



*PUBLIC HEALTH
STRATEGY
FOR 2011-2017*

PUBLIC HEALTH STRATEGY FOR 2011-2017

Adopted by Cabinet of Ministers
Order No. 504
dated 5 October 2011



MINISTRY OF HEALTH
OF THE REPUBLIC OF LATVIA



Public health is an important sector in the sustainable development of society and one form of organised public activities to ensure to inhabitants high quality of life and healthy life years for the population. Public health issues comprise both the responsibility of each individual and that of the state, since society, consisting of healthy persons, capable of work, is the precondition for successful economic development and national growth.

In pursuit of With exactly this the aim goal – to give new direction to the public health as an important issue on the agenda of all sectors for Latvia’s successful future development – the Ministry of Health has elaborated the **Public Health Strategy** for 2011 -2017 (hereinafter – the Strategy)*.

The drafting of this Strategy began in July 2010, lead by the Public Health Coordination Commission, at thate time chaired by Pēteris Apinis, President of the Latvian Medical Association. Other recognised Latvian public health experts and health care specialists, as well as experts from the World Health Organisation (WHO) Regional Office for Europe experts were involved in the elaboration and review of the document. In October 2010, the elaborated Draft Strategy was released for public debatesdiscussion, giving the opportunity to all representatives of the society and organisations to participate by offering their vision and opinion. In total more than 70 institutions of public administration, local governments, professional physicians’ and pharmacutists’ organisations, representatives of non-governmental organisations, as well as private persons submitted proposals, objections and additions. All proposals were examined and published on the websitepage of the Ministry of Health for active discussions and exchange of opinion.

To foreground the role of all sectors in safeguarding and improving public health, as well as to promote awareness of the benefits for long-term national growth and economic development ensured by good public health, on 18 April 2011, the Ministry of Health in co-operation with the WHO Regional Office for Europe and its Country Office in Latvia organised conference “Better Health for All in Latvia”. Zsuzsanna Jakab, Regional Director, WHO Regional Office for Europe, participated in the conference, emphasizing the role of public health in overall development of the country and expressed further support for implementation of Public Health Strategy. The Draft Public Health Strategy was examined at the meeting of National Development Council of 18 April 2011, chaired by the Prime Minister of the Republic of Latvia Valdis Dombrovskis, with other ministers, representatives of local governments, non-governmental organisations and other institutions among participants.

A number of public health indicators in Latvia (traumatism, premature mortality from cardiovascular diseases, maternal and infant health, etc.) still significantly fall behind the European Union average indicators, therefore one of the basic principles of public health policy, included in the Strategy developed by the Ministry of Health, is “health in all policies”. It envisages the responsibility of all sectors for safeguarding and improving public health, because, to a large extent, health is determined by factors outside the influence of health sector.

I express my gratitude to everybody, who contributed their vision and advice to the elaboration of this Strategy. I am convinced that through joint effort of all sectors we shall will succeed in improving public health indicators in the country, ensuring to all inhabitants of Latvia equal access to health promotion, disease prevention and health care services.



**Ingrida Circene,
Minister for Health**

* The Strategy was elaborated in accordance with the points of progress defined by Latvia’s strategy for sustainable development “Latvia 2030”, objectives set out in Latvia’s Strategic Development Plan for 2010 – 2013, policy planning documents in other sectors, as well as policy documents of the European Union and World Health Organisation.



I welcome and congratulate Latvia on its new Public Health Strategy 2011 -2017, which sets out an ambitious programme for action to achieve better health for all by 2017. The strategy was developed in close collaboration with the WHO Regional Office for Europe and the new European Policy for Health - Health2020 which is being developed. In this regard, I deeply value the role of Latvia as a partner and as a pathfinder in this important movement for better health for all in the European Region.

Like many of the countries within the WHO European Region, Latvia still faces important challenges in improving the health of its population and reaching its goal to increase average life expectancy by two years by the year 2017. Achieving this will need stronger and more coherent policies and governance to reduce the burden of cardiovascular disease, cancers, obesity, injuries and mental health as well as increased actions to effectively prevent and control communicable diseases such as multidrug resistant Tuberculosis.

Crucially, it will require action on health inequities and the wider social and economic determinants of people’s behaviour and their opportunities to be healthy. This is essential to ensure better health is not only an aspiration but a reality made possible for all Latvians, regardless of their income, their education, gender or other factors. To make this happen will require the commitment of all sectors to work together and to see the improvement of health as a marker of a fair and sustainable nation as well as a vital resource for social and economic development. This strategy, with its emphasis on human rights, equity and intersectoral working through the whole of government approach has strong foundations for effective action. Taken together with pooling resources, know-how, and actions through the engagement of stakeholders with and beyond national government, these foundations will go a long way to achieving success and reaching the strategic goals.

We at WHO Regional Office for Europe look forward to being a partner and providing our technical support, as you move to the hard work of implementing this strategy. You have our full support as we work together towards better health for all Latvians.



**Zsuzsanna Jakab,
Regional Director
WHO Regional Office for Europe**

Table of Contents

<i>Foreword</i>	2
<i>Abbreviations Used</i>	6
<i>Introduction</i>	7
1. Basic Principles and Aims of Public Health Policy	8
2. The Linkage of the Strategy with Other Development Planning Documents	9
3. DESCRIPTION OF THE SITUATION AND THE IDENTIFIED PUBLIC HEALTH PROBLEMS	10
3.1. Inequality in Health Sector	10
3.2. Non-infectious Diseases and their Risk Factors	12
3.2.1. Cardiac and Circulatory Diseases	12
3.2.2. Oncologic Diseases	13
3.2.3. Diabetes Mellitus	14
3.2.4. Mental (Psychic) Health	14
3.2.5. Factors influencing health (lifestyle and behaviour)	15
3.2.5.1. Dietary Habits	15
3.2.5.2. Insufficient Physical Activities	18
3.2.5.3. Smoking	18
3.2.5.4. Alcohol consumption	19
3.2.5.5. Drug consumption	20
3.3. The Health of Mother, Father and Child	22
3.3.1. Sexual and Reproductive Health	22
3.3.2. Healthy Start of Life	24
3.4. Healthy and Safe Environment	26
3.4.1. Living and Working Environment	26
3.4.2. External Causes of Death and Traumatism	27
3.5. Infectious Diseases	29
4. THE DESCRIPTION OF THE SITUATION AND PROBLEM DEFINITION IN HEALTH CARE	32
4.1. Funding of the Health System	32
4.2. Organisation of Health Care	34
4.3. Quality and Safety of Health Care Services	36
5. Policy Outcomes, Action Results and their Performance Indicators	38
6. Further actions	44
7. Reporting and Evaluation Procedure	55
ANNEXE 1	56
<i>Explanation of the terms used in text</i>	

Abbreviations Used

CHE – Centre of Health Economics
 CRPC – Consumer Rights Protection Centre
 CSB – Central Statistical Bureau
 EC – European Commission
 EMAS – Emergency Medical Assistance Service
 ESPAD – European school survey project on alcohol and other addiction-inducing substances
 EU – European Union
 EU-SILC – survey entitled “The European Union Statistics on Income and Living Conditions”
 FVS – Food and Veterinary Service
 GDP – Gross Domestic Product
 HBSC – Health Behaviour Survey in School-Aged Children
 HI – Health Inspectorate
 HIV – Human Immunodeficiency Virus
 HPC – Health Payment Centre
 ICL – “Infectology Centre of Latvia”, a state agency
 LADNS – Latvian Association of Diet and Nutrition Specialists
 LALRG – Latvian Association of Local and Regional Governments
 LANS – Latvian Association of Nutrition
 LASE – Latvian Academy of Sport Education
 LFFC – Latvian Federation of Food Production Companies
 LPA – Latvian Pharmacologists’ Association
 LPS – Latvian Physicians’ Society
 LSAA – Latvian Sports for All Association
 LSMSA – Latvian Sports Medicine State Agency
 MA – Ministry of Agriculture
 ME – Ministry of Economics
 MES – Ministry of Education and Science
 MEPRD – Ministry of Environmental Protection and Regional Development
 MF – Ministry of Finance
 MH – Ministry of Health
 MI – Ministry of the Interior
 MJ – Ministry of Justice
 MRDLG – Ministry of Regional Development and Local Government
 MT – Ministry of Transport
 MW – Ministry of Welfare
 NGOs – non-governmental organisations
 RSS – Rural Support Service
 PYLL – potential years of life lost
 RSU – Riga Stradins University
 RSU ILSEH – an agency of Riga Stradins University, entitled “Institute of Labour Safety and Environmental Health”
 SAM – State Agency of Medicines
 SCCD – State Centre for Curriculum Development
 SLI – State Labour Inspectorate
 STI – sexually transmitted infection
 TB – tuberculosis
 UL – University of Latvia
 WHO – World Health Organisation

Introduction

The Public Health Strategy for the period between 2011-2017 (hereinafter referred to as the Strategy) is a medium term policy planning document which has been developed in order to continue the implementation of the public health policy, which was started by the Public Health Strategy and its Action Plan for 2004-2010, as approved by the Cabinet of Ministers in 2001, to set new development aims and to define specific points of progress in order to reach them, and to maintain, improve and restore the health status of the Latvian population over the forthcoming seven years. One of the basic human rights is to receive healthcare. Article 111 of Satversme [the Constitution] of the Republic of Latvia provides that “the State shall protect human health”. Likewise, Article 152 of the Treaty Establishing the European Community sets out that “a high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities”. Each individual, in his or her turn, is responsible for using all opportunities provided by the state in order to maintain their own health.

Biological, psycho-emotional, social, economic, environmental, as well as lifestyle factors influence the health of each individual and, therefore, the public health. These rights, opportunities and factors have been taken as the basis in the drafting of this policy planning document.

Health as one of the basic values is the foundation for the quality of human life, the wellbeing of one’s family, and also of society as a whole. A healthy society is the foundation for a productive and efficient economy and the development of the state. Therefore, public health is an important sector for the sustainable development of society and one of the types of organised public activities is to protect, promote and restore human health.

The indicators of public health can be improved only if health is included in all policy fields in the state, and also if all the inhabitants of the state have been ensured equal opportunities to receive healthcare services. It is the joint responsibility of society, each individual, and the state to ensure, maintain and improve health by implementing various sectoral policies. If the resources of the state budget are invested in the promotion of good health and disease prevention, the costs are lower when compared to those involved in fighting the consequences - treating the diseases themselves.

The implementation of the aims and activities defined by the Public Health Strategy (hereinafter referred to as the 2002-2010 Strategy) and its Action Plan for 2004-2010 was regularly monitored, and thematic reports were prepared which allow assessments to be carried out on what has been achieved to date, and to draft the new Strategy as a continuation of the 2002-2010 Strategy.^{1;2;3;4;5;6} Positive developments have taken place as regards reaching some objectives, morbidity levels with vaccine-preventable diseases have decreased significantly, and breast-feeding indicators have improved; however, the objectives have not been reached. Negative trends have been observed with regard to other objectives; for example, adiposity and morbidity with diabetes have increased.

The aims and objectives included in this Strategy, as well as the specific points of progress being offered, should be known and accepted not only by those who are implementing health policy, but by anyone who is doing the same with policies in other sectors, since the aims set in the Strategy can be achieved only through joint effort.

1 “Taisnīgums un solidaritāte veselības jomā” Sabiedrības veselības stratēģijas 2.mērķa sasniegšanas ziņojums, v/a „Sabiedrības veselības aģentūra”, 2008 [“Justice and Solidarity in Health Sector”. Report on achieving the 2nd aim of the Public Health Strategy”, state agency “Public Health Agency”, 2008].
 2 „Zīdaiņu un pirmsskolas vecuma bērnu veselība” Sabiedrības veselības stratēģijas 3.mērķa sasniegšanas ziņojums, VEC, 2008 [“Health of Infants and Pre-School Children”. Report on achieving the 3rd aim of the Public Health Strategy”, CHE, 2008].
 3 „Skolas vecuma bērnu un pusaudžu veselība” Sabiedrības veselības stratēģijas 4.mērķa sasniegšanas ziņojums, v/a „Sabiedrības veselības aģentūra”, 2008. [Health of School Age Children and Teenagers”. Public Health Strategy. Report on achieving the 4 th aim of the Public Health Strategy, state agency “Public Health Agency”, 2008].
 4 „Pieaugušo veselība, veselīgas un aktīvas vecumdienas” Sabiedrības veselības stratēģijas 5.mērķa sasniegšanas ziņojums, VEC, 2009 [“Adult Health, Healthy and Active Old Age”. Report on achieving the 5th objective of the Public Health Strategy, CHE, 2009].
 5 Neinfekcijas slimību izplatības samazināšana” Sabiedrības veselības stratēģijas 8.mērķa atsevišķu apakšmērķu sasniegšanas izvērtējums, v/a „Sabiedrības veselības aģentūra”, 2007. [Decreasing the prevalence of non-infectious diseases. Assessment of the achievement of some objectives of the 8 th aim of the Public Health Strategy, state agency “Public Health Agency”, 2007].
 6 „Vardarbības un nelaimes gadījumu izraisītie veselības traucējumi” Sabiedrības veselības stratēģijas 10.mērķa sasniegšanas ziņojums, VEC, 2009 [“Health Disorders Caused by Violence and Accidents”. Report on achieving the 10 th aim of the Public Health Strategy, CHE, 2009].

1. Basic Principles and Aims of Public Health Policy

THE BASIC PRINCIPLES OF PUBLIC HEALTH POLICY:

Human-centered health care - the public healthcare policy is implemented by making the individual person the focus in terms of prevention, diagnostics, treatment, rehabilitation and ensuring comprehensive information regarding, and the motivation of, people.

Human rights - every person is entitled to the highest level of physical and psychosocial health during the whole of his or her lifetime.

Effective policy and good governance - a health policy is founded upon evidence-based knowledge - scientific evidence and cost effectiveness. Continuity, coordination and updating is ensured in terms of policy planning and implementation, as is the interconnectedness of policy planning documents.

Participation - the involvement of society, public administration institutions, local government authorities, non-governmental organisations, the representatives of private businesses, and foreign institutions in the process of planning, implementing and assessing a public health policy, providing the opportunity for all of Latvia's inhabitants to realise their "health potential" and facilitating as qualitative a functioning of the public health system as possible. Increasing the individual's responsibility for safeguarding and improving one's health.

Solidarity - all inhabitants of Latvia have the duty to cover the cost of maintaining the health system, by paying taxes, fees and any other payments envisaged in legislation.

Health in All Policies - other sectors, institutions and organisations should be involved and be co-responsible for maintaining and improving public health, thereby ensuring a multisectoral strategy with regard to health determining factors (including physical, emotional, economic, social, cultural and other factors).

Equal rights and opportunities for all - everyone bears an equal right to receive the necessary health promotion and healthcare services within the limits of the human, technical and financial resources available within the state, within the scope, and in accordance with the procedure defined by legal acts, irrespective of gender, age, race, skin colour, language, religious beliefs, sexual orientation, political and other views, social background, ethnic background, education, social and material status, type of occupation and other conditions.

The aim of a public health policy is to prolong the healthy life years of the Latvian population and to prevent untimely deaths, while maintaining, improving and restoring health.

To be achieved by 2017:

- to increase by **two years** the healthy life years of individuals
- (from 52.6 healthy life years for men in 2009 to 54.7 years in 2017, and from 55.8 healthy life years for women in 2009 to 57.8 years in 2017).
- to decrease by **20%** the potential years of life lost
- (from 85,338 potential years of life lost among men in 2009 to 68,270 in 2017, and from 35,793 potential years of life lost among women in 2009 to 28,634 in 2017).

To reach the main aim of the public health policy, the following objectives have been set:

- To eliminate injustice in the field of health by implementing measures to ensure equal health opportunities for all Latvian inhabitants.
- To decrease morbidity and mortality from non-infectious diseases, and to decrease the negative impact of risk factors upon the health.
- To improve the health of mother and child, and decrease infant mortality.
- To promote a healthy and safe living and working environment, and to decrease trauma and mortality from external causes.
- To decrease morbidity with infectious diseases among the population.
- To ensure an effective management of the healthcare system and a use of resources, to ensure the optimisation of costs and the sustainability of the healthcare system, as well as ensuring equal access for all Latvian inhabitants to those healthcare services that are paid for from the resources of the state budget.

The main points of progress for reaching the set aim:

- Ensuring partnership and intersector cooperation, and promoting equal health opportunities for all inhabitants
- Reducing the risk factors for non-infectious diseases
- Improving the health of both pregnant women and children
- Decreasing the impact of traumatism and environmental risks upon public health
- Preventing infectious diseases
- Developing a high quality system of healthcare services, and ensuring the equal accessibility of all services to all Latvian inhabitants.

2. Linking the Strategy with Other Development Planning Documents

The Strategy was prepared on the basis of the following documents:

- **The Sustainable Development Strategy for Latvia, "Latvia 2030"**,¹ especially the point of progress covering the quality and accessibility of health and social services, as defined in Section 2: "Long-term Investments in Human Capital".
- **The Strategic Development Plan for Latvia 2010-2013**, which proposes a healthy person in a sustainable society as a pre-condition for safe and stable development.

Other policy planning documents with which the Strategy is connected:

In the field of employment and social policy:

- Program for decreasing domestic violence 2008-2011 (aim: to monitor offences linked with domestic violence, achieving a decrease in the number of such cases and their negative consequences);²
- Action plan for the implementation of Policy Guidelines for Decreasing Disability and its Consequences for 2005-2015 (aim: the complex development and implementation of disability prevention measures);³
- Guidelines on the national family policy for 2011-2017 (aim: to promote the establishment of families, and their stability and wellbeing, and to increase the birth rate, as well as to strengthen the institution of marriage and its value in society);⁴
- Guidelines for the Development of the Field of Labour Protection 2008-2013 (aim: improving policy planning in labour protection, increasing the capacity and effectiveness of state monitoring and control mechanisms, and the practical implementation of "the culture of prevention" in society and companies);⁵
- The "Latvia Fit for Children 2010-2012" Plan (aim: creating a world that will conform to the needs and interests of all children).⁶

In the field of home affairs:

- Guidelines for limiting drugs and psychotropic substances and the spread of addiction and controls for 2011 -2017 (aim: to decrease the acceptance by society of the illegal use of drugs and psychotropic substances and the harm caused by their use to society, and to decrease the availability of these substances).⁷

In the field of education and science policy:

- Guidelines on Education Development for 2007-2013 (aim: to ensure the option for all inhabitants to acquire a high level of education through lifelong learning in accordance with individual interests, abilities and the economic development needs of the state, especially in relation to objectives that are linked with educating students on healthy nutrition, reproductive health and various dependencies, as well sports activities, etc);⁸
- National Sports Development Program for 2006-2010 (aim: to create conditions for the development of a healthy, physically and mentally developed personality);⁹
- National Youth Policy Program for 2009-2013 (aim: to improve the quality of life of adolescents by promoting their initiative, involvement in decision taking, and in public life, supporting working with young people and ensuring that adolescents enjoy an easier transition from the status of a child to that of an adult).¹⁰

In the field of transport and communications policy:

- Road Traffic Safety Program for 2007 -2013 (aim: to achieve a decrease in the number of fatal traffic accidents, especially by dealing with the following tasks - to guarantee the safety of the vulnerable participants in matters concerning road traffic use, increasing safety levels for children in road traffic use, and eliminating drink driving).¹¹

In the field of environmental policy:

- Environmental Policy Guidelines for 2009-2015 (aim: to ensure that people have the option to live in a clean and well-ordered environment).¹²

In the field of a common agricultural policy:

- Implementation plan for measures to supply fruit and vegetables to schools (2010-2013) (aim: to increase the consumption of fresh fruit and vegetables by students in institutions of comprehensive education).¹³

1 Approved at 10 June 2010 sitting of the Saeima (Latvijas Vēstnesis No.101, 29.06.2010.).

2 Approved with the Cabinet of Ministers Order No. 343 of 18 June 2008.

3 Approved with the Cabinet of Ministers Order No. 541 of 19 July 2006.

4 Approved with the Cabinet of Ministers Order No. 65 of 18 February 2011.

5 Approved with the Cabinet of Ministers Order No. 213 of 17 April 2008.

6 Approved with the Cabinet of Ministers Order No. 324 of 9 June 2010.

7 Approved with the Cabinet of Ministers Order No. 98 of 14 March 2011.

8 Approved with the Cabinet of Ministers Order No. 742 of 27 September 2006.

9 Approved with the Cabinet of Ministers Order No. 838 of 31 October 2006.

10 Approved with the Cabinet of Ministers Order No. 589 of 27 August 2009.

11 Approved with the Cabinet of Ministers Order No. 209 of 13 April 2007.

12 Approved with the Cabinet of Ministers Order No 517 of 31 July 2009.

13 Approved with the Cabinet of Ministers Order No. 115 of 24 February 2010.

3. DESCRIPTION OF THE SITUATION AND IDENTIFIED PUBLIC HEALTH PROBLEMS

3.1. INEQUALITY IN THE HEALTH SECTOR

The main aim of the Strategy¹ was to achieve an improvement of the health status of the Latvian population, approximating it to the best EU health indicators, considering such quality of life aspects as the health and social security of inhabitants.

The average life expectancy of newborns was used as the public health indicator. The general aim of the Strategy was to reach 95% of the EU average life expectancy for newborns. The aim was not reached. However, in 2009 the average life expectancy of newborns reached 92% of the EU average life expectancy of newborns. This indicator still significantly falls behind the EU average indicator, since the adjusted mortality indicators due to all causes of death in Latvia were still considerably higher than the EU average. In 2009 the average life expectancy of newborns in the EU was 79.65 years, but in Latvia it was 73.28 years.²

The gender differences within this indicator are worth noting. In 2010 the life expectancy of newborn males was 9.6 years shorter than for females.³ Also, within the EU, the life expectancy among males is shorter when compared to women, although here the difference is only six years.⁴ This reveals male mortality indicators that are too high in Latvia. The lifestyle of Latvian men is typically less healthy, involving the use of dependency-inducing substances, an unhealthy diet, and risky behaviour - men more often become the victims of traffic accidents and accidents at work, or commit suicide, which determines a higher mortality rate at a younger age for them.⁵ The adjusted mortality indicators show that in Latvia 48% men die below the age of 65 (with women the figure is 28%). But in the EU only 29% of men die below the age of 65.⁶

However, the analysis of the healthy years of a typical lifespan, according to Eurostat calculations, shows that in Latvia in 2008 a total of 77% of the span of male life expectancy was spent in the healthy years of that lifespan, but for female life expectancy this figure was down to 70%. Therefore, women in Latvia have a longer life expectancy, but a smaller proportion of years in which they can expect to live a healthy life, which is in line with results from other EU states.

