

# Country report Latvia – August 2014



Report by **Dr Vilnis Dzerve**, National CVD Prevention Coordinator for Latvia, *et al.*  
Prepared for the EACPR “Country of the Month” initiative

Contact: [email](#)

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**Health care | Risk factors | Prevention methods | Prevention activities | Cardiac rehabilitation | Future**

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## Baseline information about Latvia

The Republic of Latvia is a sparsely populated country in north-eastern Europe with about 2.0 million inhabitants. It is one of the Baltic countries and forms part of the eastern border of the European Union (EU). Riga – the capital – is the largest city, with about 700 000 inhabitants.

Latvia’s territory is 64 559 square kilometres (about twice the size of Belgium), with a flat landscape and extensive forests covering 47% of the land area and forming Latvia’s most important natural resource. The territory consists of 62 157 square kilometres land area and 2402 square kilometres inland water. About 21% of the territory (12 790 square kilometres) consists of nationally protected areas. The highest point in Latvia is Gaizinkalns, which is 311.6 m above sea level but the average elevation of Latvia is only 87 m.

At the beginning of 2014 Latvia had an estimated population of 2.0 million, with slightly more women than men (54% female). This means that since 2000 the population in the country has reduced by 350 000 or 14%. The two immediate causes for the population decline are the negative net international migration and negative population growth. While in 1990, Latvian women had 2.0 children each, this number dropped to 1.44 in 2012, which is well below the average of 1.58 in the 28 EU member states.

Latvia has an ageing population, which is common in European Union (EU) member states. The number and share of the population under 15 years of age continues to decrease, whereas the share of the population over 65 years increases. While the relative share of the people under 15 years was 21.4% in 1990, it dropped to 17.7% in 2000 and 14.8% in 2013. Simultaneously, the percentage of the population of 65 years and above is constantly rising, from 11.9 in 1990 to 15.6% in 2000 and 18.8% in 2013.

## I. Structure of Health care in Latvia

Latvia is a parliamentary republic and, consequently, the main normative acts and regulations for the health sector are issued by the parliament and the Cabinet of Ministers. Health policy priorities are determined by the Ministry of Health.

The Latvian health care system has undergone a remarkable process of transformation in the years since independence from 1991. Following experimentation with different approaches to organisation and financing, the period between 2007 and 2012 has, again, seen an impressive number of reforms.

This has led to: (1) the development of a more centralised system with state functions consolidated in fewer institutions; (2) the establishment of one central institution for purchasing health care (the National Health Service (NHS)); and (3) a health care delivery system with a strong focus on primary care (and substantially fewer hospitals).

The NHS is now the most important national institution for the implementation of health policies, administering the financial resources of the state, determining the contents of the benefits package, contracting with providers, implementing the e-health system and registering clinical guidelines and medical technologies.

Inpatient and outpatient health care in Latvia is provided by state and local government-owned institutions, private clinics and hospitals, and individuals. Independently of the type of property, all providers within the statutory system have to comply with regulations defined by the Ministry of Health and are financed by the NHS.

Primary care practices run by independent general practitioners (GPs) form the backbone of the Latvian primary health care (PHC) system. Health centres are the most important providers of secondary ambulatory care. They often operate in the premises of former polyclinics and usually employ a range of different specialists as well as GPs. About 70–80% of health centres are private (mostly in Riga) with the remaining percentage being owned by municipalities.

In addition, local (municipal) hospitals provide an important share of secondary outpatient care. Almost all dental practices and pharmacies are private. Since the reorganisation of the hospital sector in 2010, hospitals can be classified into three categories: (1) “care hospitals”, which provide long-term (medical) care after discharge from an acute hospital; (2) multi-specialty hospitals at local, regional and national level; and (3) specialised hospitals for psychiatry, trauma, maternity and narcology.

“Care hospitals”, as well as local and regional multi-specialty hospitals, are generally owned by municipalities. National multi-specialty hospitals, i.e. the university hospitals in Riga, as well as all specialised hospitals are owned by the state (national government). Rehabilitation care is provided by dedicated rehabilitation hospitals and rehabilitation centres. Only a very small portion of the hospital sector is privately owned.

