How does Latvia’s health sector contribute to the economy?
Health matters. The health sector is an important and innovative industry, as well as a source of stable employment for many people. Health systems support active and productive populations, reduce inequities and poverty, and promote social cohesion. A strong health system makes good economic sense and underpins the overall sustainable development agenda.

Countries around the world are grappling with the health, economic and fiscal implications of the COVID-19 pandemic. As they begin to recover from the crisis, difficult decisions will need to be made about how to allocate scarce resources. These snapshots share valuable evidence for policy-makers on how investing in health sectors and health systems helps to achieve national economic objectives.

This Latvia snapshot is part of a series developed by the European Observatory on Health Systems and Policies in collaboration with the WHO Barcelona Office for Health Systems Financing. It draws on cross-country comparable data and country-specific analysis and expertise to explore how well the health sector in Latvia contributes to the economy – and how it can do more, especially in the context of COVID-19.

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How does the Latvian health system contribute to the economy?

The health sector makes up a relatively small share of Latvia's economy, mainly because it has been given low priority in the government budget.

The health sector in Latvia is relatively small compared with the other 28 European Union (EU) countries, as seen in Fig. 1. In 2018, it accounted for just 6.2% of total gross domestic product (GDP), trailing neighbouring Baltic States Lithuania (6.6%) and Estonia (6.7%). It was also well below the EU average of 8.3% (WHO, 2020a). The low level of spending overall is largely due to the lack of priority that the government has traditionally attached to health. Just 9.6% of the total government budget was committed to health in 2018, well behind Estonia (12.5%) and Lithuania (12.7%), with only Cyprus (6.7%) and Greece (8.5%) allocating less on health as a share of public spending out of the EU28 that year (OECD, 2019; WHO, 2020a).

There are, however, some recent indications of a willingness to spend more. The government budget included a sharp increase in health spending in 2018, which was achieved in part by increasing the compulsory state social insurance contribution rate by 1 percentage point and by increasing the budget deficit to finance several health-sector reforms. National Health Accounts data indicate that government spending per person on health grew by 16.2% in 2018, with levels expected to have increased by a further 16% in 2019 (Behmane et al., 2019). These increases in the health budget invariably expanded the role that the health sector plays in the national economy. The government has also responded with urgency to the COVID-19 pandemic, allocating additional funds to health in 2020 to purchase necessary equipment and increase testing capacity. The social insurance contribution has been eliminated in 2021, though the expectation is that this change will not materially affect the health budget.
Despite the persistently low spending levels, there is some evidence that the health sector is an economic driver. Research and development (R&D) are important for innovation, which ultimately supports economic growth. According to the Organization for Economic Co-operation and Development, around 11% of the Latvian government’s total R&D budget was allocated to health in 2019 and 12.5% in 2018. This is relatively high when compared with the low priority that the health system received in the government budget overall in 2018 (9.6%) (OECD, 2020).

Beyond government, a range of health-related industries contribute to the wider economy. In particular, the Latvian pharmaceutical industry is increasingly relevant, with 6% average annual growth since 2011. Pharmaceutical exports have been on the rise, reaching EUR 259 million in 2018 (excluding VAT), an increase of 27% from the previous year (Behmane et al., 2019). This growth is mainly linked to re-exports by wholesalers. Pharmaceutical products were the eighth largest export sector in terms of trade value in 2019, accounting for 3.8% of total exports (USD 546 million or EUR 487.5 million). As a comparison, the largest export sector, wood and articles of wood and charcoal, made up 17% of total exports, earning USD 2.5 billion (EUR 2.3 billion), while the fifth largest, beverages, spirits and vinegar, saw 5.1% of all exports (USD 743 million or EUR 669 million) that same year1 (Harvard University, 2021). Domestic production has generally accounted for only a small share of the Latvian pharmaceutical market. There has been some recent growth driven by domestic demand, so that in 2018 local production made up 11.6% of domestic pharmaceutical consumption (Behmane et al., 2019). Nevertheless, imported generics are still usually cheaper than domestically produced generics. As spending on pharmaceuticals is particularly high in Latvia, there seems to be an unleveraged opportunity to expand domestic production of generics, especially if nationally produced pharmaceuticals could be priced lower.

