BIOECONOMICS AND HUMAN HEALTH

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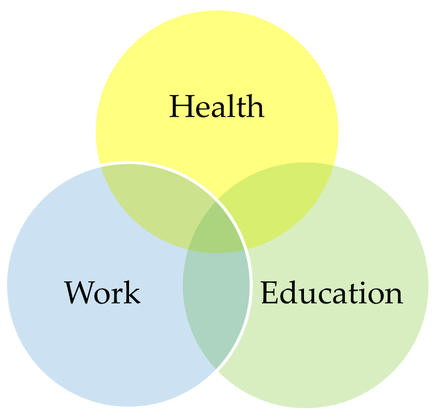
Introduction. Human capital has three dimensions - education, health and work. Each dimension interacts closely with each other. Good health both directly increases productivity and means longer planning opportunities, promoting long-term investment, including in education. Qualitative education increases the chances of working in an exciting and well-paid job. Every well-paid job increases the tax revenue that is being financed quality education, healthcare and other sectors.



The aim: is to analyze one of the dimensions of human capital in Latvia and compare them with the data of European countries. View changes in the age structure of the workforce and related problems.
Methods and Data sources: Data derived from national official statistics provided by Eurostat and OECD. An overview of health status and health systems in the EU Member States has been used.
Keywords: workforce, health care, economic development

The factors determining the public health are climate, income level, health care system and healthy lifestyle. Due to the Mediterranean climate, life expectancy in Spain is 83 years and in Italy 82.7 years, however, the climate factor is not a decisive factor, as a similarly high life expectancy can be observed in the polar circle of existing countries - 82.2 years in Sweden and 82.5 in Norway. The average life expectancy in Latvia is 74.8 years, which lags behind the countries by about 8 years, while the average life expectancy in the EU is 80.6 years.