The most important source of revenue for the health system is the general tax system (income, value added and other taxes), contributing only around 60% of total health expenditure. The second most important source of financing is out-of-pocket (OOP) payments, consisting of user charges for all statutorily financed services (although exemption mechanisms exist), direct payments for services not financed by the state (such as dental care for adults and cosmetic surgery), or used outside the normal treatment pathways (e.g. to avoid waiting lists). In 2010 the average monthly OOP per one household member was LVL (Latvian Lat) 10.40 (€14.60), contributing to 5.8% of total household expenditure. About 60% of OOPs was spent on medical goods (mostly

medicines, including over-the-counter (OTC) drugs) dispensed to outpatients, while outpatient care services accounted for another 25%. Higher income groups spend higher amounts in absolute terms but these constitute a lower share of their income.

Several mechanisms exist to protect the population from catastrophic expenditures or underuse of services, which could result from user charges. These include exemption mechanisms for certain population groups and low-income households and a cap on user charges

Since 2010, global budgets have been introduced to control overall hospital expenditure and currently plans exist to implement a diagnosis-related group (DRG) based hospital payment system.

Public health services in Latvia are provided by the government and financed mainly by the national budget. In addition, municipalities implement and finance local programmes, while the NHS pays for some services provided by GPs (such as immunizations). Two national institutions are responsible for public health activities in Latvia: the Ministry of Health and the Centre for Disease Prevention and Control (CDPC).

The Ministry of Health is the most important national authority responsible for the coordination of health promotion and disease-prevention activities of local governments and it supervises the CDPC.

## **Cardiovascular Health**

Cardiovascular diseases (CVD) are the most prevalent causes of death in Latvia (55% of all death events) and the most prevalent causes of hospitalisation. In 2012, 66.000 CVD patients received medical treatment in hospitals (17% of all hospitalised patients). The number of CVD patients subject to medical treatment in hospitals has been decreasing over time; however, this fact cannot be evaluated as the decrease of morbidity, but can rather be considered as the increased use of ambulatory healthcare services. Women are most frequently treated in hospitals due to CVD.

In 2012, the average duration of CVD-related treatment in hospitals was seven days, which is slightly more in comparison to 2011. Duration of medical treatment in hospitals increases proportionally to a patient's age, so the average duration of treatment is ~five days for patients in the age group 18-44, while for patients in the age group 60+ the average duration of treatment is seven days.

There is high percentage of cardiovascular diseases in the structure of outpatient visits; approximately 17% of all diagnoses each year the second most prevalent diagnoses after respiratory system diseases. The importance of primary healthcare specialists in the CVD treatment process can be proven by the fact that in approximately 92% of those cases, when a CVD patient has visited a doctor, a patient has turned to a primary healthcare specialist, mainly to a general practitioner. In the year 2013, there have been over a half million patients registered at primary healthcare specialists for the dynamic control with regard to CVD. Hypertensive diseases are the most common CVD cases - 55% (of registered and controlled patients).

Each year approximately 16 thousand people die due to CVD. Since 2007, the percentage of premature death cases (before reaching the age of 64) has been decreasing each year (26% in 2006; 20% in 2012). The mortality rate has also decreased, while in 2012 it reached the lowest level in the last ten years - 155 per 100,000 of people in the age group below 64 years. Regardless of the observed decrease, the CVD-related premature mortality rate is still three times higher than the average EU rate and is the highest for the Baltic States. Various ischemic heart diseases are the main causes of death for the CVD group, as these diseases constitute up to 52% of all CVD causes. Cerebrovascular diseases (cerebral infarction, stroke, various cerebrovascular defects) are the second most significant group, while hypertensive diseases are in the third place.

The mortality caused by ischemic heart diseases has remained relatively stable during the last ten years, while the mortality caused by cerebrovascular diseases has decreased, also in relation to the age group below 64. The mortality caused by cerebrovascular diseases in women is approximately 1.5 times higher in comparison to men, while in the age group below 64 it is almost two times higher for men in comparison to women.

