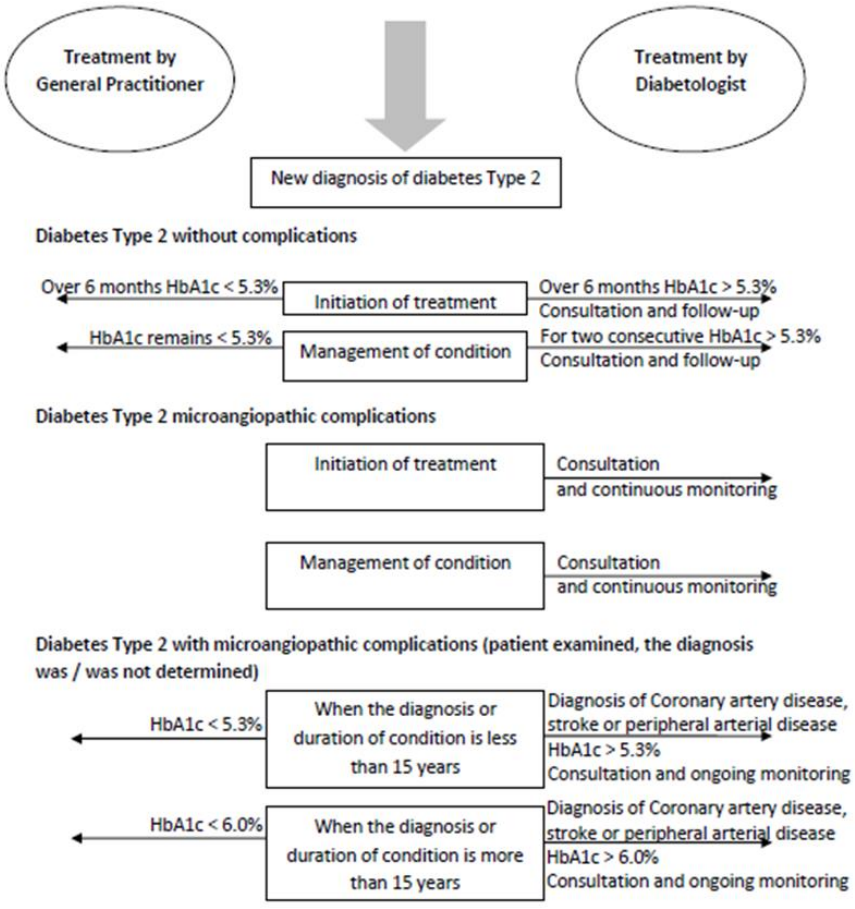
Development of clinical guidelines or disease management pathways

Chronic disease management pathways, or clinical guidelines, should be available for all high prevalence chronic diseases, to give guidance to health care providers and patients over expectations of the care that should be delivered and received. Latvia introduced a disease pathway for cardiovascular disease in 2019, and a diabetes pathway in 2020 (National Health Service, 2020[32]). This represents a very positive step towards developing best practice guidelines for chronic disease care. For the moment these pathways are focused on information for General Practitioners, but could be expanded to integrate other care providers (for example specialists, or patient-support groups), and be produced in a patient-facing format.

Chronic disease pathways, which could be produced in both patient-facing and clinician-facing formats, should clearly establish the professional responsibilities of health professionals at different stages of disease. These pathways can be used to set quality expectations for chronic diseases such as diabetes and cardiovascular disease, and standardise quality of care across Latvia. The pathways can also be used to clarify expected roles for different care providers. For example, it does not seem necessary that stable diabetes patients regularly see specialist endocrinologists, but rather they could be managed by GPs.

A simple care pathway for diabetes, from the Czech Republic, can be found in Figure 3.12. Other countries, for example England (Figure 3.13) have developed more complex pathways which include expectations at different stages of the disease, the roles for different care providers, key interventions and target outcomes. England's 'NHS RightCare Pathway: Diabetes' includes, for example, an expectation that care planning and an annual review take place for patients with both Type 1 and Type 2 diabetes, and the Pathway includes links to supportive documentation to help with care planning. In England, the expectation is that a lot of diabetes care is provided by multidisciplinary teams in community care settings, and the Pathway includes details of the services that the team would usually provide (patient education, pregnancy advice, foot protection team).

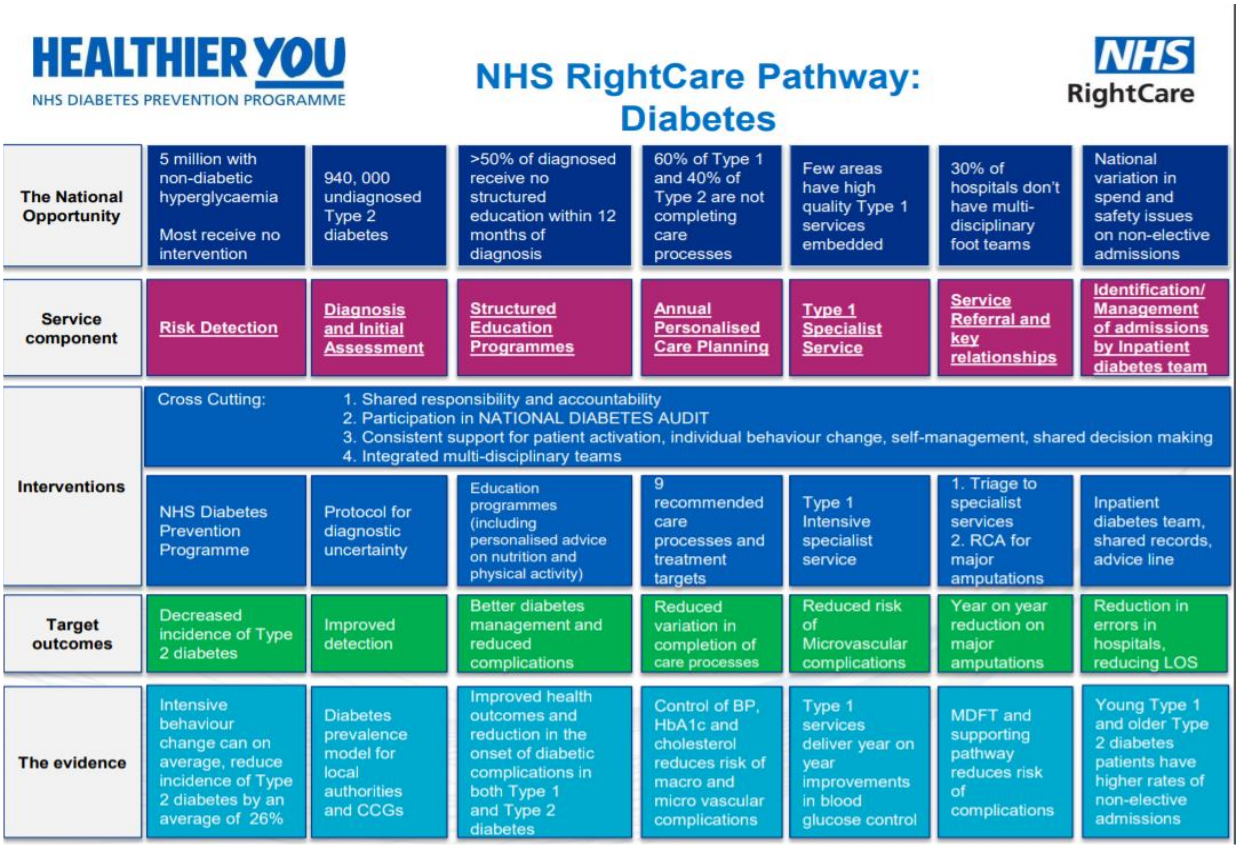
Figure 3.12. The Czech Republic – care pathway for patient with type 2 diabetes



Source: Adapted from the Czech Ministry of Health, published in OECD (2014[45]), *OECD Reviews of Health Care Quality: the Czech Republic 2014: Raising Standards*, https://dx.doi.org/10.1787/9789264208605-en.

Figure 3.13. Diabetes pathway in England – NHS RightCare Pathway: Diabetes, summary table

England's diabetes pathway defines the core components of an optimal diabetes service for people with or at risk of developing Type 1 and Type 2 diabetes, assessed to delivers the better value in terms of outcomes and cost



Source: NHS England (2018[46]), *NHS RightCare Pathway: Diabetes,* https://www.england.nhs.uk/rightcare/products/pathways/diabetes-pathway/.

Having established clear chronic disease management pathways, there is a need to ensure that other levers within the system are effectively aligned with the pathway. This includes aligning payment and reimbursement incentives, as well as ensuring that health professionals have the tools and capacities they need to undertake the responsibilities expected of them. For example, when it comes to diabetes, more limits on frequency of specialist visits, or limits to reimbursement for visits without a referral, could be introduced. At the same time, GPs would need to have the capacity to take on the main responsibility for diabetes management especially for stabilised patients, including ensuring the capacity to do blood sugar testing in all practices, and prescribing a full range of therapeutic pharmaceuticals.

Development of chronic care management programmes led by dedicated multi-disciplinary teams

Disease management programmes (DMP) have long been a recognised best practice approach for chronic diseases (Box 3.7). Chronic conditions are frequently complex to manage, at risk of a range of complications, and such programmes can offer comprehensive care to patients tailored to their disease. For example, a disease management programme for diabetes could offer diet and exercise support to help patients control their blood glucose levels and reduce their BMI, group sessions focused on education or peer support, and regular scheduled check-ups (Box 3.7).

Box 3.7. Disease Management Programmes (DMP)

Definitions of disease management (programmes) vary substantially. Common features are: (1) an integrated approach to care/coordination of care among providers, including physicians, hospitals, laboratories and pharmacies; (2) patient education; and (3) monitoring/collecting patient outcomes data for the early detection of potential complications. DM programmes do not normally involve general coordination of care. They also not normally include preventive services such as flu vaccination.

Source: (Knai et al., 2014[47])

Disease management programmes have been found to be effective for a range of chronic conditions, including depression, heart failure and diabetes (Knai et al., 2014[47]). A review of systematic reviews or meta analyses found positive impacts of that disease management programmes: for chronic heart disease DMPs contributed to reducing health care use and mortality; DMP for diabetes improved functional status and clinical outcomes and sometimes reduced health care use; for COPD functional status and clinical outcomes were improved along with some reduced health care use; and DMPs for depression improved functional status and clinical outcome, quality of life, and patient satisfaction (Knai et al., 2014[47]).

In Germany, disease management programmes are a primary way of structuring care for people with common and costly chronic conditions, follow a coordinated approach to treatment, following evidence-based guidelines, introduced as a way of improving quality and efficiency and reducing fragmentation in care (Erler, Fullerton and Nolte, 2015[48]; Busse, 2004[49]). German DMPs exist for breast cancer, type 1 and 2 diabetes, coronary heart disease, asthma and COPD. Patients who could be covered by a DMP choose whether to take part, and select a physician (usually their GP) who then acts as the coordinating physician. These DMPs usually include self-management support through an approved education programme, coordination of care between the GP, specialist, and inpatient care as necessary, and decision support using evidence-based guidelines (ibid.). Physicians involved in the DMPs are obliged to have met certain training standards, and attend specific trainings to be able to participate, and a defined set of indicators are used to track the patients within DMPs which allows providers to compare their patient data with that of other practices (ibid). Although there have not been evaluations of all of the DMPs, and some studies have been unable to find evidence of improved medical outcomes, broadly the DMPs have been found to have improved quality of care for chronic diseases (Erler, Fullerton and Nolte, 2015[48]; Szecsenyi et al., 2008[50]; Fuchs et al., 2014[51]). Since their introduction in 2003 DMPs have been linked to a risk compensation scheme, offering health insurance funds an incentive for participation, and enrolment has grown year-on-year.

Development of bundled payments for chronic conditions

Bundled payments for chronic conditions have been introduced in OECD countries to incentivise coordination of care for chronic conditions between providers, or provide a broader set of care (for example education, regular checks, occasional specific checks) for chronic conditions (OECD, 2020[52]; OECD, 2016[53]). Bundled payments can encourage collaboration within and across care settings, contribute to greater standardisation of care for example by requiring adherence to quality criteria, and can strengthen data availability by requiring the collection of monitoring indicators or integration of data systems across care settings, and control overall costs (OECD, 2016[53]). Canada and France have used bundled payments for chronic conditions with some success (Box 3.8)

Box 3.8. Bundled payments for chronic conditions in Australia, and France

Bundled payments are currently used in six OECD countries, and have been found to be effective in improving care quality for chronic conditions. In Canada and France bundled payments have been introduced focusing on improving care, establishing financial incentives for better coordination between providers, and a more wrap-around package of care.

Bundled payments for Comprehensive Care Management in Canada

In Canada, the province of Manitoba, introduced Comprehensive Care Management (CCM) tariffs to physicians in 2017. This is a bundled payment that supports physicians to provide care to patients with complex needs in order to promote continuity, co-ordination and access to care, whilst also making care more comprehensive and patient-centred. The tariffs encourage the use of interprofessional teams and promote preventive care. The overarching objective is to encourage physicians to treat more patients suffering from diabetes, asthma, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), hypertension, and coronary artery disease who typically require longer GP visits and more time to co-ordinate care. Five tariffs became available as of 1 April 2017 to pay eligible physicians for the annual management of primary health care for enrolled patients, and these payments are scaled according to complexity. CCM tariffs also include data requirements that help track the quality of care and registration of patients with complex needs.

Bundled payment for health teams in France

In France, a new five-year pilot programme was launched in 2019 to experiment with bundled payments. The programme, called 'Payment for Health Professional Teams' (*Paiement en Equipe des Profesionnels de Santé (PEPS*), has the objective is to ensure greater care integration, improved patient care pathways, and greater care co-ordination between primary health care and secondary care providers. The bundled payment will substitute the fee-for-service schemes, and will only apply for patients followed by a GP in a multi-professional health care centre (Centres de Santé). The pilot targets diabetes patients and elderly patients (aged 65 years and over), but also includes all patients having a named GP. Bundled payments will eventually be rolled out nationally from 2023 if evaluations show positive results.