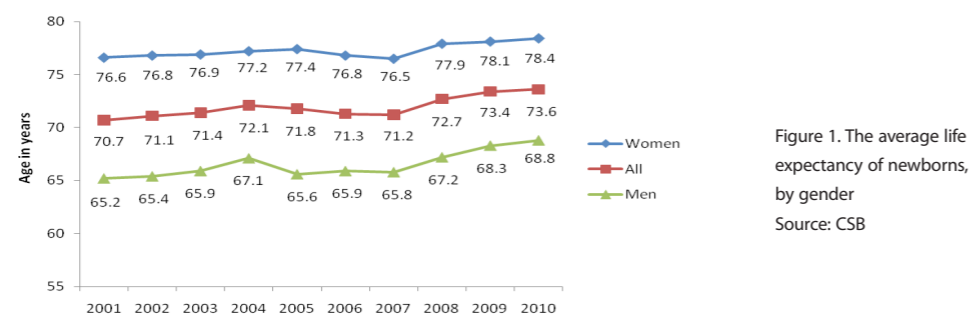


Figure 1. The average life expectancy of newborns, by gender
Source: CSB

In Latvia, 11.3% of men and 15.2% of women rate the condition of their health as 'poor' and 'rather poor', and 48.3% of men and 41.2% of women rate it as 'good'. With the general increase in age of the population, the numbers of inhabitants who assess their own health condition as being 'good' decreases.⁷

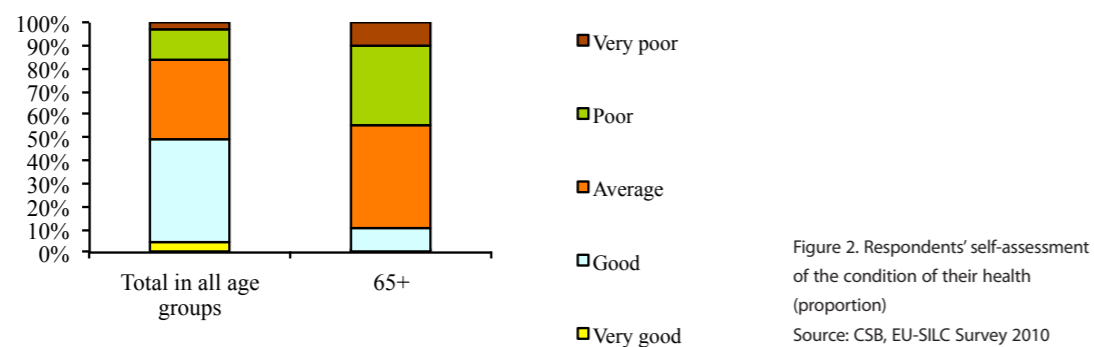


Figure 2. Respondents' self-assessment of the condition of their health (proportion)
Source: CSB, EU-SILC Survey 2010

The indicator, which proves inequality in health, is the difference between life expectancy for newborns in rural and urban populations. For rural inhabitants it is shorter by approximately two years.⁸

In Latvia, inequality in the health sector is caused also by socioeconomic factors, which are proven by different health indicators in various population groups. Poverty is an important factor, one which determines poor health, since the lack of financial resources is a very significant factor in limiting the accessibility of healthcare services. In the EU SILC population survey of 2008, 16% of respondents in Latvia indicated that they could not afford medical examinations, and this is the highest indicator amongst all the EU states.⁹ This shows that lower income households are more at risk of not receiving the necessary medical assistance than other households.

The survey data covering comparisons of health self-assessment in individuals depending upon income levels indicate that a smaller percentage of inhabitants with a lower income (52.2% of men, and 46.6% of women) characterise their state of health as 'good' and 'rather good' compared to those with a higher income (66.7% of men, and 60.8% of women).¹⁰

A life lived in poverty is often linked with various forms of what can be termed risky behaviour, such as an increased use of psychoactive substances (tobacco, alcohol), depression, anti-social behaviour and crime, with an increased risk of consuming unsafe food, and a broad range of somatic problems.¹¹ The CSB data for 2008 show that in Latvia the poverty risk index, which characterises the proportion of the population that is exposed to poverty, was at 26%. Moreover, this indicator is higher among women (27%) than among men (24.2%).¹²

The accessibility of healthcare services (both in financial and regional terms, as well as the accessibility of specialists) characterises the quality and effectiveness of the healthcare system. In Latvia a section of the population has no access to healthcare when this becomes necessary, due to financial conditions.¹³ The survey data indicates that 45.5% of respondents who needed healthcare services during the previous year and who rejected them did so due to financial considerations.¹⁴

The studies on the accessibility of healthcare services reveal that almost one fifth (17.7%) of respondents believe that during the last twelve months they really needed a consultation with a specialist doctor, but this was not carried out due to constrained financial resources (23.7%), or due to waiting lists (12.8%), or due to distance or a lack of transportation (5.4%). This shows that accessibility problems in this sector are one of the most pronounced. Respondents from low income households (below 100 LVL) approach specialist doctors with a frequency which is almost half that of people whose household income is medium or high.¹⁵

Likewise, inequality in Latvia can be observed when comparing the scope of healthcare services that are accessible to general society, along with the funding procedures used for it and the healthcare of prison inmates and the funding for that, something which causes serious problems, since both systems function in isolation.

Identified problems:

- The average life expectancy at birth significantly differs for men and women, which to a large extent is linked to an unhealthy lifestyle (using dependency-inducing substances, unhealthy nutrition) and risky behaviour, which is typical in men.
- The accessibility of healthcare services differs for areas of the Latvian population, something that is influenced both by financial and geographical conditions.
- The organisation of healthcare for prison inmates causes levels of inequality in the accessibility of healthcare.

Objective: To eliminate inequality in the field of healthcare services, by implementing measures to ensure equal opportunities for all Latvian inhabitants to access healthcare services.

To achieve the objective:

- Equal access to the promotion of good health, disease prevention, early disease diagnostics, and healthcare services, irrespective of a person's place of residence, age, gender, or social and legal status, should be ensured;
- Cooperation between public administration institutions, local government authorities, and non-governmental organisations in order to improve the accessibility of health promotion measures is something that should be ensured;
- Monitoring the health status of the general public should be ensured.

1 Public Health Strategy (The Cabinet of Ministers meeting of 06.03.2001).

2 WHO European Health for all database.

3 CSB data.

4 WHO European Health for all database, the data of 2008.

5 „Paredzamā mūža ilguma atšķirības sievietēm un vīriešiem”. V/a „Sabiedrības veselības aģentūra”, Rīga, 2007 [“Differences in life expectancies of women and men.” State agency “Public Health Agency”, Rīga, 2007].

6 Latvia From Exuberance to Prudence (A Public Expenditure Review of Government Administration and the Social Sector), Europe and Central Asia Regional Office Human Development Department, 2010.

7 EU-SILC survey 2010, CSB, 2011.

8 CSB data.

9 Taisnīgums un solidaritāte. v/a „Sabiedrības veselības aģentūra”, 2008. [Justice and Solidarity. State agency “Public Health Agency”, 2008].

10 Latvijas iedzīvotāju veselību ietekmējošo paradumu pētījums 2008, Rīga, 2010.

[Study of the Health Affecting Habits of Latvian Population 2010, Rīga, 2011].

11 WHO, Health for All Policy Framework for WHO Region for Europe, “Health – 21”, 1999.

12 Poverty risk index - the share of inhabitants (in percentage) below the threshold of the poverty risk, which is set at 60% of the available median income recalculated per equivalent consumer. The annual poverty risk threshold in Latvia in 2008 was 2295 LVL in one-person household and 4819 LVL for a household consisting of 2 adults and two children below the age of 14. The data are given with reference to the income reporting year.

13 Access to health care and the financial burden of out-of-pocket health payments in Latvia. WHO, 2009.

14 Pētījums „Iedzīvotāju apmierinātība ar veselības aprūpes pakalpojumiem un to saņemšanas iespējām”, Veselības obligātās apdrošināšanas valsts aģentūra, 2008 [Study “Inhabitants' satisfaction with health care services and the possibilities to receive them”, State Compulsory Health Insurance Agency, 2008].

15 G. Briģis „Iedzīvotāju veselības apsekojuma analīze”, 2008 [G. Briģis “Analysis of Population Health Survey”, 2008].

3.2. NON-INFECTIOUS DISEASES AND THEIR RISK FACTORS

3.2.1. Cardiac and Circulatory Diseases

Cardiac and circulatory diseases form the most significant public health problem in Latvia and one of the most important in the whole world. The high mortality, morbidity and hospitalisation indicators serve as a proof of that. Even though the number of deaths caused by circulatory diseases was smaller in 2010, it is still the most prevalent cause of death (causing 54.1% of all deaths).¹ The indicators of mortality caused by circulatory diseases among the Latvian population are twice as high as the average EU indicators. In 2009 the total adjusted mortality indicator in Latvia for circulatory diseases per 100,000 of the population was 479.5, while in Lithuania this was 496.78, in Finland it was 218.07, and in Austria it was 213.12, but the average in EU countries was at 232.77.2 The total mortality rate from circulatory diseases is higher among women (749.0 per 100,000 people in the population) when compared to men (701.5 per 100,000 of the population). But in the 0-64 age group among males the mortality rate from circulatory diseases (237.0 per 100,000 inhabitants) is three times higher than among women (81.7 per 100,000 inhabitants).³ Even though, since 2001, the total adjusted mortality indicator from circulatory diseases in Latvia has been decreasing slightly every year (in 2001 it was 606.82 per 100,000 inhabitants), diseases of the circulatory system remain a significant public health problem in Latvia.

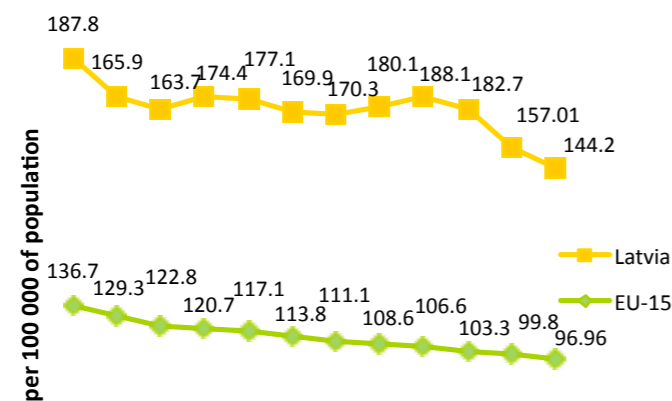


Figure 3. Untimely morbidity (0-64 years) from cardiovascular diseases in Latvia and in the EU (1998-2009)
Source: WHO Health for all database

Every year the number of newly diagnosed cardiovascular diseases increases, and in general the morbidity level from this in Latvia is very high. In 2010, hypertensive diseases had a leading role among all other cardiovascular diseases with a figure of 40.2%, while cerebrovascular diseases were at 9.1%, angina was at 10.3%, and chronic ischemic heart disease was at 5.4%.⁴

The cardiac health of the Latvian population is significantly influenced by the prevalence of cardiac and circulatory disease risk factors among the population. The cross-section survey of cardiac and circulatory disease risk factors in the Latvian population,⁵ serves to reveal that an increased arterial blood pressure above 140/90 mmHg is observed on average in 45% of population, reaching a frequency of between 60-70% in the over-55s. The prevalence of high cholesterol levels (above 5.0 mmol/l) is high - between 40-50% in the 25-34 age group, reaching between 75-85% in the over-55s. Approximately 34% of the population have increased fasting glycaemia above 5.66 mmol/l, but 5.4% of them reach the diagnostic criterion for diabetes mellitus, which is 7.0 mmol/l. Prevalent obesity is also observed, in more than 30% of the population the body mass index exceeds 30kg/m². These points focus upon the attitude of inhabitants towards their own health and their ability to link the presence of risk factors with the possibility of developing cardiovascular diseases in the future. The Latvian population is gradually taking better care of its health; however, this is not sufficient. In a survey that was carried out in 2010, a total of 66.9% of respondents admitted that they had had their blood pressure measured during the last year, while 30.2% had their blood cholesterol levels measured, and 32.8% had their blood sugar levels measured. Preventive activities increase with age; moreover, studies show that women are more active in this regard.⁶ For every third (30.9%) inhabitant who had had their blood cholesterol levels measured, the result was elevated: for men in the 55-64 age group the figure was 42.6%, but for women in the same age group it was higher at 52.1%. The fact that the majority of the population - 84.3% in cases of increased cholesterol levels - received advice on diet is a factor that must be assessed positively.⁷

An international study on secondary cardiovascular prevention,⁸ revealed that in Latvia, after suffering a myocardial infarction or heart surgery, coronary disease patients continue smoking (21.6%), or suffer from increased body weight (80.9%), elevated bloody pressure (58.6%), or elevated cholesterol levels (64.0%), and 23.8% of patients have diabetes mellitus. This data shows that the prevalence and elimination of risk factors is not only a problem for the healthy section of the population, but pertains also to patients.

1 CHE database The Causes of Death of Latvian Population.

2 PVO Health For All database.

3 CHE data.

4 CHE data.

5 „Latvijas iedzīvotāju kardiovaskulāro un citu neinfekcijas slimību riska faktoru šķērsriezuma epidemioloģisks pētījums” (1.ziņojums) Latvijas Ārsts, sept. 2010 [A cross-sectional epidemiological study of the risk factors of cardiovascular and other non-infectious diseases among Latvian population” (1st Report), Latvijas Ārsts, September, 2010].

6 Latvijas iedzīvotāju veselību ietekmējošo paradumu pētījums 2010. Rīga, 2011 [Study of the Health Affecting Habits of Latvian Population 2010. Rīga, 2011].

7 Latvijas iedzīvotāju veselību ietekmējošo paradumu pētījums 2008. Rīga, 2010 [Study of the Health Affecting Habits of Latvian Population 2008, Rīga, 2010].

8 EUROASPIRE III: a survey on the lifestyle, risk factors and use of cardioprotective drug therapies in coronary patients from 22 countries, European Cardiovascular Prevention and Rehabilitation, 2009, 16,2,121-137.

A significant task to be faced in Latvia is that of trying to improve public awareness and to promote the development of both personal skills and lifestyle and behavioural changes to ensure good levels of cardiac and circulatory results with simple and effective measures. The most effective source of prevention for cardiac and circulatory disease is stopping smoking and taking regular physical activity, as well as one's choice of food, making sure it complies with the principles of rational or physiological nutrition (increasing the consumption of fruit and vegetables and decreasing the consumption of salt and saturated fatty acids) and maintaining an adequate body weight.

3.2.2. Oncological Diseases

For a long time malignancies have occupied second place in the reasons for causes of death, following on from cardiac and circulatory diseases. Comparing 2010 to 2009 shows that the mortality rate has increased - from 267.3 to 273.6 cases per 100,000 inhabitants.⁹ The total morbidity indicators in Latvia do not differ significantly from the average EU indicators (except for lung cancer sufferers), but the mortality indicators are higher. Male morbidity rate from malignancies (314.0 per 100,000 inhabitants) is higher than female morbidity rate (239.0 per 100,000 inhabitants). Data from the Latvian Register of Oncological Diseases shows that in 2010, a total of 10,600 people were newly diagnosed with cancer, but the total number of registered patients at the end of 2010 was 62,959.

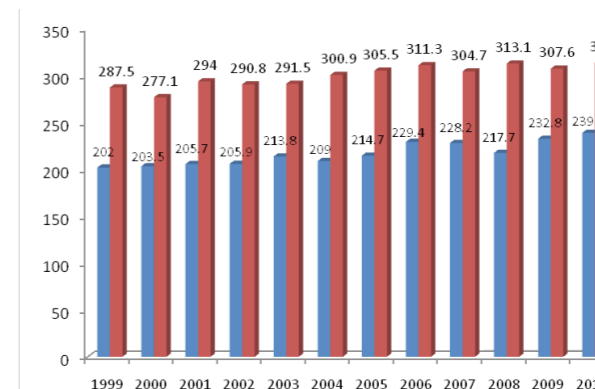


Figure 4. Morbidity from malignancies in 1999-2010, by gender
Source: CSB

Latvia has a large proportion of primary, untreated, visually discernible malignancies (breast, cervical, mouth cavity, and rectal). In 2008 visually discernible cancer in stages III and IV was detected in 25.5% of cases, in 2009 it was 25.8, but in 2010 it was higher, in 27.7% of cases.¹⁰ The high and unchanging prevalence of primary untreated cancers, in its turn, determines the comparatively high first year fatality and low five year survival indicators. The statistical indicators that characterise morbidity in Latvia are comparable to the average EU indicators, but the mortality rates from this disease group are still comparatively higher, without showing any positive changes over time.

In accordance with acts of legislation,¹¹ organised cancer screening has been introduced for breast, cervical and colorectal cancer in Latvia; however, screening for colorectal cancer can be classified as opportunistic. The coverage for the target group for breast and cervical cancer exceeds 95% (letters are sent to this section of the target group); however, the response (actual participation in screening) is not satisfactory - it is significantly lower than the internationally accepted minimum indicators (the coverage for the target group should reach 75% at least). The lowest coverage indicator is for colorectal cancer screening. Individual invitations to participate in screening are sent to the breast and cervical cancer target group, but are not sent to the colorectal cancer screening target group (which does not comply with the definition of an organised screening process). People are not being informed sufficiently about the necessity of participating in the screening program or about the potential benefits of this program.

The program for Controlling Oncological Diseases for 2009-2015,¹² has been developed to decrease the risk of oncological diseases, to increase the survival of oncological patients, and to improve their quality of life. Taking as a basis the situation in Latvia, the global experience, and WHO recommendations, the program defines five points of progress: primary prevention, cancer screening that is organised by the state, treatment, palliative care, and methodological guidance for the sector. The aim of the program can be achieved through intersectoral and multi-disciplinary cooperation. The first and main approach to be emphasised in cancer prevention is the restriction of smoking and the use of alcohol, promoting healthy nutrition and exercise in combination with screening, early diagnosis, risk reduction, appropriate treatment, and palliative care.

9 CSB data.

10 CHE data.

11 The Cabinet of Ministers Regulation No. 1046 of 19 December 2006 “The Procedure of Organising and Funding Health Care”.

12 Approved with the Cabinet of Ministers Order No. 48 of 29 January 2009.

3.2.3. Diabetes Mellitus

The number of diabetes patients is growing with every year, both in Latvia and in Europe in general. The prevalence of diabetes has increased in Latvia from 1.5% of the total population in 2000 to 2.09% in 2005 and 3.2% in 2010.¹ An especially rapid increase in the number of diabetes patients has been observed in recent years: in 2009 in Latvia 67,348 diabetes patients were recorded (or 2,995.4 patients per 100,000 inhabitants), but in 2010 this had increased to 72,654 patients (or 3,258.5 patients per 100,000 inhabitants).²

The majority of patients (93.9% of registered diabetes mellitus patients) in 2010 were Type II diabetes mellitus patients, while Type I diabetes mellitus patients numbered 5.4%, and other specific types of diabetes amounted to 0.7%. Since Type II diabetes mellitus patients are predominantly elderly people, the largest proportion of diabetes patients were in the over-60s age group (in 2009 this figure for this was 70.8% and in 2010 it was 71.4%).³ The development of Type II diabetes mellitus to a large extent is linked with an unhealthy lifestyle and excess body weight.

Currently the diagnostics, treatment and monitoring of diabetes patients in Latvia's prisons and detention centres is very difficult and limited due to insufficient funding and deficiencies in legal regulation.

It is economically more efficient to invest in the prevention of diabetes mellitus risk factors, preventive measures, a timely detection of the disease, and treatment before the disease's complications have developed. In the case of diabetes mellitus, preventive measures are very important - an adequate diet, increased physical activity, and abstaining from addiction-inducing substances, including alcoholic beverages, and not smoking.

3.2.4. Mental (Psychic) Health

Sound public mental or psychological health is an essential pre-condition for developing a stable, safe and prosperous society. The main aspect in improving public mental health is the prevention of mental diseases and suicides, improving mental health and well-being, improving somatic health, a realisation of human resources and human potential in full, decreasing prejudice and discrimination, the accessibility of specialists, intersector cooperation, the attraction of resources, etc.⁴

In 2010 the most frequent mental and behavioural disorders for patients who have been entered into the Register of Patients with Particular Diseases, were schizophrenia, schizotypal disorders and hallucinations (26.6%), mental retardation (24.0%), organic mental disorders, including symptomatic disorders (22.7%).⁵ An analysis of newly registered patients shows that, according to the method by which the disorder had been diagnosed, only 14.8% of cases involving all registered patients saw the disorder being diagnosed by a general practitioner. Most frequently, the patients themselves identified the disorder and approached a psychiatrist (18.2%) or the disorders were noticed by relatives or friends (24.7%), or they were identified by a psychiatrist (16.1%). In 8.4% of cases the diagnosis was made at the psycho-neurological medical facility.⁶

The proportion of inmates with mental and behavioural disorders is large (in 2010 a total of 6,795 had 5,896 registered cases of mental and behavioural disorders). The percentage of such persons in prisons or detention centres greatly exceeds this proportion in society; therefore they need special attention. Inmates with mental and behavioural disorders pose a threat to other inmates and staff; likewise, special methods for working with inmates are needed.