### **Percutaneous coronary intervention (PCI) resources**

There are 5 catheterization laboratories in 3 places of Latvia with distance around 200 km from each other. Two of them provide 24/7 service, two without 24/7 service and one centre provides only angiography service. In 2013, 12455 coronary angiographies (6227 per 1 million inhabitants) and 6395 (3195 per 1 million inhabitants) PCIs were performed. There were 368 primary PCIs in Acute Myocardial Infarction (AMI) per 1 million inhabitants. Drug-eluting stents (DES) were used in 50% of patients in 2013.

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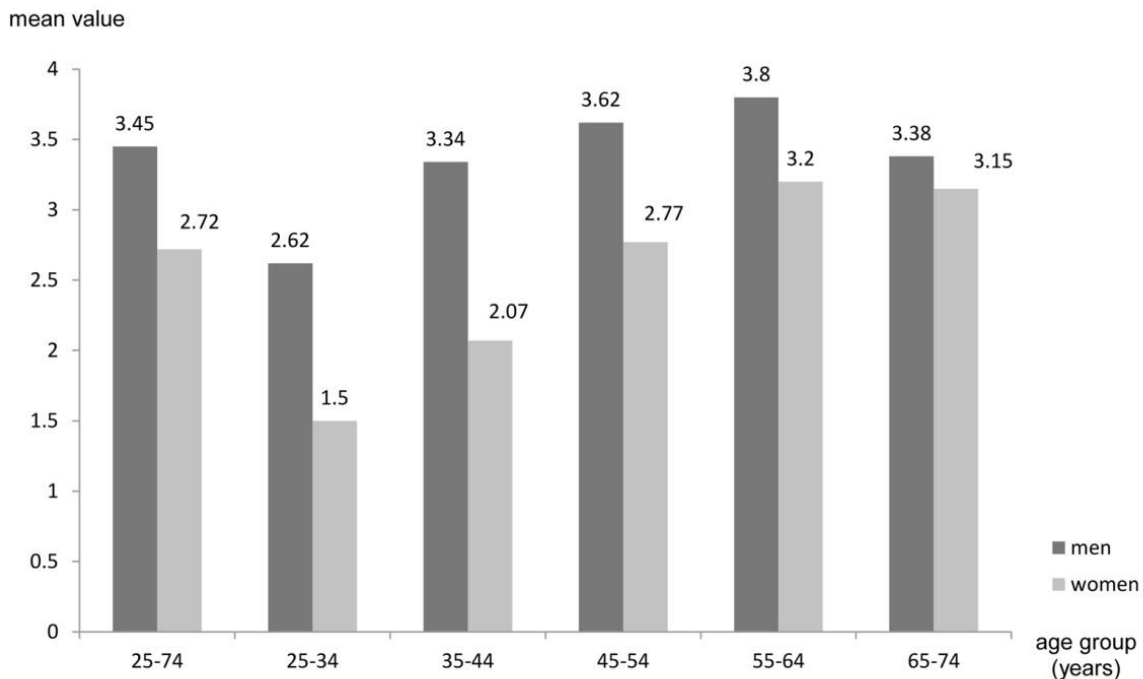
## II. Risk factor statistics

### CVD Mortality

Risk factors for circulatory system disease, such as unhealthy habits and behaviour (smoking, unbalanced diet, low physical activity and consequent high body mass index) remain highly prevalent in Latvia. In addition, the incidence of diabetes mellitus – another risk factor for circulatory system disease – more than doubled from 145 per 100 000 in 2000 to 388 per 100 000 in 2010.

According to the first population based cross-sectional epidemiological study of cardiovascular risk factors in Latvia (2010) average amount of cardiovascular risk factors (means±standard error (SE)) was 3.0 per subject for all population, 3.5 in men and 2.7 in women.

**Fig.1.** Average amount of cardiovascular risk factors in Latvia population among men and women in different age groups



Source: (2) Erglis A, Dzērve V, Pahomova-Strautiņa J, Narbutė I, Jēgere S, Mintāle I, Ligere R, Apinis P, Lejnieks A, Misiņa D, Rozenbergs A. [A population-based cross-sectional study of cardiovascular risk factor in Latvia](#). Medicina (Kaunas). 2012;48(6):310-6.

