Health at a Glance 2025

OECD Indicators



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Foreword

Health at a Glance compares key indicators for population health and health system performance across OECD Members, Key Partners and accession candidate countries. Analysis draws from the latest comparable official national statistics and other sources. This 2025 edition illustrates differences across countries and over time in terms of health status, non-medical determinants and risk factors, access to and quality of care, health spending and health system resources. The thematic chapter in this edition is on gender and health.

This publication would not have been possible without the contribution of national data correspondents from the countries covered in this report, who provided most of the data and metadata, as well as detailed feedback to a draft of the report. The OECD also recognises the contribution of other international organisations, notably Eurostat and the World Health Organization, for providing data and comments. The opinions expressed and arguments employed herein do not necessarily reflect the official views of the OECD Member countries, the European Union or other international organisations.

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Reader's guide

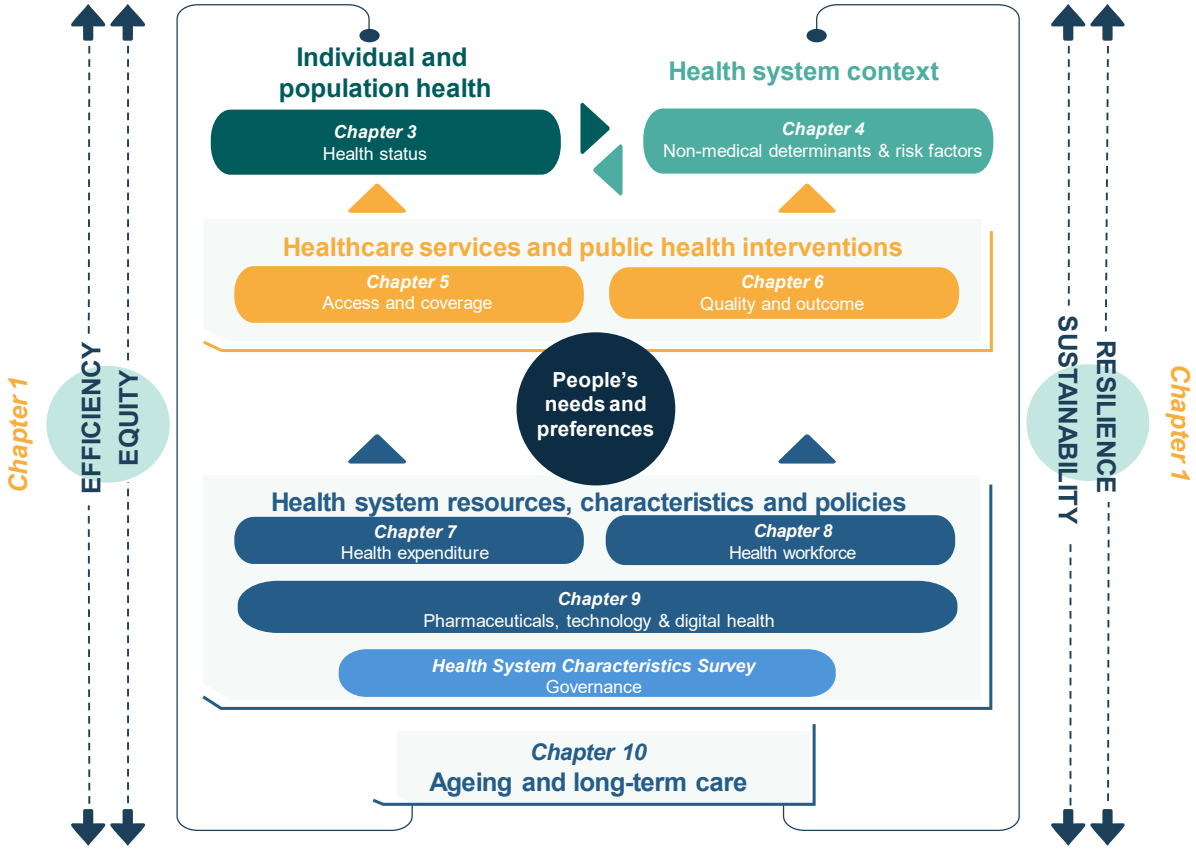
Health at a Glance 2025: OECD Indicators compares key indicators for population health and health system performance across the 38 OECD Member countries. Accession candidate and Key Partner countries are also included for some indicators – Argentina, Brazil, Bulgaria, People's Republic of China (China), Croatia, India, Indonesia, Peru, Romania, South Africa and Thailand.

Data presented in this publication come from official national statistics, unless otherwise stated.

Conceptual underpinnings

The conceptual framework underpinning *Health at a Glance* is the renewed OECD Health System Performance Assessment Framework (OECD, 2024[1]). Recently endorsed by the OECD's Health Committee, this framework considers the impact of health systems on people's health needs and preferences, within the context of the wider determinants of health beyond the health system. Figure 1 maps *Health at a Glance* indicators to this conceptual framework.

Figure 1. Mapping Health at a Glance Indicators to the OECD Health System Performance Assessment Framework



Source: Adapted from and building on OECD (2024[1]), *Rethinking Health System Performance Assessment: A Renewed Framework*, https://doi.org/10.1787/107182c8-en.

At the core of health system performance is the health and well-being of the population. When health services are of high quality and are accessible to all, people's health needs are met and their health outcomes better. Achieving access and quality goals, and ultimately better health outcomes, depends on there being sufficient resources for health. Health spending pays for health workers to provide needed care, as well as the goods and services required to prevent and treat illness. However, such spending will only contribute to better health outcomes and other health system objectives, now and in the future, if they are spent wisely. Efficiency, equity, sustainability and resilience are four cross-cutting dimensions of health system performance that are key to optimising health system resources.

At the same time, many factors outside the health system influence health status, notably socio-economic, demographic and environmental conditions. The demographic and socio-economic context also affects the demand for and supply of health services. Finally, the degree to which people adopt healthy lifestyles, a key determinant of health outcomes, depends on both effective health policies and wider socio-economic factors.

Structure of the publication

Health at a Glance 2025 compares OECD countries on each component of this general framework. It is structured around ten chapters. Chapter 1 presents an ***overview of health and health system performance***, based on a subset of core indicators from the report. Chapter 2 offers a more in-depth analysis on a particular theme, which in this edition is on ***gender and health***.

The next eight chapters then provide detailed country comparisons across a range of health and health system indicators. Where possible, time trend analysis and data disaggregated by demographic and socio-economic characteristics are included. Chapter 3 on ***health status*** highlights cross-country differences in life expectancy, the main causes of mortality, mental health, self-assessed health, and other indicators of health. Chapter 4 analyses ***non-medical determinants and risk factors*** such as smoking, alcohol, obesity, and environmental health risks. Chapter 5 on ***access and coverage*** investigates the affordability, availability, and use of services. Chapter 6 assesses ***quality and outcomes of care*** in terms of patient safety, clinical effectiveness, and whether healthcare is responsive to people's needs. Indicators across the full lifecycle of care are included, from prevention to primary, chronic and acute care. Chapter 7 on ***health expenditure and financing*** compares how much countries spend on health, how such spending is financed, and what funds are spent on. Chapter 8 examines the ***health workforce***, particularly the supply and remuneration of doctors and nurses. Chapter 9 analyses ***pharmaceuticals, technologies, and digital health***. Chapter 10 takes a closer look at ***ageing and long-term care***. This includes factors that influence the demand for long-term care, and the availability of high-quality health services. Beyond this publication, more qualitative data on health system characteristics are available at https://data-explorer.oecd.org/s/34u.

Presentation of indicators

Except for the first two chapters, indicators are presented in short sections. Each section first defines the indicator set analysed, highlights key findings conveyed by the data and related policy insights, and signals any significant national variation in methodology that might affect data comparability. After this text is a corresponding set of figures. These show current levels of the indicator and, where possible, trends over time. When an OECD average is included in a figure, it is the unweighted average of the OECD countries presented, unless otherwise specified. The number of countries included in this OECD average is indicated in the figure, and for charts showing more than one year this number refers to the latest year. The latest available comparable data are shown, typically from 2021-2023. Figures sometimes include data for a few countries that only have earlier pre-pandemic data available. In these cases, the year is indicated in a footnote under the figure.

Data limitations

Limitations in data comparability are indicated both in the text (in the box related to "Definition and comparability"), as well as in footnotes underneath the figures.

Data sources

Readers interested in using the data presented in this publication are encouraged to consult the online database *OECD Health Statistics* on OECD Data Explorer at https://data-explorer.oecd.org/s/306. Full documentation of definitions, sources and methods are available online at https://www.oecd.org/content/dam/oecd/en/data/datasets/oecd-health-statistics/Table-of-Content-Metadata-OECD-Health-Statistics-2025.pdf. More information on *OECD Health Statistics* is available at https://www.oecd.org/en/data/datasets/oecd-health-statistics.html, and on results of the Patient-Reported Indicator Surveys at https://doi.org/10.1787/c8af05a5-en.

Population figures

The population figures used to calculate rates per capita throughout this publication come from Eurostat for European countries, and from OECD data based on the *UN Demographic Yearbook* and *UN World Population Prospects* (various editions) or national estimates for non-European OECD countries (data extracted as of June 2025). Mid-year estimates are used. Population estimates are subject to revision, so they may differ from the latest population figures released by the national statistical offices of OECD Member countries. Note that some countries such as France, the United Kingdom and the United States have overseas territories. These populations are generally excluded. However, the calculation of GDP per capita and other economic measures may be based on a different population in these countries, depending on the data coverage.

Table 1. OECD country ISO codes

Australia	AUS	Japan	JPN
Austria	AUT	Korea	KOR
Belgium	BEL	Latvia	LVA
Canada	CAN	Lithuania	LTU
Chile	CHL	Luxembourg	LUX
Colombia	COL	Mexico	MEX
Costa Rica	CRI	Netherlands	NLD
Czech Republic (Czechia)	CZE	New Zealand	NZL
Denmark	DNK	Norway	NOR
Estonia	EST	Poland	POL
Finland	FIN	Portugal	PRT
France	FRA	Slovak Republic	SVK
Germany	DEU	Slovenia	SVN
Greece	GRC	Spain	ESP
Hungary	HUN	Sweden	SWE
Iceland	ISL	Switzerland	CHE
Ireland	IRL	Republic of Türkiye (Türkiye)	TUR
Israel	ISR	United Kingdom	GBR
Italy	ITA	United States	USA

Table 2. Accession candidate and Key Partner country ISO codes

Argentina	ARG	Indonesia	IDN
Brazil	BRA	Peru	PER
Bulgaria	BGR	Romania	ROU
People's Republic of China (China)	CHN	South Africa	ZAF
Croatia	HRV	Thailand	THA
India	IND		

References

OECD (2024), *Rethinking Health System Performance Assessment: A Renewed Framework*, OECD Health Policy Studies, OECD Publishing, Paris, https://doi.org/10.1787/107182c8-en. [1]

Executive summary

While countries have recovered from the pandemic, fundamental health challenges remain

- Life expectancy has recovered and is on an upward trajectory. Life expectancy averaged 81.1 years across OECD countries in 2023. However, it remained below pre-pandemic levels in 13 OECD countries.
- In total, there were over 3 million premature deaths in 2023 among people aged under 75 that could have been avoided through better prevention and healthcare interventions. Diseases of the circulatory system and cancer are the two leading causes of death, accounting for almost half of all deaths in OECD countries.
- For men, external causes – including suicide, accidents and violence – is the leading cause of potential years of life lost, whereas for women it is cancer. Women live longer than men, but they also spend more years in poor health (6.3 years after age 60, compared to 5.0 years for men).
- Amongst primary care users aged 45 and older, 82% reported having at least one chronic condition, and 52% two or more, on average across the OECD countries participating in the Patient-Reported Indicators Surveys (PaRIS).
- Mental ill-health remains a concern, particularly amongst young people. On average, 52% of 15-year-olds reported multiple health complaints including feeling low, having repeated headaches or dizziness in 2022, up from 37% in 2014.

Health systems account for around a tenth of economic output and employment

- In 2024, OECD countries spent 9.3% of their GDP on health. This is down from the peak reached during the COVID-19 crisis, but higher than pre-pandemic levels. In 16 OECD countries, health spending accounts for more than 10% of GDP.
- Projections point to spending from public sources as a share of GDP growing on average by 1.5 percentage points (p.p.) by 2045, driven largely by technological change, rising expectations of what healthcare can achieve, and ageing populations.
- Yet health spending already makes up 15% of government spending, a share that has increased slightly in most OECD countries over the past decade. Raising this share further may be challenging in many countries, given competing policy priorities and public finance constraints.
- The health workforce is growing, with about one in every nine jobs being in health or social care, on average across OECD countries. This looks set to increase further as demand for healthcare continues to increase. Foreign-trained workers are helping to fill gaps, with on average 20% of all doctors trained abroad in 2023, up from 16% in 2010.

Healthcare quality and access indicators show improvements over time

- Health indicators show continued improvement in the quality of acute care services. For example, the chance of survival after a heart attack or stroke is higher now than a decade ago: 30-day mortality rates following a heart attack averaged 6.5% in 2023, down from 8.2% in 2013, and for ischaemic stroke the figures were 7.7% in 2023 and 9.3% in 2013.
- Primary care is helping to keep people well and out of hospital, with avoidable hospital admissions falling in 28 of 30 OECD countries over the last decade. Patient satisfaction with primary care services is high, including amongst those with more complex needs: on average 87% of primary care users aged 45 and older with chronic conditions rated the care they received positively, and 78% trusted the last healthcare professional they saw.

Health system performance can be further improved, though more health spending does not always guarantee better outcomes

- Despite most countries having universal healthcare systems, some access problems remain. Waiting times remain a policy challenge in several countries. Socio-economic disparities are large, with people in the lowest income quintile 2.5 times more likely to report unmet medical care needs than those in the highest income quintile.
- Patient safety is an important concern – for example, only 44% of physicians and nurses perceived staff levels and work pace to be safe. And whilst safe prescribing in primary care has on average slightly improved over time, in terms of reduced volumes of antibiotics and opioids prescribed, these improvements have been small in most countries.
- Overall, countries with higher health spending have better health outcomes, but this is not always the case. For example, eight countries spend less than average on health as a share of GDP but still achieve better (lower) avoidable mortality rates.

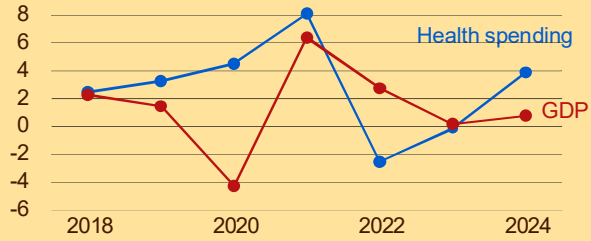
A renewed focus on value-for-money is essential for healthy populations and sustainable health systems, with preventive interventions playing a key role

- Combatting risk factors for health throughout the lifecycle is key to long-term health gains at low cost. Yet obesity rates continue to rise in over four-fifths of OECD countries, with 54% of adults overweight or obese, and 19% obese, on average. Harmful alcohol use is a concern, with 27% of adults reporting binge-drinking at least once per month. Whilst smoking rates have fallen, 15% of adults still smoke daily, and vaping rates are increasing.
- These risk factors extend to children. Amongst 15-year-olds, 20% were overweight or obese; 38% consumed alcohol in the last month; 15% smoked and 20% vaped at least monthly, on average across OECD countries. Some risky behaviours start even earlier in life: on average, 15% of 13-year-olds and 5% of 11-year-olds reported drinking alcohol in the last month.
- Many preventive and primary healthcare interventions are highly cost-effective in addressing these risk factors. Yet prevention spending only accounted for 3%, and primary healthcare spending 14%, of total health spending in 2023. The priority given to both prevention and primary healthcare spending is largely unchanged since a decade ago, with increases in prevention spending during the pandemic proving to be temporary.
- Improving the efficiency of input use is critical. Revisiting the health staff mix is one way in which efficiency can be enhanced, yet growth in the number of nurses and nursing graduates has been slower than for doctors and medical graduates. Innovation in service delivery also has great potential, notably through greater use of digital health. Here, indicators highlight some promising developments: for example the role of teleconsultations continues to grow and comprised 13% of all doctor consultations in 2023.

Infographic 1. Key facts and figures

Health spending on the rise again and back to pre-pandemic growth rates

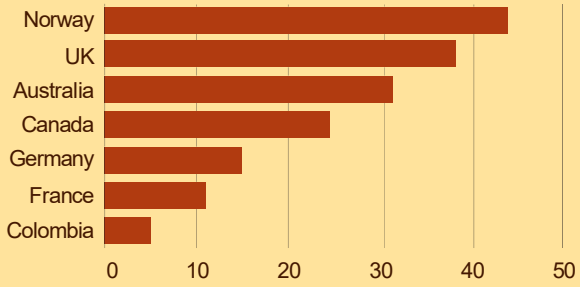
% annual real growth in health expenditure and GDP per capita, OECD average, 2018-2024



In 2024, OECD countries allocated around 9.3% of their GDP to health on average (above 8.8% prior to the COVID-19 pandemic). In 16 OECD countries it accounts for more than 10% of the economy.

Many countries turn to foreign-trained doctors to expand medical workforce

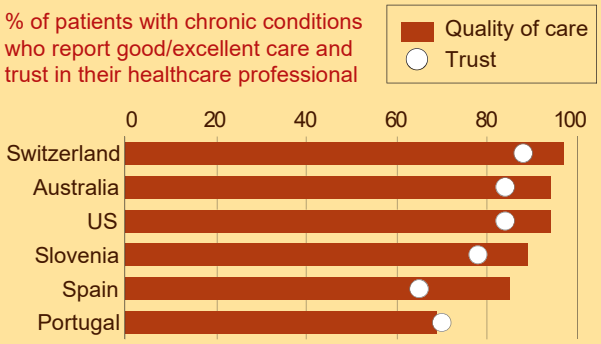
% of foreign-trained doctors, 2023



On average, 20% of all doctors across OECD countries were trained abroad in 2023, up from 16% in 2010.

Focusing on patient needs is critical to high quality care

% of patients with chronic conditions who report good/excellent care and trust in their healthcare professional



On average, 87% of patients with chronic conditions rated the care they received positively, and 78% trusted the last healthcare professional they saw.

Too many adults smoke, drink alcohol, have unhealthy diets, and lack exercise

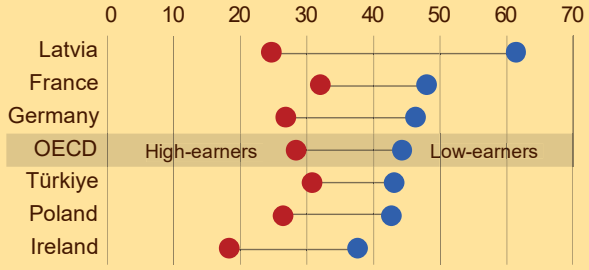
People aged 15 or over

	Obesity (%, self-reported)	Alcohol (litres consumed per capita)	Smoking daily (%)
OECD	19.0	8.5	14.8
Hungary	22.2	10.3	24.9
Korea	5.1	7.8	15.3
Sweden	16.5	7.4	8.5
UK	29.0	9.3	10.5
US	34.5	9.5	8.0

These risk factors extend to children under 15: on average, 38% consumed alcohol in the last month, while 15% smoked and 20% vaped at least monthly.

Low earners much more likely to report long-standing chronic conditions

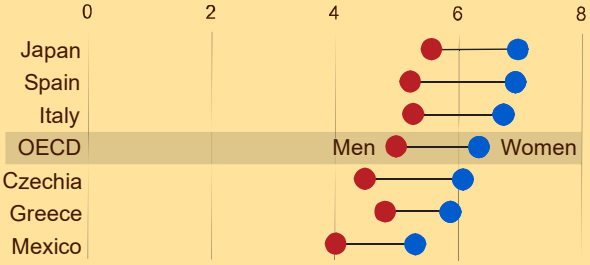
% of people reporting a long-standing illness or health problem, by income quintile, 2024 (or nearest year)



44% of people in the lowest income quintile report a long-term chronic condition, compared to only 28% in the highest income quintile.

Women live longer than men but spend a larger share of their life in poor health

Expected years spent with activity limitations after age 60



Women at age 60 can expect to live 3.4 years longer than men, but also to spend more years with activity limitations (6.3 vs 5.0 years).

1 Indicator overview: Country dashboards and major trends

This chapter analyses a core set of indicators on health and health systems. Country dashboards shed light on how countries compare across five dimensions: health status, non-medical determinants and risk factors, access, quality, and health system capacity and resources. Cross-cutting dimensions of health system performance – efficiency, equity, sustainability and resilience – are also explored.

Introduction

Health indicators offer an "at a glance" perspective on how healthy populations are, and how well health systems perform. This chapter provides a comparative overview of OECD countries across core indicators, organised around five dimensions of health and health systems (Table 1.1). Indicators are selected based on how relevant and actionable they are from a policy perspective, as well as the more practical consideration of data availability across countries.

Table 1.1. Population health and health system performance: Core indicators across five dimensions

Dimension	Indicator
Health status (Chapters 3, 10)	Life expectancy – years of life at birth Avoidable mortality – preventable and treatable deaths (per 100 000 people, age-standardised) Chronic conditions – diabetes prevalence (% adults, age-standardised) Self-rated health – population in poor health (% population aged 15+)
Non-medical determinants and risk factors (Chapter 4)	Smoking – daily smokers (% population aged 15+) Alcohol – litres consumed per capita (population aged 15+), based on sales data Obesity – population with body mass index (BMI) ≥ 30 (% population aged 15+) Ambient air pollution – exposure to ambient particulate matter, especially $PM_{2.5}$
Access to care (Chapters 5, 10)	Population coverage, eligibility – population covered for core set of services (% population) Population coverage, satisfaction – population satisfied with availability of quality healthcare (% population) Financial protection – expenditure covered by compulsory prepayment schemes (% total expenditure) Service coverage – population reporting unmet needs for medical care (% population)
Quality of care (Chapters 6, 10)	Safe primary care – antibiotics prescribed (defined daily dose per 1 000 people) Effective primary care – avoidable hospital admissions (per 100 000 people, age- and sex-standardised) Effective preventive care – mammography screening within the past two years (% of women aged 50-69) Effective secondary care – 30-day mortality following acute myocardial infarction and ischaemic stroke (per 100 admissions for people aged 45 and over, age- and sex-standardised)
Health system capacity and resources (Chapters 5, 7, 8, 9, 10)	Health spending – total health spending (per capita, USD using purchasing power parities) Health spending – total health spending (% GDP) Doctors – number of practising physicians (per 1 000 people) Nurses – number of practising nurses (per 1 000 people) Hospital beds – number of hospital beds (per 1 000 people)

Note: Avoidable hospital admissions cover asthma, chronic obstructive pulmonary disease, congestive heart failure and diabetes. See the chapters listed in the table for information on definition and comparability issues for each of these indicators, and the weblink to metadata in the "Readers' Guide".

Based on these indicators, *country dashboards* are produced. These compare a country's performance to that of other countries and to the OECD average. Comparisons are made based on the latest year available. For most indicators this refers to 2023, or to the nearest year if 2023 data are not available for a given country.

Country classification for each indicator is into one of the following three colour-coded groups:

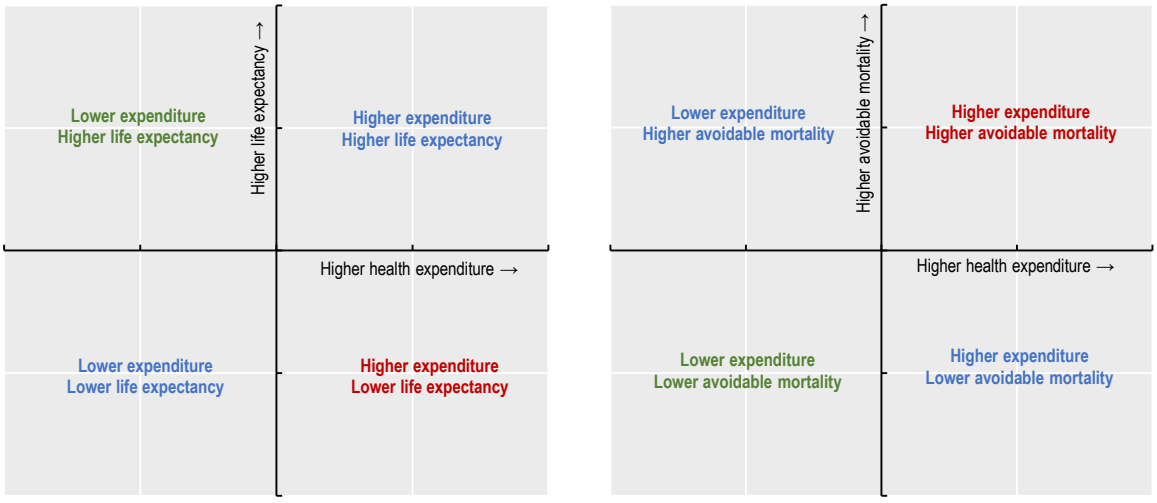
- blue when the country's performance is close to the OECD average
- green when the country's performance is considerably better than the OECD average
- red when the country's performance is considerably worse than the OECD average.

The exception to this grouping is the dashboard on health system capacity and resources, where indicators cannot be easily classified as showing better or worse performance. Here, lighter and darker shades of blue signal whether a country has considerably less or more of a given healthcare resource than the OECD average.

The chapter also provides a high-level summary of cross-cutting dimensions of health system performance. This includes exploring cross-country associations between health spending and health outcomes, access, and quality of care. *Quadrant charts* illustrate simple associations (not causal relationships) between how much countries spend on health and how effectively health systems function. Figure 1.1 shows the interpretation of each quadrant, taking health outcome variables as an example. Further information on the methodology, interpretation and use of country dashboards and quadrant charts is provided in the boxed text. A high-level summary of other efficiency indicators, alongside indicators for equity, sustainability, and resilience, is also provided. Such dimensions are in line with the renewed OECD Health System Performance Framework (OECD, 2024[1]).

Note that analysis in this chapter does not indicate which countries have the best-performing health systems, particularly as only a subset of the many indicators in *Health at a Glance* are included here. Rather, the analysis identifies some relative strengths and weaknesses. This can help policymakers determine priority action areas for their country, with subsequent chapters in *Health at a Glance* providing a more detailed suite of indicators, organised by topic area.

Figure 1.1. Interpretation of quadrant charts: Health expenditure and health outcome variables



Methodology, interpretation and use

Country dashboards

The classification of countries as being close to, better or worse than the OECD average is based on an indicator's standard deviation (a common statistical measure of dispersion). Countries are classified as "close to the OECD average" (blue) whenever the value for an indicator is within one standard deviation from the OECD average for the latest year. Such a classification reflects relative position across countries, but not performance against absolute benchmarks. Particularly large outliers (larger than three standard deviations) are excluded from calculations of the standard deviation to avoid statistical distortions.

For a typical indicator, about 65% of countries will be close to the OECD average, with the remaining 35% performing significantly better (green) or worse (red). When the number of countries that are close to the OECD average is higher (lower), it means that cross-country variation is relatively low (high) for that indicator. Changes over time by country are also indicated in the dashboard.

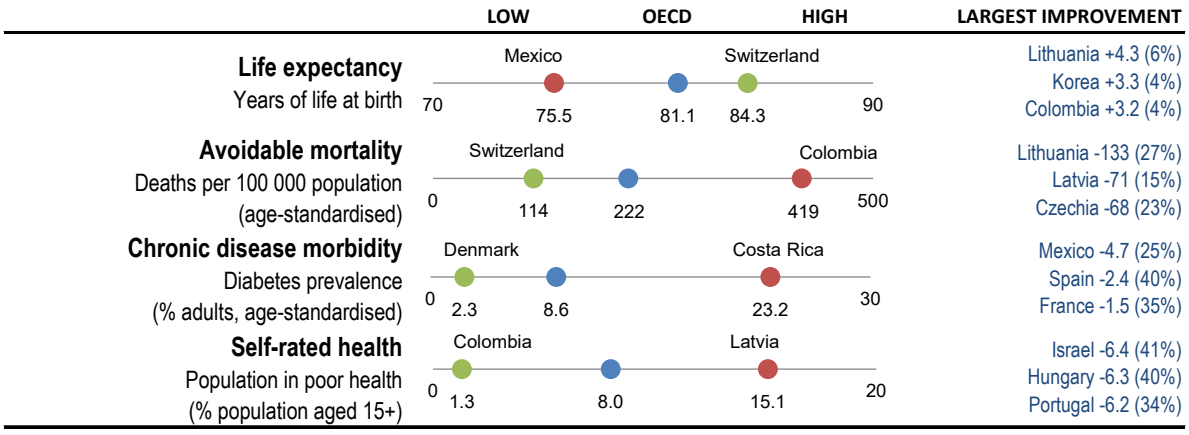
Quadrant charts

Quadrant charts plot health expenditure per capita against another indicator of interest (on health outcomes, access and quality of care). They show the percentage difference of each indicator compared to the OECD average. The centre of each quadrant chart is the OECD average. Data from the latest available year are used. A limitation is that lagged effects are not considered – for example, it may take some years before higher health spending translates into longer life expectancy.

Health status

Four indicators reflect core aspects of both the quality and quantity of life. Life expectancy is a key indicator for the overall health of a population; avoidable mortality focusses on premature deaths that could have been prevented or treated. Diabetes prevalence shows morbidity for a major chronic condition; self-rated health offers a more holistic measure of mental and physical health. Figure 1.2 presents a snapshot of health status across OECD countries, and Table 1.2 provides more detailed country comparisons.

Figure 1.2. Health status across the OECD, 2023 (or nearest year)



Note: Data for Chronic disease morbidity for 2022. Largest improvement shows countries with largest changes in absolute value over ten years (% change in brackets); 2010-2023 (LE), 2013-2023 (Avoidable mortality), 2012-2022 (Chronic disease morbidity) and 2014-2024 (Self-rated health).
Source: OECD Health Statistics 2025; WHO Global Health Observatory 2024.

Switzerland, Japan, Spain and Israel lead a large group of 27 OECD countries in which life expectancy at birth exceeded 80 years in 2023. Mexico and Latvia had the lowest life expectancy, at less than 76 years. While life expectancy often fell during the pandemic, the latest data show signs of a subsequent recovery. However, life expectancy in 2023 was still below pre-pandemic levels in 13 OECD countries.

Avoidable mortality rates (from preventable and treatable causes) were lowest in Switzerland and Luxembourg, where fewer than 130 per 100 000 people died prematurely. Colombia, Mexico and Latvia had the highest avoidable mortality rates, at over 400 premature deaths per 100 000 people. The avoidable mortality rate for men (303 deaths per 100 000) was double that of women (149 per 100 000), on average across OECD counties.

Diabetes prevalence in 2022 was highest in Costa Rica, Türkiye, Mexico and Chile, with 14% or more of adults living with diabetes (data age-standardised to the world population). They were lowest in Denmark, France and Spain, at under 4%. Prevalence rates have increased in most OECD countries, but have fallen in Mexico, Spain, France and Israel. Such upward trends are due in part to rising rates of obesity and physical inactivity.

Almost 8% of adults considered themselves to be in poor health in 2024, on average across OECD countries. This ranged from over 13% in Japan and Latvia, to under 3% in New Zealand and Colombia. However, socio-cultural differences, the share of older people and differences in survey design affect cross-country comparability. People with lower incomes are generally less positive about their health than people on higher incomes in all OECD countries.

Investing more in health systems contributes to gains in health outcomes by offering more accessible and higher-quality care. Differences in risk factors such as smoking, alcohol and obesity also explain cross-country variation in health outcomes. Social determinants of health matter too – notably income levels, better education and improved living environments.

Table 1.2. Dashboard on health status, 2023 (unless indicated)

	Life expectancy[1]		Avoidable mortality [2]		Chronic disease morbidity (2022)		Self-rated health (2024) [3]	
	Years of life at birth		Deaths per 100 000 population (age-standardised)		Diabetes prevalence (% adults, age-standardised)		Population in bad/very bad health (% population aged 15+)	
OECD	**81.1**	**+**	**222**	**+**	**8.6**	**-**	**8.0**	**+**
Australia	83.0	+	146	+	8.1	-	3.8	+
Austria	81.9	+	175	+	5.2	-	8.4	+
Belgium	82.5	+	184	+	6.7	-	8.3	+
Canada	81.7	+	184	+	6.8	-	3.2	-
Chile	81.6	+	229	+	14.0	-	6.1	N/A
Colombia	77.5	+	419	-	12.3	-	1.3	N/A
Costa Rica	81.0	+	241	-	23.2	-	N/A	N/A
Czechia	79.9	+	229	+	7.7	-	9.1	+
Denmark	81.8	+	175	+	2.3	+	7.7	-
Estonia	79.1	+	323	+	8.8	-	12.3	+
Finland	81.6	+	191	+	7.4	-	6.1	+
France	83.0	+	162	+	2.7	+	9.7	-
Germany	81.1	+	195	+	6.6	+	10.9	-
Greece	81.8	+	213	-	7.2	-	7.0	+
Hungary	76.7	+	390	+	11.2	-	9.6	+
Iceland	82.4	+	150	+	5.4	-	7.5	-
Ireland	82.9	+	166	+	7.8	-	4.8	-
Israel	83.8	+	134	+	7.9	+	9.1	+
Italy	83.5	+	145	+	7.2	-	5.9	+
Japan	84.1	+	135	+	6.4	-	13.5	N/A
Korea	83.5	+	151	+	10.4	-	11.3	+
Latvia	75.6	+	412	+	9.3	-	15.1	+
Lithuania	77.6	+	356	+	11.2	-	12.1	+
Luxembourg	83.4	+	123	+	5.9	-	6.2	+
Mexico	75.5	+	418	-	14.3	+	N/A	N/A
Netherlands	81.9	+	149	+	6.4	-	6.0	-
New Zealand	82.0	+	N/A	N/A	9.0	-	2.9	-
Norway	83.1	+	N/A	N/A	5.6	-	9.7	-
Poland	78.4	+	316	-	10.8	-	9.8	+
Portugal	82.5	+	180	+	7.4	-	12.1	+
Slovak Republic	78.2	+	297	+	8.9	-	11.9	+
Slovenia	82.0	+	187	+	10.8	-	8.4	+
Spain	84.0	+	142	+	3.6	+	7.3	+
Sweden	83.4	+	133	+	5.1	-	8.0	-
Switzerland	84.3	+	114	+	4.3	-	4.4	-
Türkiye	77.3	+	287	-	16.6	-	7.1	N/A
United Kingdom	81.0	+	227	-	8.8	-	8.3	+
United States	78.4	-	312	-	12.5	-	3.4	-

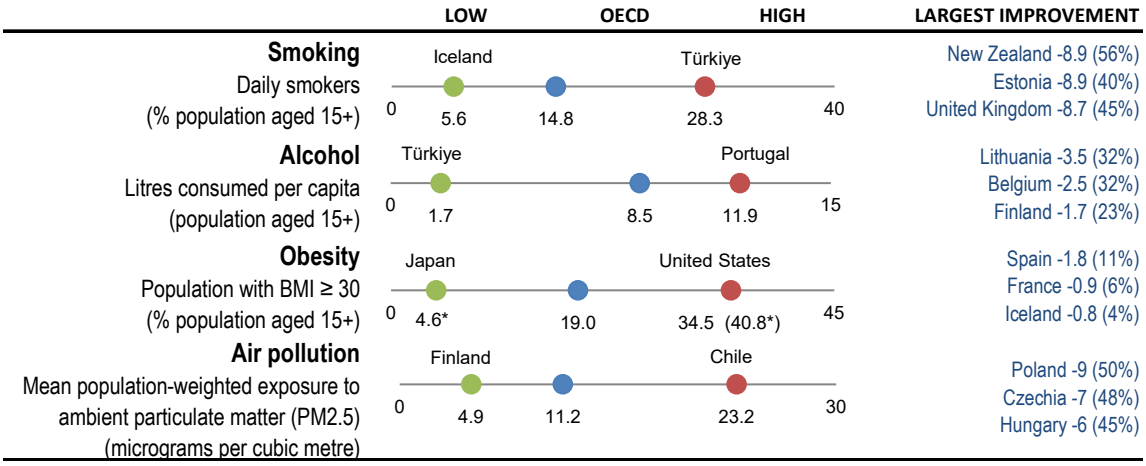
Better than the OECD average.
Close to the OECD average.
Worse than the OECD average.

1. 2024 data for Chile, Colombia and Mexico, 2022 data for Türkiye.
2. 2020-2022 data for Belgium, Canada, Chile, Colombia, Costa Rica, Denmark, Estonia, Finland, France, Germany, Greece, Iceland, Ireland, Israel, Italy, Japan, Korea, Mexico, Poland, Portugal, the United Kingdom and the United States.
3. 2019-2023 data for Australia, Canada, Chile, Colombia, Iceland, Israel, Japan, Switzerland, the United Kingdom and the United States.
Note: The symbol + indicates an improvement over time, - a deterioration over time, = no change. Costa Rica is excluded from the standard deviation calculation for diabetes prevalence.

Non-medical determinants and risk factors for health

Smoking, alcohol consumption and obesity are the three major individual risk factors for non-communicable diseases, contributing to a large share of worldwide deaths. Air pollution is also a critical environmental determinant of health. Figure 1.3 presents a snapshot of these indicators across OECD countries, and Table 1.3 provides more detailed country comparisons.

Figure 1.3. Risk factors for health across the OECD, 2023 (or nearest year)



Note: For obesity, values are self-reported except if marked with an asterisk when measured data are used. Data for air pollution for 2020. Largest improvement shows countries with largest changes in absolute value over the past decade (% change in brackets); 2013-2023 (Smoking, Alcohol, Obesity), 2010-2020 (Air pollution).
Source: OECD Health Statistics 2025; OECD Environment Statistics 2025.

Smoking causes multiple diseases, including cancers, cardiovascular and respiratory diseases. Across OECD countries, 14.8% of people aged 15 or older smoked daily in 2023. The proportion of daily smokers was highest in Türkiye, Hungary and Greece, where at least one in four people smoked daily. Iceland and Costa Rica had the lowest rates (6% or less) of daily smokers. Over the past decade, smoking rates declined in most countries, with a 26% average reduction since 2013.

Alcohol use is a leading cause of death and disability worldwide, particularly among people of working age. Measured through sales data, Latvia and Portugal reported the highest levels of consumption in 2023 (above 11.5 litres of pure alcohol per person per year). Average consumption was lowest in Türkiye, Israel, Costa Rica and Colombia (under 5 litres). Average consumption has fallen in most countries since 2013. Still, harmful drinking is a concern among certain population groups, and about one in four adults reported heavy episodic drinking at least monthly in the past year.

Obesity is a major risk factor for many chronic conditions, including diabetes, cardiovascular diseases and cancer. On average in 2023, 19% of the population was obese, and 54% of the population was overweight or obese (based on self-reported data). Obesity rates were highest in Mexico, the United States and New Zealand, and lowest in Japan and Korea (based on a combination of self-reported and measured data). Caution should be used when comparing countries with reporting differences, however, since obesity rates are generally higher when using measured data.

Air pollution is not only a major environmental threat but also causes a wide range of adverse health outcomes. OECD projections estimate that ambient (outdoor) air pollution may cause 6-9 million premature deaths a year worldwide by 2060. On average across OECD countries, populations were exposed to 11.2 microgrammes of fine particulate matter ($PM_{2.5}$) per cubic metre in 2020. Exposure to ambient air pollution has declined over time in most countries. But only one country, Finland, has levels of $PM_{2.5}$ pollution below the WHO Air Quality Guidelines of 5µg per m^3.

