

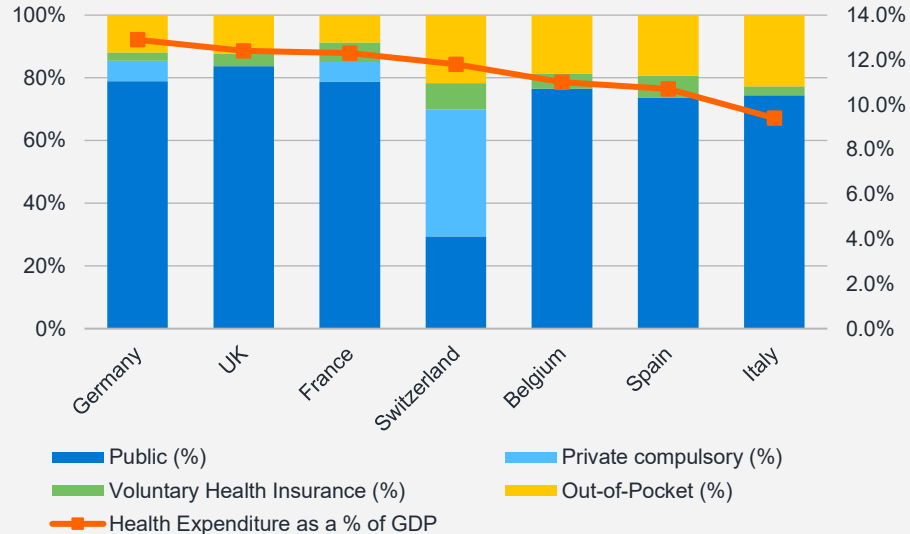
This article provides an overview and analysis of healthcare system structures, financing models, access, cost trends, and key health challenges across seven countries (Belgium, France, Germany, Italy, the United Kingdom, Spain, and Switzerland), leveraging open data available in each market.

- European healthcare systems share the common ambition of providing universal coverage and high-quality care, yet they differ substantially in how they are financed, organized, and accessed.
- While some countries rely primarily on tax-funded national schemes and others on social or private insurance models, all face similar pressures: growing demand for chronic disease management, widening inequalities in access, and persistent workforce and infrastructure challenges.
- At the same time, health spending continues to rise, driven by technological innovation, population aging, and the expanding burden of mental and long-term conditions—raising important questions about efficiency, affordability, and future reform.
- In all geographies, insurers are now developing services that go beyond traditional insurance coverage, leveraging innovation to offer concrete solutions to challenges such as access to care, tailored care pathways, and preventive health measures.
- Germany, the U.K., and France spent the most on healthcare as a % of GDP (≈12%–13%) in 2021. Public funding dominates in most countries (U.K., France, Spain, Italy, Belgium, and Germany), while Switzerland relies heavily on private insurance.

## Overview on healthcare systems

COUNTRY	COVERAGE MODEL	FUNDING SOURCES	ROLE OF PRIVATE INSURANCE
Belgium	Compulsory insurance	Social security, copayments, private insurance	For extra benefits
France	Universal, mandatory	Social security (public), complementary insurers, out-of-pocket	Compulsory for employees and widely used for extra coverage
Germany	Universal, statutory/private	Income-based contributions, private insurance, out-of-pocket	For higher earners; supplements
Italy	Universal, regionally run	Taxes (public), out-of-pocket, private insurance	Limited; regional variation
United Kingdom	Universal, tax-funded (NHS)	Taxes (public), optional private insurance, out-of-pocket	Optional for quicker access and greater choice
Spain	Universal, tax-funded	Taxes (public), private insurance, out-of-pocket	For faster access, extra services
Switzerland	Mandatory private insurance	Individual premiums, deductibles, subsidies, out-of-pocket	For non-basic services

## Overview on spending (2021)



Source: [WHO](#)

- Belgium operates a compulsory health insurance system, primarily funded through income-based social security contributions. Every resident must register with a health insurance fund (“mutualité”/“ziekenfonds”) to be reimbursed for medical expenses. Residents are free to choose their fund, and all approved funds must accept eligible applicants.
- Healthcare is not entirely free: Patients typically pay providers directly and are later reimbursed for part of the cost by their health fund. The remaining portion—the copayment (“remgeld”/“ticket modérateur”)—is paid out of pocket by the patient. Reimbursement rates depend on the type of care, whether the provider is conventioned (i.e., has agreed to official fee schedules), and the patient’s income level.
- In addition to the mandatory scheme, individuals may purchase supplementary insurance for broader benefits (in terms of type and quality of care) and higher reimbursements, either through the health fund or private insurers. Social security contributions that finance the basic system are income-based, while premiums for supplementary insurance depend on factors such as age and coverage level.
- Patients have free choice of doctor, specialist, hospital, or clinic. Non-conventioned providers may charge fees above official rates; these extra costs are not reimbursed and are borne by the patient unless covered by private insurance.

## Accessibility

Belgium’s healthcare system offers **broad coverage**, with 99% of the population insured, and generally **low levels of unmet medical needs** (1.0% compared to the EU average of 2.2%). However, cost pressures, waiting times, and regional disparities continue to affect equitable access to care.

**Financial inequalities** persist, as 2.8% of the lowest-income group report unmet medical needs, compared to 0% among the highest-income group. **Significant out-of-pocket (OOP) costs**, ranging from 17% to 18%, can create additional barriers, especially for low-income households. Beyond financial challenges, **long waiting times**, particularly in mental health services, remain a concern. Furthermore, **regional differences** in service availability contribute to unequal access.

During the COVID-19 **pandemic**, access to elective and specialist care declined, and OOP expenses increased, with lower-income households being affected the most.

Source : [OECD Belgium: Country Health Profile 2023](#)

## Health expenditure trend

FIGURE 1: HEALTH SPENDING, SHARE OF GDP (2021)

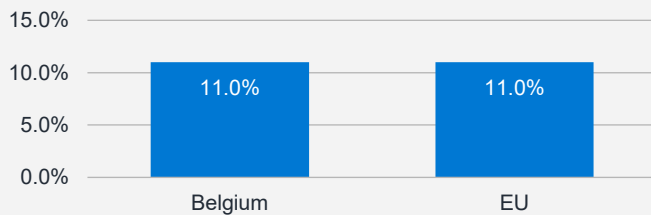
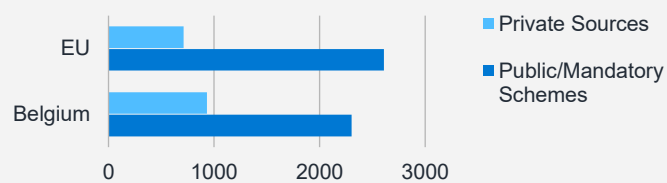


FIGURE 2: PUBLIC VS. OUT-OF-POCKET HEALTH AVERAGE EXPENDITURE PER PERSON, 2021 (EUROS)



Source: [OECD Belgium: Country Health Profile 2023](#)

According to data from 2021, Belgium allocates roughly **11% of its GDP to health**, which is consistent with the EU average. However, Belgium stands out for its relatively high per capita health expenditure compared to other European countries.

A key strength of the Belgian system is **its nearly universal coverage**: Approximately 99% of residents are protected by compulsory public health insurance. This widespread coverage, complemented by supplementary insurance options, provides strong financial protection and helps keep out-of-pocket (OOP) costs for essential healthcare services relatively low for most people.

Nonetheless, **OOP payments** account for **17%–18% of total health spending** and focus mainly on dental care, outpatient medicines, and medical devices, where reimbursement rates tend to be less generous.

Despite spending caps and targeted subsidies intended to promote equity, **lower-income** households continue to experience greater financial strain and, as a result, may be forced to delay or forgo needed care.

## Private health insurance stakes

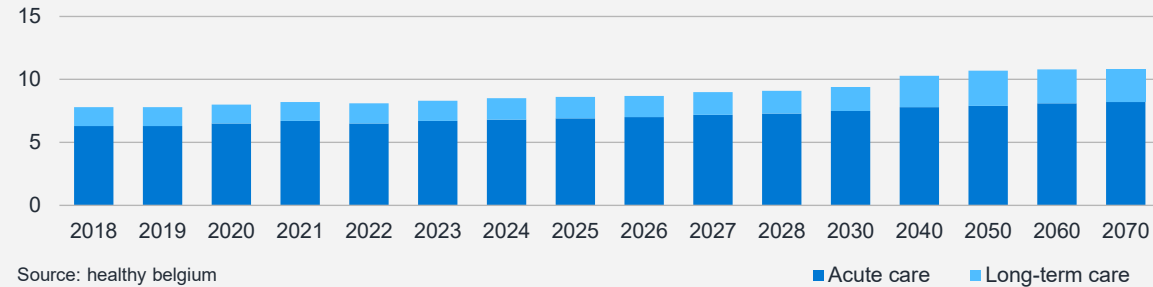
**Private health insurance** in Belgium plays a **complementary** role, enhancing comfort and financial protection for those who can afford it. It is not designed to replace the public insurance system. Its purpose is to limit OOP expenses, improve the quality of services (for example, by providing access to private hospital rooms), or ensure faster access to certain healthcare services.

Private insurance supplements Belgium’s universal public health system by covering copayments, private rooms, and nonreimbursed services such as dental, optical, or physiotherapy care. Approximately **80% of Belgians** hold some form of hospitalization or supplementary health insurance, which is often provided through mutualities or employer-based group plans.

Participation in private health insurance is generally **voluntary**. For most contracts, premiums depend on age and the level of coverage. Because participation is voluntary and **lower-income groups** are less likely to afford private insurance, strengthening financial protection and reducing inequalities remains a key focus for Belgium.

## Overview on costs

FIGURE 3: PUBLIC EXPENDITURE ON ACUTE AND LONG-TERM CARE (GDP %) (2018-2022 AND PROJECTIONS 2023-2070)

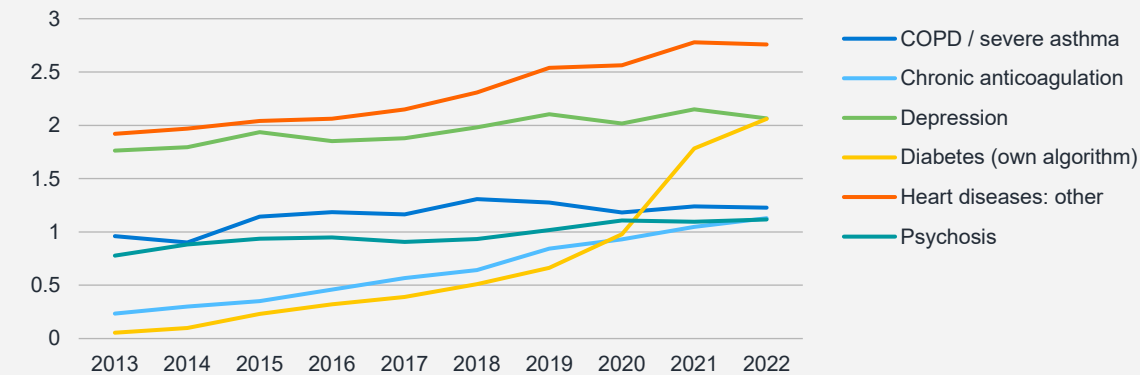


Source: healthy belgium

- In 2022, public health expenditure was **€44.0 billion** (8.0% of the GDP), mostly for acute care.
- Public health spending is projected to rise to 10.7% of GDP by 2050 and 10.8% by 2070. Long-term care expenditure will nearly double as share of GDP, exceeding the EU average.
- This is compensated by lower public expenditure on acute care than the EU average.

The chart below highlights the **diseases with the highest expenditure** and **illustrates the inflation-adjusted evolution of costs over time**.

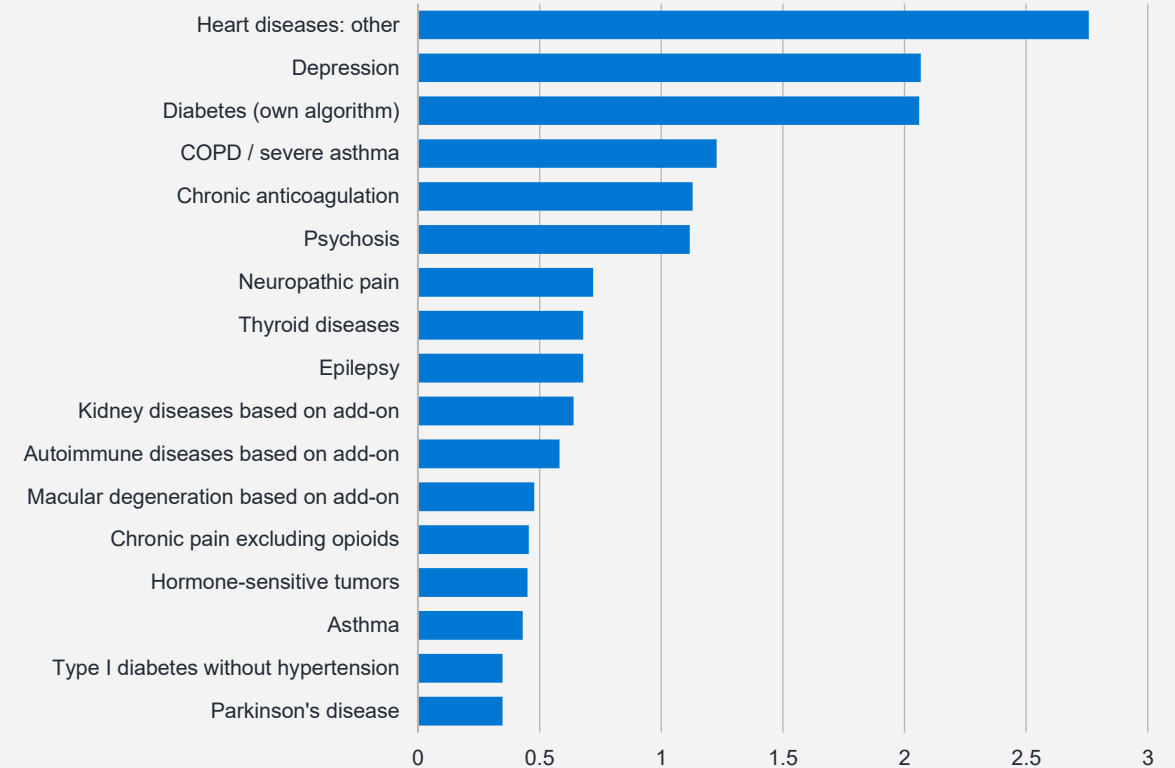
FIGURE 4: EVOLUTION OF DIRECT MEDICAL COSTS FOR MAIN CONDITIONS, ADJUSTED FOR INFLATION, BELGIUM, 2013-2022 (BILLIONS OF EUROS)



Source: healthy belgium

## Overview on pathologies

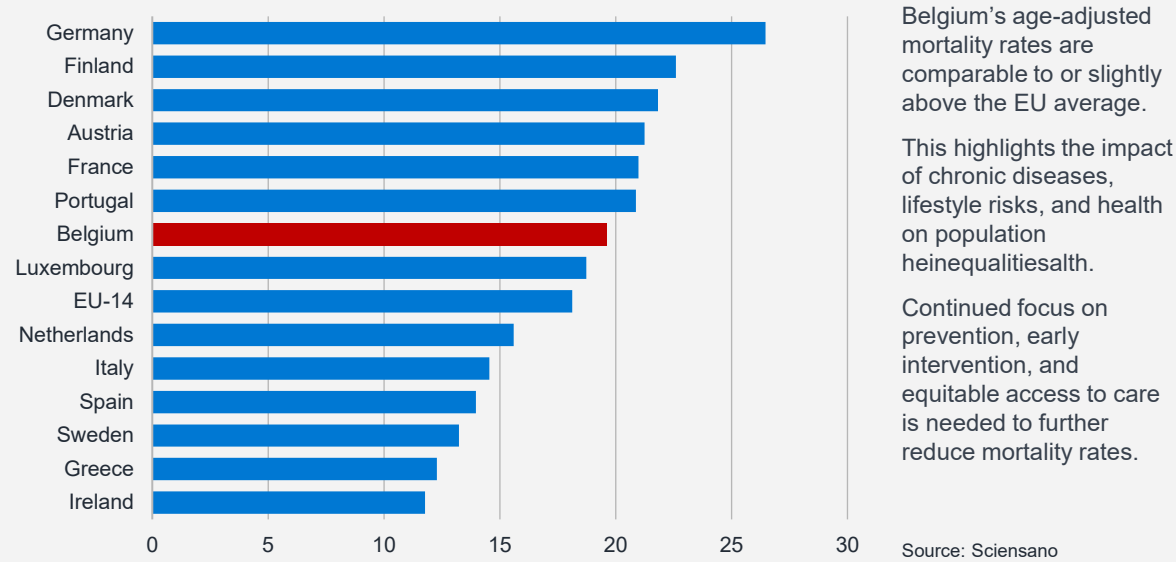
FIGURE 5: RANKING OF DIRECT MEDICAL COSTS FOR MAIN CONDITIONS, BELGIUM, 2022 (BILLIONS OF EUROS)



Source: healthybelgium

- **Direct medical costs** include all expenses related to **hospital admissions, outpatient visits, and reimbursed medication use**.
- **Diseases with the highest direct medical costs include heart disease, depression, diabetes, and asthma, reflecting lifestyle and environmental factors.**

FIGURE 6: AGE-ADJUSTED MORTALITY RATES PER 100,000, BY COUNTRY OF RESIDENCE (EU-14), 2021



## Chronic diseases and lifestyle-related risk factors

- Above-EU-average rates of alcohol consumption, drug use, and obesity influenced by social and cultural factors.
- Drug abuse tends to be less stigmatized in Belgium than in many other European countries and is more common among men, younger adults, full-time workers, and those with lower education levels.
- Smoking rates remain a concern, particularly among certain population groups.
- These factors contribute to avoidable morbidity and healthcare costs.