The prevalence of “classic” risk factors in Latvia is extremely high:

Risk factors	All population		Men		Women	
	%	95% CI	%	95% CI	%	95% CI
Total Chol $\geq 5$ mmol/l	75,2	73,83-76,57	72,0	69,63-74,37	78,0*	76,35-79,65
TG $\geq 1,7$ mmol/l	27,0	25,59-28,41	33,9	31,40-36,40	24,1*	22,40-25,80
LDL-C $\geq 3,0$ mmol/l	73,7	72,30-75,10	73,1	70,76-75,44	73,9	72,15-75,65
HDL-C $\leq 1,0$ mmol/l for men or $\leq 1,2$ for women	16,3	15,13-17,47	17,0	15,02-18,98	15,9*	14,45-17,35
Glucose 5,6 – 6,99 mmol/l	28,7	27,89-29,51	35,3	32,77-37,83	24,9*	23,18-26,62
Glucose $\geq 7,0$ mmol/l	5,4	4,68-6,12	6,3	4,84 – 7,36	4,9	4,04 – 5,76
AH	44,8	43,22-46,38	52,9	50,26-55,54	40,2*	38,25-42,15
BMI:						
overweight	37,7	36,16-39,24	44,6	41,97-47,23	33,7*	31,82-35,58
obesity	30,1	28,64-31,56	25,6	23,29-27,91	32,6*	30,74-34,46
Smoking:						
ex-smoker	15,1	13,96-16,24	25,8	23,49-28,11	9,1*	7,96-10,24
daily smoker	18,2	16,98-19,42	30,5	28,36-33,24	11,4*	10,14-12,66

\*  $p < 0.05$

Source: (2) Erglis A, Dzērve V, Pahomova-Strautiņa J, Narbute I, Jēgere S, Mintāle I, Ligere R, Apinis P, Lejnietis A, Misiņa D, Rozenbergs A. [A population-based cross-sectional study of cardiovascular risk factor in Latvia](#). Medicina (Kaunas). 2012;48(6):310-6.

The first population based cross-sectional epidemiological study of cardiovascular risk factors in Latvia covering the entire country established the high prevalence of “classical” cardiovascular risk factors. The data can be utilised as a baseline for future monitoring of health prevention activities with possibility of international comparison of results. The greatest part of cardiovascular diseases can be prevented by changing everyday life habits.

It is also important to perform preventive health examinations and timely diagnostic of diseases, as well as to ensure timely treatment. For this reason, the project of a *Cardiovascular Health Improvement Action Plan for 2013-2015* was elaborated in 2012.

