



State of Health in the EU

Lithuania

Country Health Profile 2023

The Country Health Profile Series

The *State of Health in the EU's Country Health Profiles* provide a concise and policy-relevant overview of health and health systems in the EU/European Economic Area. They emphasise the particular characteristics and challenges in each country against a backdrop of cross-country comparisons. The aim is to support policy makers and influencers with a means for mutual learning and voluntary exchange. For the first time since the series began, the 2023 edition of the Country Health Profiles introduces a special section dedicated to mental health.

The profiles are the joint work of the OECD and the European Observatory on Health Systems and Policies, in co-operation with the European Commission. The team is grateful for the valuable comments and suggestions provided by the Health Systems and Policy Monitor network, the OECD Health Committee and the EU Expert Group on Health Systems Performance Assessment (HSPA).

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Data and information sources

The data and information in the *Country Health Profiles* are based mainly on national official statistics provided to Eurostat and the OECD, which were validated to ensure the highest standards of data comparability. The sources and methods underlying these data are available in the Eurostat Database and the OECD health database. Some additional data also come from the Institute for Health Metrics and Evaluation (IHME), the European Centre for Disease Prevention and Control (ECDC), the Health Behaviour in School-Aged Children (HBSC) surveys

and the World Health Organization (WHO), as well as other national sources.

The calculated EU averages are weighted averages of the 27 Member States unless otherwise noted. These EU averages do not include Iceland and Norway.

This profile was finalised in September 2023, based on data that were accessible as of the first half of September 2023.

Demographic and socioeconomic context in Lithuania, 2022

Demographic factors	Lithuania	EU
Population size	2 805 998	446 735 291
Share of population over age 65 (%)	20.0	21.1
Fertility rate ¹ (2021)	1.4	1.5
Socioeconomic factors		
GDP per capita (EUR PPP ²)	31 481	35 219
Relative poverty rate ³ (%)	20.9	16.5
Unemployment rate (%)	6.0	6.2

1. Number of children born per woman aged 15-49. 2. Purchasing power parity (PPP) is defined as the rate of currency conversion that equalises the purchasing power of different currencies by eliminating the differences in price levels between countries. 3. Percentage of persons living with less than 60 % of median equalised disposable income. Source: Eurostat Database.

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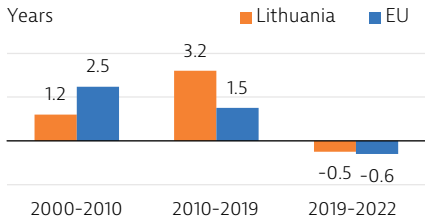
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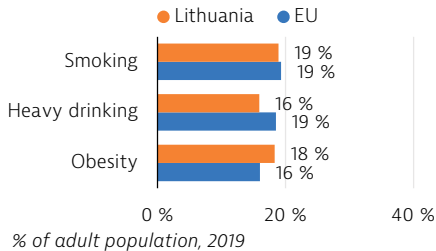
1 Highlights



Changes in life expectancy at birth

Health Status

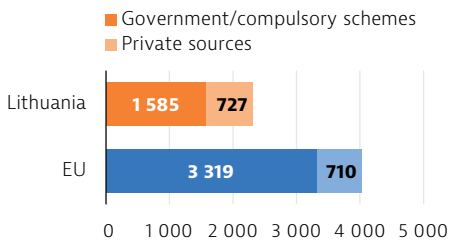
Lithuania made substantial improvements to life expectancy at birth between 2010 and 2019, but the rate fell by more than 2 years in 2021 due to the COVID-19 pandemic. By 2022, life expectancy was still lower than in 2019 by 0.5 years. Ischaemic heart disease remains the leading cause of mortality, and is responsible for almost a third of all deaths.



% of adult population, 2019

Risk Factors

Nearly one in five Lithuanian adults reported smoking every day in 2019, which is close to the EU average. Some 16 % of adults reported regular heavy drinking in Lithuania compared with 19 % on average in the EU. The adult obesity rate has increased to 18 %, and was higher than the EU average of 16 % in 2019.



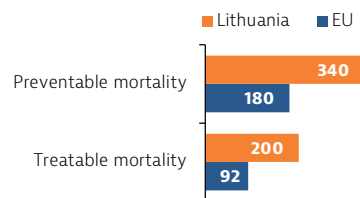
EUR PPP per capita, 2021

Health System

At EUR 2 312, health spending per capita in Lithuania is still far below the EU average. However, as a share of GDP, public spending on health has been growing, and in 2021 reached 5.4 % of GDP. There is substantial reliance on out-of-pocket expenditure, which amounts to 30 % of total health spending, driven by household spending on medicines and dental care.

Effectiveness

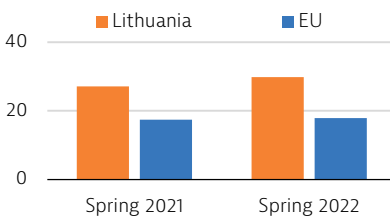
Lithuania has among the highest levels of preventable and treatable mortality in the EU, suggesting weaknesses in both public health and healthcare delivery. The inclusion of COVID-19 as a preventable cause of death in 2020 resulted in an increase in preventable mortality to 340 deaths per 100 000 population in 2020, following a substantial decline in the previous decade.



Age-standardised mortality rate per 100 000 population, 2020

Accessibility

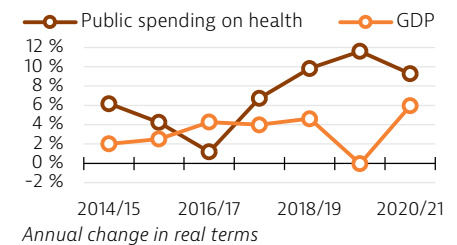
Nearly three in ten people reported unmet healthcare needs during the pandemic. Substantially fewer people attended cancer screening in 2020 and 2021, and the number of visits to primary care, which fell in 2020 and 2021, had not returned to the pre-pandemic level in 2022. The main barrier to access is long waiting times, exacerbated by health workforce shortages.



% unmet healthcare needs

Resilience

Increased public spending on health in 2020 and 2021 was channelled to the COVID-19 response even as GDP growth fell to 0 %. National Health Insurance Fund reserves were used to boost the salaries of health professionals and to meet extra demand. Challenges in workforce availability, distribution and skill mix, however, may hinder health system resilience in the long term.



Annual change in real terms

Mental Health

The burden of mental health issues increased during the pandemic, prompting policies to improve accessibility of services. Depression is the most prevalent mental health issue, and is more often reported by women and people in the lowest income group. Despite progress in reducing suicide rates, particularly among men, they remain the highest in the EU. Mental health services are available in primary care settings, but new multi-disciplinary teams often lack funding and capacity to treat complex patients.

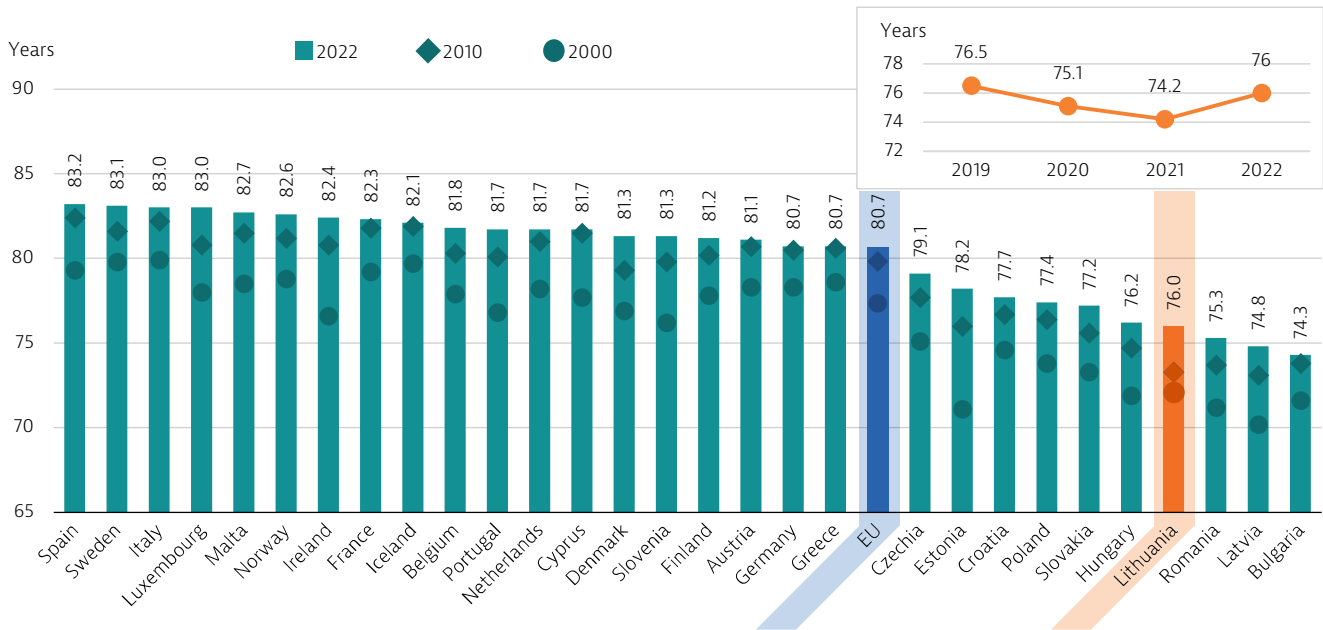
2 Health in Lithuania

Lithuanians have one of the lowest levels of life expectancy in the EU

The gap in life expectancy at birth between Lithuania and the EU was narrowing in the decade before the emergence of COVID-19. The pandemic

resulted in a very steep drop of 2.3 years over 2020 and 2021. Recovery in 2022 brought life expectancy back up to 76 years (or 75.3 years, according to national data (Statistics Lithuania, 2023)) – nearly 5 years below the EU average (Figure 1).

Figure 1. Life expectancy at birth fell sharply but almost recovered after the pandemic



Notes: The EU average is weighted. The 2022 data are provisional estimates from Eurostat that may be different from national data and may be subject to revision. Data for Ireland refer to 2021.

Source: Eurostat Database.

The gender gap in life expectancy is much greater in Lithuania than the EU average. Lithuanian women live almost 9 years longer than men (80.3 years compared to 71.5 years in 2022). This gender gap is one of the widest in the EU and can in part be attributed to the very high mortality from ischaemic heart disease and external causes among Lithuanian men.

Ischaemic heart disease mortality has fallen, although it remains the leading cause of death

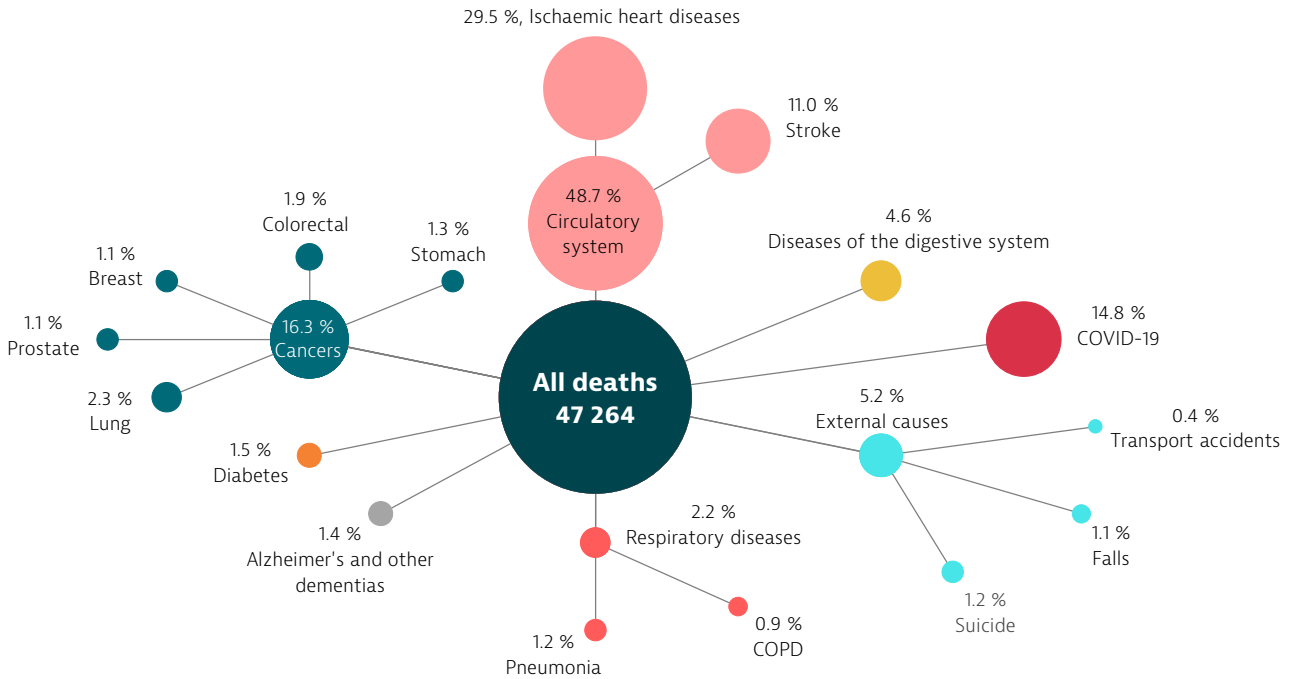
In 2021, ischaemic heart disease was the leading cause of death in Lithuania, accounting for almost one third of all deaths. Mortality from stroke accounted for 11 % of all deaths (Figure 2). Cancer is the second major cause of death in the country, with lung, colorectal and stomach cancer the most frequent causes of death from malignancies. External causes claimed almost 2 500 lives, with suicides accounting for a quarter of those (see Section 6). In 2021, COVID-19 accounted for about 7 000 deaths (15 % of all deaths).