FIGURE 8: DRUG USERS AND EDUCATION LEVEL (%)

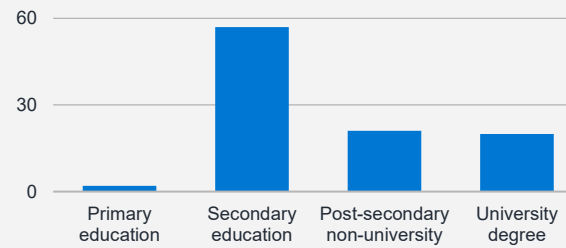


FIGURE 9: DRUG USERS AND EMPLOYMENT (%)

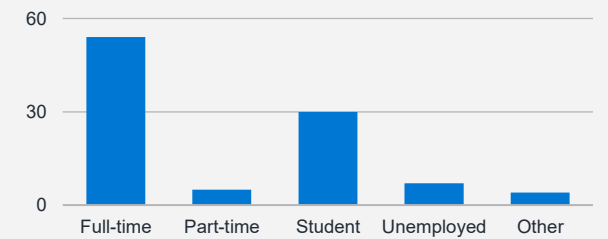
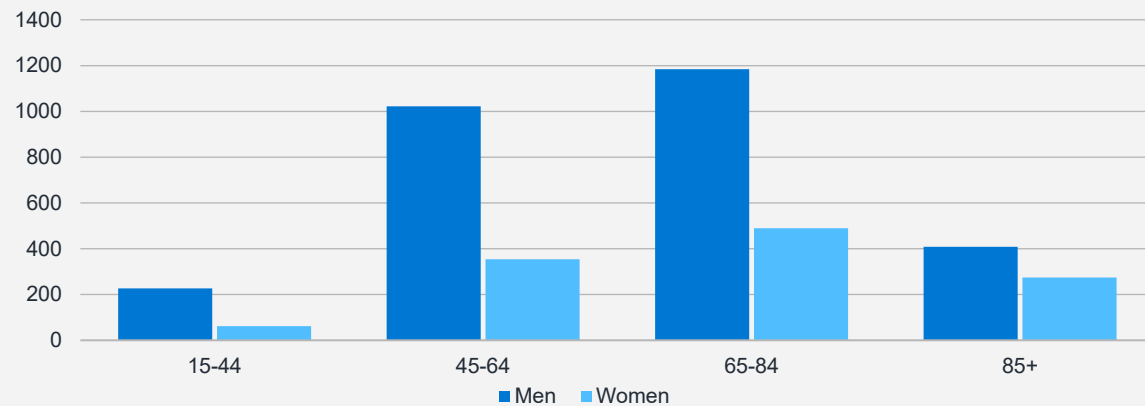


FIGURE 7: DISTRIBUTION OF ALCOHOL-ATTRIBUTABLE DEATHS, BY AGE AND SEX, BELGIUM, 2021



## Challenges relatively specific to Belgium

- **Complex and fragmented healthcare system (federal/regional structure):** Cooperation between different levels of care and regions remains a major challenge.
- **Large regional and socioeconomic health disparities:** Health differences between regions are larger in Belgium than in many other EU countries. There are also significant differences at the neighborhood level, especially in major cities. Socioeconomic inequality is directly reflected in life expectancy and disease prevalence.
- **High hospital admission rates and length of stay:** There is a strong hospital-oriented culture and relatively less emphasis on primary care and prevention compared to some neighboring countries.
- **Access to mental care:** Waiting lists and fragmentation in mental health care are recurring issues; reforms have been initiated, but integration with other types of care remains difficult.

Sources:

- Sciensano: Health statistics Belgium
- OECD Belgium country Health Profile 2023
- HealthyBelgium.be

- The French health system is universal and funded by compulsory social security contributions. All residents are eligible for public health coverage, ensuring broad access to care. Healthcare is delivered by a mix of public hospitals, private clinics, and self-employed medical professionals—most of whom are contracted to provide services at regulated fees.
- Health insurance is mandatory. Basic coverage (via Assurance Maladie) reimburses the main part of standard care; private insurers cover the rest (e.g., dental and optical care, which are poorly reimbursed by the public system). Since 2016, all private-sector employers are required to offer complementary health insurance to their employees, and around 95% of the population is covered.
- The market is dominated by mutuelles (nonprofits), with some for-profit insurers also active. Regulation strongly applies to so-called responsible contracts, which account for most of the market. These must comply with minimum coverage requirements and the principle of solidarity (no medical risk selection and community-rated contributions).

## Health expenditures trends

FIGURE 10: HEALTH SPENDING, SHARE OF GDP (2021)

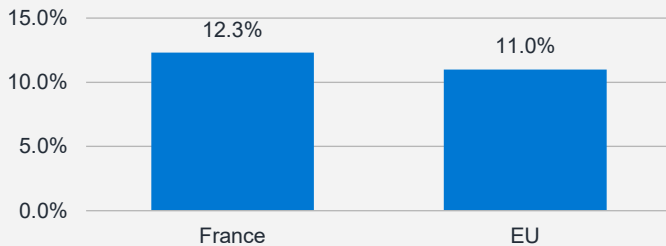
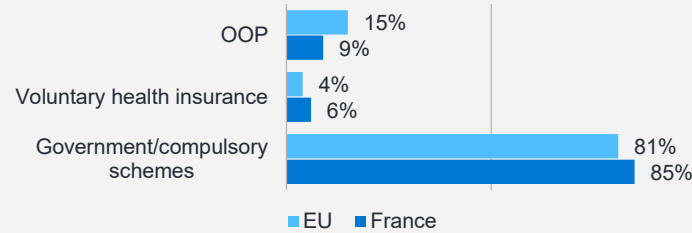


FIGURE 11: HEALTHCARE EXPENDITURE DISTRIBUTION IN FRANCE (2021)



Source: [OECD France: Country Health Profile 2023](#)

**France ranks among the highest health spenders in Europe.** In 2021, total health expenditure amounted to **12.3% of GDP**, one of the highest levels in Europe (second only to Germany). In absolute terms, spending has continued to rise steadily: **Current health expenditure reached about €333 billion in 2024<sup>1</sup>** (all payers combined), representing a year-on-year increase of **3.6%** (compared to 2.0% inflation).

The **public sector** (Assurance Maladie) finances most of the spending, while **complementary insurers** and **households** cover the remainder. In recent years, public insurance and complementary insurers have slightly increased their share of total costs, partly due to reforms such as **“100% Santé” (2019–2021)**, which expanded coverage for dental, optical, and hearing care with no OOP spending. As a result, the **share of household OOP spending** has declined: In 2024, it represented only **7.8%<sup>1</sup> of health consumption expenditure**, down from **8.4%<sup>2</sup> in 2019**.

Overall, in 2024, **state funding and mandatory insurance** together accounted for **79.4%<sup>1</sup> of total health expenditure**, while **complementary insurers** accounted for **12.8%<sup>1</sup>**.

<sup>1</sup> [Les dépenses de santé en 2024](#)  
<sup>2</sup> [Les dépenses de santé en 2023](#)

<sup>3</sup> [OECD France: Country Health Profile 2023](#)  
<sup>4</sup> [OECD health and care workforce](#)

<sup>5</sup> [info.gouv.fr](#)  
<sup>6</sup> [World Health Organization](#)

## Accessibility

**France has a lower physician density than the EU average**, with about **3.2 doctors per 1,000 inhabitants in 2021<sup>3</sup>**, compared to **4.1 per 1,000<sup>3</sup>** across the EU. The **number of general practitioners per capita** has been declining steadily over the past decade.<sup>3</sup> The **current and anticipated shortage** is exacerbated by an **aging medical workforce**—more than **40% of doctors are aged 55 and over<sup>4</sup>**.

**Access disparities** are significant. **Rural and low-density areas** are particularly affected, leading to so-called **“medical deserts.”** In 2024, 6 million French people did not have a regular general practitioner, and **87% of the territory** was classified as a **medical desert<sup>5</sup>**. Patients in these areas often struggle to find a **regular family doctor**, and **waiting times** for some specialists exceed **three months** in many regions. At the same time, **hospital bed availability**—a key indicator of system capacity—has fallen sharply over recent decades. In 2021, there were about **5.7 beds per 1,000 inhabitants<sup>3</sup>**, still above the EU average of **4.8<sup>3</sup>** but far below France’s historical peak of **11 per 1,000<sup>6</sup>** in the early 1980s.

## Private health insurance stakes

Nearly all French residents have some form of **complementary health insurance**, and the market is mature. Most of these policies are **employer-sponsored group plans** because of a 2016 law that made it mandatory for private-sector employers to offer coverage. It will be similar in the public service because of a social protection reforms, with employer contributions gradually increasing by 2026. Most contracts are **responsible contracts**, which means they follow a **community-rating principle** and are subject to **minimum coverage standards**. The rest are individual policies, often purchased through mutual insurance associations.

The **public sector increasingly relies on complementary insurance** to cover services partially reimbursed by the public healthcare. Reforms like **“100% Santé” (2019–2021)** expanded coverage for dental, optical, and hearing care without OOP costs, but this also shifted part of the funding onto complementary insurers.

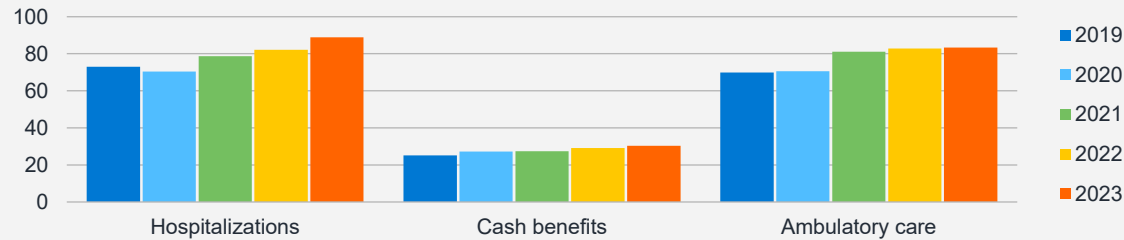
Competition between private insurers often revolves around coverage of extras (like private hospital rooms or alternative medicines). In recent years, complementary insurers have expanded into new areas. For example, many now reimburse **osteopathy or psychological therapy sessions**, which are not paid for by the public insurance, as a way to attract customers.

## Overview on costs

The cost of **public healthcare in France** has **increased** consistently in recent years.

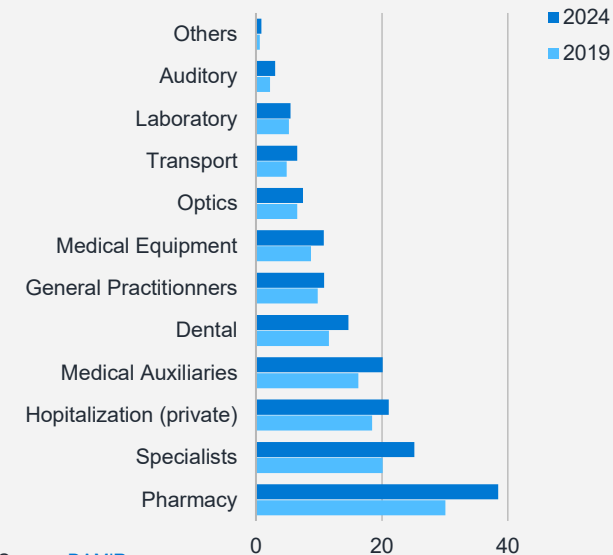
Between 2019 and 2023, the cost of **hospitalizations** has increased by 22%, **cash benefits** by 20%, and **ambulatory care** by 19%.

FIGURE 12: COST OF PUBLIC HEALTHCARE IN FRANCE (€ BILLION)



Source: [data-pathologies](#)

FIGURE 13: AMOUNTS OF EXPENDITURE PER CARE ITEM (€ BILLION)



Source: [DAMIR](#)

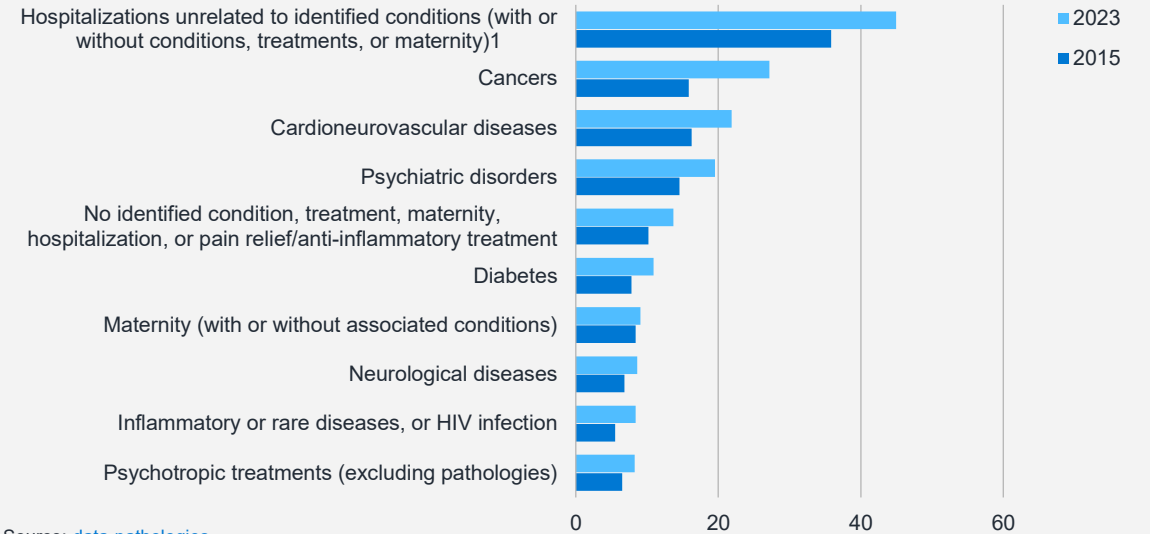
Between 2019 and 2024, several key healthcare spending categories in France have significantly increased.

**Pharmaceutical expenditures** rose 28%, driven by rising treatment volumes. **Specialist care** (+25%) and **medical auxiliaries** (+24%) reflect increased demand for chronic disease management and aging-related services. **Dental** (+27%), **optical** (+14%), and especially **auditory care** (+37%) surged following the rollout of the “100% Santé” reform, which eliminated OOP costs for selected services.