Source: OECD (2020[52]), *Realising the Potential of Primary Health Care,* https://dx.doi.org/10.1787/a92adee4-en

3.4.4. Create more capacity in primary care for patient education, disease management, and disease detection

Primary care providers, and specifically General Practitioners, are at the heart of secondary and tertiary prevention in Latvia. While some interventions are managed vertically, for instance breast and cervical cancer screening, and there are a small number of chronic disease cabinets for instance for diabetes, the bulk of screening, disease risk detection, patient contact, and chronic disease management, lies with General Practitioners. To strengthen secondary and tertiary prevention capacity, and impact, Latvia should look to increase capacity in primary care.

However, as previously discussed in this chapter, given that Latvian GPs are broadly agreed to already be significantly time and resource stretched increasing secondary and tertiary prevention activities in primary care would require some further investment of resources in the sector. Should such resources be available, to improve secondary and tertiary prevention the priorities for increasing capacity should be focused on patient education, comprehensive disease management, and, eventually some systematic or opportunistic screening and check-ups to detect disease. Exploring whether there are ways for other health workers –

for instance nurses or pharmacists – to play a role in delivering some of these key prevention activities is a possibility for Latvia to explore (Box 3.9).

Box 3.9. Changing workforce skills – a bigger role for nurses and pharmacists in chronic disease management

Nurses and pharmacists are playing a growing role in supporting chronic disease care, for example leading disease management programmes or clinics, undertaking some disease checks and tests, and providing patient education. There is also some good evidence for these changing workforce roles representing good value-for-money. Research confirms that expanding professional roles or delegating tasks to some primary health care professionals improves efficiency;. nurses or community pharmacists can, for example, help meet patients' clinical needs more effectively and comprehensively, with less use of physician time, and at lower costs (OECD, 2020[52]). In some cases, cost savings are found by shifting tasks to less expensive health workers; some estimations show that up to 77% of preventive care and 47% of chronic care could be effectively delegated to non-physician team members (Shipman and Sinsky, 2013[54]). Extensive evidence suggests that nurses in general practice can help overcome shortages of primary physicians, providing tasks including patient education, co-ordination, prevention advice or drug prescriptions and by working in collaboration with primary health care physicians. A systematic review of more than 60 studies found that advanced nursing roles in primary care contributed to better patient outcomes, greater patient satisfaction and reduced hospitalisation (Matthys, Remmen and Van Bogaert, 2017[55]).

A growing number of OECD countries, including Australia, Belgium, Canada, England, Finland, Italy, Switzerland and the United States, are giving a bigger role to community pharmacists in promotion and prevention activities (OECD, 2020[52]). systematic reviews have also found that community pharmacist-led interventions in chronic disease management can improve clinical outcomes in a wide array of chronic diseases (Newman et al., 2020[56]).

In some OECD countries community pharmacists are engaged in health promotion activities, screening programmes, vaccination and counselling activities. They are allowed to monitor particular clinical parameters and screen for undiagnosed conditions including, for example, cardiovascular risk assessment, colon cancer screening, and some infectious diseases such as HIV and tuberculosis (OECD, 2020[52]). In Switzerland, pharmacists have been taking a leading roll in colorectal screening with the "No to Colorectal Cancer" campaign developed by the Swiss Pharmacy Association. The programme offers a screening service in collaboration with doctors. Pharmacists have to screen patients aged between 50 and 75 who have not had a colonoscopy within ten years. The pharmacist uses a questionnaire to determine a patient's risk of colon cancer. Then either a stool test is performed by the pharmacist, or the pharmacist will refer the patient to a primary health care physician. The pharmacist discusses the results of the stool test and those patients with negative results are scheduled for follow-up screening in two years. Evidence from the Swiss Pharmacy Association shows that within six weeks, the programme detected an estimated 58 cases of cancer and 368 cases of advanced adenoma. Overall, the programme was found cost-neutral, compared to the cost of preventive treatments.

There are fewer examples of community pharmacists playing a key role in chronic disease management. However, systematic reviews which have also found that community pharmacist-led interventions in chronic disease management can improve clinical outcomes in a wide array of chronic diseases (Newman et al., 2020[56]), and some good evidence that when community pharmacists provide patient education and behavioural counselling this can improve medication adherence and therapeutic outcomes in patients with chronic conditions (Mossialos et al., 2015[57]). Italy and Finland have both introduced diabetes programmes led by community pharmacists (OECD, 2020[52]). In Finland, the

"Apteenkkien Diabetesohjelma" programme gives pharmacists a key role in coordinating care and delivering prevention information. Belgium also has a 'pharmacist co-ordinator' role for patients with chronic conditions, launched in 2017, under which the pharmacist is expected to have a global view of all of the patient's medications, to co-ordinate with the primary health care team and assess potential gaps in medication use. The aim is to allow patients with chronic illnesses to better manage their health and to stay autonomous as much as possible, but also to reduce the workload of primary health care physicians. In Italy a national diabetes prevention campaign was launched in 2017, with 5 600 pharmacies and 160 000 patients participating. Among the patients examined, around 3% were found to be diabetic and 9% had a previous diagnosis of diabetes. In addition, 36% of patients were diagnosed with prediabetes, with high risk of developing diabetes within the next ten years.

At Chapter 4 of this report underlines, at present the role of pharmacists as a provider of public health service is sufficiently recognised enough in Latvia. Indeed, the role of the community pharmacist has changed over recent years in most OECD countries. Pharmacists can play a key role in giving advice to patients and supporting them to navigate their health needs, and manage their care. For example, in response to the rising burden of chronic disease and multi-morbidity pharmacists can be called upon to tailor advice to the complex needs of individual patients, while the shift away from hospital care means pharmacists are increasingly providing diverse services, in community pharmacies or as part of integrated health care teams. In Latvia there are clear opportunities for pharmacists to play a different role in the health care system.

3.5. Conclusion

There is clear scope for GPs and primary care nurses to play a more active role in patient education, screening promotion, and disease management, but given the current workforce situation, it seems unlikely that there is sufficient capacity. Secondly, there are some perverse incentives that exist in the system, especially in the area of disease management, which encourage over-use of specialist care. For example, after an initial referral from a GP diabetic patients have free access to endocrinologists, which is reimbursed, even if their condition is stabilised. Given that specialists receive a fee-for-service payment for patient visits, there appears to be a strong incentive to keep seeing patients whose conditions are not particularly complicated, and could be managed by GPs. There are weak clinical guidelines and pathways for the management of diabetes, and other chronic conditions, including over the division of responsibilities between primary and specialist care providers. In addition, there are some unusual restrictions on GP prescribing, notably that GPs are not allowed to initiate prescribing of some key second line diabetes drugs, or anti-retrovirals.

To strengthen Latvia's secondary and tertiary prevention, firstly, there is a clear need for patient and population education focusing on a range of topics, including screening, disease management, use of generics, and antibiotics. GPs and especially nurses in GP practices should take a more active role in this. Second, there appear to be some ways that cancer screening could be strengthened, for example using text message invites, and/or pre-booked appointments for screening included in the invitation letter. Third, there is a need to establish clearer patient pathways and expectations for chronic conditions, for example through more gatekeeping regarding specialist care visits, and aligning the reimbursement schedule accordingly. Finally, to make meaningful improvements in both early disease detection and disease management, there is a need to create more capacity in primary care. Expanding primary care capacity should include expanded roles for nurses and, in particular, pharmacists. Pharmacists should be seen as key public health actors, who could be far more involved in directing care to patients, patient education, and even as care coordinators. At the same time, further resource investment in primary care – the lynchpin of secondary and tertiary prevention in Latvia – is warranted. If this investment were to be made, it would

be appropriate to focus on encouraging more general population health literacy, patient education, and further active disease management for example through chronic disease management programmes.

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4 Effective use of pharmaceuticals

Access to medicines is a fundamental pillar of any functioning health system. In Latvia, the outpatient pharmaceutical sector is well-established and regulated, and while the necessary functions and institutions are in place, patient access remains impaired by high levels of out-of-pocket payments. While this may be attributed, in part, to a low level of public health spending overall, within the pharmaceutical sector there are a number of policy options that would enhance affordable access in the short and medium term, with only modest impact on public budgets. Nonetheless, the current level of public spending on health in general (and on medicines in particular) remains among the lowest within the OECD, and greater public investment in health will be needed to substantially improve affordable and sustainable access to outpatient medicines in the longer term.

4.1. Introduction

Within the context of functioning health systems, essential medicines are those that should be available at all times, in adequate amounts, in the appropriate dosage forms and with assured quality, at prices both the individual and the society can afford (Quick et al., 2002[1]). The importance of access to essential medicines is recognised in the Sustainable Development Goals (SDGs). SDG 3.8 mentions the importance of "access to safe, effective, quality and affordable essential medicines and vaccines for all" as a core component of Universal Health Coverage (UHC) (WHO, 2017[2]).

Ensuring access to essential medicines can make an important contribution towards improving public health. In countries where access is not guaranteed, or where high out-of-pocket payments prevail, patients may forego or postpone filling prescriptions and purchasing medicines, or may be entirely unable to access care for financial reasons (Goldman, Joyce and Zheng, 2007[3]) (Niëns et al., 2010[4]). This can lead to more rapid progression of disease and poorer health outcomes. High out of pocket costs for medications are not limited to low- and middle-income countries, but have also been identified in some high-income countries in Europe, particularly in relation to the treatment of chronic diseases (Arsenijevic et al., 2016[5]).

In Latvia, the pharmaceutical sector has been at the centre of attention in recent years. It is broadly recognised that it has become costly both for patients and the public payer, impairing patient access to needed therapeutics, and generating substantial pressures on public finances. The objective of this chapter is to describe and analyse the current landscape of the pharmaceutical sector in Latvia and to propose policy options to address the ongoing challenges.

The chapter begins by describing the organisation of the Latvian pharmaceutical system, the institutions involved, and the general regulatory arrangements. It then describes how, despite a solid legal and organisational framework, the outpatient pharmaceutical sector presents significant issues of concern in Latvia. Discrepancies between current levels of medicines consumption and the epidemiological profile of the population have been observed, and despite increasing expenditure on medicines, Latvians face substantial difficulties in accessing needed medicines. Finally, the chapter outlines some policy options for enhancing patient access and providing better financial protection from the costs of ill health, while at the same time improving the efficiency of public spending on medicines.

4.2. General organisation of the Latvian pharmaceutical sector

The legislation and policies governing the pharmaceutical sector are well defined in Latvia. The pharmaceutical department of the Ministry of Health, the State Agency of Medicines (SAM) of Latvia, the National Health Service (NHS) and Health Inspectorate (HI) are the main institutions responsible for the development and implementation of pharmaceutical-related policies.

4.2.1. The State Agency of Medicines is responsible for all regulatory activities

In order for a pharmaceutical product to access the Latvian market, the SAM (or the European Medicines Agency for centrally-authorised products) must first have granted marketing authorisation that allows the medicine to be sold on the Latvian market. According to the Latvian Ministry of Health, as of 2018 4 252 medicines were registered in Latvia.

The SAM is the national regulatory authority for pharmaceutical products and is responsible for assessing the quality, safety and efficacy of human medicines. The SAM issues marketing authorisations, maintains the register of medicines, schedules medicinal products according their access status (prescription or over-the-counter), and is responsible for pharmacovigilance, including the collection of adverse event reports.

It also issues licences to manufacturers and regulates pharmaceutical manufacturing, wholesaling, retailing and importing/exporting activities (Behmane D, 2019[6]).

Since 2019, the SAM has also had responsibility for Health Technology Assessment activities (see Box 4.1). This was previously a responsibility of the NHS, but the function was split in that year and some of the staff were transferred to the SAM. The NHS remains responsible for reimbursement decisions, usually relying on budget impact analysis (see the section below).

Box 4.1. Health Technology Assessment

Health technology assessment (HTA) is a multidisciplinary process that systematically assesses information not only on the clinical benefits, but also on the social, ethical and economic aspects of the use of health technologies and health care interventions. HTA aims to inform policy and decision-making in health care, with a focus on how best to allocate limited resources among health technologies and interventions. It is frequently used to determine the relative value-for-money provided by a new medicine compared to existing treatment options in order to prioritise the use of efficient and effective health technologies.

Many countries have established HTA systems to inform decision-making, but the extent to which HTA is used for coverage decisions varies. While some countries systematically apply HTA to all new medicines (e.g. Denmark, France and Poland), others only assess those causing particular concerns due to, for example, uncertain effectiveness, high prices or high budget impact (e.g. the United Kingdom).

In Latvia, HTA is undertaken for each drug proposed for reimbursement. The effectiveness of the new drug is compared with already reimbursed drugs or other reference products. Cost-effectiveness analysis and budget impact analysis are also part of the HTA process, but no explicit incremental cost-effectiveness ratio (ICER) threshold has been defined. The evaluation work is shared between the SAM and the NHS.

Source: Silins and Szkultecka (2017[7]) *Drug Policy in Latvia*. WHO Regional Office for Europe (2018[8]), "Can people afford to pay for healthcare? New evidence on financial protection in Latvia".

4.2.2. Reimbursement decisions are the responsibility of the NHS

The NHS is the responsible institution for decisions regarding the reimbursement of pharmaceuticals and the inclusion of products in the positive list (see Box 4.2). To have a product included in the positive list, a pharmaceutical company must submit an application to the NHS containing the opinion of the SAM, together with an assessment of comparative effectiveness and cost-effectiveness of the medicine for the intended patient group (see Box 4.3).

Box 4.2. Positive lists for reimbursement of medicines

A positive list, to which new medicines are added for reimbursement if they fulfil predefined criteria, is the main instrument used by most countries to manage their medicines benefit packages. Medicines included in a positive list may be dispensed at the full or partial expense of a third-party payer.

Some countries employ more than one positive list (Croatia, Slovenia), usually corresponding to different levels of reimbursement. Others have a single positive list that may be divided into different parts according to the different reimbursement and/or prescribing rules that apply.

Similar to the majority of EU countries, Latvia uses a positive list to define the basket of medicines publicly covered.

Source: WHO Regional Office for Europe (2018[9]), "Medicines Reimbursement policies in Europe".

Regulation No. 899 (on the Reimbursement of Expenditures for Medicinal Products and Medicinal Devices) determines the conditions for the reimbursement of outpatient medicines. The NHS evaluates applications on the basis of the information provided by companies and the results of HTA evaluations conducted by the SAM. It eventually makes a decision for or against the inclusion of a medicine in the positive list.

Clinical factors that are weighed in the evaluation include the burden of disease and the therapeutic value of the medicine. Economic criteria include the results of cost-effectiveness analyses and the expected budget impact of the reimbursement decision for public finances. The basis for the evaluation is the common Baltic guidelines for economic evaluation of pharmaceuticals (see Box 4.3), which, with minor changes, have been adapted to each of the Baltic states' national legislation.