The broader indicator of excess mortality, defined as deaths that occurred (regardless of their cause) above a five-year baseline derived from pre-pandemic levels (2015-19), suggests that the direct and indirect death toll related to COVID-19 was particularly high in 2021, exceeding the expected number of deaths by 18 %. Excess mortality fell in 2022 but remained above the pre-pandemic level. The excess mortality rate in 2021 was mainly driven by COVID-19 deaths (95 %).

Fewer than half of Lithuanians consider themselves to be in good health

In 2022, only 48 % of Lithuanian adults reported being in good health – the lowest rate in the EU. As in other countries, people with higher incomes are more likely to report being in good health: 72 % of those in the highest income quintile considered themselves in good health compared to only 25 % of those in the lowest. This income gap in self-reported health is the widest in the EU, but is similar to the gaps in Estonia and Latvia.

Figure 2. Circulatory system diseases and cancer were the leading causes of death in 2021



Note: COPD refers to chronic obstructive pulmonary disease. Source: Eurostat Database (data refer to 2021).

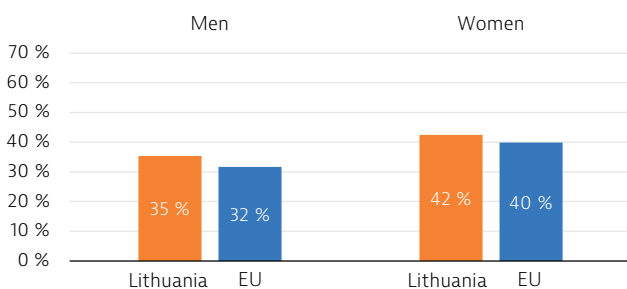
Older Lithuanians have shorter lifespans and fewer healthy life years than their counterparts in most EU countries

As in other EU countries, Lithuania has experienced a demographic shift towards an older population over the past two decades, with the proportion of people aged 65 and over rising from 14 % in 2000 to 20 % in 2020. The share is projected to increase to 31 % of the population by 2050. Life

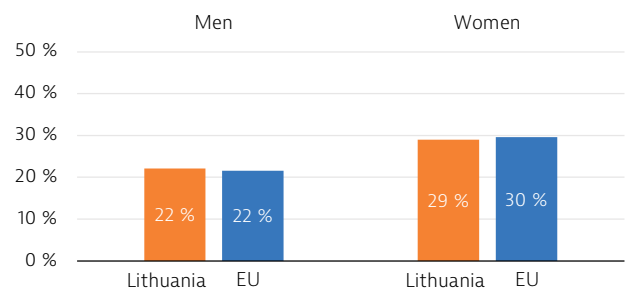
expectancy of people at age 65 remains below the EU average, especially for men (13.6 years of remaining years of life compared to the EU average of 17.4 years). Lithuanian women can expect to live 5.5 years longer than men at age 65 (19.1 years compared to EU average of 21 years). As in other EU countries, older Lithuanian women are more likely than men to report multiple chronic conditions and limitations in daily activities (Figure 3).

Figure 3. Older Lithuanians spend a substantial proportion of their lives with disabilities

Proportion of people aged 65 and over with multiple chronic conditions



Limitations in daily activities among people aged 65 and over



Sources: Eurostat Database (for life expectancy and healthy life years) and SHARE survey wave 8 (for chronic conditions and limitations in daily activities). Data refer to 2020.

Cancer incidence is above the EU average for men, but below it for women

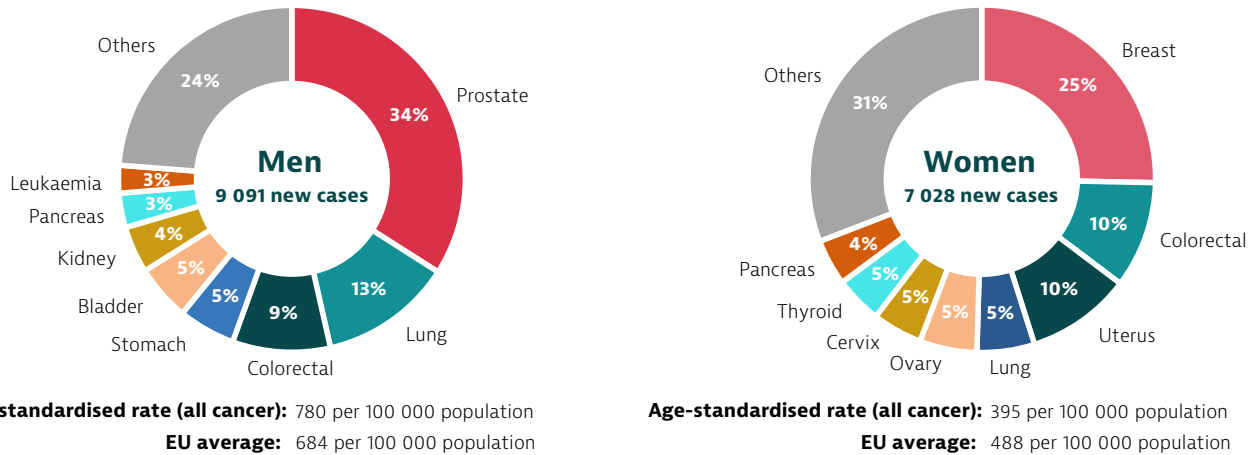
According to the latest estimates from the Joint Research Centre, around 16 100 new cancer cases were expected to be diagnosed in Lithuania in

2022. Cancer incidence was expected to be higher than the EU average among men, but substantially lower among women. The main cancer sites among men were predicted to be prostate, lung and colon, while among women the leading cancer was

breast cancer, followed by colon and uterine cancer (Figure 4). Cancer prevention programmes have gradually been expanded over the past 15 years,

but the COVID-19 pandemic had a detrimental impact on the availability of cancer screening services in 2020 and 2021 (see Section 5.1).

Figure 4. In 2022, more than 16 000 people in Lithuania were expected to be diagnosed with cancer



Notes: Non-melanoma skin cancer is excluded; uterus cancer does not include cancer of the cervix.
Source: ECIS – European Cancer Information System.

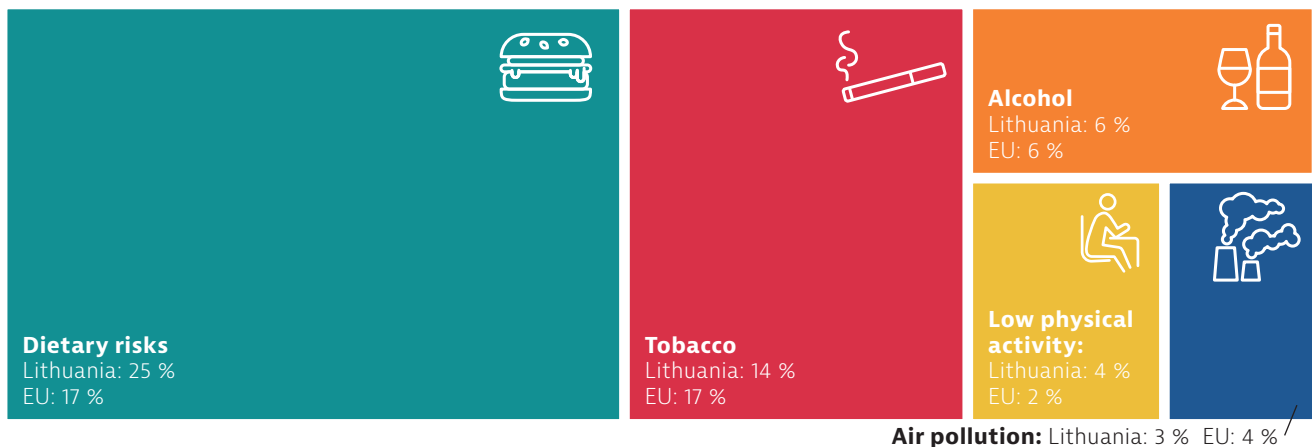
3 Risk factors

Lifestyle and environmental risk factors account for nearly half of all deaths in Lithuania

The high mortality rates and poor health status of the Lithuanian population are largely linked to behavioural risk factors. It is estimated that in 2019 approximately 44 % of all deaths in Lithuania could be attributed to behavioural and environmental risk factors, including dietary risks, tobacco smoking, alcohol consumption and low physical activity (Figure 5).

Some 25 % of all deaths in 2019 (9 500 deaths) were related to dietary risks (including low fruit and vegetable intake, and high sugar and salt consumption), which is substantially above the EU average (17 %). Tobacco consumption, including second-hand smoking, is responsible for an estimated 14 % (over 5 300) of all deaths. About 6 % of deaths were linked to alcohol consumption and 4 % to low physical activity. Air pollution in the form of fine particulate matter (PM_{2.5}) and ozone exposure alone accounted for about 3 % of all deaths in 2019.

Figure 5. Most deaths in Lithuania can be attributed to behavioural risk factors



Notes: The overall number of deaths related to these risk factors is lower than the sum of each one taken individually, because the same death can be attributed to more than one risk factor. Dietary risks include 14 components such as low fruit and vegetable intake, and high sugar-sweetened beverages consumption. Air pollution refers to exposure to PM_{2.5} and ozone.

Sources: IHME (2020), Global Health Data Exchange (estimates refer to 2019).