In Latvia the indicators reflecting the mental health of the population have worsened. In general, 64.7% (58.4% of men and 70.7% of women) have noted that during the last month they have experienced tension, stress and depression. Feelings of stress and depression are most frequently experienced by both genders in employable age, between 25 to 54 years of age. On average, 26.9% of the total, or 24.9% of men and 28.8% of women, indicate that during the last year they have experienced episodes of depression.⁷ During the last year, 50.8% of boys and 64.2% of girls have experienced irritation or a bad mood more often than once per week.⁸ It is worrying that 27% of school students between the ages of 15-16 admit that they have considered suicide, but 12% of them have actually attempted to commit suicide.⁹

Latvia is one of the countries with the highest suicide rate in Europe. In 2010, a total of 435 people committed suicide, which constitutes 19.4 per 100,000 of inhabitants. Most often suicides are committed by men in the 45-59 age group.¹⁰ & 11 Suicides (in the 15-64 age group) rank as the fifth most frequent cause of death. Among men the mortality rate for attempted suicides (36.2 per 100,000 inhabitants) is up to seven times higher than among women (5.1 per 100,000 inhabitants).¹² The consistent decrease in the number of suicides, which was observed over the last fifteen years, stopped in 2008-2009, possibly, under the impact of the economic recession.

1 CHE data.

2 Ibid.

3 Ibid.

4 WHO Regional Office for Europe, Mental Health facing the challenge, building solutions, Report from the European Ministerial Conference, Copenhagen, 2005.

5 CHE data.

6 Garīgā veselība Latvijā 2009. gadā, tematiskais ziņojums, VEC, 2010 [Mental Health in Latvia in 2009, thematic report, CHE, 2010].

7 Latvijas iedzīvotāju veselību ietekmējošo paradumu pētījums, 2010. Rīga, 2011 [Study of the Health Affecting Habits of Latvian Population 2010, Rīga, 2011].

8 Velika B. u.c., Veselība un psihosociālā labklājība skolas vecuma bērniem Latvijā, HBSC, Rīga, 2008 [Velika B., et al. Health and psychosocial wellbeing of school age children in Latvia, HBSC, Rīga, 2008].

9 Koroļeva I. u.c., Atkarību izraisīto vielu lietošanas paradumi un tendences skolēnu vidū, ESPAD, Rīga, 2008 [Koroļeva I., et al. The habits and trends of using addictive substances among school students, ESPAD, Rīga, 2008].

10 CSB data.

11 Taube M, Dambergā I, Pašnāvības Latvijā – situācija, perspektīvas, risinājumi, ziņojums par situāciju, Rīga, 2009 [Taube M., Dambergā I. Suicides in Latvia – the situation, prospects, solutions, report on the situation, Rīga, 2009].

12 CSB data.

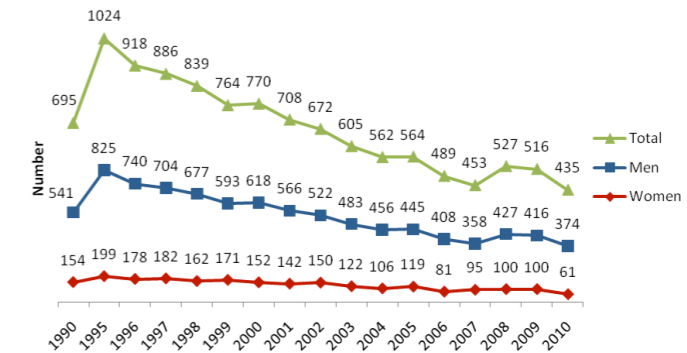


Figure 5. The dynamics of the number of suicides from 1990-2010, by gender
Source: CSB

Isolated short-term campaigns and activities aimed at reducing prejudice against persons with mental health problems, decreasing the number of suicides, and supporting people in situations of crisis, have been carried out in Latvia.¹³

In 2008 the guidelines entitled "Improving the mental health of the population in 2009-2014",¹⁴ were adopted with the aim of providing to the population high quality mental healthcare which could conform to their needs. An action plan for the implementation of the guidelines is needed in order to implement a consistent and continuously planned policy. To ensure the implementation of a successively planned policy, the Cabinet of Ministers has charged the Ministry of Health with drafting a plan for the implementation of the Guidelines,¹⁵ defining measures to improve the development of mental healthcare services, promoting mental health, and improving the legislative basis.

3.2.5. Factors influencing health (lifestyle and behaviour)

A healthy lifestyle has an essential role in preserving and improving health. As mentioned before, the most significant public health problems in Latvia are cardiac and circulatory diseases. The main behaviour factors, which facilitate the development of circulatory diseases, are unhealthy nutrition, insufficient physical activity and smoking. In 80% of cases circulatory diseases are linked to the presence of these risk factors. The features of a healthy lifestyle are sufficient physical activity, a rational or physiological diet, and an absence of harmful habits (smoking and alcohol consumption).

3.2.5.1. Dietary Habits

Nutrition has a crucial role in improving and maintaining health indicators. A balanced diet with a high nutritional value is needed to ensure the growth and the development of the body, to promote a high capacity for work and wellbeing. However, only 49% of Latvian inhabitants consider the food that they consume daily to be generally healthy, but 39% admit that their daily diet is not healthy.¹⁶ In general men have poorer dietary habits such as, for example, a low intake of vegetables, or a low proportion of full-grain and bran bread consumption.¹⁷ The WHO recommends that at least 400g of vegetables and fruit be consumed daily;¹⁸ however, only 35.3% of inhabitants consume fresh vegetables every day. Likewise, only 21.5% of inhabitants consume fruit and berries on a daily basis. Only 33.1% of men and 49.8% of women do not add salt to their food, but almost one man in every ten (9.0%) adds salt to his food before tasting it, while women do this less frequently, amounting to 4.3% of the total.¹⁹ The average amount of salt consumed by Latvian inhabitants every day is 7.1g per day, which exceeds the recommended daily amount of 5g per day.²⁰ Excessive consumption of salt is a very important risk factor in cardiac and circulatory diseases, since it increases the risk of hypertension.

13 Erdmane A, Leimane-Veldmeijere I, Muciņš R, Veits U, Ziņojums par Pasaules Veselības organizācijas garīgās veselības deklarācijas un rīcības plāna ieviešanu Latvijā, Rīga, 2009 [Erdmane A., Leimane-Veldmeijere I., Muciņš R., Veits U., Report on the Implementation of World Health Organisation Declaration and Action Plan on Mental Health in Latvia, Rīga, 2009].

14 Approved with the Cabinet of Ministers Order No. 468 of 6 August 2008.

15 Ibid.

16 „Sabiedrības veselības analīze Latvijā 2006”. Veselības statistikas un medicīnas tehnoloģiju valsts aģentūra, Rīga, 2007 [The Analysis of Public Health in Latvia. State Agency of Health Statistics and Medical Technologies, Rīga, 2007].

17 Latvijas iedzīvotāju veselību ietekmējošo paradumu pētījums 2008. VEC, 2010 [Study of the Health Affecting Habits of Latvian Population 2008, CHE, 2010].

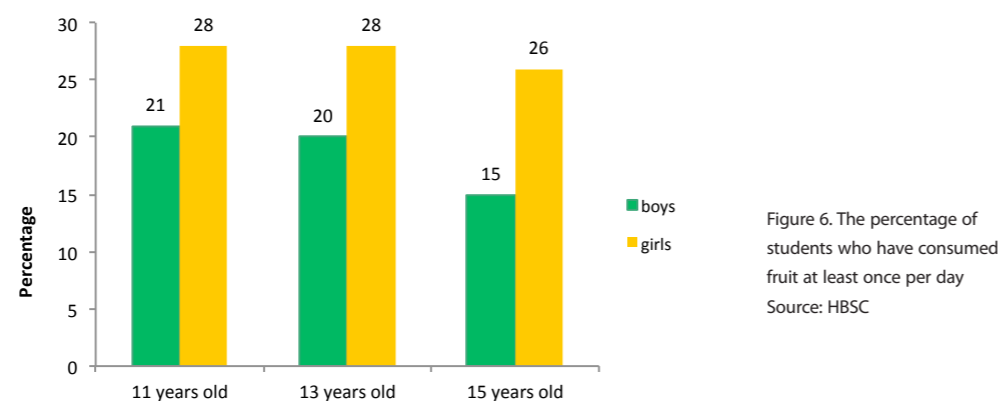
18 Diet, nutrition and the prevention of chronic diseases. Report of a joint WHO/FAO expert consultation. Geneva, World Health Organization, 2003.

19 Latvijas iedzīvotāju veselību ietekmējošo paradumu pētījums, 2010. Rīga, 2011. [Study of the Health Affecting Habits of Latvian Population 2010 Rīga, 2011].

20 Latvijas iedzīvotāju visaptverošais pārtikas patēriņa pētījums 2007-2009., Nacionālais diagnostikas centrs, PVD Pārtikas centrs, Rīga, 2009. [A comprehensive survey of Latvian population food consumption patterns 2007-2009. National Centre of Diagnostics, FVS Food Centre, Rīga, 2009].

Milk is a very important source of calcium for the body, and yet almost half of the Latvian population (54.3%) do not consume milk daily. Latvian inhabitants are similarly reluctant to use sour milk products.¹ Inhabitants with a higher level of education, along with city dwellers, as well as women, are more prone to changing their dietary habits.²

During the teenage years the need for nutrients physiologically increases, and the nutritional value and the balance of food consumed is important. Educating students and their parents on issues of healthy nutrition is very important, thereby promoting the choice of a healthy diet among school students. A study shows that in general girls have healthier dietary habits: girls consume chips and soft drinks less frequently than boys. A total of 39.8% of students eat sweets at least once per day. On average only 23% of school students consume fruit and vegetables every day. Only approximately one third of girls and one fifth of boys consume vegetables every day.³



In almost every second Latvian comprehensive school (46.7%) there is a café or a shop, and in 12.4% of them there is a food and drink vending machine from which students can purchase items that are predominantly sweets and calorie-rich treats. The students in Riga and in schools with Russian as the language of instruction have the greatest opportunity of purchasing sweets and calorie-rich treats from a café or shop that is located in the school or from food and or drinks vending machines.⁴

In 2006, a Cabinet of Ministers Regulation was adopted,⁵ prohibiting distribution in institutions of education any drinks, sugar confectionery and chewing gum that contains certain food additives, including colourings, sweeteners, preservatives and other substances, as well as food products with a high concentration of salt. The regulation was developed with the aim of restricting the availability of food products in the institutions of education that are unnecessary in the daily diet of children (including crisps, salty nuts, coloured sweets, or sweetened and coloured drinks).

To ensure balanced nutrition for first grade pupils, beginning on 1 September 2007, pupils have been receiving a state-funded free lunch. Quality criteria have been set for free lunches such as, for example, excluding the use of potato chips, sausages, and ketchup, but milk, fresh vegetables and lean meat must be included.⁶ In 2010 the subsidy for providing free lunches to first grade pupils was LVL 2,264,018 (0.80 LVL per pupil). To ensure balanced nutrition for primary school students of all ages, free lunches should also be introduced for pupils in the other grades, 2-9, if appropriate state budget funding becomes available.

To promote the accessibility of healthy food in institutions of education, in 2007 the Ministry of Health prepared a handbook entitled "Preparing Balanced Menus for Pupils of Grades 1-4", which was intended for free distribution to all catering blocks at institutions of education. The handbook contains practical recipes for making not only delicious, but also healthy school lunches, so that lunch will provide all students their necessary nutrients.

Since 2004 the support program for supplying certain milk products to the students of institutions of comprehensive education, the so-called "School Milk" program, has been available in Latvia. The European Commission funds the program; and its basic aim is linked to the promotion of a healthy diet and milk consumption among school students. In the 2010-2011 school year the program for supplying fruit and vegetables to schools, or "The School Fruit", was introduced, with the aim of promoting higher rates of consumption in fruit and vegetables among school students. In the 2010-2011 school year, 78% of the grade 1 State Agency of Medicines-6 students who were enrolled in schools were registered for participation in the program.

Childhood obesity causes extensive and serious health and social problems in the future life of the child. Due to incorrect nutrition in the pre-school age, one fifth of first graders (22.9%) have excessive body weight or obesity (and in Riga this figure is higher, at 28.2% of first graders). Moreover, its proportion among boys aged 7-8 is larger than among girls; however, during the last two years the proportion of first grade girls aged 7-8 suffering from obesity has increased faster than the proportion of boys suffering from obesity. The greatest proportion of first graders with excessive body weight has been observed in Riga and other large cities, as well as in schools with Russian as the language of instruction (especially for boys). However, the greatest increase in excessive body weight and obesity (+4.5%) during the last two years has been observed in schools with Latvian as the language of instruction. One in ten first graders in Latvia is underweight, most often in small towns and in the countryside.⁷ Several studies performed in other countries proves that food product advertising influences children's taste, shopping habits and food consumption. Even an advertising spot that is just thirty seconds long significantly influences the choice of food for two year-old children.⁸ According to the Eurobarometer study, 17% of Latvian inhabitants believe that food advertising fully influences children's dietary habits and 53% indicate that advertising to a large extent influences dietary habits.⁹ Studies have proven that TV advertising is linked with the obesity of children aged between two to eighteen.¹⁰ On average, Latvian school students spend 4.78 hours watching TV on weekdays and 5.48 hours over the weekends.¹¹

Since 2003 it has been possible to study nutritional science at Riga Stradins University, and since 2006 it has been possible to acquire a health science master's degree in nutrition (within the framework of the inter-institutional academic master level programme, "Nutritional science"). Nutrition specialists can participate in the processes of health promotion, education, treatment and rehabilitation at hospitals, institutions of education, health centres, food production and catering companies, etc. However, nutrition specialists have so far been insufficiently involved in performing these duties.

To promote the consumption of healthy food in society, the Cabinet of Ministers has approved both the guidelines entitled "Healthy Nutrition 2003-2013",¹² and a plan for implementing these guidelines,¹³ envisaging being able to inform society about issues related to healthy nutrition and developing nutritional recommendations for different social groups, integrating issues of healthy nutrition in comprehensive secondary education programmes, as well as other measures.

Unhealthy dietary habits involving the consumption of sweet drinks and sweets and insufficient care for oral hygiene can influence dental health. Dental caries is still a significant problem in Latvia, affecting the population in all age groups. The prevalence of dental caries is characterised by the DMF index (the number of decayed, missing and filled teeth). The DMF index for permanent teeth in children of the age of twelve has decreased from 5.8 in 1993 to 3.08 in 2010; however, it is still high according to WHO classification.¹⁴

Thanks to active preventive measures, the dental health status of children and teenagers has significantly improved during recent years. The work to provide information and to motivate people that has been carried out by dental health centres covers 74.6% of the country's population in rural regions and cities, and partly also in Riga. Dental health centres regularly assess children's oral health status and the prevalence of dental and oral cavity diseases, and they inform the parents of children about anything they discover in this area. In 2009, 15,959 children had their dental health evaluated.

The measures to inform and educate the public that have been carried out over the last ten years have led to the improved care of the oral cavity. In 2010, 40.4% of men and 65.1% of women brushed their teeth more than once per day, but 12.1% of men and 2.5% of women brushed their teeth less frequently than once a week. Caring for dental health, including regular visits to the dentist, is an indicative value that reveals the adult population's general attitude towards their health. In 2010, 48.3% of population did not visit the dentist even once (56.0% of men and 41.0% of women).¹⁵

1 Latvijas iedzīvotāju veselību ietekmējošo paradumu pētījums 2010. Rīga, 2011
[Study of the Health Affecting Habits of Latvian Population 2010, Rīga, 2011].

2 Ibid.

3 Uztura paradumi un ķermeņa masa skolas vecuma bērniem Latvijā., Rīga, 2007 [Dietary habits and body mass of school age children, Rīga, 2007].

4 Bērnu antropometrisko paradumu un skolu vides pētījums Latvijā. SVA, Rīga, 2008
[A study of children's anthropometric habits and school environment. PHA, Rīga, 2008].

5 The Cabinet of Ministers Regulation No. 693 of 22 August 2006 "An Amendment to Regulation No. 610 of 27 December 2002 "Hygiene requirements for institutions of comprehensive primary, comprehensive secondary and vocational education" and Regulation No. 692 of 22 August 2006 "Amendment to Regulation No. 596 of 27 December 2002 "Hygiene requirements for institutions of education implementing pre-school education programs"".

6 The Cabinet of Ministers Regulation No. 1206 of 28 December 2010 "Procedure for calculating, allocating and using state budget resources for catering to pupils of primary education institutions".

7 Bērnu antropometrisko paradumu un skolu vides pētījums Latvijā, 2010. Rīga, 2011.

[A study of children's anthropometric habits and school environment in Latvia, 2010. Rīga, 2011].

8 "The challenge of obesity in the WHO European Region and the strategies for response" WHO, 2007.

9 Health and food, Special Eurobarometer, November 2006.

10 "The challenge of obesity in the WHO European Region and the strategies for response" WHO, 2007.

11 Fiziskā aktivitāte un sēdošs dzīvesveids skolas vecuma bērniem Latvijā, Veselības veicināšanas valsts aģentūra
[Physical activity and sedentary lifestyle among school-age children in Latvia, State Agency for Health Promotion].

12 Approved with the Cabinet of Ministers Order No. 556 of 4 September 2003.

13 Approved with the Cabinet of Ministers Order No. 856 of 10 November 2004.

14 CHE data

15 Latvijas iedzīvotāju veselību ietekmējošo paradumu pētījums, 2010. Rīga, 2011.

[Study of the Health Affecting Habits of Latvian Population 2010, Rīga, 2011].

3.2.5.2. Insufficient Physical Activity

Physical activity is an important factor in influencing the levels of health in all ages. The consumption of energy levels of between 1000-1500kcal per week or 250-350kcal per day, which can be achieved by intense body movements that cause additional sweating, is classed as being physical activities. The recommended amount of weekly physical activity is five times a week or three times per week for intensive movement. The WHO recommends that adults dedicate at least thirty minutes every day to physical activities;¹ however, only 12.2% of Latvian inhabitants comply with this recommendation. The 2010 survey on health-influencing habits amongst the Latvian population shows that for the majority of the population this is insufficient - in 2010, 39.9% of inhabitants were engaged in some form of physical activity for at least half an hour every day or two to three times per week and more often; moreover, women were significantly less active (34.7%) than men (45.3%).²

In accordance with data from the survey performed by the Market and Public Opinion Research Centre SKDS,³ almost half or 49% of inhabitants responded that they do not engage in any physical or sporting activities at all.

In accordance with the Eurobarometer survey,⁴ in Latvia 44% of the population does not engage in any physical or sporting activities at all, while the average percentage in the EU is 39%. Likewise, it was found that in Latvia only 28% of inhabitants engage in physical or sporting activities one or two times a week, while the EU average is 40%.

The ways in which leisure time can be spent are of a kind that predominantly involve little physical activity - the majority of inhabitants (41.5%) spend their leisure time reading or watching TV. A total of 42.1% of inhabitants ride State Agency of Medicines bicycles or go for walks, but only 16.5% spend their leisure time jogging gently or engaging in other physical activities.⁵

Insufficient physical activity is one of the most significant factors that negatively affects the health of school-aged children. The proportion of school children whose general level of physical activity could be considered as being sufficient (involving activity taken at least five days a week and for at least sixty minutes a day), is 46.3%. The proportion of girls with sufficient levels of physical activity is on average 14% per cent smaller than that of boys.⁶ Quite often, the physical activities of children are restricted by insufficient opportunities to use the school's sports hall or sports grounds, as well as by inadequate infrastructure in their place of residence.

In 2006, with the aim of creating pre-conditions for the development of a healthy, physically and mentally developed personality, the National Sporting Development Program for 2006 -2012 was approved.⁷ Starting with 2009, the state budget does not provide sufficient resources for its implementation, i.e. at an amount that is sufficient to ensure the involvement of inhabitants in activities which have been designed for promoting a healthy and active lifestyle. The objectives envisaged by the program are aimed at involving children and adolescents in sporting activities, including sports for all, or in promoting the development of high achievement sports. To highlight the development of sports for all, as well as the provision of measures that are intended to reduce sports-related injuries, following an assessment of the aims and objectives included in the Sporting Policy Guidelines for 2004-2012,⁸ and in the National Sporting Development Program for 2006-2012,⁹ the Sporting Policy Guidelines for 2013-2020 should be elaborated.

3.2.5.3. Smoking

Smoking is a significant risk factor for several chronic diseases, such as oncological, circulatory, and respiratory tract diseases, and for diabetes. Smoking also has a long-term effect upon the ingestion and reproductive system and delivers an adverse impact to oral and dental health and pulmonary functional abilities.¹⁰ Thanks to extensive smoking restrictions in public places that have been laid down in legal acts, positive trends in the prevalence of smoking have been observed in Latvia. Moreover, Latvia is one of the few WHO European Region states in which legal acts require the placement of warnings and colour photos on the packaging of tobacco-related products and which prohibit the advertising of tobacco products on television and radio and in public places. The implementation of these measures since 1998 has resulted in a gradual decrease of daily smokers both among men and women. The proportion of men who smoke on a daily basis has decreased from 51.3% in 1998 to 45.0% in 2008, while the proportion of women who smoke on a daily basis has also decreased, from 19.2% to 15.6%.¹¹ The 2010 survey shows that the overall proportion of daily smokers is 33.7% (47.4% men and 20.7% women). The proportion of daily smokers among women is larger in Riga and the other largest cities in Latvia (28.8% and 22.6% respectively), but among men in the largest cities and rural territories it is 52.8% and 48.5% respectively.¹² In Latvia the mortality rates for men from diseases that are related to smoking in the age group 35-45 is the highest in the European Union.¹³

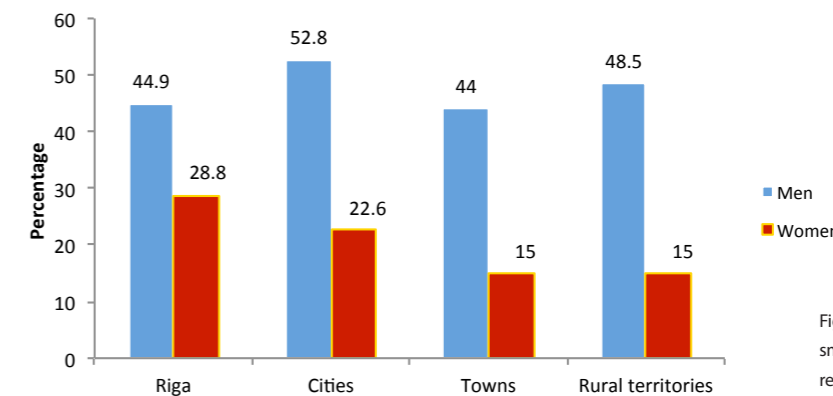


Figure 6. Proportion of daily smokers by gender and place of residence (percentage)
Source: FINBALT

It must be noted that the use of tobacco products is a topical issue amongst adolescents. Study data shows that in general 43% of school students (46.8% of boys and 38.8% of girls) aged 13 to 15 years are currently using tobacco products. A total of 18.2% of students in this age group are daily smokers. Compared to the 2002 study data, smoking among boys and girls has increased by more than 5%.¹⁴ The legal act provides that it is prohibited to sell tobacco products to persons below the age of eighteen,¹⁵ and their sale is also prohibited at educational institutions and in terms of installing vending machines that would make them easily accessible to children and adolescents. However, survey data shows that the majority of school students who smoke (46.7%), also purchase their cigarettes from shops and kiosks, and of these 56.2% admit that during the last month no one refused to sell them these products because of their age.¹⁶

The proportion of households that are exposed to tobacco smoke is high. A total of 54.5% of men and 44.5% of women have noted that in the family someone smokes in the presence of others. The proportion of those exposed to smoking above average levels for both genders is found in the 15-24 age group; likewise the impact of passive smoking is greater in groups with a lower level of education. A total of 14.4% of men and 3.9% of women are forced to spend more than five hours in work premises that are filled with tobacco smoke. More than half (56.9%) of school students (13-15 years old) live in homes in which someone smokes in their presence, and 73.3% of school students spend time outside their homes in places in which someone smokes in their presence.¹⁷ The ban on smoking in public premises has improved the situation; however, the requirements set out in legal acts are not fully complied with.