Box 4.3. Common Baltic guidelines for economic evaluation of pharmaceuticals

The common Baltic guidelines for economic evaluation of pharmaceuticals are a result of the very close collaboration the Baltic states have developed over years. Other examples include the joint procurement of vaccines under the Baltic Partnership Agreement.

While there are many scientific and methodologic guidelines available to support the economic evaluation of medicines, they cannot be generalised to every country, as economic circumstances and health care system structures may differ substantially. However, as the Baltic states share similar social and economic conditions, the three countries agreed to utilise pharmaco-economic analyses (including cost-effectiveness and budget impact analyses) to inform drug reimbursement and other state funding decisions.

The common Baltic Guidelines for Economic Evaluation of Pharmaceuticals provide the basis for the pharmaco-economic analyses submitted as part of each application to include a new drug in the positive list for reimbursement. They are intended for use by all the institutions undertaking HTA activities in the Baltic States.

Using common principles facilitates co-operation between state institutions in the evaluation of applications and simplifies the application process for marketing authorisation holders.

Source: Mitenbergs et al. (2012[10]), "Latvia: Health system review".

4.2.3. The positive list is divided into four categories

The list of publicly covered outpatient pharmaceuticals consists of four parts.

- List A includes groups and sub-groups of interchangeable pharmaceutical products, for which the NHS reimburses at a single "reference" price. The groups may consist of products containing the same active ingredient, or groups of products within the same class considered therapeutically substitutable (e.g. 'statins', angiotensin II receptor antagonists).

- List B consists of reimbursed products that cannot be substituted or interchanged.
- List C contains high unit-cost pharmaceutical products with annual treatment costs exceeding EUR 4 300. The number of patients to be treated with list C medicines is defined on an annual basis. Prescription of a medicine included in list C must be requested by a group of specialists and is approved by the NHS on an individual basis.
- List M contains pharmaceutical products for pregnant women, women up to 70 days post partum and children under 24 months.

Lists A and B comprise 1 727 products (corresponding to 424 different molecules or combinations of molecules) and list C comprises 33 (corresponding to a similar number of molecules). The limited numbers of products in lists B and C largely reflect budget constraints.

Medicines included in the positive list are also classified into one of three reimbursement categories (100%, 75%, and 50%, see Table 4.1). The reimbursement category depends on the indications for which a particular medicine has been approved (i.e. disease-specific eligibility, see Box 4.4) (Silins and Szkultecka-Dębek, 2017[7]).

As of 1 April 2020, retail pharmacies dispense the product with the lowest price (i.e. the reference price for the group). Where a patient refuses the medicine offered by the pharmacy and requests a different product within the reference group, the medicine is no longer eligible for reimbursement and the patient must pay the full price for *all* the medicines on the same prescription (see next section). In addition, a prescription fee of EUR 0.71 per item applies to any medicine reimbursed at 100% (with exemptions for selected patient groups, e.g. children and asylum seekers).

Table 4.1. Reimbursement categories for outpatient medicines

Reimbursement category	Criteria	Examples
Category I (100% reimbursement)*	Full reimbursement of the reference price of medicines treating chronic, life-threatening diseases or a disease that results in a severe, irreversible disability, and the treatment of which requires the use of the respective medicinal products to maintain the patient's vital functions.	Cancers, diabetes, inflammatory bowel disease, HIV, etc.
Category II (75% reimbursement)	Reimbursement of 75% of the reference price of medicines for chronic diseases, the treatment of which without the administration of the respective medicinal products would complicate the maintenance of the patient's vital functions, or a disease that results in a severe disability.	Parkinson's diseases, depression, hypertension, chronic ischaemic heart disease, stroke, heart failure, asthma, etc.
Category III (50% reimbursement)	Reimbursement of 50% of the reference price of medicines for chronic or acute diseases, the treatment of which requires administration of the medicinal product to maintain or improve the patient's health condition.	Osteoporosis, gastric ulcer, COPD, lipoprotein metabolic disorders, etc.

Note: *the three reimbursement categories apply to disease categories, not to drugs. This means that a same drug may be reimbursed at different levels, depending on the pathology it is intended to treat. * A prescription fee of EUR 0.71 per item applies to medicines reimbursed at 100%.*
Source: Silins and Szkultecka-Dębek (2017[7]), "Drug Policy in Latvia".

Prices for medicines in list A are updated quarterly (1 January, 1 April, 1 July and 1 October) by the NHS. Other changes to the lists of reimbursed medicines are made by the NHS on the first day of each month.

Box 4.4. Eligibility for coverage by third-party payers

Four arrangements can be described regarding eligibility for reimbursement.

- **Product-specific eligibility:** A medicine is considered either reimbursable (its expenses are fully or partially paid for by a third-party payer) or non-reimbursable. The competent authority for pharmaceutical reimbursement or a third-party payer determines the reimbursement status of each medicine. The majority of European countries rely on such scheme (France, Spain, Italy, etc.).
- **Disease-specific eligibility**: In this approach, the reimbursement status and the reimbursement rate of a medicine are linked to the disease to be treated. The same medicine may be reimbursed at different rates depending on the patient's disease. Disease-specific reimbursement for outpatient medicines is the main scheme in Latvia and the other Baltic States as well as in Malta. Some other countries such as France use it as a supplementary scheme.
- **Population group-specific eligibility**: Under this scheme, specific population groups are eligible for pharmaceutical reimbursement at 100%, or at a higher rate than the standard reimbursement rate. Eligible population groups may be based on conditions (e.g. chronic or infectious diseases, disability, pregnancy), age (e.g. children, the elderly), status (e.g. pensioners, war veterans) or means (e.g. people on low incomes, unemployed). Population group-specific reimbursement is a key scheme in, for example, Cyprus and Ireland. Several European countries, including Latvia, have adopted elements of the population group-specific eligibility approach to complement other key programs.
- **Consumption-based eligibility**: With this approach, reimbursement coverage increases with increasing pharmaceutical consumption, as measured by an insured patient's gross pharmaceutical expenditure within a specified time period (usually a year). Once a patient has reached a defined threshold of out-of-pocket payment (the so called "safety net"), the third-party payer fully or partially covers any additional pharmaceutical expenses incurred by the patient within the remaining time period. Consumption-based eligibility schemes protect patients that require more pharmaceutical care (such as the chronically ill) from excessive out-of-pocket payments. Consumption-based reimbursement in the outpatient sector is the predominant approach used in Denmark and Sweden.

In disease-specific reimbursement schemes, as currently in place in Latvia, the same medicine may be reimbursed at different levels depending on the patient's condition. For example, a medicine treating asthma and COPD may either be reimbursed at 75% or 50% depending on the diagnosis. Latvia also reports some population group-specific eligibility, as some groups (e.g. asylum seekers, children under 18) benefit from a complete waiver of medicine co-payments.

Source: WHO Regional Office for Europe (2018[9]), "Medicines Reimbursement policies in Europe".

4.2.4. Prices are regulated at all levels of the distribution chain

Pricing policies are defined as "regulations and processes used by government authorities to set the price of medicines or to exercise price control" (Vogler and Zimmermann, 2016[11]). They are closely linked to reimbursement policies where a third-party payer covers the cost of the medicine. The price of a medicine is the sum of three elements: the ex-factory (or manufacturer's) price (i.e. the price at which the manufacturer sells it), the distribution margins or mark-ups (wholesale and retail) and any taxes (e.g. VAT). Price regulation can be applied at any step of the distribution chain, for example through control of manufacturers' prices or through the regulation of distribution margins and mark-ups. In Latvia prices are fully regulated for reimbursed medicines but only partially regulated for non-reimbursed products.

For medicines not included in the positive list the principles for the determination of prices are defined in Regulation N 803 "Regulation on pricing principles for medicinal products". For these products, only the distribution chain margins are regulated, which means that for each non-reimbursed medicine the

pharmacy prices are the same in any community pharmacy throughout the country. The regulation of the margins for non-reimbursed medicines is organised as follows:

- The wholesale price is calculated by multiplying the price declared by the manufacturer by a percentage margin and adding an additional fixed margin and the VAT (see Table 4.2). The percentage and fixed margins are defined in the regulation and depend only on the price declared by the manufacturer.
- The price at which a pharmacy sells a non-reimbursed medicine is determined by multiplying the procurement price (either the ex-factory or wholesaler's price without VAT) with a percentage margin and adding a fixed margin and the VAT (see Table 4.3).

Marketing authorization holders declare ex-factory prices to the SAM twice a year (or when prices are changed or a new product is placed on the market). The retail prices are then calculated and published on the agency's website for consumers and other interested parties.

Table 4.2. Levels of margins applied for the calculation of wholesaler's prices of non-reimbursed medicines in 2020

Manufacturer's price (EUR)	Percentage margins	Fixed margin (EUR)
0 – 4.26	18%	-
4.27 – 14.22	15%	0.13
14.23 and over	10%	0.84

Source: Republic of Latvia (2005[12]), Regulation of Cabinet of Ministers No. 803, 2005.

Table 4.3. Levels of margins applied for the calculation of pharmacy prices of non-reimbursed medicines in 2020

Procurement price (EUR)	Percentage margins	Fixed margin (EUR)
up to 1.41	40%	0.00
1.42 – 2.84	35%	0.07
2.85 – 4.26	30%	0.21
4.27 – 7.10	25%	0.43
7.11 – 14.22	20%	0.78
14.23 – 28.45	15%	1.49
28.46 and over	10%	2.92

Source: Republic of Latvia (2005[12]), Regulation of Cabinet of Ministers No. 803, 2005.

For medicines in the positive list, manufacturers' prices are negotiated between the NHS and the market authorization holder and distribution margins are defined in Regulation N°899 on "Procedures for reimbursement of expenses toward the purchase of medicinal products and medical devices for the outpatient care".

Manufacturers' prices are indirectly regulated by virtue of cost-effectiveness evaluations, and in parallel through external price referencing (EPR, see Box 4.5). Comparator countries are the Czech Republic, Denmark, Estonia, Lithuania, Poland, Romania, the Slovak Republic and Hungary. The manufacturer's price of a reimbursable medicinal product may not exceed that of the third lowest manufacturer price of

the same medicinal product in the reference countries, and may also not exceed the manufacturer price in Estonia and Lithuania.

Box 4.5. External Price Referencing (EPR)

External Price Referencing is a key pricing mechanism often applied in the outpatient sector. It is the practice of using the prices of a medicine in one or more countries to derive a benchmark or reference price. This reference price can then be used to set or negotiate the price of the product in a given country.

Several countries (including Austria, Belgium, Estonia and Romania) apply external price referencing as a starting-point to set the list price for some medicines (typically new on-patent medicines). A second step involves negotiations between the third-party payer and the pharmaceutical manufacturer on the specific reimbursement price and conditions.

Source: WHO Regional Office for Europe (2018[9]), "Medicines Reimbursement policies in Europe".

After manufacturer's prices are set, distribution margins for reimbursable medicines are also defined:

- Wholesaler price is calculated by adding the wholesale margin to the ex-manufacturer's price. Wholesalers' margins are defined in Table 4.4.
- The pharmacy retail price is defined by multiplying the wholesaler price with a percentage margin and by adding to it a fixed margin and the VAT. Margins for reimbursable medicines are presented in Table 4.5.

VAT for general goods is set at 21% but is 12% for both reimbursed and non-reimbursed medicines. Reduced rates of VAT for medicines are common in the EU, but at 12% Latvia's rate remains higher than in several countries, e.g. 2.1% in France, 5% in Lithuania and Hungary.

Table 4.4. Levels of wholesaler margins for reimbursable medicines in 2020

Manufacturer's price (euro)	Percentage margins
0.01 – 2.83	10%
2.84 – 5.68	9%
5.69 – 11.37	7%
11.38 – 21.33	6%
21.34 – 28.44	5%
28.45 – 142.27	4%
142.28 – 711.42	3%
711.43 – 1 422.86	2%
1 422.87 and more	1%

Source: Republic of Latvia (2006[13]), Regulations No 899 on "Outpatient Treatments And Medicines For The Purchase Of Medical Equipment For The Refund Order".

Table 4.5. Levels of margins applied for the calculation of pharmacy prices of reimbursed medicines in 2020

Wholesaler price (in euros)	Percentage margins	Fixed margin (euros)
0.01 – 1.41	30%	0.00
1.42 – 2.83	25%	0.07
2.84 – 4.25	20%	0.21
4.26 – 7.10	17%	0.43
7.11 – 14.21	15%	0.57
14.22 – 21.33	10%	1.28
21.34 – 28.44	7%	1.92
28.45 – 71.13	5%	2.49
71.14 and more	0%	6.05

Source: Republic of Latvia (2006[13]), Regulations No 899 on "Outpatient Treatments And Medicines For The Purchase Of Medical Equipment For The Refund Order".

4.2.5. The pharmaceutical retail sector is quite concentrated

There are 86 wholesale companies in Latvia, albeit with the top ten accounting for 80% of the total market. This is a very high number for a rather small country like Latvia (just as a comparison, Australia has only three wholesale companies) and limits possible economies of scale. In the retail sector, pharmaceutical services may only be provided by municipal pharmacies (which are public entities), or by private community pharmacies operating under government licence. For private pharmacies, the law requires that at least 50% of the shares must be owned by a certified pharmacist, or at least half the board must consist of certified pharmacists.

The retail sector is quite concentrated, with a high degree of horizontal integration. Horizontal integration refers to a situation where a single person (or corporation) owns more than one community pharmacy. It may allow economies of scale, but it can also lead to limited competition and even monopolies when the same person or entity controls a significant share of the market through one or several chains of community pharmacies (WHO Regional Office for Europe, 2019[14]; OECD, 2014[15]). Based on information shared by the Ministry of Health, the Latvian pharmaceutical retail market is currently dominated by five chains, which represent 69% of the total market and account for a total value of around EUR 255 million. Only 20% of community pharmacies are owned by pharmacists, the rest belonging to one of the chains operating in the country. This situation is the consequence of changes to the regulation of community pharmacies introduced in 2010 which gave non-pharmacists the right to own pharmacies, and thus created the potential for large consortia to be established. It is also worth noting that only a limited public health role is devolved to pharmacists (see below).

