



LATVIA

# Country Cancer Profile

2023



European  
Commission



BETTER POLICIES FOR BETTER LIVES

## The Country Cancer Profile Series

The European Cancer Inequalities Registry is a flagship initiative of the Europe's Beating Cancer Plan. It provides sound and reliable data on cancer prevention and care to identify trends, disparities and inequalities between Member States and regions. The Country Cancer Profiles identify strengths, challenges and specific areas of action for each of the 27 EU Member States, Iceland and Norway, to guide investment and interventions at the EU, national and regional levels under the Europe's Beating Cancer Plan. The European Cancer Inequalities Registry also supports Flagship 1 of the Zero Pollution Action Plan.

The Profiles are the work of the OECD in co-operation with the European Commission. The team is grateful for the valuable inputs received from national experts and comments provided by the OECD Health Committee and the EU Expert Thematic Group on Cancer Inequality Registry.

## Data and information sources

The data and information in the Country Cancer Profiles are based mainly on national official statistics provided to Eurostat and the OECD, which were validated to ensure the highest standards of data comparability. The sources and methods underlying these data are available in the Eurostat Database and the OECD Health Database.

Additional data also come from the World Health Organization (WHO), the International Agency for Research on Cancer (IARC), the International Atomic Energy Agency (IAEA), the Institute for Health Metrics and Evaluation (IHME) and other national sources (independent of private or commercial interests). The calculated EU averages are weighted averages of the 27 Member States unless otherwise noted. These EU averages do not include Iceland and Norway. Purchasing Power Parity (PPP) is defined as the rate of currency conversion that equalises the purchasing power of different currencies by eliminating the differences in price levels between countries.

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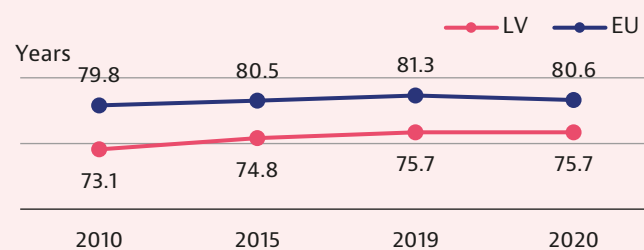
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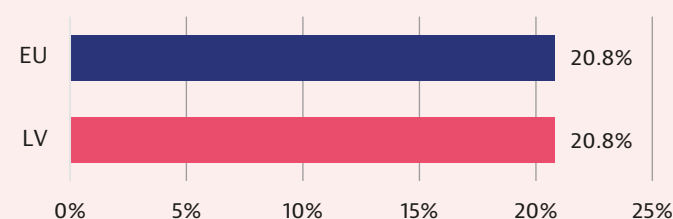
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## Summary of the main characteristics of the health system

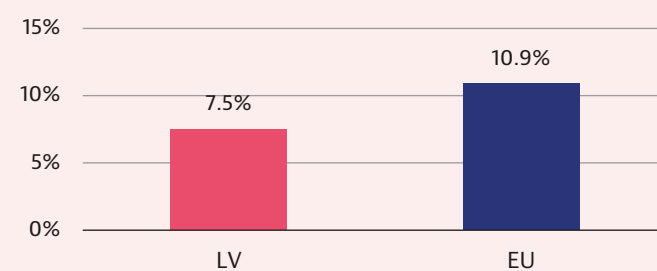
### LIFE EXPECTANCY AT BIRTH (YEARS)



### SHARE OF POPULATION AGED 65 AND OVER (2021)

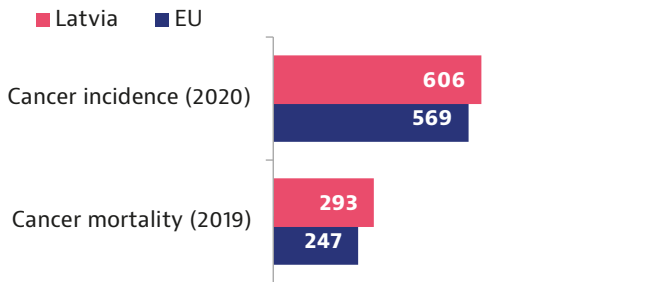


### HEALTH EXPENDITURE AS A % OF GDP (2020)

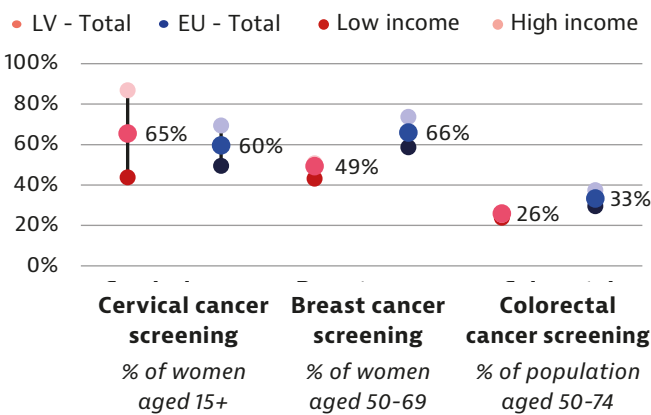
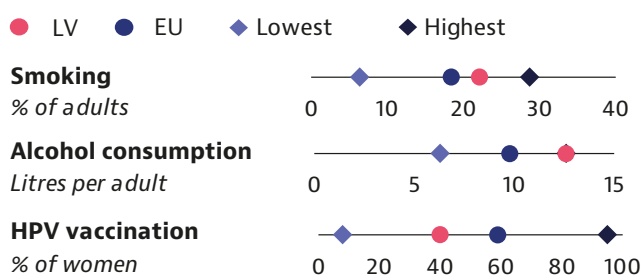


Source: Eurostat Database.

# 1. Highlights



Age-standardised rate per 100 000 population



## Cancer in Latvia

Estimated cancer incidence is higher in Latvia than the EU average. It is particularly high among men, and for prostate, breast, colorectal and lung cancers. Following a slow decline, Latvia has one of the highest cancer mortality rates in the EU, notably for cervical, uterus and gastric (stomach) cancers. To tackle these issues, the third national cancer plan was launched in 2021.

## Risk factors and prevention policies

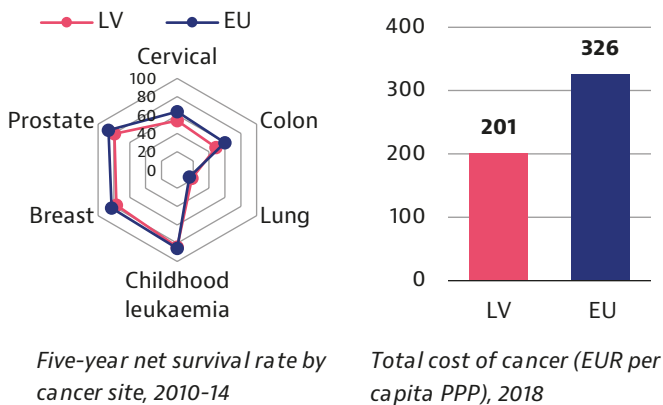
Health promotion is an important priority in Latvia, and a number of policies have been implemented in recent years. However, prevalence of risk factors for cancer such as smoking and alcohol consumption is high. Latvia has low rates of human papillomavirus (HPV) vaccination compared to other EU countries.

## Early detection

Screening programmes for breast and cervical cancer were introduced in 2009. Screening participation rates remain low for breast cancer but are higher than the EU average for cervical cancer. Colorectal cancer screening is not population-based, and participation rates are low in Latvia – particularly among men and those with lower education levels.

## Cancer care performance

Financial access to cancer care is good in Latvia, but issues of accessibility exist. In recent years, waiting times for cancer diagnosis and procedures have improved, but access to new cancer drugs and home or palliative care is still limited. Through ongoing development of quality assurance, cancer survival rates have improved recently, but they remain lower than the EU averages. Latvia has one of the lowest levels of spending on cancer care in the EU, in part because cancer care cost increases are contained through pharmaceutical pricing policies.



## 2. Cancer in Latvia

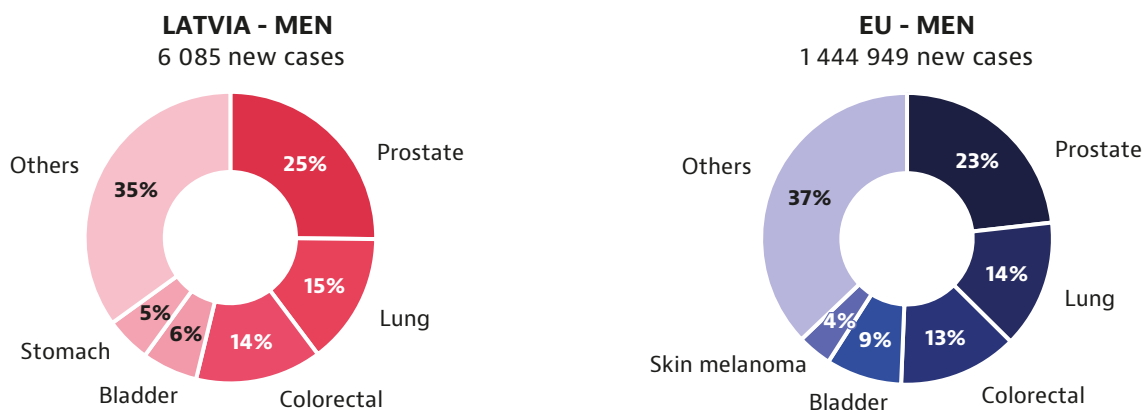
### Cancer incidence rates are high, particularly for prostate, breast, colorectal and lung cancers

Estimated cancer incidence rates are high in Latvia. According to European Cancer Information System (ECIS) of the Joint Research Centre based on incidence trends from pre-pandemic years, almost 12 400 people were expected to be newly diagnosed with cancer in 2020 (Figure 1). The

age-standardised rate was 606 new cases per 100 000 population in 2020 – almost 7 % higher than the EU average (569 per 100 000 population). Cancers with the highest number of new cases were expected to be prostate (219 per 100 000 population), breast (109 per 100 000 population), colorectal (87 per 100 000 population) and lung (60 per 100 000 population) cancers.