**Medical transport** spending has increased 35%. These transport services are predominantly used by elderly patients. To curb this growing expenditure, public authorities are considering reforms.

## Overview on pathologies

FIGURE 14: COST OF MAIN PATHOLOGIES (2023 VS. 2015) IN € BILLION



Source: [data-pathologies](#)

Between 2015 and 2023, the French healthcare system saw a marked rise in the cost of major pathologies. The most striking increases are observed in **cancers** (+71%, from €15.9 billion to €27.2 billion), **inflammatory or rare diseases, or HIV infection** (+52%), and **diabetes** (+39%). The prevalence of **cardiovascular and neurovascular diseases**, and **psychiatric disorders** also rose significantly, above +30%.

Currently, all services and medications directly related to a long-term condition are reimbursed at 100%, but recent discussions aim to **restrict coverage for medications deemed unrelated to the primary chronic condition**, signaling a possible partial rollback of full reimbursement in the future.

In chronic diseases, diabetes remained a focal point: 2023 data show that around **6.5% of the population<sup>2</sup>** is treated for diabetes.

1. This group includes all hospital stays unrelated to any of the 57 identified pathologies, whether the patients have one of these pathologies or none.

2. [Pathologie — Data ameli](#)

## Focus on diabetes

FIGURE 15: PREVALENCE OF DIABETES BY AGE GROUP (2023) AND EVOLUTION IN PREVALENCE BETWEEN 2015 AND 2023

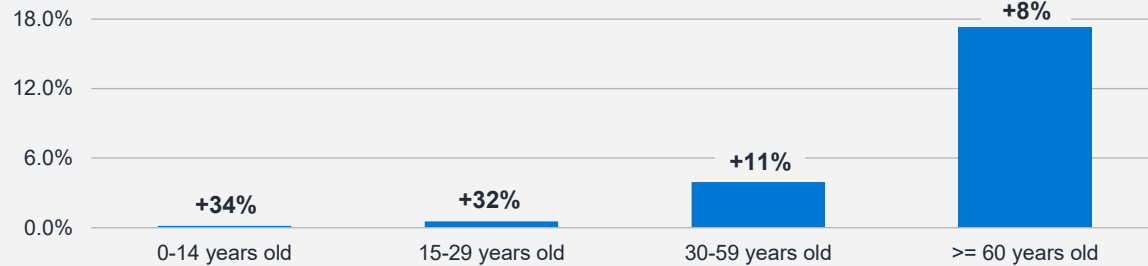
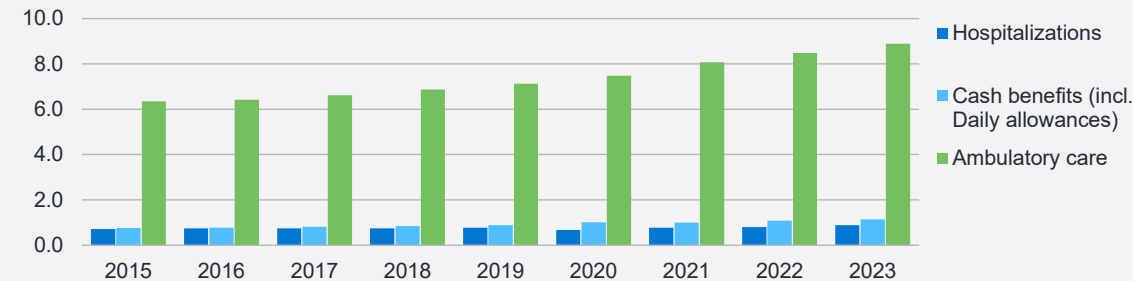


FIGURE 16: DIABETES HEALTH SPENDING (€ BILLION)



Source: [data-pathologies](#)

France is dealing with a high and rising burden of chronic diseases, which has implications for both healthcare costs and the labor market. According to national health insurance data, over **15 million people** in France<sup>1</sup> are being treated for cardiovascular diseases or related risk factors (including hypertension and high cholesterol) or diabetes.

**Elderly people** are more affected by **diabetes** (types 1 and 2 combined) than **younger people**; however, the increase in **prevalence** between **2015 and 2023** is more than **three times higher** among those ages **15–29** than among those **over 30**, which raises concerns for the future.

**Patients with chronic conditions account for a large share of healthcare utilization.** They require regular doctor visits, laboratory tests, medications, and sometimes hospitalizations for complications. **Since 2015, diabetes-related costs have risen sharply: hospitalizations by 24%, disability benefits by 44%** (including **daily allowances by 105%**), and **outpatient care (including medications) by 40%**.

## Focus on sick leave

FIGURE 17: PUBLIC REIMBURSEMENTS OF DAILY ALLOWANCES (€ BILLION)

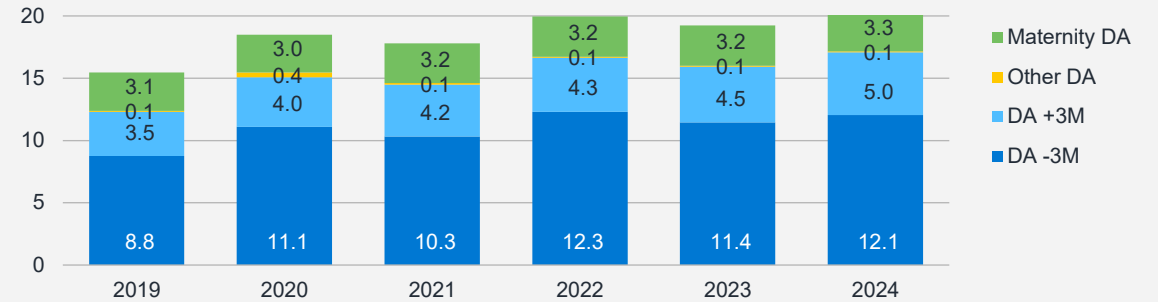
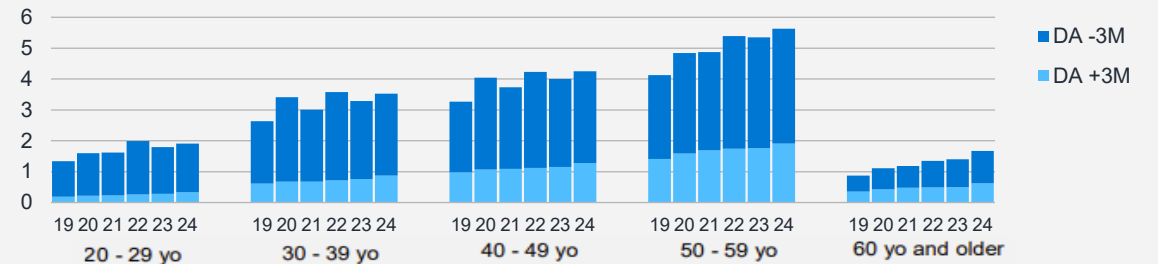


FIGURE 18: PUBLIC REIMBURSEMENTS OF DAILY ALLOWANCES (€ BILLION), BY AGE GROUP



Source: [DAMIR](#)

Between 2019 and 2024, **spending on sickness daily allowances increased significantly: absences longer than three months by 41%** and **shorter-term leaves (under three months) by 38%**.

The increase is **more pronounced among people over 60**, due to the **rising average retirement age**, and among **20–29-year-olds for long-term absences over three months**, driven by **mental health issues**.

**Mental health issues have emerged as a leading cause of long-term sick leave**, alongside musculoskeletal disorders. In response, both public authorities and insurers are intensifying efforts on **occupational health and prevention**. The government's Mon Soutien Psy programme now offers up to 12 fully reimbursed psychological support sessions per year (60% by public healthcare, 40% by private insurers), without needing a GP referral. This also includes workplace wellness programs, mental health support (some mutuelles offer confidential counseling services), ergonomics to prevent injuries, and stricter monitoring of frequent absences.

1. [sante.gouv.fr](#)

- The German healthcare system is based on the principle of solidarity, which ensures that all insured individuals have access to medical services regardless of their income. The system is divided into two main types: statutory (public) health insurance and private health insurance (full and supplementary). Only self-employed persons, civil servants, judges, or individuals whose income exceeds a certain threshold can be fully privately insured. Around 10% of the population has full private insurance.
- Contributions to statutory health insurance are income-based, while contributions to private health insurance depend on the age at entry and the selected benefits. Employees share their contributions equally with their employers. In Germany, health insurance is mandatory, so the population is covered either by statutory or private health insurance.
- A key feature of German private health insurance is the funding principle, in contrast to the pay-as-you-go system used in statutory health insurance. This approach provides independence from demographic developments.
- The basic coverage of statutory health insurance can be topped-up by supplementary insurance from private health insurers to complement state reimbursement. Almost 40% of the population has supplementary insurance.

## Accessibility

Germany has a higher physician density than the EU average, with about **4.5 doctors per 1,000 inhabitants in 2021**, compared to **4.1 per 1,000** across the EU. Physician density in Germany increased steadily, starting from **3.3 in 2000**.

There is an anticipated shortage of physicians, caused by an aging medical workforce—more than **30% of doctors are aged 55 and over**—a trend similar to that observed in the EU as a whole.

Unmet needs for a medical examination or treatment can arise due to costs, distance to the place of treatment, or waiting times. Germany ranks among the countries with **the lowest rates of unmet medical needs**, and there are almost **no differences between income groups**.

The **hospital bed availability**—a key indicator of system capacity—was about **7.8 beds per 1,000 inhabitants in 2021**, significantly above the EU average of **4.8** and considered as overcapacity.

## Health expenditures trends

FIGURE 19: HEALTH SPENDING, SHARE OF GDP (2021)

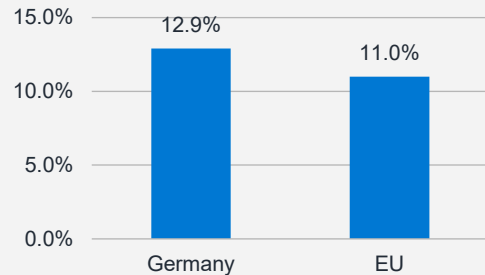
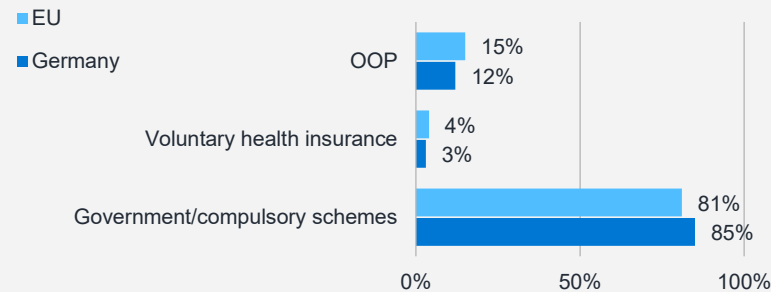


FIGURE 20: HEALTHCARE EXPENDITURE DISTRIBUTION IN GERMANY (2021)



Source: OECD

**Germany is a high health spender by international standards.** In 2021, total health expenditure amounted to **12.9% of GDP**, the highest level in Europe. In absolute terms: **current health expenditure reached about €492 billion in 2023** (all payers combined), after €489 billion or a **0.6% increase** from the previous year. Special attention should be paid to the portion of approximately €75 billion: This represents an additional subsidy from the state and is financed through general tax revenues. A similar amount was also provided in previous years.

Due to the extensive coverage by the health insurance system, the **share of private household spending** on healthcare in Germany is below the EU average: In 2021, it accounted for **12%** of health expenditure, whereas the EU average was **15%**.

## Private health insurance stakes

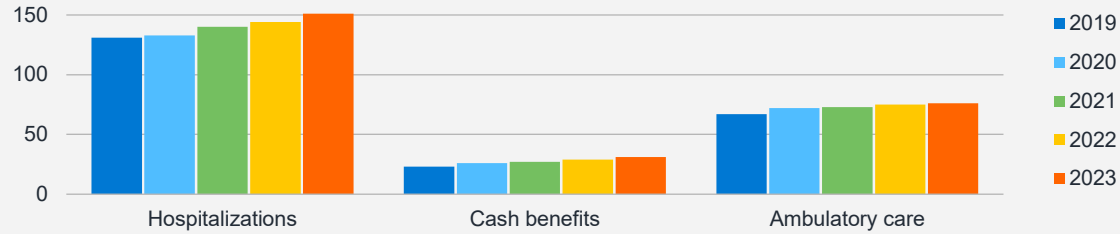
The private health insurance sector represents an industry branch of the German economy. In 2023, there were approximately **45 private health insurance companies**, including 25 for-profit and 20 nonprofit (mutual) insurers. These companies are heavily regulated by financial market supervisory (BaFin).

In 2023, there were about **38 million insurance policies**, of which around 9 million fully replaced statutory health insurance. The remaining 29 million policies were supplementary insurance. The number of supplementary insurance policies has grown steadily in recent years, by about 2.5% per year. A new type of policy currently emerging is **company health insurance**, where supplementary insurance is offered through employers. In the meantime, the number of these insurance contracts has surpassed the threshold of 2 million.

In 2023, insurance companies generated €48 billion in premium income, with €36 billion in benefit payments. The surplus in premium income is mainly due to the special feature of the German private health insurance system—the **funded system**: A portion of the premium income is used to build insurance reserves, which are drawn upon when benefit payments increase at higher ages of the insured. This calculation approach makes the system independent of demographic developments. In 2023, the reserves amounted to €328 billion.

## Overview on costs

FIGURE 21: COST OF HEALTH IN GERMANY (€ BILLION)

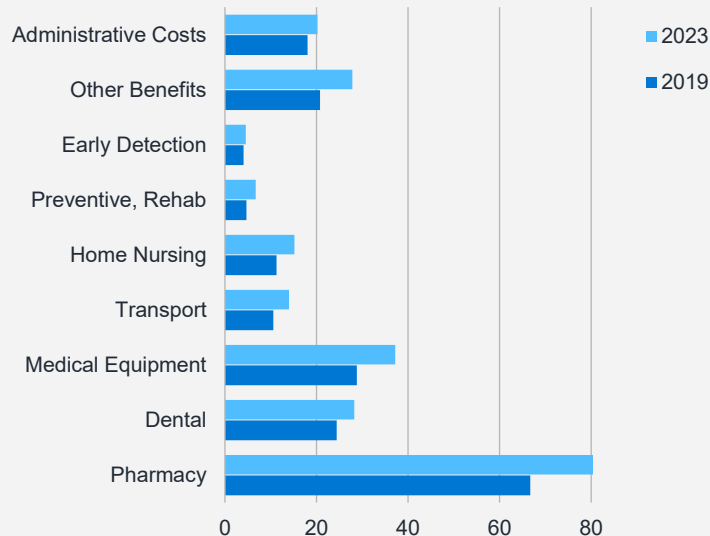


Source: Gesundheitsdaten KBV

The cost of **healthcare in Germany** has **increased** consistently in recent years.

Between 2019 and 2023, the cost of **hospitalizations** has increased by 18%, **cash benefits** by 36%, and **ambulatory care** by 15%.

FIGURE 22: AMOUNTS OF EXPENDITURE PER CARE ITEM (€ BILLION)

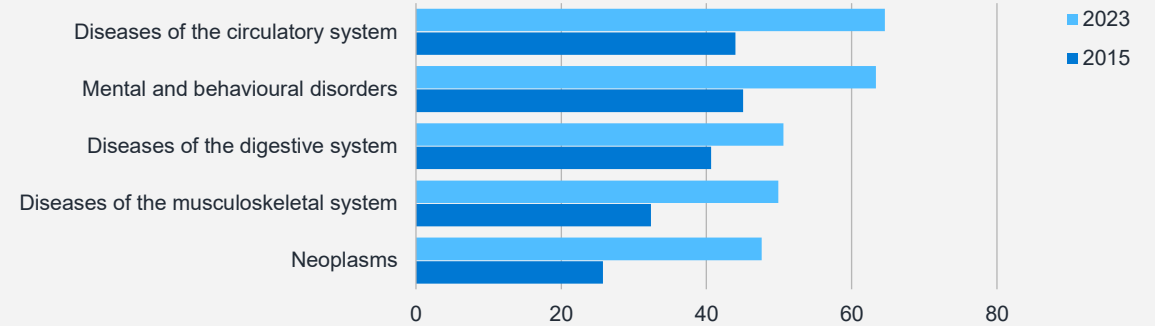


Between 2019 and 2023, several key healthcare spending categories in Germany have increased disproportionately. **Preventive and rehabilitation** rose **44%** as an emerging and government-supported aspect of healthcare. **Home nursing** (+37%) is a part of long-term care, which is currently at the center of discussions about the healthcare system due to rapidly rising costs.