4.3. Despite a solid legal framework, the outpatient pharmaceutical sector in Latvia has significant flaws

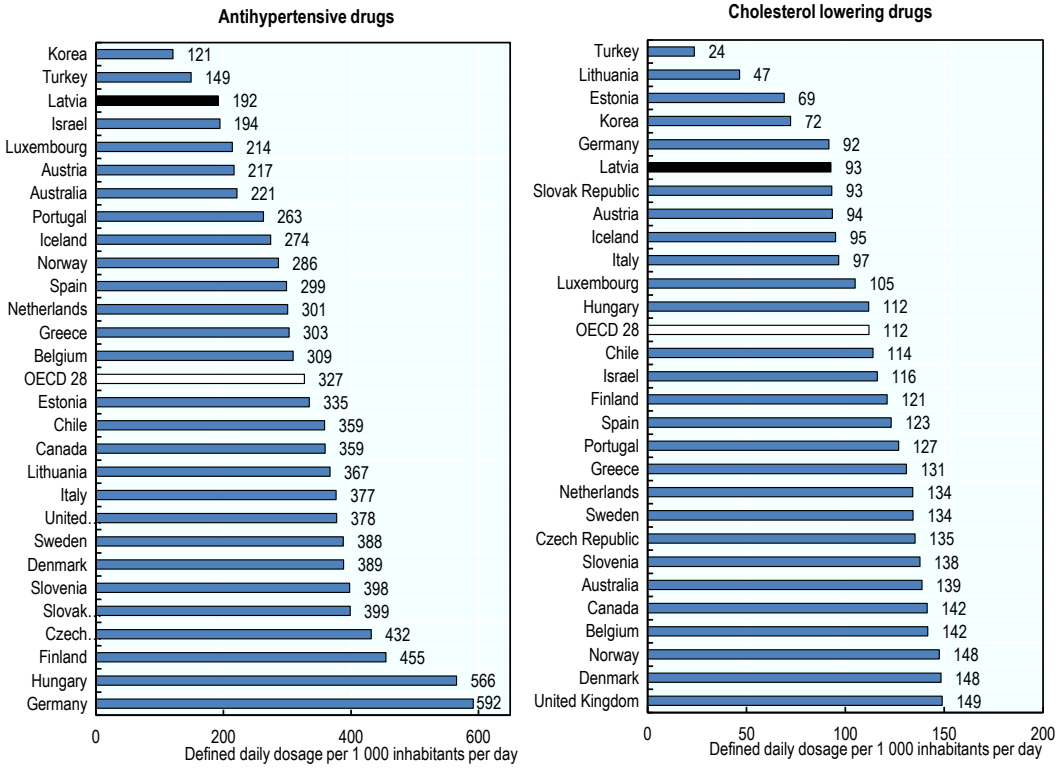
Despite the existence of a comprehensive and well-established legal and organisational framework, access to outpatient medicines remains sub-optimal in Latvia. There are significant inconsistencies between the levels of utilisation of certain medicines and those that may be expected given the epidemiological profile of the population. There are also important access issues for patients. These are driven by a number of factors:

- Despite medicines representing a growing share of the health system's budget, the magnitude of overall public expenditure on health is low, limiting the number of medicines publicly covered and requiring high out-of-pocket payments;
- As a result, the current reimbursement system is not adequately protecting patients (and particularly vulnerable populations) from the costs of ill-health;
- Widespread misconceptions around generic medicines give rise to significant inefficiencies; and
- The extent of horizontal integration in the retail pharmaceutical sector limits competition.

4.3.1. Pharmaceutical consumption in Latvia is not commensurate with the burden of disease

Latvia has the third highest level of treatable mortality in the EU, with more than half of it attributable to cardiovascular diseases (OECD/European Observatory on Health Systems and Policies, 2019[16]). Pharmacotherapies play a key role in both primary and secondary prevention of such chronic diseases (Wald and Law, 2003[17]; Law, Wald and Rudnicka, 2003[18]; Law et al., 2003[19]).

Figure 4.1. Antihypertensive (left panel) and cholesterol lowering (right panel) drugs consumption, 2019 (or nearest year)



Note: data on the left panel refer to the sum of the following classes: C02-antihypertensives, C03-diuretics, C07-beta blocking agents, C08-calcium channel blockers, C09-agents acting on the renin-angiotensin system. For the right panel data refer to class C10-lipid modifying agents.
Source: OECD (2020[20]), *OECD Health Statistics* (database), https://stats.oecd.org/Index.aspx?ThemeTreeId=9.

Despite this situation, cardiovascular drug consumption levels are among the lowest in the OECD. Consumption of antihypertensive drugs in Latvia, is particularly low (192 Defined Daily Doses per 1 000

inhabitants per day, see Box 4.6 and Figure 4.1) given the burden of cardiovascular diseases in the country but also in comparison with levels of consumption across the OECD (327 on average) and in the other Baltic States (335 in Estonia, 367 in Lithuania). Similarly, the use of cholesterol-lowering agents is low in Latvia (93 DDDs per 1 000 inhabitants per day), almost 20% below the OECD average (Figure 4.1).

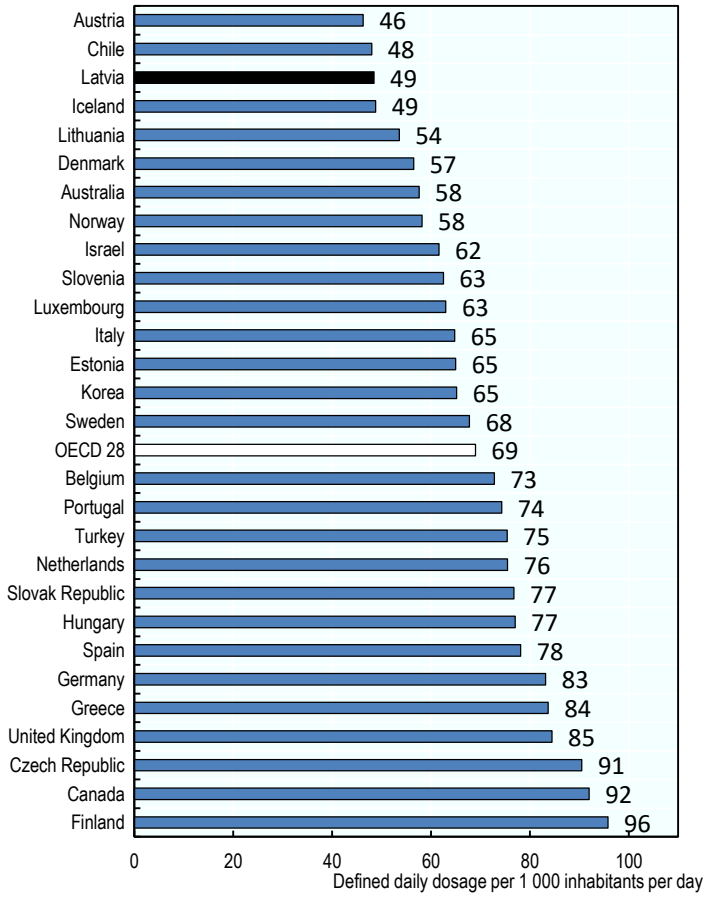
Box 4.6. Defined Daily Dose

The defined daily dose (DDD) is the assumed average maintenance dose per day for a drug used for its main indication in adults. DDDs are assigned to each active ingredient in a given therapeutic class by international expert consensus. For example, the DDD for atorvastatin is 20mg, which is the assumed maintenance daily dose to treat pain in adults. DDDs do not necessarily reflect the average daily dose actually used in a given country.

Source: OECD (2019[21]), *Health at a Glance 2019: OECD Indicators*, https://doi.org/10.1787/4dd50c09-en.

Diabetes is the fifth cause of death in Latvia and the mortality rate from this condition has increased by 50% between 2000 and 2016. The country also reports some of the highest mortality rates from this condition in the EU (OECD/European Observatory on Health Systems and Policies, 2019[16]). Yet, the use of anti-diabetic drugs in Latvia is among the lowest reported in the OECD (Figure 4.2). At 49 DDDs per 1 000 inhabitants per day it is nearly one-third below the OECD average (69 DDDs per 1 000 inhabitants per day).

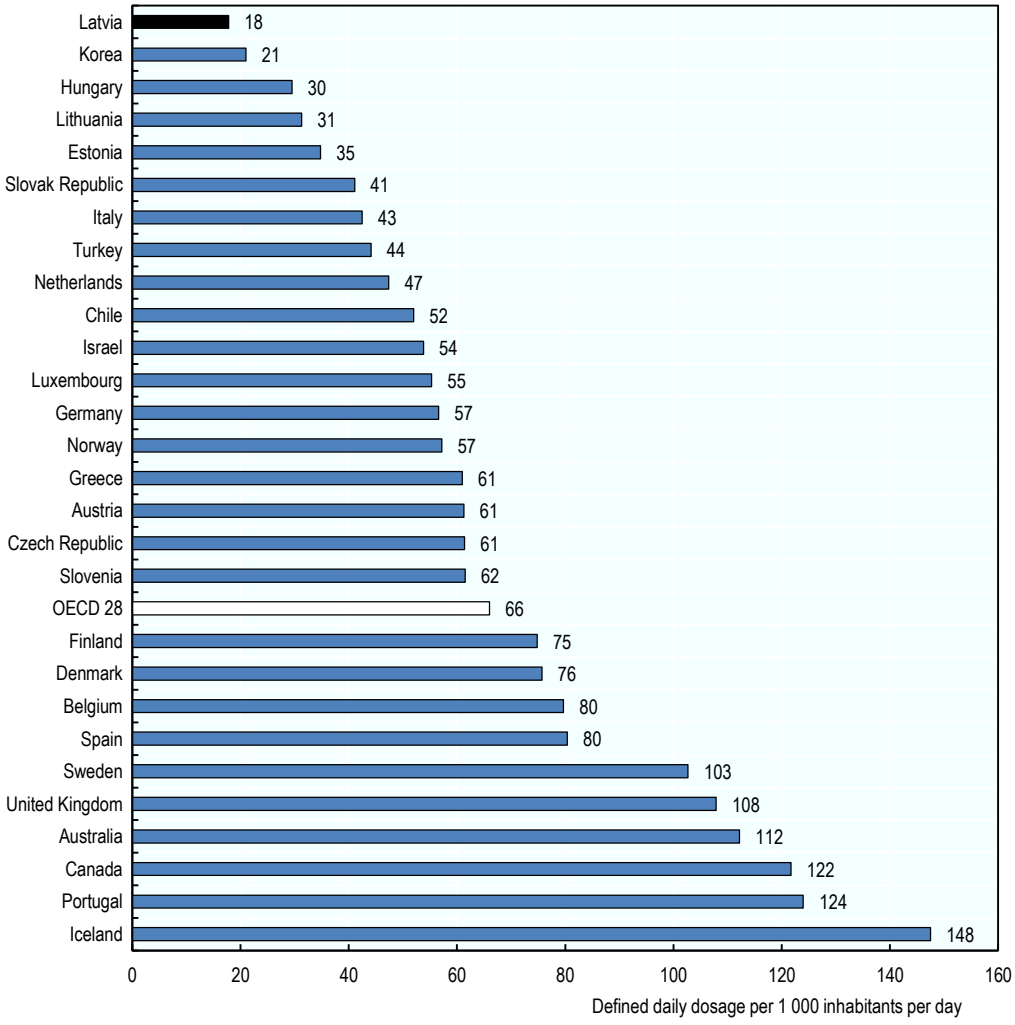
Figure 4.2. Oral antidiabetic drugs consumption, 2019 (or nearest year)



Note: Data refer to class A10.
Source: OECD (2020[20]), *OECD Health Statistics* (database), https://stats.oecd.org/Index.aspx?ThemeTreeId=9.

Mental health is also a major public health issue in Latvia. The country reports the second highest mortality rate from suicide in the EU (after Lithuania) and the fourth in OECD countries, with more than 18 deaths per 100 000 population in 2016 (OECD, 2019[21]). This is well above the OECD average (almost 12 per 100 000 inhabitants). Despite this, the level of anti-depressant consumption in Latvia is the lowest reported, 18 DDDs per 1 000 inhabitants per day, only one-quarter of the OECD average and just over half of what is reported in Lithuania (Figure 4.3).

Figure 4.3. Antidepressant drugs consumption, 2019 (or nearest year)



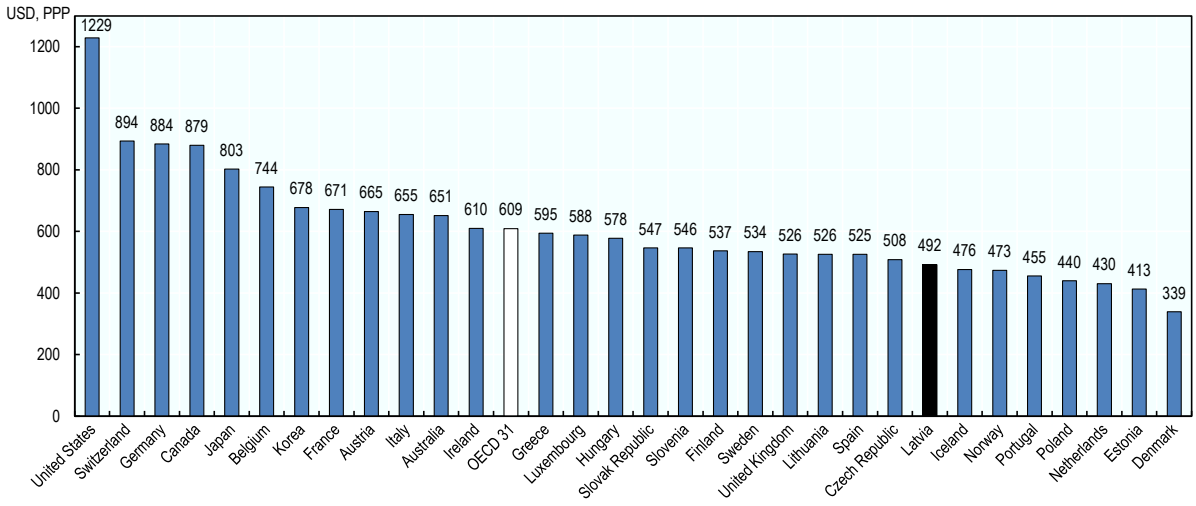
Note: Data refer to class N06A-antidepressants.
Source: OECD (2020[20]), *OECD Health Statistics* (database), https://stats.oecd.org/Index.aspx?ThemeTreeId=9.