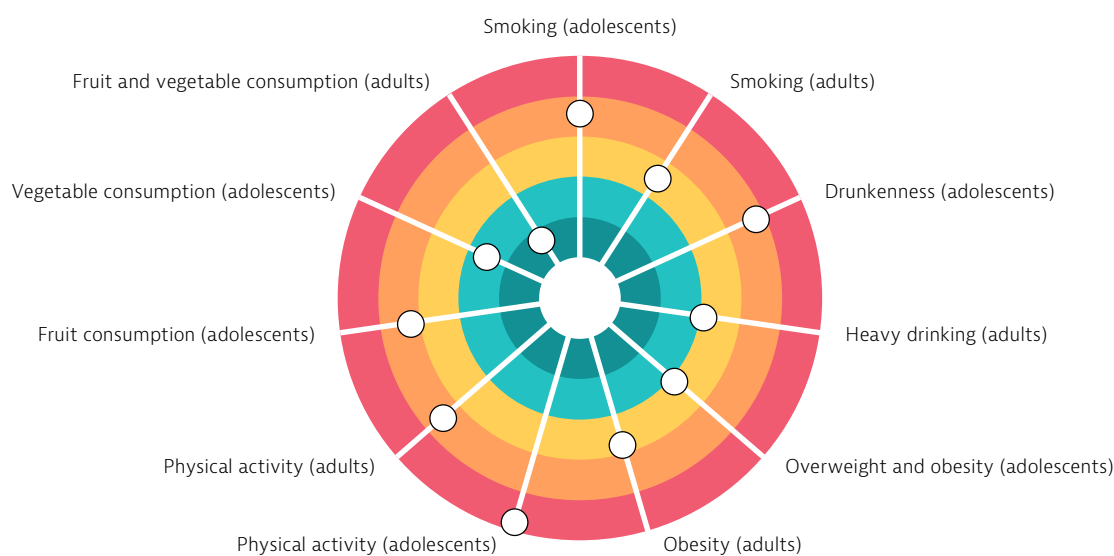
Excessive alcohol consumption is still a major risk factor

Although alcohol consumption in Lithuania decreased from the peak of 14.7 litres per adult in 2010 to 11.1 litres in 2019, it has been rising again, and in 2021 reached 12.1 litres per adult. Heavy drinking is much more frequent among men, with 27 % reporting heavy drinking at least once a month in 2019, compared to 7 % of women.¹ In 2022, a quarter (24 %) of 15-year-olds reported having been drunk more than once in their life – the lowest share reported in the past two decades

in Lithuania, but still above the EU average of 18 % (Figure 6).

Between 2016 and 2018, stricter alcohol control measures were introduced, including a ban on alcohol sales in petrol stations, a full ban on advertising of alcohol on TV, radio and the internet, reduced retail sales times and an increase in the legal age for purchasing alcohol from 18 to 20. These actions were accompanied by several alcohol excise tax increases, and part of the revenues raised were earmarked for funding public health projects (see Section 5.1).

Figure 6. Alcohol and tobacco consumption are important public health issues in Lithuania



Notes: The closer the dot is to the centre, the better the country performs compared to other EU countries. No country is in the white "target area" as there is room for progress in all countries in all areas.

Sources: OECD calculations based on HBSC survey 2022 for adolescents indicators; and EHIS 2019 for adults indicators.

Smoking rates among adolescents have fallen in recent years

In 2019, 19 % of Lithuanian adults reported smoking every day, which is close to the EU average. Smoking was much more prevalent among men (30 %) than women (10 %). Smoking among adolescents has fallen in Lithuania in recent years, with 21 % of 15-year olds reporting that they had smoked in the past month in 2022, compared to 17 % on average across the EU. Strengthened enforcement of the ban on tobacco advertising online and further restrictions on smoking areas were introduced in 2020 and 2021 (see Section 5.1), but use of electronic cigarettes and vaping, especially among children, is a growing concern (LTR, 2023).

Obesity rates among adults are slightly above the EU average

The obesity rate among adults in Lithuania is slightly higher than the EU average. More than one in six adults were obese (18 %) in 2019, compared to 16 % on average across the EU. This is linked to unhealthy diets and at least in part to a lack of physical activity. Only one in five adults in Lithuania (21 %) reported engaging in at least 150 minutes of physical activity per week – a much lower proportion than the EU average of 33 %. Findings from a recent Eurobarometer survey show that 32 % of Lithuanian adults took part in exercise with at least some regularity in 2022 (the EU average was 38 %). Overweight is also a growing issue among adolescents: 20 % of 15-year-olds were overweight or obese in 2022, up from 13 % in 2014, now registering just below the EU average (21 %).

¹ Heavy drinking is defined as consuming six or more alcoholic drinks on a single occasion for adults.

A policy promoting healthy eating and physical activity was adopted in 2020. It sets out guidance on planning and evaluation of these activities for municipal public health bureaus, and mainly relies on tackling population health literacy, improving the nutritional value of school meals and other foods, and creating an environment that enables a healthy lifestyle.

Socioeconomic inequality contributes to health risks

Many behavioural risk factors in Lithuania are more common among people with lower incomes. In 2019, a quarter of adults in the lowest income quintile were obese, compared to 11 % of those in the highest. Similarly, low levels of physical activity and low fruit and vegetable consumption were more prevalent among those with lower incomes. The higher prevalence of risk factors among socially disadvantaged groups contributes to inequalities in health and life expectancy.

4 The health system

A major restructuring reform of the Lithuanian healthcare system was initiated in 2022

The Lithuanian health system is financed from contributions to a social health insurance scheme, governed by the National Health Insurance Fund (NHIF). Funding comes from payroll contributions from the working population and the general government budget to cover the non-working population to ensure universal coverage. The Ministry of Health is responsible for health system regulation and policy making. Apart from governing the NHIF, it oversees a number of subordinate agencies, which are tasked with medicines control, public health functions, and licensing of services and health professionals. The Ministry also (co)owns some healthcare providers, including all tertiary hospitals.

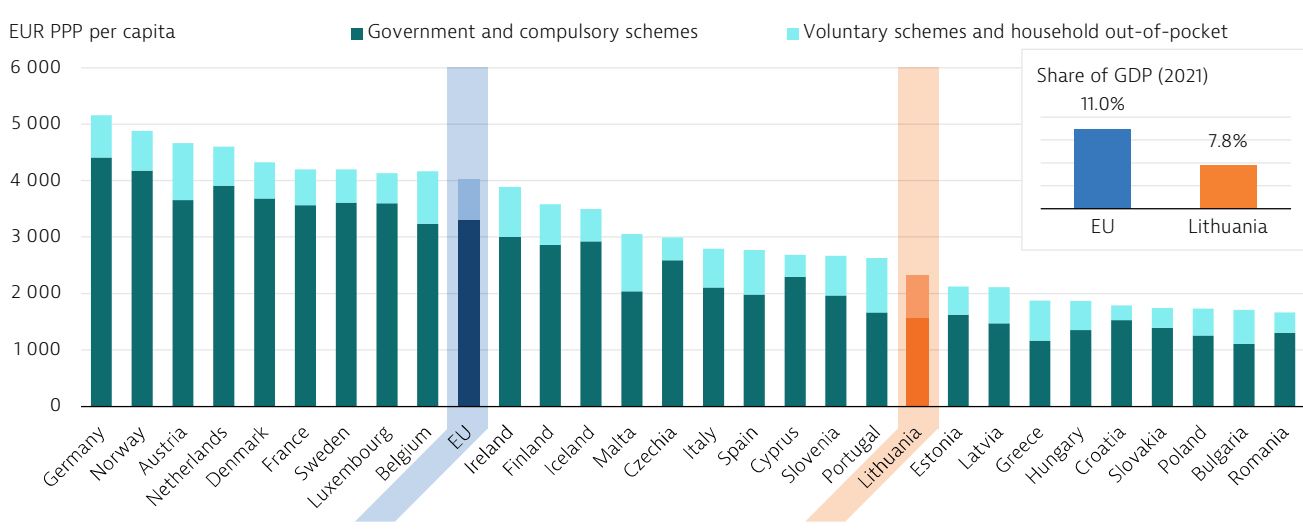
Municipalities own primary healthcare centres and most district hospitals, and are responsible for some public health functions. The role of the private sector in inpatient care is very limited, but it is substantial in provision of outpatient specialist care – in particular, dental care. Many general practitioners (GPs) are also private providers. The NHIF routinely contracts private providers for primary and some specialised outpatient care.

In early 2022, the Ministry of Health initiated a major healthcare services restructure (the fifth since 2004). Between 2022 and 2024, the reforms aim to centralise ambulance services, establish a new type of provider (municipal health centres), create a model for long-term care, modernise hospital services, and enhance health system resilience (see below and Section 5.3).

Public spending on health in Lithuania was boosted by funds dedicated to the COVID-19 response

Total health expenditure in Lithuania reached 7.8 % of GDP in 2021. A notable increase in spending started in 2019 and continued in the first two years of the COVID-19 pandemic. At EUR 2 312 per capita (adjusted for differences in purchasing power) in 2021, health expenditure was higher than in Estonia and Latvia, but still just over half the EU average (EUR 4 028) (Figure 7). The public share of spending amounted to 69 % in 2021, and reached 5.4 % of GDP, reflecting the prioritisation of public financial support during the COVID-19 crisis. Substantial sums were directed to procurement of vaccines, COVID-19 tests and personal protective equipment, and to the organisation of hotlines and other action for mental health support (see Section 6).

Figure 7. Lithuania spends considerably less on health than many other EU countries



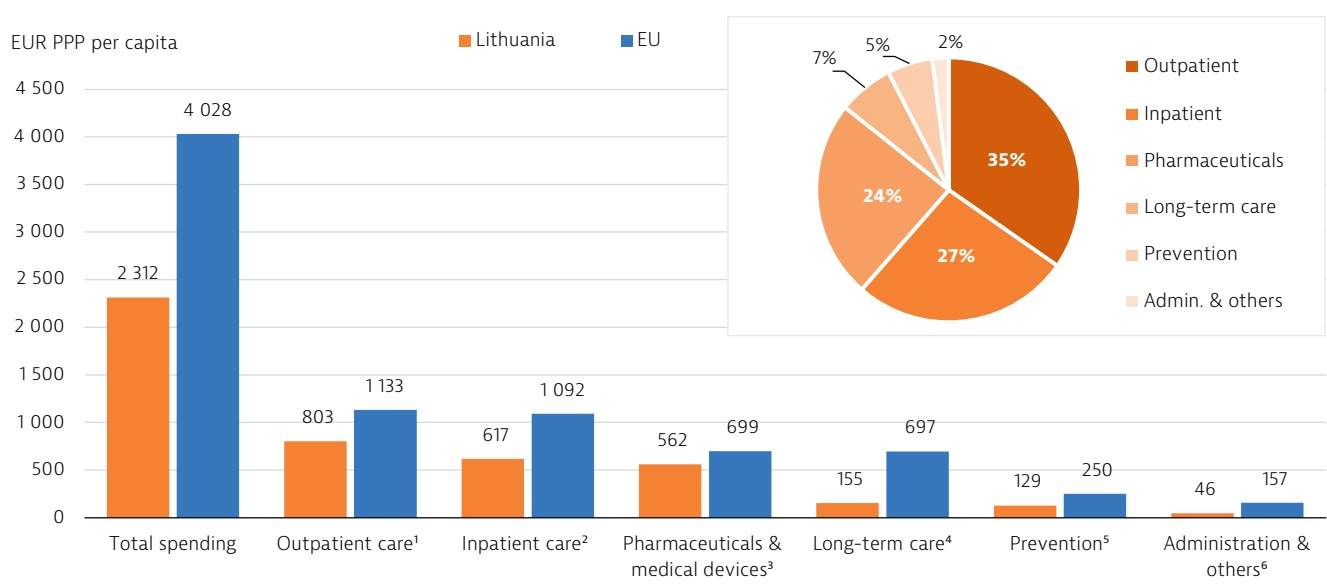
Note: The EU average is weighted.
Source: OECD Health Statistics 2023 (data refer to 2021, except Malta (2020)).

Spending on prevention increased greatly during the pandemic

In 2021, 35 % of current expenditure on health was on outpatient care, followed by inpatient care (27 %) and pharmaceuticals and medical devices (24 %) (Figure 8). Although the changes in the shares of these three key drivers of spending are small, they

point to a very gradual shift away from dominance of the inpatient sector and pharmaceuticals. The share of long-term care has remained stable over time, at around 7 %, while the share of prevention has grown markedly – from less than 3 % in 2019 to over 5 % in 2021 – reflecting extra resources needed for the pandemic response.

Figure 8. Outpatient care is the largest area of health spending



Notes: 1. Includes home care and ancillary services (e.g. patient transportation); 2. Includes curative-rehabilitative care in hospital and other settings; 3. Includes only the outpatient market; 4. Includes only the health component; 5. Includes only spending for organised prevention programmes; 6. Includes health system governance and administration and other spending. The EU average is weighted.
Source: OECD Health Statistics 2023 (data refer to 2021, except Malta (2020)).