The popularity of the consumption of other types of tobacco products is growing in Latvia. In the youngest age group (15-24), 50.4% of men and 41.8% of women had smoked a water pipe during the last year. A total of 12.0% of men and 0.3% of women in this age group admit having tried snuff or chewing tobacco, even though the sale of both snuff and chewing tobacco is prohibited in Latvia.¹⁸

Healthcare staff have an important role to play in decreasing smoking. Even very brief and simple advice provided by a healthcare specialist may significantly help to increase the number of cases in which people quit smoking. However, as survey data shows,¹⁹ a significant proportion of medical students are also smokers - from 19.6% of dentistry students up to as much as 49.6% of nursing students.

In practice it means that only a small number of smokers receive advice from their doctor to quit smoking. In 2010, only 17.2% of daily smokers were advised by their doctor to quit smoking. Family members have been more actively urging to quit smoking - a total of 53.9% of them, as well as other persons amounting to 27.4%.²⁰

The majority of prison inmates smoke and have smoking-related health disorders, as well as other addictions.

3.2.5.4. Alcohol consumption

Alcohol consumption is a significant indicator for assessing the prevalence of alcohol use and its consequences in a country, as well the general public health status. According to CSB data, in 2009 the consumption of absolute alcohol per capita was 6.1 litres, but when calculating per capita consumption among the population of fifteen year-olds and older, the figure was 7.01 litres. The registered consumption of legal alcohol comprises all registered alcohol that has been produced and sold in the country, as well as information concerning foreign alcohol trade.

1 Steps to health. A European framework to promote physical activity for health. Copenhagen, WHO Regional Office for Europe, 2007.

2 Latvijas iedzīvotāju veselību ietekmējošo paradumu pētījums 2010. Rīga, 2011 [Study of the Health Affecting Habits of Latvian Population 2010. Rīga, 2011].

3 Latvijas iedzīvotāju sportošanas paradumi, SKDS, 2007 [Sports habits of Latvian population, SKDS, 2007].

4 Survey on Sport and Physical Activity, Special Eurobarometer, March 2010.

5 Latvijas iedzīvotāju veselību ietekmējošo paradumu pētījums 2010. Rīga, 2011 [Study of the Health Affecting Habits of Latvian Population 2010. Rīga, 2011].

6 „Fiziskā aktivitāte un sēdošs dzīvesveids skolas vecuma bērniem Latvijā”. VVVA

[Physical activity and sedentary lifestyle among school-age children in Latvia. State Agency for Health Promotion].

7 Approved with the Cabinet of Ministers Order No. 838 of 31 October 2006.

8 Approved with the Cabinet of Ministers Order No. 632 of 15 September 2004.

9 Approved with the Cabinet of Ministers Order No. 838 of 31 October 2006.

10 „Smēķēšanas un alkohola lietošanas izplatība skolas vecuma bērniem Latvijā 1991.-2006.” SVA, Rīga, 2008

[The prevalence of smoking and alcohol consumption among school-age children in Latvia, PHA, Rīga, 2008].

11 „Latvijas iedzīvotāju veselību ietekmējošo paradumu pētījums” 2008. Rīga, 2010. [Study of the Health Affecting Habits of Latvian Population 2008, Rīga, 2010].

12 „Latvijas iedzīvotāju veselību ietekmējošo paradumu pētījums” 2010. Rīga, 2011. [Study of the Health Affecting Habits of Latvian Population 2010. Rīga, 2011].

13 Projekts „HEM – Novērst atšķirības starp Eiropas Savienības iedzīvotājiem”. v/a SVA.

[Project “HEM - preventing differences between the inhabitants of the European Union”, state agency Public Health Agency].

14 Starptautiskais jauniešu smēķēšanas pētījums 2007.gada aptauja Latvijā”. v/a „Sabiedrības veselības aģentūra”, 2007

[International study of smoking among adolescents, 2007 survey in Latvia”. State agency “Public Health Agency”, 2007].

15 Likums „Par tabakas izstrādājumu realizācijas, reklāmas un lietošanas ierobežošanu”

[Law “On restricting the sales, advertising and use of tobacco products”].

16 Starptautiskais jauniešu smēķēšanas pētījums 2007.gada aptauja Latvijā”. v/a „Sabiedrības veselības aģentūra”, 2007

[International study of smoking among adolescents, 2007 survey in Latvia”. State agency “Public Health Agency”, 2007].

17 Ibid.

18 Latvijas iedzīvotāju veselību ietekmējošo paradumu pētījums 2010. Rīga, 2010

[Study of the Health Affecting Habits of Latvian Population 2010. Rīga, 2011].

19 Global Health Professional Student Survey (GHPSS), WHO, 2009.

20 Latvijas iedzīvotāju veselību ietekmējošo paradumu pētījums 2010. Rīga, 2010

[Study of the Health Affecting Habits of Latvian Population 2010. Rīga, 2011].

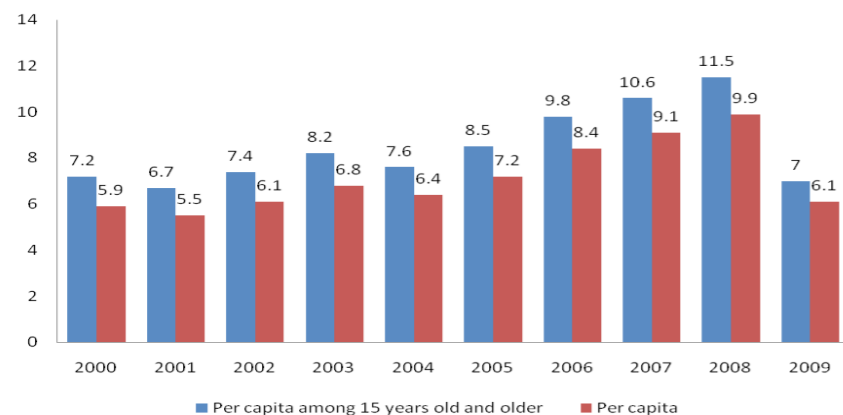


Figure 7. Consumption of absolute alcohol in litres in Latvia, 2000-2009
Source: CSB

Starting with 2009 the CSB uses only data on registered alcohol in calculating the rates of alcohol consumption per capita. Calculating unregistered or illegal alcohol consumption is problematic, because it is not counted.¹ According to the Eurobarometer study in 2009, in Latvia a comparatively small number of respondents consume alcohol every day (2%); however, 33% of respondents consume alcohol between two to three times per month.²

During the last decade a stable trend has continued in Latvia - the decreasing number of traffic accidents caused by drivers who have been under the influence of alcohol. In 2010, a total of 317 road traffic accidents with injuries were caused by drunken drivers, which is 7.9% of the total number of injuries caused by road traffic accidents and is 1.6% smaller than the figure for 2009.

It is statistically proven that binge drinking is linked with criminal behaviour, especially among young males. In 2010, when compared to 2009, the number of crimes committed whilst being under the influence of alcohol has decreased by 27% (In 2009, 4,586 crimes were committed whilst being under the influence of alcohol, but in 2010 this figure had fallen to 3,349).³

To decrease alcohol consumption in society, concerted intersectoral cooperation is needed, as well as concrete measures for decreasing the accessibility of alcoholic beverages, the illegal circulation of alcohol, and trade and advertising restrictions, which will be set out by the Action Plan for Decreasing Alcohol Consumption.

3.2.5.5. Drug consumption

In Latvia so far, two large-scale representative surveys have been carried out, allowing the use of drugs amongst the population to be identified. The results of both surveys indicate that in 2007, when compared to 2003, the indicators for people trying drugs and the recent use of drugs (during the previous year) amongst the population have significantly increased in all age groups and for both genders. According to the results from the 2008 study, every fourth person amongst the students who took part in the survey (24.6%) in grades 9-10 in Riga has tried one of the illegal substances.⁴

During the last years the number of newly treated drug users has gradually increased - in 2006 there were 390 first time patients who were treated for drug or psychotropic substances addiction or abuse, but in 2007 a total of 611 persons were diagnosed with this, and in 2008 it rose again to 645 persons. In 2009 and 2010 this indicator significantly decreased to 435 and 429 patients respectively.⁵

The number of inmates who have used drugs before sentencing and who continue to use them in places of imprisonment is large. According to one study,⁶ a total of 66.1% of the total number of the prison population used drugs, but 31.8% also continue using them in places of imprisonment. Dependency treatment is not accessible in prisons or detention centres (only detoxification is available), which increases the risk of repeated crime after the release of these untreated persons, as well as the risk of spreading infectious diseases, typical of addicted persons (HIV, hepatitis viruses, etc), in society following their release.

The Cabinet of Ministers, with the aim of decreasing the public acceptance of the use of illegal drugs, and the harm caused by their use and accessibility, approved Guidelines for Restricting and Controlling the Spread of Narcotics and Psychotropic Substances and Addiction to them for 2011-2017.⁷ These guidelines envisage a number of measures aimed at the prevention of drug addiction and drug use, as well as an improvement of the healthcare for drug addicts and drug users. It provisions for providing around-the-clock medical assistance at multi-profile hospitals to addiction patients with acute health problems, considering the coverage provided by addiction medicine, and this is something that should be taken up in elaborating the Action Plan for Restricting Alcohol Consumption.

Identified problems:

- Latvia has high morbidity and mortality levels caused by non-infectious diseases (cardiac and circulatory diseases, oncological diseases and diabetes), the progression of which to a large extent is influenced by the person's lifestyle (nutritional habits, physical activities and use of addiction-inducing substances). Untimely mortality caused by non-infectious diseases is higher among men than among women.
- The care for and knowledge about safeguarding their health and the available options for timely diagnosis and treatment of diseases is insufficient amongst inhabitants (especially males).
- A large section of the Latvian population exhibits unhealthy nutritional habits - the insufficient consumption of vegetables, fruit and berries, and the excessive use of salt; moreover, men have poorer nutritional habits than women.
- The majority of the Latvian population are insufficiently engaged in physical activities, since there is a lack of awareness in the role that physical activities can play in safeguarding the health, skills, abilities and resources for engaging in physical activities; likewise, the environment for promoting physical activities is underdeveloped and is not sufficiently accessible (bicycle paths, and a sufficient number of sports halls and sports grounds).
- Health indicators for adolescents are deteriorating, which is influenced by the growing prevalence of smoking and drug use among young people, unhealthy nutritional habits and a lack of participation in physical activities.
- Prejudices against people with mental health disorders are still prevalent in society, which hinders the inclusion of these persons in society.
- People with mental health disorders do not seek timely help in primary healthcare, as a result of which mental health problems are predominantly diagnosed on an in-patient level.
- Under the impact of the economic recession, high mortality indicators (especially among men) from suicides continue, and the number of people feeling stress, tension and depression grows.

Objective: To decrease the rates of morbidity and mortality from non-infectious diseases, and to decrease the negative impact of risk factors upon the health.

To achieve the objective:

- Continue implementing the policy for promoting a healthy choice in society and make a healthy choice the easiest choice, using a taxation policy and raising public awareness.
- Continue implementing a united policy for the promotion of a healthy diet, improving the knowledge of inhabitants in regard to the significance of a balanced diet in maintaining and improving health levels, facilitating the availability of healthy and nutritious food in educational institutions, and ensuring that primary school students have access to free lunches.
- Continue implementing a united policy to promote physical activities in society, emphasising the promotion of people sports, improving the opportunities for people to engage in physical activities, ensuring an environment and infrastructure that promotes physical activities, and developing people's skills and abilities to engage in physical activities.
- Continue implementing a united policy to decrease the use of various addiction-inducing substances (tobacco products, alcohol, drugs) in society by improving the knowledge levels of inhabitants about the adverse effect of these substances upon their health, by restricting advertising and accessibility, and by developing legal acts to regulate the distribution of new tobacco products.
- Continue implementing a united policy for promoting mental health, educating society about the issues of mental health promotion and prevention, training general practitioners to work with people with mental health disorders, and improving the accessibility of mental healthcare services.
- Ensure regular monitoring, research and analysis of the situation concerning the prevalence of risk factors for non-infectious diseases in society.

1 "Atkarību izraisīto vielu lietošanas izplatība un sekas Latvijā 2009. gadā". VEC, 2010

["The use of addiction inducing substances and its consequences in Latvia in 2009". CHE, 2010].

2 "EU citizens' attitudes towards alcohol". Special Eurobarometer 331, 2010.

3 Data of Road Traffic Safety Directorate and the State Police, 2010.

4 Riska un aizsargājošo faktoru ietekme uz atkarību izraisīto vielu lietošanu. Ziņojums par pētījuma rezultātiem Rīgā. Rīga; Rīgas atkarības profilakses centrs, 2007
[The impact of risk and protective factors upon the consumption of addictive substances. Report on study results. Riga; Riga Addiction Prevention Centre, 2007].

5 CHE data.

6 "Narkotiku lietošanas izplatība ieslodzījuma vietās Latvijā, VEC, SIA "Sociālģoģisko pētījumu institūts", 2010
["The prevalence of drug abuse in Latvia's places of deprivation of liberty", CHE, Ltd."Social Studies Institute", 2010].

7 Approved with the Cabinet of Ministers Order No. 98 of 14 March 2011.

3.3. THE HEALTH OF THE MOTHER, FATHER AND CHILD

3.3.1. Sexual and Reproductive Health

The health and development of a child before birth and during the first year of life are mainly determined by the mother's health, as well as the parents' knowledge about their own and the expected baby's health, and their care for the child. The reproductive health indicators are very important indicative indicators, ones which characterise the general state of public health.

Educating young people about reproductive health issues has an important role in improving the quality of life of adolescents. Knowledge about contraceptives does not always guarantee that these means will be used during their first sexual relations, which shows that the education process does not sufficiently focus upon relevant problems in sexual relationships. The report on the population's reproductive health shows that in the age group from fifteen to nineteen years a total of 73% of men and 51% of women used contraception in their first sexual relations.¹

Unwanted pregnancy is the most negative consequence of sexual activities amongst youths. Moreover, young people should be considered as being one of the HIV infection risk groups, since 37.2% of newly infected cases are in the under-thirties age group (2.6% of them are also below eighteen).² The use of condoms protects both against STIs (including HIV infection) and unwanted pregnancy. As the study data shows, condoms are the most frequently used means of contraception among adolescents. Countrywide reports on the contraceptive means used by adolescents differ greatly. In accordance with the available data on the situation in Latvia, 86% of boys and 77% of girls (aged fifteen years old) have indicated that they used contraceptives during their last sexual relations, utilising condoms, but 7% of boys and 11% of girls have indicated that hormonal contraceptives were used.³

Condoms, intrauterine devices and hormonal contraception are the most popular known methods of contraception in Latvia. But the most frequently used ones are condoms, coitus interruptus, and hormonal pills. The study shows that women are better informed about contraceptive methods and means than men.⁴ People are better informed about the means of contraception; however, one of the obstacles to their use could be the accessibility of contraception, especially for persons with a low income.

One of the most important indicators, characterising behaviour habits, is the number of abortions. During the last few years the number of abortions has decreased in Latvia. In 2008 the number of abortions per 1,000 women of reproductive age was 18.0, while in 2009 it was 15.6, and in 2010 it was 13.3. The number of abortions among young women is also decreasing. In 2010 the number of abortions among women aged between fifteen and seventeen was 5.7 per 1,000 women in this age group (in 2009 it was 6.1, and in 2008 it was 7.1), but among women aged between eighteen and nineteen it was 14.8 (in 2009 this was at 16.5, and in 2008 it was 24.2).

The number of babies born to underage mothers (15-17 years) continued decreasing in 2010, constituting 1.4% of newborns (in 2009 it was 1.7%, and in 2008 it was 2.1%).⁵

According to CSB data in 2010, in Latvia a mother's average age at the time at which her first child is born was 26.4. During the last few years the trend has been for this age to increase. Since 2004 a summary of the birth-rate coefficient has shown a gradual increase,⁶ reaching the indicator 1.453 in 2008; however, in 2009 and in 2010 it slightly decreased (1.319 and 1.177 respectively).⁷

Increased body weight and obesity leave a negative impact upon a woman's health and fertility. In the case of obesity, female reproductive functions suffer - a woman is unable to become pregnant or to carry the child. The fact that the level of obesity is high among Latvia's women is worrying. The survey indicates that in 2010, a total of 17.9% of the women surveyed were obese.⁸

The study shows that men less frequently take care of their reproductive health when compared to women. The majority of men have never visited an urologist, a venereologist or an andrologist. Only 12% of respondents had consulted these doctors during the last twelve months. However, 63% of those women involved in the survey responded that they went for a preventive gynaecological examination once a year or more.⁹

The health of a child is significantly affected by the mother's health and her lifestyle habits during pregnancy. Any infection of the sexual organs plays a significant role in the development of complications during pregnancy, which can cause early labour and hereditary infections. The risk of contracting infections is increased by an early start of an individual's sexual life, the frequent changing of sexual partners, and insufficient knowledge about preventing STIs and sexual hygiene. Smoking, the consumption of alcohol, drugs and other addiction-inducing substances have a negative impact upon the health of pregnant women and also on foetal development. Approximately 10% of women giving birth have smoked during pregnancy, 0.5% have used alcohol, and 0.1% have used drugs.¹⁰ Smoking, and the consumption of alcohol, drugs and other addictive substances leave a negative impact upon the health of pregnant women and on foetal development, which can often lead to miscarriages, developmental disorders of the foetal organ systems, early labour, and the birth of premature babies, stillborn infants, and newborn mortality during the first week of life.

The fact that since 2004 the number of women who have registered a pregnancy prior to the twelfth week of that pregnancy has decreased is something that should be assessed in a negative light; in 2008 the proportion of such women was at 90%, in 2009 it was 88.4%, but in 2010 it was 87.5%.¹¹

In 2008, when compared to 2007, maternal mortality significantly decreased, reaching the indicator of 12.5 per 100,000 live births (in 2007 it was 25.8). However, in 2009 maternal mortality dramatically increased, reaching the indicator of 46.1 per 100,000 live births. The cause of death in eight out of ten deceased women was linked directly with pregnancy.¹² In 2010 this indicator decreased (26.1 per 100,000 live births), and in four out of five mothers who died the cause of death was directly linked with pregnancy. And yet this indicator is still the highest in the EU (in 2009 the average maternal mortality rate in the EU was 6.33 per 100,000 live births).¹³

Compared to 2009, in 2010 the number of registered STI cases has decreased by 12% (1,807 cases in 2009 and 1,588 cases in 2010). Even though, since 1999, morbidity with syphilis in Latvia has decreased by 6.2 times, still it is the highest among the EU countries after Romania (in Latvia in 2008 the figure was 10.3 cases per 100,000 of the population, while in Romania it was 18.67 per 100,000 of the population). In 2008 as to morbidity with gonorrhoea, Latvia (with 21.5 per 100,000 of the population) ranked second among EU countries after the United Kingdom (31.29 per 100,000 of the population).¹⁴ Chlamydia is the disease of people in the reproductive age group, with 69% of all registered cases being men and women in the 15-29 age group. Since the chlamydia screening program in Latvia covers only pregnant women, the official figures for morbidity with chlamydia (21.6 per 100,000 of the population) is much lower than in other European countries, for example, Ireland (581.6 per 100,000 of the population), Norway (490.4 per 100,000 of the population), and Sweden (456.3 per 100,000 of the population). Chlamydia usually proceeds asymptotically (without symptoms) (in 70% of women and 50% of men), the untreated infection frequently causes infertility and influences the reproductive health of both men and women.

Statistical data on infertility is not available in Latvia; however, the experience of developed countries shows that approximately 10-15% of couples are infertile. Among women the most frequent causes of infertility is blocked fallopian tubes, which occurs after infection (frequently after gonorrhoea infection), surgical interventions into the organs of the reproductive system, as well as ovary dysfunction, incorrect positioning of the uterus, uterine or ovary malignancies, metabolic disorders, etc. Male infertility can be caused by decreased sperm count or lack of it, as well in cases when the sperm count is normal, but the sperm is unviable, and by other causes. The National Family Policy Guidelines for 2011-2017,¹⁵ deal with infertility in a demographic context, envisaging the objective, which is to assess the possibility of introducing state support measures for infertility treatment and to inform society about the threats and risks to reproductive health, all of which increase infertility. To assess the possibility of introducing state support measures, the prevalence of infertility problem in Latvia should be assessed.