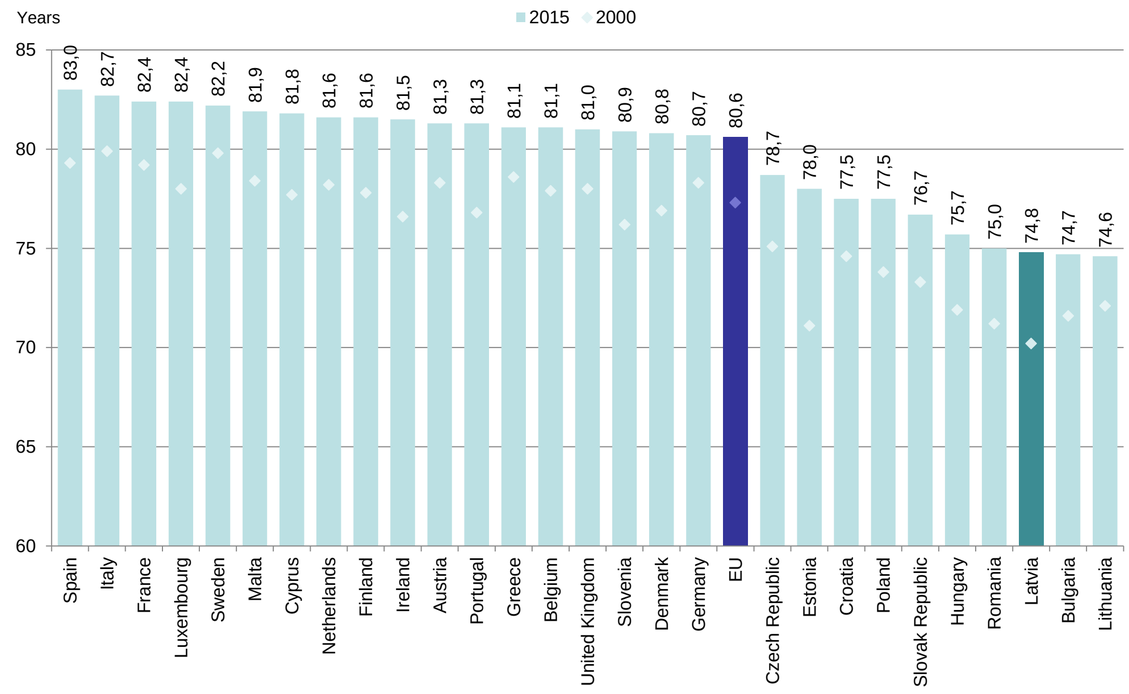


Fig.1. **Life expectancy among EU countries (2015)**

The majority of the Latvian population is not satisfied with the health care system. Public funding is one of the lowest in the EU. Latvia's expenditure on health care in 2015 was 5.8% of GDP or 1071 EUR per capita, while the EU average was 9.9% of GDP or 2797 EUR per capita. A significant proportion of health care expenditure is paid by the population from their own pocket.