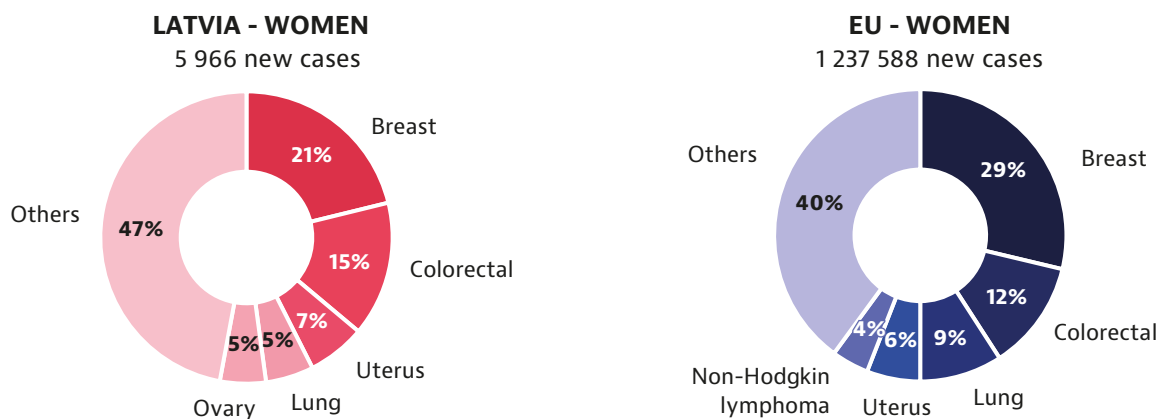
**Figure 1. Cancer incidence rates are significantly higher among men than among women in 2020**

#### Distribution of cancer incidence by sex in Latvia and the EU



#### AGE-STANDARDISED RATE (ALL CANCER)

**Latvia** 852 per 100 000 population  
**EU** 686 per 100 000 population



#### AGE-STANDARDISED RATE (ALL CANCER)

**Latvia** 492 per 100 000 population  
**EU** 484 per 100 000 population

Note: Corpus uteri does not include cancer of the cervix. These estimates were created before the COVID-19 pandemic, based on incidence trends from previous years, and may differ from observed rates in more recent years.

Source: European Cancer Information System (ECIS). From <https://ecis.jrc.ec.europa.eu>, accessed on 09/05/2022. © European Union, 2022.

Age-standardised incidence rates for adults – particularly among elderly people – were expected to be higher than the EU average, but for paediatric cancer, the rate for children aged 0-14 years was expected to be 15 per 100 000 population, which is similar to the EU average.

**Cancer incidence is very high among men and the gender gap is very large for lung cancer**

In 2020, the cancer incidence rate for men in Latvia was the highest in the EU, and the gender gap was the second largest. The incidence rate among men was 24 % higher than the EU average, and the rate among women was slightly higher than the EU average (Figure 1). The gender difference was very large for lung cancer: the incidence rate for men was over five times higher than the rate for women, corresponding to a large gender gap in smoking rates. Incidence rates were also much higher among men than women for gastric (stomach), kidney and colorectal cancers.

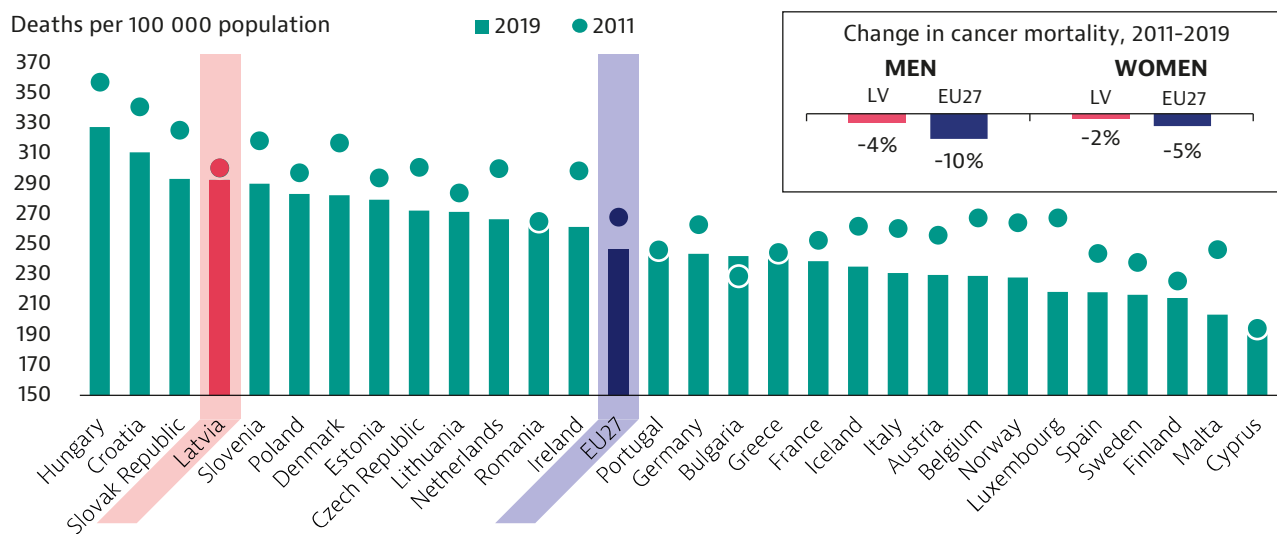
Compared to other EU countries, Latvia has high incidence rates for many cancers. In 2020, gastric (stomach) cancer was expected to constitute 6 % of new cancer cases in men and 4 % in women, significantly higher than the EU average (over

90 % higher for men and over 60 % higher for women). Expected incidence was also higher than the EU average for colorectal cancer among both men and women and for lung cancer among men. Incidence was also comparatively high for less common cancers. For cervical cancer, incidence was almost twice the EU average, and the rate for ovarian cancer was the highest in the EU. However, incidence of skin cancer was about half the EU average, although increasing. In 2013, the estimated number of new rare cancer cases in Latvia was 2 523.

**Although cancer mortality has decreased, Latvia has among the highest rates in the EU**

Between 2011 and 2019, the cancer mortality rate decreased by only 3 % in Latvia – slower than the EU average 8 % decline. In 2019, the rate (293 per 100 000 population) was the fourth highest in the EU (Figure 2), and over one in five deaths were due to cancer. The cancer mortality rate for men (455 deaths per 100 000 population) was the highest in the EU, while the rate for women (213 deaths per 100 000) was 12 % higher than the EU average, leading to a large gender gap compared to many other EU countries.

**Figure 2. Following a slow decline, cancer mortality rate was the fourth highest in the EU in 2019**



Note: The EU average is weighted (calculated by Eurostat for 2011-2017 and by the OECD for 2018-2019). Source: Eurostat Database.

**Mortality rates for some cancers including cervical cancer is much higher than the EU average**

Lung, colorectal, prostate, breast, gastric (stomach) and pancreatic cancers are the leading causes of cancer death in Latvia (Figure 3). The mortality rate for lung cancer among men decreased, but

more slowly than the EU average, reflecting high incidence and high prevalence of smoking.

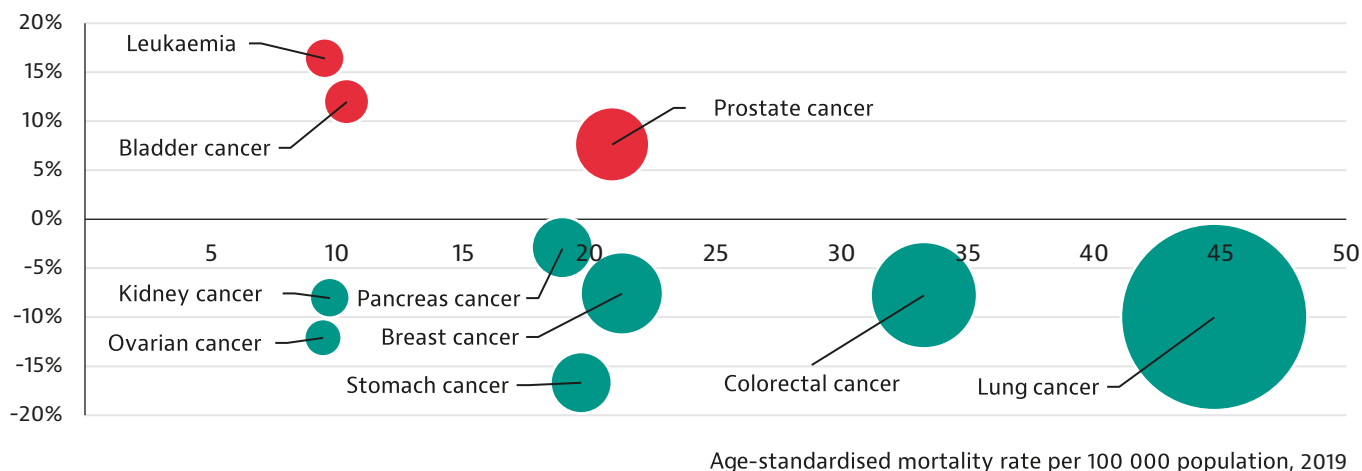
Mortality rates for some cancers were significantly higher in Latvia than the EU averages. In 2019, mortality rates were the highest in the EU for kidney, ovarian and uterus cancers. Gastric (stomach) cancer accounted for an overall mortality rate of 20 per 100 000 population, the

second highest among EU countries. The cervical cancer mortality rate was the third highest in the EU and almost three times higher than the

EU average, suggesting a need to increase human papillomavirus (HPV) vaccination and screening rates and to improve access to specialist care.