Changes to the provider network still lack clarity

A national report noted that the restructuring of the provider network initiated in 2022 lacked an overall framework, consistency and stakeholder input; therefore, practical steps to implement

it remain undetermined (National Audit Office, 2023a). Municipal health centres – the newly formed provider units – are expected to provide 80 % of healthcare services through a close linkage between expanded primary care teams and specialist services. Meanwhile, despite several

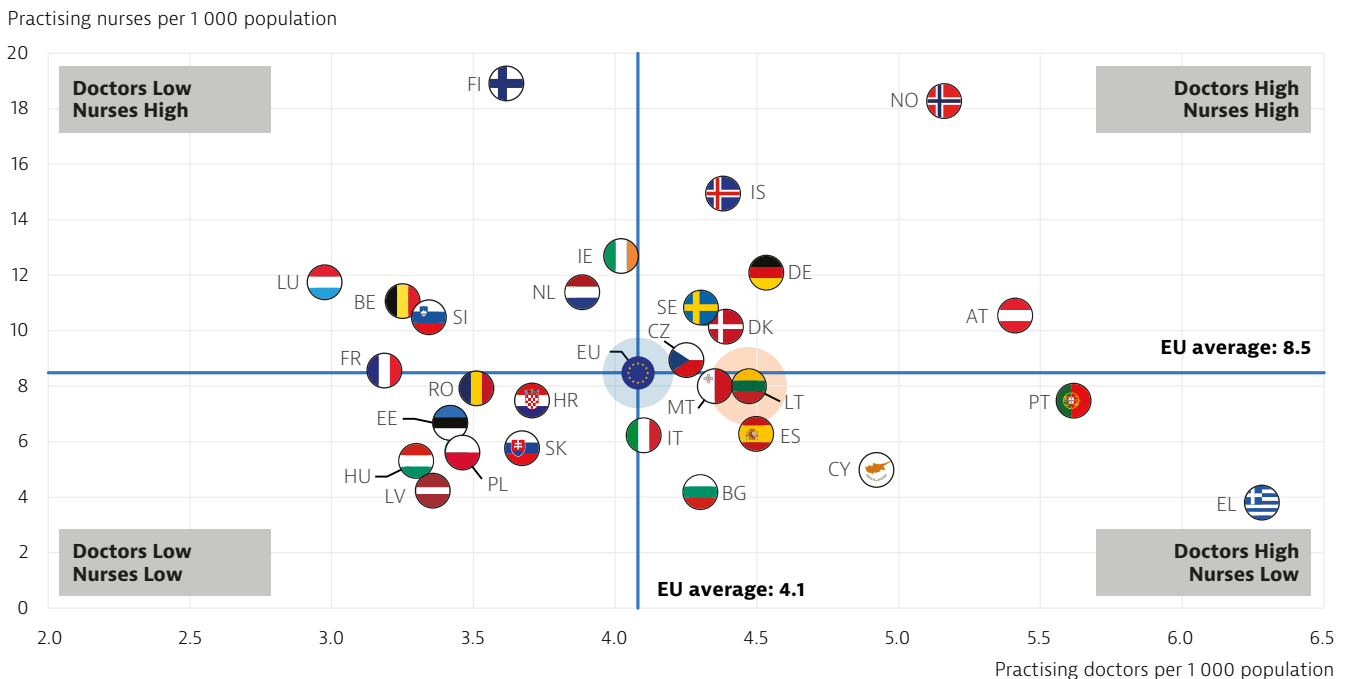
mergers and closures of inpatient departments of district hospitals, there is still over-reliance on hospital care (see Section 5.1), with 6.1 beds per 1 000 population compared to the EU average of 4.8 per 1 000 in 2021.

Shortages of nurses persist

Lithuania has a relatively high ratio of practising doctors (4.5 per 1 000 population in 2021 – above the EU average of 4.1 per 1 000), but because the growing demand is not being met, there is a

predicted shortage of over 3 000 nurses and over 400 GPs by 2030 (National Audit Office, 2023a). In 2021 there were 7.9 nurses per 1 000 population, which is below the EU average of 8.5 (Figure 9). The National Health Strategy target to restore the nurse to doctor ratio to 2:1 by 2020 has now been pushed back to 2025, in expectation of positive developments in terms of increasing the number of nursing students and enhancing retention rates (see Section 5.3).

Figure 9. The number of doctors in Lithuania is high, but shortages are predicted in the future



Notes: The EU average is unweighted. The data on nurses include all categories of nurses (not only those meeting the EU Directive on the Recognition of Professional Qualifications). In Portugal and Greece, data refer to all doctors licensed to practise, resulting in a large overestimation of the number of practising doctors (e.g. of around 30 % in Portugal). In Greece, the number of nurses is underestimated as it only includes those working in hospitals. Source: OECD Health Statistics 2023 (data refer to 2021 or the nearest available year).

5 Performance of the health system

5.1 Effectiveness

Avoidable mortality rates in Lithuania are high

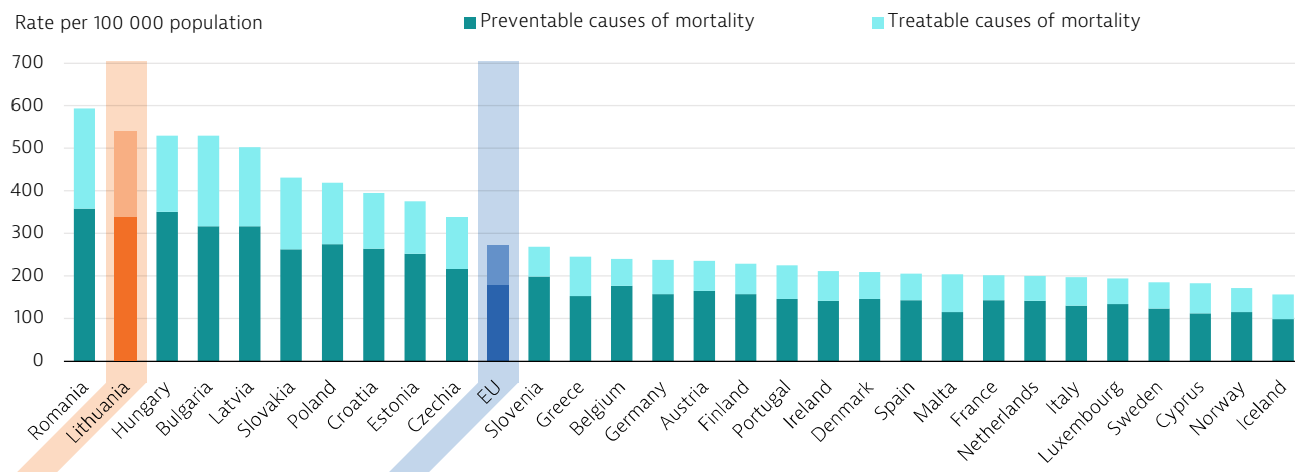
In 2020, Lithuania had the second highest rate of avoidable (preventable and treatable) mortality in the EU, driven by premature deaths from ischaemic heart disease (Figure 10). For preventable mortality, other key causes were alcohol-related disorders, accidents, COVID-19 and lung cancer. Stroke, colorectal and breast cancer, and pneumonia also played an important role in treatable mortality. Although avoidable mortality rates reduced in Lithuania by a third between 2011 and 2019 (from

721 per 100 000 population to 466 per 100 000), there was a sharp increase in 2020 for both preventable and treatable causes of mortality. This reflects the impact of COVID-19 on deaths and access to services, but is also due to a rise in mortality from cardiovascular diseases (see Section 2).

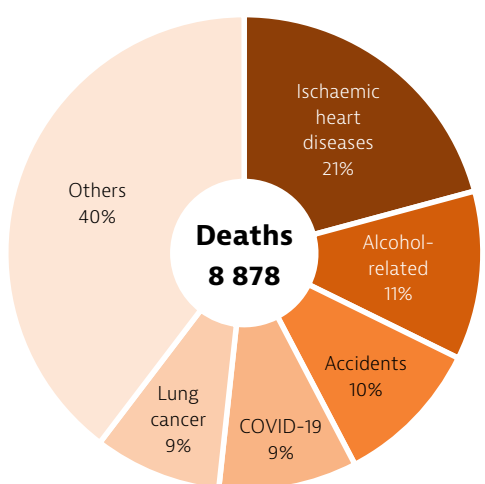
Public health policies targeting alcohol consumption have stalled

In 2020, among people aged under 75, there were nearly 2 000 deaths from alcohol-related disorders, lung cancer and road traffic accidents

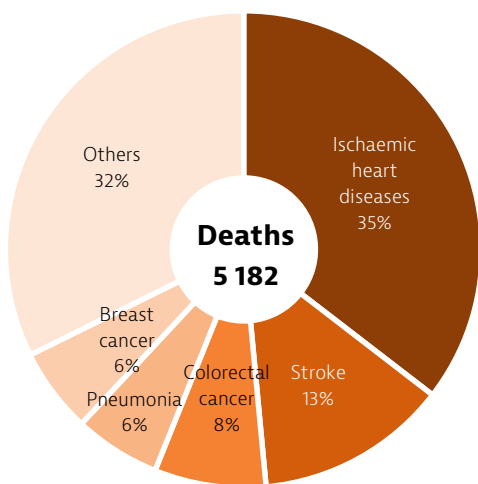
Figure 10. Very high rates of preventable and treatable mortality in Lithuania are driven by ischaemic heart disease



Preventable causes of mortality



Treatable causes of mortality



Lithuania

Notes: Preventable mortality is defined as death that can be mainly avoided through public health and primary prevention interventions. Treatable (or amenable) mortality is defined as death that can be mainly avoided through healthcare interventions, including screening and treatment. Both indicators refer to premature mortality (under age 75). The lists attribute half of all deaths from some diseases (e.g. ischaemic heart disease, stroke, diabetes and hypertension) to the preventable mortality list and the other half to treatable causes, so there is no double-counting of the same death. Source: Eurostat Database (data refer to 2020).

that could have been prevented through stronger public health policies such as tobacco and alcohol control and road traffic safety regulations. A string of policies to reduce alcohol affordability and availability, as well as a ban on advertising, were introduced in 2016-18, but progress has stalled more recently (see Section 3). In response to the rising use of electronic cigarettes and vapes – specifically among younger people – the sale of vaping products containing colours, flavours or scents (except for tobacco) was banned in 2022.

Vaccine hesitancy has been growing among parents of small children

Influenza immunisation coverage for older people (21 % in 2022) and human papillomavirus (HPV) vaccination coverage for girls (71 % in 2022) has

been growing, albeit from low levels in 2017. Routine childhood vaccination coverage largely exceeded the 95 % herd immunity threshold until 2010, but it has gradually fallen since then, with coverage for diphtheria, tetanus and pertussis (DTP) among 1-year-olds in 2021 standing at 90%. Despite a measles outbreak in 2019, immunisation coverage with two doses of the measles, mumps and rubella vaccine fell from 93 % in 2019 to 87 % in 2022. Although providers sought to maintain routine immunisation services throughout the pandemic, coverage for many vaccinations has fallen more recently.

Inequalities in cancer screening coverage limit accessibility

Between 2019 and 2021, coverage of some cancer screening programmes fell sharply. Coverage for breast cancer among the target group who had been screened in the previous two years fell from 53 % to 46 %, while for colorectal cancer screening it fell from 56 % to 48 %. The screening rate for cervical cancer remained stable at around 53 %.

There are major inequalities in cancer screening coverage by income and geographically. For example, in 2019, cervical cancer screening coverage varied from 34 % among women in the lowest income quintile to 58 % among those in the highest (Eurostat, 2019). In 2020, coverage across municipalities ranged from 28 % to 75 % (Hygiene Institute, 2022).