Although the health sector remains a stable source of jobs, the health workforce is small compared with the EU average

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1 Conversion rate for 2019 from Global Economic Monitor (GEM), Exchange rate, new LCU per USD extended backward, period average (accessed 17 March 2021).
The health sector accounted for 3.9% of the economically active population in 2018, which is below the EU average (5.3%), Estonia (4.4%) and Lithuania (5.2%), and on a par with Malta (3.9%) (see Fig. 2). Health employment in Latvia has remained stable since at least 1997 (albeit at low levels), including during the marked increase in unemployment due to the 2008/2009 financial crisis (Eurostat, 2020b). Even as national data currently suggest high rates of unemployment due to the COVID-19 crisis (8.4% in the third quarter of 2020 compared with the third quarter in 2019), it seems unlikely that health sector employment will destabilize (Eurostat, 2020a; Latvia Central Statistics Database, 2020).

Despite being a stable source of jobs overall, ensuring there are enough health workers, particularly in rural areas, remains a challenge in the Latvian health system. The emigration of young health workers, internal migration and the anticipated retirement of a considerable share of general practitioners mean that demand for health workers outstrips supply, contributing to serious concerns about access. At 3.3 physicians per 1000 population in 2018, the current number of practicing medical doctors in Latvia is below the EU average of 3.8 per 1000 population (Eurostat, 2020a), and Latvia has one of the lowest numbers of practicing nurses and midwives in the EU with 484 nurses and midwives per 100 000 population in 2007, less than half the EU average (Behmante et al., 2019).

Steps to address workforce shortages and “brain drain” include a 2018 increase in salaries and further commitments to long overdue annual salary increases between 2019 and 2021. There are also new financial incentives to work outside Riga; however, there is no evidence yet on whether these measures have been effective. COVID-19 has also prompted additional government measures to improve working conditions for health-care workers. For example, in 2020, the government allowed more (but limited) legal overtime hours at higher pay rates and introduced bonuses of 20–50% of monthly salaries for doctors, auxiliaries and pharmacists combating COVID-19 (WHO, EC, European Observatory, 2020).

Targeted public investments in prevention, rehabilitation and quality of care could substantially improve population health, fostering a healthier and more productive workforce

Fig 3 Chronic underfunding of health services contributes to high treatable mortality in Latvia

Source: WHO (2020a); Eurostat (2020a).

Notes: PPP Int$, purchasing power parity International dollars.
Due in part to low levels of public spending on health, Latvia reports higher rates of treatable mortality (that is, deaths in people under 75 that could have been avoided through provision of optimal quality health care) than other countries in the region. As represented in Fig. 3, a total of 198 deaths per 100 000 people could potentially have been avoided in 2017 – one of the highest treatable mortality rates in the EU and almost double the EU28 average (109 deaths per 100 000) (Eurostat, 2020a; WHO, 2020a). Not only are further increases in public spending on health needed to address consistently high treatable mortality rates, but these funds need to be used more effectively. Because many of these deaths occur among people under 75 years of age, there are significant implications for labour-force participation and productivity.

Additionally, a high share of the population suffers from non-communicable diseases, which affects health and productivity and may also increase vulnerability to COVID-19. According to Institute of Health Metrics and Evaluation data, Latvia has the sixth highest cardiovascular disease prevalence of the EU28; it also has the fourth highest stroke prevalence and the second highest disease burden due to stroke among 50- to 69-year-olds in the EU, as measured by years lived with disability per population (IHME, 2020). Considering the economic costs of premature exit from the labour market, there is a strong economic case for the government to act on these challenges by investing in cost-effective public health and preventive measures.

Investing in children’s health is also a sound and prudent proposition in terms of maximizing educational attainment and future economic growth. There has been real progress, with the infant mortality rate at 3.2 per 1000 in 2018, down from 10.3 per 1000 live births in 2000, a reduction of nearly 70%. In 2019, Latvia had good coverage of childhood vaccinations (Eurostat, 2020a), with coverage of the third dose of the diphtheria–tetanus–pertussis vaccine reaching 99%, and with 96% of children immunized with two doses of measles-containing vaccine (WHO, 2020b). Nonetheless, the World Bank’s Human Capital Index suggests that a child born in Latvia today can expect to be 71% as productive by age 18 as a child with a complete education and full health (EU average: 73%) (World Bank, 2020).