**Figure 3. Mortality rates fall for most cancers except prostate and bladder cancers and leukaemia**

Change in cancer mortality, 2011-2019 (or nearest year)



Note: Red bubbles signal an increase in the percentage change in cancer mortality during 2011-2019; green bubbles signal a decrease. The size of the bubbles is proportional to the mortality rates in 2019. The mortality of some of these cancer types is low; hence, the percentage change should be interpreted with caution. Bubble sizes for mortality rates are not comparable between countries. Source: Eurostat Database.

Cancer mortality rates vary widely across regions in Latvia. The eastern region of Latgale has a significantly higher age-standardised cancer mortality rate than the rest of Latvia (Figure 4), while the national average is 309 per 100 000 population. The lowest standardised mortality rate is in Riga; this may be explained by better access

to diagnostics and high-quality treatment. Over the past decade, regional inequalities in cancer mortality rates have increased, with the highest rise in Latgale (15 %), probably related to high prevalence of unhealthy lifestyles and less access to high-quality cancer care (Cabinet of Ministers, 2021).

**Figure 4. Cancer mortality rates vary widely across regions**



Source: Cabinet of Ministers (2021).

During 2000 and 2018, potential years of life lost due to malignant neoplasms in Latvia saw the third lowest relative decrease among EU countries of 14 %, and accounted for 1 832 years of life lost among 100 000 people aged up to 75 years in 2018. The relative decrease was larger among men (19 %) than women (7 %), with 2 249 and 1 530 years of life lost in 2018, respectively.

### To tackle the high burden of cancer, Latvia introduced three comprehensive cancer plans

Latvia introduced its first National Cancer Control Programme in 2009. During the implementation period, cancer screening programmes were rolled out nationally. Subsequently, the Plan for Improving Health Care Services in Oncology for years 2017-2020 was implemented to improve primary diagnosis and treatment for the most frequent cancers, to improve the screening uptake

and quality, and to expand the availability of palliative care. To continue tackling the high cancer burden, Improving Oncology Health Services Plan 2022-2024 (National Cancer Plan) was introduced in 2021, during the pandemic (Box 1), and implementation started in July 2022. The Plan focuses on prevention, screening, access to and quality of cancer care, cancer data infrastructure, human resources and patient satisfaction (Cabinet of Ministers, 2021). These priorities align with the Europe's Beating Cancer Plan (European Commission, 2021).

The updated National Cancer Plan aims to reduce premature cancer mortality rate from 106 per 100 000 population in 2019 to 100 per 100 000 in 2024. Latvia has also introduced other relevant policies to promote prevention and improve access to and quality of cancer care.

#### Box 1. A wide range of stakeholders were involved in developing Latvia's third National Cancer Plan

The third National Cancer Plan was developed based on input from a wide range of stakeholders in the midst of the COVID-19 pandemic. The first draft was prepared following consultations with representatives of the Ministry of Health, its subordinate institutions, health professionals

and providers, patient organisations and the pharmaceutical industry, which took place between December 2020 and March 2021. The draft Plan then went through public consultation, inviting feedback from all concerned to incorporate range of views.

## 3. Risk factors and prevention policies

### The promotion of healthy lifestyles is an important policy priority in Latvia

In recent years, spending on prevention has increased in Latvia, reaching 3.1 % of health expenditure in 2020, although still lower than the EU average of 3.4 % (OECD, 2022). This includes EU funding for Latvia's Public Health Strategy 2014-2020 (OECD, 2016) for municipalities to develop their own local health promotion plans, overseen by the Ministry of Health (OECD, 2020a). Municipalities are responsible for health promotion and prevention, and are supported by the National Centre for Disease Prevention and Control (CDPC) in developing activities and information campaigns to promote healthy lifestyles and reduce health risk factors. The CDPC provides guidelines, training and seminars to municipalities to facilitate implementation of primary prevention policies, and promotes exchange of information and experience

across regions. Some municipalities have health promotion co-ordinators, who are often teachers or social workers, offering community workshops to promote healthy lifestyles based on CDPC materials. General practitioners (GPs) are also expected to play a key role in health promotion.

### Unhealthy lifestyles are common, and alcohol consumption is an ongoing challenge

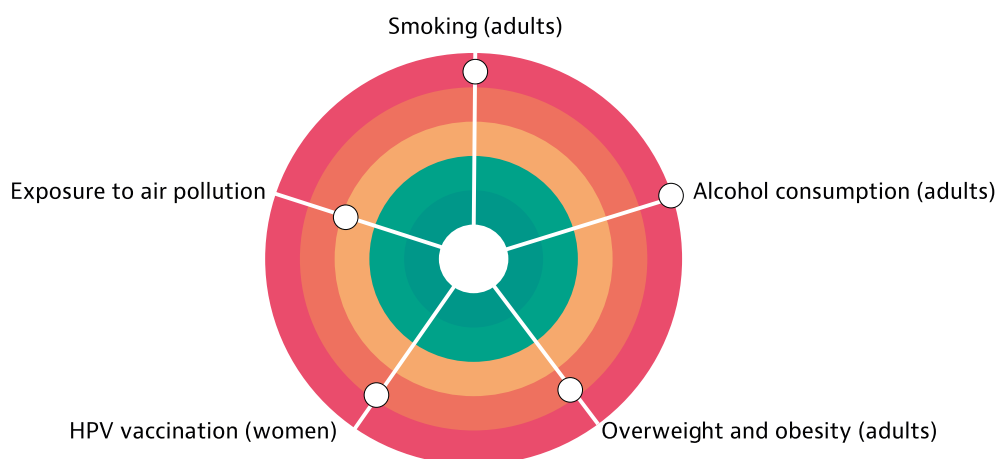
Prevalence of risk factors is high in Latvia (Figure 5), especially alcohol consumption. Latvian people aged 15 years and over on average consumed the highest amount of alcohol (12.6 litres of pure alcohol on average per year) in the EU in 2020, at almost 30 % above the EU average (9.8 litres). Hazardous alcohol drinking is also higher than the EU average, and in 2014 the proportion of men who had daily average consumption of more than 40 grams of pure alcohol was fourth highest

in the EU, and much higher than the proportion of women. Socioeconomic differences also exist: the share of people who had heavy episodic drinking in a week was lower among men with higher (4.6 %) than lower (8.1 %) education levels, but higher among women with higher (1.6 %) than lower (1.3 %) education levels in 2018.

Several initiatives have been implemented to control alcohol consumption, including the Handling of Alcoholic Beverages Law in 2004, the Action Plan for Reduction of Alcohol Consumption and Restriction of Alcohol Addiction for 2012-2014,

and the Public Health Strategy 2014-2020, which aimed to reduce average consumption to 9.5 litres in 2020. The Action Plan to reduce alcoholic beverage consumption and curb alcoholism 2020–2022 called for tougher restrictions on advertising and availability of alcoholic beverages. Latvia is also developing more comprehensive regulations to tackle harmful alcohol consumption, including through the Handling of Alcoholic Beverages Law and the Electronic Mass Media Law. However, wider support will be needed before adoption by the government.

**Figure 5. Latvia has higher risk factors for cancer than other EU countries**



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

Sources: OECD calculations based on the European Health Interview Survey (EHIS) 2019 for smoking and overweight/obesity rates, OECD Health Statistics 2022 and WHO Global Information System on Alcohol and Health (GISAH) for alcohol consumption (2020), WHO for HPV vaccination (through the WHO/UNICEF Joint Reporting Form on Immunization) (2020) and Eurostat for air pollution (2019).

### Smoking remains a major public health issue, particularly among men

Smoking rates in Latvia are among the highest in the EU, and are particularly high for men. In 2019, 22 % of people aged 15 years and over reported smoking daily, compared to the EU average of 18 % (Figure 6). The proportion of daily smokers among men was the second highest in the EU, and the gender gap is marked: the rate was nearly three times higher among men than women (34 % vs. 12 %). Daily smoking was more prevalent among people aged 35-54 years, and more common among people with lower education levels.