1 Iedzīvotāju reproduktīvā veselība. Pārskats par situāciju Latvijā (1997-2003)
[Reproductive health of the population. An overview of the situation in Latvia (1997-2003)].

2 ICL data.

3 Inequalities in young people's health. HBSC International report from the 2005/2006 survey. WHO, 2008.

4 Iedzīvotāju reproduktīvā veselība. Vērtējums un ieteikumi. Rīga, 1998
[Reproductive health of the population. Assessment and recommendations". Rīga, 1998].

5 CHE data.

6 The average number of children, which could be born to one woman during her lifetime, if the birth-rate in each age group would remain on the level of the year when calculations are done.

7 CSB data.

8 Latvijas iedzīvotāju veselību ietekmējošo paradumu pētījums 2010. Rīga, 2010
[Study of the Health Affecting Habits of Latvian Population 2010. Rīga, 2011].

9 Iedzīvotāju reproduktīvā veselība. Pārskats par situāciju Latvijā (1997-2003)
[Reproductive health of the population. An overview of the situation in Latvia (1997-2003)].

10 Mātes un bērna veselība perinatālajā periodā. V/a „Sabiedrības veselības aģentūra”, 2009
[The health of mother and child during the perinatal period. State agency “Public Health Agency”, 2009].

11 „Latvijas veselības aprūpes statistikas gadagrāmata 2009” VEC, 2010 [The Year-Book of Latvian Health Care Statistics, 2009”; CHE, 2010]; CHE data.

12 „Latvijas veselības aprūpes statistikas gadagrāmata 2009” VEC, 2010 [The Year-Book of Latvian Health Care Statistics, 2009”; CHE, 2010].

13 WHO Health for All database.

14 Ibid.

15 Approved with the Cabinet of Ministers Order No. 65 of 18 February 2011.

3.3.2. Healthy Start of Life

The health and wellbeing of Latvian newborns, infants and children of pre-school age (between 1-5 years) is still lower when compared to other EU countries.

Infant mortality is one of the indicators that characterises both the general health of mother and child and also healthcare before and after birth, which indirectly characterises the socioeconomic conditions in the country in general.

Perinatal mortality (the perishing of the foetus before birth or during labour, or the death of the newborn during the first week of life) in Latvia has been decreasing over time; in 2009 this indicator was at 9.6 per 1,000 live and stillborn births, but in 2010 this indicator decreased to 8.2. This indicator in Latvia is higher than the average in the EU and the highest among all Baltic States. It is mainly caused by the comparatively large number of stillborn children.¹

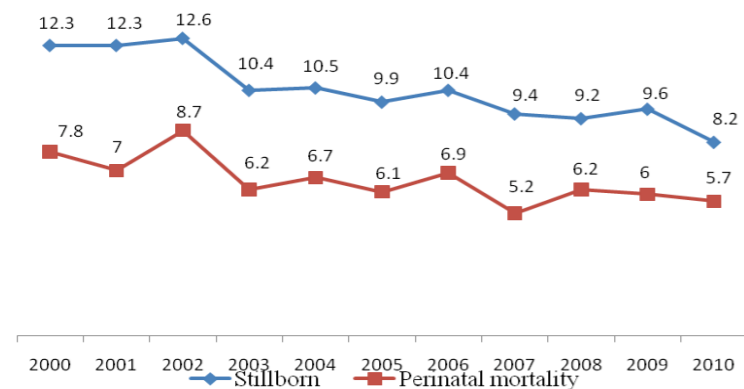


Figure 8. Perinatal mortality rates per 1,000 live and still born births in 2000-2010
Source: CHE

Since 2001 the infant mortality rate indicator (covering children who have died during the first year of life, with rates at 11.0 per 1,000 live births) has decreased to 5.7 per 1,000 live births in 2010.² In Latvia it is approximately twice as high as the EU average. The main causes of infant mortality (approximately 50-60% of all children who die during the first year of life) are concrete perinatal conditions (for example, intrauterine hypoxia, hereditary and aspiration pneumonia, etc). Hereditary anomalies are the cause of death for approximately one third of children who die during the first year of life, and also external causes continue to be the cause of infant death, even though they can be limited or even prevented.³

Perinatal and infant mortality indicators can be influenced both by the mother's and by the father's attitude towards pregnancy, the lifestyle and health status of both parents, and the parents' knowledge of childcare and injury prevention, as well as the quality of work performed by the respective healthcare service providers.⁴

A mother's milk is one of the most significant factors for promoting the health of newborns and infants and in the prevention of infectious diseases. Every year the proportion of children who have been breast-fed up to the age of twelve months is growing in Latvia (in 2006 it was 17.9%, in 2007 it was 18.2%, in 2008 it was 18.9%, in 2009 it was 20.8%, and in 2010 it was 21.7%). An increase has also been observed in the proportion of children who have been breast-fed for six months (from 45.8% in 2007 to 52.5% in 2010).⁵ To compare: in 2009 in Estonia this indicator was 53.2%, but in Lithuania it was only 35%.⁶ The positive trend in breast-feeding indicators was influenced by the work done to educate and inform society and the development and implementation of measures to promote breast-feeding. During the previous planning period the "Baby Friendly Hospital" initiative was launched and implemented with WHO support, and the Commission for Promoting Breast Feeding and various breast-feeding consultants were also active. However, currently, when the state has limited options for providing financial assistance for promoting breast feeding, NGOs have a significant role in promoting breast feeding, actively providing support and assistance to young mothers in solving breast feeding related problems. The activities of healthcare institutions and the competence of healthcare personnel also promote breast-feeding. To improve the quality of work of medical facilities, quality criteria for in-patient medical facilities (including those providing obstetric help) should be defined and introduced.

The most frequent cause of death for children in the 1-5 year old age group is external causes of death. The information provided by the CHE database on the Causes of Death indicates that in this age group the most frequent causes of death are drowning, poisoning, suffocation, falls, and exposure to smoke, fire and flames.

According to the data in the CHE Register of Patients with Particular Diseases on hospitalised patients who had suffered trauma and injuries, in 2010, a total of 594 boys and 433 girls under the age of five had suffered trauma. Most often traumas occur at home, a total of 74.6% (766 cases). In 2010 the most frequently encountered injuries among children were bruises (196 cases), open wounds (219 cases), burns or scalding (205 cases), bone fractures (224), and in 140 cases, concussions.

Children under the age of five most frequently suffer injuries in connection with falls, or coming into contact with hot liquids and hot surfaces. In this age group the accessibility of chemical substances that are hazardous for health also creates a risk, as they can cause poisoning or chemical burns. The main cause of trauma among children is an unsafe environment and insufficient parental responsibility - children are not supervised and a safe home environment is not created. In 2005 the Saeima adopted amendments to the Law on the Protection of the Rights of the Child,⁷ envisaging penalties being imposed upon parents or guardians who leave a child without supervision.

The analyses of the 154 cases of chemical burns of the oesophagus in 2003-2007, which was carried out by the state-owned "Children's Clinical University Hospital", shows that most frequently chemical burns of the oesophagus occur at home in children in the 1-3 year age group (111 out of 154 cases). The most frequent agents that have caused burns or poisoning among children are household chemical products. The most important achievement in improving child safety were the amendments to Cabinet of Ministers Regulation No.334 of 20 April 2004: "Regulation on food pollution and requirements on the packaging and labelling of food products containing caustic chemical substances",⁸ in 2009, prohibiting the retail sale of concentrated vinegar essence (above 10% of the unit's total mass).

To improve the health of mother and child, to decrease maternal and infant mortality, to ensure high quality pregnancy care and the care of newborns at a high level, a united implementation of the approach to mother and child healthcare must continue.

Identified problems:

- Insufficient knowledge of the general public, including teenagers and adolescents, about issues relating to sexual and reproductive health and STI prevention.
- Insufficient parental knowledge about the negative effects of addiction-inducing substances upon the health of pregnant women and the foetus, about the importance of starting pregnancy care in a timely fashion, and preventive measures to decrease child traumas.
- A lack of data about infertile couples, the infertility treatment and in vitro fertilisation procedures in Latvia does not allow for the production of a substantiated assessment of the available options for introducing state supported measures for infertility treatment, and information about the accessibility of contraceptive means for various target groups, including persons on low incomes, is also lacking.

Objective: To improve the health of mother and child, and decrease infant mortality.

To achieve the objective:

- Continue implementing the united policy to promote maternal and child health, improving pregnancy and newborn care, increasing the knowledge among pregnant women about the negative impact of addiction-inducing substances upon the health of the pregnant woman and foetus and promoting breast feeding and appropriate complementary food.
- Educate society in general (especially adolescents) about reproductive health issues and STI prevention, decreasing the number of unwanted pregnancies and cases of STIs.
- To assess the prevalence of infertility in Latvia by collecting data on infertile couples and on fertility treatment and in vitro fertilisation procedures being performed.
- To assess the accessibility of contraceptive means and their use among persons with low income or poor persons, and their role in decreasing the number of abortions.

1 Mātes un bērna veselība perinatālajā periodā. V/a „Sabiedrības veselības aģentūra”, 2009
[The health of mother and child during the perinatal period. State agency "Public Health Agency", 2009].

2 CHE data.

3 Mātes un bērna veselība perinatālajā periodā. V/a „Sabiedrības veselības aģentūra”, 2009
[The health of mother and child during the perinatal period. State agency "Public Health Agency", 2009].

4 Ibid.

5 CHE data.

6 WHO Health For All database.

7 The Law of 17 March 2005 "Amendments to the Law on the Protection of the Rights of the Child".

8 The Cabinet of Ministers Regulation No.368 of 28 April 2009 "Amendments to the Regulation of the Cabinet of Ministers Regulation No.334 of 20 April 2004 "Regulation on food pollution and requirements on the packaging and labelling of food products containing caustic chemical substances".

3.4. A HEALTHY AND SAFE ENVIRONMENT

3.4.1. Living and Working Environment

In the European region more than 1.7 million of fatal cases (18% of all deaths) are connected to environmental factors.¹ Physical, chemical and biological environmental factors can significantly influence the quality of life and cause health disorders; however, it is frequently impossible to measure clearly the health impact of these factors, because the values of their impact are usually low; again however, they affect people throughout their lives and have a long latency period before health problems appear. Moreover, the impact of these factors can be complex, ie. they act jointly with other lifestyle habits. One of the main tools for assessing the impact of environmental factors upon human health is human biomonitoring, which is not conducted in Latvia. The number of studies in the field of environmental health, which would integrate various impacts to which people are subjected during their lifetime - environmental factors, the quality of their living and working environment, heredity, lifestyle habits, etc - is insufficient in Latvia.

The EU and WHO strategic environmental health policy planning documents,² highlights several priorities: safe drinking water and swimming waters, sanitary conditions, especially in the climate change context; the quality of indoor and outdoor air; the prevention of diseases that are caused or could be caused by other physical, chemical and biological environmental factors, including noise, nanotechnologies, electromagnetic fields, as well as risks and trauma in the working environment, etc.

The Eurobarometer survey shows that 80% of the Latvian population, when assessing their attitude towards the environment, identify the environment as the most important factor affecting their living environment.³ However, when assessing the impact of concrete environmental factors upon health, 56% of the Latvian population believe that their health is influenced by the general quality of housing, but 24% are worried about the hazardous effect of chemical substances. Another study shows that 28% of the Latvian population perceive the surrounding air pollution as a hindrance, but for 37% of them noise is a hindrance in their places of residence - especially in Riga, where 46% of inhabitants suffer from excessive noise.⁴ Traffic is the most often mentioned cause of noise by inhabitants (76% of cases).

To set the basis for safeguarding and restoring the quality of the environment and for a sustainable use of resources, while at the same time limiting the adverse impact of environmental factors upon human health, the CM has approved the Environmental Policy Guidelines for 2009-2015.⁵ The guidelines deal with environmental issues in five thematic sections: air, water, land, nature and climate.

During recent years, slight improvements have been observed in regard to accidents at work (the number of registered accidents at work in 2008 was 1,781, in 2009 it was 1,203 accidents, and in 2010 it was 1187). The number of registered severe accidents has significantly decreased, constituting 265 cases in 2008, but in 2009 this was at 175 cases, and in 2010 it was at 164 cases; likewise, the number of registered fatal accidents at work has also decreased - in 2008, 43 such cases were registered, in 2009 this was 32 cases, but in 2010 it was down to 23 cases.⁶ However, as regards the total number of accidents and their decrease when compared to the EU states, in Latvia the total number of registered accidents is extremely low, which is mainly linked to the fact that no accidents at work are registered or investigated in Latvia.⁷ Therefore, the causes of accidents are not identified in order to prevent their recurrence. Hiding accidents, and failing to investigate and register them facilitates the development of disability and a lowered capacity for work for the victims, who are not entitled to receive state funded treatment and rehabilitation.

In 60-70% of cases the victims of accidents are employees whose experience in the profession does not exceed one year or was between one and three years in length. It shows that employees who start performing new duties in companies do not receive adequate prior briefings and training.⁸

As regards the incidence of occupational diseases, it should be noted that the number of registered patients with occupational diseases has rapidly increased in the period from 2007 to 2009. Such an increase could be explained by the fact that with the worsening of the economic situation many inhabitants wanted to settle the formalities in order that they might receive official confirmation of their occupational disease, thereby entitling them to receive compensation. Only in 2010 was the stabilisation of the number of newly registered patients with occupational diseases observed - it decreased by 17% when compared to 2009 (in 2010 it was 1,150; in 2009 it was 1,385); however, the general assessment of the situation shows that the number is very high. According to the data of the Latvian National Register of Patients with Occupational Diseases, in the period between 1993 to 1 August 2011, a total of 10,140 patients with occupational diseases were registered, with the total number of registered occupational diseases exceeding 25,000. Slightly more than 60% of all patients with occupational diseases are women.

The statistics for occupational diseases show that the number of patients with occupational diseases is growing every year; moreover, the number of registered untreated occupational diseases is growing, which to a large extent means that people see an occupational disease specialist too late and that other healthcare personnel are not sufficiently informed about the impact of adverse work environmental factors upon human health.

The measures for ensuring a safe environment which poses no hazard to health are defined by the Guidelines of Labour Protection for 2008-2013.⁹

1 The European Health Report 2009. Health and health systems, WHO 2009.

2 Children's Environment and Health Action Plan for Europe (CEHAPE)(2004); The Declaration of the European Environment and Health Ministers Conference in Parma on health and environment of 11 March 2010; The draft of European Second Environment and Health action plan (2010).

3 Eurobarometer survey, Special "Electromagnetic fields", 2007.

4 Vides faktoru ietekme uz veselību. Latvijas iedzīvotāju aptaujas rezultāti. v/a „Sabiedrības veselības aģentūra”, 2008.

[The impact of environmental factor upon health. Latvian population survey results, state agency "Public Health Agency", 2008].

5 Approved with the Cabinet of Ministers Order No. 517 of 31 July 2009.

6 State Labour Inspectorate, Public Report of 2010.

7 Pētījums „Darba apstākļi un riski Latvijā, 2009-2010”, SIA „Inspecta Prevention”, 2011

[Survey "Working conditions and risks in Latvia, 2009-2010", Ltd. "Inspecta Prevention", 2011].

8 State Labour Inspectorate, Public Report of 2009.

9 Approved with the Cabinet of Ministers Order No.213 of 17 April 2008.

3.4.2. External Causes of Death and Trauma

To a large extent trauma is caused by an unsafe environment. For example, it has been assessed that 25% of road traffic accidents in Western Europe are attributable to environmental conditions such as, for example, road infrastructure, pavement coverings, and equipment for pedestrians and cyclists.¹⁰ In Latvia mortality from external causes ranks third in the total structure of causes of death.

In Latvia, every year 40,000 potential years of life are lost below the age of 65 due to external causes of death. The greatest number of potential years of life are still being lost in road traffic accidents, while drowning ranks second, and suffocating and other respiratory disorders occupy third place. The significance of various external causes differs in different age groups.¹¹

Mortality from external causes is decreasing every year. In 2010 it reached the indicator 94.1 per 100,000 inhabitants (in 2009 this was 95.7, in 2008 it was 108.2).¹² The information from the CHE database on the Causes of Death in the Latvian Population in 2010 shows that the highest mortality rates from external causes per 100,000 of the population is in the employable age group - 94.3 cases - but among children the highest indicators of mortality rates from external causes are in the 15-19 year age group (38.0 per 100,000 of inhabitants). The second highest mortality rate is among children in the 1-4 year age group (16.3 per 100,000 inhabitants), while among school age children this indicator fluctuates around twenty cases per 100,000 inhabitants. The mortality rates for external causes differs significantly for women (39.9 per 100,000) and men (157.3 per 100,000).

In the group of external causes of death, both in the employable and school age, traffic accidents are the most frequent cause of death. Compared to 2004 the traffic accident mortality indicator has decreased in both these groups. In the 15-19 year age group this indicator was 24.9 per 100,000 of the population in 2004, but in 2010 it was 14.6 per 100,000 of the population. In the employable age group it was 27.6 per 100,000 of the population and 12.9 per 100,000 of the population, respectively.¹³

Fatal cases due to external causes are those that can be prevented, by promoting environmental safety measures (road traffic, home safety, etc), and also by carrying out an education society on the impact of lifestyle habits and behaviours upon the health of people. The implementation of the Road Traffic Safety Program,¹⁴ proves that positive results in this field can be achieved, and as a result of this the mortality rates caused by traffic accidents significantly decreased.

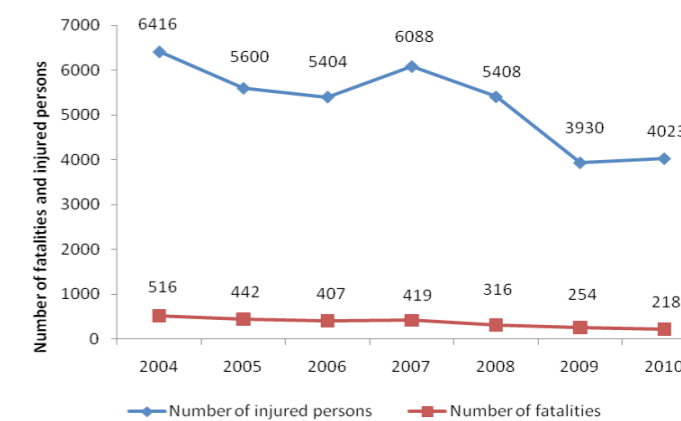


Figure 9. The number of fatalities and injuries in traffic-related incidents
Source: Road Traffic Safety Directorate

10 The European Health Report. Health and health systems, WHO 2009.

11 Potenciāli zaudētie dzīves gadi Latvijā 2008.gadā. VEC, 2009 [Potential years of life lost in Latvia in 2008. CHE, 2009].

12 CHE data.

13 Register of Causes of Death of Latvian Population.

14 Approved with the Cabinet of Ministers Order No. 209 of 13 April 2007.



Since 2001 there has been a significant decrease in the number of children below the age of five who have died in road traffic accidents, from 46 cases per 100,000 to 14.2 per 100,000 in 2010. This trend strongly correlates with the increased usage of child seats in cars during the recent years. The survey carried out in 2010 showed that 36.8% of respondents have used child seats almost every time when transporting young children (40.4% of women and 33.0% of men).¹ However, this indicator is not sufficient and means that approximately 60% of the population still do not use child seats when transporting children.

Traumas are one of the most frequent causes of prolonged or permanent incapacity for work or disability. Many people who have suffered trauma of some kind feels the consequences of it for many years afterwards. The calculations performed by the WHO show that traumas constitute 10% of all disability-adjusted life years, DALY, and it is estimated that this indicator could increase to 20%. Therefore, the consequences of various traumas has a significant impact upon society. In Latvia every tenth case of first-time disability is caused by injury, poisoning or the impact of other external factors. In the structure of the causes of first-time disability, those disabilities caused by external factors rank in fourth place. The consequences of traumas leads to first-time disability among young people.²

According to the WHO calculations, a total of 68%, or more than two out of every three trauma cases (including fatal ones), are preventable; and the proportion of preventable traumas is even higher among children.³

An unsafe environment and insufficient parental responsibility are the main causes of traumas in children. Child safety is likewise influenced by the safety of toys and other daily household items such as, for example, various objects containing batteries and magnets, food-like objects, or lighters. Numerous measures in the field of product safety where this is linked to the protection of children are implemented in the EU.⁴ The goods which are included in the EC report on dangerous products (RAPEX⁵) are not sufficiently identified in Latvia and are often accessible to children. The Consumer Rights Protection Centre has contributed a great deal to the monitoring of product safety requirements, including that of toys,⁶ and in 2009 it established a hotline for reporting consumer injuries, with the financial support from the EU.

Traumas suffered during physical activities are typical among teenagers. The survey showed that during the previous year almost half of the school students who were included in the survey and who were aged eleven, thirteen and fifteen had suffered traumas.⁷ The greatest rate of traumas is observed during informal sporting activities and physical activities - cycling, skating and roller-skating without protective measures, driving motor vehicles before acquiring a driver's licence, swimming in unsuitable locations, and playing various games in demolished buildings and on incomplete construction sites.

To implement a united and continuous policy for decreasing the number of traumas and deaths from external causes, a policy-planning document must be developed which defines measures for trauma prevention.

Intentional harm - violence and self-harm - is also a cause of traumas, injuries and mortality. One of the most topical problems in contemporary society is domestic violence, which is linked with violence among intimate partners, along with violence against children and the elderly. Domestic violence manifests itself both as physical and emotional violence. Neglecting children, which causes severe injuries in those children, is also considered to be violence.

CHE data shows that in 2010, 138 persons have died as the result of a violent attack. The greatest proportion of persons who have died from violence are in the 250-60 age group. Data from the Register of Patients with Particular Diseases on patients who have suffered traumas and injuries shows that in 2010, 258 persons suffered injuries because of their husband, wife or partner.

The "Program for decreasing domestic violence in 2008-2011",⁸ which was developed by MW, and the National Family Policy Guidelines for 2011-2017,⁹ both deal with the issue of decreasing violence.