Table 1.3. Dashboard on non-medical determinants and risk factors, 2023 (unless indicated)

	Smoking[1]		Alcohol[2]		Obesity[3]		Air pollution (2020)	
	Daily smokers (% population aged 15+)		Litres consumed per capita (population aged 15+)		Population with BMI ≥ 30 (% population aged 15+)		Exposure to ambient particulate matter (micrograms per cubic metre)	
OECD	**14.8**	**+**	**8.5**	**+**	**19.0**	**-**	**11.2**	**+**
Australia	8.5	+	10.5	-	25.4 (30.7*)	-	8.1	-
Austria	20.6	N/A	11.3	+	16.6	-	10.9	+
Belgium	12.8	+	7.8	+	21.7*	-	11.1	+
Canada	8.7	+	8.1	+	23.7 (24.3*)	-	6.3	+
Chile	16.0	+	N/A	N/A	30.7	-	23.2	-
Colombia	9.8	N/A	4.2	-	N/A	N/A	13.9	+
Costa Rica	6.2	+	3.4	-	N/A	N/A	14.1	+
Czechia	15.9	+	11.2	+	19.3	-	14.1	+
Denmark	11.0	+	9.3	+	18.7	-	8.9	+
Estonia	13.2	+	10.9	+	19.9	-	6.1	+
Finland	11.3	+	7.4	+	24 (30.2*)	-	4.9	+
France	23.1	+	10.4	+	14.4	+	9.5	+
Germany	14.6	+	10.6	+	16.7	-	10.3	+
Greece	24.9	N/A	6.6	+	12.2	N/A	14.2	+
Hungary	24.9	N/A	10.3	+	22.2 (33.2*)	-	14.0	+
Iceland	5.6	+	7.7	-	21.4	+	5.5	+
Ireland	14.0	+	9.4	+	21 (22.2*)	-	8.0	+
Israel	17.0	-	2.7	-	18.1	-	18.6	+
Italy	19.5	+	8	-	11.8	-	14.3	+
Japan	15.7	+	6.7	+	4.6*	-	12.6	-
Korea	15.3	+	7.8	+	5.1 (7.2*)	-	N/A	N/A
Latvia	22.6	N/A	11.7	-	23.3*	-	11.8	+
Lithuania	18.9	N/A	11	+	20.3	-	9.2	+
Luxembourg	15.1	+	10.7	+	16.5	-	8.7	+
Mexico	8.5	-	6.2	-	36*	-	14.4	+
Netherlands	13.2	+	7.8	+	14.9	-	10.8	+
New Zealand	6.9	+	8.2	+	33.8*	-	6.3	+
Norway	8.0	+	6.2	-	16	-	6.1	+
Poland	17.1	N/A	10	+	18.5	-	17.8	+
Portugal	14.2	N/A	11.9	-	15.9	+	8.3	+
Slovak Republic	21.0	N/A	9.4	+	19.4	-	15.3	+
Slovenia	17.4	N/A	9.7	-	19.4	-	14.0	+
Spain	19.8	+	11.1	-	14.9	+	9.7	+
Sweden	8.5	+	7.4	-	16.5	-	5.6	+
Switzerland	16.1	+	8	+	12.1	-	9.0	+
Türkiye	28.3	-	1.7	-	20.2	-	22.1	+
United Kingdom	10.5	+	9.3	+	29 (28*)	-	9.7	+
United States	8.0	+	9.5	-	34.5 (40.8*)	-	7.7	+

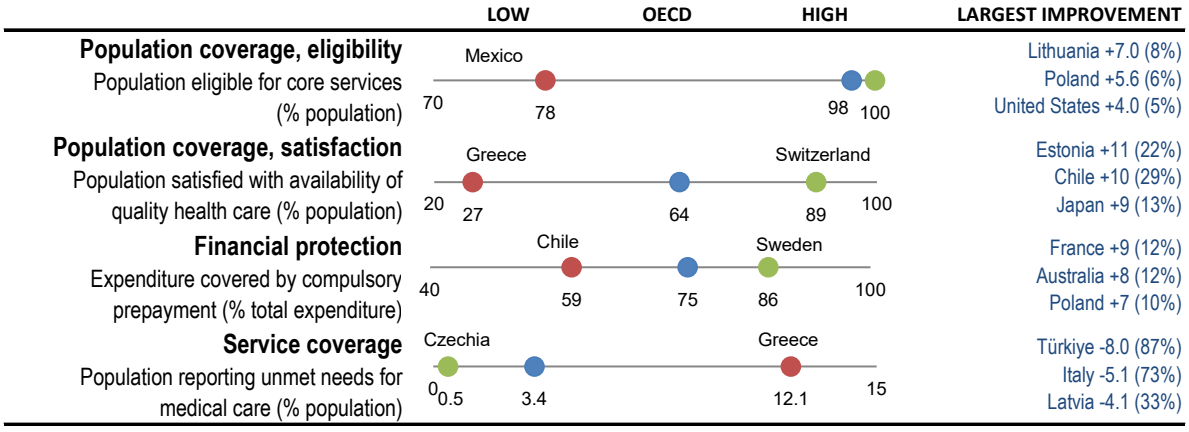
Better than the OECD average.
Close to the OECD average.
Worse than the OECD average.

1. 2024 data for Denmark, Estonia, Iceland, Ireland, Israel, Luxembourg, New Zealand, Norway. 2019-2022 data for Australia, Austria, Chile, Colombia, Finland, Germany, Greece, Hungary, Latvia, Lithuania, Poland, Portugal, Slovenia, the Slovak Republic, Spain, Switzerland and Türkiye.
2. 2024 data for Ireland, Norway and Mexico. 2020-2022 data for Australia, Belgium, Canada, Colombia, Germany, Greece, Israel, Italy, Luxembourg, Portugal and the United States.
3. 2024 data for Ireland, Israel and Korea. 2019-2022 data for Australia, Austria, Canada, Czechia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Latvia, Lithuania, Luxembourg, Mexico, Norway, Poland, Portugal, Slovenia, the Slovak Republic, Spain, Switzerland, Türkiye and the United Kingdom.
Note: The symbol + indicates an improvement over time, - a deterioration, and = no change. For obesity, values are self-reported except if marked with an asterisk when measured data are also shown. Measured data are typically higher and more accurate than self-reported data, but with less country coverage.

Access to care

Ensuring equitable access is critical for high-performing health systems and more inclusive societies. Population coverage – measured by the share of the population eligible for a core set of services and those satisfied with the availability of quality healthcare – offers an initial assessment of access to care. The proportion of spending covered by prepayment schemes gives further insight into financial protection. The share of populations reporting unmet needs for medical care offers a measure of effective service coverage. Figure 1.4 presents a snapshot of access to care across OECD countries, and Table 1.4 provides more detailed country comparisons.

Figure 1.4. Access to care across the OECD, 2023 (or nearest year)



Notes: Largest improvement shows countries with largest change in absolute value over ten years (% change in brackets). 2014-2024 (Population coverage, eligibility, Population coverage, satisfaction, Service coverage) 2013-2023 (Financial protection). Eligibility for population coverage is 100% in 26 countries. Population eligibility and satisfaction data from 2024.
Source: OECD Health Statistics 2025, Gallup World Poll 2024, Eurostat based on EU-SILC.

In terms of the share of the population eligible for coverage, most OECD countries have achieved universal (or near-universal) coverage for a core set of services. However, in Mexico, population coverage was 78% in 2024, and coverage was below 95% in a further three countries (Costa Rica, Estonia, the United States).

Satisfaction with the availability of quality health services offers further insight into effective coverage. On average across OECD countries in 2024, 64% of people were satisfied with the availability of quality health services where they live. Citizens in Switzerland, Belgium, Denmark and Luxembourg were most likely to be satisfied, whereas fewer than 50% of citizens were satisfied in Greece, Türkiye, Hungary, Italy, Chile and Colombia. Satisfaction levels have decreased slightly over time in a majority of OECD countries.

The degree of cost sharing applied to those services also affects access to care. Across OECD countries, around 75% of all healthcare costs were covered by government or compulsory health insurance schemes in 2023. However, in Chile, Latvia, Korea, Greece and Portugal only about 60% of all health spending was covered by publicly mandated schemes.

In terms of service coverage, on average across 28 OECD countries with comparable data, only 3.4% of the population reported that they had unmet care needs due to cost, distance or waiting times in 2024. However, over 8% of the population reported unmet needs in Greece, Canada, Finland, Estonia and Latvia. Socio-economic disparities are significant in most countries, with the income gradient largest in Greece, Latvia and Finland.

Table 1.4. Dashboard on access to care, 2023 (unless indicated)

	Population coverage, eligibility (2024) [1]		Population coverage, satisfaction (2024) [2]		Financial protection [3]		Service coverage (2024) [4]	
	Population eligible for core services (% population)		Population satisfied with availability of quality healthcare (% population)		Expenditure covered by compulsory prepayment (% total expenditure)		Population reporting unmet needs for medical care (% population)	
OECD	**98**	**+**	**64**	**-**	**75.1**	**+**	**3.4**	**+**
Australia	100	=	71	-	72.8	+	N/A	N/A
Austria	100	=	78	-	76.7	+	1.0	-
Belgium	98	-	86	-	73.6	-	1.3	+
Canada	100	=	50	-	70.3	-	9.1	N/A
Chile	97	+	44	+	59.3	-	N/A	N/A
Colombia	99	+	46	+	N/A	N/A	N/A	N/A
Costa Rica	93	-	70	+	N/A	N/A	N/A	N/A
Czechia	100	-	75	-	84.5	-	0.5	+
Denmark	100	=	86	+	83.3	-	3.1	-
Estonia	94	=	62	+	75.8	+	8.5	+
Finland	100	=	61	-	81.0	+	8.5	-
France	100	=	60	-	84.4	+	4.1	-
Germany	100	=	81	-	85.9	+	0.8	+
Greece	100	N/A	27	-	60.9	-	12.1	-
Hungary	96	=	41	-	73.7	+	1.0	+
Iceland	100	=	62	-	83.6	+	2.8	+
Ireland	100	=	65	-	76.6	+	2.9	+
Israel	100	=	73	+	62.1	-	N/A	N/A
Italy	100	=	44	-	73.1	-	1.9	+
Japan	100	=	80	+	84.8	+	N/A	N/A
Korea	100	=	69	+	60.4	+	N/A	N/A
Latvia	100	=	54	+	59.6	-	8.4	+
Lithuania	99	+	53	+	67.3	+	4.3	-
Luxembourg	100	=	86	-	85.6	+	1.0	-
Mexico	78	-	56	+	N/A	N/A	N/A	N/A
Netherlands	100	+	83	-	82.7	+	0.6	-
New Zealand	100	=	63	-	N/A	N/A	N/A	N/A
Norway	100	=	80	-	85.7	+	1.6	-
Poland	97	+	51	+	77.6	+	3.8	+
Portugal	100	=	58	-	61.5	-	2.5	+
Slovak Republic	96	+	56	-	78.9	+	1.6	+
Slovenia	100	=	71	-	73.6	+	3.4	-
Spain	100	+	62	-	73.2	+	1.8	-
Sweden	100	=	75	-	86.1	+	2.2	-
Switzerland	100	=	89	-	67.5	+	1.3	-
Türkiye	99	+	41	-	N/A	N/A	1.2	+
United Kingdom	100	=	61	-	81.5	+	4.5	-
United States	93	+	75	-	N/A	N/A	N/A	N/A

Better than the OECD average.
Close to the OECD average.
Worse than the OECD average.

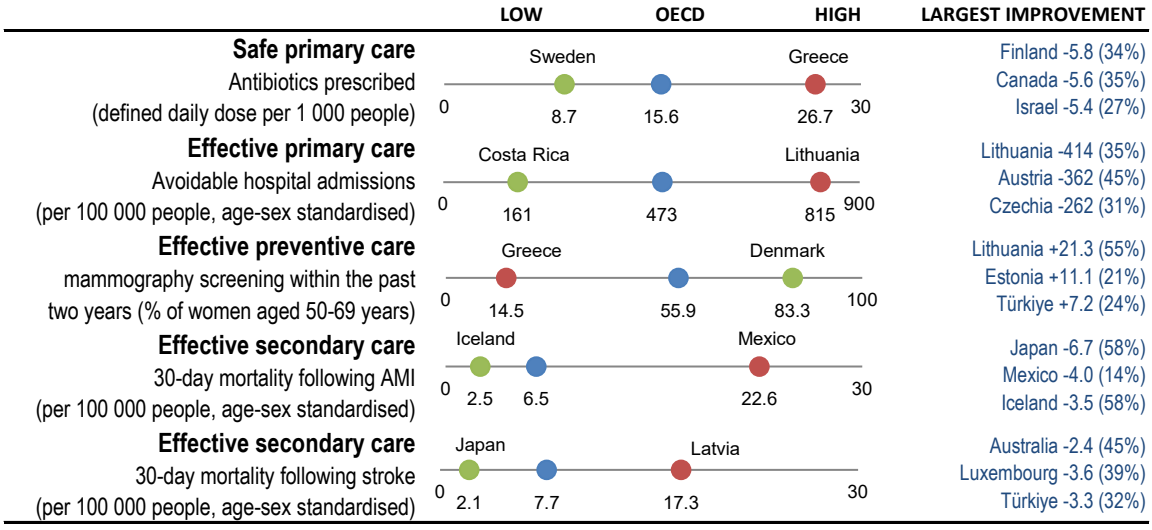
Note: The symbol + indicates an improvement over time, - a deterioration, and = no change. Mexico is excluded from standard deviation calculation for coverage.

1. 2021-2023 data for Austria, Belgium, Costa Rica, Denmark, Germany, Hungary, Iceland, Japan, Korea, Mexico, the Netherlands, Poland, Portugal, the Slovak Republic, Sweden, Switzerland, Türkiye, the United Kingdom and the United States.
2. 2023 data for Luxembourg.
3. 2022 data for Australia, Israel, Norway and the United Kingdom.
4. 2018-2023 data for Canada, Iceland, Switzerland and the United Kingdom.

Quality of care

High-quality care requires health services to be safe, appropriate, clinically effective and responsive to patient needs. Antibiotic prescriptions and avoidable hospital admissions are examples of indicators that measure the safety and appropriateness of primary care. Breast cancer screening is an indicator of the quality of preventive care; 30-day mortality following acute myocardial infarction (AMI) and stroke measures the clinical effectiveness of secondary care. Figure 1.5 presents a snapshot of the quality and outcome of care across OECD countries, and Table 1.5 provides more detailed country comparisons.

Figure 1.5. Quality of care across the OECD, 2023 (or nearest year)



Note: Largest improvement shows countries with largest changes in absolute value over ten years; 2013-2023 (% change in brackets).
Source: OECD Health Statistics 2025; ECDC 2023 (for EU/EEA countries on antibiotics prescribed).

The overuse, underuse or misuse of antibiotics and other prescription medicines contribute to increased antimicrobial resistance and represent wasteful spending. The total volumes of antibiotics prescribed in 2023 varied three-fold across countries, with Sweden, the Netherlands and Austria reporting the lowest volumes per population, and Greece and Korea reporting the highest. Across most OECD countries, the volume of antibiotics prescribed has decreased slightly over time.

Asthma, chronic obstructive pulmonary disease, congestive heart failure and diabetes are all chronic conditions that can largely be treated in primary care – hospital admissions for such conditions may signal quality issues in primary care, with the proviso that very low admission rates may also partly reflect limited access. Aggregated together, such avoidable hospital admissions were highest in Lithuania, Germany and the United States in 2023, among 31 countries with comparable data. In almost all countries, these avoidable hospital admissions have been declining over the past decade.

Breast cancer is the cancer with the highest incidence among women in all OECD countries, and the second most common cause of cancer deaths among women. Timely mammography screening is critical to identify cases, allowing treatment to start at an early stage of the disease. In 2023, mammography screening rates were highest in Denmark, Sweden, Finland and the United States (80% or higher among women aged 50-69). Screening rates were lowest in Greece, Mexico and Costa Rica (all under 25%).

Mortality following AMI and stroke are long-established indicators of the quality of acute care. Both have been declining steadily in the last decade in most countries, yet important cross-country differences still exist. Looking at the two indicators together, Mexico and Latvia had the highest 30-day mortality rates in 2023. Norway, Australia, the Netherlands and Japan had the lowest rates (comparisons based on unlinked data, as defined in Chapter 6).

Table 1.5. Dashboard on quality of care, 2023 (unless indicated)

	Safe primary care[1]		Effective primary care[2]		Effective preventive care[3]		Effective secondary care[4]		
	Antibiotics prescribed (defined daily dose per 1 000 people		Avoidable hospital admissions (per 100 000 people, age-sex standardised)		Mammography screening within the past 2 years (% women aged 50-69)		AMI	Stroke	
							30-day mortality following AMI or stroke (per 100 000 people, age-sex standardised, unlinked data)		
OECD	**15.6**	**+**	**473**	**+**	**55.9**	**+**	**6.5**	**7.7**	**+**
Australia	17.8	+	606	+	51.3	-	3.3	4.1	+
Austria	9.5	+	440	+	40.1	+	6.0	6.0	+
Belgium	19.1	+	529	+	58.0	-	7.0	8.0	+
Canada	10.5	+	440	+	N/A	N/A	4.5	7.6	+
Chile	N/A	N/A	264	+	39.5	+	8.3	8.7	+
Colombia	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Costa Rica	N/A	N/A	161	+	21.7	-	N/A	N/A	N/A
Czechia	15.0	+	592	+	60.3	+	5.2	8.1	+
Denmark	14.3	+	514	+	83.3	-	4.5	4.9	+
Estonia	11.2	-	384	+	64.5	+	9.1	8.0	+
Finland	11.1	+	411	+	81.5	-	7.0	9.4	+
France	22.3	+	N/A	N/A	46.7	-	N/A	N/A	N/A
Germany	11.7	+	810	+	52.0	-	7.9	7.0	=
Greece	26.7	+	N/A	N/A	14.5	N/A	N/A	N/A	N/A
Hungary	13.1	+	N/A	N/A	47.7	+	6.5	7.7	+
Iceland	17.2	+	343	+	56.0	-	2.5	8.9	+
Ireland	20.7	-	545	+	69.3	-	5.6	6.8	+
Israel	14.5	+	443	+	70.5	+	4.5	4.4	+
Italy	21.2	+	224	+	55.4	-	4.7	6.9	+
Japan	10.0	+	N/A	N/A	44.7	+	4.9	2.1	+
Korea	25.5	-	376	+	70.1	+	8.4	3.3	+
Latvia	13.3	-	N/A	N/A	36.1	+	13.5	17.3	+
Lithuania	16.3	-	815	+	59.7	+	9.6	11.7	+
Luxembourg	18.7	+	554	-	54.9	-	8.6	5.6	+
Mexico	N/A	N/A	301	+	20.2	+	22.6	17.0	+
Netherlands	8.8	+	364	+	70.2	-	2.9	5.1	+
New Zealand	N/A	N/A	N/A	N/A	67.9	-	4.6	6.7	+
Norway	14.1	+	458	+	76.6	+	2.6	4.0	+
Poland	21.8	-	809	+	37.3	N/A	6.7	10.5	+
Portugal	18.0	-	236	+	55.5	N/A	7.1	9.3	+
Slovak Republic	19.0	+	728	+	42.7	N/A	5.4	7.6	+
Slovenia	11.9	+	402	+	77.5	-	5.7	11.7	+
Spain	22.5	-	426	+	68.9	N/A	6.3	9.4	+
Sweden	8.7	+	384	+	83.0	N/A	3.4	4.9	+
Switzerland	N/A	N/A	459	-	50.0	+	6.2	7.9	+
Türkiye	12.1	-	N/A	N/A	37.4	+	6.0	7.0	+
United Kingdom	15.6	+	447	+	66.4	-	6.4	8.5	+
United States	N/A	N/A	733	+	79.8	-	5.2	4.5	+

Better than the OECD average.
Close to the OECD average.
Worse than the OECD average.

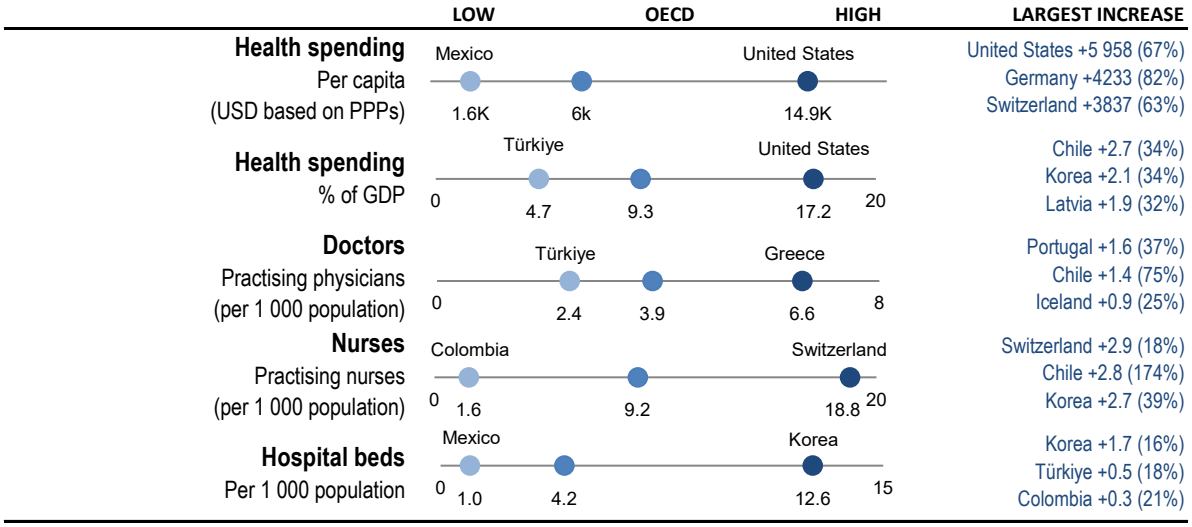
1. 2019-2021 data for Israel, Japan, Sweden and the United Kingdom.
2. 2020-2022 data for Chile, Costa Rica, Mexico and the United States.
3. 2020-2022 data for Japan, Mexico and Switzerland.
4. 2021-2022 data for Chile, Mexico, New Zealand and the United States.

Note: The symbol + indicates an improvement over time, - a deterioration, and = no change. Avoidable hospital admissions cover asthma, chronic obstructive pulmonary disease, congestive heart failure and diabetes. Mexico is excluded from standard deviation calculation for AMI mortality. Colour coding for effective secondary care is based on the average level of 30-day mortality following AMI or stroke (per 100 000 people, age-sex standardised).

Health system capacity and resources

Having sufficient healthcare resources is critical to a resilient health system. More resources, though, do not automatically translate into better health outcomes – the effectiveness and distribution of spending is also important. Health spending per capita summarises overall resource availability. The number of practising doctors and nurses provides further information on the supply of health workers. The number of hospital beds is an indicator of acute care capacity. Figure 1.6 presents a snapshot of health system capacity and resources across OECD countries, and Table 1.6 provides more detailed country comparisons.

Figure 1.6. Health system capacity and resources across the OECD, 2023 (or nearest year)



Note: Health spending data from 2024. Largest increase shows countries with largest changes in absolute value over ten years (% change in brackets); 2014-2024 (Health spending), 2013-2023 (Doctors, Nurses and Hospital beds).
Source: OECD Health Statistics 2025.

Overall, countries with higher health spending and higher numbers of health workers and other resources have better health outcomes, access and quality of care. However, the absolute quantity of resources invested is not a perfect predictor of better outcomes – risk factors for health and the wider social determinants of health are also critical, as is the efficient use of healthcare resources.

The United States spent considerably more than any other country (USD 14 885 per person, adjusted for purchasing power) in 2024, and also spent the most when measured as a share of gross domestic product (GDP). Health spending per capita was also relatively high in Switzerland, Norway, Germany, the Netherlands and Austria. Mexico, Colombia, Costa Rica and Türkiye spent the least, at less than USD 2 500 per capita. Trends in the health-to-GDP ratio over the past two decades translate into a distinct pattern with significant step increases in 2009 and 2020, and a period of stability in between.

A large part of health spending is translated into wages for the workforce. The number of doctors and nurses is therefore an important indicator to monitor how resources are being used. In 2023, the number of doctors ranged from 2.5 or fewer per 1 000 population in Türkiye to 5 or more per 1 000 in Austria, Italy, Norway, Greece and Portugal. However, numbers in Portugal and Greece are overestimated as they include all doctors licensed to practise. On average, there were just over 9 nurses per 1 000 population in OECD countries in 2023, ranging from around 3 per 1 000 or fewer in Colombia, Türkiye and Mexico to over 15 per 1 000 in Switzerland, Norway and Iceland. In Switzerland, associate professional nurses explain this high density.

The number of hospital beds provides an indication of resources available for delivering inpatient services. COVID-19 highlighted the need to have sufficient hospital beds (particularly intensive care beds), together with enough doctors and nurses. Still, a surplus of beds may cause unnecessary use and therefore costs – notably for patients whose outcomes may not improve from intensive care. Across OECD countries, there were on average 4.2 hospital beds per 1 000 people in 2023. Over two-thirds of OECD countries reported between 3 and 8 hospital beds per 1 000 people. Korea and Japan, however, had far more hospital beds (12-13 per 1 000 people), while Mexico, Costa Rica and Sweden had relatively few.

Table 1.6. Dashboard on health system capacity and resources, 2023 (unless indicated)

	Health spending (2024)				Doctors[1]		Nurses[2]		Hospital beds[3]	
	Per capita (USD based on purchasing power parities)		% GDP		Practising physicians (per 1 000 population)		Practising nurses (per 1 000 population)		Per 1 000 population	
OECD	**5 967**	**+**	**9.3**	**+**	**3.9**	**+**	**9.2**	**+**	**4.2**	**-**
Australia	7 469	+	10.3	+	4.2	+	13.0	+	3.8	+
Austria	8 401	+	11.8	+	5.5	+	10.6	N/A	6.6	-
Belgium	7 750	+	11.0	+	3.4	+	11.5	+	5.4	N/A
Canada	7 301	+	11.3	+	2.7	+	10.0	+	2.5	-
Chile	3 749	+	10.5	+	3.3	+	4.4	+	1.9	-
Colombia	1 877	+	8.1	+	2.5	+	1.6	+	1.9	+
Costa Rica	1 935	+	6.8	-	N/A	N/A	N/A	N/A	1.1	-
Czechia	5 014	+	8.5	+	4.2	+	9.0	+	6.4	-
Denmark	7 071	+	9.4	-	4.5	+	10.5	+	2.3	-
Estonia	3 768	+	7.8	+	3.5	+	6.6	+	4.1	-
Finland	6 655	+	10.6	+	2.9	+	12.7	+	2.6	-
France	7 367	+	11.5	-	3.9	N/A	8.8	+	5.4	-
Germany	9 365	+	12.3	+	4.7	+	12.2	+	7.7	-
Greece	3 607	+	8.1	+	6.6	+	3.8	+	4.2	-
Hungary	3 303	+	6.5	-	3.6	+	5.5	N/A	6.5	-
Iceland	6 770	+	9.0	+	4.5	+	15.2	-	2.6	-
Ireland	7 813	+	6.9	-	3.8	+	13.7	N/A	2.9	+
Israel	4 352	+	7.6	+	3.5	+	5.6	+	3.0	-
Italy	5 164	+	8.4	-	5.4	N/A	6.9	+	3.0	-
Japan	5 790	+	10.6	-	2.6	+	12.2	+	12.5	-
Korea	4 797	+	8.4	+	2.7	+	9.5	+	12.6	+
Latvia	3 411	N/A	7.6	+	3.4	+	4.2	-	5.0	-
Lithuania	4 259	+	7.6	+	4.6	+	7.5	-	5.5	-
Luxembourg	8 087	+	5.9	+	4.0	+	14.2	+	3.9	-
Mexico	1 588	+	5.9	+	2.7	+	3.0	+	1.0	-
Netherlands	8 436	+	10.0	-	3.9	+	11.1	+	2.3	-
New Zealand	6 097	+	10.1	+	3.7	+	11.7	+	2.5	-
Norway	9 393	+	9.7	+	5.0	+	15.6	+	3.3	-
Poland	4 284	+	8.1	+	3.9	N/A	5.9	+	6.3	-
Portugal	5 212	+	10.2	+	5.8	+	7.6	+	3.4	-
Slovak Republic	4 021	+	8.4	+	3.8	+	5.7	-	5.7	-
Slovenia	5 527	+	9.9	+	3.5	+	10.5	+	4.1	-
Spain	5 346	+	9.2	+	4.4	+	5.9	+	2.9	-
Sweden	7 871	+	11.3	+	4.5	+	11.0	-	1.9	-
Switzerland	9 963	+	11.8	+	4.5	+	18.8	+	4.4	-
Türkiye	2 309	+	4.7	+	2.4	+	2.9	+	3.1	+
United Kingdom	6 747	+	11.1	+	3.4	+	9.1	+	2.4	-
United States	14 885	+	17.2	+	2.7	+	12.4	+	2.8	-

Above the OECD average.
Close to the OECD average.
Below the OECD average.

1. 2017-2022 data for Japan, Sweden and the United States.
2. 2017-2022 data for Belgium, France, Japan and Sweden.
3. 2016-2022 data for Australia, Costa Rica and the United States.

Note: The symbol + indicates an increase over time, - a reduction, and = no change. Japan and Korea are excluded from the standard deviation calculation for hospital beds. The United States is excluded from standard deviation calculation for health spending.

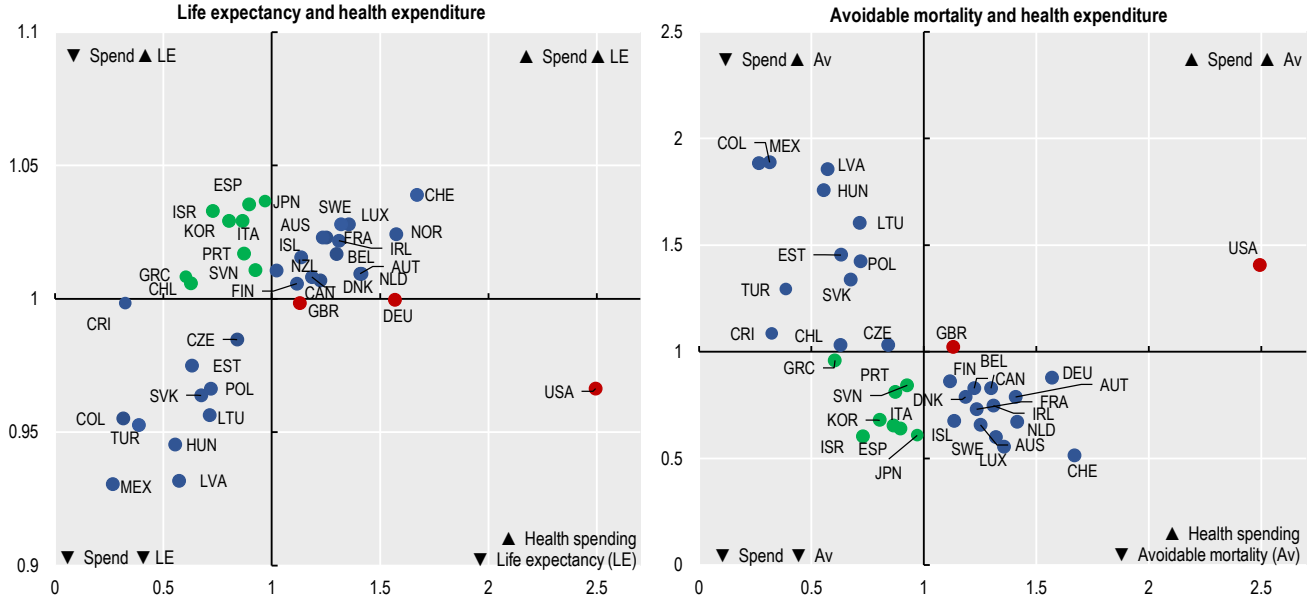
Cross-cutting dimensions of health system performance – quadrant charts

Quadrant charts plot the association between health spending and selected indicators of health system goals. They provide simple insights on efficiency by illustrating the extent to which spending more on health translates into stronger performance across three dimensions: health outcomes, access and quality of care. Note, though, that only a small subset of indicators for these three dimensions are compared against health spending, with quadrant charts showing simple statistical correlations rather than causal links. For a more in-depth analysis, see (OECD/The Health Foundation, 2025[2]).

Health spending and health outcomes

Figure 1.7 illustrates the extent to which countries that spend more on health have better health outcomes (note that such associations do not guarantee a causal relationship).

Figure 1.7. Association between health spending and health outcome indicators



There is a clear positive association between health spending per capita and life expectancy at birth (Figure 1.7). Among the 38 OECD countries, 17 spend more and have higher life expectancy than the OECD average (top right quadrant). A further 11 countries spend less and have lower life expectancy than the OECD average (bottom left quadrant).

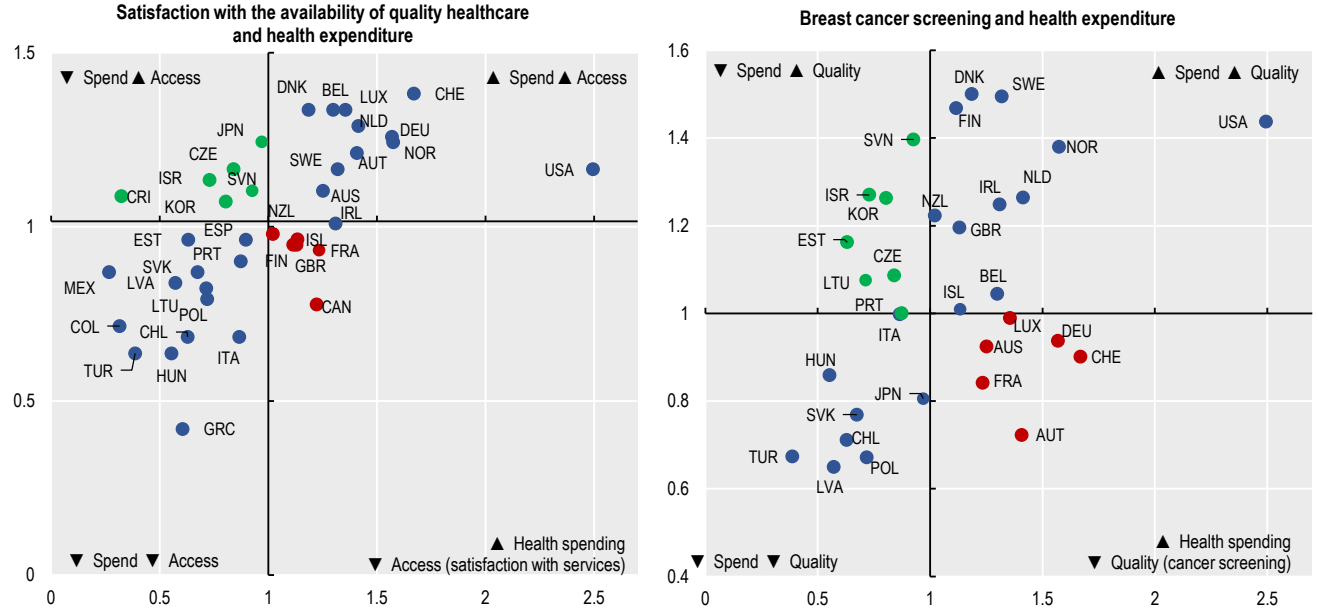
Of particular interest are countries that deviate from this basic relationship. Nine countries spend less than the OECD average but achieve higher life expectancy overall (top left quadrant). This may indicate relatively good value for money of health systems, notwithstanding the fact that many other factors also have an impact on health outcomes. These nine countries are Korea, Spain, Italy, Israel, Portugal, Chile, Greece, Japan and Slovenia. Germany, the United Kingdom and the United States fall in the bottom right quadrant, with the United States having much higher spending than other OECD countries but lower life expectancy than the OECD average.

For avoidable mortality, there is also a clear association in the expected direction (Figure 1.7). Among OECD countries, 14 spend more and have lower avoidable mortality rates (bottom right quadrant), and 12 spend less and have more deaths that could have been avoided (top left quadrant). Eight countries spend less than average but have lower avoidable mortality rates – Israel, Japan, Korea, Italy, Spain, Portugal, Greece, Slovenia (bottom left quadrant). The United States spends much more than the OECD average but has worse avoidable mortality rates.

Health spending, access and quality of care

Figure 1.8 illustrates the extent to which countries that spend more on health deliver more accessible and better-quality care (note that such associations do not guarantee a causal relationship).

Figure 1.8. Association between health spending and access and quality indicators



In terms of access, Figure 1.8 shows a clear positive correlation between the share of the population satisfied with the availability of quality healthcare where they live and health spending per capita. Among OECD countries, 12 spent more and had a higher share of the population satisfied with availability than the OECD average (top right quadrant). The converse was true in 14 countries (bottom left quadrant). In Canada, health spending was 22% higher than the OECD average, but only 50% of the population were satisfied with the availability of quality healthcare (compared to 64% on average across OECD countries). In Korea and Czechia, health spending per capita was relatively low, but a noticeably greater share of the population was satisfied with the availability of quality healthcare than the OECD average.

In terms of quality of care, Figure 1.8 shows the relationship between health spending and breast cancer screening rates. While there is an overall weak positive correlation between health spending and the share of women screened regularly, seven countries spent less than the OECD average yet had higher cancer screening rates (top left quadrant), while six countries spent more than the OECD average and had lower cancer screening rates (bottom right quadrant).

Links to further indicators of cross-cutting health system performance

Alongside these quadrant charts, a number of other cross-country indicators offer further insights into the cross-cutting health system performance dimensions of efficiency, equity, sustainability and resilience. Table 1.7 lists these indicators, with the selection based in part on those in the renewed OECD Health System Performance Framework and those indicators that are reported in this edition of *Health at a Glance*.