Several policies have been introduced to reduce smoking rates, including the 2014 Tobacco Law, smoking restrictions in public places and a 2016 law limiting use of tobacco and related products or equipment. In 2016, a smoking cessation advisory helpline was developed, and the new National

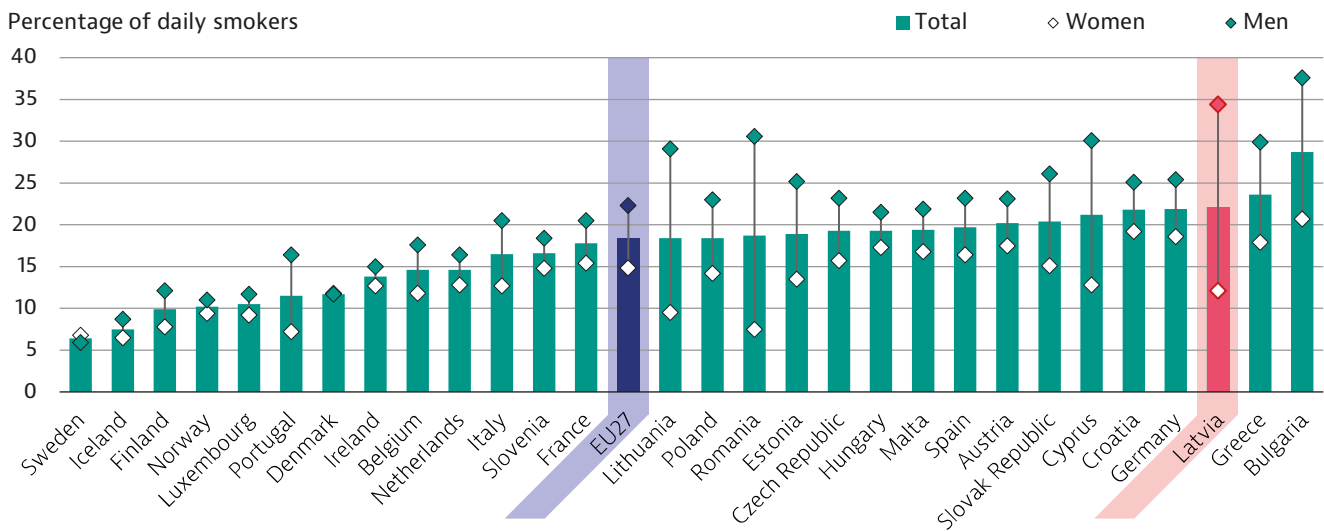
Cancer Plan allocated a budget of EUR 17 000 to support it from 2021 to 2023. The Public Health Strategy 2021-2027 aims to strengthen regulation of tobacco and nicotine-containing products to reduce their availability, direct and indirect advertising and marketing.

### Almost three in five Latvian adults are overweight or obese

In 2019, 58 % of adults were overweight or obese – above the EU average of 53 %. The rate among women is the third highest in the EU, and among women aged 65 years and over it is the highest. Prevalence of overweight and obesity is high among men with higher education and women with lower education levels. The Public Health Strategy 2014-2020 identified obesity and overweight as a policy priority, and the Public Health Strategy 2021-2027 includes health promotion campaigns and development of educational material and



**Figure 6. The smoking rate in Latvia is the third highest in the EU, and particularly high among men**



Note: The EU average is weighted (calculated by Eurostat).  
Source: Eurostat Database (EHIS). Data refer to 2019.

activities targeting specific population groups, such as schoolchildren, and an increasing role for GPs in health promotion to tackle this increasing challenge.

High prevalence of overweight and obesity are associated with unhealthy eating habits. In 2019, only 39 % of Latvians aged 15 years and over reported consuming one portion or more of vegetables per day, which is lower than the EU average of 51 %, and only 35 % of Latvians reported consuming one portion of fruit or more daily – again, much lower than the EU average of 56 %. In recent years, poor eating habits have become more prevalent across all population subgroups by gender, age, income and educational attainment, and prevalence was particularly high among people with lower education levels in 2018. This is despite the introduction of several policies including a ban on junk food in schools, social and health care institutions, introduction of nutrition norms in 2016 and regulations on the maximum level of trans-fatty acids in foodstuffs in 2018.

Physical inactivity is also a common problem in Latvia, contributing to the high prevalence of overweight and obesity. Only one in five people reported engaging in at least 150 minutes of moderate physical activity each week – lower than about one in three on average across the EU.

**Latvia made specific efforts to prevent cervical, skin and liver cancers**

Alongside general preventive measures to reduce behavioural risks of developing cancers, Latvia introduced HPV vaccination to tackle high incidence of cervical cancer, although coverage

rates are still low (Box 2). To prevent skin cancer, provision of cosmetic tanning services is regulated, and in 2018, the GDPC organised a public information campaign to reduce the risks posed by sunbathing and cosmetic tanning. Furthermore, to tackle relatively high prevalence of hepatitis C, which is associated with liver cancer, Latvia introduced the Action Plan for 2018-2020 targeting elimination of communicable diseases including hepatitis C.

**Box 2. Despite efforts to raise awareness, human papillomavirus vaccination coverage rates are low**

HPV vaccination was introduced for girls in 2010 and boys in 2022. It is provided free of charge by GPs to girls aged 12-18 years and boys aged 12-14 years. Since 2017, the CDPC has organised targeted information campaigns (including social media discussions) to promote HPV vaccination uptake. However, the vaccination rate among 15-year-old girls decreased prior to the COVID-19 pandemic, reaching 39 % in 2019 (down from 61 % in 2016), although it increased slightly in 2020 to 40% (see Section 5.4).

**Exposure to air pollution is similar in Latvia compared to the EU**

In 2019, exposure to PM<sub>10</sub><sup>1</sup> in Latvia reached 20.2 µg/m<sup>3</sup>, which is similar to the EU average (20.5 µg/m<sup>3</sup>). Latvia also had a similar concentration of PM<sub>2.5</sub> (12.1 µg/m<sup>3</sup>) to the EU average (12.6 µg/m<sup>3</sup>). According to the Institute for Health Metrics and Evaluation, ozone and PM<sub>2.5</sub> exposure accounted for an estimated 5 % of all deaths in Latvia in 2019, a rate similar to the average across the EU (4%).

<sup>1</sup> Particulate matter (PM) is classified according to size: PM<sub>10</sub> refers to particles less than 10 micrometres in diameter; PM<sub>2.5</sub> to particles less than 2.5 micrometres in diameter.

## 4. Early detection

### Population-based screening programmes were introduced for breast and cervical cancers but not for colorectal cancer

In 2009, breast and cervical cancer screening programmes were rolled out nationwide. Free mammograms are now available to women aged 50-69 years every two years at 27 designated mammography providers that meet quality assurance criteria. The NHS sends invitation letters to target group for breast cancer screening. For cervical cancer screening, women aged 25-70 years are eligible. The NHS sends invitation letters for free cytology-based screening to women at ages 25 and 28 years. Invitation letters for free primary HPV screening are sent to women aged 30-70 years, and in 2025, it is planned that the interval of cervical cancer screening invitations for this age group will be changed from every three years to every five years.

Colorectal cancer screening is not population-based and thus invitation letters are not sent to target populations. But GPs provide free colorectal cancer screening to the target population as part of the general health prevention programme (Box 3). The target population and screening methods changed recently. Prior to 2014, a faecal occult blood test was provided to people aged 50 years and over annually, but the target population was changed to those aged 50-74 years. Since 2019, a faecal immunochemical test has been provided every two years.

#### Box 3. Latvia provides general health prevention including prostate cancer screening

In Latvia, primary health care provides prostate cancer screening every two years to men aged 50-75 years, and men aged 45 years and over with the family history of prostate cancer, and diabetes examinations (via blood test) to people aged 40 years and every three years after the age of 45 years. In addition to annual preventive examinations by GPs, people at ages 40, 45, 50, 55, 60 and 65 years can receive assessments of cardiovascular diseases, based on smoking history, blood pressure, body mass index, blood test and electrocardiogram evaluation. These preventive services are provided free of charge.

### Breast cancer screening rates remain low in Latvia

In 2019, 49 % of women aged 50-69 years reported having a mammogram in the past two years, which is the fourth lowest rate in the EU and almost 17 percentage points lower than the EU average. Breast cancer screening rates were lower among those with lower education levels (31%, as compared to 51% among higher education levels), and among those with lower incomes (43%, as compared to 51% among higher income levels). Breast screening participation rates among those with lower education levels are among the lowest rates in the EU, even though the number of mammographs per population was higher than the EU average (OECD, 2022).