Analyses of the consumption figures of major groups of medicines in Latvia clearly show significant discrepancies with the actual burden of disease. This may be attributable in part to differences in medical practice or clinical guidelines, but is more likely to reflect financial and potentially other limitations in access to outpatient medicines for a substantial proportion of the population.

4.3.2. Spending on pharmaceuticals is low but represents a growing share of the health system's budget

The low levels of medicines consumption in Latvia are linked to the low level of spending on medicines. In 2018, Latvia spent USD PPP 492 per capita on medicines (EUR 412, adjusted for purchasing power parity), among the lowest levels in the OECD (Figure 4.4).

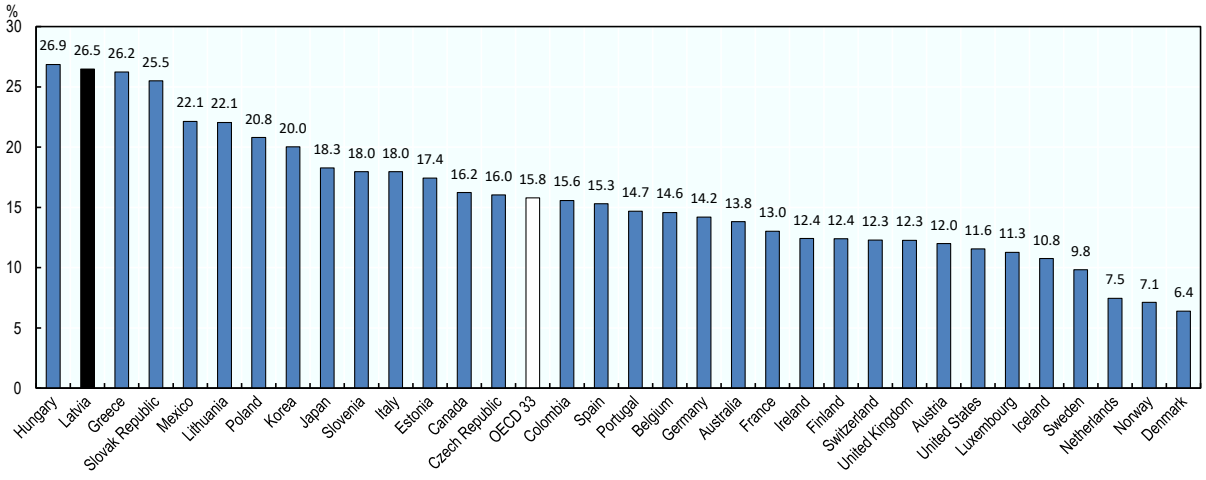
Figure 4.4. Total spending on retail pharmaceuticals in USD per capita, 2018



Note: values are adjusted for Purchasing Power Parity.
Source: OECD (2020[20]), *OECD Health Statistics* (database), https://stats.oecd.org/Index.aspx?ThemeTreeId=9.

After inpatient and outpatient care, pharmaceuticals (excluding those used in hospitals) usually represent the third largest item of health care spending, accounting for 16% of health expenditure on average in OECD countries. Considering that demand for medicines is quite price inelastic, it is logical to expect that in countries with a smaller health care budget in absolute terms, pharma will absorb a more important share of their overall health budget. This explains in part why in Latvia outpatient medicines account for 27% of current expenditure in health (Figure 4.5), the second highest level in OECD countries after Hungary.

Figure 4.5. Retail pharmaceutical expenditure as a percentage of current expenditure on health, 2018

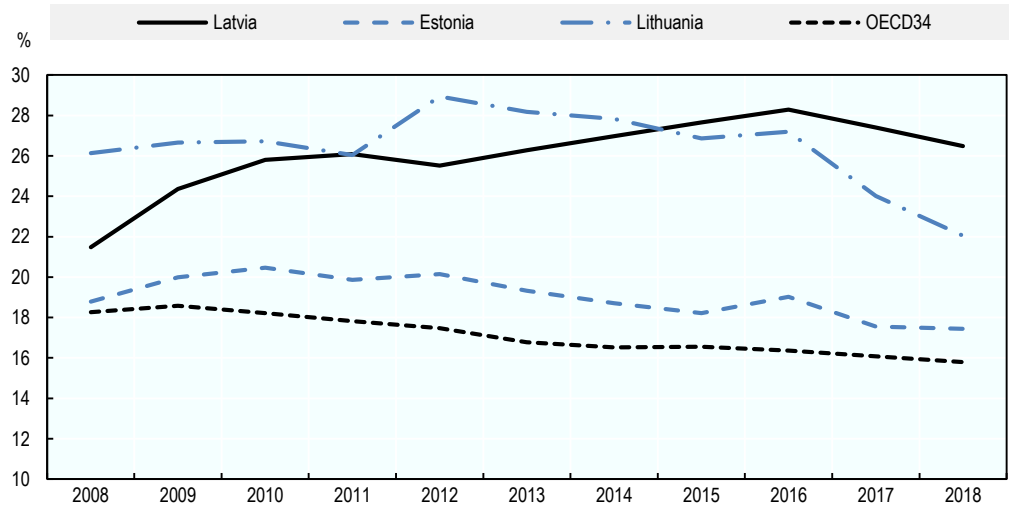


Source: OECD (2020[20]), *OECD Health Statistics* (database), https://stats.oecd.org/Index.aspx?ThemeTreeId=9.

Over the past ten years, pharmaceuticals have represented a growing share of health expenditure in Latvia, accounting for 21% in 2008 and reaching 27% in 2017. This steady increase is striking when

compared to the situation in the two other Baltic States, where the proportion of health expenditure on pharmaceuticals decreased or remained stable over the same period (Figure 4.6).

Figure 4.6. Evolution of retail pharmaceutical expenditure as a percentage of current expenditure on health

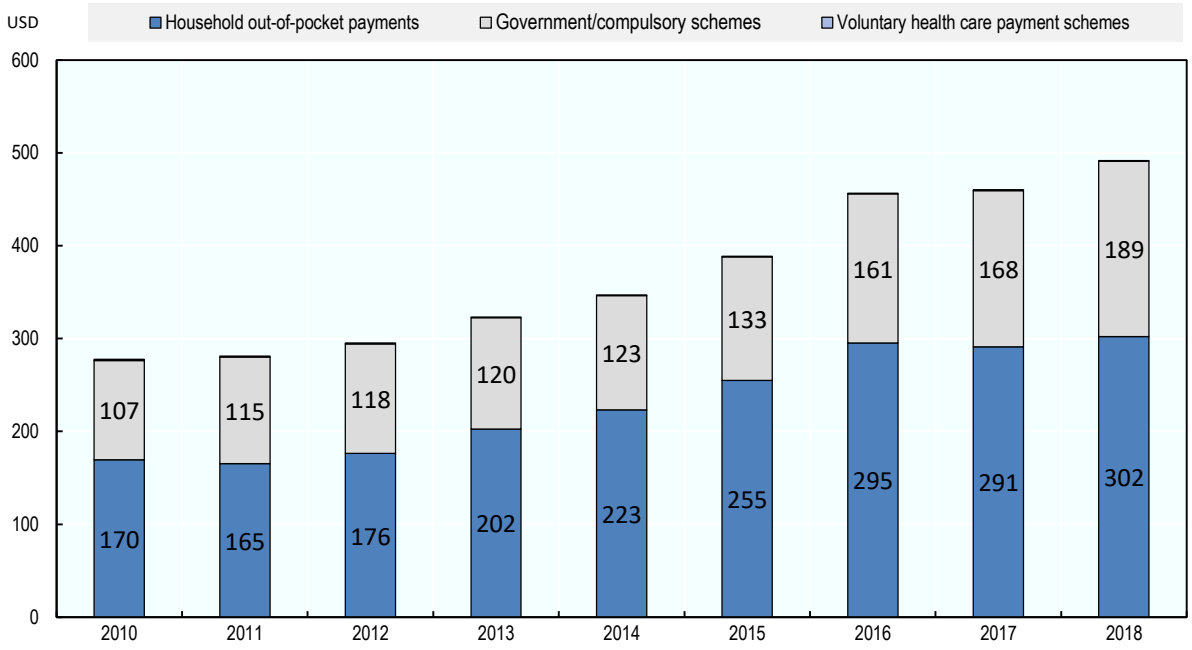


Source: OECD (2020[20]), *OECD Health Statistics* (database), https://stats.oecd.org/Index.aspx?ThemeTreeId=9.

4.3.3. High out-of-pocket payments on outpatient medicines constitute a major barrier in access to care

As shown in Figure 4.7, public expenditure on pharmaceuticals has increased at a slower pace than the overall growth in pharmaceutical spending, meaning that the proportion borne by patients increased over years. Out-of-pocket expenditure on pharmaceuticals accounted for 59% of total expenditure on medicines in 2011 (USD 165, EUR 176) and peaked at 65% (USD 255, EUR 213) in 2015.

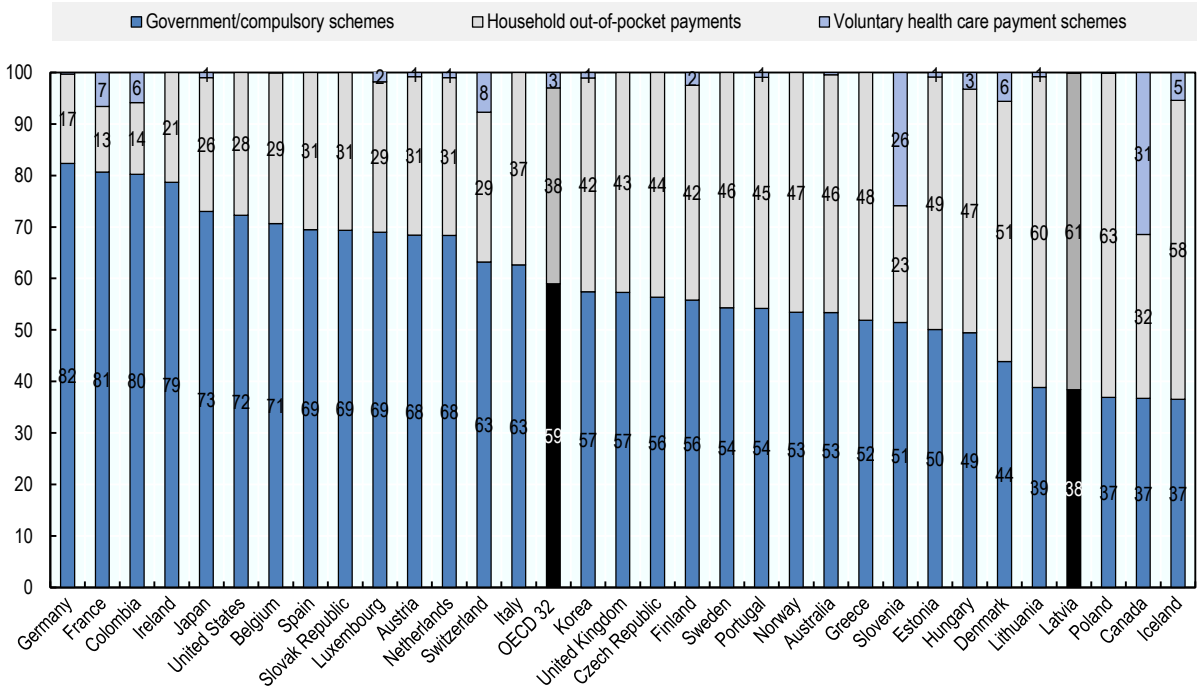
Figure 4.7. Expenditure on retail pharmaceuticals by type of financing in Latvia, USD per capita



Note: contribution from voluntary health care payment schemes is marginal in Latvia and accounts for roughly USD 1 per capita each year.
Source: OECD (2020[20]), *OECD Health Statistics* (database), https://stats.oecd.org/Index.aspx?ThemeTreeId=9.

Across OECD countries, government programs and compulsory insurance schemes play the largest roles in pharmaceutical funding. On average, these mechanisms cover 59% of spending on pharmaceuticals. By contrast, in Latvia more than 60% of pharmaceutical spending is out-of-pocket payment, one of the highest proportions reported, and only 38% is publicly covered (Figure 4.8). This means that in Latvia the majority of the expenditure on retail pharmaceuticals is currently borne by patients themselves.

Figure 4.8. Expenditure on retail pharmaceuticals[1] by type of financing, 2018 (or nearest year)

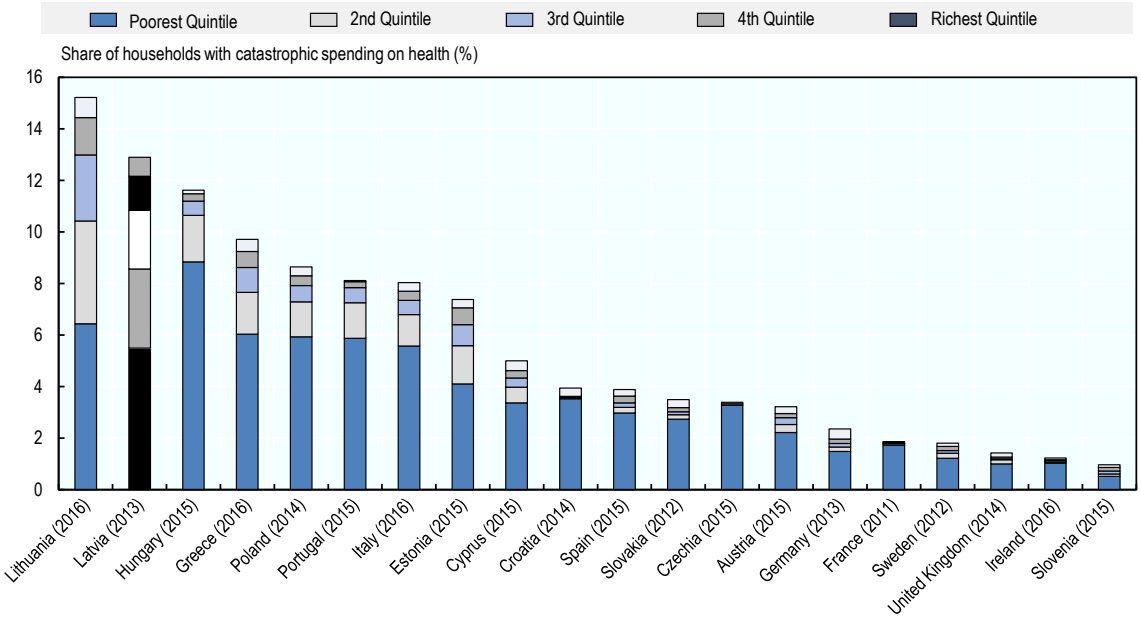


Source: OECD (2020[20]), *OECD Health Statistics* (database), https://stats.oecd.org/Index.aspx?ThemeTreeId=9.