Children suffer from violence not only in the family but also at their institution of education, where both physical and emotional violence is typical among school students. The survey on the health habits of school students shows that bullying is widespread in schools. Data from the 2005-2006 school year indicated that during the previous couple of months approximately half of students had suffered at least once from bullying.¹⁰

The timely rehabilitation of patients who have suffered traumas is essential. It improves the quality of life of these patients, decreases their temporary incapacity for work and ensures disability prevention. Patients who have suffered traumas and do not receive timely rehabilitation run the risk of becoming disabled.

1 Latvijas iedzīvotāju veselību ietekmējošo paradumu pētījums, 2010. Rīga, 2011

[Study of the Health Affecting Habits of Latvian Population, 2010. Riga, 2011].

2 „Vardarbības un nelaimes gadījumu izraisītie veselības traucējumi”, VEC, 2009 [Health Disorders Caused by Violence and Accidents. CHE, 2009].

3 „Traumatisms un ārējie nāves cēloņi bērniem un jauniešiem”, SVA, 2007

[Traumatism and external causes of death among children and adolescents, Public Health Agency, 2007].

4 General Product Safety Directive 2001/95/EC.

5 Rapid Alert System for Non-Food Products.

6 The Cabinet of Ministers Regulation No. 132 of 15 February 2011 "Regulation on the Safety of Toys".

7 Skolēnu veselības paradumu pētījuma (HBSC pētījums) 2005./2006.gada aptaujas dati, VEC

[A Survey of School Students' Health Habits (HBSC survey). 2005/2006 survey data, CHE].

8 Approved with the Cabinet of Ministers Order No. 343 of 18 June 2008.

9 Approved with the Cabinet of Ministers Order No.65 of 18 February 2011.

10 Vardarbības un nelaimes gadījumu izraisītie veselības traucējumi. VEC, 2009 [Health Disorders Caused by Violence and Accidents. CHE, 2009].



Identified problems:

- The lack of research in the field of environmental health is an obstacle for conducting a comprehensive assessment of the environmental factors that have an impact upon human health.
- Measures to decrease the impact of environmental factors have not been implemented in full, which significantly influences the quality of life.
- A lack of unbiased information on environmental risk factors can be observed in society, which is something that hinders an objective assessment of the potential health risks of various environmental factors.
- A low level of awareness among the population about the risk factors in the work environment and the impact of these upon the health (this strategy does not deal with issues related to limiting and preventing risks in the working environment, since they are included in the policy planning documents for the relevant sector).
- Healthcare personnel are insufficiently informed about factors that can cause occupational diseases and about the timely diagnosis of occupational diseases.
- Living conditions for the population are not sufficiently safe to prevent trauma. Trauma is one of the most frequent causes of long-term or permanent incapacity for work or disability.

Objective: To promote healthy and safe living and an equally safe working environment, and to decrease trauma and mortality from external causes of death.

To achieve the objective:

- To identify the impact of environment risk factors upon health, to inform society about environment risk factors and possibilities they might have to decrease the hazardous effect of these factors upon their general health, also taking these factors into consideration in the planning process, and to inform the employees of healthcare institutions about the correct management of medical waste.
- To inform healthcare personnel of the factors that cause occupational diseases and the timely diagnosis of occupational diseases.
- To facilitate the development of a safe environment, to improve general knowledge amongst population in regard to any possibilities there might be to avoid traumas in everyday life, during leisure activities and while engaging in physical activities, on the correct course of action to take in the case of an injury in order to prevent trauma, and facilitating the creation of a safe environment.
- To implement the effective surveillance of the market for goods and services to ensure that only safe goods and services are accessible to the consumer

3.5. INFECTIOUS DISEASES

In many countries around the world and in the EU, including Latvia, the prevalence of several infectious diseases has been interrupted, restricted or fully eliminated by the introducing new and effective vaccines, improving the system of epidemiological supervision, and by effectively coordinating international action in terms of dealing with epidemics. At the same time the risk of epidemics occurring still exists, since today infectious diseases are spreading around the world with worrying speed, disregarding national borders and the standard of living in any particular country. The outbreak of SARS in 2003, the spread of the influenza pandemic in 2009, and the outbreak of poliomyelitis in Tajikistan in 2010 prove that infectious diseases can pose a significant threat to public health. The spread of infectious diseases (including TB, HIV and STIs) is facilitated by migration, drug abuse and lifestyle (prostitution), the inaccessibility of hygiene and preventive means, socioeconomic factors, climate change, etc.

The survey information,¹¹ showed that 1.7% of the Latvian population (1,714 per 100,000 of the population) are infected with the C hepatitis virus (HCV). The average number of HCV patients for every single general practice could be 34, but in the majority of cases this is known neither by general practitioners or the patients themselves, because usually this viral infection exhibits no specific symptoms. Patients with an asymptomatic course of hepatitis C pose the greatest threat of an epidemic. HCV is a serious threat to public health and the most dangerous one among all hepatitis viruses, because in 80% of cases the condition becomes chronic and the number of liver cirrhosis and/or liver cancer cases significantly increases. The number of people infected with hepatitis C who are living in Latvia exceed by ten times the number in other countries such as, for example, Sweden or the United Kingdom. It is impossible to carry out HCV tests among Latvia's prison population; therefore, no objective data about the prevalence of the disease is available. However, on the basis of expert opinion and the specifics of living conditions in prisons or detention centres, the rate of HCV infection among prison inmates could be very high, many times higher than in society in general. Foreign studies and statistical data also show that the HCV infection rate among prison populations is much higher than in society.

Latvia is still one of those EU countries that has high indicators of the prevalence of HIV infection: in 2009 the incidence (the number of new cases) indicator was 12.2 per 100,000 inhabitants (in 2008 it was 15.8) or the second highest, exceeding the average European indicator (50.3) 2.6 times. In some population groups the prevalence is very high (among the users of injectable drugs it is between 22-23%, close to the critical limits - 5% - among men who have sexual relations with other men, and also among prison inmates a total of 7% of them are HIV infected), therefore placing Latvia among those countries in which an HIV epidemic is not general, but is concentrated in some population groups with increased risky behaviour. The proportion of AIDS patients has increased rapidly (in 2009, 4.3 cases per 100,000 inhabitants were recorded, which is the highest morbidity rate in the EU countries). The percentage of prison inmates with AIDS is also high (1,074 cases per 100,000 of the population). The measures for restricting HIV infection are defined by the Program for Limiting the Spread of Human Immunodeficiency Virus (HIV) for 2009-2013.¹²

11 "C virushepatīta izplatība Latvijā", LIC, 2009 [The Prevalence of Hepatitis Virus C in Latvia, ICL, 2009].

12 Approved with the Cabinet of Ministers Order No. 437 of 30 June 2009.

Until 2010, morbidity with TB was decreasing, reaching the indicator of 36.6 per 100,000 of the population in 2009 (and it was the same in 2010); however, at the end of 2010 and the beginning of 2011 a trend was observed which showed a growing number of TB cases. The mortality indicators also improve (4.5 per 100,000 of the population in 2009 and 3.5 per 100,000 of the population in 2010).¹ However, according to the WHO Region for Europe data, Latvia belongs to the eighteen high priority countries in the European region for TB control and is one of 27 countries in the world with the highest level of multi-resistant TB (MDR-TB). Several problems in the fight against tuberculosis are causes of concern, high mortality rates from tuberculosis, especially during the first year after diagnosing, which points to a belated detection of disease cases. In 2010, 35% of deceased TB patients died during the first month following diagnosis, and in 18% of those who had died, tuberculosis was detected during the post mortem. In 2008-2009 an increase in the number of multi-resistant cases has been registered. The increase in the proportion of extensively resistant TB (MR/XR-TB) among MR-TB patients is a negative trend; in 2009 it reached 14%, and was at 17% in 2010. The number of registered TB/HIV dual infection cases is increasing with every year. The proportion of TB/HIV among newly diagnosed TB cases in 2009 reached 6.9%, and was at 7.6% in 2010, which according to WHO guidelines points to the situation of TB/HIV co-infection epidemics.

The socio-economic situation is also an important factor, one which influences the spreading of infectious diseases. A study,² has shown that an increase in TB morbidity and mortality can be expected, linked to the current global economic recession.

During 2008-2009 the epidemiological situation regarding acute intestinal infections and hepatitis A became significantly worse in Latvia. During the last seven years a stable trend of increasing morbidity with acute intestinal infections with viral aetiology has been observed, and since 2004 the number of cases has increased more than 2.5 times (from 1,928 to 5,050 cases). The Hepatitis A outbreak in 2008 and 2009 affected more than 5,000 inhabitants (only 1,226 cases were registered during the previous eight years), of which 85% were hospitalised. In 2007 in Latvia nine group cases of acute intestinal infections and hepatitis A cases with five and more affected were registered, but in 2009, 63 outbreaks were registered. Group cases are predominantly linked with people getting infected at home and at children's institutions of education. The hepatitis A epidemics, which is a comparatively easily controllable disease, proved once again that outbreaks of infectious diseases are possible if the system for preventing and controlling infectious diseases is not being constantly maintained and developed.

Every year the epidemic activity of influenza, with smaller or greater intensity, is observed during autumn, winter period. Every year influenza causes severe complications for many patients and becomes the cause of death in tens of cases; it is especially dangerous to patients with pulmonary diseases, cardio-vascular diseases, metabolic disorders and other chronic diseases. The population immunisation level against influenza in Latvia is very low compared to other EU countries, during the recent years it reached only on average 0.8%. The vaccination level in the age group "65 and above" during the last seasons was one of the lowest in the EU countries - 2.4 - 2.6%. To compare - in the United Kingdom and the Netherlands 70% and more are vaccinated in this age group.

For several years already the National Immunisation Program³ has been public health priority in Latvia. Healthcare and public health specialists have achieved the accessibility of high quality immunisation services on the local and the national level. Notable achievements have been reached in preventing vaccine preventable diseases. By 2008 vaccination coverage in the framework of immunisation program had been achieved for all age groups, which is the main cause for decreasing morbidity. Through the implementation of the program every year 30 000 cases of various infectious diseases and more than 100 death cases among children are prevented. The morbidity with several infectious diseases has decreased by 99.95% and even more. Even though there has been an increase in the morbidity with various infectious diseases, which are linked to hygiene conditions and the quality of life during the last years (hepatitis A, acute intestinal infections), the incidence indicators regarding vaccine preventable diseases have remained unchanged due to the positive impact of the immunisation program (see Table).

Table. The number of vaccine preventable diseases in 1960 and in 2010 in Latvia
Source: ICL

Vaccine dependent disease	Year	
	1960	2010
Tetanus	12	0
Diphtheria	209	2
Whooping cough	2495	9
Measles	19744	0
Epidemical parotitis	11714	3
Poliomyelitis	17	0
Total:	34 191	14

However, ICL monitoring results indicate that in 2009-2010 the immunisation indicators have significantly worsened. In some age groups they no longer meet the objectives of the National Immunisation Program. To improve immunisation indicators and decrease the morbidity with vaccine preventable diseases, the activities launched in the framework of the National Immunisation Program should be continued, providing scientifically substantiated information on the importance of vaccination and implementing a united approach to immunisation promotion.

Identified problems:

- The number of HCV infected patients is high, but not all of them receive adequate healthcare services. Large number of group cases of acute intestinal infections.
- Latvia is among those EU countries with high indicators of HIV prevalence, moreover, the number registered TB/HIV dual infection is growing every year.
- The TB morbidity and mortality rates and resistant TB level are high in Latvia. The high mortality from TB, especially during the first year after diagnosing the disease, reveals belated detection of the disease.
- The risk of outbreaks/ epidemics of vaccine preventable diseases is increasing, because the proportion of immunised population is decreasing.

Objective: To decrease morbidity with infectious diseases.

To reach the objective:

Continue implementing united policy for preventing infectious diseases and restricting their spreading by maintaining and improving a prevention and control system of infectious diseases, by educating society about most effective preventive measures against infectious diseases, promoting timely detection of TB cases and decreasing the spread of multiresistant TB.

¹ ICL data.

² Arinaminpathy N, Dye C. Health in financial crisis: economic recession and tuberculosis in Central and Eastern Europe. J.R.Soc. Interface published online 28 April 2010 (rsif.royalsocietypublishing.org, access 9 February 2011).

³ The Order of the Cabinet of Ministers No. 43 of 31 January 2008 "On the National Immunization Program for 2008 - 2010".

4. THE DESCRIPTION OF THE SITUATION AND PROBLEM DEFINITION IN HEALTHCARE

4.1. FUNDING OF THE HEALTH SYSTEM

In Latvia the greatest source of healthcare revenue are general, un-earmarked taxes. The budget of the MH is approximately 6% of GDP. In 2010 the proportion of national (public) funding according with the approved budget was 3.5% of GDP, at the end of 2010 3.9% of GDP and in 2011 in accordance with the budget amendments 3.7% of GDP, and the rest is private funding. The long-term aim is to re-allocate the proportion of public and private funding, decreasing the part of private funding. The RL Saeima every year approves the health budget for the coming year. (The funding of the health system is depicted in Figure)

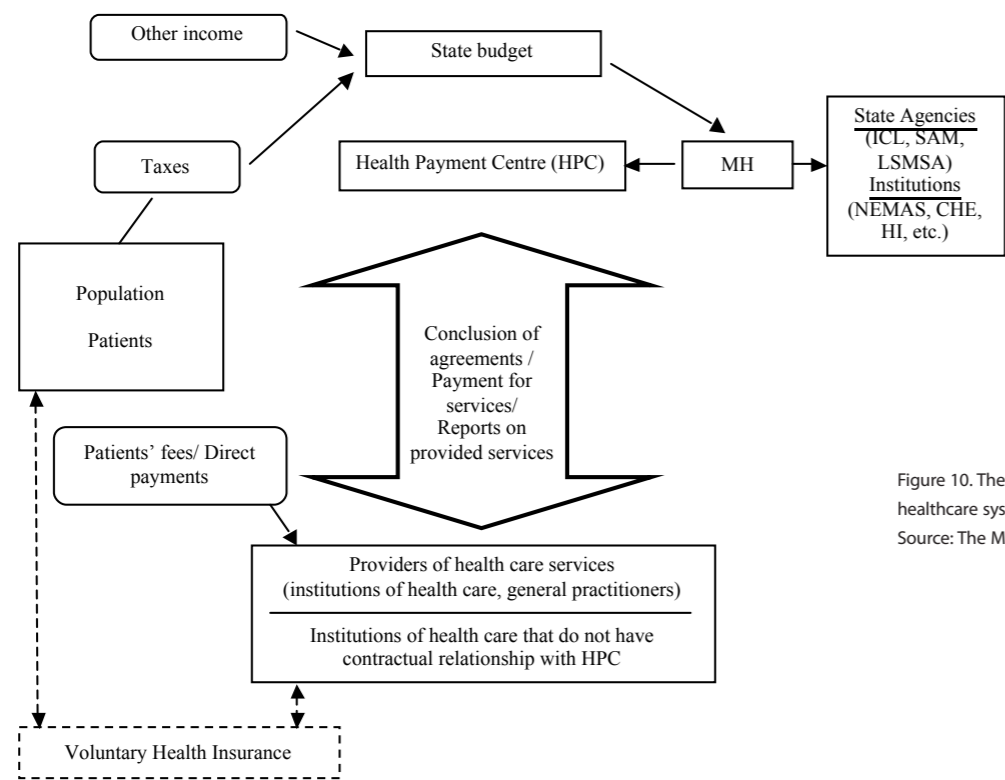


Figure 10. The funding of the healthcare system in Latvia
Source: The Ministry of Health

The budget of the Ministry of Health (including funding from the EU Structural Funds) at the end of 2010 was 496.1 million lats,¹ which is approximately 11.2% of the total state budget and 3.9% of GDP. In accordance with the amended budget of 2011, in compliance with MF orders, MH budget expenditure is 499.1 million lats, which is approximately 10.5% of the total state budget and 3.74% of GDP. The proportion of national expenditure allocated for health in Latvia characterises the national support to the health system. The funding allocated for health in Latvia for many years already has been one of the lowest (in some years - the lowest) in the EU and fluctuates between 3.28% of GDP in 2005 till 3.9% of GDP in 2010, and has decreased till 3.7% of GDP in 2011. EU countries allocate from 4.6% to 7% of GDP for healthcare.²

In Latvia the resources of the state budget allocated for healthcare are (sectoral budget programme 33.00.00 "Ensuring healthcare") administered by the Health Payment Centre. The proportional allocation of resources for paying for healthcare services is defined in a legal act.³ HPC plans the allocation of resources in compliance with it: at least 45% for out-patient healthcare services, no more than 53% for in-patient healthcare services.

1 The budget of 2010 with the Orders of the Cabinet of Ministers and the Ministry of Finance at the end of the year.
2 Eurostat data.
3 The Cabinet of Ministers Regulation No. 1046 of 19 December 2006 "The Procedure of Organising and Funding Health Care".

The reimbursement system for medicines and medical equipment is an essential part of the healthcare system. A well-developed system of reimbursement allows the patient to be treated as an outpatient, it prevents cases of unnecessary hospitalisation. Every year the list of reimbursement medicines is expanded, including diseases, for which the cost of medicines for their treatment is reimbursed from the resources of the state budget (the number of medicines in the reimbursement list of 2008 - 1094 and 146 items of medical equipment, in 2009 - 1125 medicines and 152 items of medical equipment).⁴ According to HPC data in 2009 482461 Latvian inhabitants (or 21.4%) received medicines reimbursed from the state budget. The funding allocated by the state was 29 lats per capita. In Estonia in 2009 64.7% of insured persons received reimbursed medicines, and the expenditure of Estonian Health Insurance Fund for reimbursement medicines was 46 lats per capita.⁵ In Latvia at the end of 2009 the national funding for reimbursing the costs of medicines and medical equipment was 66.6 million lats, at the end of 2010 - 71.6 million lats, in 2011 (with budget amendments) - 73.0 million lats.

The largest amount of resources of the state budget for reimbursement medicines in 2009 was spent for the treatment of endocrine, nutritional and metabolic diseases, treatment of circulatory diseases, treatment of tumours and the diseases of the nervous system.⁶

The proportion of private payments for healthcare services, compared to the national funding, also reveals the scope of national support. Patients' direct payments for healthcare services have increased from 23.9% in 2004 to 40.8% from the total expenditure for healthcare services in 2006. The proportion of national funding has respectively decreased from 76.1% in 2004 to 59.2% in 2006.^{7;58}

Patients' direct payments include patients' fees, payment for services, which are not covered from the national healthcare budget resources, payments to service providers for which a receipt of payment is not provided, as well as expenditure for purchasing medicines. In Latvia the level of patients' direct payments is high in all income groups, however, the probability of facing proportionally high expenditure for healthcare is higher in low income households, compared to high income households. Because of high patients' direct payments households can end up in deeper poverty.⁹ It must be noted that the funding system should ensure a fair distribution of burden - the inhabitants' financial contribution for healthcare should conform to their ability to pay.¹⁰

According to CSB calculations regarding the structure of household expenditure, in 2009 expenditure for health constituted 5.3% of the total expenditure. It is 124 lats annually per one member of household. The largest part of it (67%) was spent for purchasing medications.¹¹ According to the information provided by SAM the total turnover of medicines, which reached consumers, in 2009 was 195.69 million lats.¹²

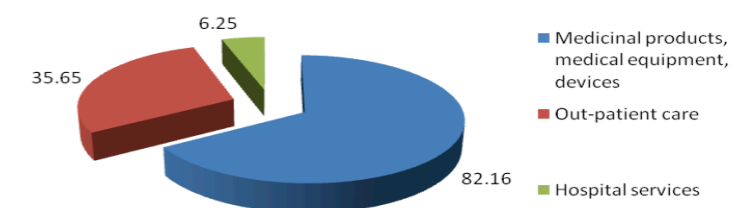


Figure 11. The breakdown of household health expenditure, average per member of household in 2009 (in lats).
Source: CSB

Identified problems:

- High level of patients' direct payments for healthcare services, which significantly impacts the accessibility of healthcare.
- Insufficient financial state support for the health system;
- Large household expenditure for purchasing medicines.

4 Public Report of the State Agency of Medicine Prices for 2009, Riga, 2010.

5 Estonian Health Insurance Fund Annual Report 2009.

6 HPC data.

7 E.Tragakos "Veselības aprūpes sistēmas pārejas periodā: Latvija. Pārskats par veselības aprūpes sistēmu." WHO (2008). [E.Tragakos "Health Care Systems in Transition: Latvia. A review of the health care system." WHO, 2008].

8 World Health Statistics 2009, WHO (2009).

9 Access to health care and the financial burden of out-of-pocket health payments in Latvia. WHO, 2009.

10 Estonia Health system performance assessment. WHO, 2010.

11 CSB data.

12 Public Report of the State Agency of Medicines for 2009.

4.2. ORGANISATION OF HEALTHCARE

Primary healthcare is the first stage, when a person encounters healthcare system. It is provided by the team of a general practitioner (general practitioner, doctor's assistant (flesher), nurse and receptionist), dentists, pharmacists and midwives. General practitioners ensure to the patients registered with them general healthcare (treatment of acute and chronic diseases), including surgical operations provided on out-patient basis, rehabilitation, pregnancy care and post-partum care, prescribe medicines, refer for diagnostic examinations and specialists to receive secondary healthcare services, and they also work on prevention (including immunisation), as well as ensure the monitoring of chronically ill patients (for example, patients with mental health disorders). A general practitioner's field of activities includes cooperation with the local government and the social service of a local government, ensuring multisectoral approach to dealing with patient's health problems.