### The cervical cancer screening rates were above the EU average, but income inequalities are marked

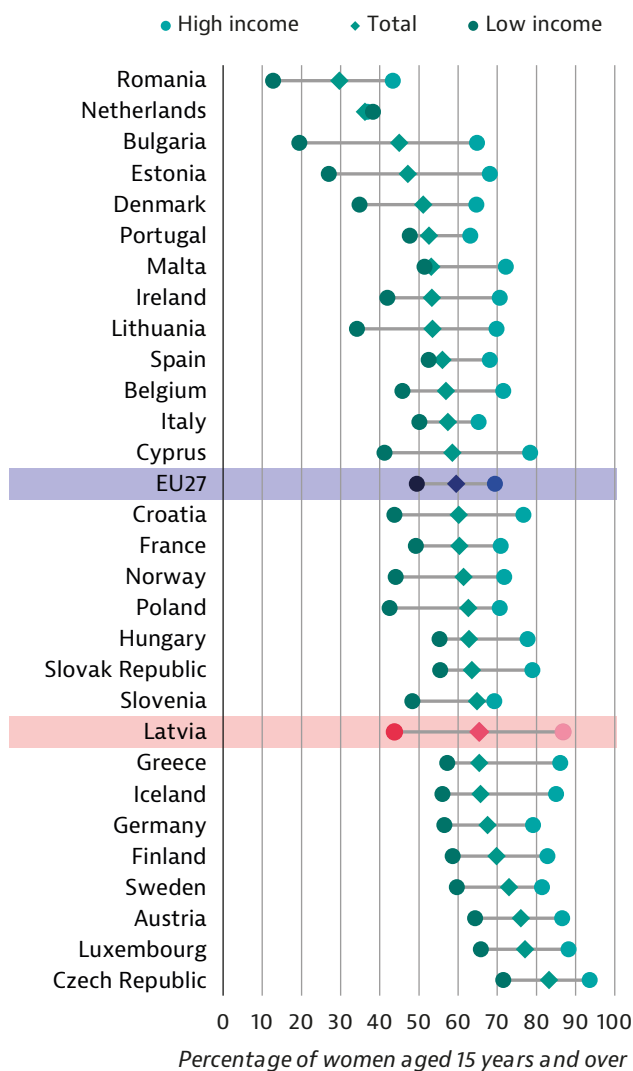
The cervical cancer screening rates in Latvia were higher than the EU average. In 2019, 65 % of women aged 15 years and over reported having cervical cancer screening in the past three years – almost 6 percentage points higher than the EU average, and much higher than breast cancer screening uptake. Cervical cancer screening rates may be high because Latvian women have a long habit of seeking gynaecological consultation for an annual check-up. Despite the relatively high screening rates, however, cervical cancer incidence and mortality rates are also high, and the survival rate is low, suggesting that the screening programme may not lead to effective management of precancerous conditions.

Inequalities in cervical cancer screening are marked. The gap between people on higher and lower incomes is the second largest in the EU – a 43 percentage-point difference (Figure 7). In addition, the 48 percentage-point difference by educational attainment is the third largest in the EU. These call for targeted approaches to increase uptake among those with low income and education levels.

### Colorectal cancer screening is low, particularly among men

The proportion of people aged 50-74 years who reported having a faecal occult blood test in the past two years was 26 % in 2019 – about 8

**Figure 7. The difference in cervical cancer screening rates by income level was second largest in the EU**



Note: The EU average is weighted (calculated by Eurostat). The figure reports the percentage of women aged 15 years and over who reported having a cervical smear test in the past three years.  
Source: Eurostat Database (EHIS). Data refer to 2019.

percentage points lower than the EU average. The gender difference in colorectal cancer screening uptake was the second largest in the EU, and the difference between those with lower (16 %) and higher (31 %) education levels was the largest in the EU. On the other hand, the income gap was small.

**Efforts have been made to increase cancer screening uptake**

Prior to 2017, only women with invitation letters for breast and cervical cancer screening were able to undergo screening. Since 2018, however, Latvia’s health care management information system allows health care institutions to identify target women who were invited to screening, so those without physical invitation letters are able

to attend, leading to an increase in uptake of both breast and cervical cancer screening.

Latvia provides financial incentives to GPs who provide breast and cervical cancer screening to increase rates. Following a bonus payment introduced at the start of both screening programmes in 2009, quality assurance criteria and a compulsory pay-for-performance scheme were introduced as part of primary care reforms in 2013. GPs who meet annual quality assurance criteria on areas including cancer screening and early detection receive additional payments. The quality assurance criteria are being revised, and a separate payment is now available for GPs to increase screening rates for breast, cervical, colorectal and prostate cancers.

Latvia has also attempted to increase awareness of cancer screening. Public information campaigns were carried out in 2010, a year after the introduction of breast and cervical cancer screening programmes, leading to increased uptake in 2011. Since then, various communication tools have been used to organise activities and share information on cancer screening. Educational materials on cancer screening are also distributed not only to the public but also to medical institutions, GP practices, municipalities, non-governmental organisations and educational institutions. The Ministry of Health plans to undertake a pilot project to invite target groups to attend colorectal cancer screening.

**Latvia is developing mechanisms to improve quality of cancer screening**

Despite a lack of overarching management, coordination and oversight of cancer screening, some progress has been made. To improve screening effectiveness, strategic procurement was introduced in 2017, and mammography service providers were required to meet quality assurance standards, such as a minimum quantity of screening performed, leading to better access to high-quality cancer screening. In 2019, the Law on Patients’ Rights was amended, requiring the CDPC to process patient data to monitor quality control of organised cancer screening. To facilitate effective monitoring, legal frameworks need to be further developed to allow data linkages and interoperability of data collected by various actors.

# 5. Cancer care performance

## 5.1 Accessibility

### **There is no financial barrier to accessing cancer care in outpatient and inpatient settings**

In Latvia, cancer care provided in both outpatient and inpatient settings is free of charge. Patients, however, need to make a symbolic copayment of EUR 0.71 per prescription for cancer drugs and cover half of the cost for medical devices. Children aged up to 18 years, people requiring certain care (such as dialysis), long-term care and palliative care, or asylum seekers are not required to make copayment for health care including cancer care.

However, when a more expensive product instead of the cheapest reference product is prescribed, all patients need to pay the difference between the retail price and reference price. Children aged up to 24 months can receive prescription medicines not included in the positive list, but that have a nationally or centrally authorised registration in EU countries, at a reimbursement level of 50 % if they meet criteria set by legislation. In addition, municipalities are expected to ensure access to cancer care by providing subsidies to cover transportation costs to health care facilities.

### **Availability of resources to improve access to cancer care is increasing**

Due to a decline in the density of oncologists from 3.26 per 100 000 population in 2005 to 3.08 per 100 000 in 2015, and an increasing share of medical oncologists being in the retirement age (20 % in 2021 and 24 % in 2022), Latvia has funded additional residencies in oncology since 2019. Plans to fund more to improve access to specialised cancer care and reduce regional inequalities are also in place. Recently, the number of vacancies for cancer-related professionals has decreased, but their distribution is not yet balanced across regions. To improve care quality, Latvia also developed unified licensing and certification systems to train medical professionals with specialised skills in cancer care.

Over the past two decades, availability of medical equipment in Latvia has improved, reaching the EU average. Since the first National Cancer Control Programme was implemented in 2009, numbers of computerised tomography (CT) scanners have increased by about 30 %, of magnetic resonance

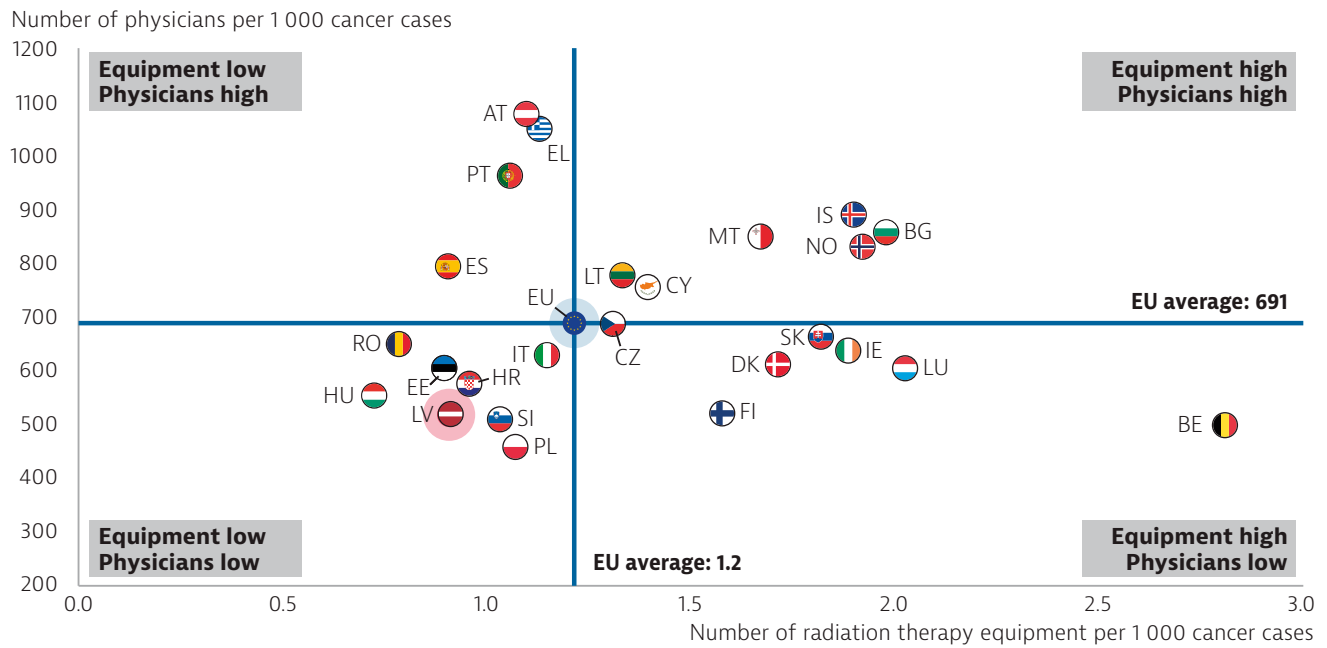
imaging (MRI) units have increased by about 80 %, and of radiation therapy equipment have increased over two-fold. In 2019, the number of CT scanners per 100 000 population was much higher in Latvia (3.7) than the EU average (2.4) while availability of MRI units was similar to the EU averages. Nonetheless, availability of resources is still low for the number of cancer cases (Figure 8), and access to cancer care is not even across regions.