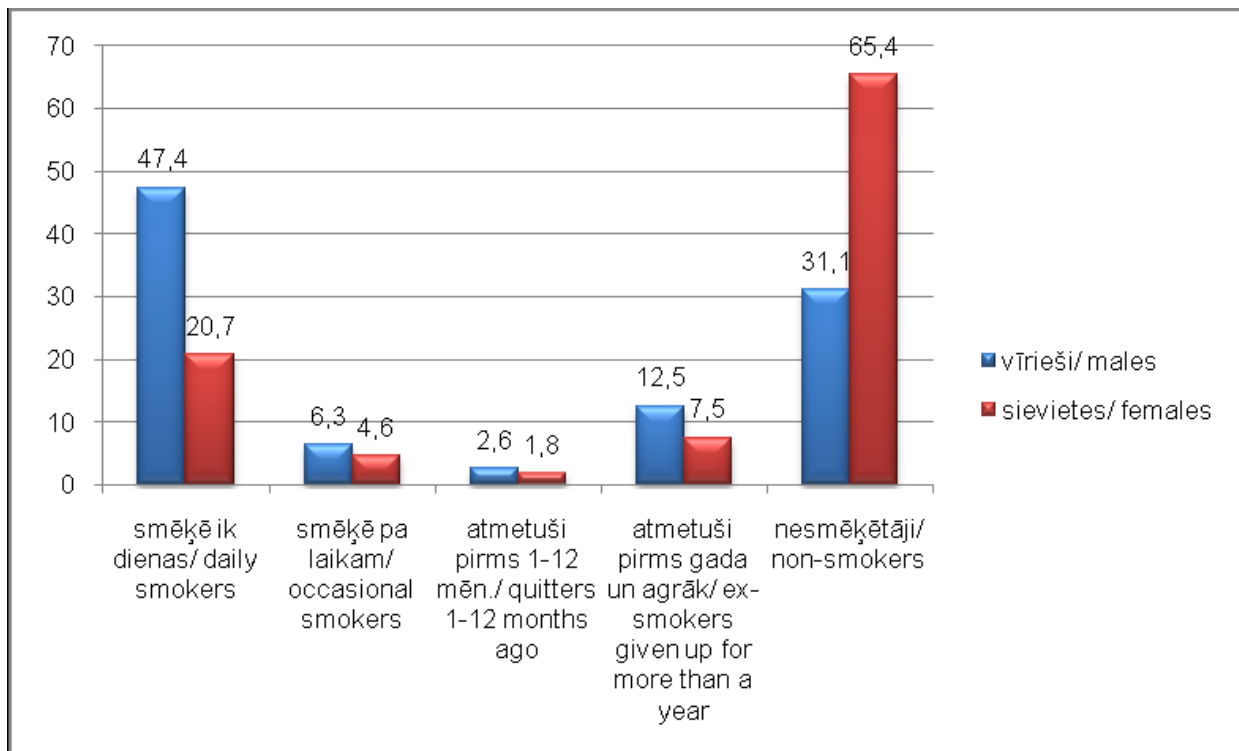
### Smoking

One of the most important risk factors affecting the health status is smoking. In 2008 the prevalence of smoking among adults (aged 15 or more) was 46% for men and 13% for women, making Latvia the country with the second highest smoking prevalence in Europe behind Greece (Eurostat, 2012). Tobacco use among 15–24-year-olds was 35% for young male and 13% for young female Latvians. In 2010 the standardised death rate (SDR) attributed to smoking-related causes was 435.8, which was far above the EU12 average (330.6). In fact, in spite of considerable reductions in smoke-related deaths over

the past years (25% reduction since the year 2000), the smoking related SDR remains the second highest in Europe.

More men than women are subject to passive smoking in their work place. The proportion of male exposed to tobacco smoke at work more than 1 hour per day is 9.6%, but that of female 2.8%. Larger proportion is exposed to passive smoking at home; 48.5% men and 34.3% women report that someone in the family smokes in the presence of other people.

The FINBALT survey data show that 47,4% men and 20,7% women smoke daily but 6,3% men and 4,6% women smoke occasionally.



Source: (3) Health behaviour among Latvian adult (15-64) population 2010; <http://www.spkc.gov.lv>

## Hypertension

The proportion of subjects with hypertension increases considerably with age in both genders. There is an interaction in the prevalence of hypertension between gender and age groups. This indicates a higher prevalence of hypertension in men than in women of younger age groups and steeper increase in the prevalence of hypertension with age for woman than for men comparing age groups from 25-34 to 55-64 years. According to the data of the FINBALT study for the year 2012 (based on responses provided by people), hypertension has been treated or diagnosed in 12% of inhabitants (age group 15-64) within the last year. 13% of respondents have used medicines for lowering high blood pressure during the last week. This rate has been increasing over time in comparison to survey data for the previous years. There are 5% of respondents who have reported that they had never measured their blood pressure, while 22% of respondents had never measured cholesterol level in blood and 21% of respondents had

never measured glucose level in blood. Even in the age group 55-64, each tenth respondent (15% of men and 7% of women) had never measured cholesterol level in blood.

### **Lipids and glucose**

The prevalence of increased total cholesterol as well LDL cholesterol level was very high in both gender groups (72,0% and 78,0 men / women; 73,1 and 73,9 men / women respectively) without significant group difference. The prevalence of decreased HDL-cholesterol level is 16,3% in all study group without statistically significant difference between gender groups (17.0% in men and 15,9% in women). The prevalence of hypertriglyceridemia amounts to 27% in all study group and it is more pronounced in men group (33,9% in men and 24,1% in women,  $p < 0,05$ ). Hyperglycemia with statistically significant difference between gender groups was stated in 39,2 % of investigated persons. With an exception for HDL-C, the values of prevalence of all parameters have a trend to increase with age in both gender groups.