Table 1.7. Possible indicators on cross-cutting dimensions of efficiency, equity, sustainability and resilience

Dimension	Indicator/s	Where to find in *Health at a Glance*
System-wide efficiency	Health expenditure vs. health outcomes, access, quality of care	Chapter 1 – Figures 1.7, 1.8, 1.9, 1.10
	Health sector prices	Chapter 7 – Figures 7.6, 7.7, 7.8
	Relative spend on preventive care	Chapter 7 – Figure 7.17
Efficiency in hospital care	Average length of stay	Chapter 5 – Figure 5.23
	Bed occupancy rate	Chapter 5 – Figure 5.20
	Same day surgery	Chapter 5 – Figures 5.27, 5.28
Efficiency in primary care	Number of consultations per doctor	Chapter 5 – Figure 5.18
Efficiency in pharmaceuticals	Share of generics in total pharmaceutical market	Chapter 9 – Figures 9.7, 9.8
Equity in health	Life expectancy, women vs. men	Chapters 3 and 10 – Figures 3.1, 10.3
	Cancer incidence and mortality, women vs. men	Chapter 3 – Figures 3.7, 3.8, 3.9
	Longstanding illness, low vs. high income	Chapter 3 – Figure 3.15
	Suicide rates, hospitalisations due to self-harm, women vs. men	Chapter 3 – Figures 3.19, 3.20
	Self-rated health, low vs. high income	Chapters 3 and 10 – Figures 3.22, 10.4
Equity in non-medical determinants	Smoking, women vs. men, girls vs. boys	Chapter 4 – Figures 4.1, 4.8
	Alcohol use, women vs. men, girls vs. boys	Chapter 4 – Figures 4.11, 4.13
	Illicit drug use, women vs. men, girls vs. boys	Chapter 4 – Figures 4.4, 4.5, 4.6, 4.8
	Nutrition and physical activity, women vs. men	Chapter 4 – Figures 4.14, 4.16
	Obesity, women vs. men, girls vs. boys, low vs. high income	Chapter 4 – Figures 4.21, 4.22, 4.23, 4.24
Equity in service utilisation	Unmet need, low vs. high income	Chapter 5 – Figures 5.5, 5.6
Equity in financial protection	Catastrophic health spending, low vs. high income	Chapter 5 – Figure 5.10
Fiscal sustainability	Public and private health spending as share of GDP	Chapter 7 – Figures 7.1, 7.2, 7.3
	Public health spending as share of government spending	Chapter 7 – Figure 7.12
	Revenue sources for funding government health spending	Chapter 7 – Figure 7.13
	Health spending projections	Chapter 7 – Figures 7.25, 7.26
Environmental sustainability	Greenhouse gas emissions in healthcare	Chapter 4 – Figure 4.27
Resilience – vulnerability of populations	Population with longstanding illness, chronic conditions	Chapter 3 – multiple
	Population with various risk factors	Chapter 4 – multiple
	Share of population aged 65+ and 80+	Chapter 10 – Figure 10.1
Resilience – health system capacity	Spending on crisis preparedness and critical care capacities	Chapter 7 – Figure 7.22, 7.23, 7.24
	Capital expenditure on health	Chapter 7 – Figure 7.20, 7.21
	Hospital beds, intensive care beds, bed occupancy rate	Chapter 5 – Figures 5.19, 5.20, 5.21
	Health workforce numbers	Chapter 8 – multiple

References

OECD (2024), *Rethinking Health System Performance Assessment: A Renewed Framework*, https://doi.org/10.1787/107182c8. [1]

OECD/The Health Foundation (2025), *How Do Health System Features Influence Health System Performance?*, OECD Publishing, Paris, https://doi.org/10.1787/7b877762-en. [2]

2 Which diseases affect men and women differently – and why this matters

Key findings

There is a clear gender health disparity across OECD countries: men die younger, while women live longer but spend more of their lives in poor health. This stark contrast highlights a dual challenge for health systems – not only to extend life expectancy but also to improve quality of life in the additional years gained. This chapter provides new evidence on which diseases affect men and women differently, and why this matters. It offers cross-country insights on health inequalities among men and women in terms of health outcomes and risk factors for health across OECD countries. Initial analysis points to five key findings:

- **Women live longer than men in all OECD countries, but the gap varies from 3 to 10 years across countries**. Over the past decade, most OECD countries have narrowed the gap between women and men in life expectancy at birth. However, eight countries saw the gap widen – notably Mexico (from 5.6 to 6.5), the United States (from 4.8 to 5.3 years), Latvia (from 9.6 to 10.1), Israel (from 3.6 to 4.0), and Iceland (from 3.2 to 3.6). Other countries showing a widening gap were Canada, Costa Rica and the United Kingdom.
- **Differences in death rates by disease reveal distinct drivers of premature mortality for men and women.** Among men, external causes – including suicide, accidents and violence – are the leading contributor of potential years of life lost, accounting for 31% of the top ten causes of premature deaths across OECD countries. This points to urgent prevention needs, as many of these deaths are avoidable and linked to mental health issues, risk-taking behaviour and occupational hazards. Suicide rates remain between two and eight times higher among men than women, despite declines in recent decades. In contrast, cancer is the leading cause of potential years of life lost among women across OECD countries.
- **The morbidity – mortality disparity: women spend a larger share of their life in poor health, despite living longer.** Across OECD countries, women report more years with activity limitations after age 60 than men (6.3 vs. 5.0 years), resulting in a smaller share of life in good health (74% vs. 76%). In the Netherlands, Sweden, Belgium, Germany and Türkiye, the gender gap reaches 3 percentage points (p.p.), probably reflecting differences in access to care, health behaviours and occupational risks. OECD Patient-Reported Indicator Surveys (PaRIS) data confirm that women aged 45 and over with chronic conditions report worse physical and mental health, lower well-being, and poorer social functioning (OECD, 2025[1]). Comparable results are found in the Eurostat European Health Interview Survey (EHIS).
- **Gender gaps in disease susceptibility are largely driven by differences in behaviour and risk exposure.** Men consistently smoke more, are twice as likely to engage in heavy episodic drinking, consume fewer vegetables (except in Mexico and Korea), and are more likely to be overweight or obese across all OECD countries. They also face higher risks from illicit drug use. In contrast, women report lower physical activity in all OECD countries except Denmark, Finland and Sweden.
- **Social inequalities in health underpin some differences between men and women.** PaRIS data on people reporting good or excellent health show clear patterns by education level and gender. On average across OECD countries, men with higher education levels report being healthier, with a 13.2 p.p. gap between groups with low and mid/high education levels. For women, the gap is even larger, averaging 15.2 p.p. There are also differences within education levels: among people with low education levels, on average, men report better health than women (by 4.3 p.p.); the same is true among those with mid/high education levels (by 2.8 p.p.). These results are consistent with findings from the EHIS.

This chapter highlights six key areas with room for policy action

- **Targeted prevention is urgently needed to reduce premature deaths from cardiovascular disease – particularly among men.** Public health strategies should include tailored approaches for men, such as early screening for hypertension and high cholesterol, behaviour change programmes, and efforts to increase men's participation in preventive care. Adapting cardiovascular risk assessment, diagnosis and treatment to reflect the different needs of women and men could help to achieve more equitable health outcomes.
- **Reducing the cancer burden and premature deaths from cancer among women could benefit from a targeted approach across the life course.** Priorities include cost-effective population-wide interventions to reduce smoking and harmful alcohol consumption in men, and strengthening screening and early detection efforts. For women, priorities involve expanding colorectal screening and ensuring equitable access to breast and cervical cancer screening – especially for underserved groups such as women in rural areas, migrant populations and low-income communities.
- **Prevention of external causes of death needs to better account for differences between men and women.** External causes – including suicide, accidents and violence – are the leading drivers of premature mortality among men – particularly those of working age. Policies should prioritise early intervention through accessible, stigma-free mental health services and targeted efforts to prevent "deaths of despair" linked to alcohol, drugs and social isolation. While men are more likely to die by suicide, women more often report suicidal thoughts and attempts. Prevention efforts must close diagnosis and help-seeking gaps among men, while also addressing the growing mental health needs of young women through outreach, peer support and crisis care.

- **The different patterns of multimorbidity for men and women observed in PaRIS data show the need for tailored care plans based on the mix of chronic conditions.** For men, the combination of cardiovascular disease and related risks calls for integrated heart health prevention and management. Both men and women often have a mix of unrelated conditions, but women more often report combinations like arthritis and breathing problems. These differences highlight the importance of designing care plans that address both related and unrelated conditions, ensure strong co-ordination between specialists, and support patients in managing their own care.
- **Social gradients of access and quality of health services call for targeted interventions among populations with low education levels, and multisectoral policies.** Population-level and community-based interventions, community outreach, stronger safety nets and tailored prevention can help reduce health disadvantages for women and men with low education levels. Expanding access to education is key to help narrow gender health gaps.
- **Health disparities can be explained in part by differences in how women and men access and experience care.** Medical education and guidelines often overlook how diseases present differently in men and women, reflecting a historical lack of inclusive research. PaRIS data confirm that men are more likely to rate the quality of care positively and to report higher levels of trust in the health system.

Introduction

Significant gaps persist between men's and women's health, reflecting differences in disease onset, severity and survival. These gaps arise from a complex mix of biological and socio-economic factors, lifestyle choices and risk exposures, as well as potential disparities in access to and experiences with healthcare. Addressing these inequalities requires countries not only to tackle socio-economic gaps but also to ensure that health policies and services account for the different needs, risks and behaviours of men and women. At the 23 January 2024 OECD Meeting of Health Ministers, Ministers called on the OECD to help countries address gender health inequalities by developing better data and analysis on health disparities, patient experiences and outcomes (OECD, 2024[2]). Promoting gender equality is also vital for economic growth, stronger democracy, social cohesion and societal well-being. Yet significant gender gaps persist, especially in economic outcomes, with women in full-time work still earning less than men (OECD, 2023[3]). Closing gender gaps in workforce participation could boost the gross domestic product (GDP) of OECD countries by an average of 9.2% by 2060, while ignoring these gaps risks undermining future prosperity (OECD, 2023[3]).

This chapter provides new evidence on which diseases affect women and men differently, and why this matters. It offers cross-country analysis of gender health inequalities in outcomes, lifestyles and risk factors across OECD countries to uncover differences in disease susceptibility between women and men, aiming to help policymakers design more targeted and effective health policies. The analysis draws on disaggregated data, notably: 1) data routinely collected by the OECD Working Parties on Health Statistics and Healthcare Quality and Outcomes; 2) data from the Patient-Reported Indicator Surveys (PaRIS) initiative;[1] and 3) data from a review of relevant literature. Most health monitoring systems focus restrict data collection on to men and women, though some countries also collect data on non-binary populations.

This chapter has five sections. The next sections examine cross-country trends in differences in life expectancy between men and women. "How do causes of mortality differ between women and men?" covers differences in causes of mortality, focussing on cardiovascular disease (CVD) and cancer. "Despite living longer, women experience more prolonged physical and mental illness" explores patterns in healthy years, physical and mental health, well-being, social functioning, and multimorbidity. "Health inequalities stem from a complex interplay of biological, social and lifestyle factors, as well as unequal access to and experiences of healthcare" examines gender gaps in risk factors and socio-economic inequalities in health, and explores gender differences in how health systems respond to treatment needs. The final section outlines the main conclusions.

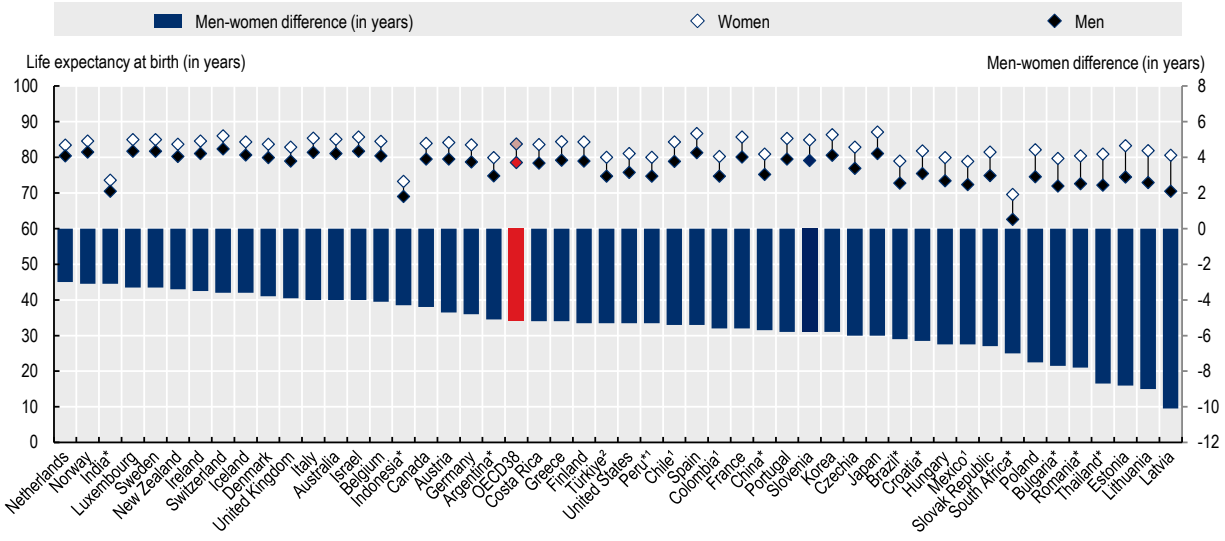
Women live longer than men in all OECD countries, but the gap varies from 3 to 10 years across countries

Across OECD countries, men die earlier than women. In 2023, average life expectancy at birth was 83.7 years for women and 78.5 for men, creating a gender gap of 5.2 years. Gender differences in longevity at birth (Figure 2.1) vary more than three-fold across OECD countries – from about 3 to 10 years. In 2023, the largest disparities were observed in Latvia (10.1 years), Lithuania (9.0), and Estonia (8.8), largely due to particularly low life expectancy of men. The smallest gaps were found in the Netherlands (3 years), Norway (3.1), and Sweden and Luxembourg (3.3).

Among Key Partner and accession countries, gender differences in life expectancy at birth followed patterns like those in OECD countries, ranging from 3.1 to nearly 9 years. Thailand (8.7) and Romania (7.8) showed the widest gaps, again driven by lower male longevity. India and Indonesia show exceptionally small gender gaps in life expectancy, not because men are healthier than elsewhere, but because women's survival advantage is constrained by social, cultural and healthcare factors – especially maternal mortality, unequal healthcare access, and disease burden.

Figure 2.1. Life expectancy differences at birth between women and men show more than three-fold variation across OECD countries

Life expectancy at birth, 2023 (or nearest year)



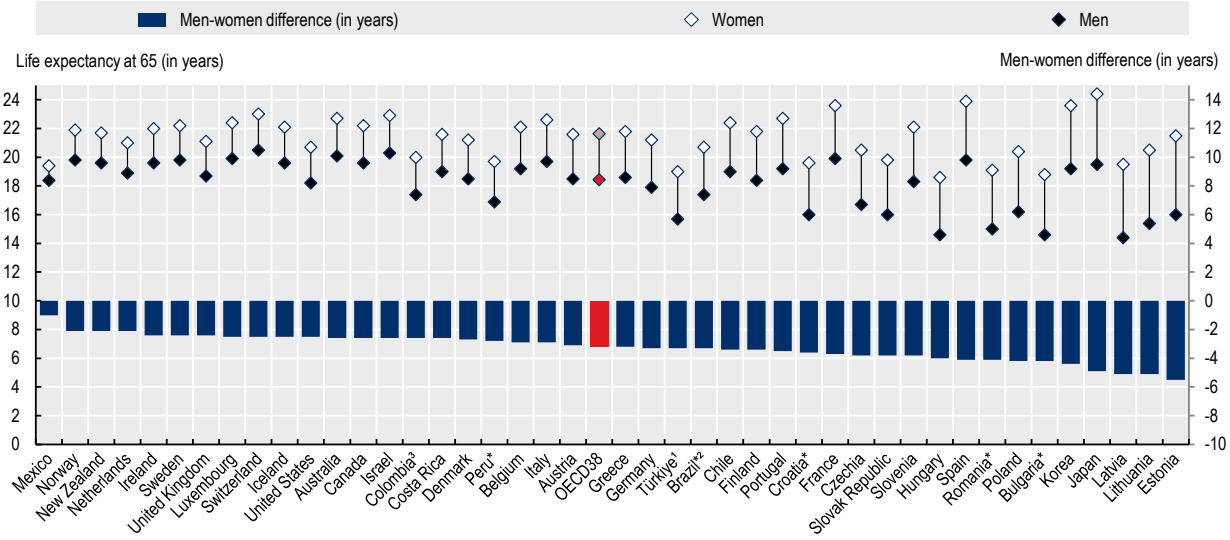
Note: The bar shows the difference in values for men as compared to women. * Accession/partner country. 1. 2022 Data. 2. 2024 Data.
Source: OECD Health Statistics 2025, based on Eurostat for EU countries.

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Figure 2.2 illustrates life expectancy at age 65 for both men and women. The figure confirms a consistent longevity advantage for women across OECD countries. The gap narrows when looking at life expectancy from age 65 (compared to life expectancy at birth). Still, variation across countries widens: there is a five-fold variation in this gap, ranging from approximately 1 year in Mexico to over 5.5 years in Estonia.

Figure 2.2. There is five-fold variation in the life expectancy gap at age 65 between men and women, from about 1 to over 5 years

Life expectancy at age 65, 2023 (or nearest year)



Note: The bar shows the difference in values for men as compared to women. * Accession/partner country. 1. 2022 data. 2. 2021 data. 3. 2020 data.
Source: OECD Health Statistics 2025, based on Eurostat for EU countries.

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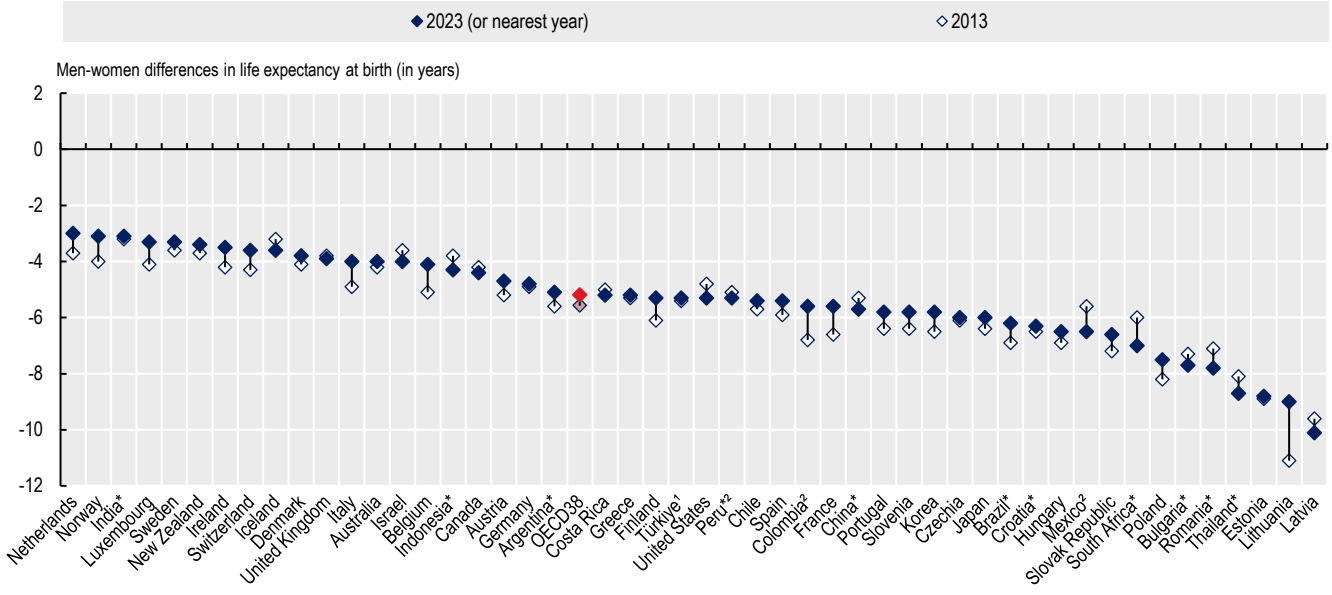
Most OECD countries narrowed the life expectancy gap between men and women over the past decade, but in eight OECD countries it widened significantly

Between 2013 and 2023, the average OECD gap in life expectancy between men and women declined slightly from 5.6 to 5.2 years (Figure 2.3). While the average gender difference remained stable, most countries saw gradual progress in narrowing the gap, mainly due to rising male life expectancy driven by reductions in cardiovascular mortality (OECD/The King's Fund, 2020[4]; Raleigh, 2019[5]). For example, Lithuania reduced its gap by 2.1 years (from 11.1 to 9.0 years), and in Colombia, Belgium, France, Italy and Norway, the gap was reduced by about one year over the same period.

However, eight OECD countries saw widening gaps, including Mexico (from 5.6 to 6.5 years), the United States (from 4.8 to 5.3 years), Latvia (from 9.6 to 10.1), Israel (from 3.6 to 4.0) and Iceland (from 3.2 to 3.6). Other countries showing a widening gap were Canada, Costa Rica and the United Kingdom. Some of these countries have experienced decelerating improvements in CVD outcomes, combined with life expectancy losses from infectious diseases, as well as from mental and nervous system disorders – including (in North America) the opioid crisis.

Some accession/partner countries saw notable increases in the life expectancy gap between men and women – Romania (+0.7 years), Thailand (+0.6) and Indonesia (+0.5) – reflecting worsening men health, with gaps exceeding 7 years, which is well above the OECD average. In contrast, some narrowed their gaps, including Brazil (-0.7 years), Argentina (-0.5), and Croatia (-0.2).

Figure 2.3. Gender life expectancy gaps narrowed in most OECD countries between 2013 and 2023, but widened in eight



Note: * Accession/partner country. 1. 2022 data. 2. 2024 data.
Source: OECD Health Statistics 2025, based on Eurostat for EU countries.

StatLink https://stat.link/z86tsm

How do causes of mortality differ between women and men?

Mortality patterns reveal distinct causes of premature mortality

Analysis of the top ten causes of mortality with the largest differences between men and women in OECD countries reveals marked gender disparities in both the level and distribution of deaths across disease categories. These differences can be explored through three complementary lenses: absolute mortality rate differences, proportional contribution to overall mortality and cause-specific rankings, as presented in Table 2.1.

Table 2.1. Differences in mortality by disease reveal distinct drivers of mortality for men and women

Ranking of top ten causes of mortality by absolute difference (men-women) in mortality rate (per 100 000), in descending order, OECD average, 2023 (or nearest year)

Causes[1]	Absolute difference in rate per 100 000 (men – women)	Men (rate per 100 000)	Share[2] (ranking) of mortality rates among men	Women (rate per 100 000)	Share[2] (ranking) of mortality rates among women
Cardiovascular diseases	93	319	32% (1)	226	34% (1)
Neoplasms (include cancers)	78	229	23% (2)	151	23% (2)
External causes[3] (include suicide)	52	89	9% (4)	37	6% (6)
Respiratory diseases	39	103	10% (3)	64	10% (3)
COVID-19	29	69	7% (5)	40	6% (5)
Gastrointestinal diseases	18	51	5% (7)	33	5% (7)
Metabolic conditions	11	57	6% (6)	46	7% (4)
Symptoms, signs, ill-defined causes	9	40	4% (8)	31	5% (8)
Genitourinary disorders	7	28	3% (9)	21	3% (9)
Certain infectious and parasitic diseases	6	21	2% (10)	15	2% (10)
Total (all-causes)	345	1 097		752	

1. Only level causes (broad category groups) of mortality are included, as presented in the OECD Health Statistics database.
2. Share among the top ten causes of mortality.
3. External causes of death include accidents, suicides, homicides and other causes.

Note: OECD averages are weighted with the 2022 OECD population data, using country rates age-standardised to the 2015 OECD population. New Zealand is not included as no data from 2019-2023 are available. Data from Belgium, Finland, Germany, Norway and Poland are not available for symptoms, signs, ill-defined causes.
Source: OECD Health Statistics 2025, based on the WHO Mortality Database.

In 2023, men consistently had higher mortality, particularly from CVD, cancer, respiratory illnesses, suicide and external causes, and COVID-19. While CVD and cancer accounted for more than half of all deaths in both men and women, CVD and neoplasms (including cancer) contributed a larger share to female mortality – reflecting women's higher burden of age-related conditions, partly due to their longer life expectancy. Premature mortality, measured by potential years of life lost (PYLL) before age 75, shows major gender gaps (Table 2.2). In 2023, men across OECD countries had nearly twice the PYLL rate of women (7 308 vs. 4 448 years per 100 000), with external causes, CVD, and gastrointestinal diseases driving the largest gaps. Proportionally, cancers caused the most PYLL among women (31%), while external causes and suicide led for men (31%), followed by CVD (19%). External causes like accidents, assaults and suicide made up a much larger share of PYLL for men, reflecting higher risk exposure. Notably, cancer topped rankings for women but placed third for men.

These findings highlight critical policy priorities. For men, targeted action is needed to reduce preventable deaths from CVD, mental health issues, and injury or violence. For women, premature mortality is largely driven by cancer, underscoring the need for timely screening, early diagnosis and fair access to treatment. Reducing premature deaths across OECD countries will require gender-sensitive strategies that reflect distinct mortality patterns and tackle their root causes.

Men and women often differ in the timing, severity and outcomes of certain diseases, driven by biology, lifestyle and behaviour, access to high-quality care, or a combination of these factors. Research shows that CVD typically develops 5-10 years earlier in men, with coronary heart disease often the first event, while women are more likely to experience a stroke (Heydari et al., 2022[6]; Peters and Woodward, 2022[7]) – partly due to smaller hearts and narrower vessels (Haupt, Carcel and Norton, 2024[8]). Men are also 4.5 times more likely than women to develop and die from oesophageal cancer (Haupt et al., 2021[9]). Hormonal differences and other factors including genetic influences may further contribute to disease susceptibilities. There is evidence suggesting women are more prone to depression and Alzheimer disease, and men more prone to Parkinson disease, schizophrenia and neurodevelopmental conditions such as autism (Barth et al., 2023[10]; Haupt, Carcel and Norton, 2024[8]; Loke, Harley and Lee, 2015[11]). Women's symptoms are frequently overlooked, delaying diagnosis and treatment of conditions like cancer and CVD (Din et al., 2015[12]; Maas and Appelman, 2010[13]). Men typically develop CVD earlier due to higher risk exposure and the absence of oestrogen's protective effects, while women's risk surges after menopause (Merz and Cheng, 2016[14]; Stanhewicz, Wenner and Stachenfeld, 2018[15]).

Studies show that women with or at risk of CVD face higher misdiagnosis, worse outcomes and greater rates of mortality after acute events (Wenzl et al., 2022[16]). Other influences – such as ageing, environmental and lifestyle factors – also probably play a role, although their individual effects are difficult to isolate (see section "Health inequalities stem from a complex interplay of biological, social and lifestyle factors, as well as unequal access to and experiences of healthcare").

The following sections examine cross-country variations in the three leading causes of mortality: CVD, which is the main cause of death for both men and women; external causes (including suicide), the leading cause of premature death among men; and cancer, the leading cause of premature death among women.

Table 2.2. Measured in potential years of life lost, cancer in women and external causes (including suicide) in men are the leading killers

Ranking of top ten diseases by absolute difference (men-women) in potential years of life lost (PYLL) (per 100 000), in descending order, OECD average, 2023 (or nearest year)

Causes[1]	Absolute difference in PYLL per 100 000 (men – women)	Men (PYLL per 100 000)	Share[2] (ranking) of PYLL among men	Women (PYLL per 100 000)	Share[2] (ranking) of PYLL among women
External causes[3] (includes suicide)	1 317	2 028	31% (1)	711	21% (2)
Cardiovascular diseases	713	1 268	19% (2)	556	16% (3)
Gastrointestinal diseases	251	468	7% (4)	217	6% (4)
Symptoms, signs, ill-defined causes	202	355	5% (5)	152	4% (8)
Neoplasms (include cancers)	154	1 215	18% (3)	1 061	31% (1)
COVID-19	133	327	5% (7)	194	6% (7)
Metabolic conditions	120	336	5% (6)	216	6% (5)
Respiratory diseases	112	316	5% (8)	204	6% (6)
Certain infectious and parasitic diseases	73	167	3% (9)	93	3% (9)
Mental health conditions	71	115	2% (10)	45	1% (10)
Total (all-causes)	3 260	7 308		4 048	

1. Only level causes (broad category groups) of mortality are included, as presented in the OECD Health Statistics database.
2. Share among the top ten causes of mortality.
3. External causes of death include accidents, suicides, homicides and other causes.
Note: PYLL is a measure of the impact of different mortality causes for those aged 0-74, putting a higher weight on premature deaths among younger individuals. OECD averages are weighted with the 2022 OECD historical population data, using country rates age-standardised to the 2015 OECD population. New Zealand and Norway are not included as no data from 2019-2023 are available.
Source: OECD Health Statistics 2025, based on the WHO Mortality Database.

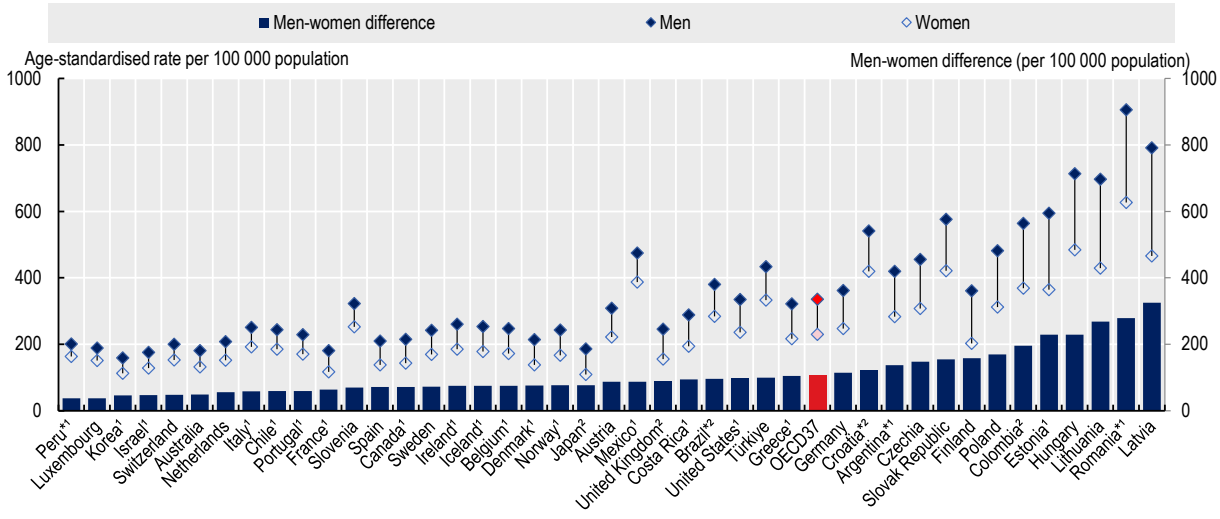
Cardiovascular disease is the leading cause of death for both men and women

CVD deaths cover conditions like heart attacks, strokes, heart failure and vascular diseases. Many are preventable, as key risk factors – high blood pressure, cholesterol, smoking, obesity, inactivity and poor diet – are well known and modifiable through early detection and timely treatment.

CVD is the leading cause of death for both men and women across OECD countries, but men face a far greater burden. In 2023, CVD mortality was 93 deaths per 100 000 higher in men than in women (319 vs. 226) (Table 2.1). While CVD made up a similar share of total deaths (34% in women, 32% in men), the absolute rates reveal a marked disadvantage for men, especially in premature mortality. Men face nearly twice the early CVD death rate at 1 268 vs. 556 PYLL per 100 000 – an absolute gap of 713 PYLL (Table 2.2). CVD is the second leading cause considering the share of PYLL among men (19%) and the third among women (16%). Previous OECD analysis showed that pre-pandemic life expectancy gains were slowing or reversing in some countries, with the longevity gains declining more slowly for men than for women due to stalled CVD mortality improvements (OECD/The King's Fund, 2020[4]). The forthcoming OECD report *State of CVD in the EU* (OECD, forthcoming[17]) highlights that premature CVD deaths (under age 65) are 2-3 times higher in men than women. In OECD countries, the mortality rate due to CVD is almost double for men compared to women, with even larger gaps in countries including Latvia, Lithuania and Hungary (Figure 2.4). While ischaemic heart disease drives most of the male excess mortality, stroke shows much smaller gender differences, suggesting that gaps reflect both biological and system-level factors. Large cross-country variations further point to differences in male risk exposure, preventive care and health system effectiveness, as briefly discussed in section “Men display higher smoking, harmful alcohol use and risky behaviours”. It should also be noted that much of the available evidence has focussed more on incidence and outcomes in men, while cardiovascular events in women are comparatively less reported and researched, which may limit the full understanding of gender disparities (Burgess, 2022[18]).

Figure 2.4. Men face about 50% more cardiovascular disease mortality risk than women

Age-standardised mortality rates due to diseases of the circulatory system, 2023 (or nearest year)



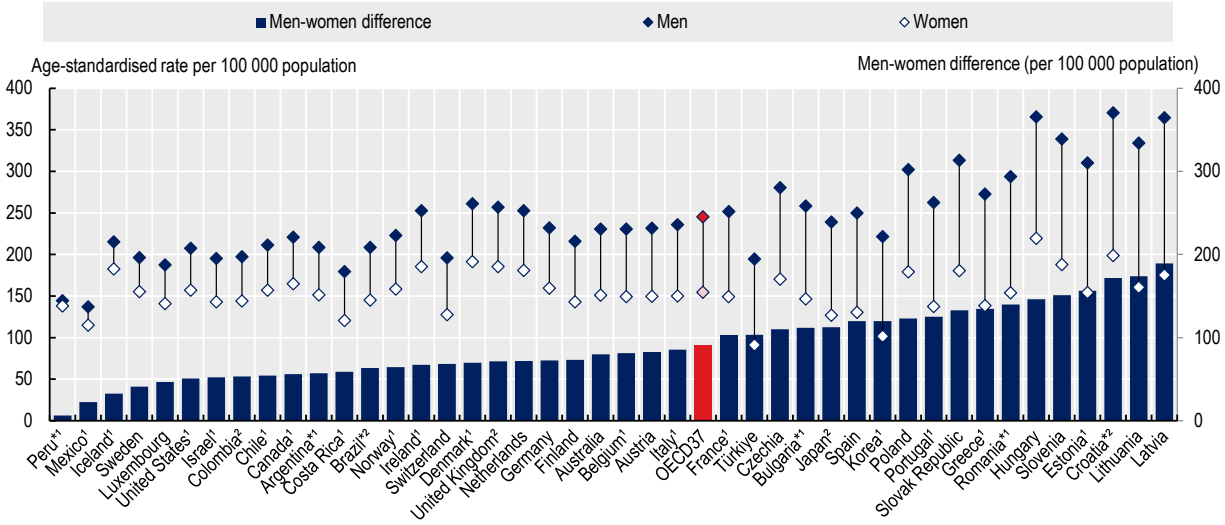
Note: The bar shows the difference in values for men as compared to women. * Accession/partner country. 1. 2022 data. 2. 2021 data.
Source: OECD Health Statistics 2025, based on WHO Mortality Database.

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Cancer is the leading cause of premature mortality among women across OECD countries

In 2023, cancer was the second leading cause of death after CVD across OECD countries, accounting for 23% of all deaths in both men and women. Men had a significantly higher cancer mortality rate, with 78 more deaths per 100 000 than women (Table 2.1). The widest gender gaps were observed in Latvia, Lithuania, and Estonia, where cancer mortality for men was more than twice that of women, probably reflecting higher risk exposures among men and possibly poorer access to timely diagnosis and care (Figure 2.5). Mexico, Iceland, and Sweden had the smallest gaps, suggesting more balanced risk profiles and/or access to care between men and women. While this may suggest more balanced risk profiles and/or access to care between men and women, a small gap in cancer mortality may also result from worse outcomes for women (e.g. due to delayed diagnosis, treatment disparities, or higher exposure to certain risks), which would narrow the gap for negative reasons.

Figure 2.5. Cancer mortality across OECD countries, 2023 (or nearest year)



Note: The bar shows the difference in values for men as compared to women. * Accession/partner country. 1. 2022 data. 2. 2021 data.
Source: OECD Health Statistics 2025, based on the WHO Mortality Database.

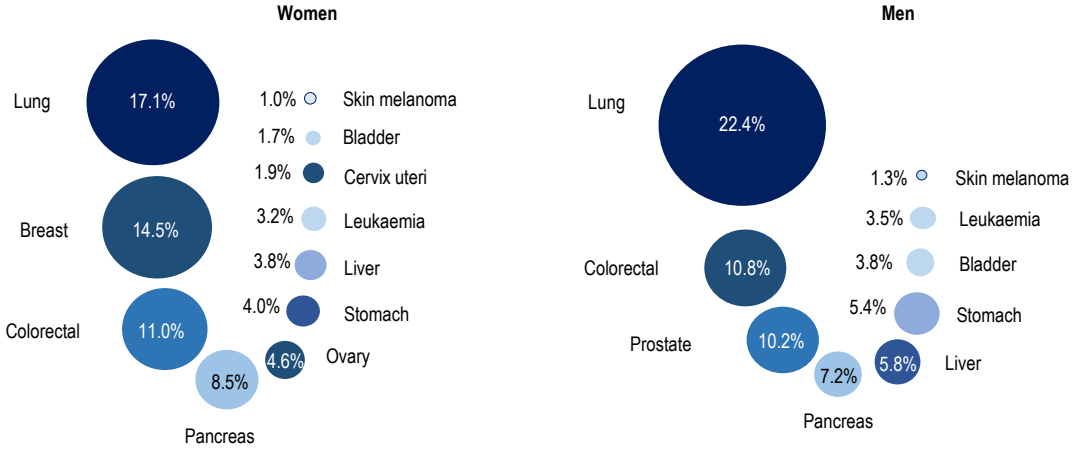
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Cancer was the leading cause of premature mortality (PYLL) among women, making up 31% of all PYLL, while for men it ranked third (18%) after external causes and suicide, and CVD (Table 2.2). Although men bear a heavier premature cancer burden overall, cancer's higher share of PYLL for women underscores its critical role in early female mortality.

The types of cancer driving mortality differ between men and women, reflecting a combination of biology, behaviour and gaps in prevention. Lung, liver, stomach and bladder cancers disproportionately affect men. In 2023, lung cancer was the top killer for both men and women, but hits men harder (22.4% vs. 17.1%) due to historically higher smoking rates, although rising rates in women reflect increased tobacco use (Figure 2.6). Liver, stomach and bladder cancers are also more common in men – linked to alcohol, infections and diet. Among women, cancers specific to female biology account for a large share of cancer mortality. Breast cancer is the second leading cause, accounting for 14.5% of cancer deaths, followed by ovarian cancer (4.6%). These patterns highlight the vital role of effective screening, early detection and access to timely treatment.

Some cancers place a shared burden on both men and women. Colorectal cancer is a major cause of death for women (11.0%) and men (10.8%), with screening key to reducing mortality (OECD, 2024[19]). Pancreatic cancer, known for its poor prognosis, accounts for 8.5% of cancer deaths in women and 7.2% in men, underscoring the urgent need for improved early diagnostic tools and more effective treatment options. Prostate cancer ranks third of cancer-related deaths among men (10.2%); while early detection offers high survival, its steady mortality share points to challenges in diagnosing aggressive cases and ensuring timely, effective treatment (OECD, 2024[19]).

Figure 2.6. Main causes of cancer mortality differ between men and women across OECD countries, 2023 (or nearest year)



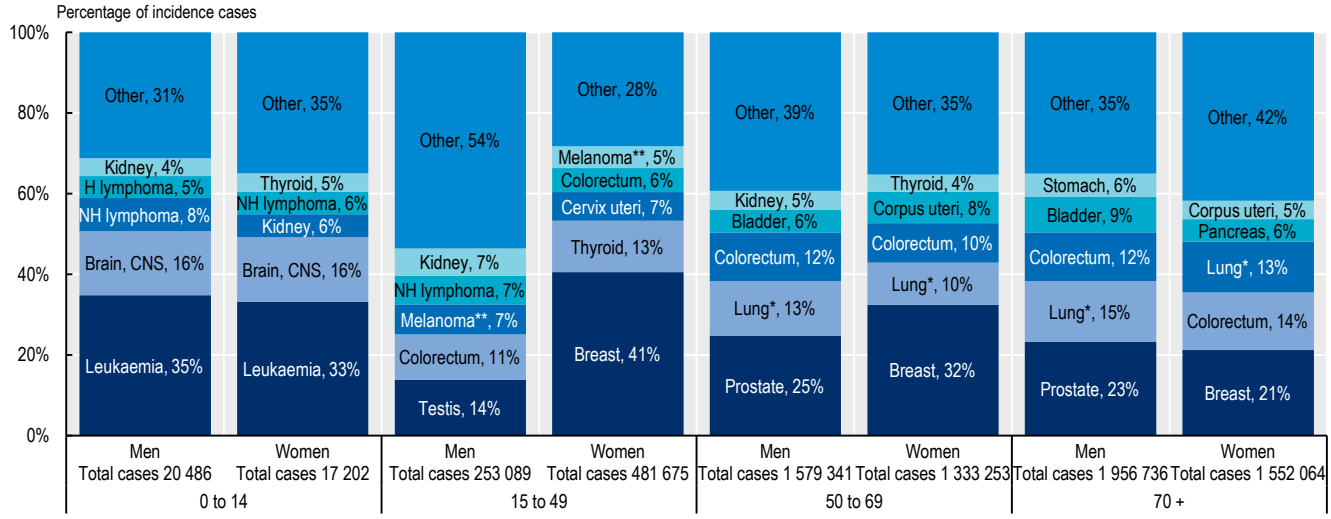
Note: Shares of the sum of cancer-related deaths across OECD countries.
Source: OECD Health Statistics 2025, based on the WHO Mortality Database.