### **Waiting times for cancer diagnosis and procedures have improved**

In 2016, Latvia set waiting time targets to improve timeliness in accessing cancer care. The current targets include a) 30 days for examination after suspected results of cancer screening; b) 10 working days for primary diagnostic test from referral by GP or gynaecologist; c) 10 working days between primary and secondary diagnosis; and d) 30 days between secondary diagnosis and treatment strategy development. Latvia has also set waiting times for diagnosis, colonoscopy, mammography, oncology, chemotherapy and radiation therapy by medical institution, to identify challenges, address access issues and support provider selection for citizens. In 2016, Latvia introduced fast-track access for cancer patients (called the Green Corridor), fully paid by state budgets, to streamline diagnosis and treatment decisions for suspected cancer cases. This requires specialist consultation and diagnostic examination within 10 working days of the date of referral. Fast-track access for recurrent cancer patients (called the Yellow Corridor) was also established to ensure timely access to care.

Following these measures, access to cancer care improved in Latvia. The longest waiting times for a mammogram decreased by 4 days (to 28 days), for chemotherapy decreased by 54 days (to 42 days) and for radiation therapy decreased by 10 days (to 32 days) between 2015 and 2019. The average waiting times for an appointment with an oncologist also decreased. After the introduction of the Green Corridor, the proportion of patients diagnosed at early stages increased from 50 % in 2015 to 55 % in 2017 (OECD, 2020b). However, access times for some services are still long, and the waiting time for colonoscopy was still 144 days in 2019 (NHS, 2019).

**Figure 8. Despite the high burden of cancer, availability of resources is low in Latvia**



Note: The EU average is unweighted (calculated by the OECD). Radiation therapy equipment from hospitals and providers of ambulatory care. Data refer to medical doctors (excluding nursing and caring professionals).

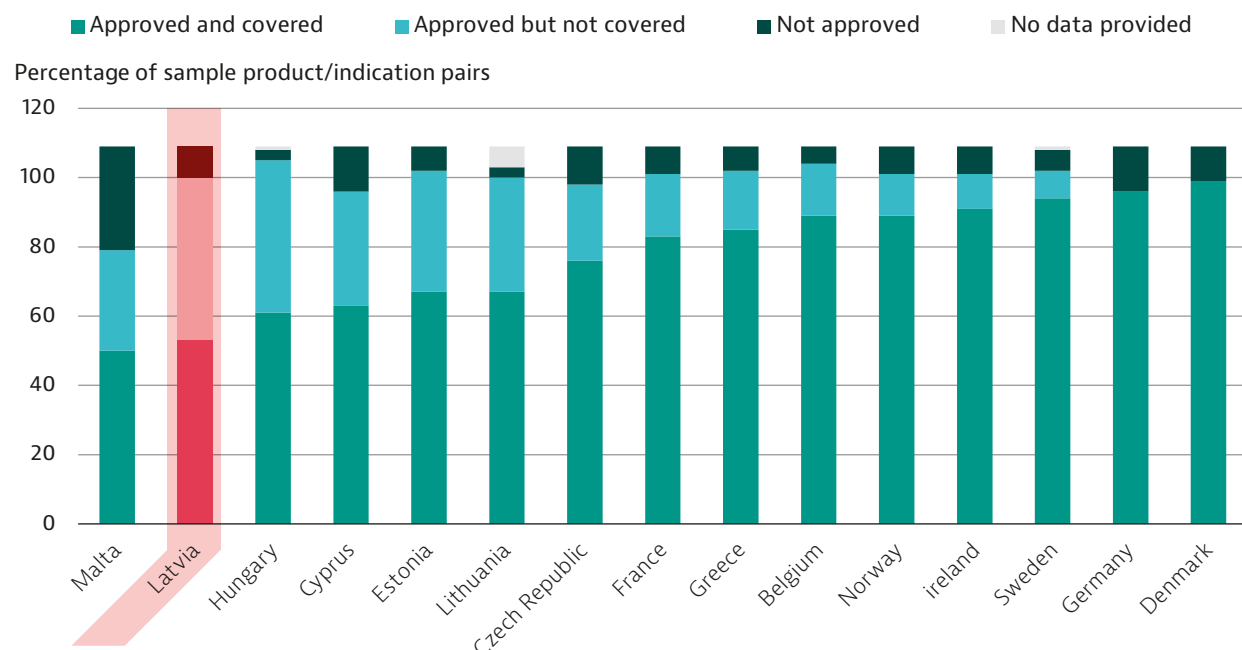
Source: Eurostat and OECD Health Database (data refer to 2020, or nearest year).

**Access to new cancer drugs is still limited**

Compared to other EU countries, the proportion of authorised cancer drugs that are not covered is high in Latvia. Among 109 products and indication pairs studied, over 40 % were approved but not covered in Latvia (Figure 9). For example, while in all other countries studied at least one protein-kinase inhibitor and one monoclonal antibody were reported as subsidised for non-small

cell lung cancer treatment, Latvia does not cover any monoclonal antibodies. Coverage decisions are made based on cost-effectiveness and budget impact criteria. For drugs that are not covered, off-label use is still possible, and patients can access them by paying out of pocket if they are authorised, but this raises concerns over equity in access to innovative drugs (OECD, 2020c).

**Figure 9. The proportion of authorised cancer drugs that are not covered in Latvia is high**



Source: Chapman, Paris, and Lopert (2020).

Nonetheless, access to cancer drugs has been improved recently. Since 2018, the number of cancer drugs covered has increased significantly through increased funding and cost reductions as a result of price negotiations and centralised procurement of intravenous drugs (see Section 5.3). Managed entry agreements are also available for some new cancer drugs, and patients meeting inclusion criteria are approved to receive the treatment free of charge.

### Home care, rehabilitation and palliative care are limited for cancer patients

Although a wider range of cancer treatment and services has become available over time, some services are still limited in Latvia due to a lack of funding. For example, only 64 cancer patients received inpatient rehabilitation services in 2021, although the number of cancer patients with a wide range of physical, emotional and cognitive impairments is increasing. Failure to provide rehabilitation as part of the overall treatment and care reduces the return on resources invested in the diagnosis and treatment of cancer patients. To facilitate cancer patients' return to social and economic life, a psycho-emotional support day centre was established in 2019. These services still need to be developed and become accessible to fulfil patients' health, psycho-emotional and social needs.

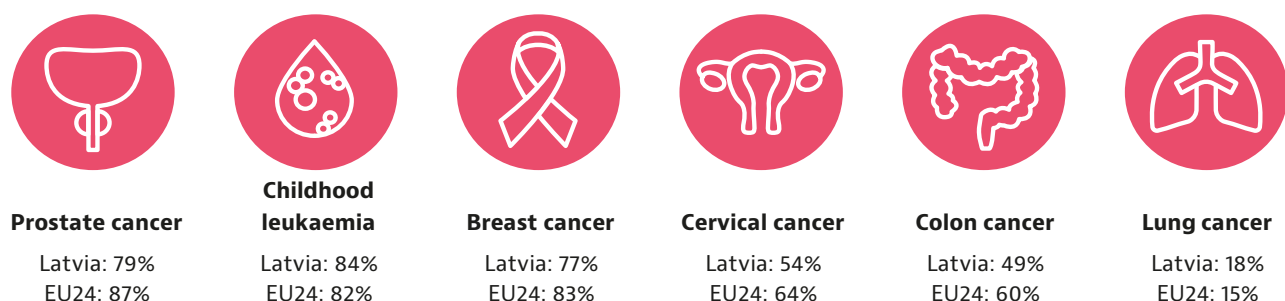
Home care and palliative care services have been developed and covered in recent years, but state-funded palliative care services are not sufficient for both adults and children and the structure of palliative care provision is fragmented. A recent survey found a low level of satisfaction among people who received palliative care and suggested needs to improve its access and quality (Strautmane, Behmane and Ludviga, 2019[1]). Hence, these services also need to become more widely available, as demand is growing (Cabinet of Ministers, 2021).

## 5.2 Quality

### Survival rates have improved in recent years but remain below the EU averages for most cancers

Reflecting improvements in access to cancer care, the proportion of advanced cancer cases is decreasing, leading to better outcomes. Since 2000, five-year survival rates have increased for rectal, prostate, colon, gastric (stomach) and breast cancers, approaching to the EU averages, and the rate for childhood leukaemia continued to be higher than the EU average in 2010-2014 (Figure 10).

**Figure 10. Survival rates for Latvian cancer patients are generally lower than the EU averages**



Note: Data refer to people diagnosed between 2010 and 2014. Childhood leukaemia refers to acute lymphoblastic cancer. Source: CONCORD Programme, London School of Hygiene and Tropical Medicine.

However, during 2010-2014, survival rates were low for breast, cervical and colorectal cancers. Population-based breast and cervical cancer screening was only introduced in 2009, and its benefit was not yet captured in survival rates among patients diagnosed between 2010 and 2014. The survival rate for breast cancer was the fifth lowest in the EU among patients diagnosed in 2010-2014, but stage distribution and case fatality rates for all stages improved between 2013 and 2017 (Cabinet of Ministers, 2021), suggesting that survival rates have also further improved. Similarly, the survival rate for cervical cancer was

the lowest in the EU among patients diagnosed during 2010-2014, but since then screening uptake has increased, and the share of patients diagnosed at stages 3 and 4 slightly decreased from 41 % in 2013 to 36.7 % in 2017. Nonetheless, case fatality rates did not improve for all stages, suggesting that further improvements could be made in providing effective cervical cancer treatment. For colorectal cancer, stage distribution and case fatality rates did not improve between 2014 and 2017, suggesting the need to improve access to diagnosis and effective treatment.