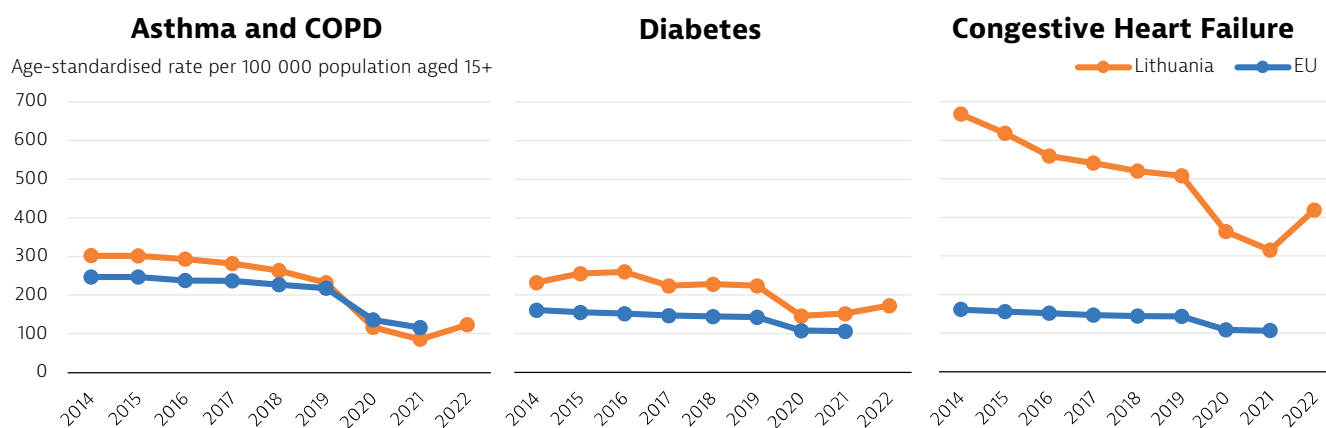
Primary healthcare is not yet able to address common health problems adequately

In 2020, there was a sharp decline in avoidable hospital admissions for asthma and chronic obstructive pulmonary disease, diabetes and congestive heart failure (Figure 11). However, the

interpretation of this decline is complex because of limitations placed on planned services during the pandemic and an overall decline in hospitalisations (see Section 5.3). In 2022, avoidable admissions have risen again for all conditions, and remain driven by particularly high rates of hospitalisations due to congestive heart failure.

A priority programme, carried out through primary care, aimed to prevent cardiovascular disease and its complications by offering free annual health checks for people aged 40-60. Programme coverage increased steadily from 28 % of the eligible population in 2013 to 44 % in 2021, with a drop to 32 % in 2020 due to COVID-19. In the meantime, annual funding available for the programme more than doubled – from EUR 5 million to EUR 11 million – between 2015 and 2021 (NHIF, 2023). Nevertheless, primary care services suffer from multiple weaknesses, including a limited range of preventive, early diagnostic and primary-level care services, and a lack of appropriate competencies within primary care teams (Ministry of Health, 2022).

Figure 11. Following a sharp drop in 2020, avoidable hospital admissions for chronic conditions have begun to increase



Note: Admission rates are not adjusted for differences in disease prevalence across countries.

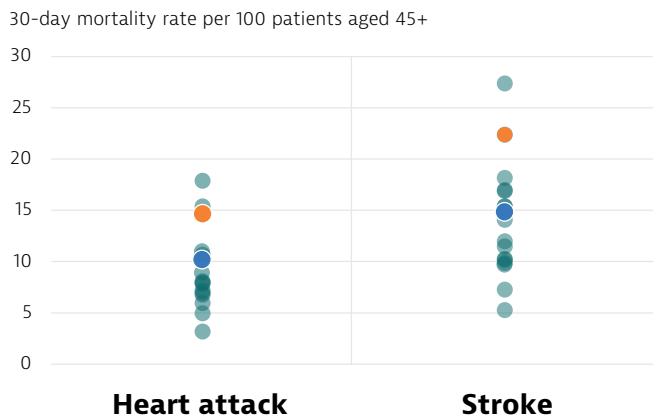
Source: OECD Health Statistics 2023.

Variable care quality across providers suggests an absence of common standards

Effectiveness of hospital care in Lithuania remains a challenge, with indicators showing among the highest levels of mortality in the 30 days following hospitalisation for heart attacks and ischaemic stroke in the EU (Figure 12). Although there was a gradual improvement between 2015 and 2019, from the beginning of the pandemic, mortality rates increased for both heart attack (15 % in 2021) and stroke (22 %), in contrast to 10 % and 15 % averages for EU countries where comparable data

for 2021 are available. Lack of care integration and coordination, as well as wide variability in care quality across providers, present persistent challenges. Inspections by the State Healthcare Accreditation Agency (2020) revealed that some district hospitals were not complying with care quality standards for heart attack and stroke services, particularly in terms of round-the-clock availability of specialist physicians and rapid access to the necessary diagnostics.

Figure 12. Hospital mortality for heart attack and stroke exceeds that of most EU countries



Note: Figures are based on patient data and have been age- and sex-standardised to the population admitted to hospital for heart attack and ischaemic stroke.
Source: OECD Health Statistics 2023 (data refer to 2021 or nearest available year).

5.2 Accessibility

Rates of unmet needs for healthcare in Lithuania are slightly above the EU average

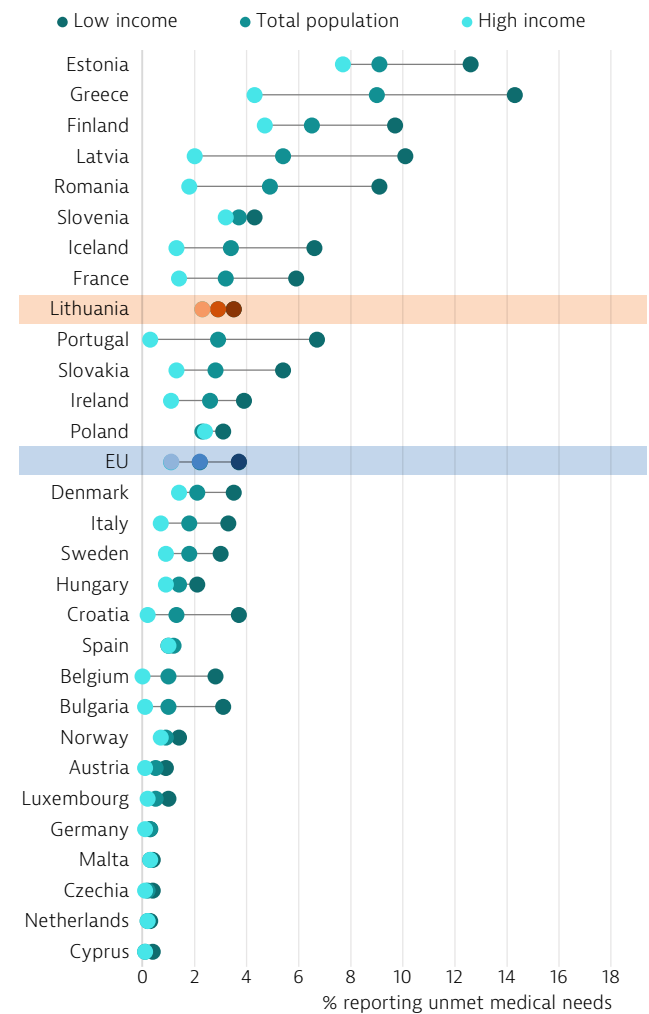
According to the annual EU-SILC survey, 2.9 % of respondents on average, and 3.5 % of those on low incomes, declared having unmet needs for medical examination due to costs, distance to travel or waiting times in 2022, compared to the overall EU average of 2.2 % and the EU average among those on low incomes of 3.7 %. These figures are substantially lower, however, than in neighbouring Estonia and Latvia (Figure 13). The rate of unmet needs for dental care in Lithuania was 2.4 %, which is lower than the EU average of 3.4 %.

At the same time, results of two waves of Eurofound surveys (2021; 2022)² on unmet needs for healthcare during the pandemic show that levels were consistently high in Lithuania, at 27 % of respondents in spring 2021 and 30 % in spring 2022, compared to 17-18 % in the EU on average in both years.

Compulsory social health insurance is intended to cover all residents

Nearly all legal residents in Lithuania (>99 %) are covered by the social health insurance scheme. About half the population pay mandatory contributions and the other half (people receiving their pension, social or disability benefits or income support; children under 18; one parent/legal guardian of a child under 8 or two or more children under 18; registered unemployed people;

Figure 13. The income gap in unmet needs for healthcare in Lithuania is smaller than in the EU



Notes: Data refer to unmet needs for a medical examination or treatment due to costs, distance to travel or waiting times. Caution is required in comparing the data across countries as there are some variations in the survey instrument used.
Source: Eurostat Database, based on EU-SILC (data refer to 2022, except Norway (2020) and Iceland (2018)).

asylum seekers; and certain other groups) are eligible for state-sponsored coverage. Ukrainian refugees who are employed in Lithuania are entitled to health coverage at the same level as residents, while others are entitled to emergency care and a few other services. Undocumented migrants (except for some very vulnerable groups, such as unaccompanied minors) are only covered for essential medical aid, while some primary care services may be available in larger migrant accommodation centres. People who are not insured are still entitled to access emergency services.

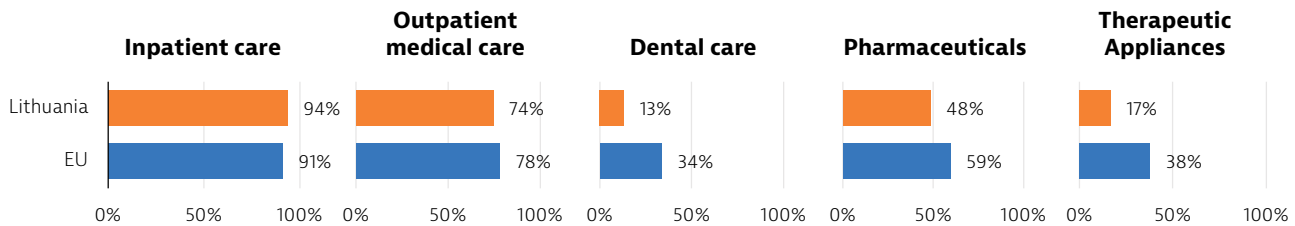
² Eurofound survey data are not comparable to EU-SILC due to differences in methodology.

The benefits package covers a wide range of services, but copayments are applied to medicines and dental care

The benefits package covers preventive care; primary, secondary and tertiary level services; medical rehabilitation and nursing care; and medicines and medical products. Outpatient visits and hospitalisations are free of charge with a referral, but public providers may set user charges

for some diagnostic tests and consumables, materials for dental care and specialist consultations without a referral. In 2021, the level of public financing for medicines, therapeutic appliances (like glasses) and dental care in Lithuania is substantially below the EU average (Figure 14), which in turn results in high levels of out-of-pocket (OOP) payments for these services.

Figure 14. Less than 20 % of spending on dental care and less than 50 % on medicines is publicly funded



Notes: Outpatient medical services mainly refer to services provided by generalists and specialists in the outpatient sector. Pharmaceuticals include prescribed and over-the-counter medicines and medical non-durables. Therapeutic appliances refer to vision products, hearing aids, wheelchairs and other medical devices. The EU average is unweighted.

Source: OECD Health Statistics 2023.

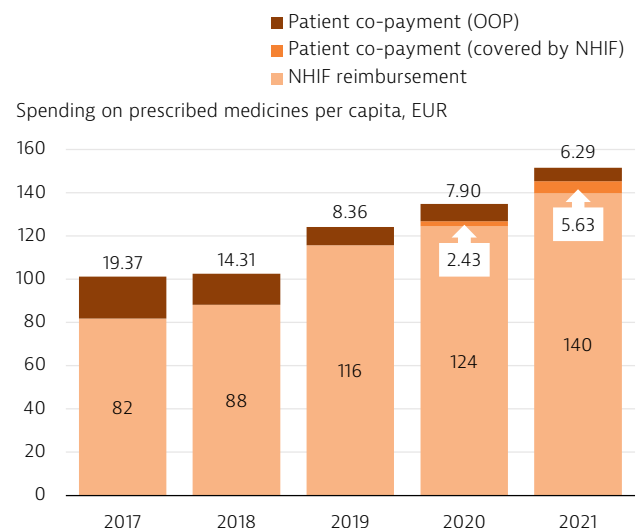
There are notable efforts to expand the coverage of reimbursable medicines

The share of public funding for medicines has increased markedly – from 35 % on average in 2006-17 to 48 % in 2021 – while the average copayment for prescribed reimbursed medication fell from EUR 19 per capita in 2017 to EUR 6 in 2021 (Figure 15), following a series of measures introduced between 2018 and 2020. These included promoting generic prescribing, mandating pharmacists to offer the cheapest option first, raising the reimbursement rate of many medicines to 100 % and extending exemptions from copayments. Outpatient medicines for treatment of certain conditions (including cancer, cardiovascular diseases, diabetes, tuberculosis, epilepsy, asthma and schizophrenia) are fully reimbursed (List A), whereas some medicines (List B, containing only antimicrobials) are reimbursed at 100 % for children and severely disabled people and 50 % for pensioners and people with less severe disabilities.

