

Latvia

The Republic of Latvia is located on the eastern Baltic coast, bordered by Estonia to the north, the Russian Federation to the east, Lithuania to the south and Belarus to the south west. It is strategically located between the



Commonwealth of Independent States (CIS), Western Europe and Scandinavia. It covers 64,589 km², with a flat landscape and extensive forests covering 44% of the land area and forming Latvia's most important natural resource ... The national currency is the Lat (LVL), which replaced the Latvian rouble in 1993. The state language is Latvian.¹

¹ *Health Care Systems in Transition: Latvia* (2001) Copenhagen: The European Observatory on Health Care Systems: 1.

1 Palliative care service provision

1.1 Current services (last updated: May 2002)

The following palliative care services are known to exist in Latvia

		<i>Existing services (2002)</i>
Adult	Inpatient - Freestanding	0
	- Hospital unit	1
	- Hospital mobile team	0
	Nursing home	0
	Home care	0
	Day care	3
	Total	4
Paediatric	Inpatient	1
	Home care	0
	Day care	0
	Unspecified	0
	Total	1
Grand total		5

Current projects (last updated: May 2002)

The following palliative care projects are known to exist in Latvia; these are not yet operational services

		<i>Known hospice/ palliative care projects (2002)</i>
Adult	Inpatient - Hospital	0
	- Hospice	0
	Home care	0
	Unspecified	0
	Total	0
Paediatric	Hospital	0
	Hospice	0
	Home care	0
	Unspecified	0
	Total	0
Grand total		0

At the end of 2001 there were five palliative care services in Latvia: 1 adult inpatient unit and 1 paediatric unit (both Riga), together with three adult day care centres (Riga, Liepaja, Aizkraukle).

The first palliative care unit (25 beds) was opened in Riga in July 1997 and consists of a hospital inpatient unit within the 650-bed Latvian Oncological Centre, which serves the whole country. Outpatient consultations for palliative care began in the unit in 2001, with plans for a home care service: By February 2002, 336 patients and their relatives had been seen by the outpatient service. The unit's multi-disciplinary team consists of 3 doctors, nurses, caregivers, a psychologist and a chaplain; the skills of others can be drawn on if required, including anaesthesiologists, surgeons and a psychiatrist. Almost all of the patients seen have advanced cancer, with a very small number of AIDS cases. The palliative care unit and related oncological wards are said to be usually overcrowded. In 1998 the palliative care unit admitted 574 patients, 395 of whom were discharged and made use of 7,561 bed days; 98.2% of patients had a cancer diagnosis, of which the most common were breast (16.3%), lung (15.3%) and stomach (9.2%).

Palliative care is not a licensed specialty in Latvia, but each year short courses are held in Riga for interested doctors, nurses and students. The Riga unit has obtained some financial support for these courses from abroad, as well as from the Open Society Foundation in Latvia, and from pharmaceutical companies.

There is also a small palliative care unit within the oncological hospital of the seaport city of Liepaja and an outpatient facility in Aizkraukle, but it is reported that family doctors, under whose care the patients remain, are unwilling to refer to these units and that the staff there have significant unmet educational needs². There is also an outpatient palliative care team within the State Children's Hospital in Riga.

The main complaints of cancer patients experiencing pain have been listed as: family doctors do not prescribe painkillers because of limited funds; medication is prescribed only once, thereafter patients must pay for it themselves; there are difficulties in meeting with family doctors, often with long waits involved; family doctors are

disinclined to refer patients with pain to specialists; and there are complaints about the quality of the work of both family doctors and specialists.³

There is an urgent need to train more specialists in palliative care, who can then train others; but access to training opportunities is hampered by limited funds. At present palliative care in Latvia is provided entirely by personnel who have been trained abroad. Undergraduate education in palliative care began in the Riga unit in 1999-2000, with courses for nurses (4-12 hours) and medical students (10-20 hours). There are ongoing postgraduate courses for community and hospital-based nurses as well as for oncologists and family doctors. The unit has also run short courses for volunteers and for caregivers.

1.2 Reimbursement and funding for services

Funding (for insured patients) is covered by the regional sickness funds (which have a contract with the Oncology Centre), but the goal is to gain recognition for palliative care within the state budget.