### **Cancer care delivery is centralised to ensure provision of high-quality care**

Latvia has centralised cancer care delivery by concentrating resources and expertise in specialised institutions. About 80-85 % of cancer patients receive care at the Oncology Centre in Riga. Cancer care is also provided at another tertiary hospital in Riga and at two regional hospitals. Chemotherapy and radiation therapy is available at all four hospitals and children's clinical university hospital, and there is also one regional radiotherapy centre. For paediatric cancer, due to a low number of cases, Latvia will need to strengthen its collaboration with European cancer reference centres to improve diagnosis.

### **Quality assurance mechanisms are being developed for cancer care**

Latvia has made efforts to ensure delivery of high-quality cancer care throughout the country. Recently, multidisciplinary treatment has become a norm, and clinical algorithms, patient pathways and performance indicators for priority diseases including cancer have been developed. Patient pathways were developed for breast and cervical cancers, and the plan is to develop them for about 20 cancers. Based on international guidelines, existing clinical guidelines and NHS-approved medical technologies were also evaluated to identify areas for improvement. In 2017, to ensure delivery of high-quality cancer care across providers, the NHS started strategic procurement of providers, and only hospitals that meet certain criteria in terms of volume, waiting times and patient-centredness provide planned cancer care (surgery, chemotherapy and radiotherapy). These efforts led to general improvements in the quality and availability of cancer care and appropriate use of services. Following these achievements, Latvia aims to reduce inequalities in treatment outcomes further through the current National Cancer Plan, and to improve cancer care throughout patient pathways.

### **Latvia plans to strengthen information infrastructure to improve cancer care quality**

The CDPC is responsible for collecting and reporting health system information relating to public health, prevention and quality of care. It has managed administrative databases and a number of registries, including the cancer registry, since 2009. Most data are available in the public domain, sometimes disaggregated by region. Cancer screening, incidence, mortality and five-year survival rates are reported regularly in the Statistical Yearbook. Using unique identifiers, cancer registry is regularly linked with

other registries such as those on diabetes and cardiovascular diseases, hospital inpatients, mental hospital inpatients, emergency care, prescription medicines, primary care and long-term care. This rich data source could be explored further to improve quality of cancer care.

As part of the current National Cancer Plan, the government plans to invest in strengthening information systems for cancer. The CDPC manages and analyses data from its databases and registries together with NHS data to monitor key cancer statistics such as screening, incidence, stage distribution, mortality and survival rates. Data are publicly available, sometimes disaggregated by region but not by provider. However, granular data collected by different institutions are stored in a fragmented manner, without any data linkages. This hinders more comprehensive monitoring of cancer care performance. Legislation on secondary data use is being discussed to facilitate data linkages and analyses to improve the quality of health care, including cancer care.

### **Latvia has shifted its attention to provide more patient-centred cancer care**

As seen in the inclusion of patient-centred criteria as part of the strategic procurement and public consultation undertaken in preparation of the current National Cancer Plan, Latvia is committed to improving cancer care for patients and their families, based on their perspectives. Patient surveys have been conducted to learn from their experiences. For example, an evaluation survey of the Green Corridor cancer pathway highlighted that communication between patients and doctors remains poor: patients report that they lack information about treatment options and side-effects, and certain patients also have difficulty accessing information regarding their conditions.

Latvia has invested in training hospital ward managers, specialist doctors, chief nurses and nurses working at Riga Eastern Clinical University Hospital to improve communication with patients and crisis communication. Moreover, the Ministry of Health is implementing a project to develop a common platform for collecting and sharing patient-reported experience data, covering three hospitals providing cancer care. To further address people's needs, patient-reported measures could be collected and monitored systematically and used to improve cancer care quality and outcomes.

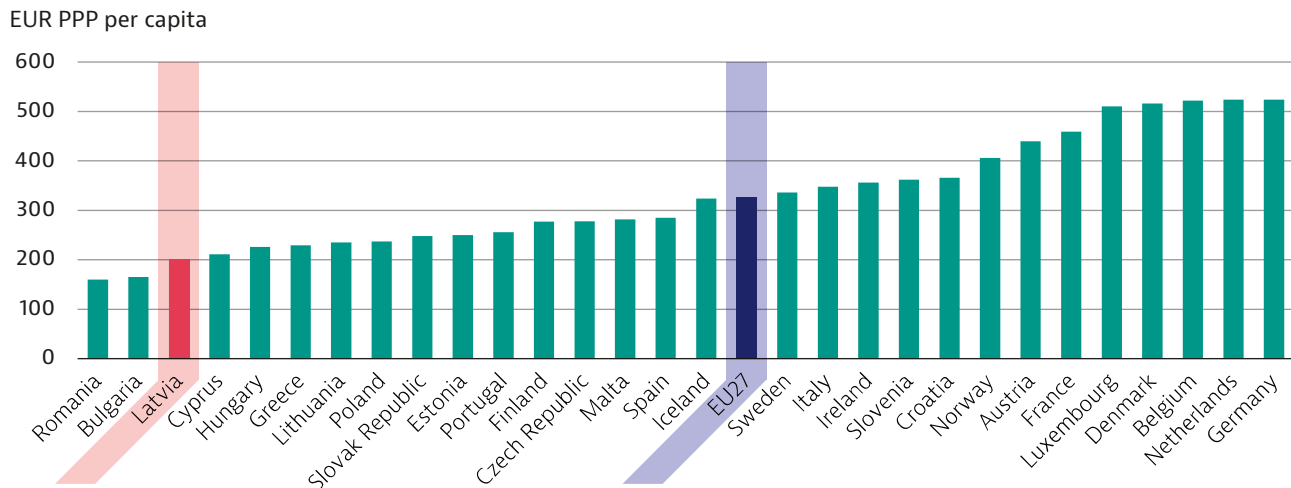
## 5.3 Costs and value for money

### Spending on cancer care in Latvia is very low

Latvia has one of the lowest levels of spending on cancer care in the EU. Health budgets are insufficient to provide full diagnostic and treatment services for cancer patients and cover their costs fully, limiting scope for improving and developing cancer care services. Although Latvia received EU funds of about EUR 287 million between 2014

and 2020 to improve services in four priority areas including cancer care, in 2018, the cost of cancer care adjusted for purchasing power parity (PPP) was EUR 201 per capita, which is the third lowest in the EU and much lower than the EU average of EUR 326 per capita (Figure 11). A wide range of activities are planned as part of the current National Cancer Plan, but financial resources are not yet allocated to most of them.

**Figure 11. Spending on cancer care in Latvia is the third lowest in the EU**



Note: The EU27 average is unweighted (calculated by the OECD).  
Source: Hofmarcher et al. (2020).

### Latvia contained cancer care cost increases through various pharmaceutical pricing policies

Cancer drugs accounted for 23 % of the direct costs of cancer care – lower than the EU average of 30 % – in 2018. This may reflect, at least in part, limited access to new cancer drugs but also efforts made to reduce drug prices. Since 2019, the NHS has provided centralised procurement of medicinal products, including chemotherapy medicine and medical devices, resulting in a positive impact not only on cost reductions but also on access and effective drug use. In 2019, the number of reference countries was increased to further reduce the prices of some cancer drugs. Following mandatory prescription of international nonproprietary names, patient copayments also decreased.

Latvia renegotiates new or existing managed entry agreements following approval and coverage of a new indication for an existing product. In 2020-2021, inclusion of new medicines and expansion of reimbursement were mostly achieved by cost reductions of already listed medicines. However, as public funding for medicines has not increased sufficiently to match demand, financing of cancer drug is a continuous challenge.

## 5.4 COVID-19 and cancer: building resilience

### During the initial period of the COVID-19 pandemic, the prevalence of risk factors for cancer increased in men with lower education levels

Between 2018 and 2020, average daily smoking rates decreased in Latvia, but men with lower education levels were an exception: almost one in two smoked daily in 2020. Compared to 2018, heavy episodic alcohol drinking increased on average in 2020, driven by a significant increase in heavy drinking among men with lower education levels; 15 % reported heavy episodic drinking in a week. Moreover, overall prevalence of overweight increased in 2020, mainly because of an increase among men with lower education levels (CDPC, 2020).