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Cancer patterns evolve with age and show clear gender differences. The recent OECD report *Beating Cancer Inequalities in the EU: Spotlight on Cancer Prevention and Early Detection* (OECD, 2024[19]) examined trends and inequalities in the cancer burden. Figure 2.7 shows that in childhood (ages 0-14), leukaemia and brain/central nervous system cancers are the most common types, with little variation between boys and girls. From ages 15 to 49, certain cancers become more prevalent in specific groups: breast cancer dominates in women (41%), while testicular cancer is most common in men (14%), underscoring the need for targeted screening and awareness efforts. In middle age (50-69), breast cancer leads in women and prostate cancer in men, followed by lung and colorectal cancers. Among older adults (70+), cancer types diversify. Pancreatic cancer becomes more common in women alongside breast, colorectal and lung cancers, while men face high rates of prostate, lung, colorectal and bladder cancers – reflecting cumulative lifetime exposures.

Figure 2.7. The most common cancers vary by age group between men and women

Percentage of total incidence cases by age group between men and women, OECD, 2022



Note: CNS: central nervous system. NH: Non-Hodgkin. * Includes trachea, bronchus and lung. ** Melanoma of skin.
Source: World Health Organization (WHO), International Agency for Research on Cancer, https://gco.iarc.who.int; Globocan 2022 (version 1.1).

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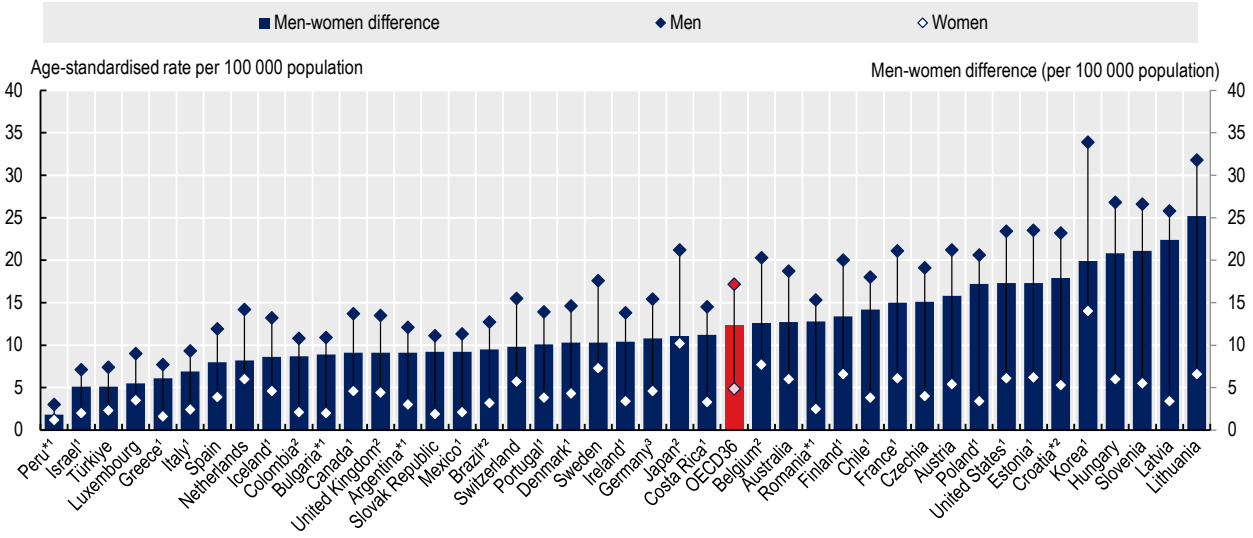
Suicide, accidents and violence are the leading drivers of premature mortality among men

External causes of death – including suicide, accidents and violence – are the leading drivers of premature mortality among men. Men lose 2 028 potential years of life per 100 000 to external causes – nearly three times more than women (711), resulting in the largest gender gap (1 317 years) across all causes (Table 2.2). These deaths account for 31% of total PYLL in men, compared to 21% in women, where external causes rank second. The scale of preventable mortality from external causes highlights urgent prevention needs. Many of these deaths – whether caused by suicide, accidents or violence – are avoidable and linked to mental health, risk-taking and workplace risks.

Targeted prevention strategies – especially for men of working age – are critical to reducing avoidable deaths and narrowing health inequalities. Suicide is a leading cause of death among men but not among women, and male suicide rates are two to eight times higher across OECD countries (Figure 2.8). The highest rates are observed in Korea, Lithuania, Hungary, Slovenia and Latvia – each exceeding 27 deaths per 100 000 – where gender gaps are also particularly wide. In Korea, for example, the suicide rate for men is over 30 per 100 000, compared to under 10 per 100 000 for women. Conversely, Türkiye, Greece and Israel report the lowest suicide rates among men (below 9), with narrower gender gaps. Although suicide rates among men have declined in some countries (including Hungary, Japan and Korea), they have remained stable or increased in others, including the United States – signalling persistent or emerging risks. Men's greater exposure to risk-taking behaviours also makes them more vulnerable to "deaths of despair" linked to alcohol and drugs (Health Canada, 2024[20]; The Kings Fund, 2024[21]).

Figure 2.8. Suicide rates remain two to eight times higher for men than women

Age-standardised mortality rates due to intentional self-harm, 2023 (or nearest year)



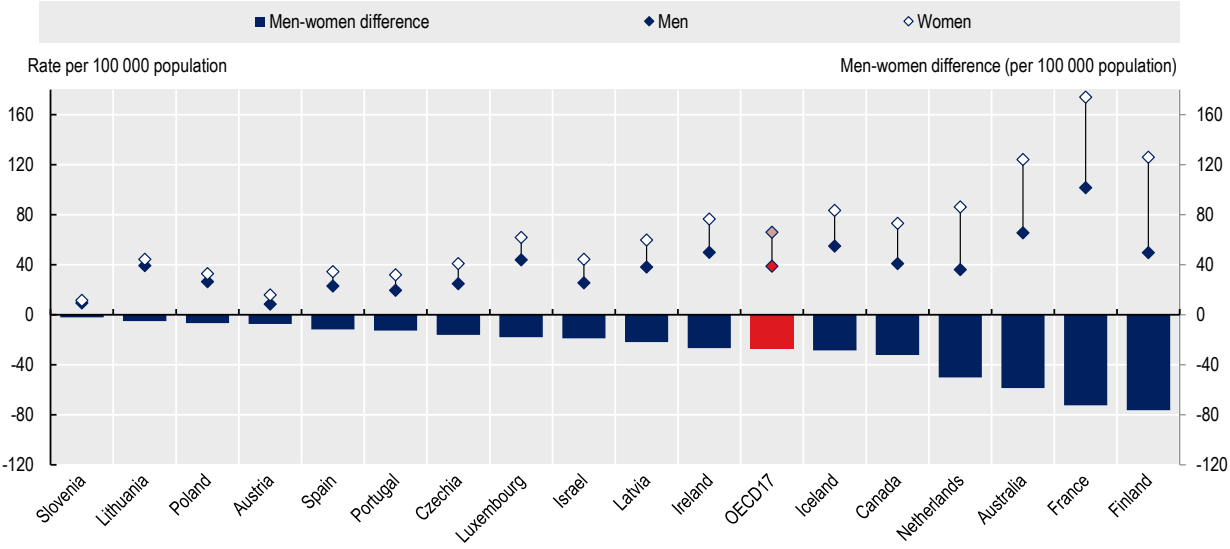
Note: The bar shows the difference in values for men as compared to women. * Accession/partner country. 1. 2022 data. 2. 2021 data. 3. 2020 data.
Source: OECD Health Statistics 2025, based on WHO Mortality Database.

StatLink https://stat.link/paub0e

While female suicide rates have remained stable or declined in most countries, the gender gap in suicidal intent is much narrower: pilot data show that women are more likely to be admitted to hospital due to self-harm (Figure 2.9), but men are more likely to die by suicide potentially due to the use of more lethal methods (Vargas Lopes and Llena-Nozal, 2025[22]). In France, for example, self-harm and suicide attempts have surged among young women since 2020 (DREES, 2024[23]). Despite data gaps, studies show that women attempt suicide more often, while men's attempts are typically more severe, driving higher male fatality rates (Qu, Zhu and Chen, 2024[24]).

Figure 2.9. Women are more likely to be admitted to hospital due to self-harm

Hospitalisations due to self-harm, 2023



Note: The bar shows the difference in values for men as compared to women. Data for Portugal cover only public (NHS) hospitals. Data on self-harm are for all ages except in Canada and France, where data start at age 10.
Source: OECD Mental Health Data Pilot Collection 2025 – see the Statlink for full details.

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Despite living longer, women experience more prolonged physical and mental illness

Women spend a larger share of their lives with activity limitations than men – even though they live longer

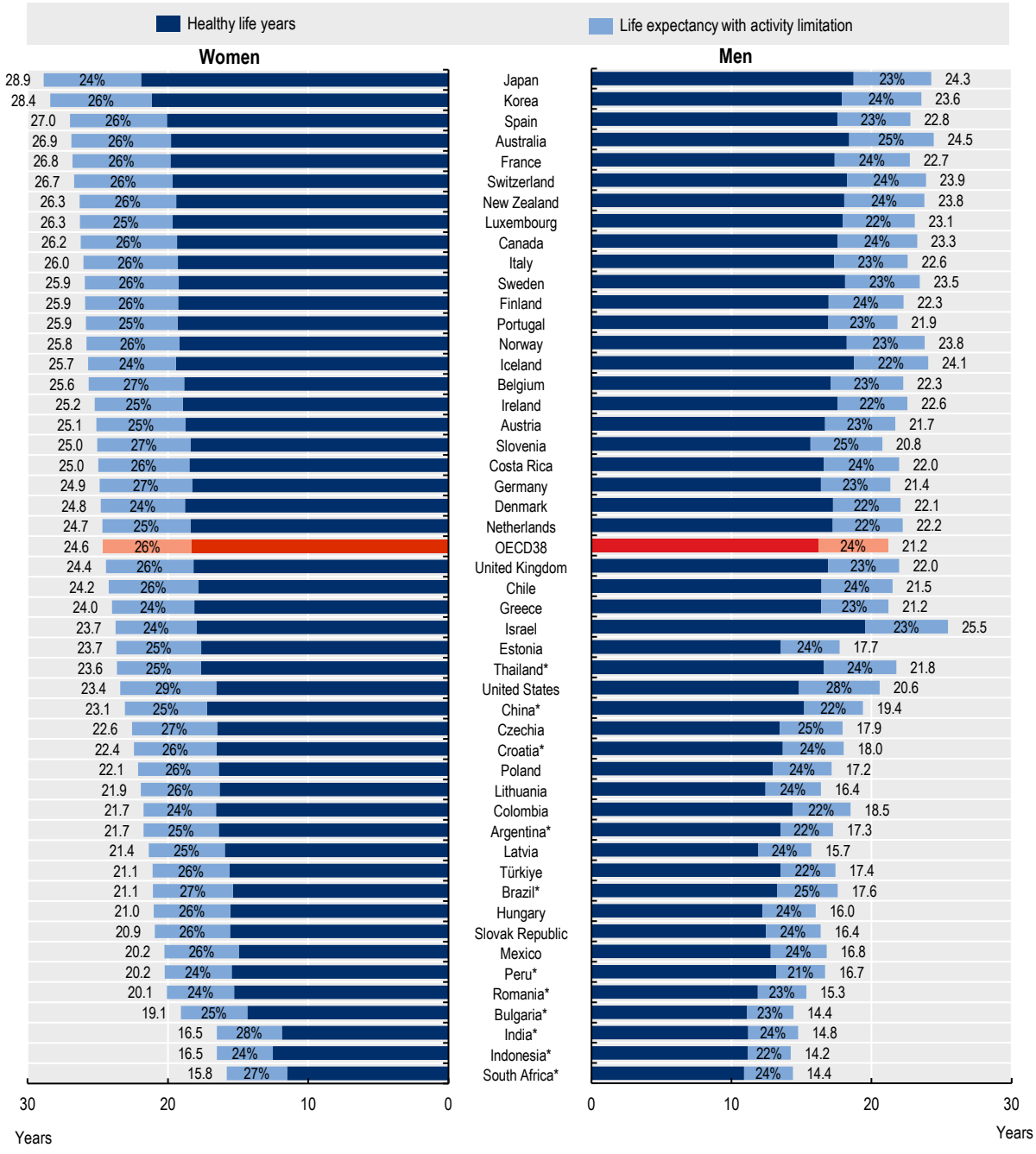
Across OECD countries, women live longer than men, but do not necessarily enjoy more healthy years. This highlights a core challenge for health systems: improving not just life expectancy but also the quality of life of those years. A recent study (Patwardhan, V. et al, 2024[25]) found that from 1990 to 2010, women bore a greater burden of morbidity-related conditions – such as lower back pain, depression, anxiety, headaches and musculoskeletal disorders – while men experienced higher rates of disability-adjusted life years from potentially fatal causes like COVID-19, road injuries and ischaemic heart disease. Women also report higher rates of chronic conditions – including angina, arthritis and depression – and greater functional limitations in areas such as mobility, vision and sleep (Boerma, T., Hosseinpoor, A., Verdes, E., & Chatterji, S., 2016[26]). While some literature suggests that differences in reporting may partly contribute to these gaps, this cannot account for more than a fraction of the observed gender differences in morbidity (Phillips, O' Connor and Vafaei, 2023[27]).

"Healthy life years" is a key indicator that measures the number of years that a person is expected to live in "full health" by taking into account disease prevalence and mortality rates. Figure 2.10 shows life expectancy and healthy life years at age 60 for women and men across OECD countries in 2021. It allows two important aspects to be explored: 1) differences between women and men in absolute healthy years; and 2) the share of healthy years within total life expectancy. While women live longer after age 60, the gender gap shrinks – or even reverses – when considering healthy life years in almost all OECD countries. Women at age 60 can expect to live 3.4 years longer than men (24.6 vs. 21.2 years), but also to spend more years with limitations (6.3 vs. 5.0 years), on average across OECD countries. As a result, women live a smaller share of their remaining years in good health – 26% of their life after 60 is spent in poor health, compared to 24% for men. In the Netherlands, Sweden, Belgium, Germany and Türkiye, the gender gap reaches 3 percentage points (p.p.). These patterns may reflect gender differences in healthcare access, health-seeking behaviour or occupational exposures.

Global studies also find that women face a larger health span – lifespan gap (i.e. the difference between life expectancy and health-adjusted life expectancy) than men. This is linked to women's higher burden of non-fatal diseases and disabilities, which degrade quality of life without shortening lifespan. These disparities were consistently observed across 183 WHO Member States, regions and income levels between 2009 and 2019, indicating a global pattern rather than region-specific issues. Among OECD countries, the largest gender disparities were found in Germany (3.6 years), Spain (3.4 years), France (3.3 years) and Portugal (3.2 years) (Garmany and Terzic, 2024[28]).

A major driver of this disparity is survivor bias: men with severe health risks (such as CVD, risky behaviours, accidents) often die earlier, leaving older men populations disproportionately made up of the healthiest survivors – skewing late-life comparisons. Women, by contrast, often survive despite chronic but non-fatal conditions like arthritis, depression and multimorbidity. Research confirms this effect: women live more years both with and without disease, highlighting the disparity of a longer but sicker life (Gordon et al., 2017[29]; Crimmins, Kim and Hagedorn, 2002[30]). Large cohort studies show that male mortality shapes outcomes, such as women's higher reported dementia risk – partly because many men at high risk have already died (Merrick and Brayne, 2024[31]; Van Oyen et al., 2012[32]). For policymakers, recognising survivor bias is critical, and better tools – like multistate models – are needed to track health transitions and guide screening, care and ageing services.

Figure 2.10. Life expectancy with activity limitation and healthy life years at age 60, 2021



Note: Percentages indicate the proportion of years lived with activity limitation relative to the total life expectancy at age 60. Values shown outside the bars represent total life expectancy at age 60. * Accession/partner country.
Source: WHO Global Health Observatory 2025.

StatLink https://stat.link/9rg8f1

Women aged 45 and over seen in primary care practices consistently report poorer health, well-being and social functioning

Women generally report poorer health compared to men. Data from PaRIS-participating countries show that among primary care users aged 45 and over who reported having at least one chronic condition, women consistently report poorer physical and mental health than men (OECD, 2025[1]). Among people reporting having at least one chronic conditions, men also score significantly better on well-being, across all PaRIS countries, with an average gender gap of 4.7 points on the 5-item WHO Well-Being Index (WHO-5), which is a screening tool for depression (Box 2.1; Figure 2.11).

Box 2.1. OECD PaRIS: the Patient-Reported Indicator Surveys

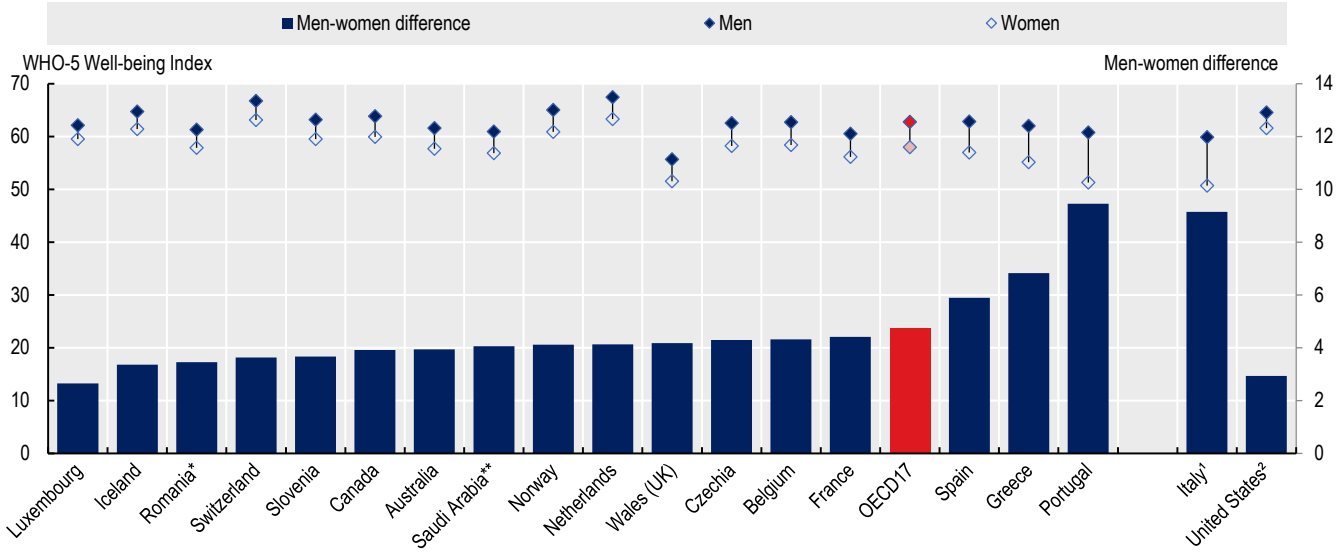
PaRIS contains the world's largest international data collection on patient-reported outcomes and experiences of primary care patients. It covers 107 011 primary care patients across 1 816 primary care practices, representing 104 million primary care users aged 45 and over, across 19 participating countries. Indicators shown in this chapter include the following:

- **Well-being**, assessed by responses to five questions measuring well-being (have felt cheerful and in good spirits, calm and relaxed, active and vigorous, fulfilled in daily life, fresh and rested), with a response options scale of 0-5. Patient scores are averaged (raw scale 0-25 converted to 0-100 scale), and a score ≥50 indicates not at risk of clinical depression. Data instrument: WHO-5 Well-being Index.
- **Social functioning**, assessed by responses to the question: "In general, please rate how well you carry out your usual social activities and roles (This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.)". Response options range from poor (1) to excellent (5). The indicator uses the percentage of patients that responded good, very good or excellent (compared to fair or poor). Data instrument: PROMIS® Scale v1.2 – Global Health scale.
- **General health**, assessed by responses to the question: "In general, would you say your health is …" where response options range from poor (1) to excellent (5). The indicator uses the percentage of patients that responded good, very good or excellent (as compared to fair or poor). Data instrument: PROMIS® Scale v1.2 – Global Health scale.
- **Experienced quality**, assessed by responses to the question: "When taking all things into consideration in relation to the care you have received, overall, how do you rate the medical care that you have received in the past 12 months from your primary care centre?", "good, very good or excellent" versus "fair or poor".
- **Trust in healthcare system**, assessed by responses to question: "How strongly do you agree or disagree that the healthcare system can be trusted?", "strongly agree, agree", "neither agree nor disagree, disagree, strongly disagree"

Source: OECD (2025), Does Healthcare Deliver?: Results from the Patient-Reported Indicator Surveys (PaRIS), OECD Publishing, Paris, https://doi.org/10.1787/c8af05a5-en.

Figure 2.11. Women report lower levels of well-being compared to men in most countries participating in PaRIS

Average scores and absolute differences for men and women on the WHO-5 Well-being Index, 2023-2024



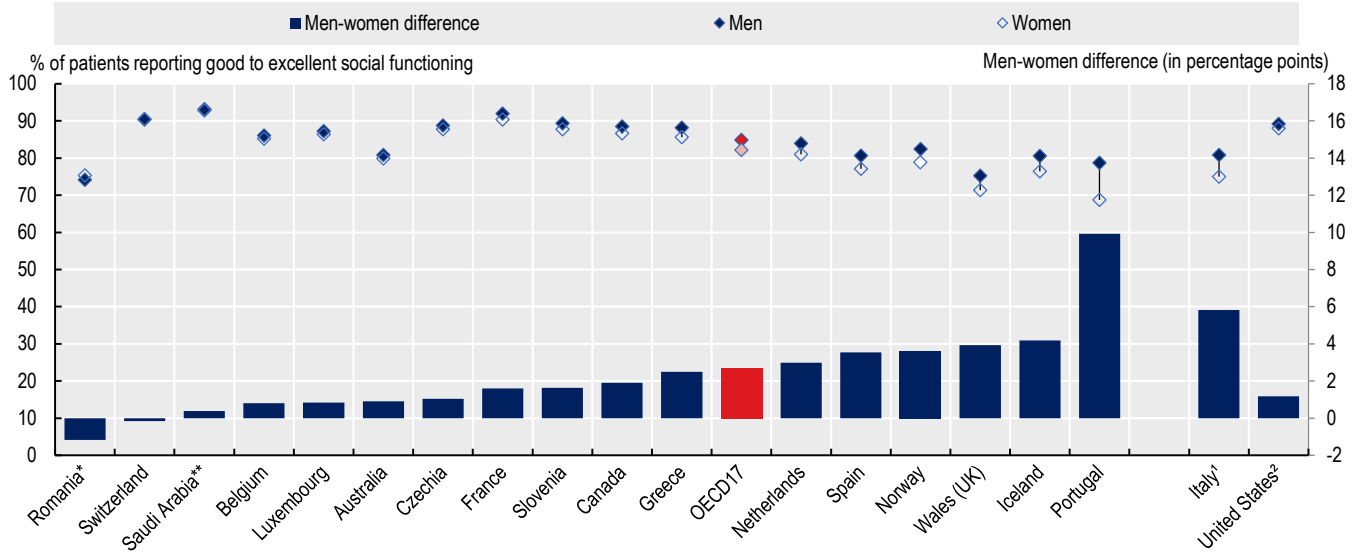
Note: The bar shows the difference in values for men as compared to women. Results for people with one or more chronic conditions. WHO-5 Well-being Index range is from 0-100 with 0 being the lowest possible well-being and 100 the highest. * Accession/partner country. ** Participated in the PaRIS survey. 1. Data for Italy refer to patients enrolled in outpatient settings for specialist visits in selected regions. 2. United States sample only includes people aged 65 and over. Differences are statistically significant (p>0.05) except for Luxembourg and the United States.
Source: OECD PaRIS 2024 Database.

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Data from PaRIS also show that, among people with chronic conditions, women report lower levels of social functioning than men in most countries, with an average gap of approximately 2.7 p.p. (Figure 2.12). The largest gender disparities were found in Portugal (9.9 p.p.), Iceland (4.2), Wales (3.9), Norway (3.6) and Spain (3.5). In contrast, Romania (1.2 p.p.) and Switzerland (0.2) were the only countries where women slightly outperformed men.

Figure 2.12. Women report lower levels of social functioning compared to men in most countries participating in PaRIS

Percentages of people who are positive about how they carry out usual social activities and roles, and absolute differences between men and women, 2023-2024



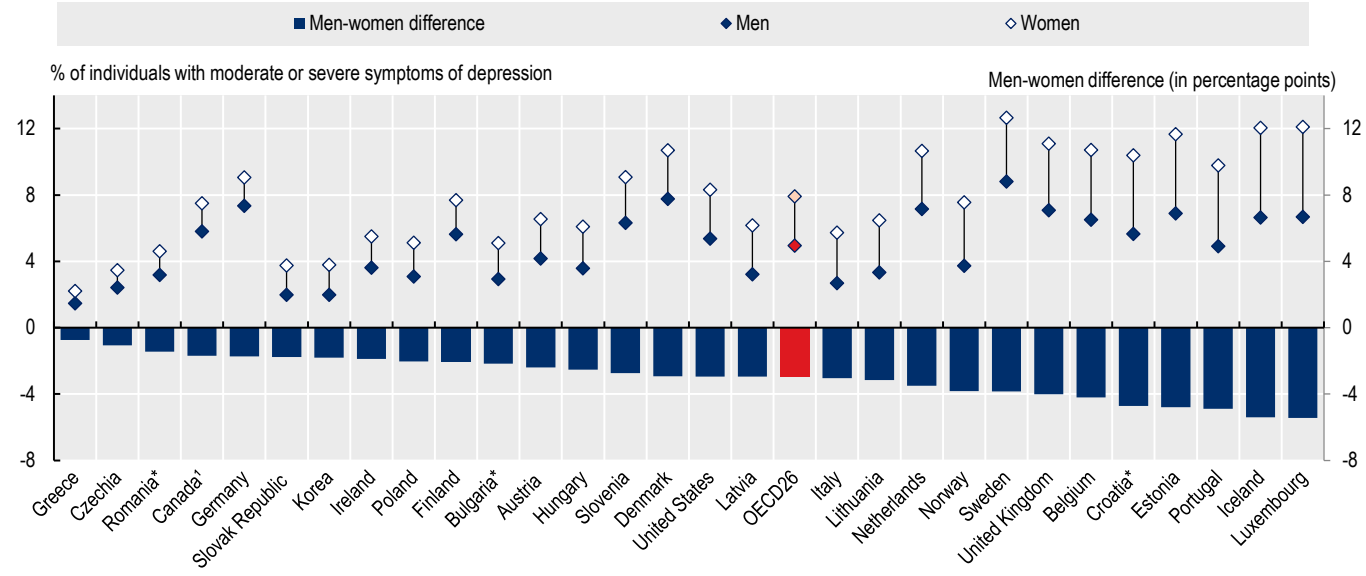
Note: The bar shows the difference in values for men as compared to women. Results for people with one or more chronic conditions. PROMIS® Scale v1.2 – Global Health. * Accession/partner country. ** Participated in the PaRIS survey. 1. Data for Italy refer to patients enrolled in outpatient settings for specialist visits in selected regions. 2. United States sample only includes people aged 65 and over. Differences are only statistically significant in Portugal ($p<0.05$).
Source: OECD PaRIS 2024 Database.

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Results from the Eurostat European Health Interview Survey (EHIS) and other similar surveys corroborate these findings. They show that women report significantly higher rates of moderate to severe depressive symptoms than men. Figure 2.13 shows that on average 5% of men and 8% of women report symptoms of moderate or severe depression, with gender gaps of 1-7 p.p. The widest gender gaps appear in Luxembourg, Iceland, Portugal and Estonia, where women's prevalence exceeds men's by 5-7 p.p. These correspond to relative differences of 23% to 113% higher rates among women compared to men. While overall depression rates vary widely – from below 5% in Korea, Greece and Czechia to over 13% in Sweden and Iceland – women consistently report higher rates. This suggests that a range of factors – including social roles, gender norms, the caregiver burden borne by women, and access to care and social support – shape these inequalities (Vargas Lopes and Llena-Nozal, 2025[22]).

While women are more likely than men to experience and report depressive and anxiety disorders, men more often present with conduct disorders, autism spectrum disorder, attention-deficit/hyperactivity disorder (ADHD) and substance-use disorders (Connery et al., 2020[33]). A recent review of the literature suggests that boys and young men are often less likely to seek care, which has been associated with later diagnoses and untreated mental illness (Sheikh A et al., 2025[34]). Suicide rates are over three times higher in men than women's, despite women reporting more suicidal thoughts and attempts (see section "Suicide, accidents and violence are the leading drivers of premature mortality among men"). Cultural norms play a key role: expectations of male stoicism deter preventive care, while caregiving burdens and limited inclusion in healthcare decisions restrict women's access to care and deepen gaps in understanding their needs (Farhane-Medina et al., 2022[35]). Tackling these disparities requires countries to rethink gender roles and enact systemic changes for equitable care. Biological, psychological and social factors all shape these gaps; for example, women face added mental health risks during pregnancy, postpartum and menopause, and from unpaid care work (OECD, 2023[36]).

Figure 2.13. Moderate or severe symptoms of depression are more common in women across all countries, 2019 (or nearest year)



Note: The bar shows the difference in values for men as compared to women. Results for people aged 18 and over, except for Korea which were aged 19 and over. Results were estimated using survey weights and are not age-standardised. Individuals are classified as having moderate or severe depressive symptoms based on a score equal or higher than 10 in the Patient Health Questionnaire (PHQ, items 8 and 9), which also corresponds to a positive screen indicating the need for further clinical assessment. * Accession/partner country. 1. Estimates for Canada are based on a publication and include data between 2015 and 2019 for the different provinces and territories.

Source: OECD estimates based on the third wave of Eurostat EHIS (2018-2020); National Health Interview Survey (NHIS) 2019 for the United States; Korea Community Health Survey 2019 for Korea; PHQ-9 for Canada; Shields (2021[37]), Shields, M. et al. (2021), "Symptoms of major depressive disorder during the covid-19 pandemic: Results from a representative sample of the Canadian population", https://doi.org/10.24095/HPCDP.41.11.04; Vargas Lopes and Llena-Nozal (2025[22]), "Understanding and addressing inequalities in mental health", https://doi.org/10.1787/56adb10f-en.

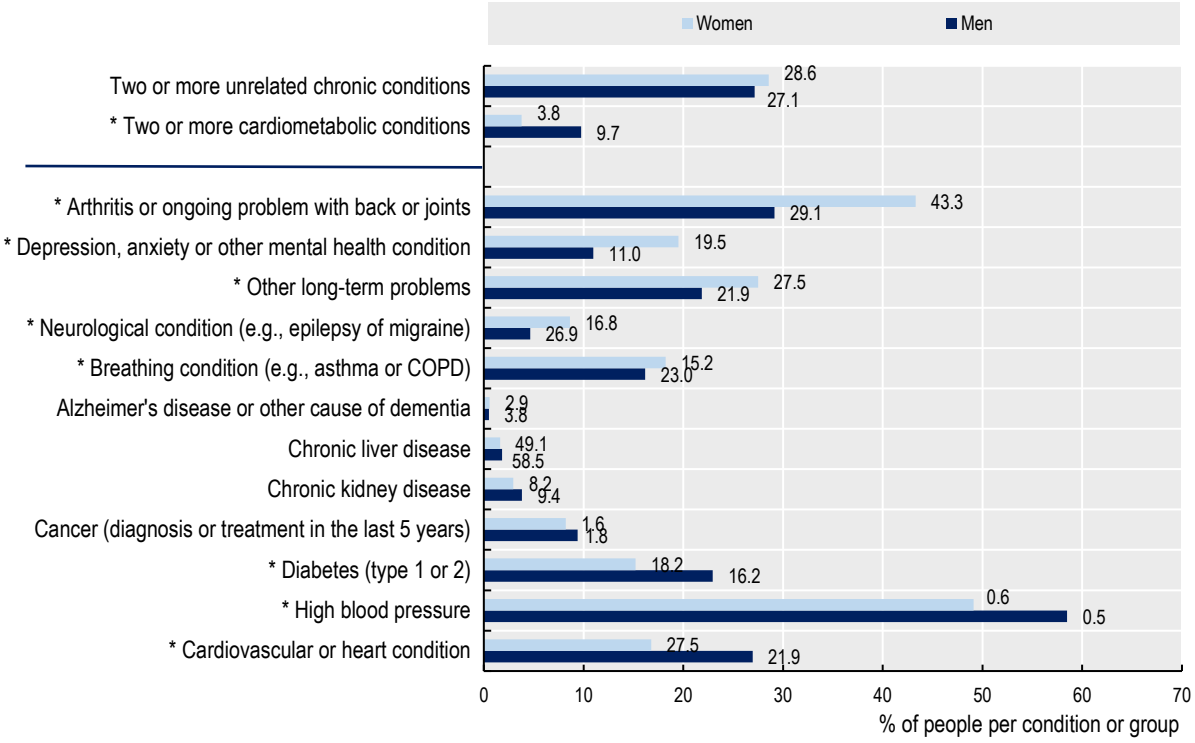
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The OECD PaRIS report shows that while men and women have similar overall rates of chronic conditions (OECD, 2025[1]), men are more likely to report cardiovascular or heart conditions (26.9% versus 16.8% of women) and high blood pressure (58.5% of men versus 49.1% of women); conversely, women are more likely to report arthritis or ongoing joint problems (43.3% versus 29.1% of men), as well as depression, anxiety or other mental health conditions (19.5% versus 11.0% of men) as shown in Figure 2.14.

PaRIS data reveal clear gender patterns in chronic condition combinations among people aged 45 and over managed in primary care. Men most often report conditions related to cardiometabolic risks – high blood pressure, CVD, diabetes and chronic kidney disease – reflecting gender differences in genetic, behavioural and environmental risk pathways. Both men and women show a high prevalence of unrelated multimorbidity – combinations of two or more chronic conditions across different body systems, which are not linked by a common underlying mechanism. However, women report a higher share of combinations that include unrelated conditions such as hypertension with arthritis, and asthma or chronic obstructive pulmonary disease with arthritis. Such differences underscore the importance of developing more tailored care plans for specific combinations of chronic conditions.

Figure 2.14. Related chronic conditions are more common in men, whereas unrelated chronic conditions predominate among women

Percentage of primary care service users aged 45 and over per condition or group of conditions, 2023-2024



Note: Cardiometabolic conditions include commonly occurring conditions that share similar genetic, behavioural or environmental pathways. In PaRIS, this group includes two or more chronic conditions of high blood pressure, cardiovascular or heart condition, diabetes and chronic kidney disease, excluding other conditions (such as arthritis or mental health). Unrelated chronic conditions include a varied assortment of individual conditions that are not explained by a common mechanism. In PaRIS, the discordant conditions group includes two or more chronic conditions, with at least one being one of the following: arthritis, breathing conditions, Alzheimer disease, neurological diseases, chronic liver disease and cancer, excluding mental health. * Difference is statistically significant ($p<0.05$).
Source: OECD PaRIS 2024 Database.

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Health inequalities stem from a complex interplay of biological, social and lifestyle factors, as well as unequal access to and experiences of healthcare

Men display higher smoking, harmful alcohol use and risky behaviours

Gender differences in disease prevalence stem in large part from behaviour and exposure to key risk factors. Across countries, men face higher risks of cancer, CVD, overdose and so-called “deaths of despair” (from alcohol, drugs and suicide) largely because of higher rates of smoking, harmful alcohol use and risky behaviours, and lower adherence to healthy lifestyles. Table 2.3 provides a dashboard of protective and risk factors for health, showing gender differences in smoking, harmful alcohol consumption, overweight, physical inactivity, and vegetable consumption, highlighting five key gender patterns.

1. **Men consistently smoke more than women (except in Iceland)**, with the largest gaps in smoking rates in Türkiye, Latvia and Korea (23-25 points), while countries including Chile and Norway show no differences in smoking rates between men and women. Over the past decade, daily smoking has fallen in most OECD countries thanks to strong tobacco control, though e-cigarette use is rising (OECD, 2023[38]). However, the latest data on cigarette smoking among 15-year-olds find that smoking rates are higher among girls than boys (this and other data below on adolescents come from the Health Behaviour in School-aged Children study).
2. **Heavy episodic drinking is reported by 34% of men and 20% of women**, with the widest gaps among OECD countries in Greece (24 p.p.) and Lithuania (23 p.p.). However, across most OECD countries, 15-year-old girls are more likely than boys to report having been drunk more than once, with the largest gender gaps seen in the United Kingdom, Spain and Italy.

3. **Men have higher overweight rates in all OECD countries,** with gaps largest (up to 20 points) in Luxembourg and Germany and smallest (2-6 points) in Türkiye, the Netherlands and the United Kingdom. Among adolescents, boys have higher overweight and obesity rates than girls in almost all countries.
4. **In most OECD countries, women report lower levels of physical activity than men – except in Denmark, Finland and Sweden, where they have slightly higher levels.** Gender gaps range from just 1-2 p.p. of physical inactivity (in Austria, Estonia, Korea, New Zealand and the United Kingdom) to as high as 16-19 p.p. in Türkiye, Costa Rica and Chile. Among 15-year-olds, boys consistently outperform girls in meeting daily physical activity guidelines.
5. **Men consistently eat fewer vegetables than women across OECD countries, except in Mexico and Korea.** While countries including Australia, Korea and New Zealand report high daily intake with little to no gender gap, others – such as Germany, Luxembourg and Finland – show both low overall intake and wide gender disparities (19-22 p.p.). Among 15-year-olds, the pattern is clear: in nearly all countries, girls are more likely than boys to eat vegetables daily, highlighting early and persistent gender differences in dietary habits.

In addition, men face a higher risk of illicit drug use, which is a major driver of preventable death. Opioid use is higher among men in most countries, with heroin still dominant in Europe, although concerns over synthetic opioids are rising (EMCDDA, 2022[39]). Men are also more likely to use cocaine (except in Israel), with 1.7% reporting past-year use across OECD countries compared to 0.7% of women.

Health inequalities between men and women are also linked to gendered health risks. For example, women are more likely to experience physical and mental health impacts of gender-based violence; they face specific health risks related to pregnancy and childbirth, and often require more care in later life due to longer life expectancy.