In 1999 palliative care was recognised for the first time in the contracts of Latvia's 8 regional sickness funds.⁴ Problems with the Sickness Funds continue, however, for example the fund in Riga (covering 1 million people) collapsed completely for several weeks in 2002 and no cover of any kind was available.

Good co-operation with the Sickness Funds is deemed essential if palliative care in Latvia is to survive. Politicians in the country are said to ignore palliative care ('saying "it is good" but doing little or nothing'). The general public is said to be largely unaware of palliative care, but 80% are in favour of euthanasia.⁵ The overall lack of resources is reflected in the low salaries of health care workers, which range between \$US 120-200 per month. There is an acute lack of available journals and up to date books about palliative care and the lack of computing facilities is also a problem.

² Vilnis Sosars, personal communication, 28 August 2001.

³ Presented by Vilnis Sosars at Palliative Medicine Course, 13-17 May 2002, Puszczykowo, Poland.

⁴ *Health Care Systems in Transition:Latvia. (2000)* Copenhagen: The European Observatory of Health Care Systems

1.3 Opioid availability and consumption

Morphine (including slow release) and dihydrocodeine are easily obtainable at the palliative care unit in Riga. Fentanyl patches are sometimes available. Nevertheless: 'There is a great lack of resources to control pain and miserable resources from the state [for] the use of weak and strong opioids ... We have no problems to obtain morphine in the units, however, outside these, family doctors due to their limited budgets do not prescribe morphine in sufficient amounts, [even though] legislation allows this. The reason is a very restricted health budget in Latvia which is a great obstacle to prescribing pain killers in necessary quantities to the patients with advanced diseases. Especially this concerns Fentanyl patches. It is permitted to prescribe 10 patches per prescription but it is too expensive for the hospitals and GPs.'⁶ Morphine in liquid form is not available in Latvia. Prescriptions for the use of opioids are tightly controlled (eg only 600mg of morphine can be placed on one prescription) and outside the bigger cities many drugs are not available.

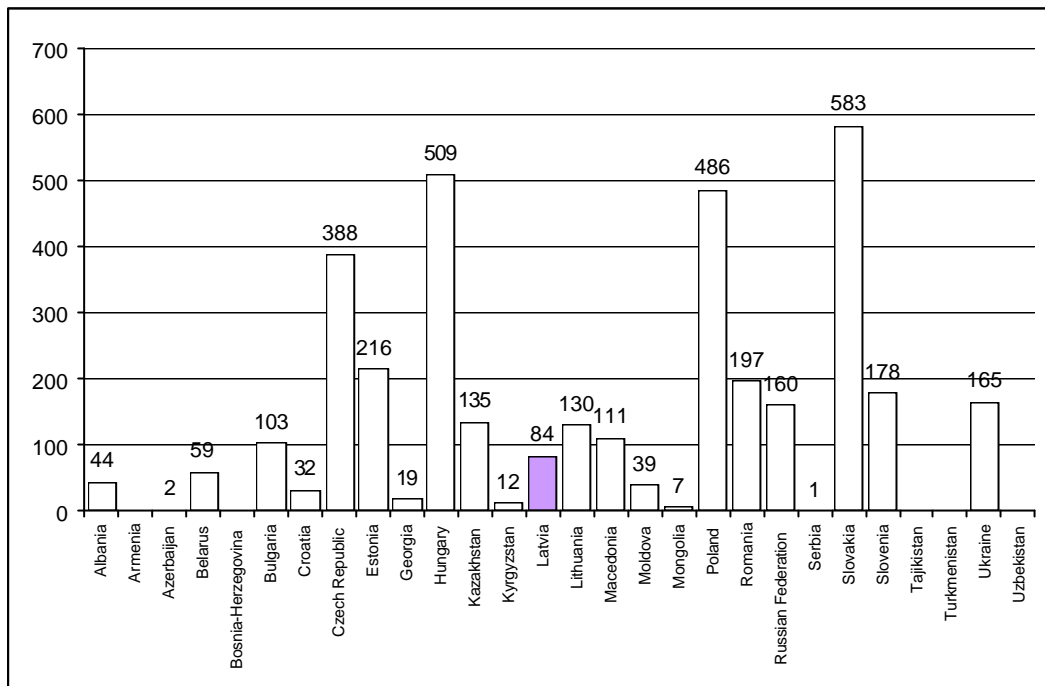
INCB data on opioid consumption in Latvia between 1994 and 1998 are available for codeine, dihydrocodeine, morphine, ethyl-morphine and methadone. In that time information on codeine consumption is available for 1998 only (2 kg) and information for dihydrocodeine in 1996 and 1998 (1 kg per annum); along with ethylmorphine only for 1998 (2 kg); morphine consumption fluctuated between 1997-8 (2,7,3 kg in consecutive years). Methadone consumption over these same three years was 1,2 and 2kg per annum. The average daily consumption of defined daily doses of these drugs per million inhabitants between 1994-98 was: codeine (5); dihydrocodeine (3); ethyl-morphine (5); morphine (84); methadone (48).⁷