Nevertheless, other prescribed medicines are not currently reimbursed. In addition, reimbursement of medicines only covers the base price; patients pay the difference between the reimbursement and retail price out of pocket, which in 2018 was set at a maximum of EUR 4.71. Since 2020, the NHIF covers this copayment for people aged 75 and over and for disabled people and pensioners on low incomes. In 2023, the government is considering further changes that include merging both the positive

lists to extend 100 % coverage for all reimbursable medicines, setting an annual cap of EUR 45 on OOP spending on reimbursed pharmaceuticals purchased at the lowest price, increasing copayments to EUR 5.87 for medicines costing over EUR 25 and only covering copayments for eligible groups if a person chooses the cheapest option.

Figure 15. Copayments for prescribed reimbursed pharmaceuticals have declined markedly



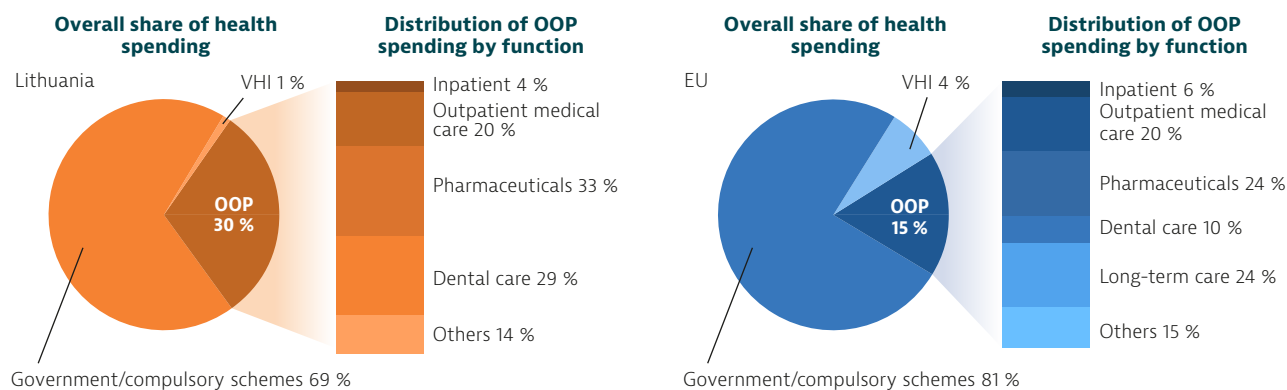
Source: NHIF (2022).

Out-of-pocket spending remains very high

Lithuania's health system is heavily reliant on OOP payments, which amounted to 30 % of overall health spending in 2021, compared to only 15 % across the EU (Figure 16). The largest share of OOP spending (33 %) is on pharmaceuticals, followed by dental care (29 %). In the years preceding the

COVID-19 pandemic, the share of OOP spending was even higher, at 32 % on average between 2012 and 2019. The reductions in OOP spending during the pandemic may be a reflection of the indirect effect of disrupted access to routine non-COVID-19 services.

Figure 16. The share of out-of-pocket spending in Lithuania is double the EU average



Notes: VHI refers to voluntary health insurance, which also includes other voluntary prepayment schemes. The EU average is weighted.
Sources: OECD Health Statistics 2023; Eurostat Database (data refer to 2021).

Catastrophic spending on healthcare largely affects poorer households

Lithuania had the second highest level of catastrophic payments in the EU after Bulgaria, at 15.2 % in 2016, which was a two-fold increase from 2007, when catastrophic payments amounted to 7 % (WHO Regional Office for Europe, 2021).³ The key driver was outpatient pharmaceuticals, followed by dental care. Catastrophic spending is heavily concentrated in the two poorest income quintiles. Reliance on OOP spending as a financing source hampers efforts to strengthen universal health coverage, but policies aimed at reducing copayments for medicines should improve the situation.

Waiting times remain an issue for many specialist care services

Waiting times have long been recognised as one of the key challenges to accessibility of care in Lithuania. The aim is that a wait for a GP appointment should not exceed 7 days and a wait for a specialist should not exceed 30 days. The NHIF now has publicly available information on waiting times for individual providers and specialties. This shows that in 2022 about one in ten patients were waiting longer than 14 days for a GP appointment, and most patients had to

wait more than 14 days for a dentist (66 %) or a psychiatrist (81 %) appointment. In specialist care, there are consistently longer waiting times for many types of care, including over 30 days for 27 % of oncology, 29 % of neurology and 40 % of cardiology patients.

The key driver of waiting lists – the impact of the pandemic notwithstanding – is the limited availability of healthcare workers (see Section 4). An online early registration system, available for both patients and providers, now allows users to see waiting times and book planned care consultations with providers that have better availability. To improve efficiency, from April 2023 additional funding has been granted to the NHIF to increased tariffs for consultations that provide multiple interventions.

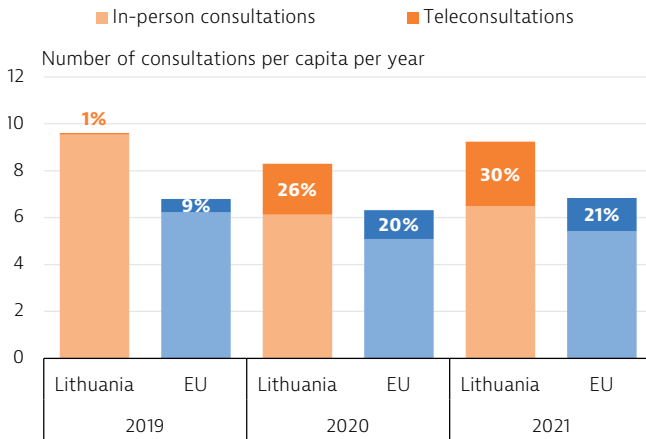
The COVID-19 pandemic prompted major shifts in digitalisation

Digitalisation in the health sector became a major focus in Lithuania during the COVID-19 pandemic. The use of teleconsultations expanded rapidly early in the pandemic from 1 % in 2019 to 26 % in 2020 and 30 % in 2021, compared to the EU average of 21 % in the latest year (Figure 17). Substantial progress has been achieved in digitalising health records and reporting, with nearly all referrals,

³ Catastrophic expenditure is defined as household OOP spending exceeding 40 % of total household spending net of subsistence needs (i.e. food, housing and utilities).

prescriptions, patient records, and birth and death certificates now done electronically. However, there are currently multiple systems, often with overlapping functions, some of which may lack user-friendliness and add to administrative burdens.

Figure 17. Teleconsultations with doctors in Lithuania grew significantly during the pandemic



Source: OECD Health Statistics 2022 (for in-person consultations) and national sources (for teleconsultations); Eurostat Database.

5.3 Resilience

The COVID-19 pandemic has proved to be the most significant disruption to health systems in recent decades. It has shed light on the vulnerabilities and challenges within countries' emergency preparedness strategies and on their ability to provide healthcare services to their populations. In response to the enduring effects of the pandemic – as well as other recent crises, such as cost-of-living pressures and the impact of conflicts like the war against Ukraine – countries are implementing policies to mitigate the ongoing impacts on service

delivery, invest in health system recovery and resilience, improve critical areas of the health sector, and fortify their preparedness for future shocks.

Service delivery was disrupted and is yet to return to pre-pandemic activity levels

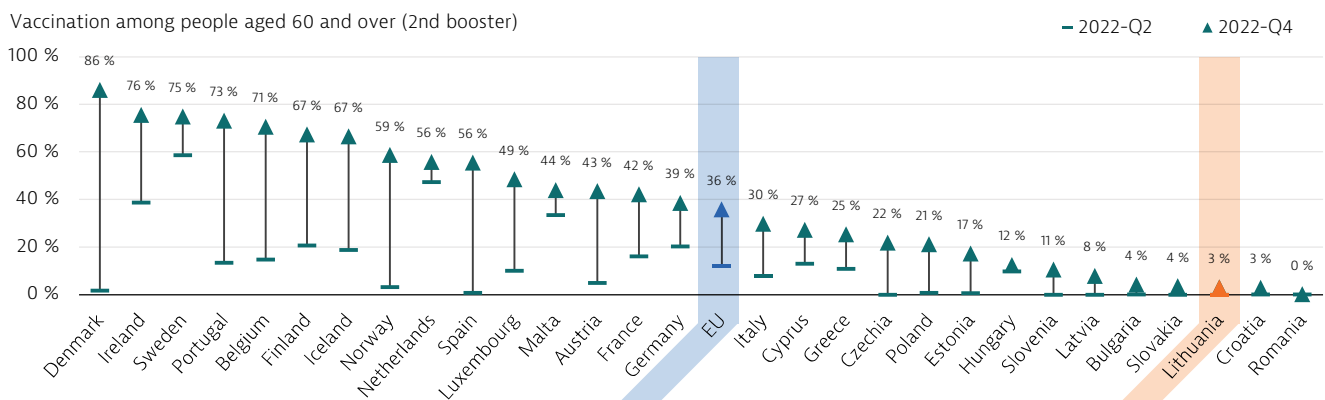
While the health system was coping with the COVID-19 pandemic, many elective services were postponed during 2020 and 2021, resulting in a sharp drop in hospitalisations and occupancy rates, and almost tripling waiting times for knee replacements to 360 days and hip replacements to 210 days on average. The share of patients waiting longer than 10 days for a GP appointment increased from 18 % in 2017 to 24 % in 2021, and the share waiting longer than 20 days for a specialist appointment increased from 47 % to 64 % in the same period (National Audit Office, 2022).

The number of outpatient visits also dropped markedly in 2020. By 2022, the scope of specialist services was largely restored, although GP visits had not yet recovered. On the other hand, emergency medicine consultations did not reduce during the pandemic, and have increased since 2020 (Hygiene Institute, 2023).

Older people in Lithuania are less well protected from new waves of COVID-19

The rollout of the COVID-19 vaccination in the initial few weeks of 2021 was rapid, and 79 % of adults were immunised according to the primary regimen. However, booster rates for vulnerable people lag far behind rates in most EU countries. This leaves Lithuania among the countries with the lowest coverage of people aged 60 and over who received a second booster in late 2022, at only 3 % compared to the EU average of 36 % in (Figure 18).

Figure 18. Most Lithuanians aged 60 and over have not received a second COVID-19 booster



Note: The EU average is unweighted.
Source: ECDC.

Continuous growth in public funding reflects a strong commitment to investing in health

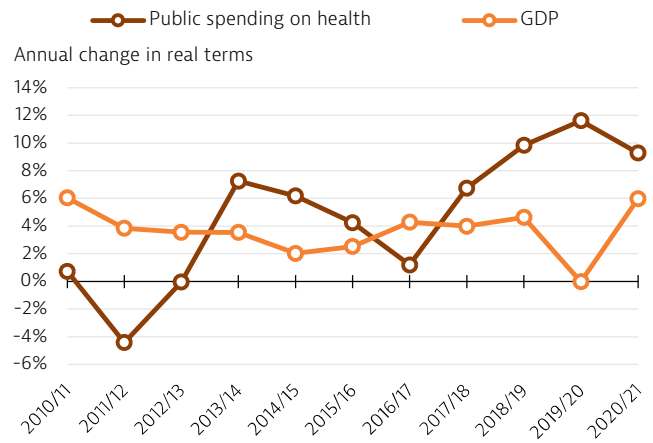
Although public spending on health as a share of GDP remains relatively low (see Section 4), investment in health has been growing steadily. With the exception of a drop during 2008-12 in the aftermath of the global economic crisis, growth in public spending on health usually exceeded that of GDP, averaging at 6 % in 2013-19. In response to the COVID-19 pandemic, more funds became available, including from the NHIF reserve.