Table 2.3. Dashboard on protective and risk factors for health, 2023 (or nearest year)

Country	Risk factors								Protective factor	
	Smoking (%)		Heavy episodic drinking (%)		Overweight (%)		Physical inactivity (%)[2]		Vegetable consumption (%)	
	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women
OECD	19	11	34	20	61	48	27	32	53	64
Argentina*	28[2]	18[2]					37	42		
Australia	9[2]	8[2]			64[2]	53[2]	26	30	98[2]	98[2]
Austria	24[1]	18[1]	28	16	60[1]	43[1]	22	24	39[1]	55[1]
Belgium	14	11	36	24	53	47	25	33	72	80
Brazil*	12[2]	7[2]	29	16	60[2]	55[2]	36	46		
Bulgaria*	38[1]	21[1]	40	13	64[1]	46[1]	36	38	48[1]	49[1]
Canada	10	7	23[2]	17[2]	63	52	39	42	71	80
Chile	16[2]	16[2]			70[3]	71[3]	32	48		
China*	48[2]	2[2]					27	19		
Colombia	14[1]	6[1]					28	41		
Costa Rica	10	3					42	59		
Croatia*	26[1]	20[1]	23	8	72[1]	58[1]	32	34	59[1]	64[1]
Czechia	20	12			68[1]	49[1]	26	29	35[1]	49[1]
Denmark	12[3]	10[3]			59	48	15	14	37[1]	54[1]
Estonia	18[3]	10[3]			62[3]	45[3]	19	20	41[1]	52[1]
Finland	12[2]	11[2]	36	18	67[2]	55[2]	13	11	33[2]	55[2]
France	25	21	20	10	50[1]	41[1]	23	31	56[1]	69[1]
Germany	18[2]	12[2]	33	22	63[2]	43[2]	15	15	36[1]	56[1]
Greece	31[1]	19[1]	59	35	63[2]	47[2]	37	42	47[1]	59[1]
Hungary	28[1]	22[1]	21	5	65[1]	52[1]	31	35	40[1]	49[1]
Iceland	5[3]	6[3]	38	29	68[1]	50[1]	25	30	52[3]	61[3]
India*	14[2]	1[2]					41	57		
Indonesia*	63[2]	3[2]					20	16		
Ireland	15[3]	12[3]	51	40	63[3]	50[3]	21	26	69[3]	77[3]
Israel	21[3]	13[3]	9	3	62[3]	47[3]	25	31	82[3]	88[3]
Italy	23	16	34	15	55	38	41	49	53	62
Japan	26	7					45	56		
Korea	27	4	48	26	41[3]	23[3]	58	63	99	98
Latvia	35[1]	12[1]	44	24			18	19	39[2]	52[2]
Lithuania	30[1]	10[1]	38	15	63[2]	55[2]	23	25	48[1]	58[1]
Luxembourg	16[3]	14[3]			59[1]	38[1]	15	16	28[1]	47[1]
Mexico	12	5					25	31	53[2]	49[2]

Country	Risk factors								Protective factor	
	Smoking (%)		Heavy episodic drinking (%)		Overweight (%)		Physical inactivity (%)[2]		Vegetable consumption (%)	
	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women
Netherlands	16	11	35	16	51	46	10	13	51	62
New Zealand	8[3]	6[3]					20	22	95[3]	96[3]
Norway	8[3]	8[3]	43	32	59[2]	44[2]	34	42	59[2]	74[2]
Peru*	2	1					32	37		
Poland	21[1]	14[1]	29	9	65[1]	49[1]	38	42	48[1]	56[1]
Portugal	20[1]	9[1]	27	10	59[2]	48[2]	50	62	36[1]	47[1]
Romania*	31[1]	8[1]			75[1]	59[1]	40	41	15[1]	19[1]
Slovak Republic	27[1]	15[1]	43	23	67[1]	49[1]	24	27	43[1]	52[1]
Slovenia	19[1]	16[1]	22	7	64[1]	49[1]	21	24	50[1]	63[1]
South Africa*	35[2]	7[2]					39	48		
Spain	23[2]	17[2]	20	11	58[2]	43[2]	22	28	41[2]	52[2]
Sweden	9[3]	8[3]	47	41	58	45	11	10	58[2]	73[2]
Switzerland	18[2]	14[2]	32	18	52	34	20	24	55[2]	74[2]
Thailand*							29	33		
Türkiye	41[2]	16[2]			57[2]	55[2]	35	54	38[2]	44[2]
United Kingdom	12	10	38	38	67[2]	61[2]	21	23		
United States	9	7			73	64	30	43		

1. 2019 data.
2. 2020-2022 data.
3. 2024 data.

Note: * Accession/partner country. See the weblink to metadata in the "Reader's guide" for country-specific definitions and population groups. **Smoking** (%): Share of population aged 15 and over who report smoking tobacco daily. **Heavy episodic drinking** (%): Share of people aged 15 and over who reported consuming ≥48 g of alcohol for women and ≥64 g for men (about 5+ drinks for women and 6+ for men) on one single occasion at least monthly in the past year. Results may differ from national sources. **Overweight**: percentage share of population aged 15+ self-reporting overweight (body mass index (BMI) ≥25), includes those reporting obesity (BMI ≥ 30). **Physical inactivity** (%): proportion of adults aged 18 and over (crude estimate) that engage in less than 150 minutes of moderate intensity physical activity per week, or less than 75 minutes of vigorous-intensity physical activity per week, or equivalent, 2022 data. **Vegetable consumption** (%): Share of population aged 15+ consuming at least one portion of vegetables per day, excluding juice and potatoes.

Source: For smoking, overweight, and vegetable consumption: OECD Health Statistics 2025; for physical inactivity: WHO 2022; Heavy episodic drinking (%): European Social Survey 2023 (European Social Survey European Research Infrastructure (ESS ERIC), 2025), complemented with national data sources for Australia, Brazil, Canada, Korea and the United States.

Populations with low education levels face wider gender gaps in health and well-being, exposing a compounded disadvantage for women with low education levels

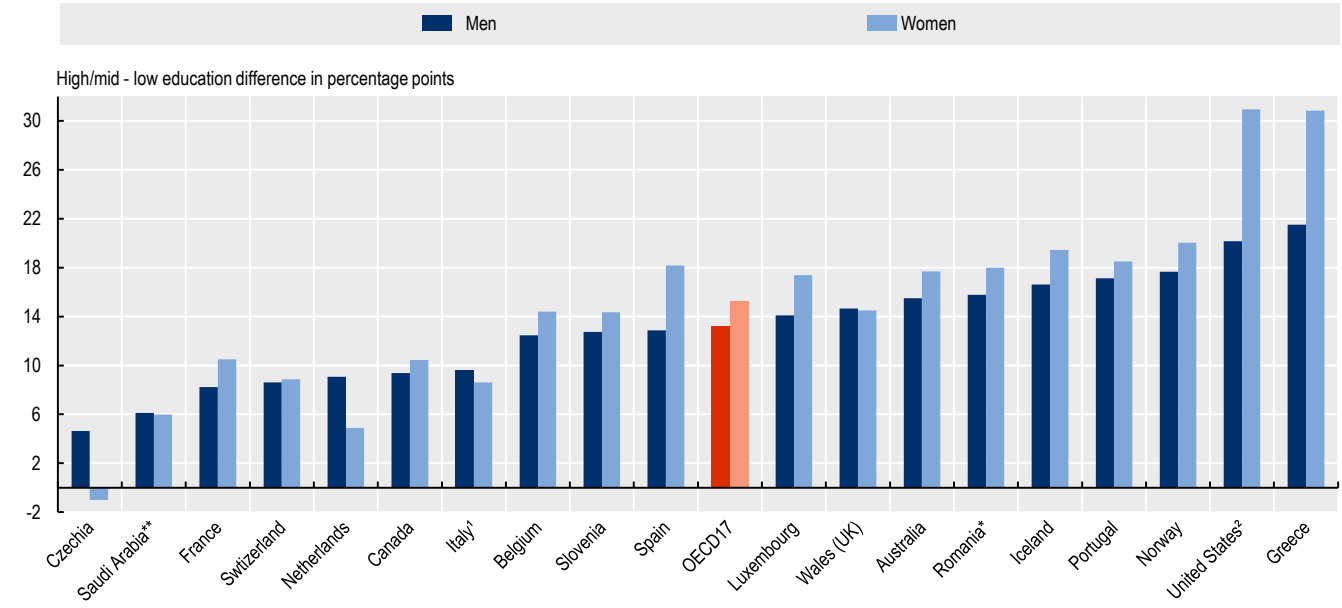
Health inequalities are shaped by the interplay between gender and socio-economic status. People with lower income and education levels are more likely to face poor physical and mental health, engage in unhealthy behaviours, and have limited access to care (OECD, 2019[40]; OECD/European Union, 2022[41]). These disadvantages are often compounded by psychological distress linked to unemployment, job insecurity and poor housing (OECD, 2021[42]).

While gender inequalities underpin many social disparities, recent data suggest that the education-related health gap in life expectancy is steeper for men. Across OECD countries, the life expectancy gap between men with high and low education levels is 8.2 years, compared to 5.2 years for women (OECD, 2022[43]). PaRIS data confirm persistent gender and socio-economic health gaps, even after adjusting for age and multimorbidity (OECD, 2025[1]). Figure 2.15 shows the p.p. difference in the share of primary care users aged 45 and over reporting good to excellent general health by education level (low vs. mid/high) among men and women, with similar results for social functioning. Three key findings emerge.

- A clear education-related health gradient exists across OECD PaRIS countries, among primary care users aged 45 and over, women generally face steeper gaps than men – an average 15.2 p.p. higher proportion of women with mid/high vs. low education levels reporting good to excellent general health compared to a 13.2 p.p. gap for men. These differences are more pronounced in the United States and Greece, with an education gap 10 p.p. wider among women than men. However, in countries such as Czechia, the Netherlands and Italy, men report a wider gap in good to excellent general health by education level than women.
- Among primary care users aged 45 and over reporting low education levels, men report slightly better general health than women on average, although gaps range widely – from 11.9 p.p. in the United States and Greece (where men with low education levels report better general health than women) to 2.4 in Czechia (where the reverse is true). Among groups with mid/high education levels, men tend to report better general health – ranging from 0.8 to 5.7 p.p. higher than women. Similar patterns appear in social functioning, with the largest education-related disparities often affecting women more, especially in Portugal, Spain and France.

Figure 2.15. Differences in general health between mid/high and low education levels vary more than four-fold between OECD PaRIS countries

p.p. differences between education levels of people in PaRIS reporting good to excellent general health, 2023-2024



Note: The bar shows the difference in values for people that report high or middle level of education as compared to those reporting low levels of educations. All within-country differences by level of education in men are statistically significant except for Czechia. All within-country differences by level of education in women are statistically significant except for Czechia, Italy and the Netherlands. 1. Data for Italy refer to patients enrolled in outpatient settings for specialist visits in selected regions. 2. United States sample only includes people aged 65 and over. * Accession/partner country. ** Participated in the PaRIS survey.
Source: OECD PaRIS 2024 Database.

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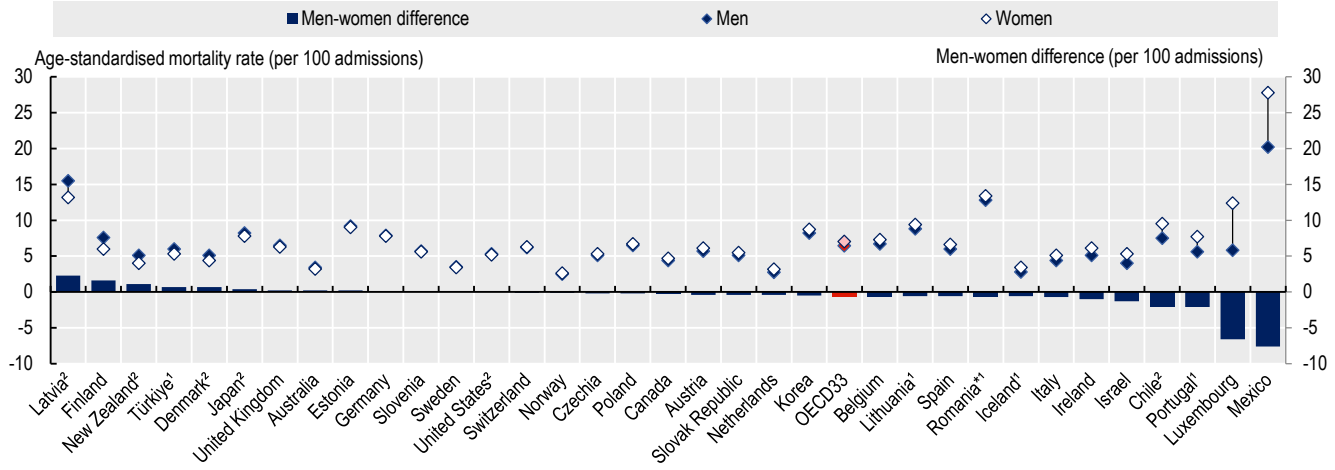
Health inequalities partly stem from differences in how women and men access and experience care

Gender differences in symptom recognition and diagnosis are a key source of treatment disparities. Medical education and guidelines often overlook how diseases present differently in men and women, reflecting a legacy of non-inclusive research. For example, women with heart attacks or strokes may report symptoms like back pain or nausea, leading to delayed diagnoses (Temkin et al., 2023[44]; American Heart Association, 2021[45]; American Heart Association, 2019[46]). Their symptoms are also more likely to be dismissed in cases like cancer, CVD (Din et al., 2015[12]; Maas and Appelman, 2010[13]), osteoarthritis (Templeton, 2021[47]) and mental health, where complex trauma may be misdiagnosed as bipolar disorder (Department of Health and Social Care, 2018[48]). Men face bias too – osteoporosis is often missed, despite high fracture rates and mortality (Adler, 2014[49]).

Access to appropriate and timely care also varies between men and women. For instance, 30-day mortality after hospital admission for acute myocardial infarction (AMI) or stroke reflects hospital care quality – including pre-hospital care, transfer patterns, length of stay and disease severity. On average, women have slightly higher 30-day mortality rates after AMI than men, with the largest gaps in Mexico (28 vs. 20 per 100 admissions), Luxembourg (12.4 vs. 5.8), Portugal (7.7 vs. 5.6) and Chile (9.5 vs. 7.5) (Figure 2.16). For ischaemic stroke, mortality differences between men and women are smaller and more variable across countries (Figure 2.17).

Figure 2.16. Heart attack 30-day mortality rates, 2023 (or nearest year)

30-day mortality rates after admission due to acute myocardial infarction in people aged 45 and over per 100 patients (during the same hospital admission, unlinked data)

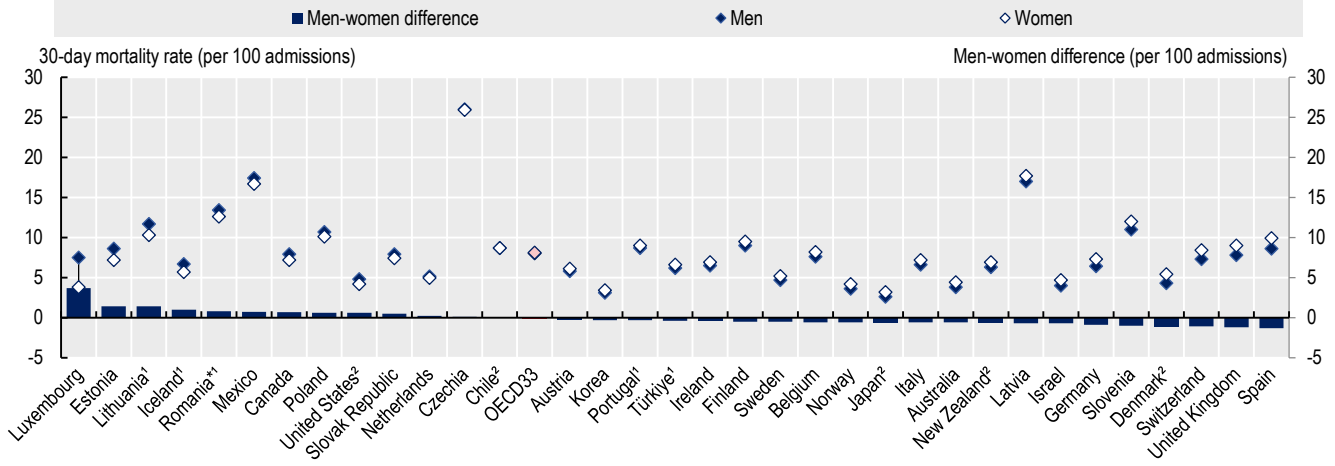


Note: Unlinked data include only deaths that occurred in the same hospital as the initial admission. The bar shows the difference in values for men as compared to women. * Accession/partner country. 1. 2024 data. 2. 2020-2022 data.
Source: OECD Health Statistics 2025.

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Figure 2.17. Ischaemic stroke 30-day mortality rates, 2023 (or nearest year)

30-day mortality rates after admission due to ischaemic stroke in people aged 45 and over per 100 patients (during the same hospital admission, unlinked data)



Note: Unlinked data include only deaths that occurred in the same hospital as the initial admission. The bar shows the difference in values for men as compared to women. * Accession/partner country. 1. 2024 data. 2. 2022 data. 3. 2021 data.
Source: OECD Health Statistics 2025.

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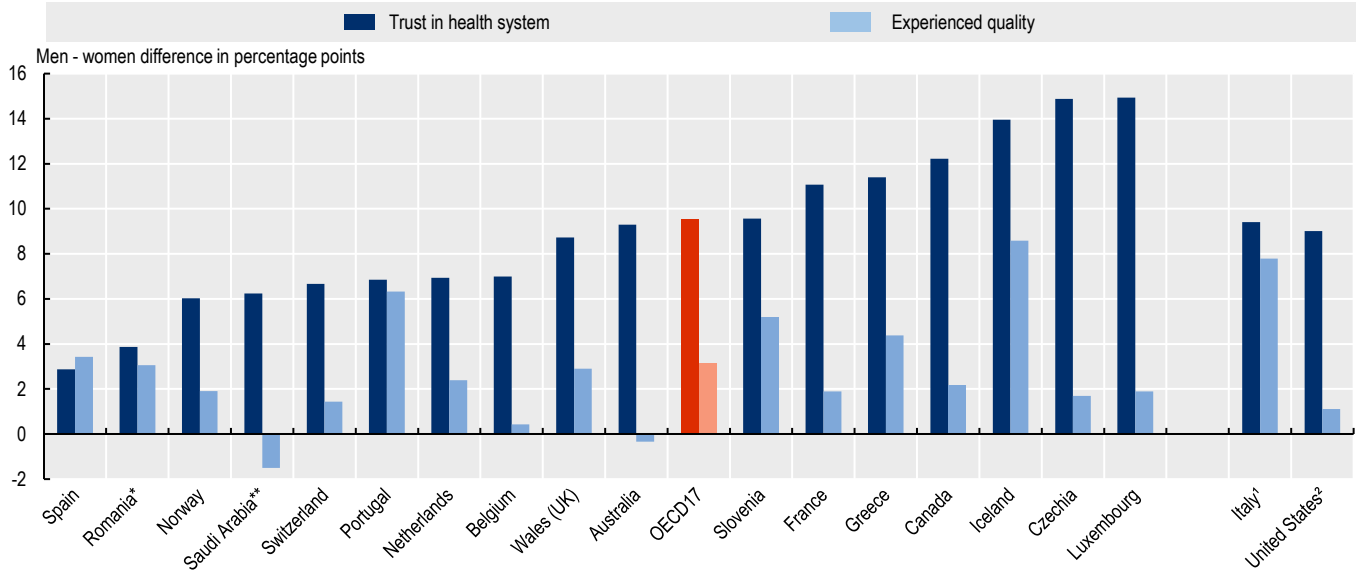
PaRIS data confirm that men and women report different experiences with healthcare. As shown in Figure 2.18, men are generally more likely to rate the quality of care positively, although significant differences are rare – only Slovenia shows a statistically significant gap. In contrast, differences in trust in the healthcare system are more pronounced: in one-third of countries, the gap exceeds 10%, and in all but two, it is over 5%, with men consistently reporting higher levels of trust. Future OECD work will compare how effectively countries deliver timely, high-quality care for women and men, identifying opportunities to reduce treatment bias and improve access for all.

Differences in diagnosis between men and women further contribute to health inequalities. Clinical guidelines often rely on clinical trials where men predominate, leading to treatment protocols that may not suit women patients. This can result in differing prescriptions despite similar needs. For instance, lecanemab – hailed for its potential to slow cognitive decline in Alzheimer disease – has shown greater effectiveness in men (Buckley, Gong and Woodward, 2023[50]). Chemotherapies work better in women due to slower drug clearance (Haupt, Carcel and Norton, 2024[8]). Yet women also report more adverse reactions to cardiovascular and psychotropic drugs (Lacroix et al., 2023[51]; Farkouh et al., 2021[52]; Raparelli et al., 2017[53]; Tamargo et al., 2017[54]). Biological factors like body composition and metabolism partly explain these trends. Since 1980, medicines have been over three times more likely to be withdrawn for safety issues affecting women (World Economic Forum, January 2024[55]).

Access gaps can arise from system inefficiencies and provider biases. Emerging evidence shows that patients treated by female doctors often have better outcomes, including lower mortality and fewer complications, as seen in studies from the United States, Canada, Sweden and Japan (Greenwood, Carnahan and Huang, 2018[56]; Dahrouge et al., 2016[57]; Wallis et al., 2017[58]; Blohm et al., 2023[59]; Okoshi et al., 2022[60]). In response, countries including Australia, France and Ireland are addressing gender disparities through national strategies and medical training reforms (Australian Government, 2019[61]; HCE, 2020[62]; National Women's Council, 2021[63]).

Figure 2.18. While gender differences in experiences with quality of care are small, fewer women than men have trust in the healthcare system

Absolute differences in the percentage of women and men who reported positive experiences regarding the quality of primary care, and trust in the healthcare system, 2023-2024



Note: The bar shows the difference in values for men as compared to women. Results for people with one or more chronic conditions. 1. Data for Italy refer to patients enrolled in outpatient settings for specialist visits in selected regions. * Accession/partner country. ** Participated in the PaRIS survey. 2. United States sample only includes people aged 65 and over. Experienced quality: gaps not statistically significant, except for Slovenia ($p<0.05$). Trust: gaps statistically significant except for Portugal, Romania, Spain and the United States ($p<0.05$).
Source: OECD PaRIS 2024 Database.

StatLink https://stat.link/02xgec

Gaps in health data and research remain – especially for conditions that disproportionately affect women or men. Research into women's specific disorders like menstrual disorders, pelvic floor disorders, violence against women, diabetes and severe hypertension during pregnancy, postpartum depression, endometriosis and menopause receive relatively less funding (Temkin et al., 2023[64]; Mirin, 2021[65]; As-Sanie et al., 2019[66]), while autoimmune diseases, though more common in women, also affect many men and should be considered separately. Male infertility, osteoporosis age-related testosterone decline, and some mental health issues are often underdiagnosed due to stigma and social norms (Rinonapoli et al., 2021[67]). The OECD is working to close these gaps through improved data collection and performance measurement under the renewed Health System Performance Assessment framework (OECD, 2024[68]).

Concluding thoughts

This analysis underscores the gender health disparity across OECD countries: men die younger, while women live longer but with more years in poor health. Men face higher premature mortality – often from preventable causes like suicide, accidents and CVD – while cancer is the leading cause of premature mortality among women. Gender gaps in health behaviours contribute to these patterns, with men more likely to smoke, drink heavily and be overweight, and women more affected by chronic conditions. Socio-economic disadvantage, especially among women with low education levels, further widens health and well-being gaps. Health inequalities partly stem from differences in how women and men access and experience care.

Future OECD work on gender and health will culminate in a forthcoming report. This will assess how well OECD health systems serve both women and men, where gender biases affect diagnosis and treatment, and which diseases remain under researched or underreported. It will identify ways to reduce treatment gaps, improve access, and highlight research and data priorities. The OECD is also expanding data collection – guided by the Working Party on Healthcare Quality and Outcomes – with a focus on developing women's health indicators.

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Notes

[1] The PaRIS flagship report (OECD, 2025[1]) compares 10 key indicators across countries, including general health, well-being, physical and mental health, social functioning, trust in the health system, care quality and co-ordination, and self-management confidence. It collects individual-level data from patient and provider surveys and information on socio-demographics (e.g. age, education, gender, income and comorbidities). Links to the questionnaires: https://www.oecd.org/health/paris/PaRIS-patient-questionnaire.pdf and https://www.oecd.org/health/paris/PaRIS-provider-questionnaire.pdf.


RESTING ECG
****** BORDERLINE ABNORMAL ******
707:Abnormal Q ?
210:Mild left axis deviation
Check abnormal Q-wave.
P-wave is unclear. Check P-wave.
Unconfirmed. MD must review. ****
2-1-3 4-2
V1
aVL
V2
V3

3 Health status

Life expectancy at birth
Main causes of mortality
Avoidable mortality (preventable and treatable)
Mortality from circulatory diseases
Cancer incidence and mortality
Maternal and infant mortality
Adolescent health
Chronic conditions
Mental health
Self-rated health

Life expectancy at birth

In 2023, life expectancy at birth was 81.1 years on average across OECD countries (Figure 3.1). Spain, Japan and Switzerland led a large group of 27 OECD Member countries in which life expectancy at birth exceeded 80 years. A second group, including the United States and the remaining OECD countries, had a life expectancy between 75 and 80 years. In all accession/partner countries, life expectancy remained below the OECD average in 2023, with levels lower than 75 years in South Africa, Indonesia, and India. Still, levels have been converging rapidly in most of these countries in recent decades. Provisional 2024 data available for some countries shows a slight year-on-year increase in life expectancy at birth.

Women live longer than men in all OECD Member and accession/partner countries. This gender gap averaged 5.2 years across OECD countries in 2023: life expectancy at birth for women was 83.7 years, compared to 78.5 years for men (Figure 3.1). These differences in life expectancy are due in part to greater exposure to behavioural risk factors among men – particularly high tobacco consumption, excessive alcohol consumption and less healthy diets (see Chapters 2 and 4). Men are also more likely to die from violent deaths, such as suicide and accidents, which are the leading cause of premature mortality among men (see Chapter 2).

Gender differences in life expectancy are especially marked in Estonia, Lithuania and Latvia, with gaps of 8 years or more. Life expectancy gaps between men and women are relatively narrow in the Netherlands and Norway, at around 3 years. Over time, the difference in life expectancy between men and women across OECD countries has declined slightly, largely due to reductions in cardiovascular mortality in men (OECD/The King's Fund, 2020[1]) and changes in behavioural risk profiles.

While women typically live longer than men, they do not necessarily enjoy more time in good health, notably in later years. Women aged 60 can expect to live 3.4 years longer than men, but also spend more years with activity limitation (6.3 vs. 5.0 years), on average across OECD countries. As a result, women live a smaller share of their remaining years in good health – 26% of their life after age 60 is spent in poor health, compared to 24% for men (see section on “Life expectancy and healthy life expectancy at older ages” in Chapter 10).

Prior to the COVID-19 pandemic, life expectancy increased in all OECD Member and accession/partner countries between 2010 and 2019, with an average increase of 1.7 years (Figure 3.1). While these gains were wiped out during the pandemic in many countries (with an average decrease of 0.7 years across OECD countries between 2019 and 2021), the latest data shows signs of a subsequent recovery. Life expectancy increased in 23 OECD countries between 2019 and 2023 by a year or more in Lithuania and Chile, and in partner country India. However, life expectancy in 2023 was still below pre-pandemic levels in 13 OECD countries, as well as accession country Thailand.

Further, gains between 2010 and 2019 actually reflect a slowdown in life expectancy in many countries compared to historical trends. There are many causes of this slowdown. In some countries, particularly the United States and Canada, opioid use has caused more working-age adults to die from drug-related accidental poisoning. More broadly, slowing improvements in rates of heart disease and stroke have tempered life expectancy gains. This is linked to rising levels of obesity and diabetes, as well as population ageing (Raleigh, 2019[2]; OECD, forthcoming[3]). These factors have made it difficult for countries to maintain previous progress in cutting deaths from cardiovascular conditions, which are the leading cause of death across OECD, see section on “Mortality from circulatory diseases”.

Definition and comparability

Life expectancy at birth measures how long, on average, people would live based on a given set of age-specific death rates. However, the actual age-specific death rates of any particular birth cohort cannot be known in advance. If age-specific death rates are falling (as has been the case over the past few decades), actual life spans will be higher than life expectancy calculated with current death rates.

Data for life expectancy at birth come from Eurostat for European Union (EU) countries plus Iceland, Norway and Switzerland, and from national sources elsewhere. Life expectancy is in some countries estimated using the unweighted average of life expectancy of women and of men, the difference between this and a weighted estimate is small in all OECD countries.

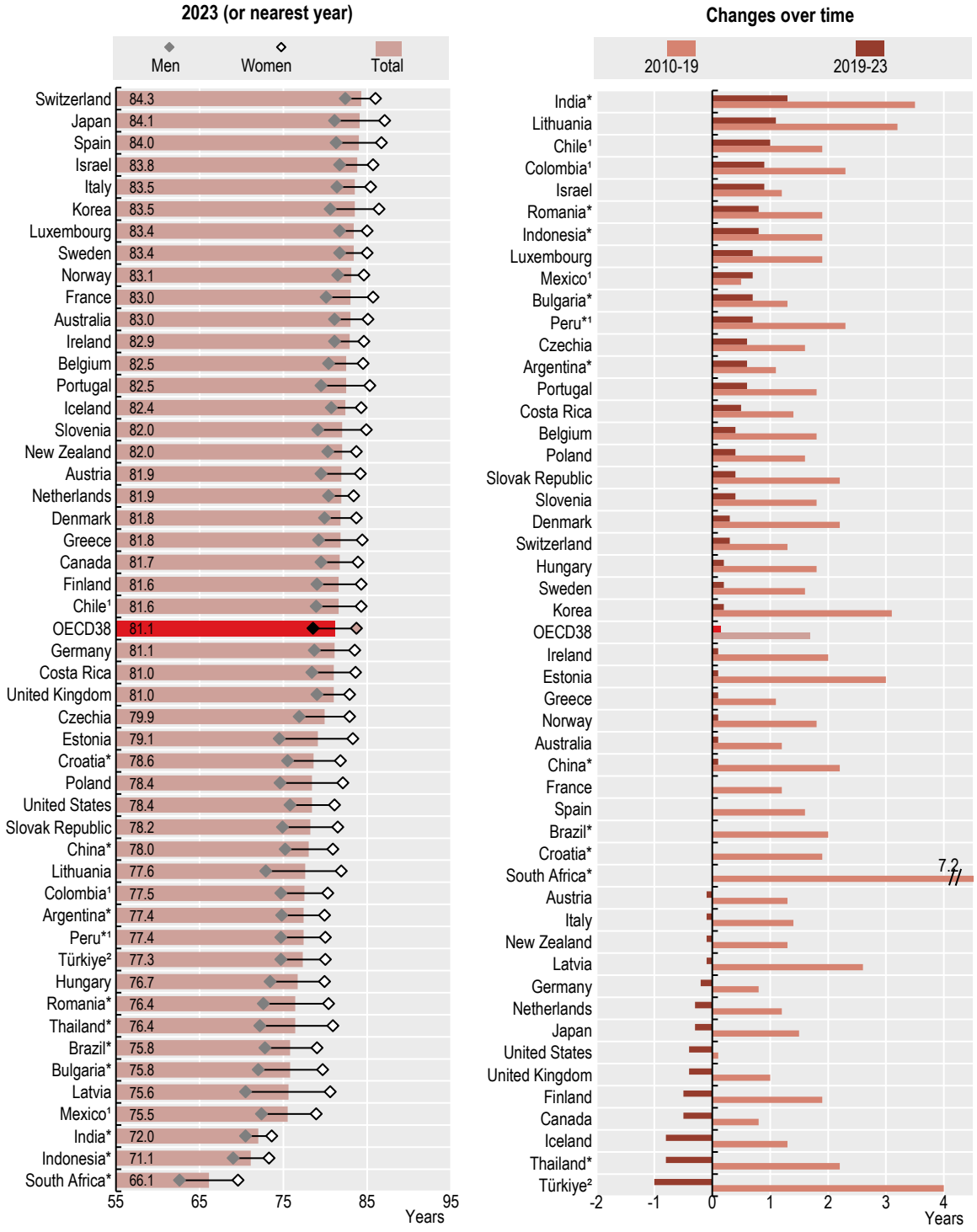
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Figure 3.1. Life expectancy at birth (2023 or nearest year) and changes over time (2010-2019 and 2019-2023)



1. 2024 data. 2. 2022 data. * Accession/partner country.
Source: OECD Health Statistics 2025, based on Eurostat for EU countries.

StatLink https://stat.link/y8rp1x

Main causes of mortality

In 2023, close to 13 million people died across OECD countries, with an average rate of 861 deaths per 100 000 population (Figure 3.2). This reflects a slightly lower mortality rate than 2021, during the pandemic. Diseases of the circulatory system and cancer are the two leading causes of death, accounting for almost half of all deaths in OECD countries. The epidemiological transition from communicable to non-communicable diseases, which has already taken place in high-income countries, is ongoing in many middle-income countries. Across 36 OECD countries in 2023, over 3 million deaths among people aged under 75 years could have been avoided (see section on "Avoidable mortality"). For example, circulatory conditions caused almost one in three deaths in the population, mainly due to heart attacks and strokes – both largely avoidable by adequate management of clinical and behavioural risk factors (OECD, forthcoming[1]).

Cancer accounted for one in five deaths across OECD countries – particularly cancer of the lungs, colon and rectum, pancreas, breast, and prostate. Respiratory diseases accounted for 9% of deaths, mainly due to chronic obstructive pulmonary disease (COPD) (3%) and pneumonia (3%). COPD and lung cancer are associated with preventable risk factors – notably smoking, but also occupational exposure to dust, fumes and chemicals, and air pollution (see Chapter 4 "Non-medical determinants and risk factors"). COVID-19 accounts for 5% of total deaths, explained by the persistent transmission of the virus and its effect on older adults and people with underlying conditions, and partially by reporting delays.

External causes were responsible for 7% of deaths across OECD countries – notably accidents (including traffic accidents, falls and poisoning), which accounted for almost 6% of all deaths, and suicides, which accounted for 1.2% of all deaths. Falls are particularly important for ageing populations, as some older adults have physical vulnerabilities and lack the support mechanism to call on medical services quickly (Xu, Ou and Li, 2022[2]).

Looking at other specific causes, conditions of the nervous system accounted for 5% of all deaths, including Alzheimer's disease (2.3% of all deaths). Diabetes represented 3% of all deaths across OECD countries and is an important risk factor for cardiovascular conditions (OECD, forthcoming[1]).

The main causes of death differ between socio-economic groups, with social disparities generally larger for the most avoidable diseases. For example, people with the lowest level of education are more likely to smoke in most OECD countries, increasing the risk of developing cancers and diseases of the respiratory system (OECD, 2019[3]).

Across OECD countries, all-cause age-standardised mortality rates in 2023 ranged from under 700 deaths per 100 000 in Japan, Switzerland, Luxembourg, Spain and Australia, to over 1 400 deaths per 100 000 in Colombia (Figure 3.3). On average, the total mortality rate across OECD countries was 861 per 100 000 in 2023, similar to the 2019 pre-pandemic mortality rate (830 per 100 000). Diseases of the circulatory system are the leading cause of death for 27 OECD countries, followed by neoplasms (mainly cancers). Neoplasms are the leading cause of death in ten OECD countries: Japan, Spain, Australia, Korea, France, Israel, Canada, the Netherlands, Denmark and the United Kingdom (Figure 3.3). Among OECD accession countries, mortality rates were highest in Brazil (1 413 per 100 000 population) and Bulgaria (1 452 per 100 000).

Definition and comparability

Mortality rates are based on the number of deaths registered in a country in a year divided by the population. Rates have been age-standardised to the 2015 OECD population (see related metadata, https://stats.oecd.org/wbos/fileview2.aspx?IDFile=9070932a-1129-450f-8170-65fc13edcd62) to remove variations arising from differences in age structures across countries and over time. Note that this results in some age-standardisation differences with other population standards used by, for example, the World Health Organization (WHO) and the EU. The source for mortality rates is the WHO Mortality Database, with recent data available for all OECD countries except New Zealand.

Deaths from all causes are classified using the International Classification of Diseases, tenth revision (ICD-10) codes A00-Y89, excluding S00-T98. The classification of causes of death is based on "chapters" (e.g. neoplasms or diseases of the respiratory system) with blocks of three-character categories. Three-character categories can be used for single conditions (e.g. pneumonia) or groups of diseases with common characteristics (e.g. malignant neoplasms (cancers) or ischaemic heart diseases). The category "other" in Figure 3.2 includes data from chapters that are less prevalent (e.g. diseases of the genitourinary system). Reporting delays, and differences in when causes of death are registered across countries may affect comparability, notably in small group categories.

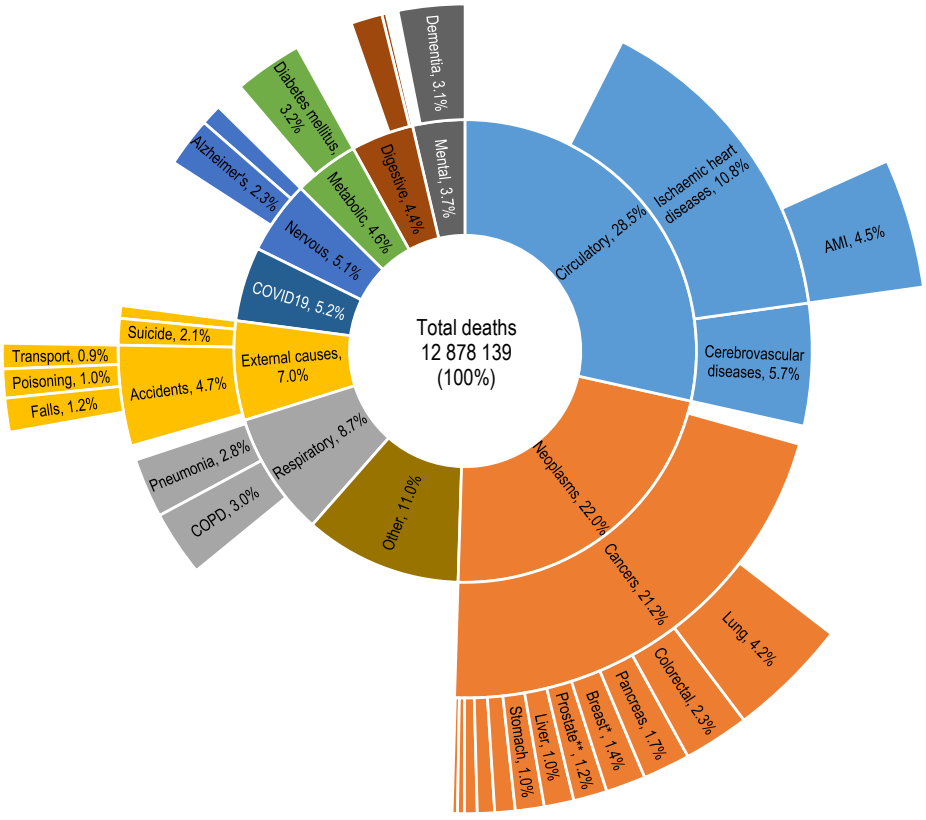
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Xu, Q., X. Ou and J. Li (2022), "The risk of falls among the aging population: A systematic review and meta-analysis", *Frontiers in Public Health*, Vol. 10, https://doi.org/10.3389/fpubh.2022.902599. [2]

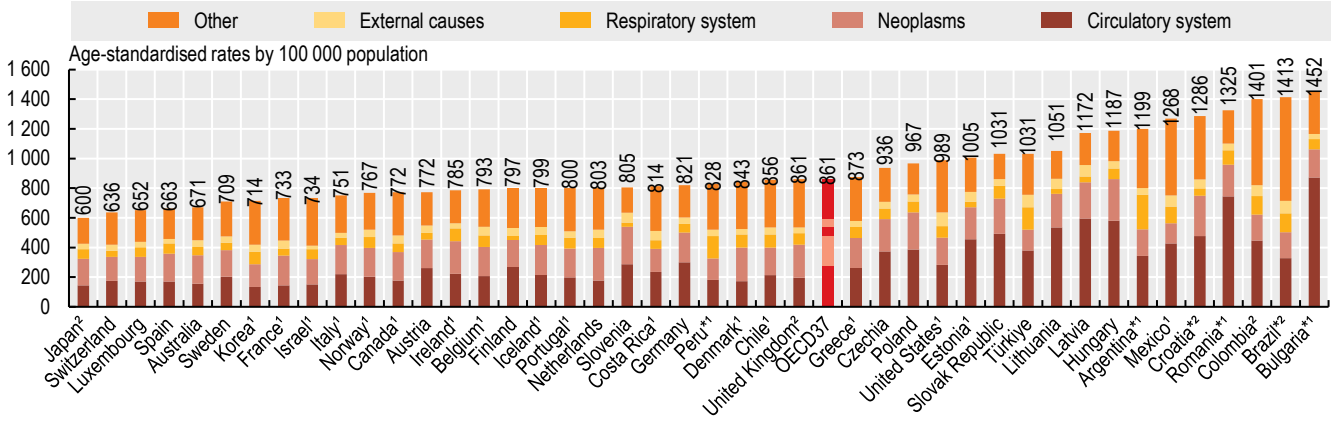
Figure 3.2. Main causes of mortality across 37 OECD countries, 2023 (or nearest year)



Note: COPD: chronic obstructive pulmonary disease. AMI: acute myocardial infarction. *Related to women. **Related to men.
Source: OECD Health Statistics 2025, based on the WHO Mortality Database.