⁵ Questionnaire data (EAPC East).

⁶ Vilnis Sosars, personal communication 14 September 2001.

⁷ International Narcotics Control Board (2000) *Narcotic Drugs: Estimated World Requirements for 2000. Statistics for 1998*. New York: United Nations.

Average defined daily doses of morphine, Central and Eastern Europe (1994-1998)



Source: Clark D, Wright M (2002) *Transitions in End of Life Care: Hospice and related Developments in Eastern Europe and Central Asia*. Buckingham: Open University Press

1.4 National and professional association

Latvia was a signatory of the Poznan Declaration (1998) and is a member of the Eastern and Central European Palliative Care Task Force (ECEPT). Its palliative care leaders subscribe, therefore, to the call for national policies, palliative care education, increased drug availability, a growth in palliative care services and an increase in public awareness.

There appears, however, to be no national palliative care or pain society in Latvia. Accreditation of centres and specialty recognition are regarded as major priorities, and standards produced by organisations such as WHO or ECEPT are regarded as central to this.

1.5 Palliative care 'coverage'

There is a service providing palliative care for every 0.48 million people in Latvia. Working towards a figure of 50 palliative care beds per 1 million inhabitants, Latvia would require an increase from the present 25 beds to a total of 120.

Ratio of hospice/palliative care services per million population, Central and Eastern Europe (2002)

	<i>Ratio 1:</i>
Estonia	1: 0.14m
Poland	1: 0.15m
Slovenia	1: 0.32m
Bulgaria	1: 0.36m
Hungary	1: 0.37m
Latvia	1: 0.48m
Lithuania	1: 0.62m
Czech Republic	1: 1.02m
Albania	1: 1.03m
Romania	1: 1.07m
Slovakia	1: 1.33m
Macedonia	1: 1.98m
Bosnia-Herzegovina	1: 2.00m
Croatia	1: 4.60m
Serbia	1: 10.50m

Source: Clark D, Wright M (2002) Transitions in End of Life Care: Hospice and Related Developments in Eastern Europe and Central Asia. Buckingham: Open University Press

1.6 Palliative care workforce capacity

In 2001 it was estimated that 5-6 doctors in Latvia were working directly in palliative care as well as about 13-15 nurses, 15-20 social workers, 2 chaplains and around 10 volunteers.

2 History and development of palliative care in Latvia

2.1 Narrative history of palliative care in Latvia

From at least 1995 there was evidence of some external interest in the development of palliative care in Latvia. An article published in the EAPC newsletter in that year reported on a visit made by Christel Pakarinen, of Karuna, Finland, who had met with the Latvian Minister of Health and some local doctors interested in starting palliative care; ideas for links had the support of the Latvian ambassador to Finland at that time.⁸ Beyond this article there appears to be no published material, even in the ‘grey’ literature relating to palliative care developments in Latvia.

In Riga, Dr Vilnis Sosars has adopted a major leadership role from his base in the Latvian Oncological Centre, where he heads the country’s only adult palliative care inpatient unit. He is the Latvian representative within ECEPT and has established good educational links with the palliative medicine department in Poznan and some doctors from Latvia have attended postgraduate courses in Bydgoszcz, Poland. Elsewhere there is no other evidence however of twinning or partnership arrangements with palliative care services in other countries.

In 1998 palliative care was included as a topic in the 2nd Baltic Congress of Oncology and Radiology and in the same year, an Albert Schweitzer Foundation seminar on palliative care and pain control was held in Latvia. These together with sickness fund recognition and the widening of educational opportunities in palliative care have been attributed to the direct influence of the Poznan Declaration, which has provided leverage for palliative care innovation in Latvia. In 2002 palliative care sessions were included in the 3rd Baltic Congress on Oncology and in the same year, in response to growing public debates about euthanasia, Vilnis Sosars and colleagues published a short pamphlet on the history of palliative care.