Financial barriers in access to care are a frequently reported issue in Latvia. 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%. 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) (OECD/European Observatory on Health Systems and Policies, 2019[16]).

Difficulties in accessing care are closely related to the high levels of out-of-pocket spending in Latvia, reaching 39% of total health expenditure in 2018 (the second highest level in the EU) (OECD/European Observatory on Health Systems and Policies, 2019[16]). Such high levels of direct payments by patients are responsible for the high incidence of catastrophic health spending in Latvia. In 2013, almost 13% of the Latvian population experienced catastrophic health spending (see Box 4.7 and Figure 4.9), 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 heavily concentrated among the poorest quintile of the population. Importantly, in all quintiles catastrophic spending was almost exclusively due to the costs of outpatient medicines. Outpatient medicines accounted for about 70% of all catastrophic out-of-pocket payments, rising to around 80% for the poorest quintiles (WHO Regional Office for Europe, 2018[8]).

Figure 4.9. Share of households with catastrophic spending on health by consumption quintile, latest year available



Source: WHO Regional Office for Europe (2018[8]), "Can people afford to pay for healthcare? New evidence on financial protection in Latvia".

Box 4.7. Catastrophic out-of-pocket expenditure

Also referred to as catastrophic spending on health, it is an indicator of inadequacy of financial protection and is defined as out-of-pocket expenditure exceeding 40% of a household's capacity to pay for health care.

Catastrophic health spending includes:

- Households that are impoverished: A household is considered impoverished if its total consumption was above the national or international poverty line or basic needs line before out-of-pocket payments and falls below the line after out-of-pocket payments.
- Households that are further impoverished: A household is further impoverished if its total consumption is below the national or international poverty line or a basic needs line before out-of-pocket payments and if it then incurs out-of-pocket payments.

Source: WHO Regional Office for Europe (2018[8]), "Can people afford to pay for healthcare? New evidence on financial protection in Latvia".

Access to outpatient medicines accounts for half the total out-of-pocket payments reported by Latvian households. Several studies have shown that financial barriers to accessing necessary medicines are strongly correlated not only with poorer health outcomes but also increased use and cost of other health services (Goldman, Joyce and Zheng, 2007[3]; Kesselheim et al., 2015[22]). In the case of Latvia, the high levels of out-of-pocket payment on pharmaceuticals are related to the limited size of the public budget for health (government and compulsory health insurance schemes represent only 57% of the current expenditure on health as opposed to 79% in the EU on average) (OECD/European Observatory on Health Systems and Policies, 2019[16]) but also to the general arrangements of the reimbursement system.

Outpatient medicines are a key source of financial hardship because of the reliance on patient out-of-pocket payments (in this case, in the form of co-insurance, which is rather regressive[1]), the existence of a prescription fee, the exclusion of medicines from the annual cap on out-of-pocket payments and the rather limited size of the positive list (see below). In addition, the reimbursement system is structured around a reference price for each molecule, which creates the possibility of extra financial burden for patients (as they may have to paying an extra co-payment if the cheapest alternative is not available or entirely out of pocket if they choose not to accept it). The Ministry of Health estimates that in 2017, EUR 25 million were paid by patients because they were not provided with (or did not choose) the cheapest available alternative of a prescribed reimbursed medicine.

In order to improve access to outpatient medicines, in July 2019 the Latvian Government approved amendments to regulations on the reimbursement of medicines. The objective 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 are enforced:

- The external reference pricing system will be revised and the basket of reference countries changed.
- A price ceiling for medicines subject to reference pricing will be introduced (the most expensive alternative will have to be less than double the price of the cheapest one).
- At least 70% of a doctor's yearly prescriptions must be by International Non-proprietary Name (INN, see Box 4.8), which should improve the dispensing by pharmacists of least priced alternatives.
- For medicines subject to internal reference pricing, it will be mandatory for pharmacies to keep stocks of the cheapest alternative.

Box 4.8 INN (International Non-proprietary Name) prescribing

INN prescribing refers to the requirement for prescribers to specify each medicine using its International Non-proprietary Name (INN) – i.e. the active ingredient name instead of the brand name – on a prescription. This enables the pharmacist to provide the patient with differently-priced alternatives for the same multi-source drug.

INN prescribing may be allowed (indicative INN prescribing in, for example, Germany, Ireland, Hungary) or required (mandatory/obligatory INN prescribing in, for example, France, Estonia, Lithuania, Italy).

Source: WHO Regional Office for Europe (2018[9]), "Medicines Reimbursement policies in Europe".

Another policy that partially explaining the high level of out-of-pocket payments for pharmaceuticals is the exclusion of outpatient medicines from the general cap on user charges. User charges per person per year for all publicly financed health services, except outpatient medicines, are capped at EUR 569 per year. This is a relatively large amount in Latvia, equal to one and a half month's minimum wage, and is unlikely to offer protection for poorer households. Only a few population groups are exempt from cost-sharing for outpatient medicines: e.g. households with an income below EUR 128 per family member per month, asylum seekers, and patients under 18. While there is no overall cap on out-of-pocket payments for outpatient medicines or for other health services in the other Baltic states, reforms introduced in recent years in both Estonia and Lithuania have reduced the financial burden related to outpatient medicines, see Box 4.11 (WHO Regional Office for Europe, 2018[8]).

The size and content of the positive list may also contribute to the high levels of out-of-pocket costs for medicines. Of the 4 252 products registered in Latvia, 1 760 (41%) are at least partially reimbursed by the NHS (i.e. products that are part of one of the reimbursement lists). However, some core essential medicines such as aspirin (anticoagulant), glibenclamide (anti-diabetic), penicillin and erythromycin (antibiotics) are currently not among the reimbursed products. The WHO Model List of Essential Medicines (World Health Organization, 2019[23]) serves as a guide for the development of national and institutional essential medicine lists and is updated and revised every two years by the WHO Expert Committee on Selection and Use of Medicines. The latest edition details the 433 drugs deemed essential for addressing the most important public health needs globally. A high-level comparison with the list of molecules reimbursed by the Latvian NHS reveals that only 165 of 433 (40%) of the molecules currently reimbursed in Latvia are also part of the WHO Model List. This figure implies two things: first, that some important medicines are not covered by the NHS (some of them are mentioned in the previous paragraph); second, that at the same time the NHS reimburses a large number of medicines molecules that do not necessarily constitute a priority. One example is fixed-dose combinations, which may reflect inefficient spending as they can often be more expensive than the aggregate costs of the constituent products[2] (Hong, Wang and Tang, 2013[24]; Sacks et al., 2018[25]).

Overall, the current reimbursement system for outpatient medicines in Latvia does not provide adequate protection against the costs of ill-health. The co-insurance rate of 25% or 50% for many medicines (100% where the reference product is declined) associated with a reimbursement amount calculated on a reference price, disproportionately affects patients suffering from chronic diseases and those with conditions requiring more expensive medicines. Comprehensive exemption arrangements for co-payments on reimbursed outpatient medicines are also missing. While targeted exemption from co-payments applies to some population groups such as children under 18 years, vulnerable groups such as pensioners or patients suffering from chronic conditions do not receive any form of protection against the financial burden of the costs of their medicines.

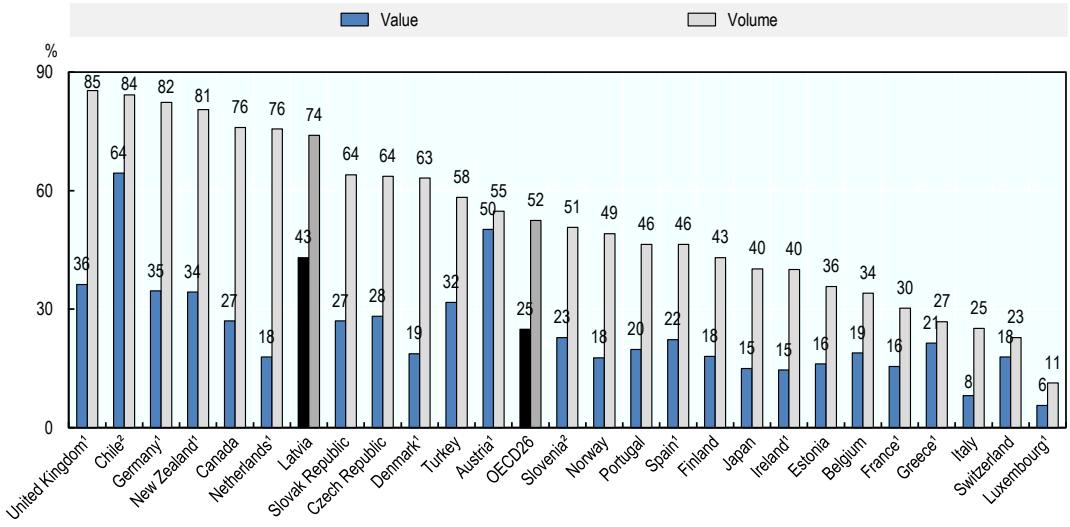
Improving access to needed therapeutics in Latvia requires a major review of the reimbursement system, including an examination of how reimbursement decisions are made and motivated, but also an increase in the funds available, through both additional public investment and disbursement of savings achieved through improved efficiency.

4.3.4. Expenditure on pharmaceuticals is not very efficient

Many countries view generic and biosimilar markets as an opportunity to increase efficiency in pharmaceutical spending. In Latvia, the first prescription of a reimbursed medicine must in theory include its International Non-proprietary Name (INN), and for multi-source medicines, pharmacists are obliged to propose to patients the cheapest versions of the medicines prescribed. In addition, pharmacists are allowed to substitute pharmaceutical products prescribed by brand name with generics unless the prescribing doctor has expressly stated otherwise.

In Latvia, the market penetration of generic medicines is quite substantial. Generics represent 74% of the market by volume (see Figure 4.10), one of the highest levels in the OECD, and some 20 percentage points above the OECD average. In terms of value, generic medicines account for 43% of the total pharmaceutical market. This level is also high when compared with countries with similar levels of generic penetration by volume (Canada, the Netherlands) and may reflect higher prices of generics relative to other medicines (off-patent originators and on-patent medicines).

Figure 4.10. Share of generics in the total pharmaceutical market, 2017 (or nearest year)



Note: 1. Reimbursed pharmaceutical market. 2. Community pharmacy market.
Source: OECD (2020[20]), *OECD Health Statistics* (database), https://stats.oecd.org/Index.aspx?ThemeTreeId=9.

Despite the level of generic penetration, distrust in generic medicines is frequently reported among prescribers and patients in Latvia, which may limit further efficiency gains. Indeed, people's preferences are an important obstacle in implementing effective generic policy. Several studies report that a high proportion of patients tend to believe that generic medicines are of lower quality and less effective than originator medicines, and as a result may feel negatively about policies promoting their utilisation (Colgan et al., 2015[26]). A recent study conducted in Latvia estimated that only 21% of the population would opt for generic medicines and that the opinion of a physician was the most important factor when choosing between generic and brand-name medicines (Salmane Kulikovska et al., 2019[27]). Such distrust towards generics may partly explain why, as previously noted, patients paid EUR 25 million out-of-pocket in addition to the statutory user charges in 2017, by choosing a more expensive alternative than the reference priced product. It is therefore important that both the authorities and health care professionals provide objective and unbiased information about generic medicines to patients to increase their acceptance.

Latvia should also do more to increase spending efficiency with generics. Many countries have implemented incentives for physicians and pharmacists to boost generic markets, which can lead to price reductions. Over the last decade, France and Hungary, for example, have introduced incentives for GPs to prescribe generics through pay-for-performance schemes. In Switzerland, pharmacists receive a fee for generic substitution; in France, pharmacies receive bonuses if their substitution rates are high, see Box 4.12 (OECD, 2019[21]). In Latvia, there are currently no financial incentives for doctors to prescribe more generics nor for pharmacists to dispense cheaper alternatives (since margins are the same for all the products, generics and originators). Possible options to consider are discussed in the next section but could for example include the introduction of incentives related to generic prescribing as part of general practitioners' pay-for-performance program; the creation of a specific distribution margin system for generics for pharmacists or the application of a fixed retail distribution margin or mark-up for generics (i.e. an absolute value) at the same level as, or even higher than that of the originators. Indeed, current retail margins, which are linked to wholesale prices, make the selling of cheaper alternatives unattractive to pharmacists.

Facilitating the market entry and inclusion in the positive list of biosimilars could also lead to substantial savings on costly medicines. Biological medicines contain active substances from a biological source, such

as living cells or organisms. When such medicines no longer have monopoly protection, “copies” (called biosimilars) of these products can be approved. Biosimilars can create price competition and improve affordability. A biosimilar is granted regulatory approval by demonstrating sufficient similarity to its reference biological product in terms of quality characteristics, biological activity, safety and efficacy. In Latvia, the potential of biosimilars has not been fully realised. Indeed, regulatory arrangements dictate that an off-patent medicine may only be added to the positive list if the originator is already reimbursed. In the case of biosimilars, some originators are very expensive biological medicines that the authorities may have decided not to add to the reimbursement list for financial reasons, thus blocking the inclusion of any subsequent biosimilar version despite a more affordable price. Changing such arrangements could allow the introduction of biosimilars of reference products not yet reimbursed, which would improve patients’ access (see Box 4.9). Biosimilar uptake could be further increased using other incentives commonly in place in other countries (incentives for prescribers, substitution by pharmacists, etc.).