StatLink https://stat.link/3iw1v7

Figure 3.3. Main causes of mortality by country, 2023 (or nearest year)



1. 2022 data. 2. 2021 data.
Source: OECD Health Statistics 2025, based on the WHO Mortality Database.

StatLink https://stat.link/ogpt0y

Avoidable mortality (preventable and treatable)

Indicators of avoidable mortality offer a general "starting point" to assess the effectiveness of public health and healthcare systems in reducing deaths from various diseases and injuries. Avoidable mortality includes deaths from preventable causes that can be avoided through effective public health measures and primary prevention interventions, and treatable deaths that are amenable to policy action through timely and effective healthcare interventions. On average, avoidable mortality rates comprise 145 deaths per 100 000 population from preventable causes and 77 deaths per 100 000 population from treatable causes in 2023.

Across 36 OECD countries, in 2023, over 3 million premature deaths among people aged under 75 could have been avoided through better prevention and healthcare interventions, an average rate of 222 deaths per 100 000 population. The avoidable mortality rate for men (303 deaths per 100 000 population) was double that for women (149 deaths per 100 000) on average across OECD countries (Figure 3.4). The age-standardised avoidable mortality rate ranged from fewer than 140 deaths per 100 000 population in Japan, Israel, Sweden, Luxembourg and Switzerland to higher than 400 deaths per 100 000 in Latvia, Mexico, Colombia, and accession/partner countries Romania, Brazil and South Africa.

Preventable causes mainly include infectious diseases and injuries, among other conditions associated with risk factors such as tobacco use – linked to cancers and cardiovascular conditions (OECD, forthcoming[1]). The average age-standardised mortality rate from preventable causes was 145 deaths per 100 000 population across OECD countries in 2023, slightly lower than in 2013 (150 deaths per 100 000). Preventable mortality rates ranged from under 85 deaths per 100 000 population in Luxembourg, Switzerland and Israel, to over 250 deaths per 100 000 in Latvia and Colombia (Figure 3.5). Preventable mortality was also high in accession/partner countries Romania, Croatia, Brazil and South Africa.

The main treatable causes of mortality include circulatory diseases (mainly heart attack and stroke), metabolic conditions such as diabetes and cancers. Mortality rates from treatable causes averaged 77 deaths per 100 000 across OECD countries, a rate slightly lower than in 2013 (86 deaths per 100 000) (Figure 3.6). They ranged from 45 or fewer deaths per 100 000 population in Switzerland, Luxembourg and Korea to over 150 deaths per 100 000 in Latvia and Mexico. Treatable mortality was also high in accession/partner countries Bulgaria, Romania and South Africa.

Definition and comparability

Based on the 2022 OECD/Eurostat definitions, preventable mortality is defined as causes of death among people aged under 75 that can be mainly avoided through effective public health and primary prevention interventions (i.e. before the onset of disease/injury, to reduce incidence). Treatable (or amenable) mortality is defined as causes of death that can be mainly avoided through timely and effective healthcare interventions, including secondary prevention and treatment (i.e. after the onset of disease, to reduce case fatality).

Avoidable mortality estimates are based on two current lists of preventable and treatable mortality adopted by the OECD and Eurostat in 2022. The attribution of each cause of death to the preventable or treatable mortality category was based on the criterion of whether it is predominantly prevention or healthcare interventions that can reduce it, with the rationale that a large part of these deaths can be avoided. Causes of death that can be both largely prevented and treated once they have occurred were attributed to the preventable category on the rationale that if these diseases are prevented, there would be no need for treatment. In cases when there was no strong evidence of predominance of preventability or treatability (as with ischaemic heart disease, stroke and diabetes), the causes were allocated on a 50:50 basis to the two categories to avoid double-counting of the same cause of death in both lists. The age threshold of premature mortality is set at 74 years for all causes as has been traditionally used in high income countries. COVID-19 was categorised as a preventable disease, as most deaths can be prevented through prophylaxis, such as vaccination or use of protective facemasks (OECD/Eurostat, 2019[2]).

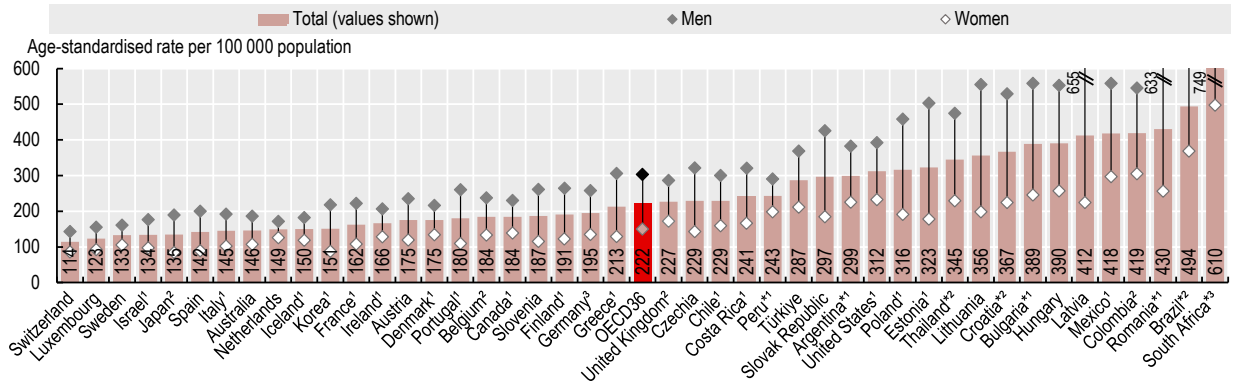
Data come from the WHO Mortality Database, and the mortality rates are age-standardised to the 2015 OECD population (see related metadata, https://stats.oecd.org/wbos/fileview2.aspx?IDFile=9070932a-1129-450f-8170-65fc13edcd62).

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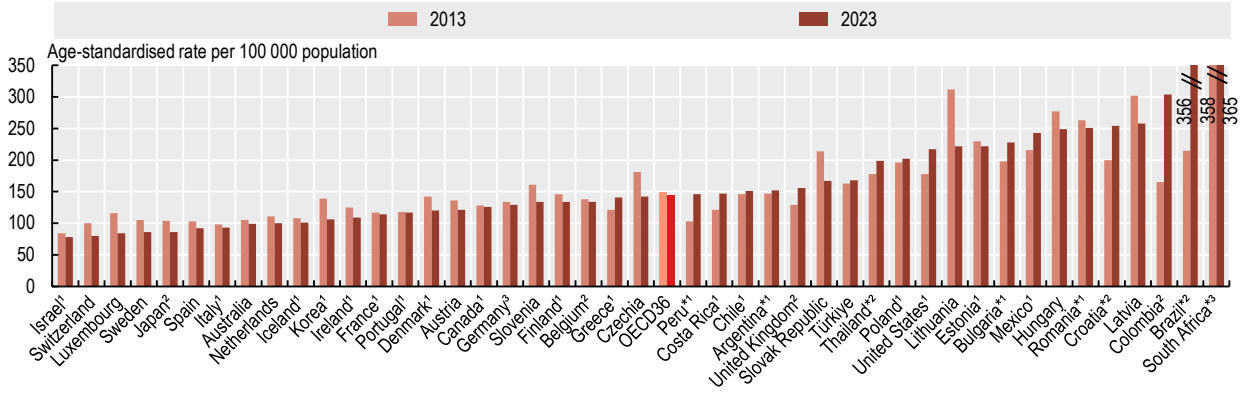
Figure 3.4. Mortality from avoidable causes, 2023 (or nearest year)



1. 2022 data. 2. 2021 data. 3. 2020 data. * Accession/partner country.
Source: OECD Health Statistics 2025, based on the WHO Mortality Database.

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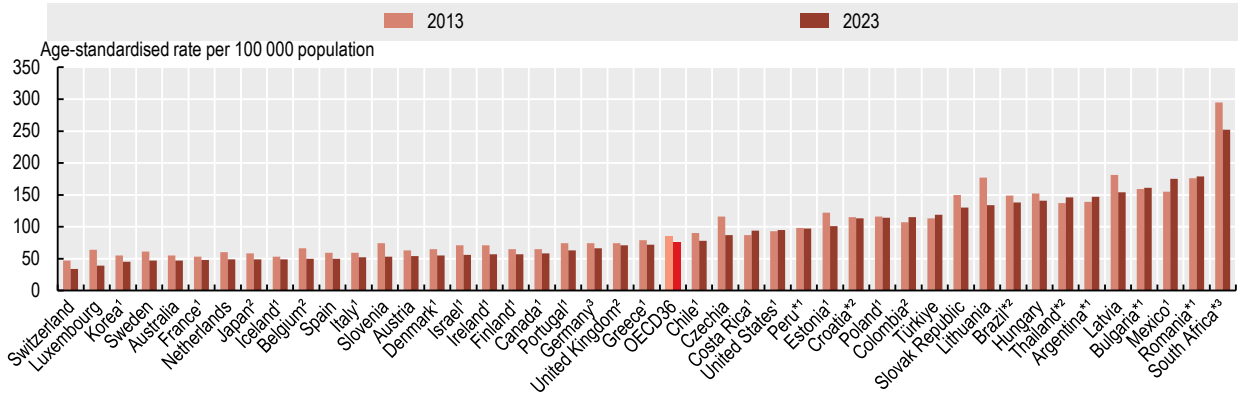
Figure 3.5. Mortality from preventable causes, 2023 and 2013 (or nearest year)



1. 2022 data. 2. 2021 data. 3. 2020 data. * Accession/partner country.
Source: OECD Health Statistics 2025, based on the WHO Mortality Database.

StatLink https://stat.link/if1ugq

Figure 3.6. Mortality from treatable causes, 2023 and 2013 (or nearest year)



1. 2022 data. 2. 2021 data. 3. 2020 data. * Accession/partner country.
Source: OECD Health Statistics 2025, based on the WHO Mortality Database.

StatLink https://stat.link/zjfk7p

Mortality from circulatory diseases

Circulatory diseases – notably heart attack and stroke – were the main cause of mortality in most OECD countries in 2023, accounting for 28% of all deaths across OECD countries (see Figure 3.2 in section on "Main causes of mortality"). The predominant cause of death among circulatory diseases are ischaemic heart diseases (i.e. heart attacks) and cerebrovascular diseases (i.e. strokes). These are most associated with a build-up of fatty deposits in the arteries, restricting blood flow, which is linked to many clinical (i.e. high cholesterol, diabetes), and behavioural (i.e. unhealthy eating habits, low physical activity) risk factors.

While mortality rates due to circulatory diseases have declined in most OECD countries over time, population ageing, rising obesity and diabetes rates, delays in diagnoses, and inadequate management may impair further reductions (OECD, forthcoming[1]). Furthermore, mortality rates due to circulatory diseases are 46% higher for men than women across OECD countries, primarily because of a greater prevalence of risk factors among men, such as smoking, hypertension, and high cholesterol (see Chapter 2 "Which diseases affect men and women differently – and why this matters" and Chapter 4 "Non-medical determinants and risk factors").

In 2023, heart attacks and other ischaemic heart diseases (IHDs) accounted for 11% of all deaths, with an average of 112 deaths per 100 000 population due to IHDs. This is 27 deaths per 100 000 lower than in 2013, with similar declines seen in most OECD countries. However, rates increased in Mexico, Colombia and Poland by more than 30%, with increases partly linked to rising obesity rates and diabetes prevalence. A significant increase was also seen in accession country Peru.

Mortality rates due to IHDs ranged from fewer than 40 deaths per 100 000 population in Luxembourg, the Netherlands, France, Japan and Korea to over 250 deaths per 100 000 in Colombia, Latvia, Mexico, the Slovak Republic, Hungary and Lithuania (Figure 3.7). As well as obesity rates and diabetes prevalence, higher rates in Mexico, Latvia and Lithuania may also be linked to higher than average 30-day mortality rates due to acute myocardial infarction after admission to hospital (see section on "Mortality following acute myocardial infarction" in Chapter 6).

Cerebrovascular diseases (including strokes) were the underlying cause of 6% of deaths across OECD countries in 2023. As well as causing many deaths, strokes have a significant disability burden. Mortality rates were higher than 100 deaths per 100 000 population in Lithuania, Latvia, and in OECD accession countries Croatia, Bulgaria and Romania (Figure 3.7). Mortality rates from stroke have fallen in all OECD Member countries since 2013, with an average reduction of 28% across OECD countries. For strokes, as for IHDs, a reduction in certain risk factors – notably smoking – has contributed to the lower mortality rate, alongside improved survival rates following an acute episode, reflecting better quality of care (see section on "Mortality following ischaemic stroke" in Chapter 6).

Socio-economic inequalities in mortality from circulatory diseases are wide in most OECD countries, largely reflecting socio-economic differences in major risk factors. Many of these deaths could be prevented, but trends in several risk factors are heading in the wrong direction, and diagnosis and management can also improve. While smoking rates have fallen overall, diabetes, high cholesterol, high blood pressure, low physical activity, obesity, and work-related stress are on the rise in many OECD countries (OECD, forthcoming[1]). A number of public health, fiscal and regulatory measures can incentivise citizens to adopt healthier lifestyles and promote better diagnosis and management, thereby reducing the burden of cardiovascular diseases on societies.

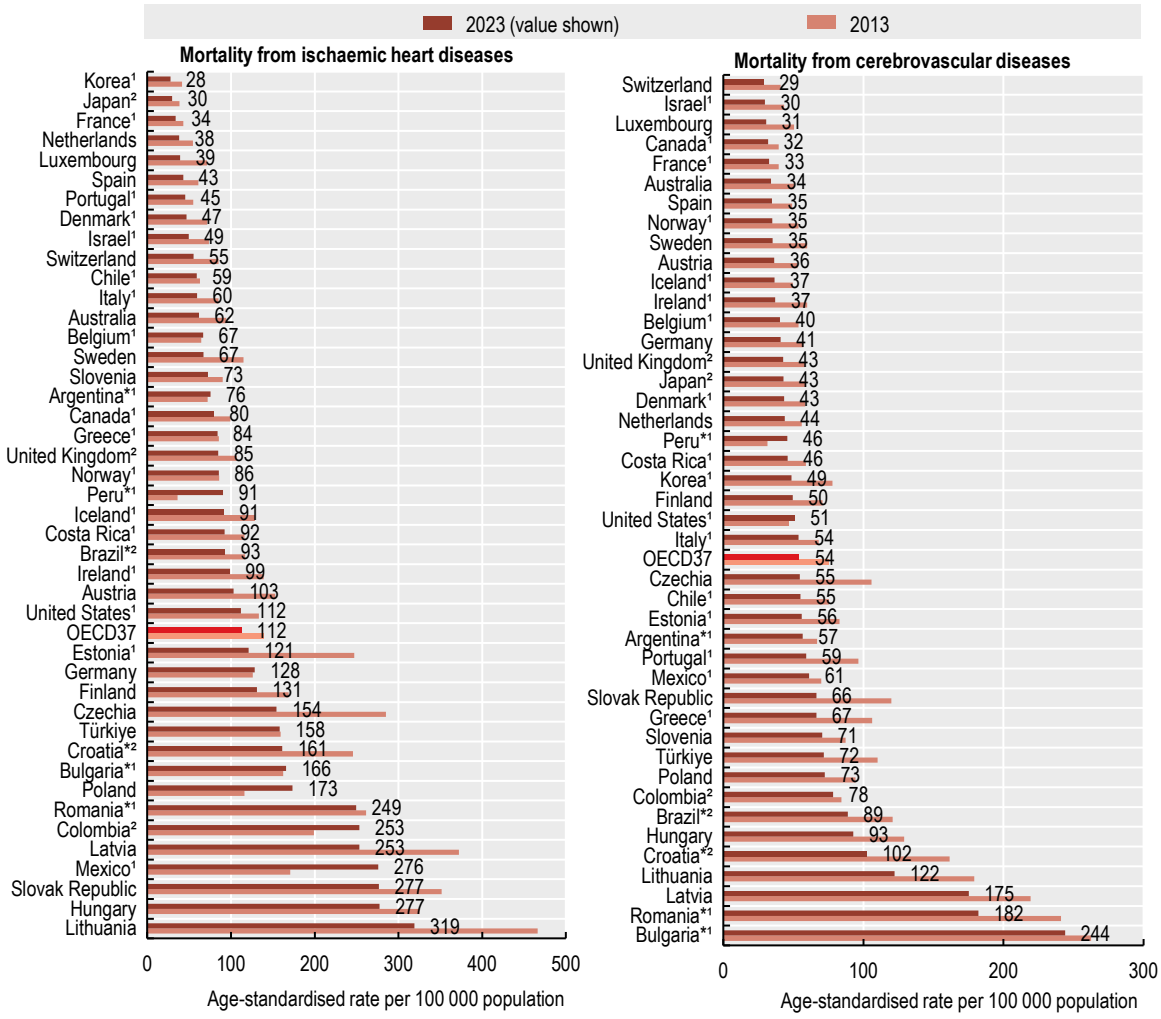
Definition and comparability

Mortality rates are based on numbers of deaths registered in a country in a year divided by the size of the corresponding population. The rates have been age-standardised to the 2015 OECD population (see related metadata, https://stats.oecd.org/wbos/fileview2.aspx?IDFile=9070932a-1129-450f-8170-65fc13edcd62) to remove variations arising from differences in age structures across countries and over time. The source is the WHO Mortality Database. Mortality from circulatory diseases includes deaths from IHDs (ICD-10 codes I20-I25), and from cerebrovascular diseases (ICD-10 codes I60-I69). Differences in medical training and practices when registering cause of death across countries may affect country comparability.

References

OECD (forthcoming), *State of Cardiovascular Health in the EU*, OECD Publishing, Paris. [1]

Figure 3.7. Mortality from circulatory diseases, 2023 and 2013 (or nearest year)



1. 2022 data. 2. 2021 data. * Accession/partner country.
Source: OECD Health Statistics 2025, based on the WHO Mortality Database.

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Cancer incidence and mortality

Cancer was the second leading cause of death in OECD countries after circulatory diseases, accounting for 21% of all deaths in 2023, although in ten OECD countries – including Japan and Spain – neoplasms (mainly cancer) have become the leading cause of death (see section on "Main causes of mortality"). The main causes of cancer-related mortality include lung (20%), colorectal (11%), pancreatic (8%), breast (7%) and prostate (6%) cancers. These five cancers represent more than 50% of all cancer deaths in OECD countries. On average age-standardised mortality rates from cancer have fallen over time in OECD countries – from 204 deaths per 100 000 population in 2019 to 191 deaths per 100 000 in 2023.

Lung cancer is the main cause of cancer mortality for both men and women, accounting for 22% of cancer deaths among men and 17% among women (Figure 3.8). Smoking represents the main risk factor for lung cancer. Colorectal cancer is also a major cause of death for both men and women, representing 11% of cancer-related deaths for both sexes. Widespread colorectal cancer screening programmes for adult populations – starting at around 50 years of age – have led to an initial increase of new cases followed by a decline in incidence rate among older adults. In recent years, however, many OECD countries have observed a rising incidence of colorectal cancer among younger patients. Apart from age and genetic factors, a diet high in fat and low in fibre, lack of physical activity, obesity, smoking and alcohol consumption all increase the risk of developing colorectal cancer.

Breast cancer is the second most common cause of cancer mortality in women (15% of deaths). Although breast cancer is the leading cause of cancer incidence among women (28%), mortality rates have declined or stabilised – indicative of earlier diagnosis and treatment – and consequently survival rates are higher (see section on "Cancer screening" in Chapter 6). Prostate cancer is the third most common cause of cancer mortality among men, accounting for 10% of all cancer-related deaths and 22% of cancer incidence, among men (Figure 3.8).

The overall cancer incidence rate was 291 deaths per 100 000 population on average across OECD countries in 2022, and was higher for men than women in most OECD countries. Incidence rates range from less than 200 deaths per 100 000 in Chile, Costa Rica, Colombia and Mexico – including accession/partner countries Peru, Thailand, Indonesia and India – to over 350 deaths per 100 000 in Norway, the United States, Denmark, New Zealand and Australia (Figure 3.9). Low incidence rates can be due to limited registry coverage, limited access to screening programmes, younger population structures, and differences in risk factor exposure.

The mortality rates from cancer averaged 191 deaths per 100 000 population across OECD countries in 2023, with consistently higher rates for men compared to women (Figure 3.10). Among OECD countries, mortality rates were highest in Hungary, Slovenia, Latvia and the Slovak Republic (230 or above per 100 000) and lowest in Mexico, Türkiye and Costa Rica (fewer than 150 per 100 000). Greater prevalence of risk factors among men – notably smoking and alcohol consumption – drive much of the differences in cancer incidence and mortality between men and women. Additionally, interventions to reduce socio-economic inequalities in cancer mortality should focus on people with lower levels of education, as this population group has higher cancer mortality rates across most OECD countries. Differences in treatment quality, access to innovative therapies, and equity of participation in screening programmes also play a critical role in explaining cancer survival gaps across countries.

Earlier diagnosis and treatment significantly increase cancer survival rates. This partly explains why, for example, countries including Norway, Australia and Belgium have below-average mortality rates despite having relatively high rates of cancer incidence. Norway has high participation (around 70%) in cancer screening programmes for breast and cervical cancer, and a higher number of healthcare professionals per cancer case than most OECD countries (OECD/European Commission, 2025[1]).

Definition and comparability

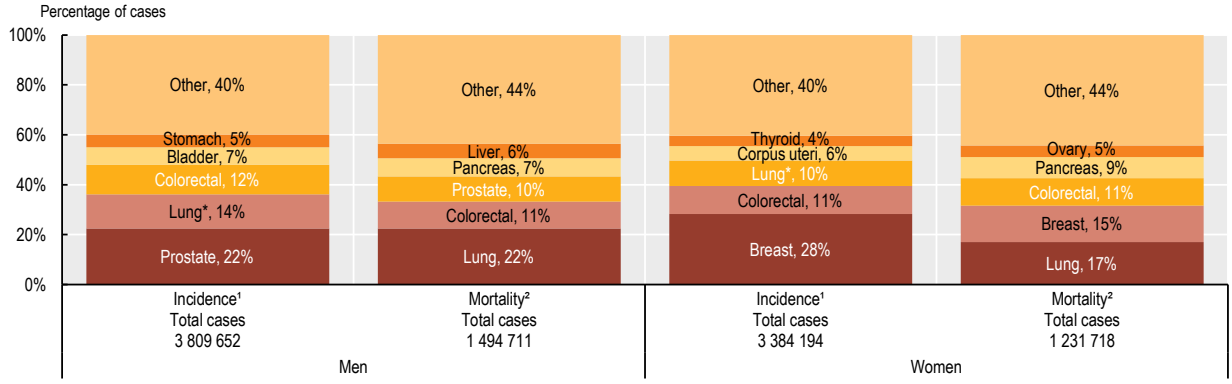
Percentage of cancer incidence cases is the sum of the absolute number of new cases of a specific type of cancer divided by the total number of cancer cases in 38 OECD countries, for women and men. Incidence rates are based on the numbers of new cancer cases registered in a country in a year, divided by the size of the corresponding population. The rates are age-standardised to the WHO world population, which typically leads to lower estimates than if age-standardised to the older OECD population. Incidence data are based on the Globocan 2022 data from the WHO International Agency for Research on Cancer (IARC) (sources and methods are available at: https://gco.iarc.who.int/today/en/data-sources-methods-by-country-detailed).

Percentage of cancer mortality cases is the sum of the absolute number of deaths of a specific type of cancer divided by the total number of cancer deaths in 37 OECD countries (excludes New Zealand where there are no recent data) for women and men. Cancer mortality rates are based on numbers of cancer deaths registered in a country in a year divided by the size of the corresponding population. The rates have been age-standardised to the 2015 OECD population (see related metadata, https://stats.oecd.org/wbos/fileview2.aspx?IDFile=9070932a-1129-450f-8170-65fc13edcd62) to remove variations arising from differences in age structures across countries and over time. The source is the WHO Mortality Database. Deaths from all cancers (i.e. malignant neoplasms) are classified as ICD-10 codes C00-C97. The international comparability of cancer mortality data can be affected by differences in medical training and practices, as well as in death certification across countries. Cancer incidence and mortality are not directly comparable as they use different populations to standardise.

References

OECD/European Commission (2025), *EU Country Cancer Profile: Norway 2025*, EU Country Cancer Profiles, OECD Publishing, Paris, https://doi.org/10.1787/bf26204a-en. [1]

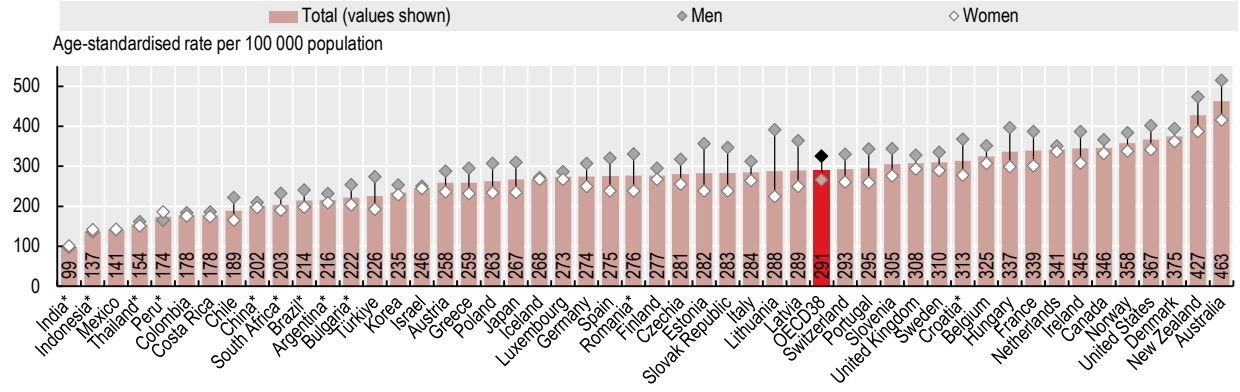
Figure 3.8. Main causes of cancer incidence and mortality across OECD countries, 2022



1. 2022 data from all 38 OECD countries. 2. 2023 (or nearest year) data from for 37 OECD countries. * Includes trachea, bronchus and lung.
Source: WHO, IARC-Globocan 2022 (version 1.1) and OECD Health Statistics 2025.

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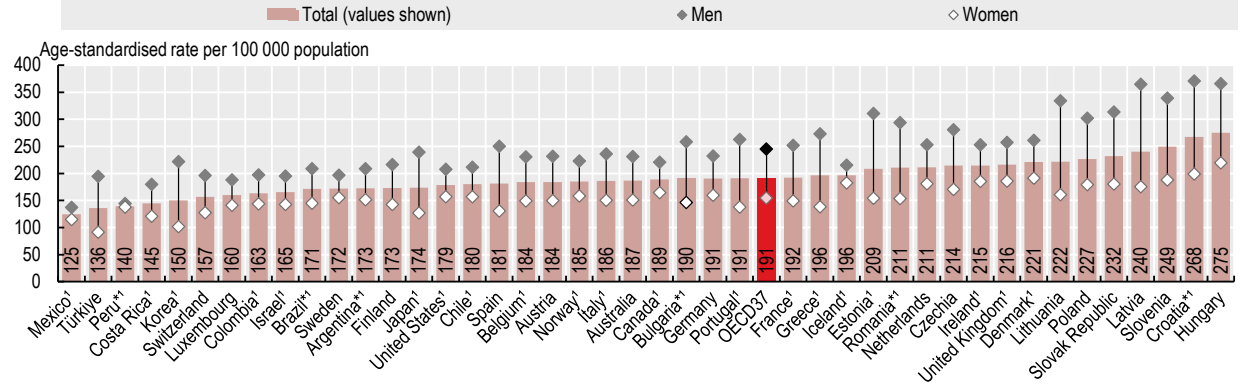
Figure 3.9. Cancer incidence, 2022



Note: Age-standardised to the world population, which typically leads to lower estimates than if age-standardised to the OECD population. * Accession/partner country.
Source: WHO, IARC – Globocan 2024 (version 1.1).

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Figure 3.10. Cancer mortality, 2023 (or nearest year)



1. 2021-2022 data. * Accession/partner country.
Source: OECD Health Statistics 2025, based on the WHO Mortality Database.

StatLink https://stat.link/tf7xc4

Maternal and infant mortality

Maternal mortality – the death of a woman during pregnancy or childbirth, or within 42 days of the termination of pregnancy – is an important indicator of a woman's health status and to assess health system performance. The Sustainable Development Goals set a target of reducing the global maternal mortality ratio to less than 70 deaths per 100 000 live births by 2030. All OECD countries had mortality ratios below this target, with an average maternal mortality ratio (MMR) of 10.3 deaths per 100 000 live births in 2023. Countries including Iceland, Ireland, Norway, Poland, the Slovak Republic, Denmark, Switzerland and Italy had 3-year average MMRs of lower than 3 deaths per 100 000 live births. However, Colombia had a 3-year average MMR of 59.5 deaths per 100 000 live births – the highest among OECD countries. Mexico also had a significantly high 3-year average MMR of 44.0 deaths per 100 000 live births. Some OECD accession countries also had high MMRs – notably Peru and Argentina (Figure 3.11).

Between the 3-year periods 2011-2013 and 2021-2023, MMRs increased in 18 OECD countries, with particularly large increases in Latvia (Figure 3.11). The main causes of maternal deaths in many high-income countries include cardiovascular conditions and suicides, and there are a higher number of maternal deaths among women aged younger than 20 or older than 40, and women with a migrant background (Diguisto et al., 2022[1]).

Infant mortality – deaths in children aged less than 1 year – reflects the impact of economic, social, and environmental conditions on the health of mothers and infants, as well as the effectiveness of health systems. Factors such as the education of the mother, quality of antenatal and childbirth care, pre-term birth and birth weight, immediate newborn care, and infant feeding practices are important determinants of infant mortality.

In the 3-year period 2021-2023, infant mortality averaged 4.0 deaths per 1 000 live births across OECD countries, down from 4.1 deaths per 1 000 live births in 2011-2013. Japan and Finland had average infant mortality rates of fewer than 2 deaths per 1 000 live births in 2021-2023. However, average infant mortality rates are still relatively high in Colombia (16.8 deaths per 1 000 live births) and Mexico (11.9 deaths per 1 000 live births), signalling the correlation that exists between maternal and infant mortality. Among OECD accession/partner countries, average infant mortality rates are around 12 deaths or higher per 1 000 live births in Brazil, Peru, Indonesia, South Africa, and India – although these countries have reduced average infant mortality rates considerably since 2011-2013, except for Peru with an 0.8 increase (Figure 3.12). While 35 OECD countries have seen a reduction in average infant mortality rates since 2011-2013, Iceland, France, and Luxembourg have seen slight increases, ranging from 0.1 (in the Luxembourg) to 1.1 (Iceland). In France, higher infant mortality was observed among mothers with multiple pregnancies, those residing in French overseas departments, and mothers aged 21 or younger, as well as those aged 44 or older (Insee, 2025[2]).

Infant mortality can be reduced through cost-effective and appropriate interventions. These include immediate skin-to-skin contact between mothers and newborns after delivery, early and exclusive breastfeeding for the first six months of life, and kangaroo parent care for babies weighing 2000 g or less. Postnatal care for mothers and newborns within 48 hours of birth, delayed bathing until after 24 hours of childbirth, and dry cord care are important in reducing deaths in the first 28 days.

Definition and comparability

Maternal mortality is defined as the number of maternal deaths, from all causes, per 100 000 live births (ICD-10 codes O00-O99). Data presented for this indicator are the averages of three years reported to the OECD from national death registries or clinical data. Note that the maternal mortality series records very small numbers, so there may be large annual fluctuations – particularly in countries with low population levels. Data for Argentina, Australia, Mexico and the United States include deaths considered to be related to pregnancy but recorded with ICD-10 codes other than O00-O99. Data for Argentina, Chile, Denmark, France, Germany, Korea, Latvia, Luxembourg and Portugal exclude late maternal deaths (42 days after end of pregnancy).

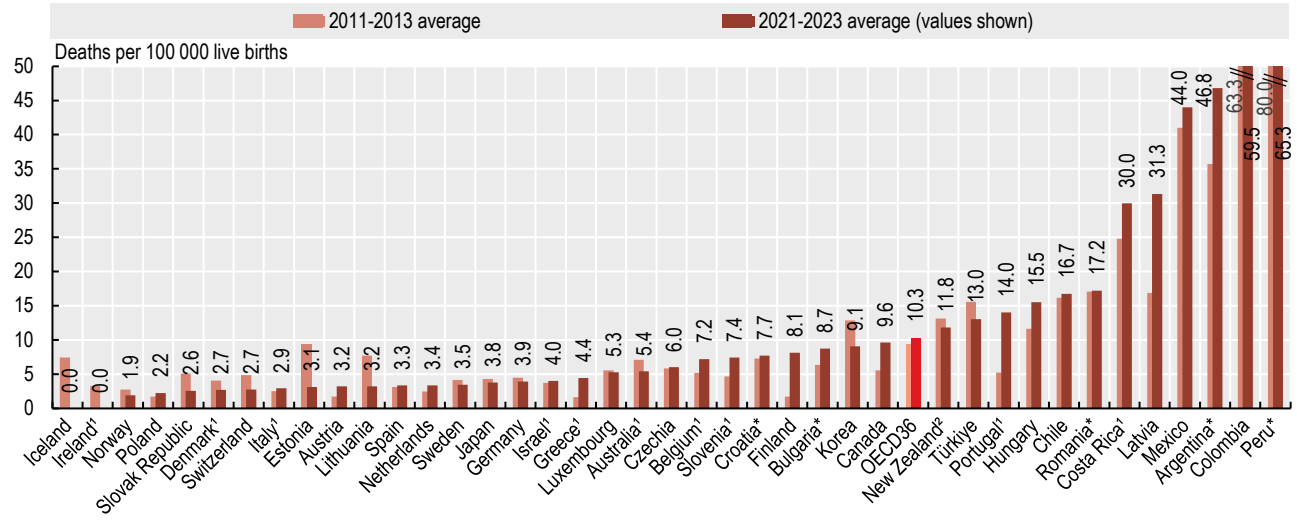
The infant mortality rate is defined as the number of children who die before reaching their first birthday in a given year, expressed per 1 000 live births, with no minimum threshold of gestation period or birthweight, as reported by countries to the OECD. Data presented for this indicator are the averages of three years. Some countries base their infant mortality rates on estimates derived from censuses, surveys and sample registration systems, and not on accurate and complete registration of births and deaths. Differences among countries in registering practices for premature infants may also add slightly to international variations in rates. For EU countries except Denmark, data come from Eurostat.

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Insee (2025), *Un enfant sur 250 meurt avant l'âge d'un an en France*, https://www.insee.fr/fr/statistiques/8547061#documentation (accessed on 29 September 2025). [2]

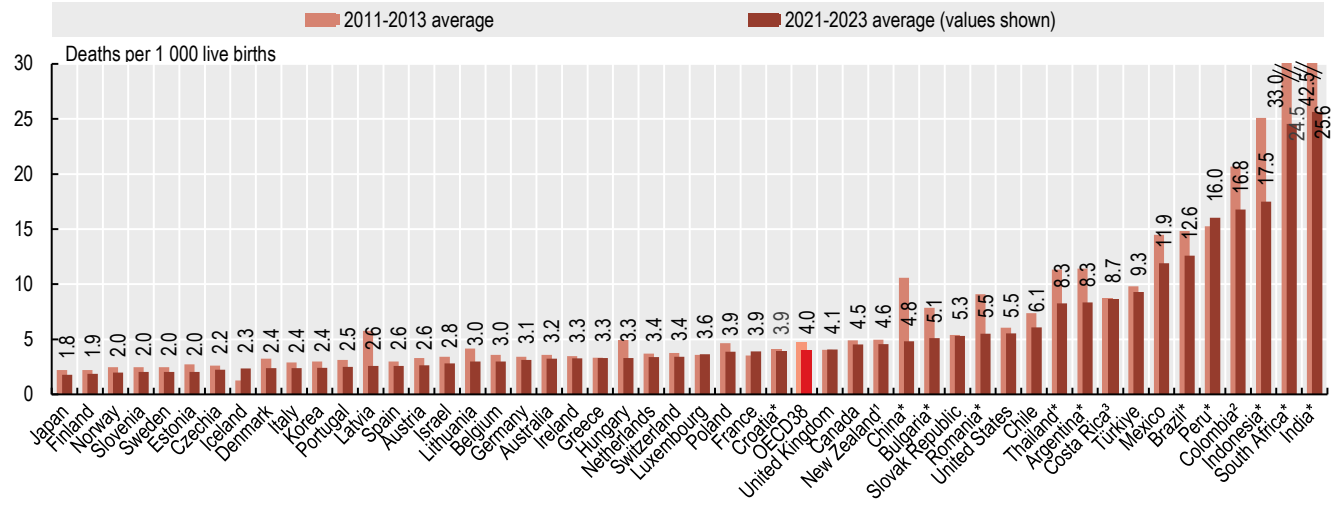
Figure 3.11. Maternal mortality, 2021-2023 and 2011-2013 (or nearest year)



1. Latest data from 2020-2022. 2. Latest data from 2018-2020. * Accession/partner country.
Source: OECD Health Statistics 2025.

StatLink https://stat.link/8yeu5d

Figure 3.12. Infant mortality, 2021-2023 and 2011-2013 (or nearest year)



1. Latest data for 2018-2022 2. Latest data for 2019-2021. 3. Latest data for 2020-2022. * Accession/partner country.
Source: OECD Health Statistics 2025, based on Eurostat for EU countries except Denmark.

StatLink https://stat.link/xg01rs

Adolescent health

Childhood and adolescence are key periods for building good lifelong health habits. Rates of multiple health complaints in children and adolescents can be a marker for overall health and well-being. Good mental health also brings broader social and economic benefits, supporting education and labour market outcomes (OECD, 2025[1]).

According to the latest HBSC data collected in 2021/22, when most countries were still experiencing the COVID-19 pandemic, over 50% of 15-year-olds experienced multiple health complaints such as feeling low or irritable, or head, stomach- or backache (Figure 3.13). The rate of 15-year-olds reporting at least two health complaints more than once a week increased from 37% in 2014 to 52% in 2022. In 2022, the highest rates of 15-year-olds reporting multiple health complaints were 66% in Italy and Greece. In 2014, the highest rate of 15-year-olds reporting multiple health complaints were 53% in Italy and 48% in Bulgaria, followed by 47% in France.

In all countries, girls reported higher rates of multiple health complaints than boys (Figure 3.14). In 2022, 68% of 15-year-old girls reported having multiple health complaints in OECD countries, compared to only 36% of boys. The most common health complaints for both genders are those frequently associated with psychological distress (nervousness, irritability, difficulties in getting to sleep, and/or feeling low). School pressure and struggling with family and peer relationships might be among the reasons contributing to increasing health complaints and psychological distress, particularly for girls (Badura et al., 2024[2]).