2.2 Hospice/beacon case studies

No information currently available.

⁸ Pakarinen C (1995) *Latvia: starting palliative care*. EAPC Newsletter No 16, Summer 1995.

2.3 Life/oral histories

No information currently available.

3 Public Health Context

3.1 Population

Latvia declared itself independent from the Soviet Union on 21 August 1991. It had an estimated population of 2.35 million in 2000, down by over 10% since 1992; in the intervening period the birth rate had fallen and the death rate had increased. Some 72% of the population live in urban areas and the capital, Riga, has a population of 856,000. Less than 15% of the population is age over 65, but the proportion has been increasing since 1987. In 1999 Latvians accounted for 55.7% of the population; followed by Russians (32.3%), Belarusians (3.9%), Ukrainians (2.9%), Poles (2.2%) and Lithuanians (1.3%). There are some complex issues of citizenship⁹, following fears that Latvians might become a minority in their own country. Russian remains the first language for 42% of the population. The largest religious group is Lutheran, followed by Roman Catholic.

3.2 Epidemiology

The leading causes of death in Latvia are diseases of the circulatory system, cancer, and external causes; the incidence of tuberculosis has been increasing since 1989. Infant mortality, though decreasing from 15.7 per 1,000 live births in 1991, remained high at 11.3 in 1999. There were 9,092 new cases of cancer in Latvia in 1998, with an increase in incidence of 11.8% over the previous decade. Cancer deaths in 1998 totalled 5,138 and in 1997 40.1% of cancer deaths occurred within one year of diagnosis. It has been estimated that at any one time more than 3,000 patients in Latvia are in need of palliative care. One respondent stated that 90% of deaths from cancer patients occur at home, creating major problems for patients and families.¹⁰

⁹ *Health Care Systems in Transition :Latvia (2001)*, Copenhagen: The European Observatory on Health Care Systems

¹⁰ Questionnaire data (EAPC East).

Population and life expectancy, Central and Eastern Europe (2000)

	<i>Population</i>	<i>Life expectancy</i>	
	<i>Millions</i>	<i>Male</i>	<i>Female</i>
Albania	3.1	64.3	72.9
Bosnia- Herzegovina	3.9	68.7	74.4
Bulgaria	7.9	67.4	74.9
Croatia	4.6	69.8	77.7
Czech Republic	10.2	71.5	78.2
Estonia	1.3	65.4	76.5
Hungary	9.9	66.3	75.2
Latvia	2.4	64.2	75.5
Lithuania	3.7	66.9	77.2
Macedonia	2.0	70.2	74.8
Poland	38.6	69.2	77.7
Romania	22.4	66.2	73.5
Serbia	10.5		
Slovakia	5.3	69.2	77.5
Slovenia	1.9	71.9	79.4

Source: World Health Report 2001

WHO age standardised death rates per 100,000 population, Central and Eastern Europe (1995-1998)