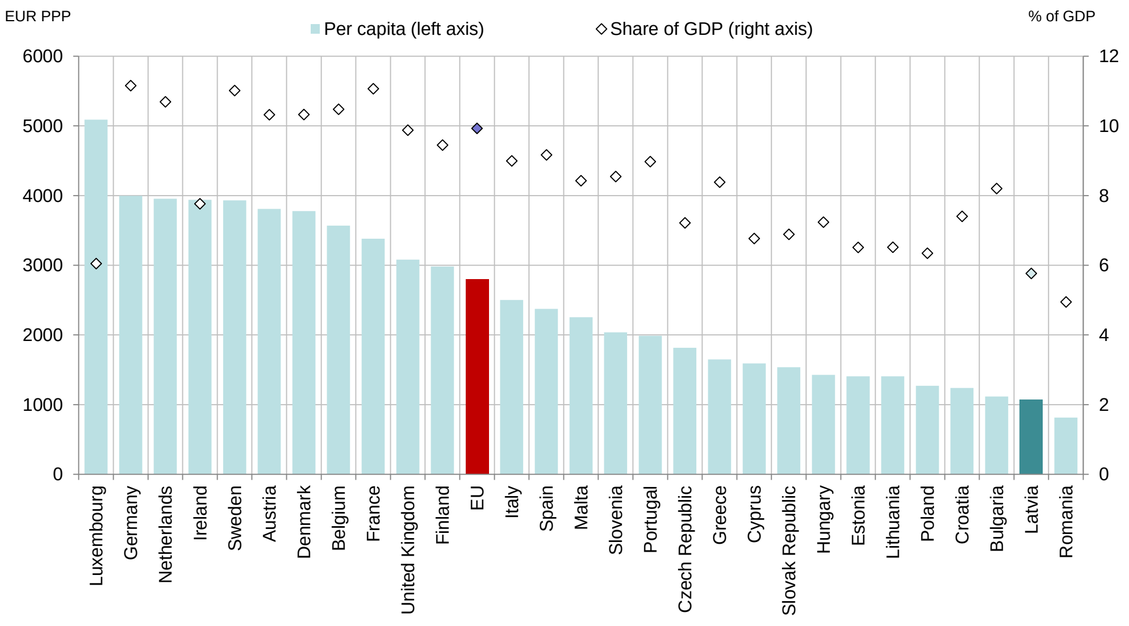


Fig.2. **Latvia's spending on health care among EU Member States (2015)**

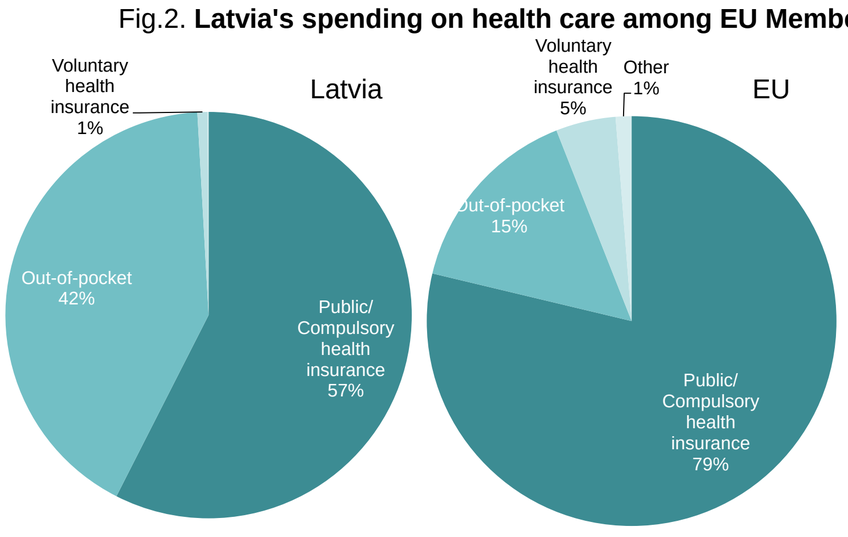


Fig.3. **Direct contributions (2015)**

In 2015, expenditure on medicines and treatments constituted 80% of total direct patient contributions, while another 10% consisted of dentistry. Therefore, many Latvian households face catastrophic direct costs.

Paid medicine reduces the availability of medical services, especially for low-income residents. The health gap in income distribution in Latvia is one of the largest in the EU. There is general health insurance in Latvia, although the coverage and depth of coverage is lower than in most other EU countries. Therefore, a large part of the population reports problems with care - mainly due to financial obstacles, but also for geographical reasons or long waiting times. In 2015, 8.4% of Latvia's population reported unsatisfied health care needs, and this was the fourth highest among all EU Member States (Figure 4). Inaccessible medical care is mainly reported by low-income persons: every sixth resident of Latvia with a low income (17.1%) reported having refused to visit a doctor or treatment for financial or other reasons, and this proportion is three times higher than the EU average (5.5%). In contrast, only 2.5% of Latvian high-income households reported unsatisfied needs.

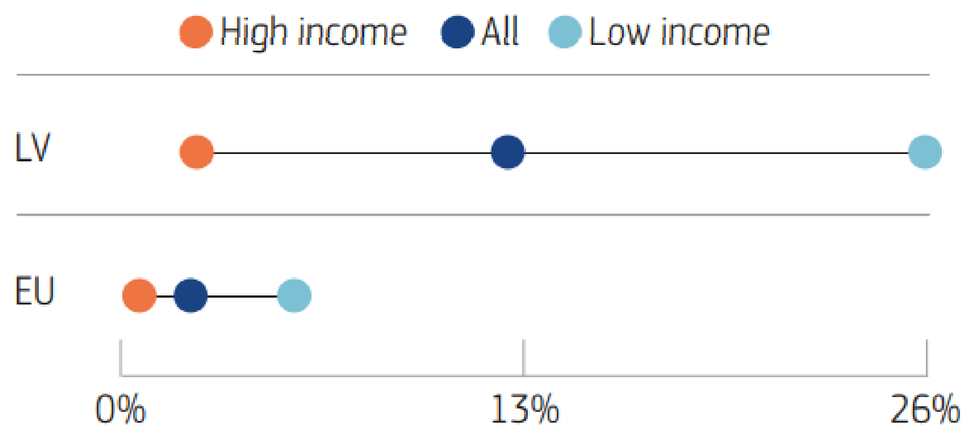


Fig.4. **Access to healthcare (unmet health needs)**

Lifestyle also has a significant impact on health. People with higher incomes smoke less and sports more - in Latvia this relationship is particularly pronounced. But, compared to other developed countries, Latvian residents smoke a lot and sports a little. Although the proportion of Latvian smokers has increased since 2000 (from 33% in 2000 to 25% in 2014), it is still higher than the EU average (21%) and is the sixth highest in the EU as a whole. Smoking is more common among men (37%) than among women (15%).
In contrast to most EU countries, alcohol consumption among Latvian adults has increased from 7.1 liters per adult in 2000 to 10.8 liters in 2015. Cutting (defined as the consumption of six or more alcoholic beverages at a time, at least once a month during the last year) is more common among men (33%) than women (8%). High alcohol consumption is also a problem among Latvian teenagers - every third 15-year-old boy and every fourth girl report that they have been drunk several times in life. This proportion is higher than in most EU countries.
More than one fifth of adults (21%) were obese in 2014, which is more than in one-sixth (17%) in 2008 and is the third highest in the EU. Unlike other risk factors, the obesity rate in Latvia is higher among women (23%) than among men (19%).