Source: Gesundheitsdaten KBV

## Overview on pathologies

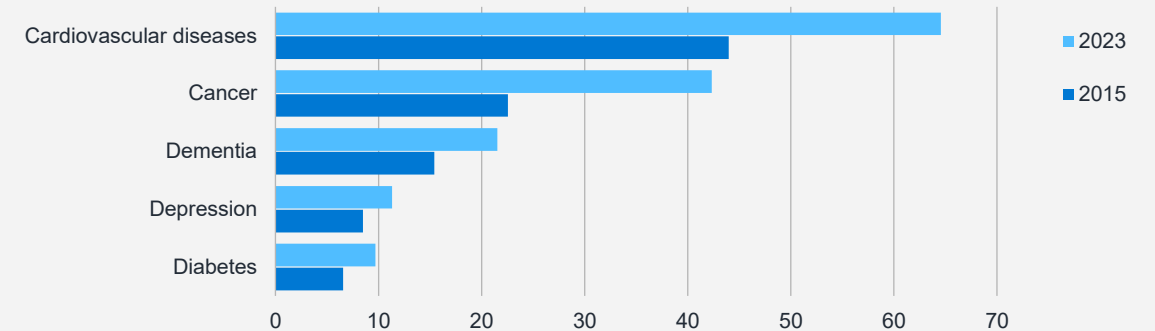
FIGURE 23: COST OF MAIN ICD-10-CATEGORIES (2023 VS 2015) IN € BILLION



Source: GENESIS-Online

More than half of healthcare costs (€276 billion out of €491 billion in 2023) were attributable to 5 out of the 21 ICD-chapters.

FIGURE 24: COST OF MAIN PATHOLOGIES (2023 VS 2015) IN € BILLION



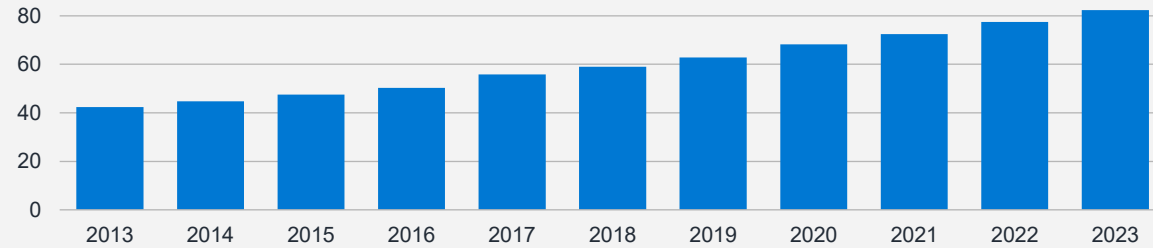
Source: GENESIS-Online

After accounting for pathology, cardiovascular diseases constitute the largest share, increasing 47% from €44 billion to €65 billion from 2015 to 2023.

However, the greatest percentage change is observed in cancer, with an increase of 88%. This development can be observed in a similar manner in other European countries, such as France.

## Focus on long-term care

FIGURE 25: COST OF LONG-TERM CARE IN GERMANY (€ BILLION)



Source: Destatis

## Reforms in the past

In recent years, the German long-term care system has been significantly reformed.

In **2016**, the reform expanded **coverage** (for example, dementia was now taken into account) and established a more comprehensive assessment system. The **2017** reform improved **counseling and oversight of care providers** and introduced measures against fraud. In **2021**, care providers were required to **pay staff according to collective wage agreements**, and both benefits and quality standards were expanded.

The consequence is a more powerful but also **considerably more expensive system**, as can be seen in the increase in expenses from **2013 to 2023 by over 90%**, from €42 billion to €82 billion.

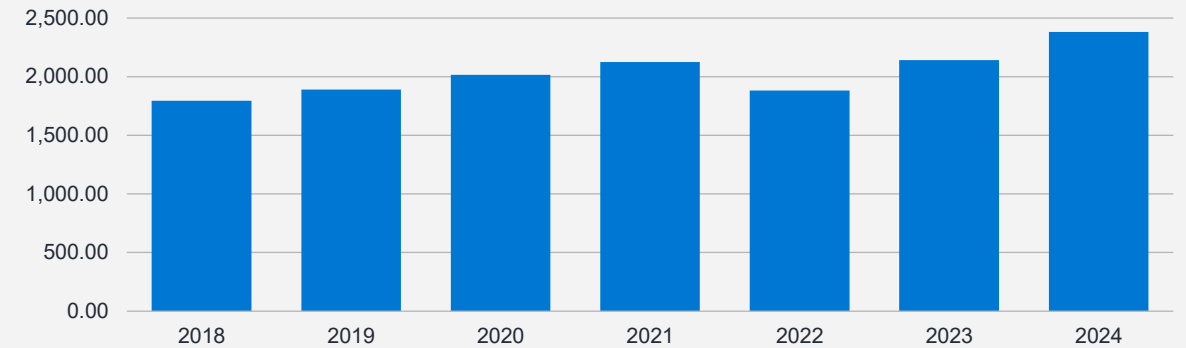
## Private health insurance

Long-term care insurance is also divided into statutory (public) and private type, with only those who are fully privately insured are coverable in the private type. The private long-term care insurance is calculated on a funded basis, analogous to private health insurance. The efficiency of this approach is immediately apparent: The long-term care **contributions** are expected to be, on average, **only about half as high (€123 per month) in 2026** as those of the pay-as-you-go system (**€244 per month**).

## OOP exposure

Although it provides extensive benefits, long-term care insurance in Germany is designed as partial coverage insurance. Additional costs, especially in nursing homes such as **accommodation, meals, and investment costs**, are largely and increasingly borne by the insured themselves through OOP contributions.

FIGURE 26: OUT-OF-POCKET CONTRIBUTIONS (€ PER MONTH AND PERSON)



Source: Verband der Ersatzkassen

As of January 1, 2022, an additional tax-funded subsidy was introduced. This initially led to a noticeable reduction in OOP contributions. However, due to overall cost developments in long-term care, the 2021 level has since been reached or even exceeded.

## Future developments

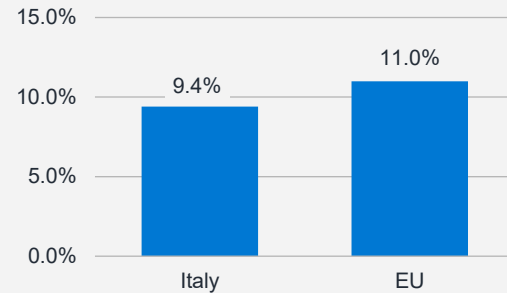
The escalating expenditure on benefits is also viewed with **concern in the forecast**. Estimates suggest that the number of people in need of care will rise to **over 6 million within the next five years** (an increase of approximately **9%** compared to 2024).

Additionally, further reforms are planned. These aim to simplify the currently complex long-term care system, making it **easier** for those affected **to understand**. In particular, home and outpatient care are to be strengthened, with **family caregivers receiving greater recognition and support**. It is also proposed to clearly separate housing from care services, so that individual support needs—rather than place of residence—**determine the scope of benefits**. Finally, additional benefits in general will be reviewed for their effectiveness and cost.

- The Italian National Health Service (SSN) is a decentralized system that ensures that all citizens and residents have the right to access essential healthcare services, regardless of income or social status. Most services are provided free of charge or with a small copayment (ticket), with exemptions for certain income groups or chronic conditions.
- The SSN operates on a regional basis: While the central government defines the Essential Levels of Care (LEA) that must be guaranteed everywhere, the regions are responsible for organizing and delivering healthcare services. Care is provided through a network of local health authorities, public hospitals, and accredited private facilities. The system also promotes public health through prevention campaigns and health education.
- Services are provided by both public and accredited private facilities, with some variation between regions. In fact, despite the goal of equal care for everyone, differences remain across regions in terms of health outcomes and service quality, with northern and central areas generally offering more advanced and higher-quality healthcare than the south.

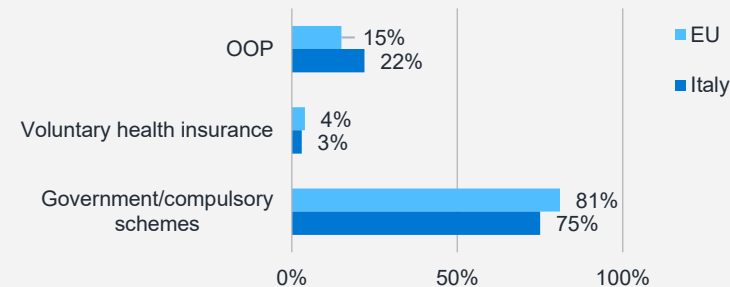
## Health expenditures trends

FIGURE 27: HEALTH SPENDING, SHARE OF GDP (2021)



Source: OECD

FIGURE 28: HEALTHCARE EXPENDITURE DISTRIBUTION IN ITALY (2021)



Source: OECD

In 2021, public and private health expenditure in Italy accounted for 9.4% of GDP, more than 1.5 percentage points below the EU average. However, the trend is decreasing year by year. In 2023, the health expenditure in Italy accounted for 8.4% of GDP, leading to an absolute value of 176 billion.

Italy's healthcare financing relies heavily on OOP payments (21.9%) and, to a lesser extent, voluntary health insurance (2.6%). Together, these sources made up 24.5% of total health expenditure in 2021, a share 30% higher than the EU average of 18.9%.

About three-quarters of Italy's health spending is publicly funded, a share that is lower than the EU average of 81%.

The inability of the National Health Service to provide timely care is increasing enrollment in private health funds, but economic challenges and inflation limit the ability to raise contributions. This will likely lead to higher OOP spending for those who can afford it, and greater unmet health needs among disadvantaged groups, resulting in worse health outcomes.

## Accessibility

Italy faces a **severe shortage of healthcare personnel**, which is a major factor behind long waiting lists for diagnostic tests and surgeries.<sup>1</sup> In 2024, Italy had about 4.2 specialist doctors and 6.5 nurses per thousand inhabitants, placing it behind major European countries such as Germany and France. Years of limited recruitment and suboptimal planning have led to a **deficit of about 30,000 specialists and 70,000 nurses compared to European standards**.

**The healthcare workforce is aging**; 27% of specialists are over 65, which is the highest rate in Europe. At the same time, **many young doctors and nurses are leaving Italy for better salaries and working conditions abroad**. This ongoing emigration, combined with a high number of unfilled training positions, puts the system at risk of an even greater shortage of medical staff in the near future.

Italy also has one of the **lowest hospital bed densities in the EU**, with only 304 beds per 100,000 inhabitants in 2023, well below the EU average. The total number of hospital beds in Italy decreased to 179,000 in 2023 (down by 20,000 since 2013). This limited capacity, combined with personnel shortages, further constrains access to timely hospital care and contributes to longer waiting lists for treatments and surgeries, which are already considerable.<sup>2</sup>

## Private health insurance stakes

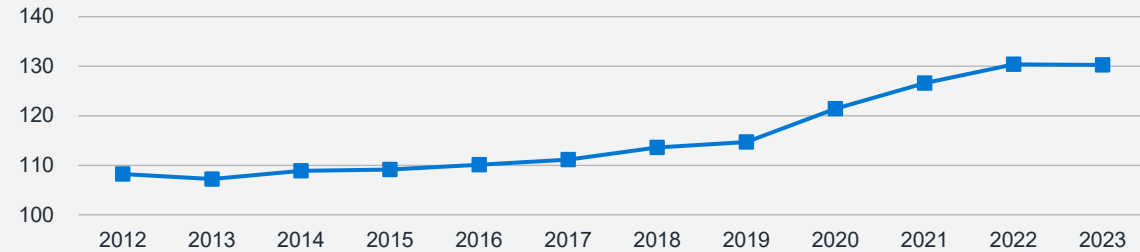
The health insurance market in Italy has remained limited. Several factors contribute to this, including a **low propensity among Italians to purchase individual policies** due to the comprehensive public system, the high cost of premiums, the availability of health funds, and tax deductions for OOP healthcare expenses. **Individual policies lack the fiscal advantages of supplementary health funds**, as premiums are not deductible and are subject to a 2.5% tax, except for long-term care policies.

In addition, **insurance companies tend to exclude coverage for pre-existing conditions and for services with a high risk of occurrence**, which further limits the appeal of these policies. Coverage is often partial, with deductibles and OOP expenses remaining for the insured, and the reimbursement model is based either on direct payment to affiliated providers or on reimbursement of expenses incurred. For these reasons, insurance companies have increasingly shifted their business toward the reinsurance of health funds, which enjoy more favorable tax treatment.

1. [Il Sole 24 ORE](#)  
2. [Quotidiano Sanità](#)

## Overview on costs

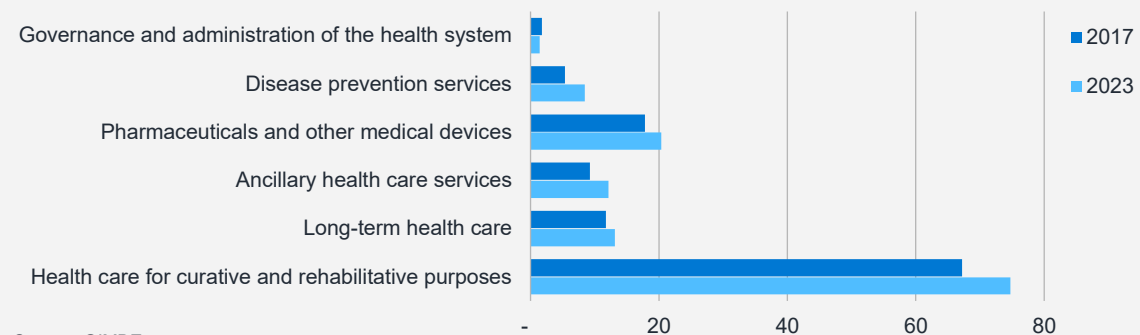
FIGURE 29: PUBLIC HEALTH EXPENDITURE (€ BILLION)



Source: GIMBE

Total public healthcare spending increased by about 17% from €111 billion in 2017 to €130 billion in 2023, highlighting a significant and broad-based rise in investment, particularly in core health services and prevention, although this growth is slower than that of GDP.

FIGURE 30: PUBLIC HEALTH EXPENDITURE FOR HEALTH CARE FUNCTIONS (€ BILLION)



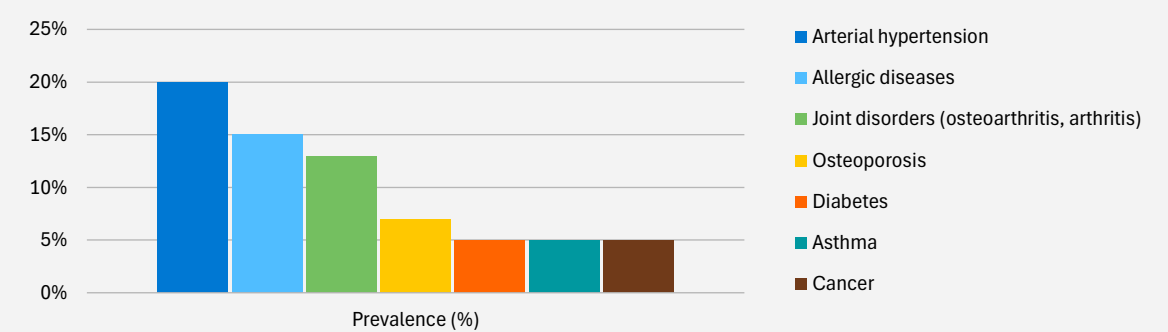
Source: GIMBE

Between 2017 and 2023, public healthcare spending in Italy increased across most functions.