Of the population aged 55–64 years, 71% were in paid work in Latvia in 2018, slightly below Estonia (73%) and Lithuania (74%), but higher than the EU average (60.9%) (Latvia Central Statistics Database, 2020). This rate is partly explained by low average pensions (around EUR 340/month in 2019) and a high risk of poverty and social exclusion among the 65 years and older population compared with other countries, which pushes people to continue working later in life to support themselves financially, regardless of their health status.

Health status is nevertheless a deciding factor in exiting the labour force early in Latvia. For example, in 2012 26.5% of 50- to 69-year-olds who were in receipt of a pension reported that they had stopped working as a result of poor health or disability (Eurostat, 2020c). A total of 74 500 people received a disability pension in 2019 – around 10% more people than a decade before (Latvia Central Statistics Database, 2020). A functioning health and social system can identify individuals in need and provide them with necessary support, and provides individuals with appropriate, timely and accessible care. As such, an increase in disability pension distribution is not necessarily a negative; in fact, it is a public good that people receive support when they need it. However, if individuals are leaving the workforce and applying for disability support because of an inability to access the health-care services necessary to avoid, prevent or mitigate a disability, this has significant health and economic implications.

Keeping people healthy across the life span contributes to their functional capacity at older ages and to a larger, healthier workforce that can participate in the economy for longer. This is especially important given that the retirement age in Latvia is being gradually increased to 65 years of age by 2025 (Latvia, 1995; Law on State Pensions).
Many households face severe financial hardship because the health system is over-reliant on out-of-pocket payments

In 2018 out-of-pocket spending accounted for 39.3% of current health expenditure, which is among the highest percentages in the EU and almost double the EU28 average (21.6%) (WHO, 2020a). The main driver of out-of-pocket spending in Latvia is outpatient medicines (Latvia Central Statistics Database, 2020).

As shown in Fig. 4, in 2016, 2.0% of households were impoverished as a result of out-of-pocket spending on health care, and a further 2.2% of households were further impoverished (that is, unable to meet their basic needs but still incurring out-of-pocket payments) (Law on State Pensions, 1995; Taube et al., 2018). The percentage of households that experienced catastrophic health spending reached 15%, up from 9.8% in 2005 and the second-highest proportion among the EU countries, after Lithuania (15.2%) (WHO Barcelona Office for Health Systems Financing, 2020). The risk of catastrophic health spending or of forgoing care for financial reasons is especially high among the poorest households (Taube et al., 2018; WHO Regional Office for Europe, 2019; WHO Barcelona Office for Health Systems Financing, 2020).

Although some mechanisms exist to protect people from catastrophic spending or under-utilization of necessary services, for example, the annual cap on user charges for all care services that are in place for the entire population, these offer only limited protection in practice. Importantly, the annual cap is set too high and does not include outpatient medicines, even though spending on outpatient medicines is the main reason for catastrophic spending in Latvia (Behmanc et al., 2019). Since 2009, very poor households and some other people in vulnerable situations have been exempt from all user charges – a decision that was key to protecting households during the economic crisis. However, the exemptions were scaled back in 2013, increasing the risk of financial hardship for many poor households (Taube et al., 2018).

**Fig 4** More than 15% of households experienced catastrophic spending in 2016, with more than half of those households impoverished, further impoverished or at risk of impoverishment as a result of paying out of pocket for health care

Source: Based on the WHO/Europe method to monitor financial protection as found in Taube et al. (2018); WHO Regional Office for Europe (2019); WHO Barcelona Office for Health Systems Financing (2020).
Key lessons

The Government is already addressing historically low government health spending, but COVID-19 highlights the urgent need for sustained investments to address concerns about access, financial protection, quality and integration across care levels, and fortify the system for future challenges.

Despite recent boosts in government spending on health, further increases are needed to address a number of shortcomings and to bring Latvia in line with the spending levels of other EU countries. This could improve population health outcomes as well as further national economic objectives. For example, more public spending could be targeted at reducing premature exits from the labour market due to ill health, creating new health sector jobs in under-served areas, and improving financial protection by expanding coverage for outpatient medicines.