In 2022, 15-year-olds in OECD countries reported an average well-being score of 54; a score above 60 means a respondent feels positive about their well-being more than half of the time (Figure 3.15). The average well-being score in 2022 was 47 for 15-year-old girls and 61 for 15-year-old boys. The lowest levels of well-being were in Poland and Slovenia. In both countries, the average well-being score was 40 for girls and 54 for boys. However, even in the best performing country – Denmark – the average well-being score for 15-year-old girls was only 57 in 2022. Mental health conditions among young people increased during the COVID-19 pandemic; suicide death rates are declining more slowly among young people than among adults, and some national data point to increases in anxiety and depression in recent years (OECD, 2025[1]; Badura et al., 2024[2]). This potentially concerning trend demands careful monitoring.

Stable family relationships and supportive social environments all contribute to positive mental health and to enhanced feelings of security and self-esteem among young people (OECD, 2025[1]). To support positive health and mental health among adolescents, many countries have implemented school-based interventions to support socio-emotional learning. The Icehearts programme in Finland focusses on improving prosocial behaviour through team sports, providing long-term mentoring support to socially vulnerable children and adolescents (OECD, 2025[1]). Zippy's Friends – which is in place in 30 countries worldwide – targets younger children (age 5-7); it aims to improve emotional literacy, resilience and coping skills, and to help young people navigate challenges through adolescence and adulthood (OECD, 2025[3]). Improving access to evidence-based mental health services is another way of supporting young people's mental health. In Belgium, for example, rapid and free access to psychologists is ensured for people under 24, including up to 8 consultations per year for lower level support and 20 consultations for specialised treatments (OECD, 2025[1]).

Definition and comparability

Data on multiple health complaints and mental well-being are taken from the Health Behaviour in School-aged Children (HBSC) study. The HBSC surveys have been undertaken every four years since 1993-94. The latest data were collected in 2021/22, during the COVID-19 pandemic, which should be considered when comparing to the results from previous years. For both indicators, differences across countries may reflect different understanding and interpretation of the questions between individuals. For both indicators, the value for Belgium is the unweighted average of the French- and Flemish-speaking regions.

The indicator on multiple health complaints (two or more, more than once a week) is based on the following symptoms experienced in the previous six months: headache; stomach ache; backache; feeling low; feeling irritable or bad tempered; feeling nervous; difficulties in getting to sleep; and feeling dizzy. The indicator on mental well-being is based on the 5-item WHO Well-Being Index (WHO-5), which assesses mental well-being by asking five, positively phrased items that respondents have to rate from 5 (all the time) to 0 (none of the time). This item was introduced for the first time in the 2021/22 survey.

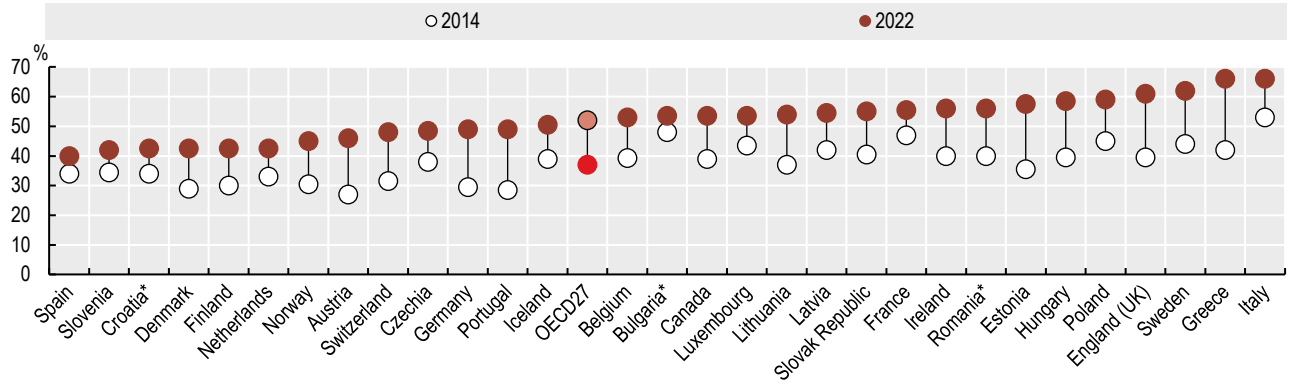
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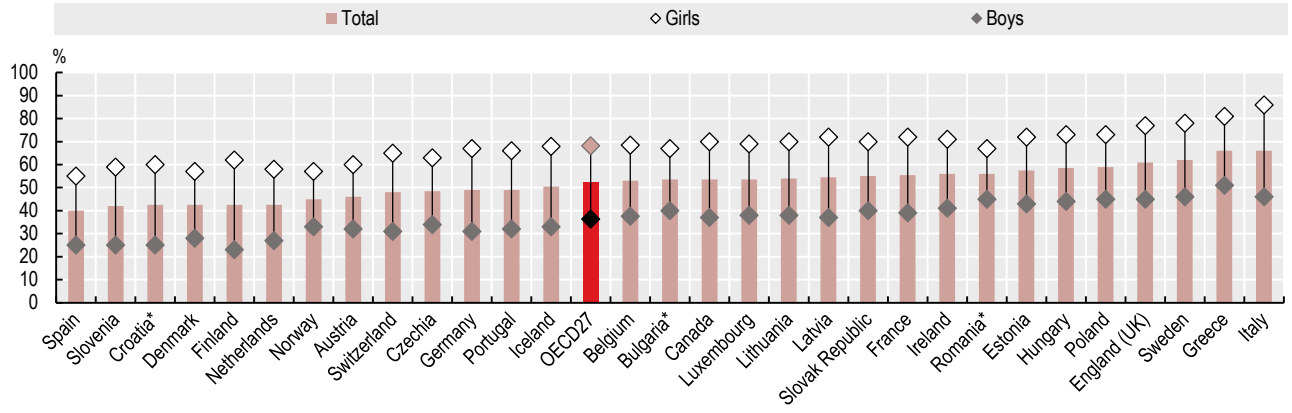
Figure 3.13. Share of 15-year-olds reporting multiple health complaints, 2022 and 2014



* Accession/partner country.
Source: HBSC Data Browser, https://data-browser.hbsc.org.

StatLink https://stat.link/bqdfvn

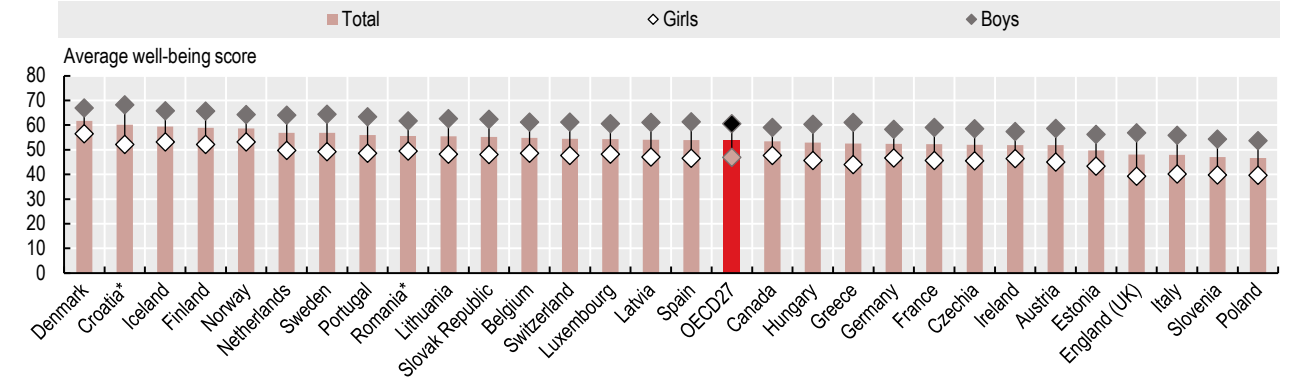
Figure 3.14. Share of 15-year-olds reporting multiple health complaints, 2022



* Accession/partner country.
Source: HBSC Data Browser, https://data-browser.hbsc.org.

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Figure 3.15. WHO-5 mental well-being score, 15-year-olds, 2022



* Accession/partner country.
Source: HBSC Data browser, https://data-browser.hbsc.org.

StatLink https://stat.link/j2fmol

Chronic conditions

Chronic conditions such as cancer, cardiovascular conditions, chronic respiratory problems and diabetes are not only the leading causes of death across OECD countries but also represent a major disability burden. Many chronic conditions are preventable, by modifying major risk factors such as smoking, harmful alcohol use, obesity and physical inactivity (see Chapter 4 “Non-medical determinants and risk factors”). Chronic conditions that are linked to risk factors – such as type 2 diabetes, heart failure and chronic kidney disease – share a common development pathway and often occur simultaneously, generating multimorbidity.

More than one-third of people aged 16 and over reported living with a long-standing illness or health problem on average across 29 OECD countries in 2021 (Figure 3.16). This figure ranges from more than one in two in Finland to just under one in five in Italy. As populations age, the prevalence of chronic conditions – including multimorbidity – rises. Health systems increasingly need to be prepared to deliver high-quality chronic care management to meet the needs of ageing populations.

Socio-economic disparities are also large: on average across OECD countries, people in the lowest income quintile are 15 percentage points (p.p.) more likely to report having a long-standing chronic condition (44%) compared to people in the highest income quintile (28%). While this disparity is observed across all OECD countries, the income gap is largest in Lithuania, Latvia, Belgium, Ireland and Czechia, where people in the lowest income quintile are more than twice as likely to have at least one long-standing illness or health problem compared to people in the highest income quintile. The income gap is smallest in the Slovak Republic and Spain, where individuals in the lowest income quintile are only 5 p.p. more likely to report living with a long-standing illness or health problem compared to individuals in the highest income quintile.

One of the most significant chronic conditions is diabetes. It has a particularly large disability burden, as it can cause cardiovascular disease, blindness, kidney failure and lower limb amputation (OECD, forthcoming[1]). The economic burden of diabetes is substantial: in OECD countries, an estimated USD 670 billion was spent on treating diabetes and preventing complications in 2021 (IDF, 2025[2]). In 2022, an estimated 8.6% of the adult population was living with diabetes on average across OECD countries (age-standardised data). Among OECD countries, diabetes prevalence was highest in Costa Rica, Türkiye, Mexico and Chile, Mexico with 14.0% of adults or more living with diabetes (age-standardised data). For OECD accession/partner countries, diabetes prevalence is also relatively high in India and Peru (Figure 3.17).

Age-standardised diabetes prevalence rates have increased in most OECD Member countries over the last decade. Exceptions are Denmark, France, Spain, Germany, Israel and Mexico. The highest increase was seen in Costa Rica, with a 6.7 p.p. increase. Large increases were also seen in accession countries Indonesia and Peru. Such upward trends are due in part to rising rates of obesity, poor nutrition and physical inactivity, as well as to their interactions with population ageing.

Living with multiple chronic conditions increases the burden on patients and on healthcare systems. Data from the OECD Patient-Reported Indicator Surveys (PaRIS) shows that 82% of primary care users aged 45 and over reported having at least one chronic condition, and 52% two or more (Figure 3.18). Among the countries participating in PaRIS, Slovenia and Greece reported the smallest proportion of primary care users with two or more chronic conditions; the highest shares were observed in the United States and Australia. As populations age, so does the prevalence of multiple chronic conditions. This calls for more co-ordinated care for people managing multiple conditions and for better collaboration between patients and healthcare professionals such as family doctors, pharmacists, nurses and other specialists (OECD, 2025[3]).

Definition and comparability

Data related to long-standing illnesses or health problems are based on the results of the EU Statistics on Income and Living Conditions instrument (EU-SILC). These data cover people aged 16 and over. Comparability of data on long-standing illnesses and health problems can be affected by people’s subjective assessment of their health, and by social and cultural factors.

Diabetes prevalence rate is the percentage of people aged 18 years and older with fasting plasma glucose ≥ 7 mmol/L (126 mg/dL), or glycated haemoglobin (HbA1c) ≥ 6.5% (48 mmol/L), or on glucose-lowering medication for diabetes. Estimates are based on population-based surveys. Estimates are age-standardised to the WHO Standard Population, which can lead to an underestimation of prevalence compared to age-standardisation based on the OECD population (older population). Crude rates (no age-standardisation) are also shown, values may differ from national reports due to methodological differences.

Data for primary care users are based on the Patient-Reported Indicator Surveys (PaRIS) International Survey of People Living with Chronic Conditions. It includes data for people aged 45 and older who have used primary healthcare services in the six months preceding the survey, linked to 1 816 practices in 19 countries (OECD, 2025[14]).

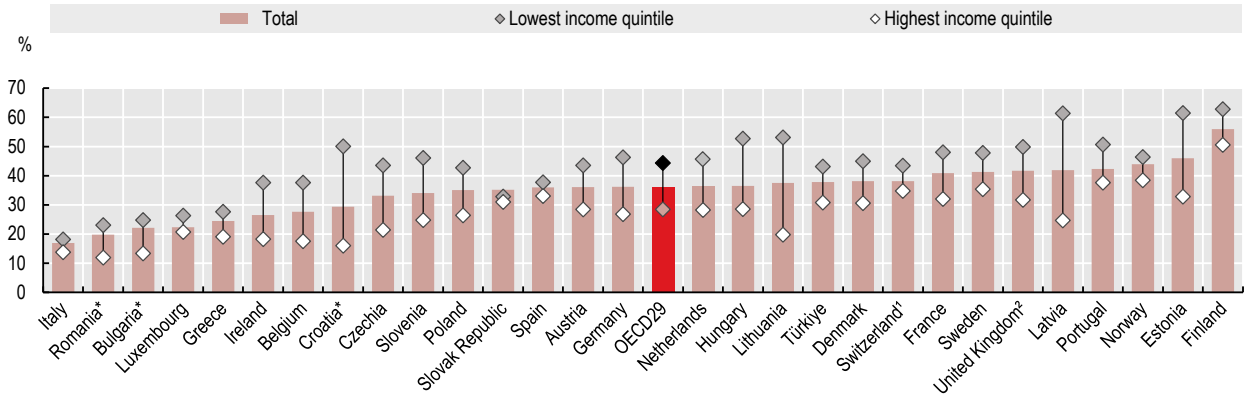
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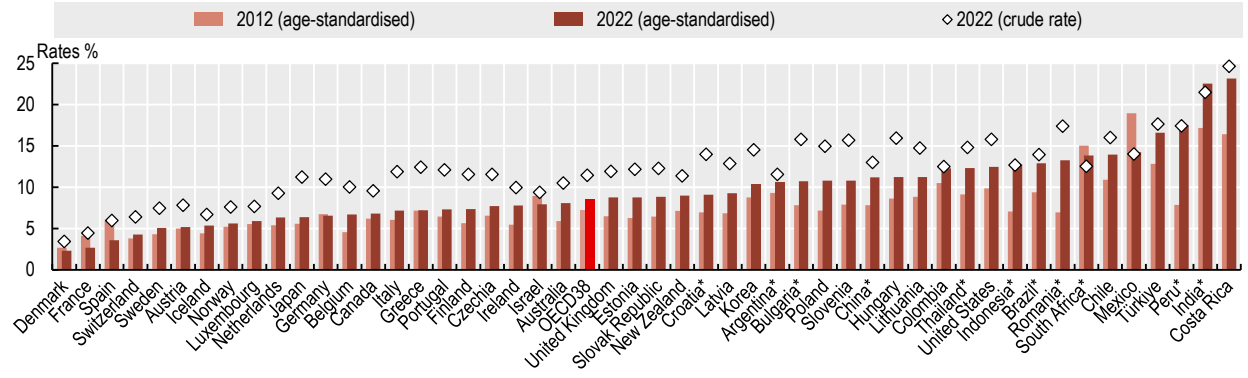
Figure 3.16. People reporting a long-standing illness or health problem, by income quintile, 2024 (or nearest year)



1. 2023 data. 2. 2018 data. * Accession/partner country.
Source: Eurostat, based on EU-SILC.

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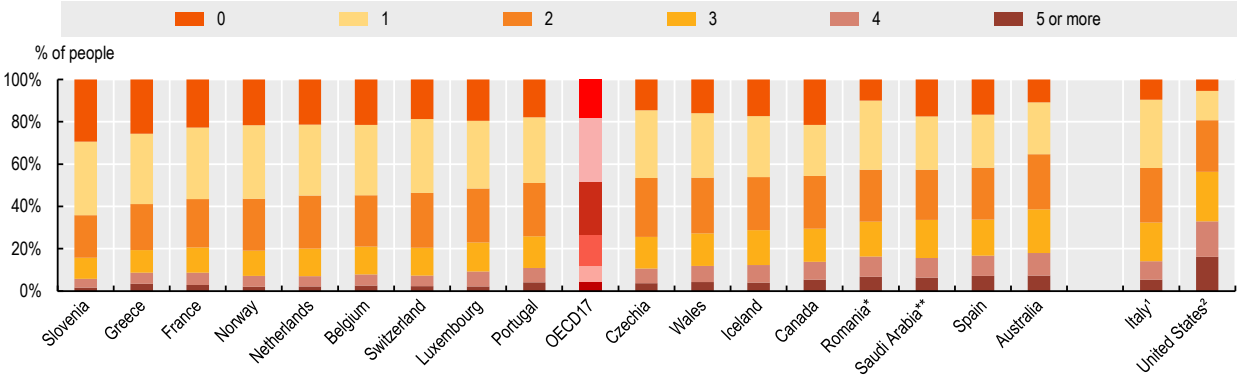
Figure 3.17. Type 1 and 2 diabetes prevalence among adults, 2022 and 2012



Note: Age-standardisation to WHO standard population. Crude estimates also presented. * Accession/partner country.
Source: WHO Global Health Observatory, 2024.

StatLink https://stat.link/3h2vw9

Figure 3.18. Primary care users aged 45 and over and number of chronic conditions, 2024



1. Data for Italy refer to patients enrolled in outpatient settings for specialist visits in selected regions. 2. United States sample only includes people aged 65 years and over. * Accession/partner country. ** Participated in the PaRIS survey.
Source: OECD PaRIS 2024 Database.

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Mental health

Good mental health is critical to individuals' well-being and productivity. Living with mental ill-health can contribute to poorer educational outcomes, higher unemployment rates, and worse physical health. Nearly half of people in OECD countries experience a mental health problem at some point in their lives, and at any given time up to one in five people are living with a mental health condition (OECD, 2021[1]).

Data from PaRIS shows that living with a chronic condition reduces people's overall well-being (Figure 3.19). On average, primary care users aged 45 and over without chronic conditions reported an average well-being score of 70 out of 100, whereas those with chronic conditions reported a well-being score ten points lower (60 out of 100). Average well-being decreases with each additional chronic condition, underscoring the importance of good healthcare and mental health care for people with multi-morbidity (see section on "Chronic conditions") (OECD, 2025[2]).

Without effective treatment and support, mental health problems can sometimes lead to self-harm and suicide. In 2023, the average suicide rate in OECD countries was 10.7 per 100 000 population, with the highest rates in Korea (23.2 per 100 000) and Lithuania (18 per 100 000) (Figure 3.20). Gender differences in mortality from suicide are significant. In 2023, the suicide rate among men was more than 3.4 times higher than the rate among women, at 17.2 deaths per 100 000 men compared to 5 deaths per 100 000 women on average across OECD countries. In Latvia and Poland this difference was even larger, with the suicide mortality rate among men 7.6 times higher than the rate among women in Latvia, and 6.1 times higher among men than among women in Poland. Thanks in part to significant investment in suicide prevention policies, deaths by suicide have been falling in OECD countries in recent years, from 15.1 per 100 000 in 2003 to 10.7 per 100 000 in 2023 (OECD, 2021[1]).

While men are far more likely than women to die by suicide, the gender gap in suicidal intent and behaviour is far smaller – and in some instances is even reversed, with higher rates among women (Vargas Lopes and Llena-Nozal, 2025[3]). Data for hospitalisations due to self-harm confirm this pattern. The number of women hospitalised due to self-harm is significantly higher than for men in all countries with available data (Figure 3.21). In 2023, women were hospitalised 1.7 times more than men on average due to self-harm for 16 OECD countries, at a rate of 66 per 100 000 women compared to 39 per 100 000 men. The biggest gender differences were observed in Finland and the Netherlands, where women were hospitalised for self-harm almost 2.5 times more than men.

Effective strategies to reduce death by suicide include good access to mental health care, targeted suicide prevention strategies, and mental health awareness and anti-stigma campaigns (OECD, 2021[1]). Effective suicide prevention measures, such as the ones included in Austria's SUPRA programme, ensure support for high-risk groups, restrict access to suicidal means, raise awareness and support, and integrate suicide prevention into broader health promotion activities (OECD, 2025[4]). By focussing on post-hospitalisation monitoring after a suicide attempt, the French suicide prevention programme VigilanS has helped reduce repeat suicide attempts among the intervention population by an estimated 24% annually (OECD, 2025[4]).

Definition and comparability

Data for primary care users aged 45 and over are based on the PaRIS International Survey of People Living with Chronic Conditions. They include data for 107 011 people aged 45 and over who used primary healthcare services in the 6-months preceding the survey, linked to 1 816 practices in 19 countries. Well-being is measured using the WHO-5 well-being index. The raw scale 0-25 was converted to a 0-100 scale. Higher scores indicate better well-being. A score below 50 suggests poor mental well-being, and a score below 60, represents when a respondent feels positive about their well-being more than half of the time.

Data on death by suicide comes from the WHO Mortality Database, where suicides are classified as ICD-10 codes X60-X84 and Y870. Data on deaths due to intentional self-harm may be underestimated in some countries (e.g. Ireland) due to late registration of deaths. Data on hospitalisation due to self-harm were collected as part of an OECD mental health data pilot, identified for most countries using primary ICD-10 codes X60-X84 and Y870. Self-harm hospitalisation data capture both suicidal and non-suicidal self-harm. Some countries use different classifications, methods, and age ranges when they identify hospitalisations due to self-harm. Data on self-harm are for all ages except in Canada and France, where data start at age 10. The registration of suicide is also a complex procedure, affected by factors such as how intent is ascertained; who is responsible for completing the death certificate; and cultural dimensions, including stigma.

References

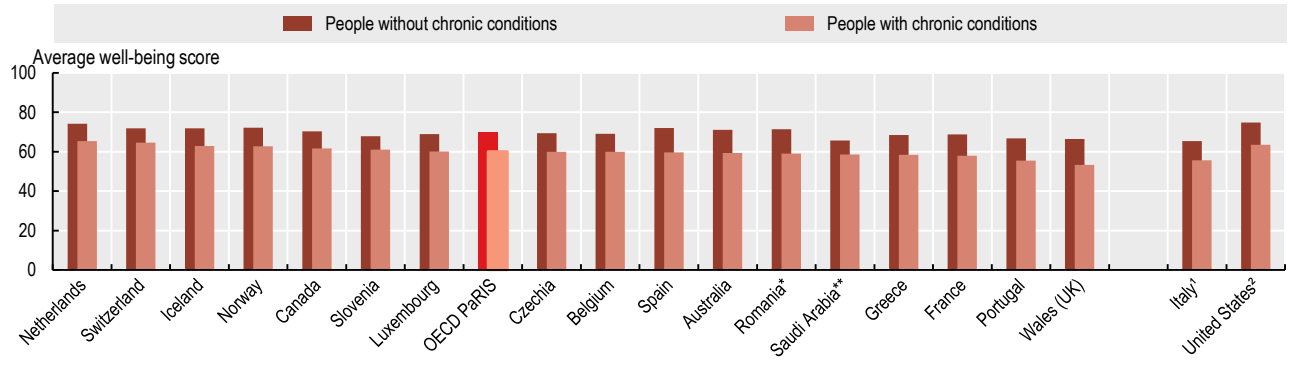
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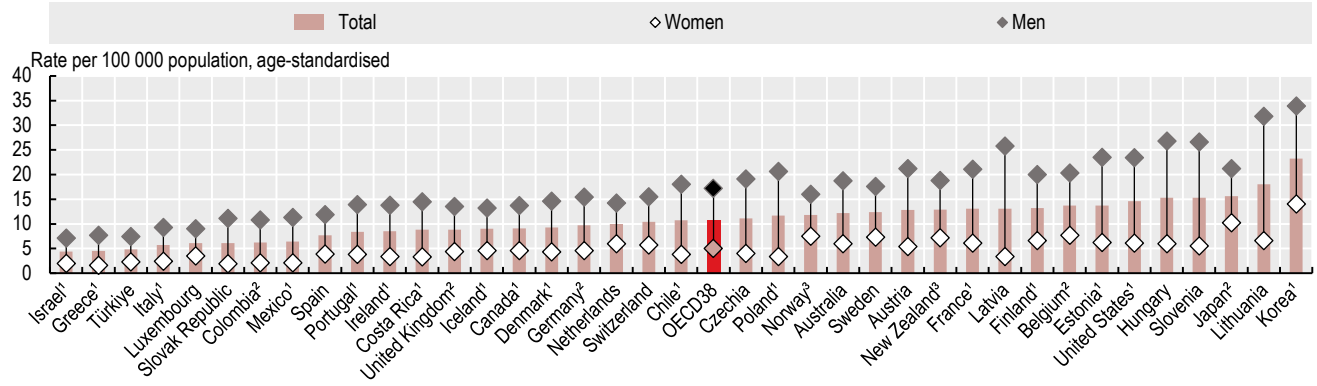
Figure 3.19. WHO-5 well-being score among primary care users aged 45 and over, with and without chronic conditions, 2024



1. Data for Italy refer to patients enrolled in outpatient settings for specialist visits in selected regions. 2. United States sample only includes people aged 65 and over.
* Accession/partner country. ** Participant in the PaRIS survey.
Source: OECD PaRIS 2024 Database.

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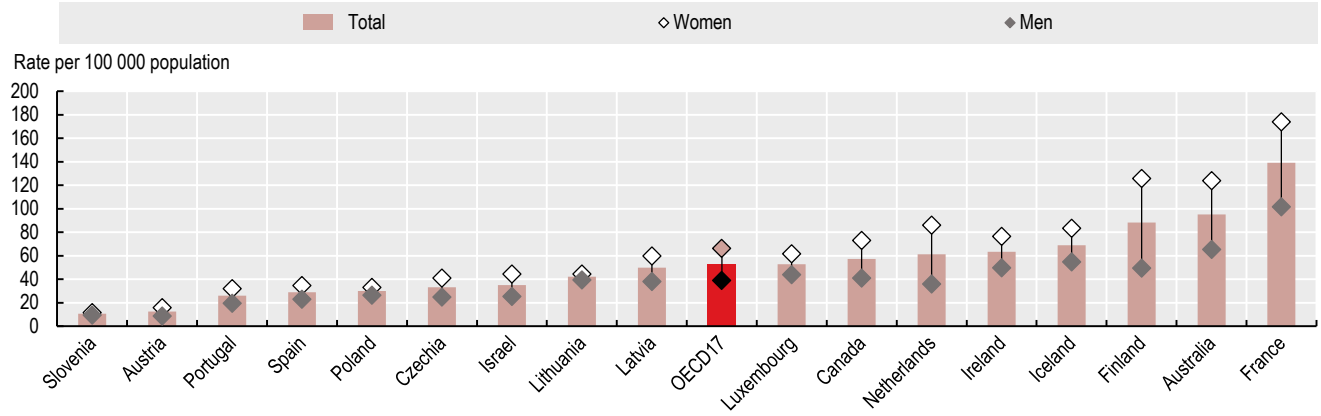
Figure 3.20. Deaths by suicide, 2023 (or nearest year)



1. 2022 data. 2. 2020-2021 data. 3. 2016-2018 data.
Source: OECD Health Statistics 2025, based on the WHO Mortality Database.

StatLink https://stat.link/as7nh4

Figure 3.21. Hospitalisations due to self-harm, 2023



Note: Data for Portugal cover only public (NHS) hospitals. Data on self-harm are for all ages except in Canada and France, where data start at age 10.
Source: OECD Mental Health Pilot Data Collection 2025 – see the StatLink for full details.

StatLink https://stat.link/d8t5lg

Self-rated health

How individuals assess their own health provides a holistic overview of both physical and mental health. Adding such a perspective on quality of life complements life expectancy and mortality indicators that only measure survival (OECD, 2025[1]). Despite its subjective nature, self-rated health has proved to be a good predictor of future healthcare needs and mortality (Palladino et al., 2016[2]). Still, international comparisons are complicated by socio-cultural differences, as well as differences in socio-economic and demographic characteristics (notably poorer and older populations are more likely to report poor health, all else being equal), and the formulation of survey questions (see the "Definition and comparability box").

Around 8% of adults considered themselves to be in poor health on average across OECD countries in 2024 (Figure 3.22). This ranged from over 13% in Japan and Latvia, followed by 12% in Estonia and Portugal, to under 3% in Colombia and New Zealand. Korea, Japan and Portugal stand out as countries with high life expectancy but relatively poor self-rated health. In general, women tend to self-report worse health than men, reflecting differences in health perception, access to care and prevalence of certain chronic conditions. The difference in poor self-rated health between men and women is largest in Lithuania, Korea and Portugal, with gaps surpassing or close to 4 p.p. In contrast, gender differences are much smaller in Canada, Australia, Colombia and Switzerland.

People on lower incomes are, on average, less positive about their health than those on higher incomes in all OECD countries (Figure 3.23). More than 80% of adults in the highest income quintile rated their health as good or very good in 2023, compared to 59% of adults in the lowest income quintile, on average across OECD countries. Socio-economic disparities are particularly marked in Lithuania and Latvia, with an income gap of 40 p.p. or more. Differences in smoking, harmful alcohol use and other risk factors are likely to explain much of this disparity (see Chapter 4 "Non-medical determinants and risk factors"). Socio-economic disparities are relatively low in New Zealand and the Slovak Republic, which have a gap of less than 8 p.p.

Self-rated health tends to decline with age. In many countries, there is a particularly marked decline in how people rate their health when they reach their mid-40s, with a further decline after reaching retirement age (see section on "Self-rated health and disability at age 65 and over" in Chapter 10). Data from the PaRIS International Survey of People Living with Chronic Conditions show that, on average across 17 OECD countries, 65% of primary care users aged 45 and over with chronic conditions report their health as good, very good or excellent, which is much lower than the 91% of primary care users aged 45 and over without chronic conditions (Figure 3.24) (OECD, 2025[1]). Across OECD countries, primary care users aged 45 and over with chronic conditions in Canada, the United States and Switzerland reported better health, with nearly 80% or more rating their general health positively. In contrast, in Portugal and Italy, about 40% or lower reported good health. These differences may reflect variations in how countries manage chronic disease care or ensure access to primary care services. When comparing primary care users without chronic conditions, differences across countries are smaller. More than 95% of primary care users without chronic conditions in France, Switzerland, Canada, the United States and Belgium reported good health. In contrast, Portugal and Italy have the lowest percentages, with less than 80% reporting good health.

Definition and comparability

Self-rated health reflects an individual's overall perception of his or her health. Survey respondents are asked a question such as: "How is your health in general?" Caution is required in cross-country comparisons for three reasons: 1) Self-rated health is subjective, and responses may be systematically different across and within countries because of socio-cultural differences; 2) Self-rated health generally worsens with age, so countries with a greater share of older people are likely to have fewer people reporting that they are in good health; 3) There are variations in categories used in survey questions across countries. In particular, the response scale used in Australia, Canada, Chile, Colombia, New Zealand and the United States is asymmetrical (skewed on the positive side): "Excellent / very good / good / fair / bad (or poor)". In most other OECD countries, the response scale is symmetrical: "Very good / good / fair / bad (poor) / very bad (poor)". This difference in response categories may introduce a comparative bias to a more positive self-assessment of health in those countries that use an asymmetrical scale.

Self-rated health by income level is reported for the first quintile (the 20% of the population with the lowest income) and the fifth quintile (the 20% with the highest income). Depending on the survey, the income level may relate to either the individual or the household (in which case the income is equivalised to take into account the number of people in the household).

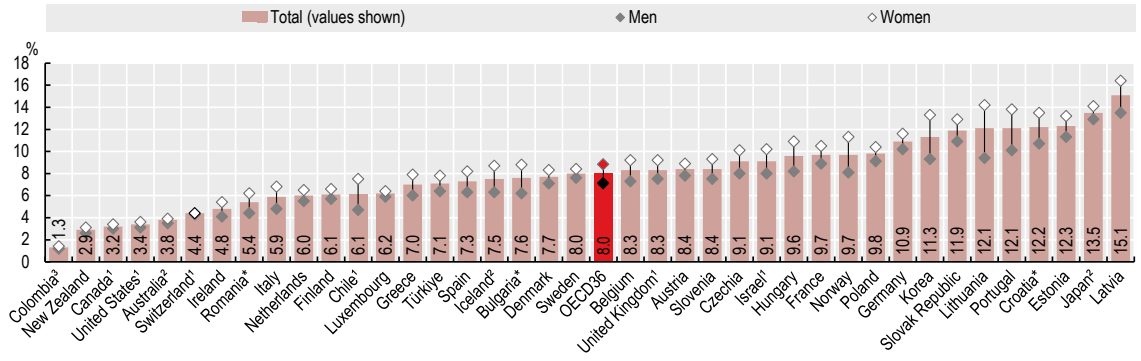
Data on primary care users aged 45 and over reporting their health as good, very good or excellent are from the PaRIS International Survey of People Living with Chronic Conditions in response to the item PROMIS® Scale v1.2 – Global Health. Answer to the question: "In general, would you say your health is …", "good, very good or excellent" versus "fair or poor" (OECD, 2025[1]). All within country differences between people with and without chronic conditions are statistically significant ($p<0.05$).

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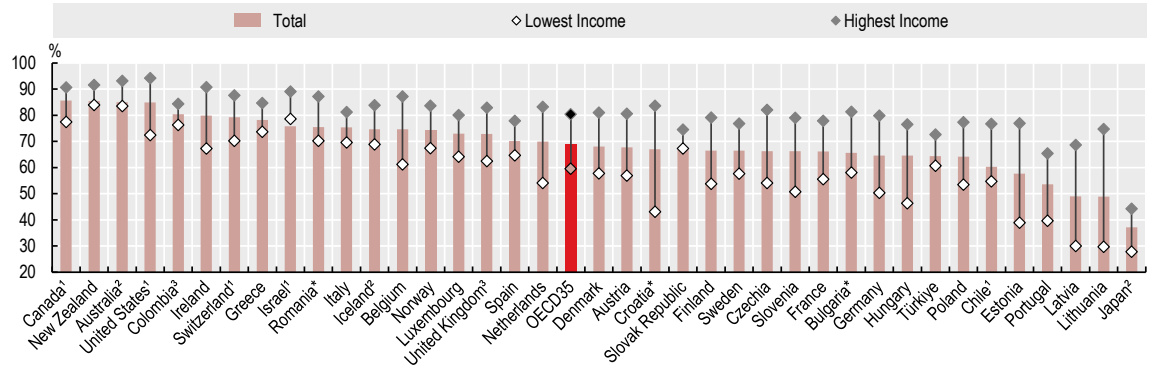
Figure 3.22. People aged 15 and over rating their own health as bad or very bad, 2024 (or nearest year)



Note: Variations exist in categories used in surveys across countries (see "Definition and comparability" box). 1. 2023 data. 2. 2020-2022 data. 3. 2019 data. * Accession/partner country.
Source: OECD Health Statistics 2025, based on EU-SILC for EU countries.

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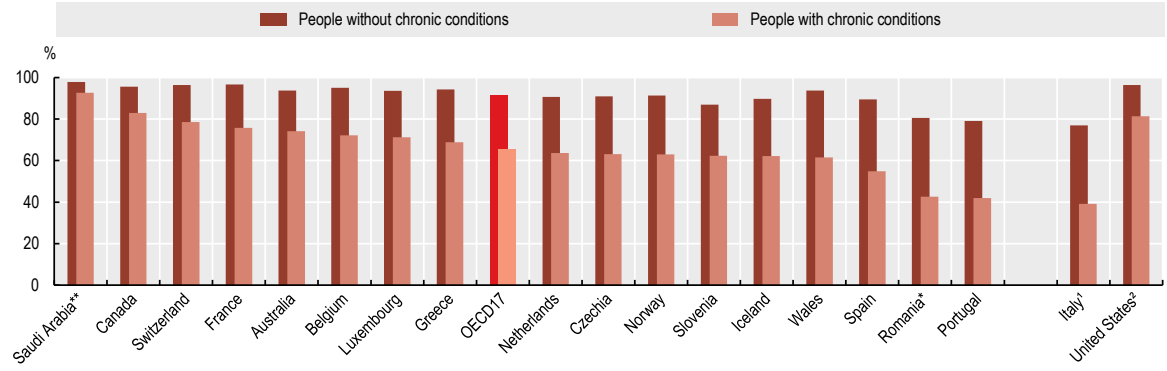
Figure 3.23. People aged 15 and over rating their own health as good or very good, by income quintile, 2023 (or nearest year)



Note: Variations exist in categories used in survey questions across countries (see "Definition and comparability" box). 1. 2023 data. 2. 2020-2022 data. 3. 2019 data. * Accession/partner country.
Source: OECD Health Statistics 2025, based on EU-SILC for EU countries.

StatLink https://stat.link/fse20m

Figure 3.24. Primary care users aged 45 and over reporting their health as good, very good or excellent, 2024



1. Data for Italy refer to patients enrolled in outpatient settings for specialist visits in selected regions. 2. United States sample only includes people aged 65 years and over. * Accession/partner country. ** Participated in the PaRIS survey.
Source: OECD PaRIS 2024 Database.

StatLink https://stat.link/dc5b8g



4 Non-medical determinants and risk factors

Smoking and vaping
Illicit drug use
Smoking, vaping and cannabis use among adolescents
Alcohol consumption
Alcohol consumption among adolescents
Nutrition and physical activity
Nutrition and physical activity among adolescents
Overweight and obesity
Overweight and obesity among adolescents
Environment and health

Smoking and vaping

Over the past decade, tobacco smoking trends have declined in most OECD countries, while vaping has increased. Nevertheless, tobacco use continues to pose a significant public health challenge. Tobacco smoking is a leading cause of multiple diseases, including cancers, cardiovascular and respiratory diseases. It accounted for an estimated 1.25 million adult deaths in OECD countries in 2022 (IHME, 2025[1]).

Across OECD countries, 14.8% of people aged 15 and over smoked daily in 2023. The proportion of daily smokers was highest in Türkiye, Hungary and Greece, as well as in accession/partner countries Indonesia, Bulgaria and China, where at least one in four people smoked daily (Figure 4.1). In contrast, the lowest rates were observed in Iceland and Costa Rica, where the proportion of daily smokers was 6% or less. Across OECD countries, men are more likely to smoke than women: on average, 18.5% of men smoked daily in 2023 compared to 11.4% of women. Some countries demonstrate large gender disparities – this gap is most pronounced in Japan, Korea, Lithuania, Latvia and Türkiye, as well as in partner countries Indonesia, China and South Africa.

Over the past decade, smoking rates have declined in most OECD countries with available data reflecting an average decrease of a quarter since 2013 (Figure 4.2). The largest declines were observed in Chile, Estonia, New Zealand and the United Kingdom, where there was an 8-9 percentage point (p.p.) fall.

At the same time, adult vaping has increased in most OECD countries. While it may serve as a smoking cessation aid in some jurisdictions, vaping can also represent a lifestyle choice. Between 2016 and 2023, regular vaping rates rose from 3% to 6% on average across OECD countries with available data (Figure 4.3). The largest increases were observed in New Zealand, where 14% of people aged 15 and over reported regular vaping in 2023, and Estonia, where the rate was 12%.

Many efforts have been made globally to reduce smoking rates and prevent smoking initiation. A majority of OECD countries have reached an advanced stage in implementing key tobacco control policies – particularly tobacco taxation and use of health warning labels on packaging. However, in some countries, progress has been more limited in areas such as enforcing bans on advertising, restricting smoking in public places and offering help to quit (WHO, 2025[2]). To strengthen its anti-tobacco policy, Australia introduced the Public Health (Tobacco and Other Products) Act in 2023, which took effect in 2024. The legislation includes regulation of new features designed to enhance the appeal of tobacco products, such as those that change the taste of cigarettes.