Spending on **healthcare for curative and rehabilitative purposes** grew from €67 billion to €75 billion, marking an increase of approximately 11.2%. **Long-term healthcare** rose from €12 billion to €13 billion (+11.8%), while **ancillary health care services** increased from €9 billion to €12 billion (+31.1%). Expenditure on **pharmaceuticals and other medical devices** went from €18 billion to €20 billion (+14.5%). **Disease prevention services**, despite a decline in 2023 compared to 2022, were still up from €5 billion to €8 billion (+57.9%) over the period. **Governance and administration** costs remained **stable** at €1 billion to €2 billion.

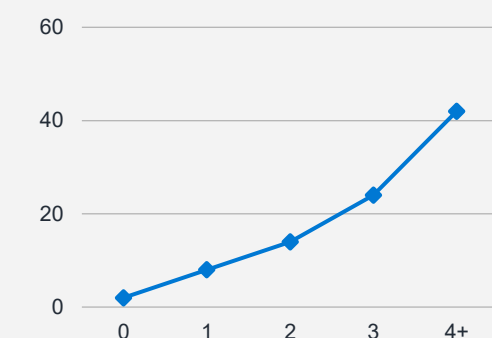
## Overview on pathologies

FIGURE 31: PREVALENCE RATES OF CHRONIC DISEASE



Source: TrendSanità

FIGURE 32: COST PER PATIENT (€ THOUSAND)



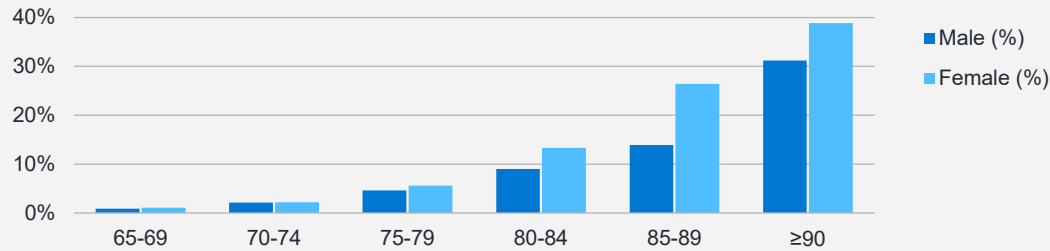
Source: Consorzio SISIFO

Between 2022 and 2023, Italy has witnessed a significant prevalence of chronic diseases among its population, with over one in three Italians (36%) living with at least one chronic condition, according to data from the UniSalute Health Observatory. The most widespread chronic disease is arterial hypertension, affecting one in five Italians (20%), followed by allergic diseases (15%) and joint disorders such as osteoarthritis and arthritis (13%). Other notable conditions include osteoporosis (7%), diabetes (5%), asthma (5%), and cancer (5%).

Chronic diseases significantly increase healthcare costs in Italy. In fact, while **chronic patients** represent only about 30% of the population, they **account for over 70% of healthcare spending**. As the number of chronic conditions increases, the cost per patient rises dramatically: from **€2,000 for nonchronic individuals** up to **over €42,000 for those with four or more chronic illnesses**. The aging Italian population and delayed disease detection further exacerbate this financial burden, posing a serious challenge to the sustainability of the national health system.

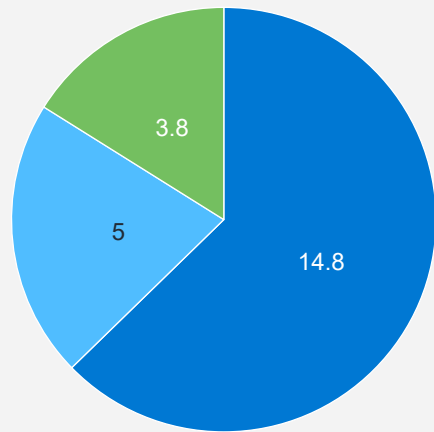
## Focus on dementia

FIGURE 33: PREVALENCE RATES BY AGE GROUPS ABOVE 65



Source: ISS

FIGURE 34: FINANCIAL BURDEN (€ BILLION)



- Out-of-pocket expenses
- Indirect costs (caregiving)
- Public healthcare system expenditure

Source: Panorama della Sanità

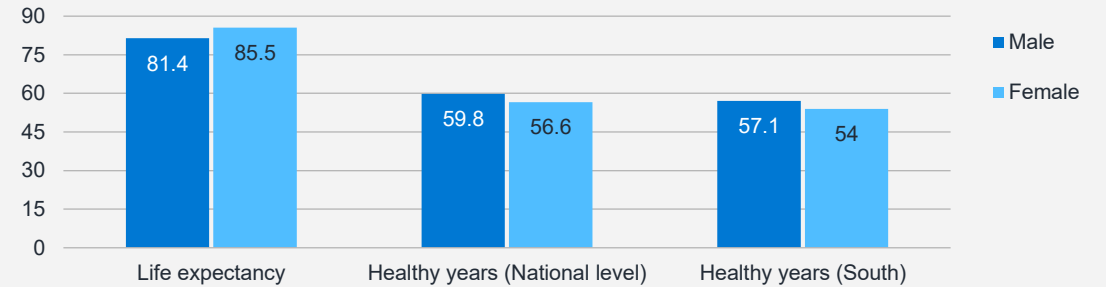
**Dementia is a growing issue in Italy, involving at least 1.5 million people**, with women being the most affected group. This number is expected to double and exceed 3 million by 2050. Alzheimer's disease, the most common form of dementia, is rising rapidly, with yearly costs per patient reaching up to €72,000. The condition currently **costs €23 billion annually**, with most expenses falling on families.

By 2050, **the overall financial burden could surpass €60 billion**. Regional disparities are significant, and many caregivers report dissatisfaction with available services, often having to leave their jobs to provide care.

Despite some progress, **early diagnosis and support remain inadequate**. Caregivers experience high levels of stress and isolation, highlighting the urgent need for better policies, improved care networks, and increased investment in dementia and Alzheimer's care in Italy.

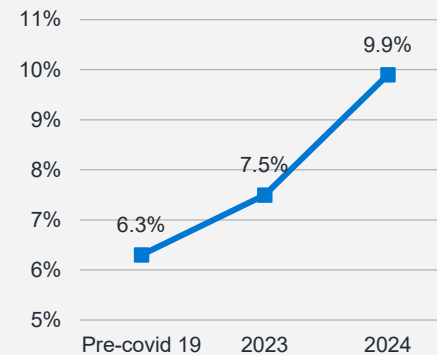
## Focus on longevity and quality of life

FIGURE 34: LIFE EXPECTANCY VS. HEALTHY YEARS (AGE)



Source: GPP Health

FIGURE 35: PEOPLE WHO FOREGO CARE



Italy's latest ISTAT report highlights a troubling paradox: While **life expectancy has reached record high**—81.4 years for men and 85.5 for women in 2024—**the years lived in good health are shrinking**. Women born today can expect only 56.6 healthy years, dropping to 54 in the south; for men, it's 59.8 years nationally and 57.1 in the south.

**Access to healthcare is increasingly unequal:** 9.9% of people gave up necessary visits or tests in 2024 (up from 6.3% in 2019) **due to long waiting lists (6.8%) and costs (5.3%)**. Private healthcare use is rising (23.9% paid OOP for their last specialist visit), but many cannot afford it. Women, middle-aged adults, and southerners are most affected; psychological distress is rising among youth and the elderly.

Three million people, representing 5% of the population, live with disabilities. Of these, 80% suffer from at least one chronic disease, and only 9.8% report being in good health. Despite low avoidable mortality (17.7 per 10,000), **the healthcare system is strained, and inequalities are growing**.

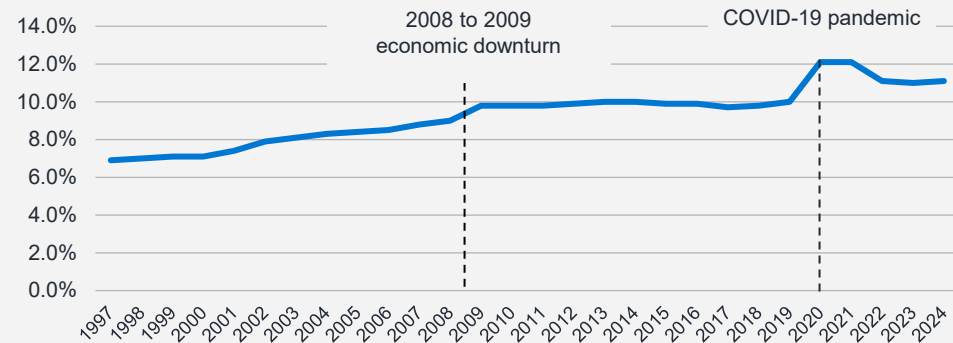
Source: GPP Health

- The U.K. operates a universal, tax-funded healthcare system centered around the NHS, which delivers care free at the point of use to all residents. Private health insurance is optional and serves as a supplement, primarily used for quicker access to care, nicer facilities, and more convenient appointment times, or for services such as dental and optical treatments that are not fully included in NHS coverage.
- Approximately 14% of the U.K. adult population had supplemental private health insurance in 2024, with the majority of those paid for by employers.<sup>1</sup> Health insurance is most popular among people in middle age, with 18% (1.7 million) of those age 35 to 44 and 19% (1.6 million) of those age 45 to 54 holding a PMI product.<sup>1</sup> Private health insurance is regulated under general insurance legislation, with no specific regulation or government subsidies for health insurance.
- The provider system is predominantly public, with the NHS functioning as both the main funder and provider of healthcare, supported by a relatively small private hospital and clinic sector.

## Government health expenditure as a % of GDP and by function<sup>2</sup>

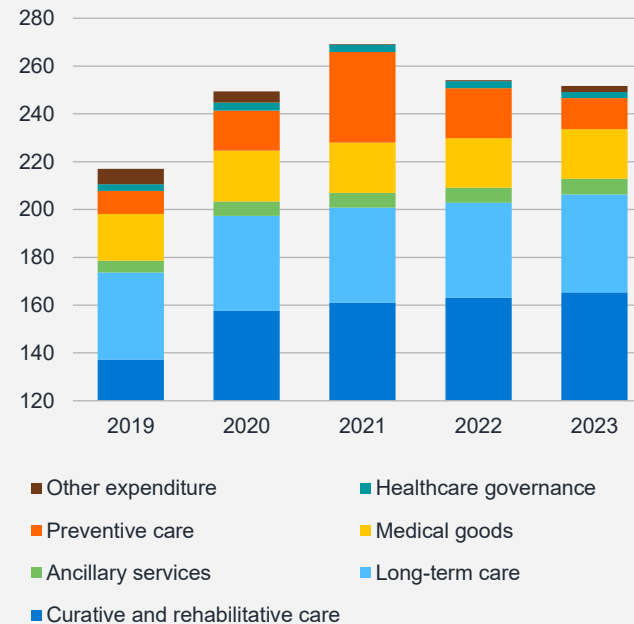
The healthcare expenditure here is defined as current spending on healthcare goods and services consumed each year, based on the international System of Health Accounts (SHA 2011). It covers government, household, employer, and insurance spending, and includes long-term care as well as medical treatment, but excludes capital investment. This is **broader than the NHS budget**, which mainly covers government-funded medical services and excludes most social care.

FIGURE 36: HEALTHCARE SPENDING AS % OF GDP



\*Real terms figures are presented in 2024 prices, adjusted for inflation using the gross domestic product (GDP) deflator.

FIGURE 37: HEALTHCARE SPENDING BY FUNCTION (IN £ BILLION)



## Healthcare Spending in the U.K.<sup>2</sup>

Healthcare accounted for **11.1%** of the U.K.'s GDP in 2024, holding steady from 2023 but above the pre-pandemic norm of **9.7%–10%**.

In cash terms, the U.K. spent **£317 billion** on healthcare in 2024, covering both government and nongovernment sources. That is **6.5% higher** than in 2023 in nominal terms, or **2.4% growth** from 2023 to 2024 after inflation.

### Source of financing<sup>2</sup>

Most funding is public: **£258 billion** from the government in 2024, **up 2.5%** in real terms from 2023. The public share of funding has steadily risen—from 74% in 1997 and 79% in 2019 to **81.3%** in 2024.

Private and other funding sources make up the remainder of the total healthcare expenditure in 2024:

- OOP payments: £46 billion (14.6%)
- Voluntary health insurance: £8 billion (2.6%)
- Charities (NPISH)L £4 billion (1.4%)
- Enterprise financing scheme: just £1 billion (0.2%)

### Spending by function (in 2024 prices\*)<sup>2</sup>

- Pharmaceuticals: down from 2022 by 5.4% in real terms in 2023, largely due to lower COVID-19 vaccine programs.
- Long-term care: up 3.1% in real terms in 2023 from 2022, driven by higher government funding.

1. [14% of UK adults now have private health insurance | The Actuary](#)

2. [Healthcare expenditure, UK Health Accounts - Office for National Statistics](#)

## Accessibility

Access to healthcare in the U.K. remains under strain, shaped by workforce shortages, rising demand from an ageing population, and uneven service provision. With around **3.37<sup>3</sup> practicing doctors per 1,000 residents in 2023, below the OECD average of 3.93,<sup>4</sup>** and a growing share of older and more complex patients, pressure on services is intensifying. With just **2.4 hospital beds per 1,000 people<sup>5</sup>** in 2023, the U.K.'s limited bed capacity makes it difficult for hospitals to manage high demand, thereby increasing backlogs and delays in care.

In England, **6.3 million<sup>6</sup>** people were on elective care lists in September 2024, while **40%<sup>7</sup> of cancer patients in April–June 2023** faced delays of over two months from urgent GP referral to treatment. In Northern Ireland (May 2022), hip replacement patients can wait up to **a decade<sup>8</sup>** from referral to surgery. In Scotland, record backlogs have driven an increase in private care use, with over **63,000** people waiting a year for an initial NHS hospital consultation and nearly **8,000** waiting more than two years in May 2024.<sup>9</sup>

Difficulties securing GP and dental appointments often push some to turn to urgent and emergency care as a first option, or to delay seeking help until conditions worsen. Limited capacity in adult social care also stalls hospital discharges, while staffing and funding pressures in residential and community services risk leaving people without the support they require.<sup>10</sup>

In England, access to healthcare remains uneven, particularly for people with protected equality characteristics. Many face barriers to timely care because services are not consistently adapted to meet their cultural, communication, or disability-related needs.<sup>10</sup>

## Private health insurance market

The U.K. private medical insurance (PMI) market has experienced renewed growth since 2020, with **14% of the U.K. population (7.6 million) covered by PMI in 2024.<sup>1</sup>** This is driven by expanded employer-sponsored schemes and heightened demand following NHS access challenges. Financing remains heavily employer-led, with **around three-quarters of premiums paid by companies**, but affordability pressures—particularly for lower-income groups—are intensifying as medical inflation outpaces wage growth.<sup>11</sup>

Coverage is evolving beyond traditional elective surgery access to include **primary care, diagnostics, mental health, and high-cost treatments such as advanced cancer therapies**, which are now a significant share of claims. Insurers are increasingly acting as “risk-poolers” for catastrophic costs, while exploring modular and high-deductible plans to manage affordability.<sup>11</sup>

Competition is growing **from hospital providers offering direct-to-consumer financing and subscription models**, though insurers retain an edge in distribution, risk management, and administration. Digitization, AI, and virtual GP services are reshaping service delivery, yet integration challenges persist and cost savings may be offset by new treatment expenses.<sup>11</sup>

3. [Doctors | OECD](#)

4. [United Kingdom Doctors per 1,000 people - data, chart | TheGlobalEconomy.com](#)

5. [Hospital beds | OECD](#)

6. [NHS backlog data analysis](#)

7. [Access to care - Care Quality Commission](#)

8. [THE FEASIBILITY OF ACHIEVING ELECTIVE CARE FRAMEWORK TARGETS FOR TOTAL HIP ARTHROPLASTY \(THA\) IN NORTHERN IRELAND | Bone & Joint](#)