### **Body mass index**

The prevalence of overweight and obesity in the respondents was 37.7% and 30.1%, respectively with statistically significant gender differences ( $p < 0.0005$ ): overweight in 44.6 % of men and in 33.7% of women; obesity in 25.6% of men and in 32.6% of woman. The overweight as well as obesity increased with age ( $p < 0.0005$ ) among women, but among men the increase is statistically significant ( $p < 0.003$ ) only for obesity.

### **Alcohol**

During last 10 years, illicit spirits sales had a significant downward pressure on legal sales of alcohol in Latvia, which happened due to several noticeable increases of excise tax rates during 2006-2011. Since 2011, there were no new tax increases, which helped stabilise illicit market growth. Although illicit alcohol still accounted for around 35% of total alcohol consumption in Latvia in 2013, legal sales of vodka and some other popular spirits stopped declining. As a result, aggregated spirits sales grew by 5% in 2013.

According to FINBALT health behaviour survey 2012 84.4% of respondents (81.3% women and 87.7% men) report having used alcohol in the preceding year. The most prevalent alcoholic drink is beer among men but wine among women. The consumption of strong alcoholic drinks is very high. During the preceding week 33.6% of men and 13.9% of women have used strong alcohol. Extensive consumption of alcohol defined as drinking six or more alcohol units on single occasion at least one time per week has been used by 5.1% of respondents.

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### III. Prevention methods and main actors

The main actors are general (family) physicians and cardiologists in collaboration with the Ministry of Health, the Centre for Disease Prevention and Control, the Latvian Society of Cardiology and the Latvian general physicians. We have more than 1300 general physicians and 165 practicing cardiologists (8,5 per 100 000 inhabitants).

The educational level of family physicians has high requirements. Every establishing, future family doctor has to accomplish them and the exam to get through the certification. After every five years he/she has to do it again (recertification), which is not common in other countries. The education to become a primary health care specialist he/she has to study for six years in the medical university of the state [we have two], afterwards there is a three year residency program.

In the residency program the establishing, future family doctors are prepared with work in hospitals for two years and seminars as residents. They work day-duties and night-duties twice a week in the state's largest hospitals, supervised by secondary and primary health care specialists entitled to be trainers. They also acquire knowledge in everyday-work in the hospital at least 8 hours a day; in addition two to four hours are spent studying literature and research in the cabinet. In their residency program, the establishing family physicians acquire knowledge to be competent to manage patients with various conditions lasting lifelong, to provide gate-keeping in various ages. Therefore the cycles of learning include health care of children, youngsters, adults and elder people separately, emphasising the meaning and differences of the age, sex and orientation, and social environment, rural and urban regions. In residency they learn as in other countries in depth the broad spectrum of general medicine. The third year is spent in general practices, where they acquire practical and theoretical knowledge in their field.

The basic benefits package of health services to be provided by family doctors is determined by a regulation of the Cabinet of Ministers and is further specified by the standard contracts with the National Health Service (NHS). Family doctors carry out basic examinations, diagnostics and treatment for acute and chronic diseases in children, adults and elderly people. They are responsible for prescribing medications from the positive list of drugs and they perform outpatient surgical procedures. They also provide family planning services, and carry out preventive activities (screening and immunisation), health promotion and health education.

The quality of primary care has been evaluated regularly since the year 2000, when a capitation model was introduced for the payment of primary health care (PHC) physicians. Quality indicators are evaluated every quarter year (depending on the indicator) and the results determine the size of bonuses, which amounts to about 15% of the capitation payments for family doctors. Quality indicators are mostly structural or process based and includes, for example, coverage of adult patients (percentage of registered patients who were seen by their GP, the proportion of children who received prophylactic check-ups and immunisations, the proportion of diabetes II patients whose glycosylated HbA1c and microalbuminuria was tested, etc.). Approximately 80% of PHC physicians have been evaluated as "good" and receive their bonuses.