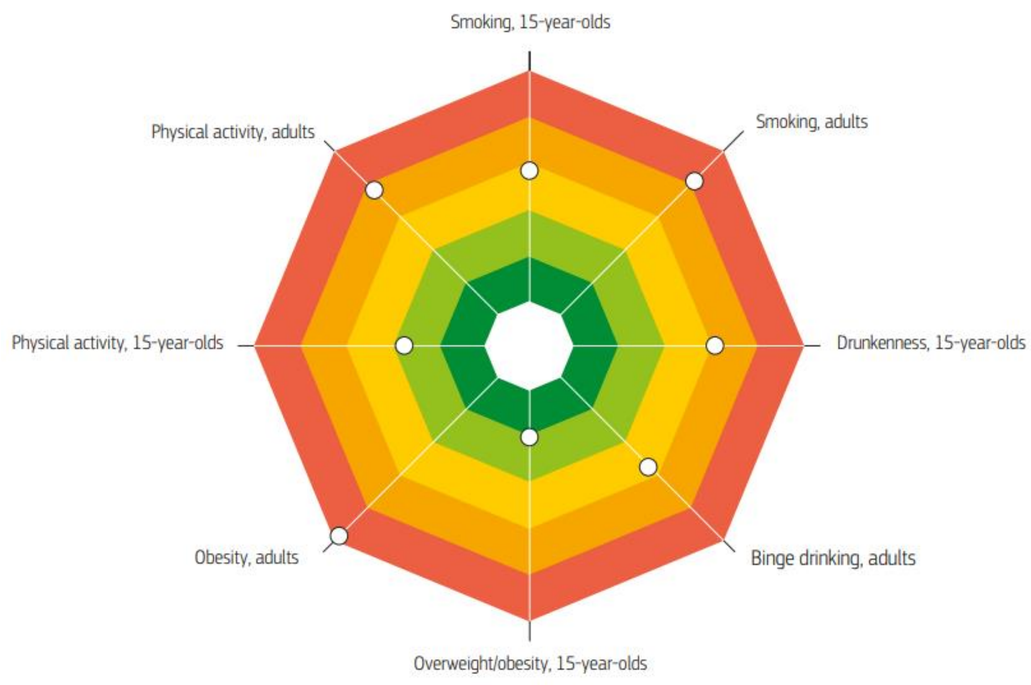


Fig.5. **Risk Factors (2014)** The closer the center is to the point, the better the national indicators are compared to other EU countries.

Conclusions. All these factors are wasting human capital in Latvia. As a result, in Latvia 4,000 people of working age die more every year as compared to the Western European mortality rates. Expenditure on health care in Latvia is among the lowest in the EU, and this leads to significant resource shortages in the healthcare system. The low level of health care spending is a problem from the perspective of sustainable public health improvement and the performance of the health care system. Government plans to increase budget spending on healthcare are crucial to addressing access to and quality of care, and should contribute to improving public health outcomes.

Resources:

1. OECD/European Observatory on Health Systems and Policies (2017), *Latvia: National Health Report 2017;*
2. «Policy challenges and reforms in small EU member state health systems: a narritive literature review» N.Azzopardi-Muscat, T.Funk, S.Buttigieg, K.E.Grech, H.Brand, 2016.
3. «Access and quality of health care system by opinion of patients in ten european countries» D.Jankauskiene, I.Jankauskaite, 2011;