The situation still remains when there is no primary healthcare nurse or receptionist working at the GP's practice, two general practitioners share one consulting room in shifts, the nurse has not been provided with a separate room for working with patients. These shortcomings make the services provided by the general practitioner and nurse less accessible, create waiting lists for receiving services, causes patients' dissatisfaction with the way general practitioners' work is organised and with the quality of services. It must be noted that legal acts do not set out sufficiently detailed requirements on the way general practitioners should organise their work, so such deviations from the understanding of best practice are possible. Solutions should be found to improve the territorial accessibility of general practices, to build the capacity of practices and to expand the competence of a general practitioner and motivation to participate in health promotion work. It is important to achieve conceptual changes in the understanding of the general practitioner's role in the health system - from "gatekeeper" to "healthcare manager". I.e., a general practitioner should be the central person, who guides the patient through health system and coordinates the treatment process, dedicates more time to the patient and aspects of health promotion and prevention, and is also responsible for effective, timely and economical treatment.

At the same time the potential of the professionals in pharmaceutical field to support the general practitioner's team is underused. Pharmaceutical care should be harmonically included in the healthcare system, creating an optimum infrastructure of service providers (pharmacists, pharmacies) and to develop criteria for providing pharmaceutical care. Special attention should be paid to using the potential of pharmacies in territories with low population density and insufficient accessibility of healthcare specialists. This would ensure the quality of services and promote their accessibility, regardless of patients' place of residence.

Latvian inhabitants can receive **secondary out-patient healthcare** at out-patient and in-patient institutions of healthcare with a general practitioner's referral or without it from directly accessible specialists, or as a service for a charge from other specialists (in the absence of a referral). Medical specialists specialising a concrete field provide these services. The general practitioner helps the patient to select among the offered healthcare services and refers the patient to the most appropriate specialist.

In developing a healthcare system, in which the general practitioner fulfils the function of "a healthcare manager", it is essential to ensure feed-back between the specialists of secondary out-patient care and the general practitioner, therefore ensuring the use of complete and credible information in the treatment process. Continuity in primary and out-patient care will improve the quality of services, facilitate trust in the doctor, as the result the number of untreated illnesses will decrease, the person will regain capacity for work sooner and in the long-term improvement in public health indicators can be expected.

In-patient healthcare services are provided by university hospitals, multi-profile hospitals, specialised hospitals and care hospitals.¹

A patient may be referred to a hospital by the specialists of primary care, secondary out-patient care and EMA service. Healthcare services of secondary and tertiary level are provided in the framework of in-patient services.

The number of acute beds (at university and multi-profile hospitals, specialised hospitals) remains fragmented across different hospitals, providing services to administrative territories with a small number of inhabitants and ensuring hospitalisation on a small scale. According to the recommendations of the World Bank the number of hospital beds should be decreased for more efficient use of the available resources.

To develop the out-patient healthcare and promote economical use of healthcare budget, in 2009 the activities of day clinics and the range of services provided by them were significantly expanded, and new healthcare service funded by the resources of the state budget - home healthcare - was introduced.

Since during the period, when the funding for healthcare system and the per capita expenditure were increasing, the effectiveness of healthcare system did not improve, for example, the number of episodes of care implemented by general practitioners and out-patient care specialists, the patients' satisfaction with the accessibility of healthcare services did not improve, measures to improve the effectiveness of healthcare system should be implemented, i.e., rational concentration of hospital services and decentralisation and regional development of out-patient services should be continued. Moreover, cooperation with social services providers, local government authorities should be promoted, to develop integrated long-term care, especially for elderly patients, patients with mental health disorders, allocating for this purpose the necessary funding.

The institution of a clinical pharmacist should also be developed and strengthened, involving them in decision taking on selection of medicines and their use during the in-patient stage, ensuring also the surveillance of medicinal therapy and the continuity in the use of medicines also in the out-patient stage.

At the **day clinic** a patient, who does not need round the clock monitoring and care provided by medical personnel, can receive diagnostic and healthcare services. The patient is referred to the day clinic to receive services paid for by the state by the general practitioner or a specialist. For cases when a patient is brought to an institution of healthcare, but is not hospitalised, **patient hotels** have been set up and will be set up in the future at the hospitals, providing an opportunity for the patient to stay overnight, if it is impossible return home or if the patient cannot arrive at the healthcare institution at the scheduled time.

Home healthcare is the healthcare provided to the patient by a nurse or a doctor's assistant (feldsher) at his or her place of residence. It is provided in those cases, when the patient does not need to be at a hospital, but because of medical indications, for example, restricted mobility, the patient is unable to reach the general practitioner or other specialist. The general practitioner takes the decision on the necessary home healthcare and its estimated length. The patient receives home healthcare, if the patient has a chronic disease and restricted mobility, because of which the patient is unable to come to the institution of healthcare, as well as in cases when the patient has been discharged from an in-patient facility or a day clinic following surgical manipulations.

Healthcare includes disease prevention, treatment during the period of illness, and also medical rehabilitation to restore the patient's capacity for work. **Medical rehabilitation** provided timely and in optimum scope and, if necessary, further development of the results achieved through rehabilitation in the framework of social and professional (vocational) rehabilitation allows to decrease or fully prevent functional disorders and their consequences, therefore preventing or decreasing temporary incapacity for work, providing disability prevention or decreasing the severity of disability. This, in its turn, improves the quality of life of these persons and the retaining or regaining of the social role for persons with functional restrictions; it also decreases the long-term financial burden to the healthcare and social system.

In accordance with legal acts² the healthcare of persons deprived of liberty is organised by the Ministry of Justice. It is separated from the general healthcare system of Latvian population. Therefore, as soon as a person arrives at a place of deprivation of liberty, he or she no longer has access to the general practitioner, reimbursement medicines, preventive health check-ups and examinations in full scope. The primary healthcare of persons deprived of liberty is provided by the healthcare personnel at the prisons or detention centres, the institutions of healthcare belonging to the healthcare system provide secondary healthcare. The healthcare of persons deprived of liberty is funded from the budget of the Ministry of Justice, except medicines for treating TB and HIV/AIDS, which are funded from the healthcare budget. Funding for the healthcare of persons deprived of liberty is envisaged in the state budget, however, the amount is insufficient.

To re-direct the healthcare system from hospital treatment to the primary and out-patient level, the principles of planning in-patient and out-patient services should be defined on policy planning level, drafting a development plan for healthcare system, criteria for planning territorial distribution and the amount of services to be provided, as well as criteria for assessing the quality of the services provided, i.e., the competencies of healthcare personnel involved in the treatment process should be defined for all levels of care.

To ensure healthcare sector with human resources and their development in the long-term, the Cabinet of Ministers in 2006 approved the program "The Development of Human Resources in Healthcare in 2006 -2015"³ It sets out the following main objectives - an effective human resources planning, providing the sector with a sufficient number of personnel in the necessary distribution and with adequate qualifications, the development of the system of education and improving the system of remuneration. In 2010 MH prepared an informative report on the implementation of the Guidelines "The Development of Human Resources in Healthcare" and the program "The Development of Human Resources in Healthcare in 2006 -2015" in 2006 -2009,⁴ which reflects the objectives that have been, have not been or have been partially met. On the basis of the data and the results of analysis obtained while preparing the report, as well as through analysing the situation in connection with the changes introduced into the healthcare system in recent years, linked with the reorganisation of hospitals, out-patient facilities, specialists' practices and day clinics, a new, updated document on the development of human resources in healthcare should be developed.

² The Cabinet of Ministers Regulation No. 199 of 20 March 2007 "

On the health care of detained and sentenced persons in pre-trial prisons and institutions of deprivation of liberty".

³ The Cabinet of Ministers Order No. 870 of 6 November 2006.

⁴ <http://polsis.mk.gov.lv/view.do?id=1774>

¹ The Cabinet of Ministers Regulation No. 60 of 20 January 2009 "Regulation on the Mandatory Requirements for Medical Facilities and their Structural Units."

Identified problems:

- Healthcare system deals with timely untreated health problems. Patients do not always have the possibility to see a doctor.
- Integrated, continuous and successive healthcare is not provided, which is fostered by the fact that persons providing healthcare are paid for the manipulations performed, not for the end result (quality) of the treatment.
- During the period when the funding for healthcare system and per capita expenditure were increasing, the effectiveness of the healthcare system did not improve, for example, the patient satisfaction with the accessibility of healthcare services did not increase. Therefore, when increasing the funding for the healthcare sector according to the state budget possibilities, it is important to introduce measures for increasing the effectiveness of the healthcare system.
- The possibility to conclude contracts only with most efficient (efficiency of work and cost efficiency) providers of out-patient services is underused. Therefore, the number and the structure of healthcare service providers are not optimal.
- Prison inmates are not provided with reimbursement medicines and items for out-patient treatment.

4.3. QUALITY AND SAFETY OF HEALTHCARE SERVICES

The most important elements of the healthcare quality is consistency in ensuring healthcare services, applying evidence-based practice, coordinated care in all stages of healthcare, prevention of possible mistakes in the care process (safety) and improving clinical effectiveness.¹

Various indicators are used to assess the quality of healthcare: the indicators of clinical outcomes (patient's assessment of the treatment outcomes, the level of hospitalisation with out-patient sensitive diagnoses, five year survival rate for concrete oncological diseases, etc.), patient safety indicators (the level of surgical infections, other healthcare related infections, the incidence of bacterial infections with resistance against antibiotics) and quality indicators of the care process (the development and implementation of evidence-based clinical guidelines, the scope of compliance with evidence-based clinical guidelines).²

To improve the quality of healthcare in Latvia evidence-based clinical guidelines should be developed and implemented. The procedure for developing, assessing, registering and approving of guidelines is set out in the Cabinet of Ministers Regulation.³ The list of approved guidelines is available on the CHE webpage.

Currently quality criteria for general practitioners are defined in a legal act.⁴ They are used to assess the work of a general practitioner; the amount of annual payment is calculated according to the rate of quality criteria met.

In Latvia the Health Inspectorate controls the quality of healthcare provided to the patients. HI controls the legal compliance of the institutions of healthcare, including the spending of budget resources; it reviews patients' complaints and carries out appropriate control measures at the institutions of healthcare. The greatest number of complaints deals with the quality of expertise on the incapacity for work, including the substantiation of the issued certificates on the incapacity for work. Complaints of persons from prisons or detention centres rank as second, but the third type of most frequent complaints concerns the work of general practitioners, as well as complaints regarding surgery/ traumatology/ obstetrics/ gynaecology and dentistry.

Healthcare related infections and microbial resistance is one of the main public health problems in the world, including the EU. Every year approximately 4 million patients in the EU member states are infected during the healthcare process, and for approximately 37 000 patients the outcome is fatal.

A number of measures to ensure the monitoring and control of healthcare related infections and microbial resistance have been implemented in Latvia, legal acts related to infection control and rational use of antibacterial agents have been developed.

Since 2004 the majority of Latvian microbiological laboratories have become part of the European Antimicrobial resistance surveillance system - EARSS, in the framework of which regular monitoring of antibiotics resistance is performed.

In 2007 systematic epidemiological surveillance of laboratory confirmed methicillin resistant *Staphylococcus aureus* (hereinafter - MRSA) cases was started, this function is performed by ICL, but the quality of hygiene and anti-epidemic regime at healthcare facilities is controlled by HI.

To limit the spread of infections connected with healthcare and to provide an insight on the measures of prevention and epidemiological control at the institutions of healthcare, guidelines on the best public health practice regarding actions, when cases of MRSA, *Clostridium difficile*, vancomycin resistant *Enterococcus faecalis*, *Enterococcus faecium* (VRE), hepatitis B, hepatitis C, HIV infection and viral aetiology acute intestinal infections are conformed at institutions of healthcare, have been prepared. The guidelines offer a summary of evidence-based practice regarding monitoring and control of healthcare related infections at the institutions of healthcare.

To ensure compliance with requirements of hygiene and anti-epidemics regime at medical facilities and to prevent nosocomial diseases, the management of medical waste at medical facilities should be regulated. Special attention should be paid to the disinfection of infected medical waste, to prevent spreading of infectious diseases and ensure disposal of medical waste in an environmentally safe way, since landfills may accept only waste, which is not infectious.

Identified problems:

- There is no comprehensive quality system for all healthcare services providers, which would allow the patient to make a motivated choice.
- The quality criteria set for the work of primary and secondary healthcare service providers are not sufficient to ensure effective and safe treatment process and long-term improvement of public healthcare indicators.

Objective: To ensure effective management of healthcare system and use of resources, to ensure optimisation of resources and long-term sustainability of the healthcare system, as well as equal access for all Latvia's inhabitants to those healthcare services, which are paid for from the state budget.

To reach the objective:

- Creation of a sustainable health system, ensuring stable and predictable funding for healthcare.
- Facilitating the decrease of patients' direct payments, improving the accessibility of healthcare services and shortening the waiting time.
- Strengthening of primary healthcare, including pharmaceutical care as the most cost effective and comprehensive level of healthcare.
- Increasing the activities of the general practitioner's team in providing care to oncology, addiction patients and patients with mental health disorders.
- Introducing the principle "money follows the patient" in the out-patient sector.
- Planning of a cost and resources effective system of in-patient healthcare.
- Developing of out-patient care and decreasing hospitalisations time of patients.
- Ensuring healthcare to prison inmates in conformity with the healthcare in society (reimbursement medicines, the rights for prison doctors to prescribe them, tests paid for by the state budget).
- Ensuring the implementation of best practice principles in treatment, facilitating the development of clinical guidelines and their implementation in practice.
- Developing of integrated long-term care, defining, which long-term care services are paid for from the healthcare budget and which - from the social budget.
- Improving the accessibility of reimbursement medicines and the quality of pharmaceutical care.

¹ Estonia Health system performance assessment. WHO, 2010.

² Estonia Health system performance assessment. WHO, 2010.

³ The Cabinet of Ministers Regulation No. 469 of 25 May 2010 "The Procedure of Developing, Assessing, Registering and Implementing Clinical Guidelines".

⁴ The Cabinet of Ministers Regulation No. 1046 of 19 December 2006 "The Procedure of Organising and Funding Health Care".

5. Policy Outcomes, Action Results and their Performance Indicators

Defined policy objective: To eliminate inequality in the field of health, by implementing measures to ensure equal opportunities for health to all Latvian inhabitants.

	Reference level	Indicator	Year	2014	2017
Policy outcome A1: The life expectancy at birth has increased.	Performance indicator: the average life expectancy at birth for men (in years) (source: CSB)	68.8	2010	69.1	71.1
	Performance indicator: average life expectancy at birth for women (in years) (source: CSB)	78.4	2010	79.1	79.6
	Performance indicator: average life expectancy at birth close to the average indicator of the EU states (%) (source: Eurostat)	91	2008	93	95
Action result A1: Guidelines on health promotion measures in local government authorities developed and forwarded to all local government authorities	Performance indicator: guidelines developed	-	2010	x	
	Performance indicator: proportion of local government authorities involved in implementing the guidelines (%)	-	2010	65	85
Action result A2: Annual intersectoral public health communications plan has been developed and implemented	Performance indicator: Regular, updated information on health promotion, disease prevention, negative impact of environmental factors upon health and possibilities to decrease it, possibilities of early disease diagnosis and healthcare services is accessible to society.	-	2010	x	x

Defined policy objective: To decrease morbidity and mortality from non-infectious diseases, decreasing the negative impact of risk factors upon health.

Policy outcome B1: Mortality from non-infectious diseases below the age of 64 has decreased.	Performance indicator: mortality from circulatory diseases (per 100000 of the population) (source: CHE)				
	including men	237.0	2010	250.9	241.7
	including women	81.7	2010	70.1	59.8
	Performance indicator: mortality from oncological diseases (per 100000 of the population) (source: CSB)	106.4	2010	102.5	102.0
	including men	123.2	2010	117.6	117.0
	including women	90.2	2010	89.0	88.8
Action result B1: An action plan for restricting alcohol consumption has been elaborated and implemented	Performance indicator: mortality from diabetes (per 100,000 of the population) (source: CHE)	5.6	2010	5.4	5.0
	including men	6.9	2010	6.0	5.8
	including women	4.2	2010	3.1	3.0
Action result B2: The amount of trans-acids in the products distributed in Latvia has been restricted	Performance indicator: The consumption of absolute alcohol per one inhabitant older than 15 years (in litres) (source: CSB)	7.0	2009	6.9	6.7
	Performance indicator: Proportion of school students, who during the last month have drunk more than 5 units of alcohol on one occasion (%) (source: ESPAD)	29	2007	25	20
	Performance indicator: Restrictions to the use of trans-acids defined in legal acts.	-	2010.	x	x

Defined policy objective: To improve the health of mother and child, decrease infant mortality.

Policy outcome C1: The health condition of children improves	Performance indicator: Infant mortality (per 1000 live births) (source: CSB)	5.7	2010	5.0	4.6
	Performance indicator: Proportion of children (15yrs), who assess their health status as good (%) (source: HBSC)	76.4	2010	78	80
Action result C1: Parents informed about the impact of addiction-inducing substances upon the health of a pregnant woman and foetus and the importance of mother's milk to ensure child's health	Performance indicator: Proportion of pregnant women who smoke (%)	10.2	2010	9	8
	Performance indicator: Proportion of infants who are breast-fed till the age of 6 months (%)	52.5	2010	53.7	56.7

Defined policy objective: To promote healthy and safe living and working environment, to decrease traumatism and mortality from external causes of death.

Policy outcome D1: Child traumatism has decreased	Performance indicator: The number of children aged 0-14 years who are discharged from in-patient institutions with the diagnosis injuries, poisoning and consequences of the impact of other external factors (per 100,000 of the population) (source: CHE)	1696.7	2010	1687.1	1677.4
	Performance indicator: The number of children aged 15-17 years who are discharged from in-patient institutions with the diagnosis injuries, poisoning and consequences of the impact of other external factors (per 100,000 of the population) (source: CHE)	2091.1	2010	2055.6	2019.8
Action result D1: Society has been informed about the most frequent causes and preventive measures of traumas	Performance indicator: Proportion of inhabitants using child seats in cars (%)	36.8	2010	45	50
	Performance indicator: Proportion of children using protective helmets (when cycling or roller-skating) (%)	19.4	2010	25	30
Action result D2: Society informed about the impact of environmental factors upon health	Performance indicator: The water profile for all official swimming sites have been elaborated and published	30	2011	46	46

Defined policy objective: To decrease morbidity with infectious diseases.

Policy outcome E1: Morbidity with infectious diseases has decreased	Performance indicator: Morbidity with TB per 100,000 of the population (source: CSB)	37.0	2010	36.6	36.0
	Performance indicator: Morbidity with HIV per 100,000 of the population (source: ICL)	12.2	2010	11.5	11.0
	Performance indicator: The number of cases of measles, rubella, poliomyelitis, tuberculous meningitis and military tuberculosis in infants of local origin (source: ICL)	1	2010	0	0
Action result E1: Updated information on preventive measures against and treatment of infectious diseases prepared	Performance indicator: the number of prepared informative materials		2010	12	12

Defined policy objective: To ensure effective management of healthcare system and use of resources, to ensure optimisation of resources and long-term sustainability of the healthcare system, as well as equal access for all Latvia's inhabitants to those healthcare services, which are paid for from the state budget.

Policy outcome F1: Balanced proportion of public and private funding for the health sector	Performance indicator: Public funding for health sector (% of GDP)*	3.87	2010	4.5	5.0
	Performance indicator: Proportion of household direct payments for healthcare services (%) (source: Eurostat)	39.3	2010	30	30
Policy outcome F2: Treatment of patients in out-patient sector increases	Performance indicator: Number of out-patient visits to a primary healthcare doctor per one patient annually, services paid by the state	2.9	2009	3.1	3.2
	Performance indicator: Average number of bed days per 1 patient (all in-patient facilities, all profiles)	8.54	2010	6.5	6.5
Action result F1: The Development Plan for Human Resources in Healthcare has been elaborated and implemented	Performance indicator: Number of doctors per 10 000 of the population (excluding dentists, interns and residents)	31.0	2010	30.0	30.0
	Performance indicator: Number of general practitioners per 10 000 of the population	5.9	2010	6.0	6.0
	Performance indicator: Number of nurses per 10 000 of the population	45.0	2010	50	60
Action result F2: Quality criteria defined for in-patient healthcare facilities	Performance indicator: Quality criteria for in-patient healthcare facilities defined in legal acts	-	2010	x	x

*The indicator may be changed depending upon the allocated state budget funding.

6. Further actions

The policy aim defined in the Strategy: To prolong the healthy life years of Latvian population and to prevent untimely death, maintaining, improving and restoring health.

Objective defined in the Strategy To eliminate injustice in the field of health, by implementing measures to ensure equal health possibilities to all Latvian inhabitants.

1. Point of progress: Ensuring partnership and intersectoral cooperation, facilitating equal health opportunities to all inhabitants					
	Tasks/ main measures for reaching the defined objective	Term	Responsible institution	Involved institutions	Envisaged funding and its sources
1.1.	To cooperate with public opinion shapers, including journalists and editors of mass media, to provide more extensive information to society about public health issues	constantly	MH	HI, LPS, Latvian Diabetes Federation, professional associations, "Mums' Club" media	Throughout the whole period the measure will be ensured within the framework of funding allocated for the current year: in 2011 in accordance with the approved budget, 2012-2014 - in accordance with the approved base budget, 2015-2017 in the same amount. The budget includes funding for implementing the measure in the amount of 32 912 lats.
1.2.	To identify mechanisms for ensuring effective provision of information to society and to submit to HM information on methods for informing society and the calculations of the necessary funding.	01.07.2014.	CHE	MH, Strategic Council of Health Sector, Institution of Chief Specialists, LPS	In 2014 additional funding from the subsidy from general revenue will be needed to outsource research of situation and drafting of recommendations for the total sum of 20 000 lats.
1.3.	To establish a working group for identifying and coordinating research in the field of public health.	31.12.2011.	MH	RSU, MES	The measure will be implemented in the framework of funding allocated in the law on the state budget for 2011.
1.4.	To develop and annual public health communications plan in cooperation with other sectors	Every year by 1 April	MH	MES, MA, ME, MT, MEPRD	The measure will be implemented in the framework of funding allocated in the law on the state budget for the current year.
1.5.	To develop guidelines on health promotion measures in local government authorities	31.12.2011.	MH	Local government authorities, LPS	The measure will be implemented in the framework of funding allocated in the law on the state budget for 2011.

Objective defined in the Strategy To eliminate injustice in the field of health, by implementing measures to ensure equal health possibilities to all Latvian inhabitants.