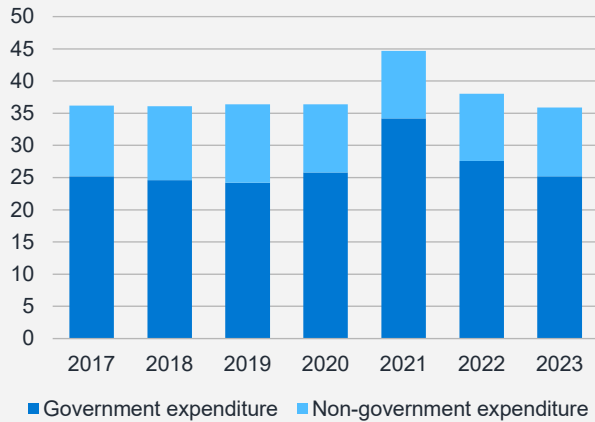
9. [Third of Scots abandon 'dying' NHS for private care](#)

10. [Access to care - Care Quality Commission](#)

11. [UK private medical insurance in 2030 and beyond](#)

## Overview on pharmaceutical spending<sup>1</sup> and cost per person<sup>2</sup>

FIGURE 38: TOTAL PHARMACEUTICAL EXPENDITURE<sup>1</sup>



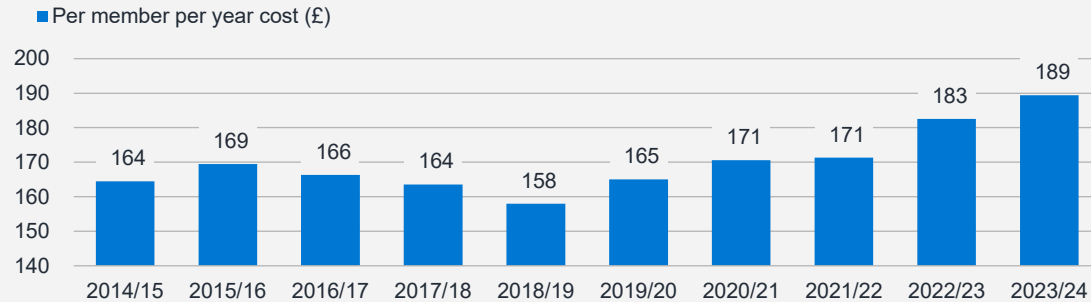
Source: ONS and PCA England

By 2023, **total pharmaceutical expenditure** in the U.K. was estimated at **£35.9 billion** (in 2024 prices), encompassing community-prescribed medicines (50.8%), over-the-counter (OTC) medicines (24.1%), immunization programs (7.4%), and treatment-administered medicines (17.7%).

Notably, **pharmaceutical spending fell by 5.4% in real terms** between 2022 and 2023, chiefly due to reduced spending on the COVID-19 vaccination program. In contrast, **nongovernment pharmaceutical expenditure grew by 3.5%**, driven largely by increased household spending on OTC medicines.

This shift reflects the gradual wind-down of pandemic-related immunization efforts and a return toward more typical patterns of medicine consumption. The decline in public immunization expenditure highlights how one-off, large-scale vaccination campaigns can sharply influence pharma budgets. As such, this underscores both the volatility inherent in public pharmaceutical spending and the growing role of private households in sustaining medicine demand post-pandemic.

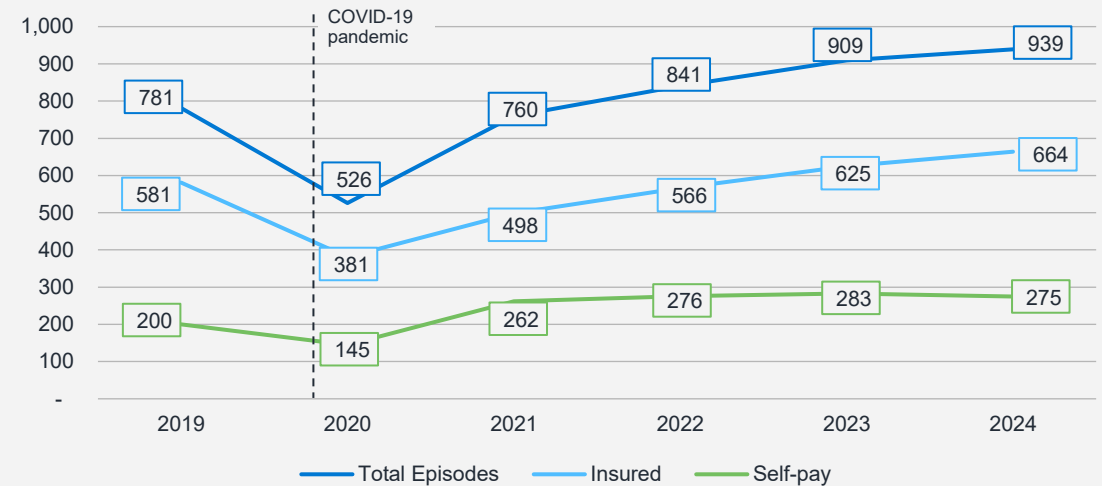
FIGURE 39: ENGLAND PHARMACY UTILIZATION AND COST ANALYSIS



Source: ONS and PCA England

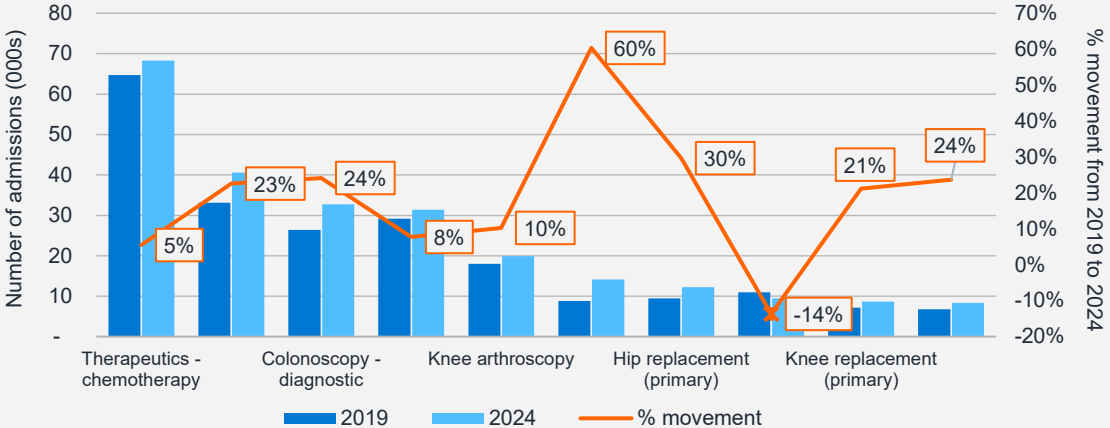
From 2014/15 to 2023/24, pharmacy costs per member per year climbed from £164 to £189. During this period, prescription costs per person increased 7% and the average cost per prescription increased 8%, showing that both increased usage and higher per-unit costs drove overall spending. The data highlights a clear, steady upward trend in pharmacy costs per person over the decade.

FIGURE 40: U.K. PRIVATE HOSPITALS/CLINICS ADMISSIONS BY YEAR<sup>3</sup>



1. [Healthcare expenditure, UK Health Accounts - Office for National Statistics](#)  
 2. [PCA England](#)  
 3. [June 2025 private healthcare market update from PHIN | PHIN](#)

FIGURE 41: TOP 10 INSURANCE-FUNDED PROCEDURES (BASED ON VOLUME IN ADMISSIONS)<sup>3</sup>



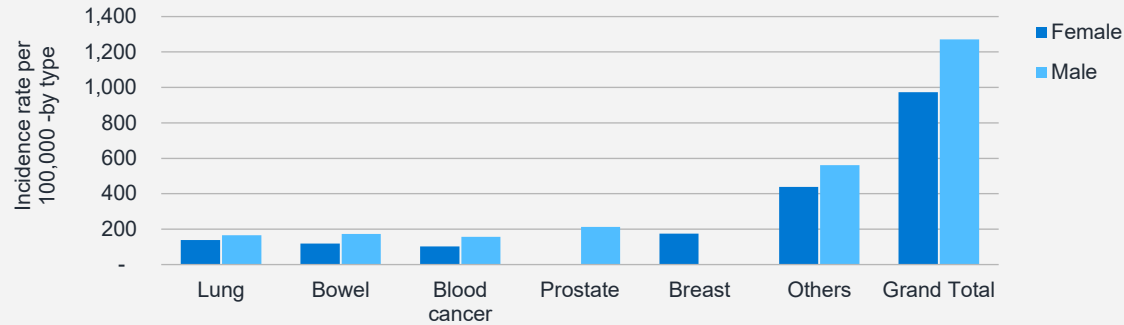
Private hospital admissions in the U.K. reached 939,000 in 2024, **up 3% from 2023** and **20% above 2019 levels**, with **growth driven mainly by insurance-funded care**. **Insured admissions rose 6%** to their highest ever, while **self-pay fell 3%** in 2024 from 2023 but still remained strong compared to historical levels. Across both sexes and all age groups, insured care showed consistent increases, whereas self-pay, despite its short-term decrease, has grown 38% since 2019 compared to 14% for insurance-funded admissions.

Between 2019 and 2024, insurance-funded procedures grew strongly, with diagnostic and therapeutic care driving the trend. Chemotherapy was the top insurance-funded procedure, while upper GI endoscopies and colonoscopies saw the fastest increase, reflecting a shift toward early detection and preventive care. Notably, bladder examinations declined by 14% from 2019 to 2024, marking a contrast to the overall upward trend.

3. [June 2025 private healthcare market update from PHIN | PHIN](#)

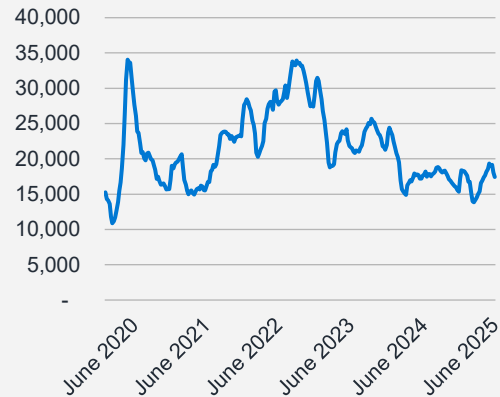
## Cancer: Incidence rate per 100,000 person and backlog under NHS England

FIGURE 42: 2022 CANCER INCIDENCE RATES (AGE-ADJUSTED) IN ENGLAND<sup>1</sup>



Source: NHSD

FIGURE 43: NHS ENGLAND: BACKLOG OF PATIENTS WAITING OVER 62 DAYS FOR CANCER TREATMENT AFTER AN URGENT GP REFERRAL<sup>2</sup>

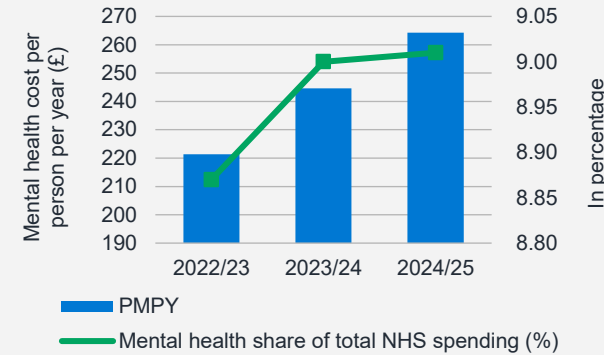


Source: NHS England

The top chart illustrates age-adjusted cancer incidence rates in England for 2022, segmented by cancer type and gender. Overall, males show higher incidence rates than females across most cancer types. During the same period, NHS cancer waiting times reached record highs, with over 50,000 people each month waiting more than two weeks to see a specialist—a backlog largely driven by the pandemic.<sup>3</sup> Research indicates that even a four-week delay to cancer surgery can increase mortality risk by 6%–8%.<sup>4</sup> Although NHS waiting times have improved by 2025, the combination of rising cancer incidence and previous delays underscores the urgent need for increased capacity and faster pathways in cancer care.

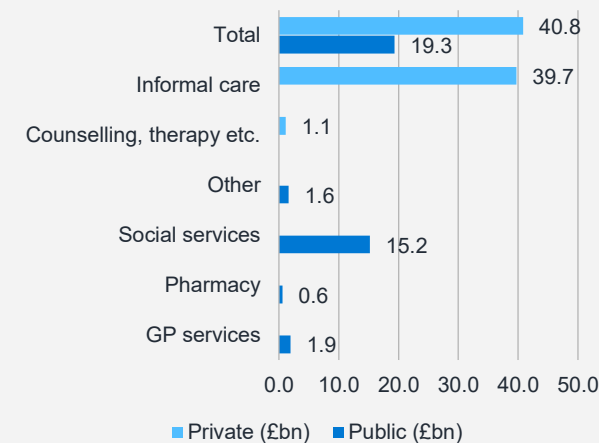
## Mental health: NHS England expenditure and funding

FIGURE 44: NHS (ENGLAND) SPENDING ON MENTAL HEALTH<sup>5</sup>



Source: UK Parliament and Mental Health Watch

FIGURE 45: SPLIT OF TOTAL MENTAL HEALTH COST IN ENGLAND<sup>6</sup>



1. [nhsd-ndrs.shinyapps.io/incidence\\_and\\_mortality/](https://nhsd-ndrs.shinyapps.io/incidence_and_mortality/)  
 2. [Backlog-of-patients-waiting-longer-than-62-days-from-urgent-GP-referral-for-suspected-cancer-we-03082025.xlsx](#)  
 3. [NHS cancer waiting times in 2022 were the worst on record | Daily Mail Online](#)

4. [Cancer waiting times: Latest updates and analysis](#)  
 5. [Mental Health: Expected Spend - Hansard - UK Parliament](#)  
 6. [Spending on mental health services per person | Mental Health Watch](#)  
 7. [The Big Mental Health Report | Mind](#)

Demand for mental health care continues to rise, intensified by the pandemic. NHS mental health spending in England has steadily increased, from £221 per person per year in 2022/23 to a £264 in 2024/25. Yet, mental health still accounts for less than 9% of total NHS expenditure.

The economic and social costs of mental ill health in England were estimated at £300 billion in 2022. Health and care services—covering treatment and support—represent the smallest share at £60.2 billion (20%). Most health and care costs are borne by individuals and their families, highlighting that most mental health costs manifest outside the health system in lost well-being and productivity.<sup>6</sup>

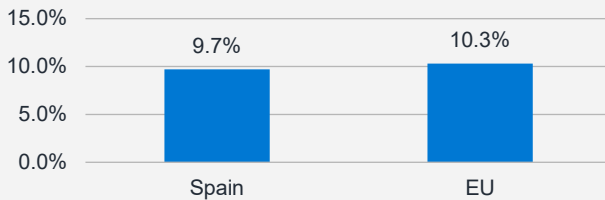
Mind, a mental health charity, revealed some interesting facts on mental health in its 2024 report<sup>7</sup>:

- In 2024, **1 in 4** in England will experience a mental health problem at some point each year.
- In 2023, 6,069 deaths registered in England and Wales were caused by suicide, with **the rates of suicide being higher for men, at around 75%**.
- For people with a severe mental illness, the risk of dying before the age of 75 is now **five times higher** than the U.K. average.

- Spain has a universal, tax-funded health system that provides unconditional access to public care. It is structured under the decentralized National Health System (SNS) and managed by the autonomous communities. Public services are fully covered by SNS, while private providers offer complementary options. The integration of public and private care ensures comprehensive access and patient choice.
- The Spanish public health system guarantees universal access and is fully funded through taxes. Care is provided free of charge and coordinated by regional health authorities within the SNS. It includes preventive, primary, and specialized services delivered through a network of hospitals and health centers. The system prioritizes equity, accessibility, and comprehensive care for all residents.
- The private health sector in Spain complements the public system by offering additional services and faster access to care. It is mainly provided by insurers, private hospitals, and independent practitioners. Many individuals purchase private insurance to cover treatments, elective procedures, or services not fully included in the public system. Overall, private care provides greater choice, convenience, and flexibility for patients.