Box 4.9. Biosimilars increase price competition and foster patient access

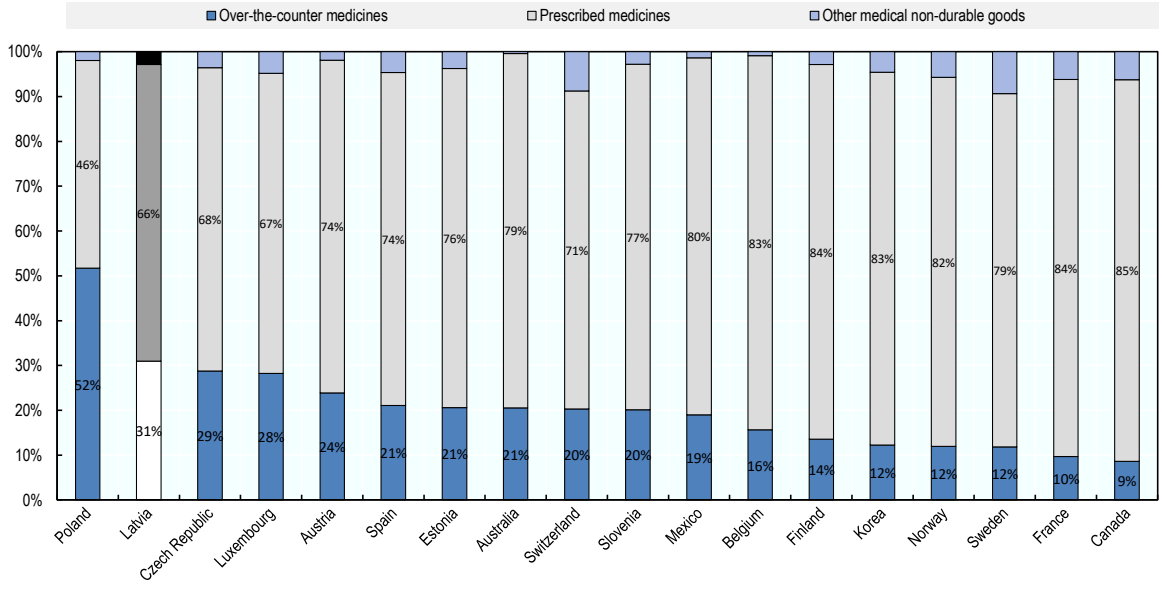
The effects of biosimilar introduction on the concerned therapeutic areas has been evidenced in the literature. In the seven therapeutic areas with biosimilar competition, average list prices in European countries have reduced since the introduction of these products (e.g. -17% for anti-tumour necrosis factor, -6% for insulins). In addition, the correlation between biosimilar volume market share and price reduction is weak. In other words, substantial savings can be achieved even when the market share of the biosimilar remains low.

Lower prices can reduce pharmaceutical expenditure but can also foster patients’ access. For most concerned therapeutic classes, there has usually been a greater increase in consumption since biosimilar entry in countries that had low starting volumes. In classes where biosimilars have been on the European market for several years (e.g. erythropoietin), there are now many examples of countries where biosimilars account for 100% of the market share for some products. This is particularly true in countries where the reference product was not always available prior to the market entry of the biosimilar(s) (e.g. Slovakia, Hungary, Romania, Poland), meaning that access to the biologic was only possible once biosimilars entered the market.

Source: QuintilesIMS (2017[28]), “The Impact of Biosimilar Competition in Europe”, www.quintilesims.com.

Finally, it is also important to note that in Latvia roughly one-third of all pharmaceutical expenditure goes to over-the-counter medicines (Figure 4.11). The extent of use of non-prescription medicines is among the highest reported in OECD countries and further contributes to the high levels of out-of-pocket expenditure. One possible contributing factor may be the overall structure of the retail sector, where a very competitive environment may be encouraging community pharmacies to push sales to increase income. Clearly further investigation of this issue is warranted.

Figure 4.11. Retail pharmaceutical spending by type of product, 2018



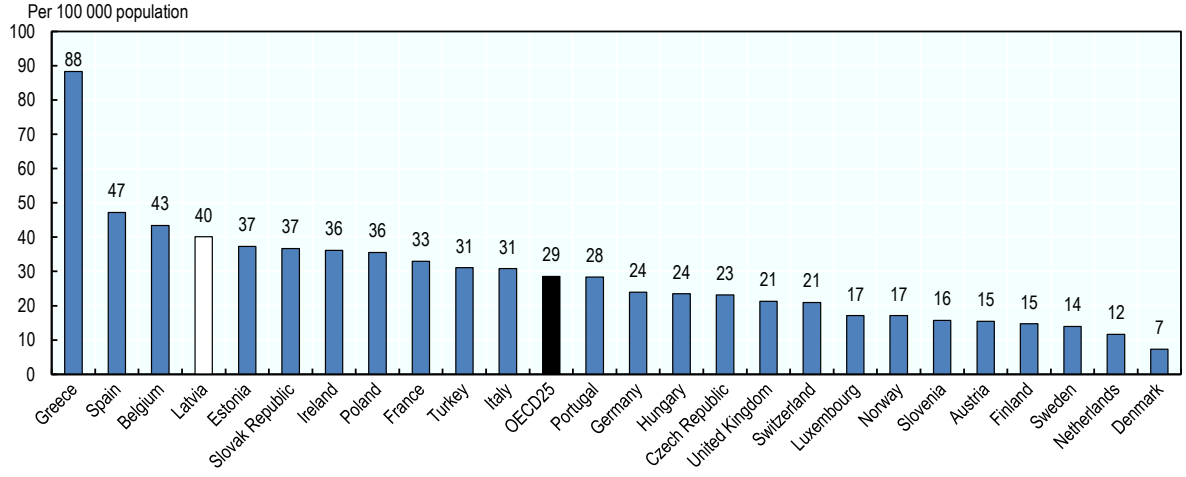
Note: share of retail pharmaceutical spending by type of product.
Source: OECD (2020[20]), *OECD Health Statistics* (database), https://stats.oecd.org/Index.aspx?ThemeTreeId=9.

4.3.5. The current structure of the community pharmacy sector raises concerns

As previously noted, the retail pharmacy sector in Latvia reflects a high level of horizontal integration. In OECD countries, the number of community pharmacies per 100 000 population ranges from seven in Denmark to 88 in Greece; with an average of 29 (Figure 4.12). This variation can be explained in part by differences in common distribution channels (some countries relying also on hospital pharmacies to dispense medicines to outpatients while others, like the Netherlands, still have doctors dispensing medicines to their patients). Latvia reports 40 community pharmacies per 100 000 inhabitants, the fourth highest rate in the OECD.

Such a high figure may not necessarily be a problem unless the pharmacies are poorly distributed across the country. In fact, the density of pharmacies is extremely high in Riga and in the big urban centres, but much lower in rural areas. In addition, the high urban density of pharmacies may induce an increased degree of competition among them. As a result of an increasing trend towards horizontal and vertical integration in the Latvian retail pharmaceutical sector, many pharmacies are now owned by wholesalers who have an interest in supplying “their” pharmacies with the products they distribute. Financial pressure on pharmacies is high and they tend to carry minimal stocks, and this can impair patient access. A national poll released in August 2020 reported that almost two-thirds of users of state-reimbursed medicines had experienced lack of availability of prescribed reimbursable medicines in retail pharmacies in the preceding months. In 29% of cases, the situation was resolved by purchasing medicines in another pharmacy. Increased competition also encourages pharmacists to sell more over-the-counter medicines and to dispense higher priced alternatives to patients to ensure their financial survival. Overall, the high density of pharmacies in Latvia constitutes an additional factor contributing to patients’ difficulties in access to and affordability of medicines.

Figure 4.12. Community pharmacies, 2017 (or nearest year)



Source: Pharmaceutical Group of the European Union (PGEU) Database 2017 or national sources.

In addition, the role of pharmacists as providers of public health services is not sufficiently recognised or valued in the country. Indeed, the role of the community pharmacist has changed over recent years in most OECD countries. The increasing burdens of chronic disease and multi-morbidity require them to tailor advice to the complex needs of individual patients, while the shift away from hospital care means pharmacists are increasingly providing other services, within community pharmacies or as part of integrated health care teams. Although their main function remains to dispense medications, community pharmacists are increasingly providing direct care to patients as well as medicine adherence support. In Latvia, no specific public health function is currently devolved to pharmacists, despite an expressed willingness to contribute more to the general public health effort. Their contribution could, for example, include more reviews of patients' prescription regimens, vaccination services or monitoring of certain health metrics (e.g. HbA1c).

4.4. Reforming certain features of the Latvian pharmaceutical sector would improve patient access and safeguard public spending

This chapter has described the current situation of the outpatient pharmaceutical market in Latvia. Overall, the pharmaceutical system possesses solid and well-functioning institutions and the regulation of the sector is well-defined. Prices of all medicines are regulated and the reimbursement procedure and management of the positive list rely on objective principles.

However, outpatient medicines not only represent a growing challenge for public finances but at the same time patient access is becoming more and more difficult. Indeed, pharmaceuticals represent more than one-quarter of current health expenditure, but Latvians still bear directly the costs of almost two-thirds of pharmaceutical expenditure.

The current situation can be explained by a conjunction of various elements. First and foremost, the low level of public expenditure on health limits the number of medicines that may be publicly covered. Second, the current reimbursement system is not providing adequate protection for patients (and particularly vulnerable populations) from the costs of ill health. Third, the health system is not optimising the expenditure of current pharmaceutical budgets because some of its features (such as broad misconceptions around generic medicine and prescribing by brand name) lead to substantial inefficiencies.

Finally, the configuration of the retail pharmaceutical market sector gives rise to misaligned competitive behaviours and does not foster access.

The policy options shown below have been developed based on these findings. They are organised around each of the functions of the pharmaceutical sector and are intended to improve patient access to outpatient medicines while at the same time supporting the authorities in their efforts to control the rising costs of this dimension of the health system. They are summarised in Table 4.6 together with the likely financial implications. However, it should be reiterated that increased public investment in health in general, and in pharmaceuticals in particular, is needed. Overall, Latvia spends much less on health per capita and as a share of GDP than most other OECD 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 in access to medicines will remain extremely difficult if the level of resources invested in the system is not increased.

Table 4.6. Overview of the suggested policy actions

		Low or limited financial implications	Substantial financial implications
Increase public investment on outpatient medicines			√
Adjustments to the pricing system	Establish distribution mark-ups more favourable to generic medicines	√	
	Introduce a ceiling to wholesalers' mark-ups	√	
	Disconnect community pharmacy remuneration from the prices of medicines	√	
Revisions of the reimbursement arrangements	Review and revise of reimbursement lists	√	
	Include co-payments on medicines in the calculation of the general cap on out-of-pocket payments		√
	Increase the reimbursement rate of pharmaceuticals included in the lowest reimbursement category		√
	Exempt additional, vulnerable population groups from co-payments on outpatient medicines		√
Efficiency gains on pharmaceutical expenditure	Improve the knowledge and acceptance of generic medicines among both patients and health professionals through public awareness campaigns	√	
	Incentivize physicians to prescribe more generics	√	
	Facilitate the reimbursement of biosimilars		√
	Improve public health responsibilities of community pharmacists	√	

4.4.1. Adjustments to the pricing system should be considered

As mentioned above, the regulation of prices in Latvia is well-established. Manufacturers' prices of reimbursed medicines are controlled through External Price Referencing and the authorities have already initiated a revision of the reference countries, which goes in the right direction since the previous list included countries either not regulating prices (Denmark) and/or having higher GDP per capita (e.g. Czech Republic, Hungary).

However, the control of the distribution margins presents various issues. First, two regulations coexist: one for reimbursed and one for non-reimbursed medicines, without any obvious reasons to justify the dichotomy. Second, for medicines there is no ceiling to wholesalers' mark-ups (see Table 4.4). This arrangement can be extremely costly for the third-party payer and by extension, for patients. Third, there is no difference in the regulation of the distribution margins for generics and originators. A single scale, with margins based on value, necessarily encourages pharmacists to dispense more expensive alternatives to increase their income.

Removing the differences in the regulation of margins between reimbursed and non-reimbursed products and replacing them with a scheme favouring generics can increase generic uptake, which can lead to price reductions. Pharmacists also need to be remunerated in a way that encourages them to dispense the least expensive products. Instead of mark-ups that encourage dispensing of more expensive drugs, fixed fees per prescription or differentiated mark-ups (between originators and generics for instance) could lead pharmacists either to equipoise, or create and incentive to dispense generics, respectively. Some countries recently changed their policies to incentivise pharmacists to dispense generics. In 2012, Portugal changed pharmacists' remuneration from fixed (flat rate regardless of price) to regressive margins (decreasing margins with increasing prices). Other countries have gone even further. In Switzerland and Belgium, for example, pharmacists receive an additional fee for generics substitution. France introduced a pay-for-performance scheme for pharmacists in 2012 with a bonus for achieving generic drug dispensing targets, see Box 4.12 (OECD, 2017[29]).

Introducing a ceiling on wholesalers' mark-ups could contribute to containing public expenditure on pharmaceuticals and reduce patients' out-of-pocket expenditure. Most OECD countries regulate wholesalers' mark-ups, relying either on a regressive scheme (as in Latvia), or on a linear scheme (as in Italy, Spain and Poland). Frequently, countries also limit the maximum possible mark-up for wholesalers; it is capped at EUR 30 in France and EUR 7.54 in Spain. As reported in Table 4.2 and Table 4.4, there is no similar ceiling on wholesalers' margins for non-reimbursed and reimbursed medicines in Latvia.

Disconnecting community pharmacists' remuneration from the price of medicines is also an option for consideration. A substantial number of OECD countries have uncoupled the prices of medicines and the remuneration of community pharmacists. In France, distribution margins comprised 81% of the remuneration of community pharmacists in 2014. In 2019, with the progressive introduction of various dispensing fees, this had declined to 26% (LEEM, 2019[30]). This evolution also limits the impact of price reductions on pharmacy incomes. This is particularly relevant as the determination of medicine prices do not involve pharmacy representatives, although affects their remuneration if it relies on mark-ups. Various countries have introduced prescription fees to complement the mark-up remunerations (e.g. Denmark, France), while others have in some aspects almost entirely disconnected remuneration from mark-ups (e.g. Australia, New-Zealand, see Box 4.10). Uncoupling medicines prices and pharmacy remuneration in Latvia could facilitate better control of pharmaceutical expenditure while safeguarding pharmacy remuneration.

Box 4.10. Remuneration of pharmacists under the Australian Pharmaceutical Benefits Scheme

Remuneration of pharmacists for prescriptions subsidised by the Pharmaceutical Benefits Scheme (PBS) in Australia made up of two elements: dispensing fees and "administration, handling and infrastructure" (AHI) fees.