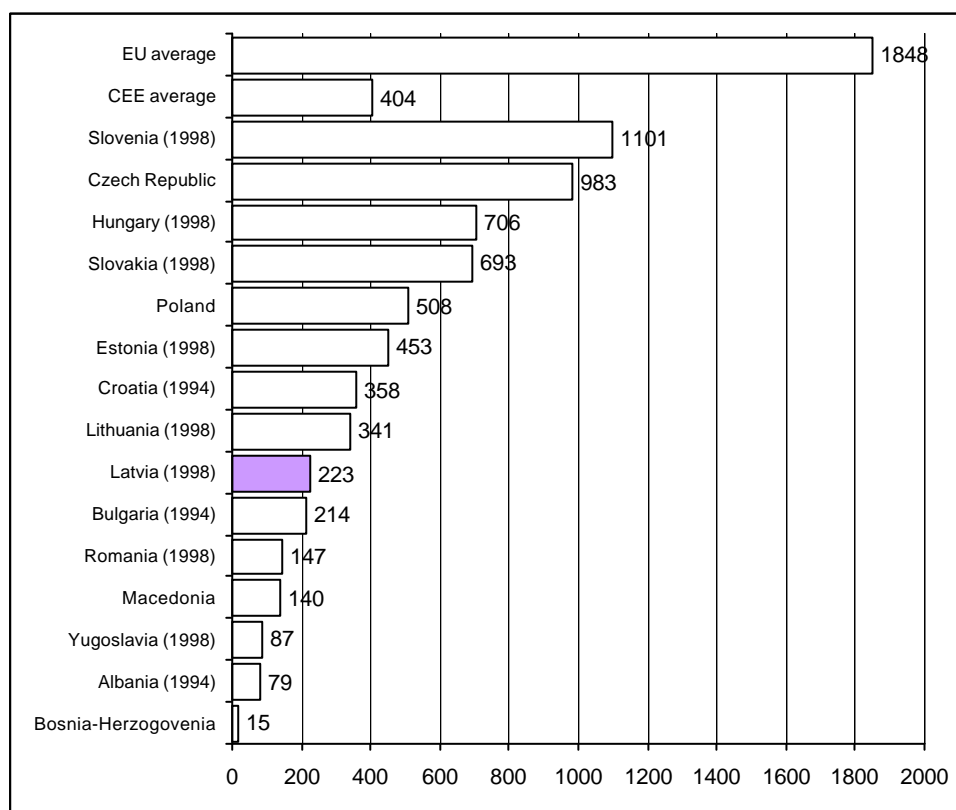
	<i>Year</i>	<i>All causes</i>	<i>Cancer</i>
Albania			
Bosnia- Herzegovina			
Bulgaria	1998	958.9	123.3
Croatia	1997	836.0	174.2
Czech Republic	1998	706.6	182.9
Estonia	1998	907.7	157.8
Hungary	1998	917.8	219.4
Latvia	1998	955.2	152.1
Lithuania	1997	817.2	149.4
Macedonia	1997	809.1	126.6
Poland	1996	812.2	165.2
Romania	1998	933.9	130.6
Serbia			
Slovakia	1995	820.9	172.3
Slovenia	1997	666.1	167.5

Source: World Health Organisation: World Health Statistics 1997-1999

3.3 Health care system

The structure of Latvia's health care system has changed several times since independence in 1991. In 1993 there was a merger between the Ministries of Health, Labour and Social Welfare, into a new Ministry of Welfare. In 1994 sickness funds were re-established, though these were not funded from insurance contributions. Then in 1998 the State Compulsory Health Insurance Agency was created. Most responsibilities for delivering primary and secondary health care rest with local government; specialised services remain the responsibility of the state. In 1998 however there were concerns among Latvian oncologists that their work might fall outside of the state budget and be allocated to the responsibility of the sickness funds.

Health care expenditure (US\$) per capita, Central and Eastern Europe



3.4 Political economy

The economy of Latvia went into serious difficulties in the years immediately after independence, but began to recover from 1994. However, a banking collapse occurred in 1995, requiring massive assistance from the International Monetary Fund.

Unemployment, which had been rising since 1992, reached 10.1% in May 1999.

Nevertheless, the transformation of the economy in Latvia has proceeded more quickly than in most parts of the former Soviet Union.

4 Ethics and ethnography

4.1 Ethical issues

No information currently available.

4.2 Ethnographic studies

No information currently available.

5 References and further reading

5.1. References

- 1: *Health Care Systems in Transition: Latvia* (2001) Copenhagen: The European Observatory on Health Care Systems: 1.
- 2: Vilnis Sosars, personal communication, 28 August 2001.
- 3: Presented by Vilnis Sosars at Palliative Medicine Course, 13-17 May 2002, Puszczykowo, Poland.
- 4: *Health Care Systems in Transition: Latvia. (2000)* Copenhagen: The European Observatory of Health Care Systems
- 5: Questionnaire data (EAPC East).
- 6: Vilnis Sosars, personal communication 14 September 2001.
- 7: International Narcotics Control Board (2000) *Narcotic Drugs: Estimated World Requirements for 2000. Statistics for 1998*. New York: United Nations.
- 8: Pakarinen C (1995) *Latvia: starting palliative care*. EAPC Newsletter No 16, Summer 1995.
- 9: *Health Care Systems in Transition :Latvia (2001)*, Copenhagen: The European Observatory on Health Care Systems
- 10: Questionnaire data (EAPC East).