Strengthening recruitment and retention of the health workforce in the public system would (especially in rural areas) improve equity of access to health services and further bolster system resilience to future emergencies.

A shortage of certain health professionals, in particular nurses, and staff retention outside urban areas are some of the main challenges that Latvia needs to address to be able to respond to future care demands. Recent salary increases and the introduction of financial incentives to work in rural areas before and since the beginning of the COVID-19 pandemic are a step in the right direction. Strategies to increase numbers in training and to retain trained professionals, as well as to attract new professions to the health system such as analysts and care coordinators, are also needed.

Improving coverage for outpatient medicines would strengthen financial protection, particularly for the poorest households.

One cause of financial hardship linked to use of health services is cost of outpatient medicines. Out-of-pocket payments are high and user charges create barriers to care for much of the population, although measures exist to minimize these, primarily for very poor households. Reducing reliance on out-of-pocket spending to finance health care will improve access to services and financial protection, giving households greater economic stability and resilience, and improving population health and productivity. As vaccines emerge, costs of all testing and treatment for COVID-19 should be covered by state funds to prevent financial hardship and disease transmission through forgone care.
Description of the health system

The National Health Service (NHS), established in 2011, provides universal population coverage. However, there are persistent access and quality challenges due to issues around geographical distribution of health professionals, user charges, as well as long waiting lists. Further, the publicly funded health benefits package is limited in scope and covers a pre-determined number of services each year that are provided by NHS-contracted providers and institutions. It excludes dental care for adults, most rehabilitation and physiotherapy, and other services.

The NHS is primarily financed through general taxation, with a purchaser–provider split and a mix of public and private providers. There has been an increase in privately financed health-care services in Latvia over recent years and the proportion of out-of-pocket payments is high largely as the result of limited government financing.

The parliament (Saeima) plays an important role in the development of national health policy and approves both the national budget and the budget of the NHS. The Ministry of Health is responsible for national health policy and the overall organization and functioning of the health system. The NHS is overseen by the Ministry of Health and is the institution that is mainly responsible for the implementation of state health policies and for ensuring the availability of health-care services in the country. The NHS is also the main purchaser of publicly funded health services. Local governments are tasked with ensuring geographical access, and, depending on budget and local priorities, maintain hospitals and long-term social-care facilities.

REFERENCES


### Key indicators

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<tr>
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<th>Latvia</th>
<th>EU Average</th>
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<tbody>
<tr>
<td>People aged 65 and above (% of total)</td>
<td>20.0</td>
<td>20.2</td>
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<tr>
<td>Life expectancy at birth (years)</td>
<td>74.8</td>
<td>81.0</td>
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<tr>
<td>GDP per person (PPP US$)</td>
<td>31 771</td>
<td>46 046</td>
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<tr>
<td>Current health spending per person (PPP US$)</td>
<td>1 896</td>
<td>3 730</td>
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<td>Health spending paid out of pocket (% of current health spending)</td>
<td>39.3</td>
<td>21.6</td>
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Data for 2018; Source: World Bank, World Development Indicators (2021); WHO, Global Health Expenditure Database (2021)

The European Observatory on Health Systems and Policies is a partnership hosted by WHO that includes international agencies, national governments, decentralized authorities and academic research institutes. It supports and promotes evidence-informed policy-making, using comparative analysis of European health systems and trends to give decision-makers insights into how their own and other systems operate; what works better or worse in different contexts; and why. Ultimately the Observatory aims to help countries strengthen their health systems to improve their peoples’ health and well-being. It engages directly with policy-makers and works with a range of experts, not least its Health Systems and Policies Network, whose members provide key knowledge and insights into health systems in countries.

WHO Barcelona Office for Health Systems Financing

The WHO Barcelona Office is a centre of excellence in health systems financing for universal health coverage. It works with Member States across WHO’s European Region to promote evidence-informed policy-making. A key part of the work of the Office is to assess country and regional progress towards universal health coverage by monitoring financial protection – the impact of out-of-pocket payments for health on living standards and poverty. Financial protection is a core dimension of health system performance and an indicator for the Sustainable Development Goals. The Office supports countries as they develop policy, monitor progress and design reforms and is part of the Division of Country Health Policies and Systems of the WHO Regional Office for Europe.