Medications in general are not provided for free, but there are different levels of reimbursement. Four reimbursement levels exist in Latvia (100%, 90%, 75% and 50%)

depending on the severity and chronic nature of the disease. All drugs containing the same indications for use are reimbursed at the same level. In Latvia, reference price grouping is applied if the drugs are interchangeable, if this includes the same indication, the same patient group, the same route of administration and no differences in efficacy or side effects. In Latvia there is no explicit generics policy, but there are special administrative procedures to favour generics, such as a faster inclusion in the reimbursement system. There are no specific supply-side mechanisms to guarantee a lower price for generics but in practice the system works on a competitive basis and a relatively high proportion of generics exist on the market. Due to budget constraints, doctors are encouraged to prescribe cheaper therapeutical options within the reimbursement system. They cannot justify overspending their budgets if they have not prescribed the cheapest medicines.

On top of the list of prevention methods are population screening campaigns, population based epidemiological and secondary prevention research, and, of course, the daily work of general physicians and cardiologists in their offices. As good and successful examples the population screening campaign of all 11 year old children and 45 year old men in Liepaja region (around 80 000 inhabitants) in 2013 and the establishment of the outpatient department in Latvian Centre of Cardiology mainly for secondary prevention could be mentioned.

The [European Guidelines on CVD Prevention in Clinical Practice \(2012\)](#) of the ESC and the [ESH/ESC Guidelines on the Management of Arterial Hypertension \(2013\)](#) were endorsed by Latvian Society of Cardiology last year. The arterial hypertension guidelines were translated in Latvian and a special international implementation meeting in Riga took place at the end of 2013.

There is a „Cardiovascular Health Improvement Action Plan for 2013-2015” as a substantial part of the „Public Health Strategy 2011-2017”, adopted by the Cabinet of Ministers 30/07/2013. The plan is under strong monitoring and audits are performed at the end of each year.

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## IV. Main Prevention activities

Main CVD prevention activities are officially published in the „*Public Health Strategy for 2011-2017*” (Adopted by the Cabinet of Ministers Order No. 504 dated 5 October 2011) and the „Action plan of improvement of CV health for 2013-2015”.

According to this plan screening of CVD of eight age/gender groups will be realised in Latvia: 11 years old children, males of 45, 50, 55 and 60 years; females of 50, 55, 60 years. The pilot project of evaluation of 11 year old children and 45 year old men population has been conducted in Liepaja (population around 80 000) last year.

Besides this there are several CV health promotion campaigns organised by the Latvian Society of Cardiology.

Some of them are:

- **World Heart Day:** Already for 9 years, starting from year 2005, the following activities are organised in Riga, by the Latvian Society of Cardiology with press activities, concerts and dancing events, public education (distributing leaflets, talks, counselling, etc), newsletters and awareness surveys. Around 5000 Latvians are active participants.
- **Campaign „Love your heart”** together with The Centre for Disease Prevention and Control: The aim of this campaign is to be informed about CVD risk factors and their prevention methods. It includes several activities, such as on-line internet TV communication sessions with the participation of leading general physicians and cardiologists, lectures, interviews and discussions in enterprises, the „Heart bus” circulating in countryside regions etc.
- **Go Red for Women:** The Latvian Society of Cardiology is guiding the “Go Red” project to reduce female coronary heart disease and stroke. To reduce heart disease in women we have to think more about and administer a healthy way of living. The Women’s day (8th March) is also a part of “Go Red” in Latvia.

### Nutrition

There is the „National food and nutrition action plan” in the framework of *The National Policy of Public Health and Nutrition in Latvia*.

The structure of the action plan:

- “Healthy nutrition”: Concept of the Cabinet of Ministers
- Part I: Political and Socio-economic Basis
- Part II: Summary of the Problem Description of the Present Situation
- Factors delaying development
- Prevention of delaying factors
- Recommendations for development

### Smoking restrictions

According to the anti-smoking law, smoking is prohibited:

- In workplaces; smoking is allowed only in places specially designated as smoking areas
- In banks, post offices and other similar institutions unless they are designated as smoking areas

- In all public transport and at public transport stops
- In parks, squares and beaches, except if the places are specially designated for smoking. At children's playgrounds.
- In cafés and restaurants smoking is allowed only in places specially designated as smoking areas
- In cinemas, theatres, concert halls, museums, video and sports halls unless they are designated as smoking areas

Persons under 18 years of age are not allowed to purchase cigarettes.