In 2020, Lithuania experienced a smaller than expected drop in GDP (with zero growth), while public spending on health grew by 12 % (Figure 19). In 2021, growth in public spending on health was sustained (9 %), while GDP grew by 6 %. Nearly EUR 560 million was allocated to the health sector for the pandemic response in 2020-21, with about EUR 460 million spent. Of this, EUR 310 million was allocated from the state budget, EUR 189 million from the government reserve and EUR 57 million from EU structural funds. Providers received about EUR 112 million to cover bonuses for health workers providing COVID-19 services, implementation of testing and vaccination programmes, and purchase of equipment for COVID-19 treatment (National Audit Office, 2022).

The Recovery and Resilience Plan allocates investment to modernising key health system infrastructure

The Lithuanian Recovery and Resilience Plan allocates some EUR 257 million to the health sector. Key priorities are improving the quality and accessibility of care and promoting innovation;

Figure 19. The health budget has increased markedly in recent years



Source: OECD Health Statistics 2023.

reforming long-term care; and strengthening health system resilience in emergency situations (Ministry of Finance, 2021). Funds have been allocated to modernising care for infectious diseases, extending digitalisation and improving emergency care infrastructure (Figure 20).

These investments will be complemented by the rollout of the EU Cohesion Policy 2021-27,⁴ through which Lithuania is set to invest a total of EUR 475 million in its healthcare system. Almost 80 % of this amount will be co-financed by the EU. Much of the EUR 321 million co-financed with the European Regional Development Fund (ERDF) will be used for improvement of health infrastructure, while the EUR 154 million co-financed with the European Social Fund Plus (ESF+) has been designated to finance various measures to improve the accessibility, quality and resilience of health services.

Figure 20. Lithuania plans to allocate EU funds to communicable diseases, digitalisation and emergency care



Notes: These figures refer to the original Recovery and Resilience Plan. The ongoing revision of the Plan might affect its size and composition. Some elements have been grouped together to improve the chart's readability.
Source: European Commission – Recovery and Resilience Scoreboard.

⁴ These EU Cohesion Policy figures reflect the status as of September 2023.

Efficiency improvements are planned to address longstanding health system challenges

There is scope for improving healthcare quality that, in turn, would greatly enhance efficiency through better health outcomes (see Section 5.1). The Ministry of Health (2022) has identified a number of further barriers to improving efficiency, including the uneven distribution of the health worker skill mix; the limited scope of primary, long-term and palliative care services; over-reliance on the hospital sector; slow rollout of health technology assessment; a lack of effective systems for updating reimbursable medicines lists; non-rational use of medicines; and financing mechanisms that do not encourage efficiency in service provision. In response, the ongoing structural reform (see Section 4) aims to expand the functions of primary care, optimise the network of healthcare providers, centralise ambulance services, create a model for long-term care and strengthen the health system's resilience by 2024.

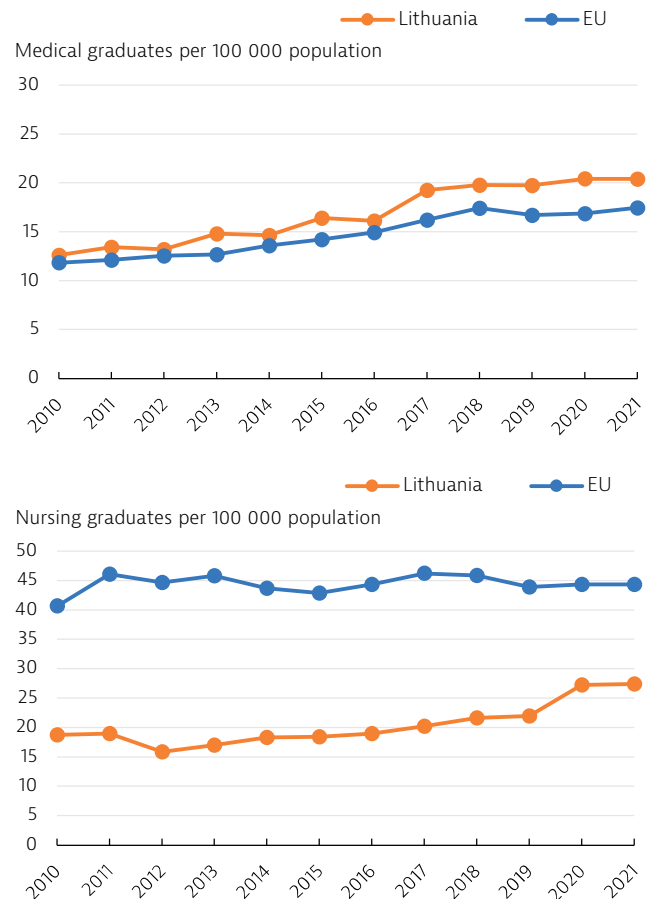
Healthcare workforce shortages and their uneven distribution may be an obstacle to achieving the reform goals

Projected shortages of healthcare workers by 2030 are substantial – particularly of nurses (more than 3 000), and of GPs and internal medicine physicians (over 800) – but the unequal distribution of the healthcare workforce across regions is also an issue. The National Audit Office (2023b) suggests that half of municipalities and a quarter of providers have no planning mechanisms to ensure enough nurses, and health workforce data collected at the sub-national level are unreliable. These factors might challenge the implementation of desired reforms aimed at strengthening health system resilience. Mechanisms that can support better planning at the national level have been improved (such as forecasting and data on waiting times), as have financial and social incentives to attract medical graduates to rural areas, but some municipalities are already experiencing critical health workforce shortages, and forecasts do not reflect expectations of the current reform.

The intake of nursing students has been growing in recent years, with the number of graduating nurses steadily rising from 474 in 2012 to 768 in 2021. Nevertheless, with 27 nursing graduates per 100 000 population in 2021, the supply of graduate nurses in Lithuania is well below EU average of 44 per 100 000, while the supply of graduate doctors exceeds that of the EU average (Figure 21).

To counter shortages, nurses' salaries increased by 63 % (and those of doctors by 54 %) between 2018 and 2021, reflecting both efforts to improve staff retention and the impact of temporary bonus payments for staff working with COVID-19 patients. The need to improve working conditions and address the well-being and mental health needs of healthcare workers is well recognised (see Section 6), but the scale of improvement required does not yet match the gap.

Figure 21. Lithuania trains fewer nurses than EU on average



Note: The EU average is unweighted.

Sources: OECD Health Statistics 2023; Eurostat Database.

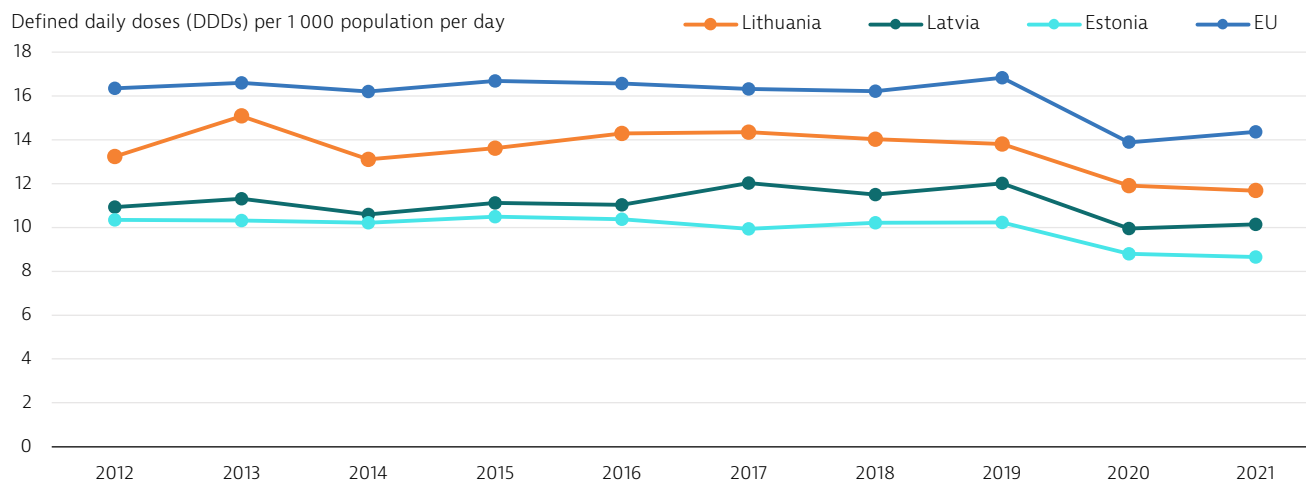
Surveillance has been strengthened to tackle antimicrobial resistance

Antimicrobial resistance (AMR) is a major public health concern in the EU, with estimates of about 35 000 deaths in the EU and European Economic Area (ECDC, 2022) due to antibiotic-resistant infections and healthcare-associated costs of around EUR 1.1 billion per year (OECD/ECDC, 2019). In Lithuania, total antibiotic consumption in 2021 (14 defined daily doses (DDDs) per 1000 population) was below the EU average (17 per 1000), due to the relatively low consumption level in the

community, which stood at 11.7 DDDs per 1 000 population in Lithuania and 14.4 DDDs on average in the EU (Figure 22). Nevertheless, consumption in healthcare institutions has been among the highest in the EU. To strengthen hospital infection

monitoring, a unified information system was introduced in 2020, and since 2022, hospital infection data reporting is mandatory for all inpatient providers.

Figure 22. Antibiotic consumption in the community in Lithuania is below the EU average



Note: The EU average is unweighted.

Source: ECDC ESAC-Net.

The COVID-19 experience has prompted recommendations to improve emergency response capacity and governance

At the initial stages of the pandemic, pre-existing excess hospital capacity allowed health authorities to designate five major hospitals to treat all COVID-19 patients. However, this became unsustainable with an increasing number of cases, and patients were also later redistributed across other providers, but without a need to create new hospital beds, as existing departments were re-designated. Intensive care unit capacity allocated to COVID-19 patients, however, was stretched to the maximum in large centres, triggering the need to set up new intensive care beds. Among the key recommendations of the National Audit Office (2022) on how the health system responded during the emergency is the need to improve governance and management capacity in emergency situations, as well as to strengthen regulations allowing the health system to utilise resources from private providers, contracted by the NHIF, during emergencies.

The EU Regulation on serious cross-border threats to health can serve as an impetus for better emergency preparedness

The pandemic has highlighted the need for better emergency preparedness for future shocks. Lithuania's Health Emergency Situation Centre has

an obligation to revise emergency preparedness plans annually. In 2022, the Ministry of Health assessed a number of emergencies as "very high probability" events: extreme weather events, forest fires, emergencies at sea, cyberattacks and mass influx of migrants (ESSC, 2022). The 2022 EU Regulation on serious cross-border threats to health requires a set of measures at the national and EU levels, which would enable countries to prevent, prepare for and manage cross-border health threats; its implementation in Lithuania remains in the very early stages.

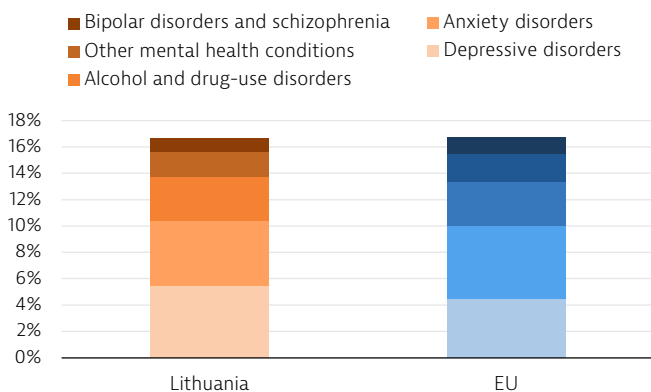
6 Spotlight on mental health

The burden of mental health issues in Lithuania is high

Although there are significant gaps in information about the prevalence of mental ill health in Lithuania, as in other EU countries, available evidence suggests that mental health issues affect many Lithuanians. The economic costs of poor mental health are substantial, with direct and indirect costs estimated at 2.6 % of GDP in Lithuania or nearly EUR 1 billion in 2015 (OECD/EU, 2018).