### Cancer screening services were disrupted in 2020

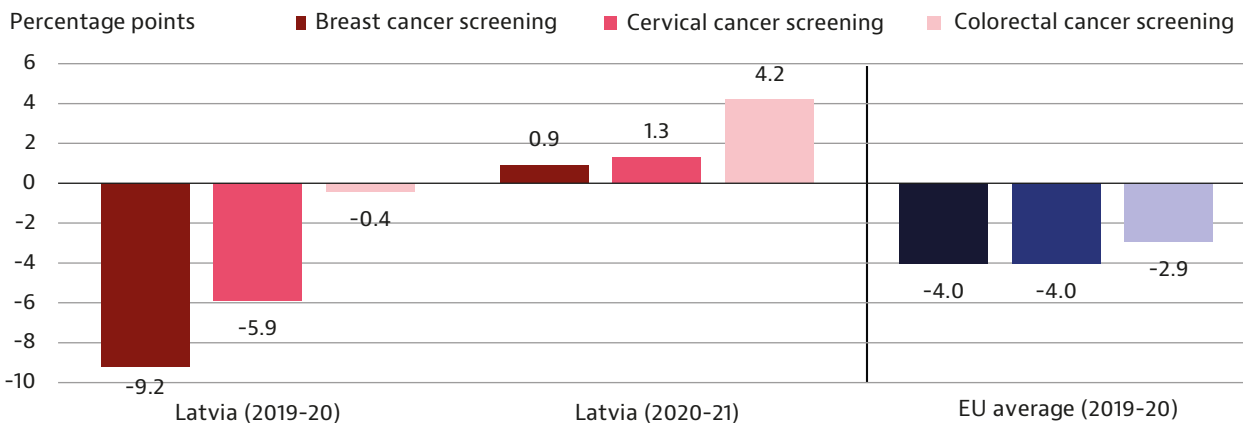
Latvia temporarily stopped cancer screening programmes between March and May 2020; following this, screening uptake increased slowly.



As a result, overall uptake of breast cancer screening in 2020 decreased substantially by over 9 percentage points, and the decline for cervical cancer screening was 6 percentage points – much larger than the decline across the EU (Figure 12).

The impact on colorectal cancer screening was small. In 2021, uptake increased for all three types of screening, but they are still lower than the pre-pandemic level except for colorectal cancer screening, which increased by 4.2 %.

**Figure 12. Screening rates for breast and cervical cancer fell more than the EU average**



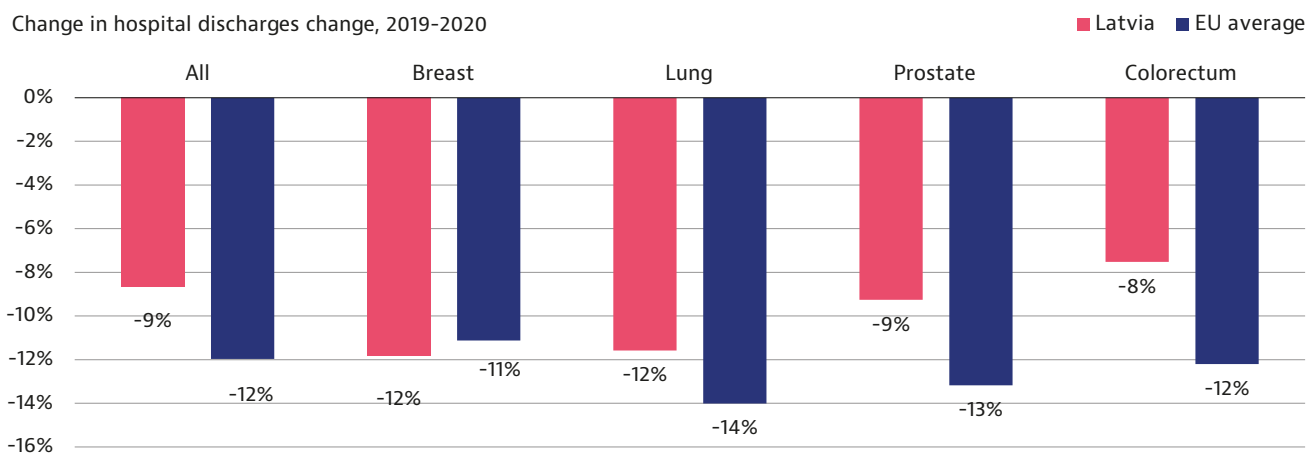
Source: OECD Health Statistics 2022.

**COVID-19 substantially reduced inpatient cancer care**

In Latvia, cancer care delivery and standards were not systematically changed to adapt to the pandemic through changes in clinical guidelines and cancer care reorganisation. During the first wave of the pandemic, a minimal level of outpatient cancer care was available, and the number of diagnoses and procedures decreased. But after the first wave, the Oncology Centre was open, and the backlogs were dealt with via health professionals working longer hours.

Available data point to a decline in cancer care services in 2020. Prior to the pandemic, the number of hospital discharges for cancer were increasing, but in 2020 total hospital discharges for cancer dropped by 9 % – lower than the EU average decline of 12 %. The decline was larger for breast cancer, but smaller for lung, prostate and colorectal cancers than the EU averages (Figure 13). For many cancers, the average length of hospital stay decreased, and the decline was large for breast cancer: from 7.4 days in 2019 to 6.4 days in 2020.

**Figure 13. Hospital discharges decreased for most cancers in 2020**



Note: Data refer to changes between 2019 and 2020. The EU average is calculated based on the countries with data for both 2019 and 2020.  
Source: OECD Health Statistics 2022.

Although the volume of hospital activity declined, waiting times became longer in 2020 than 2019, probably due to a surge of demand for care for patients with severe symptom of COVID-19. The longest waiting times for mammography grew from 28 days in 2019 to 30 days in 2020, but decreased to 21 days in 2021. Waiting times for colonoscopy

grew from 144 days in 2019 to 475 days in 2020, but decreased to 180 days in 2021. However, the longest waiting times decreased from 43 days for chemotherapy and 32 days for radiation therapy in 2019 to 26 days and 0 day in 2020, but increased to 59 days and 5 days in 2021.

## 6. Spotlight on inequalities

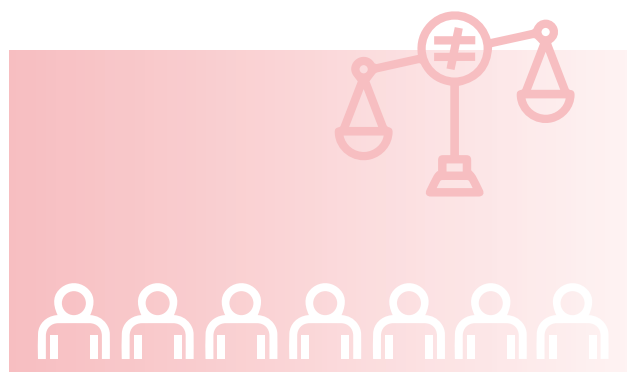
Latvia ensures good financial access to inpatient and outpatient cancer care to the whole population. But access to innovative cancer drugs is limited, and quality of care could be improved. Inequalities in cancer prevention and access to cancer screening and care are marked.

- Estimated cancer incidence rate among men is the highest in the EU, and the gender gap in incidence is the second largest in the EU. The incidence rate for lung cancer was over five times higher among men than women, corresponding with a large gender gap in smoking rates.
- Gender differences in cancer mortality are large, and wide regional variations exist between the lowest rate in the capital Riga and the highest rate in the eastern region of Latgale. Over the past decade, regional inequalities have increased, probably related to high prevalence of unhealthy lifestyles and challenges of ensuring access to cancer care in Latgale.
- Unhealthy behaviours leading to high risks of developing cancer are prevalent, particularly among certain population subgroups. The share of people with harmful drinking habits was high among men and heavy episodic drinking was prevalent among men with lower education levels and among women with higher education levels.
- Daily cigarettes smoking rates were nearly three times higher among men than women (34 % vs. 12 %), and among those with lower education levels.
- Breast cancer screening uptake was more than 64% higher among those with higher than lower education levels. For cervical cancer screening, disparities were especially marked: participation was much lower among people on lower than higher incomes (a 43 percentage-point gap) and among people with lower than higher education levels (a 48 percentage-point gap).

- Availability of professionals and medical equipment is still low for the number of cancer cases, and access to cancer care is not even across regions.

Several policies have been implemented to improve access to high-quality cancer care and to reduce disparities – including, for example, fast-track patient pathways. Average waiting times for cancer care have decreased, although waiting times for procedures and institutions still vary widely. Latvia also made efforts to contain the increasing cost of cancer drugs, improving access to innovative drugs among the population, although availability is still limited.

The COVID-19 pandemic and associated containment and mitigation measures had a substantial and prolonged impact on cancer prevention and treatment in Latvia. In 2021, breast and cervical cancer screening rates were still lower than in the pre-pandemic period. This impact on cancer care needs to be assessed, particularly for the most vulnerable populations, to improve their access to timely and high-quality cancer care.



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## Country abbreviations

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

European Cancer Inequalities Registry

# Country Cancer Profile 2023

The European Cancer Inequalities Registry is a flagship initiative of the Europe's Beating Cancer Plan. It provides sound and reliable data on cancer prevention and care to identify trends, disparities and inequalities between Member States and regions. The Registry contains a website and data tool developed by the Joint Research Centre of the European Commission (<https://cancer-inequalities.jrc.ec.europa.eu/>), as well as an alternating series of biennial Country Cancer Profiles and an overarching Report on Cancer Inequalities in Europe.

The Country Cancer Profiles identify strengths, challenges and specific areas of action for each of the 27 EU Member States, Iceland and Norway, to guide investment and interventions at the EU, national and regional levels under the Europe's Beating Cancer Plan. The European Cancer Inequalities Registry also supports Flagship 1 of the Zero Pollution Action Plan.

The Profiles are the work of the OECD in co-operation with the European Commission. The team is grateful for the valuable comments and suggestions provided by national experts, the OECD Health Committee and the EU Expert Thematic Group on Cancer Inequality Registry.

Each Country Cancer Profile provides a short synthesis of:

- the national cancer burden
- risk factors for cancer, focusing on behavioural and environment risk factors
- early detection programmes
- cancer care performance, focusing on accessibility, care quality, costs and the impact of COVID-19 on cancer care.

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