Dispensing fees for medicines reimbursed by the PBS depend on the nature of medicine concerned (e.g. ready-prepared, dangerous medicine, etc.).

AHI fees were introduced in 2015 to replace the former six-tier pharmacy mark-up. The objective was to partially de-link pharmacy remuneration from the prices of medicines, so that changes in pricing policy would have less impact on pharmacy remuneration.

AHI fees vary according to the listed PBS prices of the medicines. If the price is

- less than AUD 180 (USD 118), the AHI fee is AUD 3.54 per dispensing (USD 2.30);
- between AUD 180 to 2 089.71, the AHI fee is AUD 3.54, plus 3.5% of the amount by which the price to pharmacy exceeds AUD 180 per dispensing;
- more than AUD 2 089.71 (USD 1 365), the AHI fee is AUD 70 per dispensing (USD 46).

Source: Deloitte (2016[31]), *Remuneration and regulation of community pharmacies*.

4.4.2. The reimbursement system needs to be substantially revised

The structure of the reimbursement system is complex, and at times confusing. In particular, the rationale for the use of three levels of reimbursement is difficult to understand and the basis for the allocation to different levels is unclear. For example, a medicine that is reimbursed at 75% for an asthmatic patient may only be reimbursed at 50% for a patient with COPD.

Also, as demonstrated in the previous sections, the current features of the system do not provide adequate financial protection for patients. The range of medicines publicly covered is arguably insufficient, with several essential medicines missing from the reimbursement lists. There is also no cap on co-payments which disproportionately affects vulnerable populations, such as patients with chronic conditions.

Revising the current positive lists (list A; B, C and M) to add some current important therapeutic options not currently covered, specifically those targeting the biggest health issues in Latvia (cardiovascular disease, mental illness, diabetes), would improve patient access. As presented in the previous sections, of the 4 252 products registered in Latvia, 1 760 (41%) are at least partially reimbursed by the NHS (i.e. part of one of the positive lists). A comparison of the reimbursement lists with the WHO Model List of Essential Medicines showed that only 165 of 433 (40%) molecules on the EML were currently reimbursed in Latvia. This implies that some essential medicines are not covered by the NHS and that the NHS provide coverage of many medicines that may not necessarily constitute a priority (such as combination products). A revision of the content of the positive lists would enable better alignment of the benefit package with the burden of disease in the Latvian population. Further clarification of how these lists are reviewed and revised would also be helpful.

In addition, the overall level of out-of-pocket payments on outpatient medicines should be reduced through a combination of the following measures:

- Include co-payments on medicines in the calculation of the general cap on out-of-pocket payments and lower the overall threshold of this cap to enhance the degree of financial protection.

- Consider revising the reimbursement arrangements, starting with an increase in the reimbursement rate of pharmaceuticals included in the lowest reimbursement category (50% of the price of the cheapest alternative is reimbursed); a possible option could be to include all the medicines part of it into the current 75% reimbursement category.
- Designate additional vulnerable populations from co-payments on outpatient medicines (for example, pensioners).

As already reported, several publications have shown that financial barriers to accessing necessary medicines are not only strongly correlated with poorer health outcomes, but also with increased use of and expenditure on other health services. In the case of Latvia, outpatient medicines are the most important source of financial hardship because of the general structure of the reimbursement scheme: the reliance on co-insurance rather than flat co-payments, the existence of a prescription fee, and the exclusion of medicines from the annual cap on out-of-pocket costs. This system disproportionately affects vulnerable populations, such as people on low-incomes and those with chronic conditions. Co-insurance payments – that is, co-payments set as percentage of the price - are inequitable, and shift financial risk from the payment agency to the patient, thereby exposing them to health system inefficiencies. Caps in overall out-of-pocket spending can protect people if they are applied to all patient contributions over time, rather than being focused on specific items or types of service. In the case of Latvia, excluding outpatient medicines from the general calculation of the cap on out-of-pocket payments weakens the protection the cap provides to patients, since the majority of out-of-pocket costs arise from outpatient medicines. The measures suggested above could transform the reimbursement arrangements in ways that would substantially improve the Latvian population's protection from the costs of ill-health. The other Baltic states have made substantial progress on that direction in recent years and their experiences could inform system redesign (see Box 4.11).

Box 4.11. The other Baltic States have implemented successful policies to reduce out-of-pocket payments on medicines

Estonia

All patients in Estonia are required to make a co-payment for their outpatient medicines. Some vulnerable populations (e.g. people on low incomes, pensioners) can get these co-payments reimbursed but until 2018, the complexity of the system frequently prevented eligible people from claiming the reimbursements to which they were entitled. In 2018, the government reformed the system to enhance protection against high out-of-pocket costs. When a patient's spending on prescriptions in one year exceeds EUR 100, the government immediately covers 50% of any further costs until the patient has spent EUR 300 in total, after which the government pays 90% of any subsequent costs. Unlike the preceding system, patients are not required to apply for this benefit and wait to be reimbursed, it is calculated automatically by the pharmacy's information system.

As a result, out-of-pocket payments for prescription medicines have been significantly reduced in Estonia: in 2017, only 3 000 people benefited from additional reimbursement, but this rose to 134 000 in 2018. The number of people spending more than EUR 250 annually on outpatient prescriptions fell from 24 000 in 2017 (2.8% of the population) to 1 000 in 2018 (0.1%).

Lithuania

While there are no formal user charges for primary, outpatient and inpatient care, until recently, patients faced substantial co-payment for outpatient medicines in Lithuania. A number of measures have been taken since 2017 to decrease the level of out-of-pocket payments on pharmaceuticals. These include an increase in the reimbursement levels and caps on the price differences between the prices paid at pharmacy level and the reference reimbursement prices.

As a result, the average co-payment per prescription decreased from EUR 3.4 in 2017 to EUR 2.3 in 2019, and the share of OOP expenditure on reimbursable medicines decreased from 21.2% in 2016 to 6.8% in the first quarter of 2019.

Source: OECD/European Observatory on Health Systems and Policies (2019[16]), *Latvia: Country Health Profile 2019*, https://doi.org/10.1787/b9e65517-en. WHO Regional Office for Europe (2018[33]), Can people afford to pay for healthcare? New evidence on financial protection in Estonia.

4.4.3. While more public investment is required, some efficiency gains could be made

As mentioned above, some efficiency gains could be pursued that would support patient access while at the same time contributing to the control of the public spending on pharmaceuticals. The recent decisions of the authorities to have at least 70% of the prescriptions written using INNs is a step in the right direction, as is the introduction of a ceiling on the prices of reimbursed medicines. However, widespread misconceptions about generic medicines will remain an obstacle to any attempts to increase their uptake.

Improving the knowledge and acceptability of generic medicines among patients and health professionals is necessary. This could be achieved via new information campaigns and further efforts around initial and continuous professional education. Several countries have carried out information campaigns to promote the use of generics, explaining their equivalence and interchangeability with originator medicines (e.g. Belgium, Denmark, France, Greece, Italy, Portugal and Spain). While no formal evaluation is available, these policies, together with patent expiries of several blockbusters in recent years, have

contributed to the significant increases in the market share of generics observed over the past decade in several countries (OECD, 2017[29]).

Physicians also need to be incentivised to prescribe by INN. They can be encouraged to prescribe cheaper products by creating explicit guidelines on the prescription of the cheapest alternative as first-intention medication or nudged by prescription software that highlights price differences for products which are therapeutically equivalent. Financial incentives can also be used to encourage them to prescribe generics. Several countries use financial incentives targeting prescribers. In Belgium, since 2005, physicians who issue at least 400 prescriptions annually are evaluated on whether they prescribe a certain required percentage of “cheap medicines”. The scheme, updated in 2015, has set between 16% and 65% target share of “cheap medicines” across different medical specialities, with an average of 42%. Germany uses similar target levels and has introduced financial penalties for physicians who do not reach them. In recent years, France (in 2009) and Hungary (in 2010) introduced incentives for GPs to prescribe generics through a pay-for-performance (P4P) scheme (see Box 4.12) (OECD, 2017[29]).

Box 4.12. Policies fostering generic uptake have led to substantial savings in France

Over the past two decades, France introduced a comprehensive set of policies to foster the utilisation of generics, which led to substantial savings.

Incentives towards pharmacists:

Three policy options have been introduced to encourage pharmacists to dispense generic medicines in France:

- Since 1999, pharmacies' mark-ups on generic medicines are generally the same as those of the originators (in absolute value).
- A pay-for-performance scheme (*Rémunération sur objectifs de santé Publique*, ROSP) was created, rewarding pharmacists based on the rate of generic substitutions recorded in their pharmacies. For most molecules, the bonus begins at a substitution rate of about 75%, and increases up to a target substitution rate of 85%. In 2013, pharmacies earned an average of EUR 6 000 under the scheme (for a total cost to the national health insurance fund of EUR 135 million).
- Discounts (also known as back margins) granted by pharmaceutical companies to pharmacists are regulated by the State. In order to further encourage generic dispensing, the maximum authorised discounts for generic drugs are higher than those for originators. In addition, since 2014, the gap between generics' and originators' authorised discounts has been increased to up to 40% of the generic list price (against 17% previously) compared with 2.5% for originators.

Incentives towards doctors:

For physicians, measures to increase generic uptake have primarily been targeted at modifying prescribing behaviour:

- Physicians must be able to provide a clinical justification for any prescription for which they decline to permit generic substitution. The Health Insurance Fund can penalize a prescriber who cannot provide a clinical basis for his decision.
- Since 2015, prescription by INN has been mandatory.
- A pay-for-performance scheme (ROSP) also exists for physicians, and represents a substantial share of GP income (roughly 10%). Almost a quarter of the objectives defined of the scheme are aimed at increasing the share of prescriptions dispensed as generics.

Incentives towards patients:

The "third-party payer in exchange for generics" (*tiers-payant contre génériques*) system was implemented in July 2012. Under this system, third-party payment is granted only if a patient agrees to accept a generic instead of the originator (with the exception of those listed as non-substitutable on the prescription form). This means that if a patient still wants the originator, the reimbursement level will be the same as for the generic but the patient will have to pay for the entire prescription upfront and claim reimbursement afterwards instead of having to pay only the co-payment at point of sale.

Results

Together these measures have led to an increase in the utilisation of generics in France. Generics as a proportion of total pharmaceutical consumption increased steadily between 2008 and 2014, from 22% to 33% by value, and from 31% to 46% by volume. The substitution rate for generics also increased between 2008 and 2013, from 69% to 84.5%.

According to the government Audit Office, generic medicines generated savings of EUR 3.3 billion in 2013. These savings, were shared equally by the national health insurance fund and community pharmacies, resulting in net savings of EUR 1.6 billion for the national health insurance fund in 2013, and cumulatively EUR 12.1 billion since 2002.

Source: (French Ministry of Finance, 2017[34]).

Another means of improving the overall efficiency of the Latvian pharmaceutical system would be to facilitate biosimilar entry to the positive list. As described in the previous section, in Latvia, the full potential of biosimilars has not been realised. The regulatory arrangements require that an off-patent medicine can only be added to the positive list if the originator is already reimbursed. In the case of biosimilars, originators are very expensive biological medicines that the authorities may have decided to not cover for financial reasons, thus blocking the inclusion of biosimilar versions in the reimbursement list despite more affordable prices. Changing such arrangements could allow the introduction of biosimilars which would improve patients' access and reduce public spending where the more expensive reference products are already listed (see Box 4.9).

Finally, the role of pharmacists in the health system could be substantially enhanced. In OECD countries, community pharmacists are increasingly recognised as key health professionals delivering important contributions to the well-being of both individuals and communities over and above their role in dispensing medicines. They are often both the first and last point of contact between a patient and the health system. Countries that remunerate pharmacists on a fee for service basis for additional patient services include, among others: Australia, Canada, Denmark, France, Japan, the Netherlands, New Zealand and Spain. In France, the role of pharmacists in prevention has been expanded since 2018. They are now permitted to administer influenza vaccinations to older people and other at-risk groups for whom the vaccine is recommended. They receive a vaccination fee for this activity, paid by the Health Insurance Fund. Since February 2019, they may also dispense medicines for a continuing a treatment regime of at least three months, even when the prescription has expired (e.g. treatments for hypertension and diabetes, contraception) (European Commission, 2019[35]). As new clinical services are adopted, they may be compensated by a fee for service, a fee for performance (such as achieving a generic substitution target) or a capitation fee (WHO Regional Office for Europe, 2019[14]). In Latvia, providing an expanded professional service role for community pharmacists could contribute to better management enhanced health outcomes as well as better management of the pharmaceutical sector.

4.5. Conclusion

This chapter has described the general functions of the Latvian pharmaceutical sector and many of the current issues in the efficient administration and sustainability of it. The system appears to have solid legal and organisational foundations but grapples with the increasing costs of, and demand for outpatient medicines. For patients, the current flaws in the system lead to very high levels of out-of-pocket costs in accessing needed medicines, in turn contributing to high rates of catastrophic spending on health. One of the positive findings of this analysis is that substantial improvements to the system could be made with modest increased cost and effort for the public authorities. However, it is important to reiterate that the overall current level of public spending on health in general (and on medicines in particular) remains among the lowest in OECD countries.

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Notes

[1] Where patient contributions are structured as co-insurance, the amount paid is a fixed percentage of price of the medicine and therefore increases as the price of the medicines increases. This not only means that patient contributions for more expensive medicines are less affordable, but also that patients cannot anticipate in advance what they will be expected to pay at the pharmacy for a given item. This uncertainty also contributes to failure to fill prescriptions. (WHO Regional Office for Europe, 2019[39])

[2] Even if fixed-dose combinations drugs can lead to better adherence and control of the disease compared to the corresponding free-combination of the same molecules, their increased cost may not be offset by the clinical benefits brought in.

OECD Reviews of Public Health

LATVIA

A HEALTHIER TOMORROW

Latvia sees high rates of obesity, smoking and alcohol consumption. In turn, this results in a high incidence of preventable diseases, such as heart disease, diabetes and many cancers. This puts a burden on a health system which is already operating on a very tight budget as compared to other OECD countries. This OECD report shows that Latvia has many of the policies it needs to address these problems in place. However, Latvia needs to go further to ensure the health system can effectively prevent diseases, not just cure them. This will require redesigning policies to reach a larger population and efforts to educate the population to understand how to protect their health. Better screening programmes are needed, as is a stronger primary care sector, and access to essential medicines for all Latvians.

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