## Health expenditures trends

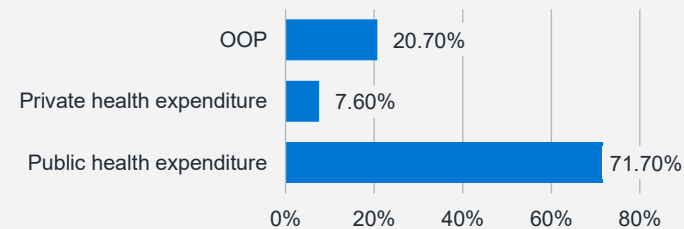
FIGURE 46: HEALTH SPENDING, SHARE OF GDP (2022)



In 2022, total healthcare expenditure in Spain amounted to **€134 billion**, representing **9.68% of GDP**. The public sector accounted for approximately **71.7%** of this spending while **OOP payments by individuals represented 20.7%** and the remaining portion was covered by private health insurance. On a per capita basis, total healthcare spending was **€2,080**, with **€1,490** funded by Ministerio de Sanidad. Although spending has been increasing in recent years, Spain's healthcare expenditure as a percentage of GDP remains slightly below the EU average of **10.29%**.

- [Spain | OECD Health at a Glance 2025](#)
- [Health at a Glance: Europe 2024](#)
- [France | OECD Health at a Glance 2025](#)
- [UK | OECD Health at a Glance 2025](#)
- [Ministerio de sanidad](#)

FIGURE 47: HEALTHCARE EXPENDITURE DISTRIBUTION IN SPAIN (2023)



Spain's healthcare system is divided into three main components: **public healthcare**, managed by the SNS via the regional governments; **private healthcare**, which includes private insurance; and **OOP spending**. In Spain, OOP healthcare spending accounts for approximately **20%–21%** of total health expenditure, which is notably higher than the EU average of around **15%** (OECD Health Statistics). This elevated level is largely due to **direct payments for hearing care, dental care, and optical services**, which are either partially covered or not included in the public health system, according to OECD. As a result, Spanish citizens bear a larger share of healthcare costs despite universal public coverage.

## Accessibility

Spain had **4.4<sup>1</sup> practicing physicians per 1,000 inhabitants in 2024**, exceeding the European Union average of **4.2<sup>2</sup>**. This level is higher than in comparable countries such as **France (3.2)<sup>3</sup>** and **United Kingdom (3.4)<sup>4</sup>**, reflecting Spain's relatively strong investment in medical human resources. A higher physician-to-population ratio contributes to better access to healthcare services and overall system performance.

In Spain, waiting times for healthcare services vary significantly between **urgent** and **nonurgent** procedures. Urgent treatments, such as emergency surgeries, are generally prioritized and addressed promptly. In contrast, **nonurgent elective surgeries**, including procedures like cataract operations and hip replacements, often experience longer delays, according to OECD. These waiting lists are **not regulated at the national level** but are managed by Spain's **autonomous communities**, which can lead to significant regional differences in access and waiting times.

Spain's waiting times for nonurgent surgeries remain relatively high. For instance, the **median wait for hip replacement** is about **118.6 days<sup>5</sup>**, while in Sweden and the U.K. it is roughly **60 days**. These differences highlight challenges in managing elective care efficiently and emphasize the need for targeted interventions at both **regional and national levels** to improve timely access to healthcare. According to the SNS, the **average waiting time for external consultations\*\*** was **95 days in 2019**, but by **2024**, it had increased to **105 days—a 10-day increase** over five years.

## Private health insurance complements

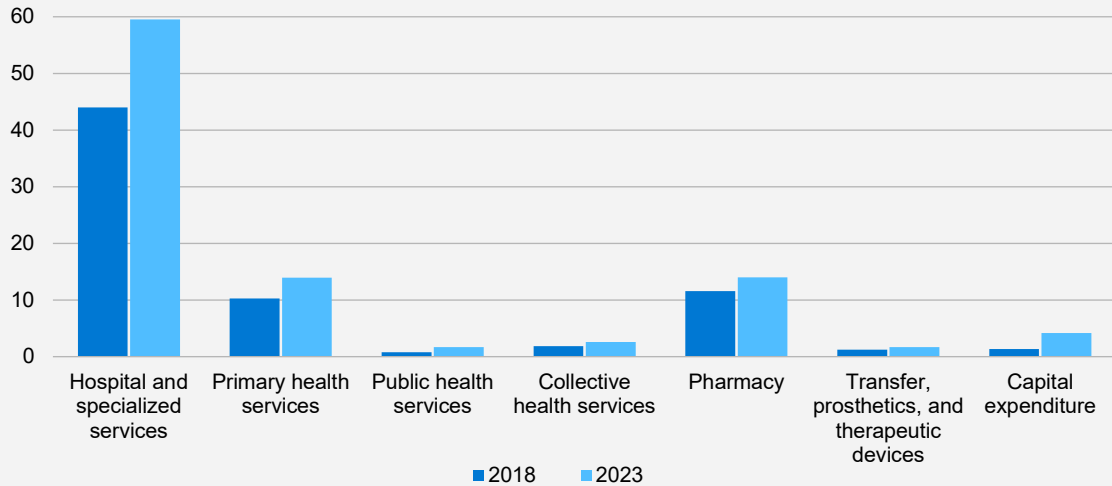
**In Spain, private hospitals affiliated with health insurers play a significant role** in the healthcare system. As stated in the [Annual report of National Health System 2023](#), they account for 40% of all hospitals and provide 18% of total hospital beds.

According to the [Fundación IDIS](#), the **private health insurance market covers around 12.6 million people** (approximately 26% of the population), most of whom use private hospitals for elective procedures, specialized surgeries, and advanced diagnostics.

**These hospitals often offer shorter waiting times, more comfortable facilities, and additional services not fully covered by the public system**, such as certain rehabilitation and diagnostic procedures. As a result, they serve as a crucial complement to Spain's public healthcare system, providing alternatives and enhancing patient access to timely care.

\*\* Including basic specialties: Gynaecology, Ophthalmology, Traumatology, ENT (Ear, Nose, and Throat), Neurology, General and Digestive Surgery, Urology, Digestive procedures, and Cardiology

FIGURE 48: AMOUNTS OF PUBLIC EXPENDITURE PER CARE ITEM (€ BILLION)

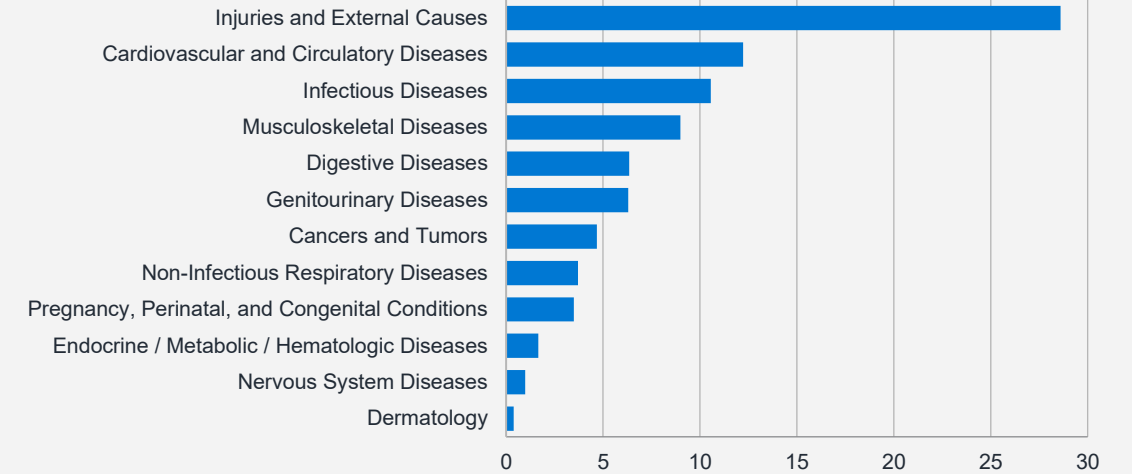


Source: INE, 2025

Between 2018 and 2023, Spain experienced a substantial increase in health expenditure. Spending on **hospital and specialized services** grew from €44.0 billion to €59.5 billion, representing an increase of approximately **35**, while **capital investment** more than **tripled**, rising from €1.4 billion to €4.2 billion. The marked growth in capital expenditure reflects ongoing investments in healthcare infrastructure and modernization, aimed at enhancing hospital capacity, technology, and overall service quality, according to the 2022–2023 Primary and Community Care Action Plan.

Expenditure on **prosthetics and therapeutic devices** also grew from **€1.3 billion to €1.7 billion**, reflecting the continued reliance on OOP payments for services such as dental care, optical devices, and hearing aids. These figures highlight the expansion of Spain's health budget, with the most pronounced increases in hospitals and infrastructure.

FIGURE 49: PUBLIC COST OF GROUP OF PATHOLOGIES IN SPAIN IN 2023\* (€ BILLIONS)

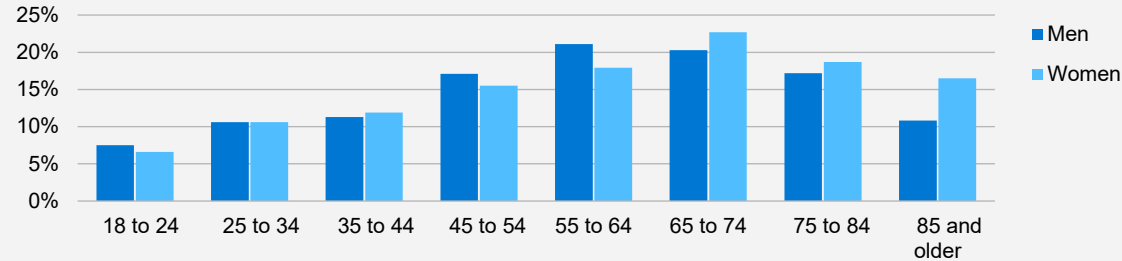


Source: Ministerio de Sanidad.

The public sector spending in Spain shows substantial differences across major disease categories. Injuries and external causes cost **28.60 billion**, which is nearly **230% higher than cardiovascular and circulatory diseases (12.23 billion)** and over **171% higher than infectious diseases (10.56 billion)**. In contrast, dermatology accounts for only **0.39 billion**, representing a very small fraction of the highest-cost category. These figures reflect public healthcare only; however, private health expenditure, which represents about **7.6% of total healthcare spending according to OECD**, adds some additional costs. Therefore, while the public sector dominates the economic burden, the overall costs of major pathologies are higher when private spending is included.

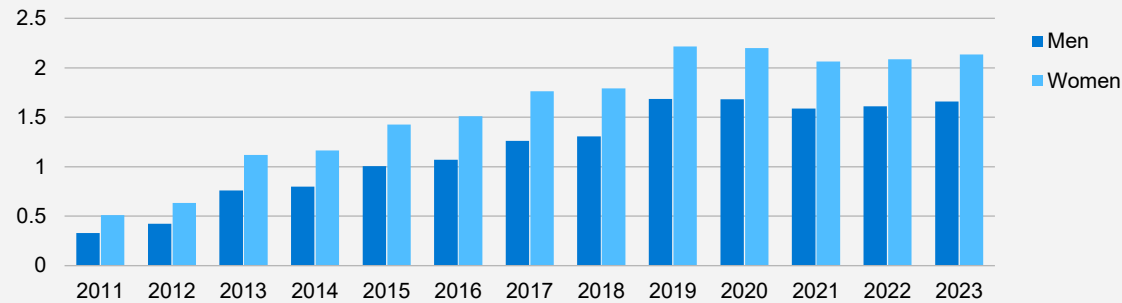
\* The costs are obtained by multiplying the number of hospital discharges by the average cost of the pathology.

FIGURE 50: OBESITY PRE-VALENCE BY AGE GROUP AND SEX IN SPAIN 2023 (% OF POPULATION AGE 18 AND OVER)



Source: INE, 2025

FIGURE 51: EVOLUTION OF OBESITY CASES IN SPAIN (IN MILLIONS)

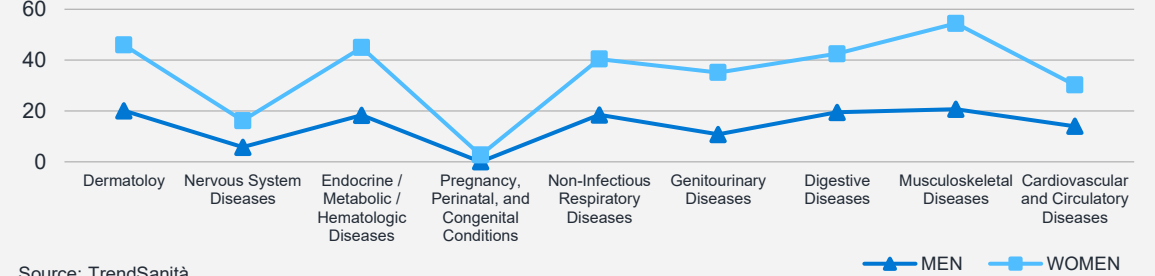


Source: Ministerio de Sanidad

Obesity is defined by the World Health Organization (WHO) as “an abnormal or excessive accumulation of body fat that may impair health, often measured using the Body Mass Index (BMI), with a BMI of 30 kg/m<sup>2</sup>.” Obesity is a growing public health concern in Spain, affecting millions of adults across the country. Between 2011 and 2023, the number of obese men increased from approximately **0.33 million to 1.66 million**, a rise of about **403%**, while the number of obese women rose from **0.51 million to 2.13 million**, an increase of roughly **318%**. This steady growth highlights the need for public health interventions targeting lifestyle, diet, and physical activity. Obesity increases risks of cardiovascular disease, diabetes, and other chronic conditions, contributing to healthcare costs.

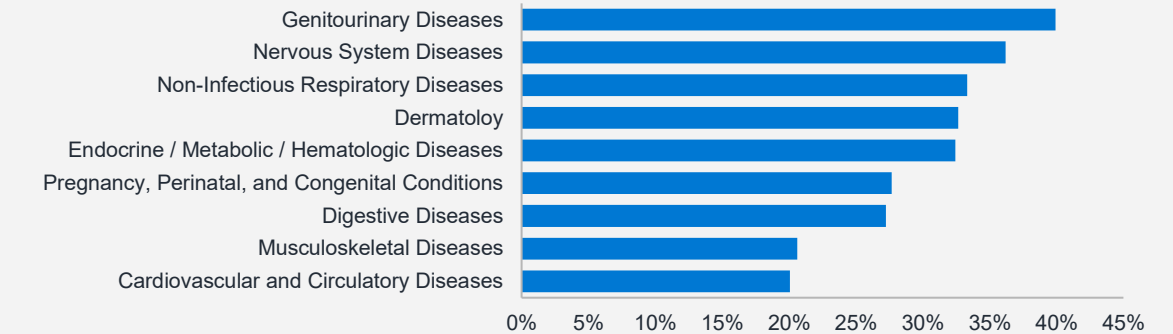
Analysis by age groups in 2023 shows that obesity prevalence is highest among **adults middle-aged and older**. For men, the highest rates are seen in the 55–64 age group (**21%**) and 65–74 (**20%**), while for women, the 65–74 group reaches **23%**. Younger adults (18–24) show lower prevalence—around **8% for men and 7% for women**—indicating that obesity becomes more pronounced with age.