1.6.	To conduct public health monitoring, inter alia, maintaining a public health monitoring and reporting system (PHMR)	constantly	CHE	MH, local government authorities, higher educational institutions	In 2011-2013 the measure will be implemented in the framework of funding allocated in the law on the state budget for the current year. In 2014 the Centre of Health Economy will need additional funding to ensure one job in the amount of 11 260 lats. Therefore the total funding needed in 2014 will be 35 785 lats, including : Remuneration (1000) - 34 785 lats; Salary (1100) - 28 032 lats; State mandatory social insurance contributions (1200) - 6 753 lats; Capital expenditure (5000) - 1 000 lats. In 2015-2017 the total necessary funding will be 34 785 lats (including for providing 1 additional job - 11 260 lats), including: Remuneration (1000) - 34 785 lats; Salary (1100) - 28 032 lats; State mandatory social insurance contributions (1200) - 6 753 lats. To ensure 1 additional job in 2014 - in the amount of 11 260 and in 2015 -201 - 10 260 lats additional subsidy from general revenue will be needed.
1.7.	To implement activities to inform target groups about health issues, i.e., taking into consideration gender differenced and developing informative materials aimed at male and female target audiences.	From 2014 constantly	MH	Latvian Diabetes Federation, Latvian Association of Osteoporosis and Diseases of Bone Metabolism, Latvian Public Health Foundation	In 2014 the measure will be implemented within the limits of the budget allocated by the law on state budget. In 2015 additional funding from the subsidy from general budget revenue will be needed in the budget program 01.00.00 "Management of the sector" sub-program 01.01.00 "Central management of healthcare" - in the amount of 2 250 lats, including: Goods and services (2000) - 2 250 lats. Developing materials 80 expert hours - 250 lats. Printing the materials (10 000 copies) - 2 000 lats.

Objective defined in the strategy: To decrease morbidity and mortality from non-infectious diseases, decrease the negative impact of risk factors upon health.

2. Point of progress: Reducing the risk factors of non-infectious diseases					
2.1.	To develop an action plan for restricting alcohol consumption	31.12.2012.	MH	CHE, MA, ME, MF, LFFC, Association "Latvian National Coalition for Tobacco and Alcohol Control" and other NGOs	In 2011 the measure will be implemented within the limits of the funding envisaged by the law on the state budget for the current year.
2.2.	To implement educational activities for the population in all age groups, taking into consideration gender differences, on the role of physical activities and healthy nutrition in maintaining health, on the role of hygiene and the impact of addiction-inducing substances upon health.	From 2014 constantly	MH	Local government authorities, RSSNS, Latvian Association of Endocrinologists, LFFC, Latvian Association of Osteoporosis and Diseases of Bone Metabolism, Latvian Foundation for Fighting Drug Addiction and Dipsomania	To implement the measure in 2014-2017 funding in the amount of 24 942 lats will be needed, including additional resources from the subsidy from general budget revenue for the budget program 01.00.00 "Management of the sector" sub-program 01.01.00 "Central management of healthcare" - in the amount of - in the amount of 11 350 lats. In 2014-2017 additional 11 350 lats in the breakdown of expenditure codes according to economic categories: Remuneration (1000) - 9 098 lats; Salary (1100) - 7 332 lats; State compulsory social insurance contributions (1200) - 1 766 lats. Goods and services (2000) - 2 252 lats.
2.3.	To provide advice to local government authorities on the implementation of the guidelines for promoting physical activities in local government authorities	From 01.03.2012	LSMSA	MH, local government authorities	In the framework of resources envisaged in the state budget for the current year.
2.4.	To support the implementation of the programme "5 a day" (or 5 helpings of fruit and vegetables per day) in Latvia, increasing the consumption of fruit and vegetables	constantly	MH	LALRG, LFFC	The measure will be implemented the framework of resources envisaged in the state budget for the current year.
2.5.	To develop informative educational materials on preparing cheap and nutritional food to persons with low income	31.12.2013.	MH	NGO	The measure will be implemented in the framework of funding allocated in the law on the state budget for the current year.
2.6.	To inform healthcare personnel (general practitioners, neurologists) on factors causing occupational diseases and timely diagnosis of occupational diseases	From 01.07.2012.	MH, MW	Association of General Practitioners, Latvian Association of Rural General Practitioners, RSU ILSEH	In the framework of resources envisaged in the state budget for the current year.
2.7.	To develop a draft legal act to restrict the amount of trans-acids in food products	30.06.2013.	MH	MA, LFFC	The measure will be implemented in the framework of resources envisaged in the state budget for the current year.

Objective defined in the strategy: To decrease morbidity and mortality from non-infectious diseases, decrease the negative impact of risk factors upon health.

2.8.	To elaborate legal regulation on food rations at catering facilities in closed institutions	31.12.2011.	MH	Latvian Association of Diet and Nutrition Specialists, LANS	In the framework of resources envisaged in the state budget for the current year.
2.9.	Continue implementing "School Milk" program, envisaging the possibility to pre-schoolers and students of comprehensive institutions of education to receive dairy products in the framework of the EU support programs	constantly	MA	RSS, MES, MH	In the framework of resources envisaged in the law on the state budget for the current year and the EU budget.
2.10.	To continue implementing the program for supplying fruit and vegetables to school, envisaging the possibility to the students of comprehensive institutions of education to receive integrated fruit and vegetables in the framework of the EU support programs	constantly	MA	RSS, MES, MH	In the framework of resources envisaged in the law on the state budget for the current year and the EU budget.
2.11.	To develop legal regulation for defining energy drinks	01.06.2012.	MA	MH, LFFC	In the framework of resources envisaged in the law on state budget for the current year.
2.12.	To ensure the transposition of the EU legal acts to regulate the distribution of e-cigarettes and any other products envisaged as substitutes for tobacco (except medical devices)	31.12.2013.	MH	CHE	In 2012-2013 the measure will be implemented within the framework of resources envisaged in the law on state budget for the current year. (see Annexe 2).
2.13.	To carry out research on the risk factors of non-infectious diseases	constantly	CHE	WHO, local government authorities, higher educational institutions, Latvian Public Health Foundation	In the framework of resources envisaged in the law on state budget for the current year.
2.14.	To carry the survey of WHO International study on smoking among adolescents (GYTS) in Latvia	School year 2014 /2015	CHE	WHO	In the framework of resources envisaged in the law on state budget for the current year.
2.15.	To identify factors hindering the organisation of cancer screening and improve screening for early diagnosis of oncological diseases	31.12.2012.	HPC	Latvian Association of Gynaecologists and Obstetricians, Latvian Association of General Practitioners, LU, Riga Eastern University Hospital	In the framework of resources envisaged in the law on state budget for the current year.

Objective defined in the Strategy: To improve the health of mother and child, decrease infant mortality.

3. Point of progress: Improving the health of pregnant women and children					
3.1.	To implement educational activities for parents on the harmful impact of addiction-inducing substances upon the health of a pregnant woman and the foetus, on healthy nutrition for children, inuring children, physical activities and safety	constantly	MH	MES, NGO, mass media, "Mums' Club" media, Association "Latvian National Coalition for Tobacco and Alcohol Control" and other NGOs, Latvian Association of General Practitioners, Latvian Association of Rural General Practitioners, Latvian Association of Gynaecologists and Obstetricians, LFFC	<p>In 2012-2017 funding in the amount of 11 479 lats is envisaged for implementing the measure.</p> <p>In 2014-2017 additional resources will be necessary from the subsidy from general budget revenue for the budget program 01.00.00 "Management of the sector" sub-program 01.01.00 "Central management of healthcare" in the amount of 2 000 lats, the breakdown according to the codes of economic categories : Goods and services (2000) - 2 000 lats.</p> <p>Organising informative educational events on topics related to family health, including: lectures, discussion groups, health weeks, and round table discussions. 6 to 10 event (the average costs of 1 event from 200 lats to 300 lats). 8 events * 250 lats = 2 000 lats.</p>
3.2.	To inform medical staff, parents and opinion shapers in mass media on the role of mother's milk in ensuring and maintaining a child's health	constantly	MH	NGO	In the framework of resources envisaged in the law on state budget for the current year.

Objective defined in the Strategy: To improve the health of mother and child, decrease infant mortality.

3.3.	To ensure education on sexual and reproductive health issues to teenagers, taking into consideration gender differences	constantly	MH	Latvia's Association for Family Planning and Sexual Health „Papardes zieds”	<p>In 2011-2013 the measure will be implemented within the framework of the funding envisaged by the law on the state budget for the current year. In 2011-2017 funding in the amount of 16 021 lats is envisaged for the implementation of the measure.</p> <p>In 2014-2017 additional funding will be necessary from the subsidy from general budget revenue for the budget program 01.00.00 "Management of the sector" sub-program 01.01.00 "Central management of healthcare" in the amount of 2 000 lats, including: Goods and services (code 2000) - 2 000 lats.</p> <p>Organising 8 seminars and discussion groups for adolescents (the average costs of organising one seminar - 250 lats).</p>
3.4.	To prepare an informative report of infertility problems in Latvia, to identify the current situation and provide recommendations for improving it	30.12.2012	MH	HPC	In the framework of resources envisaged in the law on state budget for the current year.

Objective defined in the Strategy: To promote healthy and safe living and working environment, to decrease traumatism and mortality from external causes.

4. Point of progress: Decreasing the impact of traumatism and environmental risks upon public health					
4.1.	To prepare updated information on actions to be taken in an emergency and providing first help in trauma cases	Every year till 1 March	EMAS	MH	In the framework of resources envisaged in the law on state budget for the current year.
4.2.	To educate parents and medical staff on the most frequent causes of trauma among children and safety measures to prevent traumas	constantly	MH	State Inspectorate for the Protection of the Rights of the Child, NGO	In the framework of resources envisaged in the law on state budget for the current year.
4.3.	To organise seasonal educational campaigns and road traffic safety campaigns, focusing upon the vulnerable road traffic participants, taking into consideration gender differences	constantly	Road Traffic Safety Directorate, State Police	MI, EMAS, LSMSA	In the framework of resources envisaged in the law on state budget for the current year.
4.4.	To facilitate knowledge and skills among pre-schoolers and students of comprehensive educational institutions on personal safety and healthy lifestyle	constantly	MES	SCCD	In the framework of resources envisaged in the law on state budget for the current year.
4.5.	To conduct effective surveillance of the products and services market, to ensure the accessibility of only safe products and services	constantly	CRPC, HI	ME, MH	In the framework of resources envisaged in the law on state budget for the current year.

Objective defined in the Strategy: To promote healthy and safe living and working environment, to decrease traumatism and mortality from external causes.

4.6.	To inform society about the negative health impacts of air, drinking water and swimming water pollution and individual possibilities of prevention	constantly	HI	MH, MEPRD	In the framework of resources envisaged in the law on state budget for the current year.
4.7.	To prepare proposals for decreasing the level of excessive noise in places, where it disturbs people in their work, life and leisure	01.01.2014	HI, MH, MEPRD	NGO, local government authorities, MT	In the framework of resources envisaged in the law on state budget for the current year.
4.8.	Research carried out on the impact of environmental factors (chemical substances, dust, including nanoparticles, noise, electromagnetic, ionization and other radiation, urban environment, global warming) upon human health	31.12.2017	RSU, MH	MES, MEPRD	In the framework of resources envisaged in the law on state budget for the current year, to the extent possible attracting the funding of the EU funds or other project resources.
4.9.	To inform medical facilities about handling medical waste and correct management of it	constantly	MH	HPC	In the framework of resources envisaged in the law on state budget for the current year.

Point of progress: Prevention of infectious diseases

5. Rīcības virziens: infekcijas slimību profilakse					
5.1.	To improve informing society about the significance of measures for preventing infectious diseases, including the role of vaccination	From 01.01.2012	ICL	MH	The measure will be implemented in the framework of funding allocated in the law on the state budget for the current year.
5.2.	To improve the collection of statistical data, by educating medical staff on filling out forms and reporting about concrete infectious diseases	constantly	ICL	MH	The measure will be implemented in the framework of funding allocated in the law on the state budget for the current year.
5.3.	In cooperation with WHO implement training of medical staff on prevention and diagnosis of infectious diseases	31.12.2012	ICL	WHO, Latvian Association of General Practitioners, Latvian Association of Rural General Practitioners	The measure will be implemented in the framework of funding allocated in the law on the state budget for the current year.
5.4.	To assess the effectiveness and structure of the system for epidemiological surveillance and prepare a final report	30.06.2012	ICL	MH	The measure will be implemented in the framework of funding allocated in the law on the state budget for the current year.
5.5.	To improve cooperation with European Centre for Disease Prevention and Control, obtaining the most recent information about diagnosis and prevention of new infectious diseases	constantly	ICL	MH	The measure will be implemented in the framework of funding allocated in the law on the state budget for the current year.

Objective defined in the Strategy: To ensure an effective management of healthcare system and use of resources, to ensure the optimisation of costs and sustainability of the healthcare system, as well as equal access to all Latvian inhabitants to those healthcare services, which are paid for from the resources of the state budget.

6. Point of progress: Developing a high quality system of healthcare services, ensuring the accessibility of services to all Latvian inhabitants					
6.1. Provision of healthcare services and development of resources					
6.1.1.	Elaborate a plan on the development of human resources in healthcare and a development plan for healthcare system	30.06.2012 31.12.2012	MH MH	CHE, HPC CHE, HPC	In 2011 and 2012 the measure will be implemented in the framework of funding allocated in the law on the state budget for the current year.
6.1.2.	Involving a second nurse in the GP practice, ensuring that the nurse sees patients independently	31.12.2013	MH	HPC	The measure will be implemented in the framework of funding allocated in the law on the state budget for the current year.
6.1.3.	Provision of in-patient healthcare services in hospitals, which ensure the amount of human resources and meet the quantitative criteria set in legal acts	31.12.2014	MH	HPC, CHE, local government authorities	The measure will be implemented in the framework of funding allocated in the law on the state budget for the current year.
6.1.4.	Establishing a mechanism for funding hospitals to ensure that the amount of funding to be allocated for hospitals changes depending upon meeting the defined requirements (quality of work and cost effectiveness)	31.12.2013	MH	HPC, CHE	The measure will be implemented in the framework of funding allocated in the law on the state budget for the current year.

Objective defined in the Strategy: To ensure an effective management of healthcare system and use of resources, to ensure the optimisation of costs and sustainability of the healthcare system, as well as equal access to all Latvian inhabitants to those healthcare services, which are paid for from the resources of the state budget.

6.1.5.	Development of a network of care hospitals (beds) to ensure long-term care to patients	31.12.2014	CHE	MH, LPS, local government authorities	The measure will be implemented in the framework of funding allocated in the law on the state budget for the current year.
6.1.6.	To develop out-patient care and decrease the time patients spend in hospitals, expanding the functioning of day clinics and increasing the effectiveness of services provided	31.12.2014	VM	HPC, CHE	The measure will be implemented in the framework of funding allocated in the law on the state budget for the current year.
6.1.7.	To develop and introduce quality criteria for in-patient medical facilities, introducing amendments into legal acts	01.01.2013	MH	CHE	The measure will be implemented in the framework of funding allocated in the law on the state budget for the current year.
6.1.8.	To prepare amendments to legal acts, defining the rights of prison inmates to receive reimbursement medicines and the obligation of the Ministry of Justice to cover the patient's fee for healthcare provided to prison inmates	01.10.2011	MJ	MH	The measure will be implemented in the framework of funding allocated in the law on the state budget for the current year.

Objective defined in the Strategy: To ensure an effective management of healthcare system and use of resources, to ensure the optimisation of costs and sustainability of the healthcare system, as well as equal access to all Latvian inhabitants to those healthcare services, which are paid for from the resources of the state budget.

6.2. Pharmaceuticals					
6.2.1.	Development of medicines reimbursement system, including new diagnoses and medicines	01.10.2014	CHE	SAM	The measure will be implemented in the framework of funding allocated in the law on the state budget for the current year.
6.2.2.	To develop criteria for assessing the accessibility and quality of pharmaceutical care	31.12.2012	LPA	CHE, CRPC	Within the budget of LPA.
6.2.3.	To prepare amendments to legal acts, defining quality criteria for assessing pharmacists' work	31.12.2013	MH		The measure will be implemented in the framework of funding allocated in the law on the state budget for the current year.
6.2.4.	To inform society about rational use of medicines	From 2012 constantly	CHE	SAM	The measure will be implemented in the framework of funding allocated in the law on the state budget for the current year.
6.2.5.	To introduce stricter control of the advertising of medical devices and nutrition supplements	constantly	SAM, CRPC	Latvian Advertising Association, Ethics Committees of LPA and producers	The measure will be implemented in the framework of funding allocated in the law on the state budget for the current year.

7. Reporting and Evaluation Procedure

The Ministry of Health shall provide information to the Cabinet of Ministers on the implementation of the Strategy twice in the period of validity of the Strategy: an informative report on mid-term evaluation of the Strategy in 2014 and the final report on the implementation of the Strategy in 2018. In case of necessity the Ministry of Health shall prepare amendments to the Strategy and shall submit them for review to the Cabinet of Ministers.



ANNEXE 1 to the Public Health Strategy for 2011-2017

EXPLANATION OF THE TERMS USED IN THE TEXT

Consumption of alcoholic beverages per capita - the consumption of alcoholic beverages in Latvia per capita is calculated by dividing the amount of alcohol consumed in the respective year by the average number of the population in the year. This indicator is calculated both in terms of consumed alcohol in each group of beverages and expressed as absolute alcohol.

Consumption of alcoholic beverages expressed in absolute alcohol - an indicator of alcoholic beverages consumed in Latvia, which is calculated for each group of beverages and expressed for all groups of beverages as absolute alcohol. When expressing the data as absolute alcohol, the amount of consumed alcohol in each group of beverages is re-calculated and equalled to 100% alcohol.

Day clinic - a medical facility, where the patient, who does not need care and surveillance provided by healthcare personnel, receives assistance in the form of diagnosis and treatment. Diseases and disorders are diagnosed at day clinic; patients receive treatment and care there.

Quality of life - an indicator of the well-being of a person, family, a group of persons, society, which includes physical and mental health, leisure time and spending it, work, links with society, the right to take independent decisions and to implement them, as well as material means.

Pharmaceutical care - an element of healthcare, which a pharmacist provides within his or her competence, providing pharmaceutical advice, information about medicines and their use. This care contains monitoring the use of medicines by permanent customers of the pharmacy, dissemination of medicines and other healthcare, prevention and health promotion products, preparing medicines, health promotion and advocacy of disease prevention, on the basis of recent scientific findings and considering the customers' interests, as well as ensuring customer data protection within the limits of their competence.

Integrated fruit and vegetables - products, the cultivation of which is based upon biological methods of plant protection, monitoring and recording of the spread of pests and diseases, as well as using optimal doses of fertiliser.

Average life expectancy of newborns - the number of years that the people born in a given year would live, if during their lifetime the mortality rate in every age would remain the same as in the year they were born.

Reimbursement medicines - medicines fully or partially paid for by the state, which in cases of certain diagnoses are prescribed by general practitioners or specialists mentioned in the list of reimbursement medicines. The state may reimburse the costs of medicines in the amount of 50, 75 or 100%.

Quintile - one fifth of the number of surveyed households, grouped in an increasing order according to the monetary revenue at their disposal per one member of the household. First quintile covers the poorest households, but the 5th - the most prosperous.

Abortions - cover legal, medicinal abortions and abortions performed outside medical facility.

Maternal mortality - the number of deceased women per 100,000 live born infants, who have died during pregnancy or 42 days after termination of pregnancy, irrespectively of the length and localisation of pregnancy, if the causes are linked with pregnancy or which the pregnancy or its management aggravated, but not an accident or a contingency.

Mortality - the rate of death cases, usually expressed per 100000 of the relevant population (population of the relevant age, gender, etc.).

Risk of poverty rate - number of inhabitants living beneath the level of relative poverty (the proportion of those persons, whose equivalent total net income is smaller than 60% of the national median income).

Cause of death - a disease, a pathological condition or an injury, which has caused or facilitated death, as well as an accident or an act of violence, which has resulted in death.

Predictable healthy life years - the years that the person of the given age could live in good health (without functional disorders or restrictions).

Perinatal mortality - number of stillborn children and children who die during the first week of life, per 1000 stillborn and live births. Perinatal death includes the perishing of foetus before birth, during labour (stillborn) and the death of the newborn during the first week of life (early neonatal death).

Potential years of life lost - years that a person would have lived up till a certain age (here the calculations are based upon the age of 65), if he or she had not died because of an accident, disease or some other cause.

Primary healthcare - the first and main level of healthcare system, the first stage of interaction between a patient and the provider of healthcare services, in which main health problems of the population are dealt with, using simple and cost effective medical technologies. General practitioners together with their teams (doctor's assistant or a nurse and midwife), as well as dentist, dentist's assistant, dental nurse and dental hygienist provide primary healthcare to patients registered with them at out-patient medical facilities and out-patient departments of in-patient medical facilities.

Public health - research and targeted activities aimed at disease prevention, increasing life expectancy, promoting mental (psychic) and physical health by organising large-scale activities.

Sexual and reproductive health - physical, mental and social wellbeing linked with human reproductive system.

Secondary healthcare - specialised out-patient and in-patient healthcare, targeted at emergency, acute or scheduled healthcare (provided at an out-patient medical facility, out-patient department of a hospital, emergency medical assistance facility, day clinic, hospital).

Screening diagnosis or screening - targeted search for a disease in persons, who have no symptoms linked with the disease that is searched for and who belong to a risk group (most often - specific age group), which has the highest morbidity with the disease.

In-patient care - treatment of patients, involving being under constant, round the clock care of healthcare personnel. Services of secondary and tertiary level healthcare are provided as in-patient care.

Health - physical, mental (psychic) and social welfare, which is the natural foundation for the existence and survival of the state and the nation.

Healthy life years - estimated years of life that will be lived in good health (without functional restrictions or restricted activities)

Infant mortality - the number of children, who die during their first year of life, per 1000 live births.



MINISTRY OF HEALTH
OF THE REPUBLIC OF LATVIA