Several programmes are running:

### **“Smoked and quit!”**

A programme is for young smokers, who had thought about quitting smoking. The programme includes 16 lessons, starting from motivation to quit smoking to real action and support in quitting period. The programme is for groups (5 – 10 persons) or for individual counselling. Cognitive behavioural methods are mostly used in the programme.

### **Individual counselling**

Individual counselling is addressed for all young smokers and process include information about smoking in beginning, diagnostic about smoking consequences, motivation stage, preparations for quit smoking, quit smoking, force non-smoking behaviour.

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## V. Cardiac rehabilitation

The state of cardiac rehabilitation in Latvia is less satisfactory: Although modern preventive drug therapy is widely used, only a small part of the eligible patients is enrolled in a cardiac rehabilitation programme, mainly due to financial reasons.

In general, ambulatory rehabilitation and physiotherapy are provided by individual professionals, at health centres and outpatient rehabilitation units in hospitals. Inpatient rehabilitation is provided at the National Rehabilitation Centre and at several multi-profile hospitals.

Ambulatory rehabilitation is provided by an individual specialist (mono-professional rehabilitation). This can be a physical medicine and rehabilitation specialist, physical medicine physician, rehabilitation or functional specialist, who has to ensure that care is coordinated with other health professionals and medical support persons.

Inpatient rehabilitation consists of a range of services provided by a multidisciplinary rehabilitation team (multi-professional rehabilitation). For patients with chronic functional limitations, a long-term medical rehabilitation programme exists; this includes active case management of patients to ensure that patients' functional conditions are monitored at regular intervals (at least once a year) and that necessary different rehabilitation services are coordinated with other medical professionals, the family doctor and municipalities' social services.

The National Health Service (NHS) pays for rehabilitation services if patients have a referral from the appropriate specialist, who also has to develop a medical rehabilitation plan, including the aims, technologies and conditions of completion of rehabilitation.

Cardiac rehabilitation activities in Latvia are focused on patients with myocardial infarction (MI), after heart surgery and percutaneous coronary intervention (PCI). There is one specialised centre for cardiac rehabilitation from patients from all over the country and one specialised centre in the biggest hospital of Latvia.

Patients entering outpatient cardiac rehabilitation are offered a rehabilitation programme with a typical duration of 3-4 weeks, consisting of group-based therapies (exercise training, relaxation and stress management training, education therapy, and/or lifestyle change therapy). These services are used by 10 % of all post MI and coronary artery bypass graft (CABG) patients. This is only partially paid by the NHS but, unfortunately, a high proportion has to be paid by the patients themselves.

Thus, the provision and access to cardiac rehabilitation has to be improved but the use of preventive medication shows a more targeted picture: According to data from the recent EUROASPIRE IV survey (European survey of cardiovascular disease prevention and diabetes) over 90% of the patients after MI and PCI are prescribed adequate antiplatelet therapy and statins.

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## VI. The Future

The plan in Latvia is:

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

To reach the main aim of the cardiovascular 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 on health.
- To ensure an effective management of the healthcare system and the 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.

### **Our strategy for the coming years**

Firstly, we aim to ensure partnership and inter-sectoral cooperation, facilitation of equal health opportunities to all inhabitants. Some of the ongoing activities are:

- To cooperate with public opinion shapers, including journalists and editors of mass media, to provide more extensive information to society about public health issues
- To establish a working group for identifying and coordinating research in the field of public health
- To develop and annual public health communications plan in cooperation with other sectors (Every year by 1 April)
- To develop guidelines on health promotion measures in local government authorities
- To conduct public health monitoring, inter alia, maintaining a public health monitoring and reporting system (PHMR)
- To implement a Health Promoting Hospital movement in Latvia

Secondly, we aim to reduce risk factors for non-infectious diseases. Our plan is:

- To develop an action plan for restricting alcohol consumption
- To provide advice to local government authorities on the implementation of the guidelines for promoting physical activities in local government authorities
- 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
- To develop informative educational materials on preparing cheap and nutritional food to persons with low income



- To develop a draft legal act to restrict the amount of trans-fatty acids in food products
- 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)
- To carry out research on the risk factors of non-infectious diseases

**References:**

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