According to estimates from the Institute for Health Metrics and Evaluation (IHME), one in six people in Lithuania had a mental health issue in 2019, which is equivalent to about 450 000 people. The proportion of the population with a mental health issue in Lithuania (16.3 %) was similar to the EU average (16.7 %). The most common mental disorders in Lithuania are depressive disorders (estimated to affect 5.4 % of the population), anxiety disorders (5.0 %) and alcohol and drug-use disorders (3.3 %) (Figure 23).

Figure 23. Depression, anxiety and alcohol and drug-use disorders are the main mental health issues in Lithuania



Note: The EU average is unweighted.
Source: IHME (data refer to 2019).

Depression is reported more often by women and people in the lowest income group

Data from the European Health Interview Survey (EHIS) in 2019 show that 7 % of Lithuanian adults reported experiencing depression before the pandemic. It was reported more often by women and people in the lowest income quintile. About 9 % of women reported depression in 2019, compared to 5 % of men, and both women and men

in the lowest income quintile were over eight times more likely to report depression symptoms than those in the highest.

The links between low income and poor mental health persisted throughout the COVID-19 pandemic. Survey data collected during the pandemic show that those in precarious financial circumstances were at significantly heightened risk of depression (Eurofound 2021; 2022).

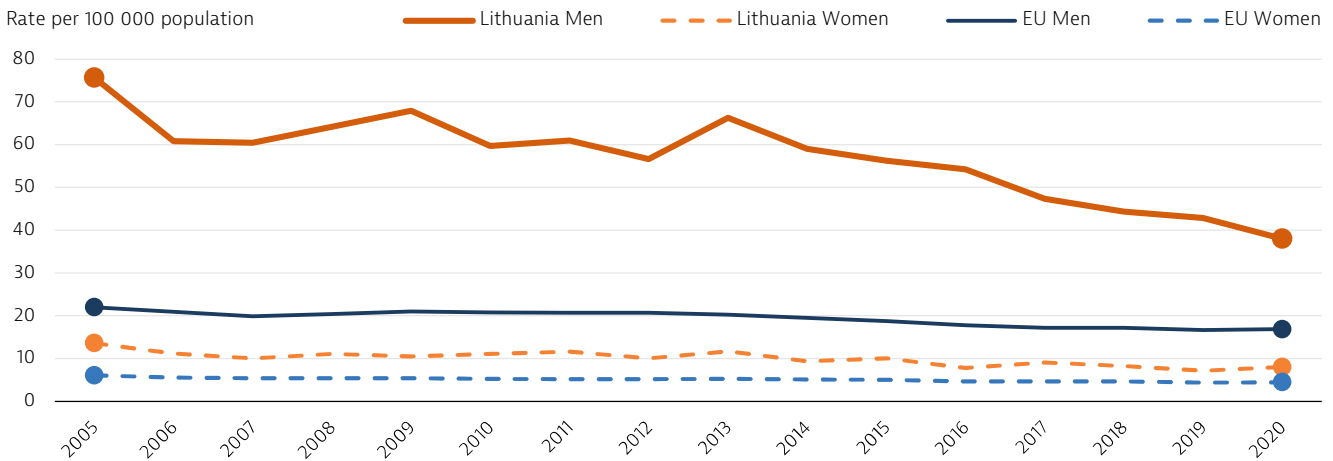
The suicide rate in Lithuania has decreased, but it remains highest in the EU

While complex social and cultural factors affect suicidal behaviours, mental health problems increase the risk of suicide. Progress has been made in reducing historically high suicide rates in Lithuania, particularly among men, but they nevertheless remain the highest in the EU. While there was some concern that suicide rates would increase during the pandemic, this was not seen in Lithuania in 2020 (Figure 24). The National Suicide Prevention Action Plan 2020-24 aims to reduce suicide mortality rates through preventive work with vulnerable groups, and ensuring better access to services for people at risk of self-harm. Moreover, in 2018 a care pathway for people in acute crisis was introduced, allowing access to specialist services within 24 hours, and requiring all municipalities to develop suicide prevention plans.

COVID-19 has increased the mental health burden on the public and among health professionals

A National Audit Office evaluation report (2021) devoted to reducing the impact of COVID-19 on mental health has shown that the burden of mental ill health increased during the pandemic, with substantially more people reporting being stressed or feeling anxiety, anger and sadness. There was a 17 % increase in visits to primary mental healthcare providers in 2020 compared to 2019, and the waiting time for children to get an appointment with a psychiatrist increased: the share of children seen within a week dropped from 75 % in 2019 to 57 % in 2021. Early in the pandemic, the government introduced a free hotline for psychological support, mobile crisis intervention teams and funding for provision of primary mental health services in public health bureaus in addition to existing services in health centres.

Figure 24. Although it has fallen, the suicide rate among Lithuanian men remains very high



Source: Eurostat Database.

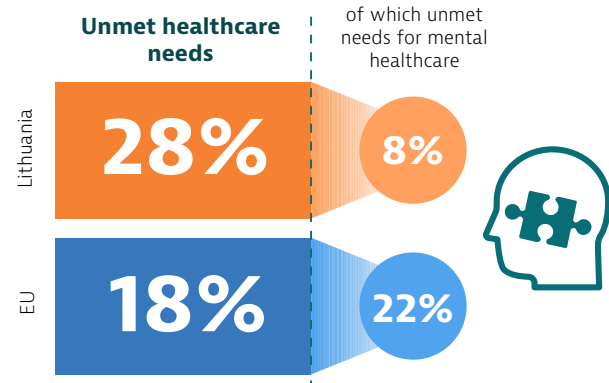
More attention has also been paid to health workforce well-being and mental health. In addition to increased levels of stress from the COVID-19 pandemic, longstanding issues of poor working conditions among healthcare providers increase pressure on health workers. Consultations by the Ministry of Health and Medical Association revealed that in 2019 three out of four health professionals suffered harassment in the workplace, while the main reasons for emotional distress were dominating hierarchical relationships, nepotism and lack of managerial skills (Ministry of Health, 2021). In response, the 2021-24 Plan on Ensuring Psychosocial Well-being in the Healthcare System seeks improvements across several areas, including harassment reporting systems, education and training, and access to mental health support.

A substantial number of people reported unmet needs for mental healthcare during the pandemic

Following implementation of Lithuania’s Mental Health Strategy (2007), mental health services have been integrated into primary care services in an attempt to shift away from inpatient care. Primary and much of secondary outpatient mental healthcare is organised by municipalities and is usually delivered in primary mental healthcare centres, which are often co-located with primary care practices and can be accessed without a referral. Primary mental healthcare centres are configured to deliver multidisciplinary support, but in practice resource and capacity constraints limit the type of care that can be delivered. As a result, there are relatively long waiting lists and people with severe mental health conditions are often referred to inpatient psychiatric care.

As in many other EU countries, a number of Lithuanians reported unmet needs for mental healthcare during the pandemic. According to a Europe-wide survey carried out in spring 2021 and spring 2022, 28 % of Lithuanians reported unmet needs for healthcare, of which 8 % was related to mental healthcare (Figure 25).

Figure 25. Some unmet healthcare needs during the pandemic were for mental healthcare



Note: Survey respondents were asked whether they had any current unmet healthcare needs and, if so, for what type of care, including mental healthcare.

Source: Eurofound (2021; 2022).

Lithuania has a range of policies in place to strengthen mental health and mental healthcare

The Lithuanian Health Protection and Promotion Development Strategy 2022-30 includes improving mental health as one of its priorities. In addition, in 2021 the Ministry of Health launched a multi-sectoral effort promoting mental health literacy, reducing stigma around mental health conditions and encouraging help seeking behaviour, with the ultimate aim of bringing suicide mortality down to the level of EU average.

7 Key findings

- Population health has been affected very negatively by the pandemic, with a substantial drop in life expectancy due to COVID-19, while the pre-existing very high burden of cardiovascular disease persists. Average life expectancy at birth fell to 74.2 years in 2021 before recovering to 76 years in 2022, which is almost 5 years below the EU average.
- High rates of alcohol and tobacco consumption among men contribute to higher mortality rates and lower life expectancy. Despite a drop in overall levels of smoking among adolescents, the increasingly common use of electronic cigarettes and vapes among children is a growing concern, and there have been calls for better regulation and action to tackle the easy accessibility of vaping products for children.
- Public spending on health increased to 5.4 % of GDP in 2021, reflecting not only investment in the COVID-19 response but also a consistent increase in public funding for health. At the same time, out-of-pocket spending remained very high, mostly driven by household payments for medicines and dental care. In response, there has been a significant expansion in coverage of outpatient prescription medicines for the treatment of certain conditions, including cancer and cardiovascular diseases.
- A major restructuring was initiated in 2022 that aims to create a new model of service provision in primary care and reorganise the hospital network, with a view to improving the quality and accessibility of services. For the reforms to achieve their goals, the key challenges relate to whether there is sufficient clarity about restructuring the hospital network, ensuring co-operation with stakeholders (particularly general practitioners) and overcoming longstanding health workforce issues.
- Projected shortages of healthcare workers – particularly of nurses, general practitioners and certain medical specialties – remain an engrained issue, along with uneven healthcare workforce distribution across regions. Some improvement in retention and planning was seen at the national level, but many municipalities and providers still lack planning mechanisms. Updated forecasts provide a better idea of future demand, but they do not account for sub-national differences or the additional expectations brought about by the current reform, which promises to improve accessibility.
- High levels of treatable and preventable mortality, avoidable hospitalisations and in-hospital mortality show persistent challenges to improving access and effectiveness of healthcare and public health services in Lithuania. The planned reform suggests that strengthening primary care and optimising specialist care is currently a key priority. Investing in improved service quality and accessibility through the Recovery and Resilience Plan and EU Cohesion Policy should also contribute to improved efficiency of the health system, along with strengthening capacity for health technology assessment, aiming for more rational use of existing resources and continuing digitalisation.
- Health system resilience has been tested during the pandemic, with capacity to care for COVID-19 patients stretched at peak times, while planned services and preventive programmes had to be postponed. By 2022, full service utilisation had not yet been restored to pre-pandemic levels across specialties. Some evaluations seeking to learn lessons from the pandemic have been carried out. Ensuring preparedness for future shocks remains a priority, and the 2022 EU Regulation on serious cross-border threats to health can serve as an impetus for stronger emergency preparedness.
- The government has expanded mental health services at the primary care level and provided additional funding to mitigate the impact of the pandemic. The suicide rate has been falling steadily over the past decade, and did not increase during the pandemic, although it remains very high – especially for men.

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Country abbreviations

Austria	AT	Denmark	DK	Hungary	HU	Luxembourg	LU	Romania	RO
Belgium	BE	Estonia	EE	Iceland	IS	Malta	MT	Slovakia	SK
Bulgaria	BG	Finland	FI	Ireland	IE	Netherlands	NL	Slovenia	SI
Croatia	HR	France	FR	Italy	IT	Norway	NO	Spain	ES
Cyprus	CY	Germany	DE	Latvia	LV	Poland	PL	Sweden	SE
Czechia	CZ	Greece	EL	Lithuania	LT	Portugal	PT		

State of Health in the EU

Country Health Profile 2023

The *Country Health Profiles* are a key element of the European Commission's *State of Health in the EU* cycle, a knowledge brokering project developed with financial support from the European Union.

These Profiles are the result of a collaborative partnership between the Organisation for Economic Co-operation and Development (OECD) and the European Observatory on Health Systems and Policies, working in tandem with the European Commission. Based on a consistent methodology using both quantitative and qualitative data, the analysis covers the latest health policy challenges and developments in each EU/EEA country.

The 2023 edition of the Country Health Profiles provides a synthesis of various critical aspects, including:

- the current state of health within the country;
- health determinants, with a specific focus on behavioural risk factors;
- the structure and organisation of the health system;
- the effectiveness, accessibility and resilience of the health system;
- For the first time in the series, an account of the state of mental health and related services within the country.

Complementing the key findings of the Country Health Profiles is the Synthesis Report by the European Commission.

For more information, please refer to: ec.europa.eu/health/state

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