FIGURE 52: NUMBER OF CASES OF MAJOR PATHOLOGIES IN 2024 BY GENDER (MILLIONS)



Source: TrendSanità

FIGURE 53: PERCENTAGE INCREASE IN MAJOR PATHOLOGIES CASES FROM 2019 TO 2024



Source: Ministerio de Sanidad; 1 [European observatory on Health System and Policies](#)

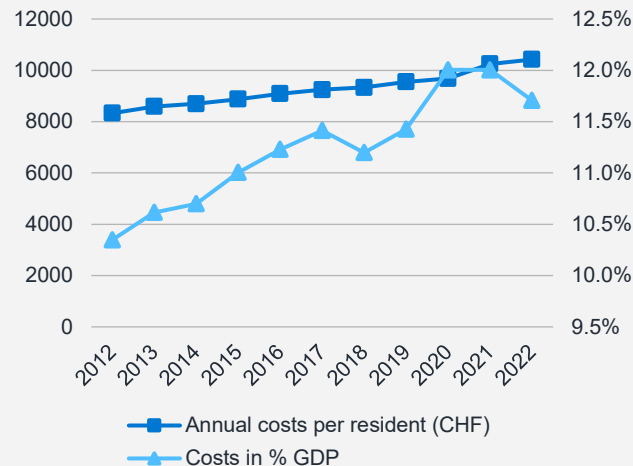
The increase in diseases in Spain is the result of interconnected demographic, behavioral, and social factors. An aging population has led to a higher prevalence of chronic conditions, such as hypertension and diabetes, while mental health disorders—particularly among women—have risen due to social and economic pressures. Additionally, the COVID-19 pandemic has intensified these challenges by affecting healthcare access and exacerbating mental health issues. At the same time, greater awareness and diagnosis of chronic conditions, along with a sharp rise in people reporting long-standing illness (**from 29% in 2020 to 39% in 2022**), have made the growing burden of disease in Spain more visible.<sup>1</sup>

In 2024, women generally exhibited higher case numbers than men across most major pathologies, particularly in musculoskeletal, endocrine/metabolic, and genitourinary diseases. The 2023 Spanish Health Survey reveals pronounced sex-based differences in health. Women report poorer overall health and a higher prevalence of chronic conditions, experience greater functional limitations, and make more extensive use of medications. These factors may help explain the higher utilization of healthcare services observed among women.

- The Swiss health system is based on mandatory private health insurance, which all residents are required to purchase. Coverage is universal in scope but financed differently from most other European systems: It is funded through individual insurance premiums, with subsidies available for low-income households. Every legal resident must contract with a private insurer for the basic package, which is strictly defined by federal law and includes hospital care, outpatient treatment, maternity services, and essential medications.
- Healthcare is delivered by a mix of public hospitals, private clinics, and self-employed professionals, with cantonal (member state or regional) governments playing a strong role in planning and financing. Insurers must accept all applicants without risk selection and offer community-rated premiums within each canton. Patients share in costs through deductibles (franchises) and copayments.
- In addition to the mandatory basic insurance, many residents purchase supplementary insurance for benefits not covered under the standard package, such as private hospital rooms, alternative medicine, or additional dental and optical services. This market is competitive but tightly regulated to ensure consumer protection.

## Healthcare costs in Switzerland

FIGURE 54: HEALTHCARE COSTS IN SWITZERLAND



Switzerland is one of the world's highest spenders on healthcare. In 2022, total health expenditure reached about **12.3% of GDP**.<sup>1</sup> In per-capita terms, this represents more than **CHF 10,000 per resident** annually.

The financing relies on **flat-rate insurance premiums** paid by individuals to private insurers. Premiums vary substantially between insurers and cantons. On top of this, patients contribute through **deductibles ("franchise")** and copayments. As a result, **OOP spending** is comparatively high, accounting for roughly **23% of total health expenditure**.<sup>2</sup>

Cantons play a decisive role: They fund a large share of hospital infrastructure and provide subsidies to help lower-income households pay their premiums. Federal risk equalization between insurers ensures solidarity across risk profiles. Despite these mechanisms, **premium growth has consistently outpaced wage growth**, fueling ongoing political debate about cost containment and reform.

1. [BFS Gesundheitsausgaben](#)  
 2. [eurohealthobservatory.who.int](#)  
 3. [FMH Ärztestatistik](#)

4. [Hplus & Wikipedia Hospital Beds](#)  
 5. [BFS Health Care Costs](#)  
 Source of the graph: [BFS Gesundheitsausgaben](#)

## Accessibility

Switzerland has a comparatively high physician density. In 2024, there were about **4.1 full-time physicians per 1,000 inhabitants**.<sup>3</sup> However, the picture looks different when focusing on primary care. The density of **general practitioners and other primary care doctors** averaged only **0.8 per 1,000 inhabitants**,<sup>3</sup> with strong regional disparities. In urban areas, the density reached about **1.0 per 1,000**, while in rural cantons it could fall to just **0.4 per 1,000**. These gaps reflect the increasing difficulty of ensuring equitable access to family doctors outside metropolitan centers.

Hospital capacity is also under pressure. The **number of hospital beds** in Switzerland has declined gradually over the past decades, stabilizing at just under 40,000 beds nationwide, which corresponds to roughly **4.4 beds per 1,000 inhabitants**.<sup>4</sup>

Overall, Switzerland combines a high overall physician supply with pronounced **urban-rural disparities** and a **steady decline in hospital bed availability**, highlighting structural challenges for the future organization of healthcare provision.

## Private health insurance complements

All residents are required to have **basic insurance** (under the Health Insurance Act, KVG). Insurers must accept all applicants without risk-selection or health questions. Premiums vary by age, canton of residence, and chosen deductible, but not by health status.

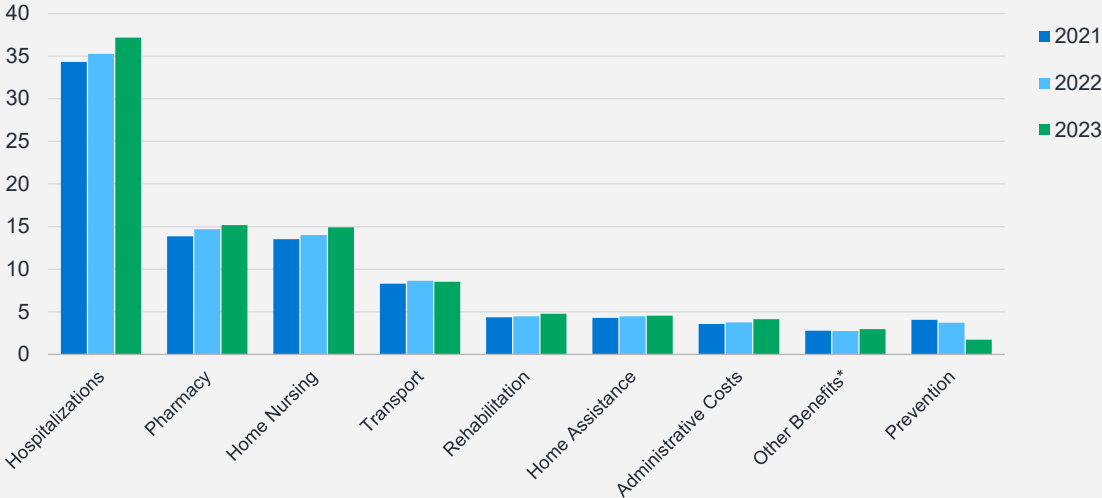
**Supplementary insurance** (under the Insurance Contract Act, VVG) is optional. It covers extras beyond the legally specified basic benefits: semi-private or private hospital rooms, additional comfort, dental care, alternative treatments, etc. In 2023, health care expenditures amounted to CHF 94 billion (CHF 881 per capita and month)<sup>5</sup>:

- 20% paid by the state for healthcare services
- 11% paid by the state for social security
- 31% paid by households for mandatory **basic insurance (CHF 29.5 billion)**
- 8% paid by households for **supplementary insurance (CHF 7.3 billion)**
- 22% paid by households for cost sharing and OOP payments

The **market structure** includes a relatively concentrated supplementary insurance sector. In 2023, the **eight largest insurers** in supplementary health insurance together held about **89.1%** of the premium volume. Major players include SWICA, Helsana, Groupe Mutuel, CSS, Visana, Sanitas, Concordia, and Assura.

## Overview on costs

FIGURE 55: AMOUNTS OF EXPENDITURE PER CARE ITEM (CHF BILLION)

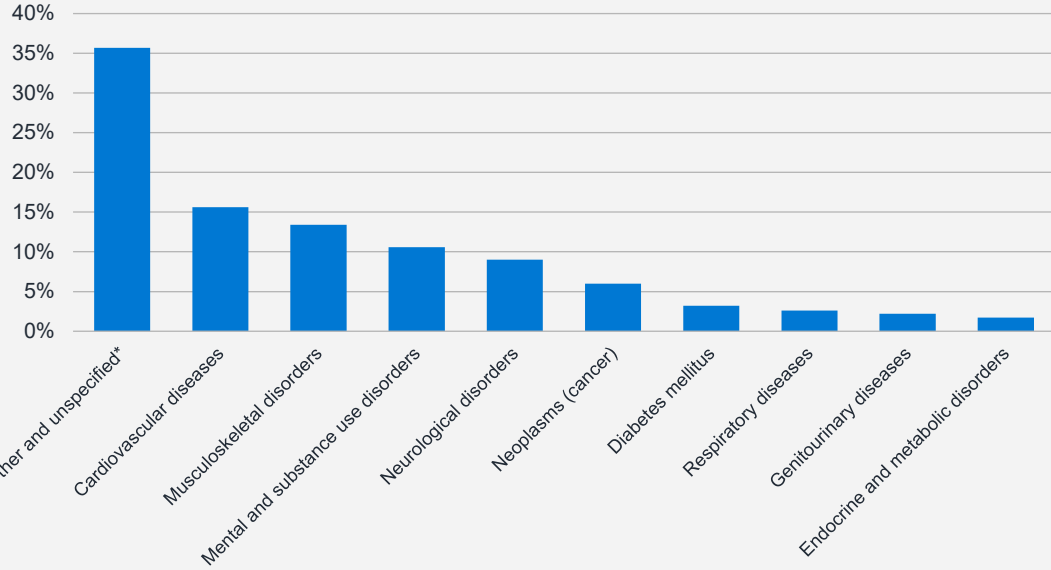


Between **2021 and 2023**, total healthcare spending in Switzerland increased steadily across most categories, with notable variation in growth rates. **Hospitalization costs** rose by **8%**, **pharmacy expenditures** by **9%**, and **home nursing** by **10%**, reflecting continued pressure from treatment intensity and aging demographics. **Administrative costs** showed the fastest increase at **15%**, underscoring the system’s growing overhead burden. **Rehabilitation** spending expanded by **9%**, consistent with higher demand for post-acute services, while **prevention** spending declined sharply by **57%**, standing out as the only area of substantial contraction within the overall upward trend.

Source of the graph and the figures in text: [Bundesamt für Statistik \(BFS\) – Kosten und Finanzierung des Gesundheitswesens \(COU\)](#) :

## Overview on pathologies

FIGURE 56: COST OF MAIN DISEASE CATEGORIES (% OF TOTAL, 2017)



A decomposition of Swiss healthcare spending (2017) shows that **cardiovascular diseases** accounted for **15.6%** of total costs, followed by **musculoskeletal disorders (13.4%)**, **mental and substance use disorders (10.6%)**, and **neurological conditions (9.0%)**. **Cancers** represented **6.0%**, and **diabetes 3.2%**. No more recent official decomposition is available, and the 2017 data may therefore not fully capture current expenditure patterns. A large residual category—“other and unspecified” (35.7%)—indicates the limitations of diagnostic coding, particularly in outpatient and long-term care data.

Source of the graph and the figures in text: [Stucki et al., BMC Health Services Research, 2023. Data year:2017.](#)

## Costs, premiums, and the role of subsidies

Switzerland’s health spending reached **CHF 94 billion** in 2023,<sup>1</sup> confirming its position among the highest per-capita spenders globally. Cost growth is driven by utilization and by medical-price dynamics—notably rising **wages in the healthcare sector, high energy and supply costs**, and the **diffusion of expensive therapies and technologies**. The result is a structural rise in unit costs across nearly all service types.

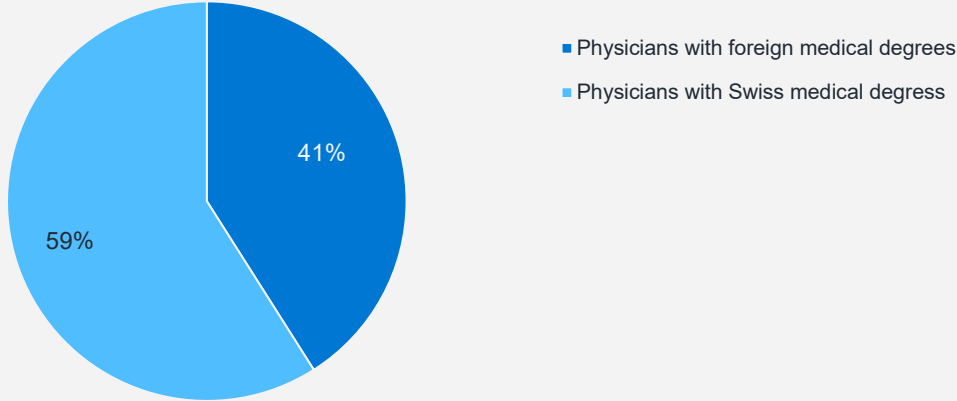
Because **compulsory health insurance premiums are flat-rate** and not linked to income, this dynamic translates directly into affordability pressure for households. Premiums continue to rise faster than wages, and the **share of household budgets absorbed by health insurance is expanding**, particularly for families and retirees with moderate incomes.

To maintain access, Switzerland relies heavily on **individual premium subsidies (Prämienverbilligungen)** financed jointly by the federal government and the cantons. In 2023, these subsidies amounted to about **CHF 5.9 billion**, supporting roughly **one in four residents**.<sup>2,3</sup> However, the upward trend in both **nominal premiums** and **subsidy outlays** reveals growing strain on cantonal budgets. Policymakers face a dual challenge: Subsidies must expand to prevent exclusion, yet excessive reliance on them risks crowding out other cantonal expenditures such as education and housing.

## Workforce scarcity and rural access

Switzerland shows a high overall physician density yet a **thin first-contact layer**. Primary care operates close to constraint while demand rises with aging. Risks are amplified by workforce demographics and sourcing: **41.3%** of doctors hold a **foreign qualification**,<sup>4</sup> and the pipeline of domestically trained physicians is insufficient to offset retirements—conditions that leave rural cantons exposed to service reductions, longer travel times, and more inter-hospital transfers. Capacity in acute care is increasingly **staff-constrained** rather than brick-and-mortar constrained, as hospital bed counts per 1,000 inhabitants have edged down while case complexity rises.

FIGURE 57: PHYSICIANS WITH SWISS VS. FOREIGN MEDICAL DEGREE



1 [BFS Health Care Costs](#)  
2 [Faktenblatt 2025 Prämienverbilligung](#)

3 [SRF Prämienverbilligungen](#)  
4 [FMH Ärzttestatistik](#)

## Solutions for a world at risk™

Milliman leverages deep expertise, actuarial rigor, and advanced technology to develop solutions for a world at risk. We help clients in the public and private sectors navigate urgent, complex challenges—from extreme weather and market volatility to financial insecurity and rising health costs—so they can meet their business, financial, and social objectives. Our solutions encompass insurance, financial services, healthcare, life sciences, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe.

[milliman.com](https://www.milliman.com)



### CONTACT

#### Belgium

Judith Houtepen  
[judith.houtepen@milliman.com](mailto:judith.houtepen@milliman.com)

Francesca Tiozzo  
[Francesca.Tiozzo@milliman.com](mailto:Francesca.Tiozzo@milliman.com)

#### France

Fanny Pouget  
[fanny.pouget@milliman.com](mailto:fanny.pouget@milliman.com)

Francois-Henri Toutain  
[francois-henri.toutain@milliman.com](mailto:francois-henri.toutain@milliman.com)

Clement Afoumado  
[clement.afoumado@milliman.com](mailto:clement.afoumado@milliman.com)

Germany  
Dennis Fehse  
[dennis.fehse@milliman.com](mailto:dennis.fehse@milliman.com)

#### UK

Joanne Buckle  
[joanne.buckle@milliman.com](mailto:joanne.buckle@milliman.com)

Somya Bansal  
[somya.bansal@milliman.com](mailto:somya.bansal@milliman.com)

#### Italy

Angela Carbone  
[angela.carbone@milliman.com](mailto:angela.carbone@milliman.com)

Nicola Biscaglia  
[nicola.biscaglia@milliman.com](mailto:nicola.biscaglia@milliman.com)

#### Spain

Jose Silveiro  
[jose.silveiro@milliman.com](mailto:jose.silveiro@milliman.com)

#### Switzerland

Bernhard König  
[bernhard.koenig@milliman.com](mailto:bernhard.koenig@milliman.com)