Across OECD countries where electronic cigarettes (e-cigarettes) are sold legally, a vast majority of countries have implemented full or partial regulatory frameworks. These typically mirror existing tobacco regulations and include minimum age restrictions for sale, bans on indoor use, health warnings on packaging, flavour restrictions, bans on advertising and monitoring of efforts. Most OECD countries have applied an excise tax on e-cigarettes. Australia has gone further by regulating vapes as a therapeutic good only permitted for sale in pharmacies where clinically appropriate, and banning the importation, manufacture, supply, and commercial possession of disposable single use and non-therapeutic vapes. In addition to regulatory approaches, some countries have adopted complete bans on e-cigarettes to deter uptake by non-smokers. For example, importation and sales of e-cigarettes are banned in Brazil and Türkiye (Sóñora et al., 2022[3]). More recently, several countries – including Belgium, France, and the United Kingdom – have introduced bans on disposable e-cigarettes.

Definitions and comparability

The prevalence of daily smoking is defined as the percentage of individuals aged 15 and over who report consuming tobacco on a daily basis. This definition excludes smokeless tobacco products, such as snus, which is used in certain countries like Sweden and Norway. Most countries report data for the population aged 15 and over, but there are some exceptions (see the weblink to metadata in the “Reader’s guide”).

Regular use of e-cigarettes, or “vaping”, is defined as the percentage of individuals aged 15 and over who use vaping devices at least once per month. The data on vaping specifically refer to e-cigarettes and do not include heated tobacco products. Caution should be used when interpreting data on e-cigarette use and vaping, as relatively small sample sizes in surveys can lead to substantial year-on-year fluctuations in reported prevalence in certain countries. For data on e-cigarette use, indicator definitions may differ between years for certain countries (see the weblink to metadata in the “Reader’s guide”).

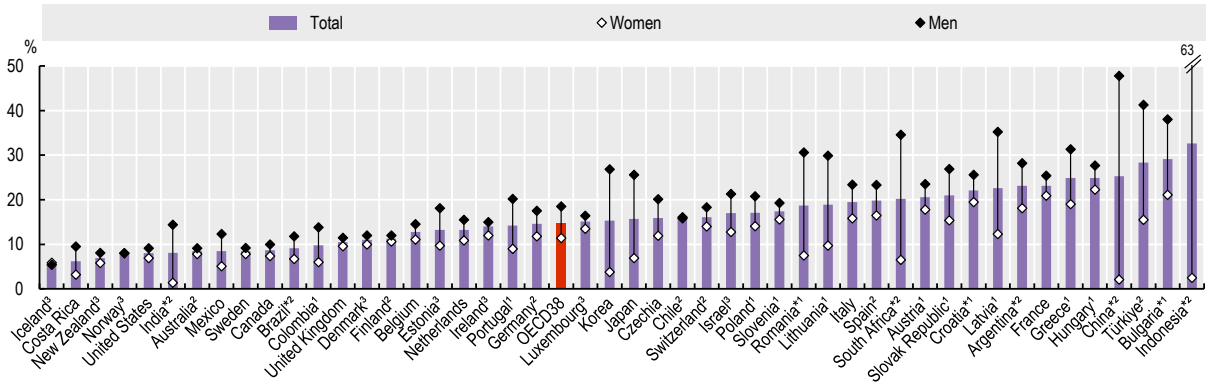
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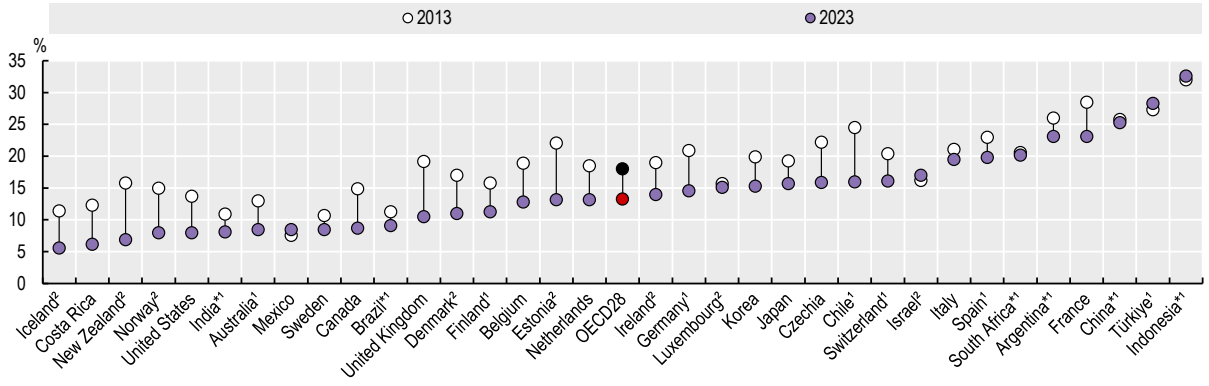
Figure 4.1. Daily smokers among people aged 15 and over, 2023 (or nearest year)



1. Latest data from 2019. 2. Latest data from 2020-2022. 3. 2024 data. * Accession/partner country.
Source: OECD Health Statistics 2025.

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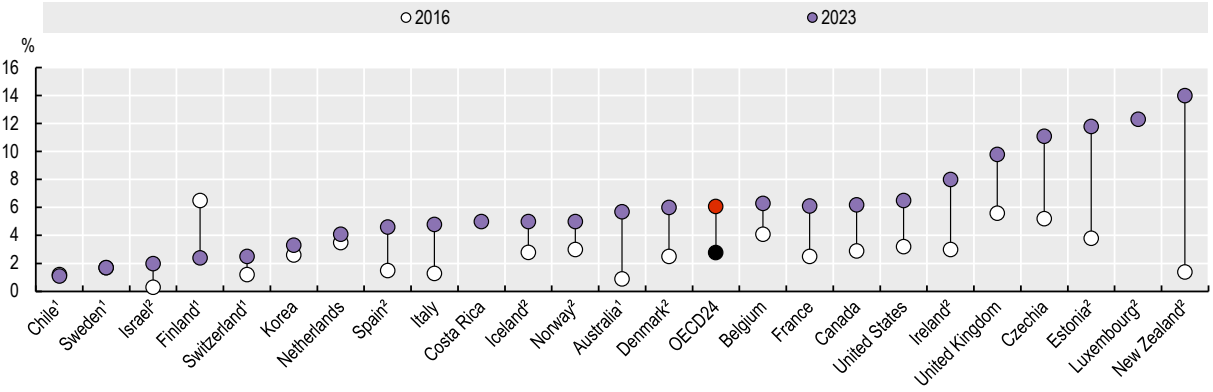
Figure 4.2. Daily smoking rates among people aged 15 and over, 2023 and 2013 (or nearest year)



1. Latest data from 2020-2022. 2. 2024 data. Countries with 2019 data are not displayed. * Accession/partner country.
Source: OECD Health Statistics 2025.

StatLink https://stat.link/xwdvmb

Figure 4.3. Regular use of vaping products among people aged 15 and over, 2023 and 2016 (or nearest year)



1. Latest data from 2022. 2. Latest data from 2024.
Source: OECD Health Statistics 2025.

StatLink https://stat.link/dn47m3

Illicit drug use

Illicit drug use is a major cause of preventable mortality and is associated with many acute and long-term conditions – including cardiovascular and respiratory diseases, neurological and mental health disorders, infectious diseases such as hepatitis C and HIV – as well as heightened risk of overdose. These risks are especially pronounced when the drugs are consumed regularly and/or in large quantities. In 2021, drug use was responsible for 5.1% of deaths caused by non-communicable diseases before the age of 70 across OECD countries (IHME, 2025[1]). Cannabis, opioids and cocaine are among the most used drugs. Over the past decade, notable increases in cocaine use have been observed, largely driven by trends in North America, South America and Europe (UNODC, 2025[2]).

In 2023, around 9% of people aged 15-64 years had used an illicit drug in the last year, mainly driven by cannabis use. The highest rates were found in Australia, where nearly 18% of people aged 15-64 had used an illicit drug in the last year, and the United States, where the rate was 25% (Figure 4.4). In nearly all countries, illicit drug use is higher among men than women. In 12 out of 25 countries, this difference exceeded 5 p.p.

Cocaine use in the last year was reported by 1.3% of people aged 15-64 across OECD countries (Figure 4.5). The proportions were highest in Australia, Canada, France and the Netherlands (2.7% or above). Men were more likely to use cocaine than women in all countries except Israel and Japan, and on average across 33 OECD countries, 2% of men had used cocaine in the past year compared to less than 1% of women.

The misuse of opioids – a narcotic pain medication used for treating moderate to severe pain – has become an increasingly serious public health concern in recent years. Illicit opioid use can lead to addiction, and is responsible for many deaths by drug overdose – notably in countries that have been hit by the opioid crisis, including the United States and Canada. In 2022, opioid use disorders were responsible for nearly 74 000 deaths across OECD countries (IHME, 2025[1]).

In 2023, illicit opioid use during the past year was reported by 0.7% of people aged 15-64 in 35 OECD countries (Figure 4.6). This proportion was lowest in Türkiye and Israel (below 0.1%). Conversely, rates exceeded 2% in Australia and Sweden, and reached 3.6% in the United States. In accession/partner countries, rates were high in India (2.1%) and below 0.5% in Indonesia, Romania and Croatia. There is no consistent gender pattern in countries with available data.

Global efforts to prevent and reduce illicit drug use have involved a combination of strategies including law enforcement and regulation, prevention efforts such as public education campaigns, harm reduction strategies, and improving access to treatment and recovery services. Countries have adopted harm reduction strategies – such as drug checking, supervised consumption sites, and needle and syringe programmes – to mitigate the risk of overdose and infectious diseases due to injecting drugs (e.g. HIV and hepatitis C). To reduce deaths from overdose, take-home naloxone programmes (providing an opioid antagonist capable of temporarily reversing the effects of an opioid overdose) are implemented in countries including Australia, Canada, Croatia, Finland and the United States.

Definitions and comparability

Data on illicit drug use come from national population surveys gathered by the European Union Drug Agency (EUDA) (available at http://www.euda.europa.eu/data/stats2025_en). The results refer to the share of people aged 15-64 who report having used illicit drugs (including cannabis, ecstasy, amphetamines, cocaine, heroin and LSD) in the last year. Dates of latest national survey data range from 2015 to 2024. These are complemented with data from the 2023 National Drug Strategy Household Survey for Australia; the 2017 National Survey on Drug, Alcohol and Tobacco Consumption for Mexico; and the 2023 National Survey of Drug Use and Health for the United States. For Australia, the indicator definition and age coverage (age 14+) differ slightly from those used by EUDA.

Data on cocaine use in the last year are from national population surveys gathered by the EUDA. They are complemented with data from the UN Office for Drug and Crime (UNODC) (available at https://dataunodc.un.org/).

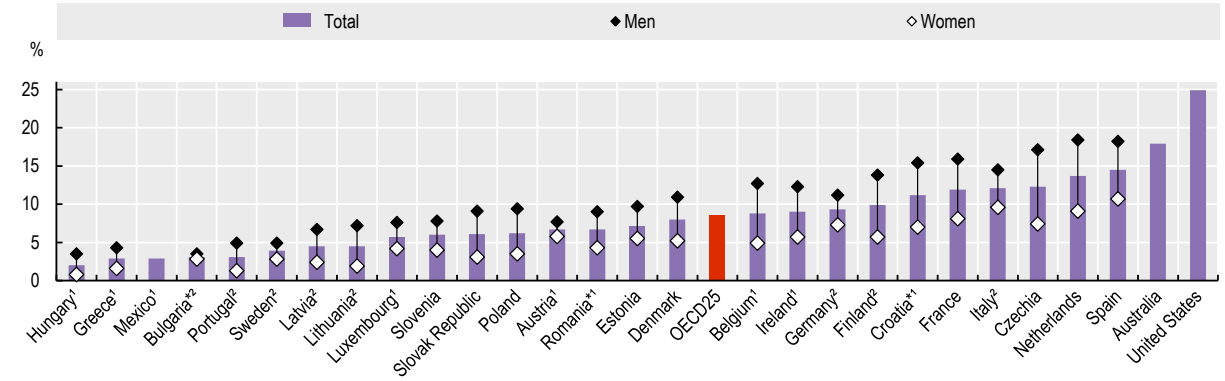
Data on opioid use come from the UNODC database. They refer to opioid use in the last year among people aged 15-64, with some differences in age coverage. Estimates were derived from household survey data or indirect estimations. Opioid use includes both opioids and opiates (e.g. opium and heroin).

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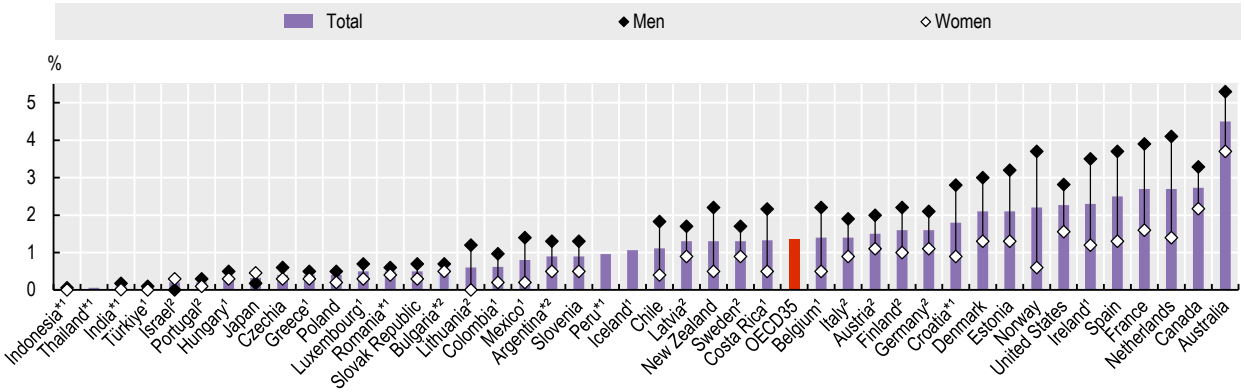
Figure 4.4. Illicit drug use in the last 12 months among people aged 15-64, 2023 (or nearest year)



1. Latest data from 2015-2019. 2. Latest data from 2020-2022. * Accession/partner country.
Source: EUDA, 2025, complemented with national sources for Australia, Mexico and the United States.

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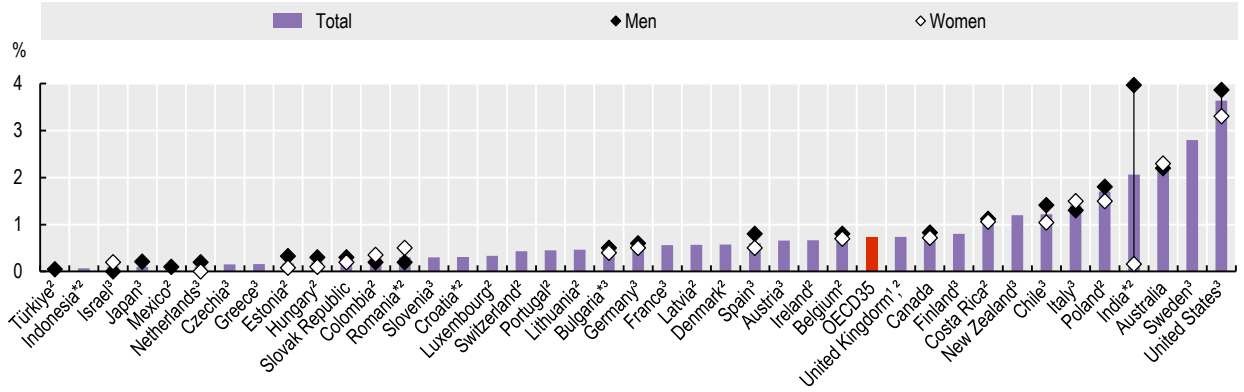
Figure 4.5. Cocaine use in the last 12 months among people aged 15-64, 2023 (or nearest year)



1. Latest data from 2015-2019. 2. Latest data from 2020-2022. * Accession/partner country.
Source: EUDA, 2025, complemented with UNODC, 2025.

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Figure 4.6. Opioid use in the last 12 months among people aged 15-64, 2023 (or nearest year)



1. United Kingdom includes England and Wales. 2. Latest data from 2015-2019. 3. Latest data from 2020-2022. * Accession/partner country.
Source: UNODC, 2024.

StatLink https://stat.link/dibf6x

Smoking, vaping and cannabis use among adolescents

Smoking is responsible for numerous diseases, including some cancers, cardiovascular and respiratory diseases. Smoking initiation and habits often develop during adolescence and early adulthood, and early onset of tobacco consumption has been associated with higher risks of dependency. Although the legal age for tobacco sales varies between 18 and 21 in most OECD countries, average smoking initiation starts before the age of 18 in many countries (Reitsma et al., 2021[1]).

In 2022, 15% of 15-year-olds reported smoking cigarettes at least once in the past month on average across OECD countries (Figure 4.7). This proportion reached a high of more than one in four in Hungary and Italy as well as accession countries Bulgaria and Croatia, compared to a rate lower than one in ten in Iceland, Canada, Ireland, Norway and Portugal. On average across OECD countries, a slightly greater proportion of girls (15%) than boys (14%) reported smoking in 2022.

Smoking rates among 15-year-olds have decreased in 27 out of 28 OECD countries since 2014. However, the decrease was generally more pronounced between 2014 and 2018 than between 2018 and 2022. This slowdown has been in part related to the COVID-19 pandemic and the increasing use of e-cigarettes.

At the same time, use of e-cigarettes among 15-year-olds has increased. Adolescent e-cigarette use is a concerning trend, as evidence indicates that e-cigarette use is associated with a heightened risk of initiating tobacco smoking among adolescents and young adults (O'Brien et al., 2021[2]). In 2022, 20% of 15-year-olds reported using an e-cigarette in the past month on average across OECD countries (Figure 4.8). Countries including Lithuania, Hungary and Poland as well as accession country Bulgaria have e-cigarette use rates exceeding 30%, compared to less than 10% in Portugal and the Netherlands. In most countries, e-cigarette use is more prevalent among girls (21%) than boys (18%), with particularly large gaps in Estonia, Ireland and the United Kingdom.

OECD countries have implemented a wide range of policies that have been effective in reducing tobacco smoking among young people. These include raising the legal age for purchasing tobacco products, increasing tobacco taxation, introducing smoking bans in public places and restricting advertising. To address rising e-cigarette use among adolescents, countries have recently tightened regulation of public indoor vaping bans, advertising restrictions, and product standards such as health warnings and labelling. Several countries – including Belgium, France and the United Kingdom – have also enacted bans on the sale of disposable e-cigarettes, which are particularly popular among younger users. In an effort to create a future tobacco-free generation, the United Kingdom has introduced a new bill to control tobacco and vapes. This includes a progressive age-based sales ban and the extension of outdoor smoke-free restrictions (e.g. outside schools and hospitals).

Cannabis use reflects another trend of substance-related risk behaviours among adolescents. On average across OECD countries, 7% of 15-year-olds reported cannabis use at least once in the past month in 2022 (Figure 4.9). This proportion ranged from over 10% of adolescents in Canada, Poland and Italy as well as accession country Bulgaria, to lower than 5% in Iceland, Portugal and Denmark, as well as accession country Romania. Since 2014, cannabis use among 15-year-olds has decreased in around 40% of OECD countries, while it increased in over 50% of countries. France, Denmark and Spain experienced the most substantial decreases, whereas Austria, Finland and Sweden exhibited the largest increases. The prevalence of cannabis use reveals gender disparities: boys are more likely (8%) than girls (6%) to report cannabis use. OECD countries have implemented diverse preventive measures to reduce cannabis use in adolescents, such as public education campaigns or legal age restrictions for cannabis possession or purchase.

Definitions and comparability

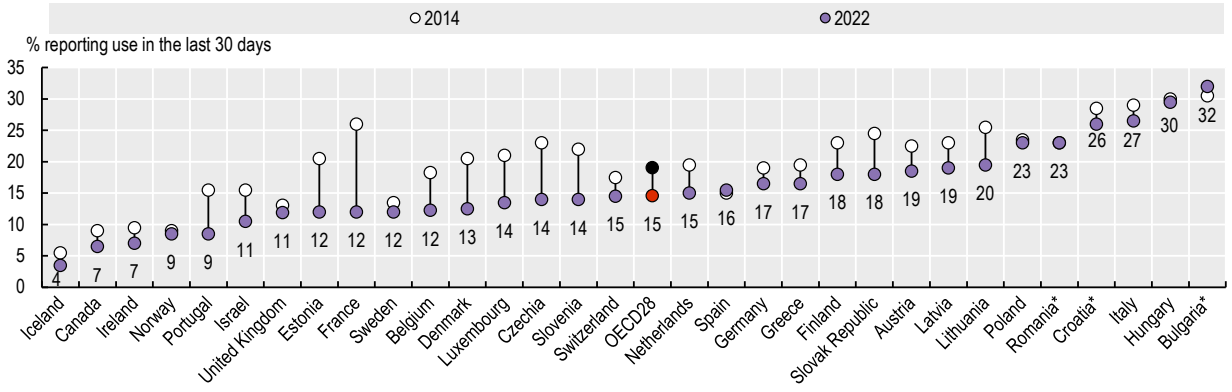
The data come from the Health Behaviour in School-aged Children (HBSC) study (available at https://data-browser.hbsc.org/). Since 1993/94, the HBSC survey has collected data every four years on substance use among children and adolescents aged 11, 13 and 15 across European countries and several other countries. The data presented focus specifically on the proportion of 15-year-olds who report having smoked a cigarette, used an e-cigarette or used cannabis at least once during the month preceding the survey. Data for Belgium refer to the unweighted average of the French- and Flemish-speaking regions. Data for the United Kingdom refer to the weighted average for England, Scotland and Wales. For cannabis smoking, data for the United Kingdom refer to the weighted average for Scotland and Wales.

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Reitsma, M. et al. (2021), "Spatial, temporal, and demographic patterns in prevalence of smoking tobacco use and initiation among young people in 204 countries and territories, 1990–2019", *The Lancet Public Health*, Vol. 6/7, pp. e472-e481, https://doi.org/10.1016/S2468-2667(21)00102-X. [1]

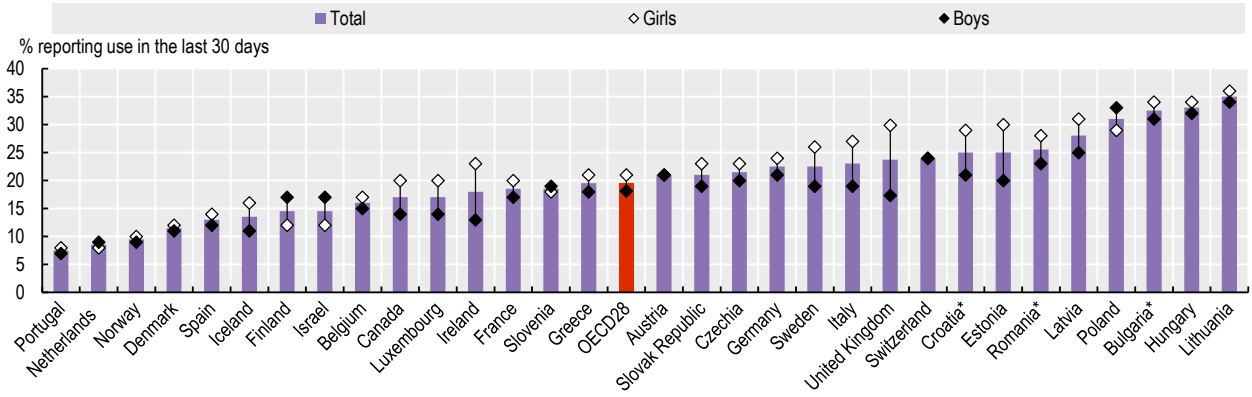
Figure 4.7. Cigarette smoking among 15-year-olds, 2022 and 2014



* Accession/partner country.
Source: HBSC Data Browser.

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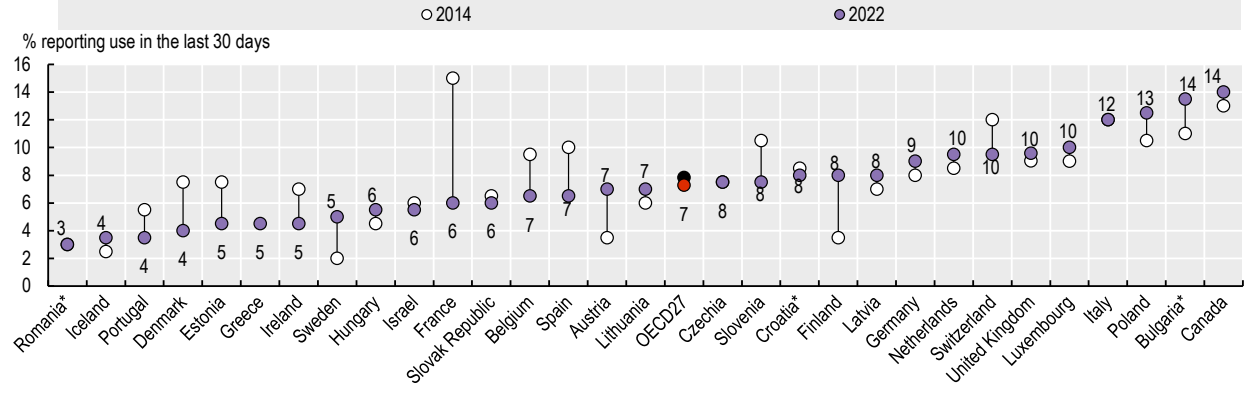
Figure 4.8. Vaping among 15-year-olds, 2022



* Accession/partner country.
Source: HBSC Data Browser.

StatLink https://stat.link/32yqdi

Figure 4.9. Cannabis smoking among 15-year-olds, 2022 and 2014



Note: Values unchanged between 2014 and 2022 in Czechia, Italy and Romania. Data for 2014 missing for Greece. * Accession/partner country.
Source: HBSC Data Browser.

StatLink https://stat.link/fn3p92

Alcohol consumption

Harmful alcohol consumption poses a major threat to population health and can lead to numerous chronic conditions and injuries, as well as alcohol dependence. Specifically, alcohol consumption is associated with an increased risk of certain cancers – including mouth, throat, liver, colorectal and breast cancers. Heavy drinkers have an increased risk of cancer compared to non-drinkers (National Cancer Institute, 2025[1]). Alcohol-related harm places a significant economic burden on countries, at an estimated 2.4% of yearly healthcare spending in OECD countries (OECD, 2021[2])**.**

Alcohol consumption varies significantly across OECD countries. In 2023, per capita annual alcohol consumption averaged 8.5 litres of pure alcohol across OECD countries (Figure 4.10). Countries with the lowest consumption, including Türkiye and accession country Indonesia, averaged below 2 litres annually. In contrast, those with the highest consumption, including Latvia and Portugal and accession country Romania, reached over 11.5 litres annually. Nearly a third of OECD countries recorded per capita consumption of 10 litres or more.

Over the past decade, most countries have seen a decrease in alcohol consumption. Between 2013 and 2023, Belgium and Lithuania as well as partner country China reported the largest declines in alcohol consumption, with reductions of 2.5 litres or more. Conversely, the largest increases were recorded in Mexico, Portugal and Spain as well as accession country Romania, where yearly alcohol consumption per capita rose by 2 litres or more over the period.

Heavy episodic drinking constitutes a highly risky drinking behaviour, which corresponds to consuming large quantities of alcohol in a short period of time. In 2023, 27% of people aged 15 and over reported heavy episodic drinking at least monthly in the past year on average across the 27 OECD countries with available data (Figure 4.11). Greece, Ireland and Sweden reported the highest rates, with over 40% of individuals reporting monthly binge drinking. Hungary, Israel and Slovenia as well as accession country Croatia reported the lowest rates (below 15%).

To address harmful drinking, a whole-of-society approach is required, recognising that not just governments but all stakeholders, including civil society and the private sector, can play a role and contribute to better health outcomes related to harmful drinking. A variety of measures, ranging from population-wide initiatives targeting all alcohol consumers to targeted interventions for those reporting harmful drinking, can have an impact on health outcomes (OECD, 2021[2]). OECD countries have implemented policies to reduce the accessibility and availability of alcohol – such as advertising restrictions or bans in specific venues such as cinemas – or complete advertisement bans, as in Norway. To make alcohol less affordable, some countries have introduced minimum unit pricing, fixing a minimum price per standard unit in addition to taxation. In 2022, Ireland implemented a minimum unit price of EUR 1 per standard drink, while Scotland and Wales (United Kingdom), introduced comparable minimum unit pricing on alcoholic beverages (Sheffield Addictions Research Group, 2024[3]). Additional measures, such as public campaigns and warning labels, aim to enhance risk awareness. Recently, Ireland adopted a regulation requiring warning labels to be included on all alcoholic beverages from 2028.

Definitions and comparability

Overall alcohol consumption is defined as annual sales of pure alcohol in litres per person aged 15 and over, with some exceptions (see the weblink to metadata in the "Reader's guide"). Data come from national sources. The methodology to convert alcohol drinks to pure alcohol may differ across countries. Official data do not adjust for tourist consumption and unrecorded alcohol consumption, such as domestic or illegal production, with some exceptions. Data for Estonia, Greece, Italy, Latvia, Lithuania and Switzerland exclude consumption of tourists visiting these countries.

Heavy episodic drinking (also called binge drinking) is defined in the 2023 European Social Survey as the share of people aged 15 and over who reported consuming ≥48 g of alcohol for women and ≥64 g for men (about 5+ drinks for women and 6+ for men) on one single occasion at least monthly in the past year. Results may differ from national sources. Data are available at https://ess.sikt.no/. They are complemented with data from the National Drug Strategy Household Survey for Australia, the Telephone Survey of Risk Factors for Chronic Noncommunicable Diseases for Brazil, the Canadian Community Health Survey for Canada, the National Health and Nutrition Survey for Korea and the National Survey on Drug Use and Health for the United States. The definition of a standard drink and the threshold number of drinks vary slightly across surveys (4+ drinks for women and 5+ for men in Brazil, Canada and the United States; 5+ for women and 7+ for men in Korea; and 4+ for men and women in Australia). Age coverage also varies (age 12+ in Canada and the United States, 14+ in Australia, 18+ in Brazil and 19+ in Korea).

References

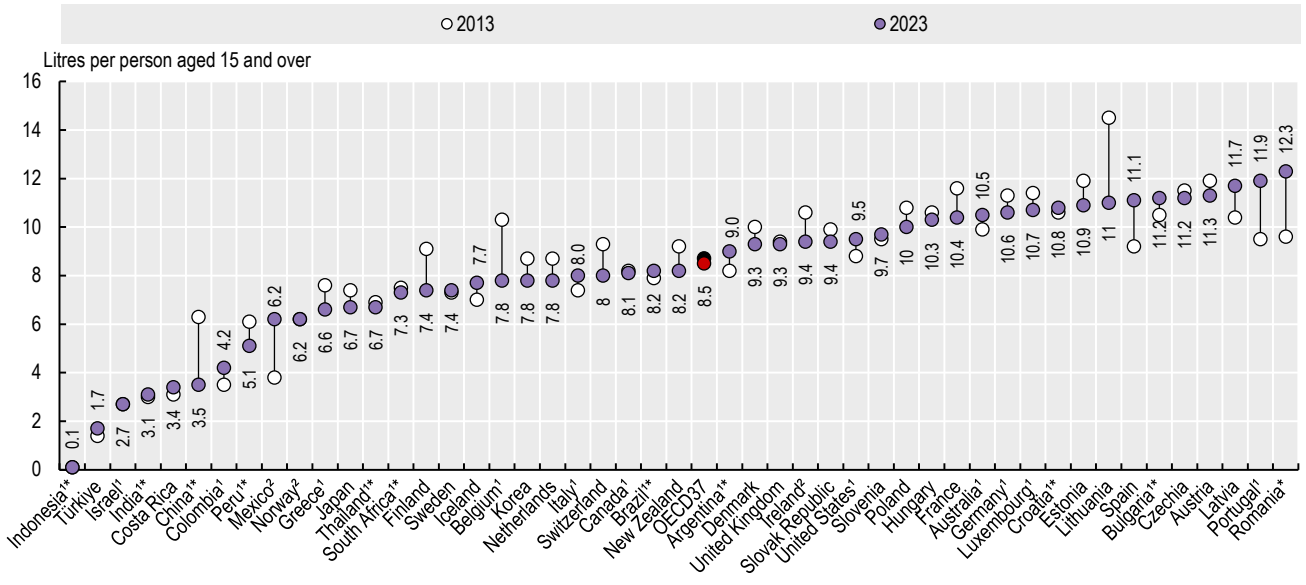
European Social Survey European Research Infrastructure (ESS ERIC) (2025), *ESS round 11 - 2023. Social inequalities in health, Gender in contemporary Europe*, Sikt - Norwegian Agency for Shared Services in Education and Research, https://doi.org/10.21338/ess11-2023. [4]

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Sheffield Addictions Research Group (2024), *Minimum Unit Pricing*, https://sarg-sheffield.ac.uk/research/minimum-unit-pricing/. [3]

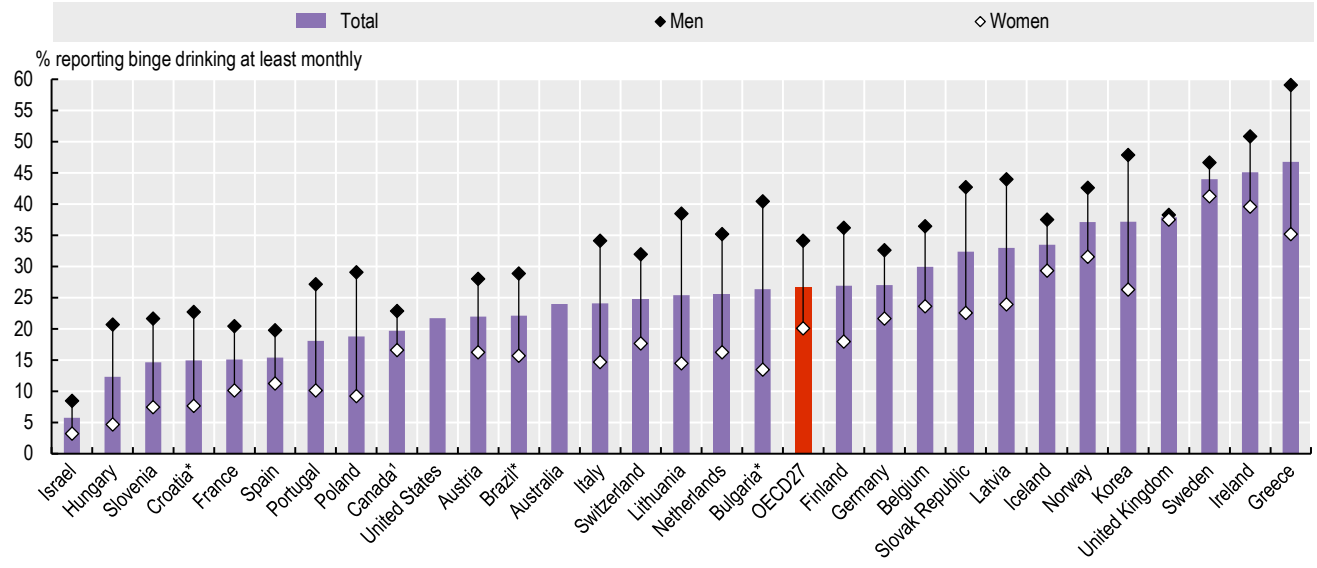
Figure 4.10. Overall alcohol consumption among people aged 15 and over, 2023 and 2013 (or nearest year)



1. Latest data from 2022. 2. Latest data from 2024. * Accession/partner country.
Source: OECD Health Statistics 2025.

StatLink https://stat.link/gb5xzw

Figure 4.11. Heavy episodic drinking among people aged 15 and over, 2023 (or nearest year)



1. Latest data from 2022. * Accession/partner country.
Source: European Social Survey 2023 (2025[4]), "ESS round 11 - 2023. Social inequalities in health, Gender in contemporary Europe", https://doi.org/10.21338/ess11-2023, complemented with national data sources for Australia, Brazil, Canada, Korea and the United States.

StatLink https://stat.link/b5meiy

Alcohol consumption among adolescents

Alcohol use at a young age has health consequences that can appear in the short, medium and long term, such as accidents, injuries and diseases. Early initiation and repeated alcohol consumption have been associated with worsened mental health conditions such as anxiety, decline in cognitive functions and higher consumption in adulthood (Spear, 2018[1]).

In 2022, across OECD countries, 60% of 15-year-olds reported having ever consumed alcohol in their lifetime, while 38% reported having consumed alcohol in the last month (Figure 4.12). Monthly alcohol drinking begins at an early age: on average, 5% of 11-year-olds and 15% of 13-year-olds reported drinking alcohol in the last month. The highest rates (10% or more) among the 11-year-olds were observed in Czechia, France, Hungary and the United Kingdom, as well as in accession countries Bulgaria and Romania. Among 15-year-olds, Denmark, Italy and Germany reported the highest rates, with 55% or more indicating alcohol consumption in the last month. Between 2018 and 2022, the share of 15-year-olds who reported consuming alcohol in the last month decreased slightly from 39% to 38%, while the share of the 11-year-olds increased slightly from 4% to 5% on average across OECD countries.

Repeated drunkenness in adolescence is a serious concern: around 22% of 15-year-olds reported having been drunk more than once in their lifetime (Figure 4.13). This proportion reached a high of more than 35% in Denmark and Hungary as well as accession country Bulgaria, compared to less than 10% in Iceland, Portugal and Israel. No consistent gender pattern was found in reported drunkenness across countries: on average, girls experienced drunkenness as frequently as boys in 2022. Lifetime prevalence of drunkenness among adolescents had been decreasing on average across OECD countries, but this downward trend recently levelled off among boys (remaining at 22% in 2019 and 2022) and reversed among girls (rising to 22% in 2022 from 19% in 2018).

To address underage drinking, many countries have adopted regulatory and preventive strategies aimed at limiting availability of alcohol and restricting its marketing. These typically include age restrictions for purchasing alcohol, limitations on sales outlets, fiscal measures, advertising bans and educational programmes (OECD, 2021[2]). In 2018, Ireland introduced the Public Health Alcohol Act with the objectives of reducing alcohol consumption, delaying initiation in children and adolescents, and regulate supply and pricing. Since its introduction, alcohol advertising has been restricted around areas frequented by children and adolescents – such as schools, playgrounds and train stations – as well as on television during certain hours of the day, in order to reduce their exposure.

Estonia and Finland have legal measures in place that restrict alcohol advertising in digital media. Finland's Alcohol Control Act (2015) prohibits alcohol marketing on social media using user-generated content, and requires that alcohol marketing does not target or depict minors. In Estonia, alcohol advertising is banned on social media through the amended Advertising Act of 2018, with the exception of websites and official social media accounts of alcohol handlers (WHO, 2023[3]).

More recently, Belgium adopted a new Alcohol Action Plan 2023-2025, aimed at reducing the availability of alcohol. Taking a holistic approach towards alcohol prevention, the plan includes regulatory measures such as banning alcohol sales through vending machines, strengthening prevention activities and improving access to alcohol-related treatment and care.

Definitions and comparability

Data come from the HBSC study (available at https://data-browser.hbsc.org/). Since 1993/94, the HBSC survey has collected data every four years on alcohol use among children and adolescents aged 11, 13 and 15 across European countries and several other countries. The data focus specifically on the proportion of adolescents (aged 11, 13 and 15) who report having consumed alcohol in the previous month, and those (aged 15) who report having been drunk on at least two occasions during their lifetime. Data for Belgium refer to the unweighted average of the French- and Flemish-speaking regions. Data for the United Kingdom refer to the weighted average for England, Scotland and Wales.

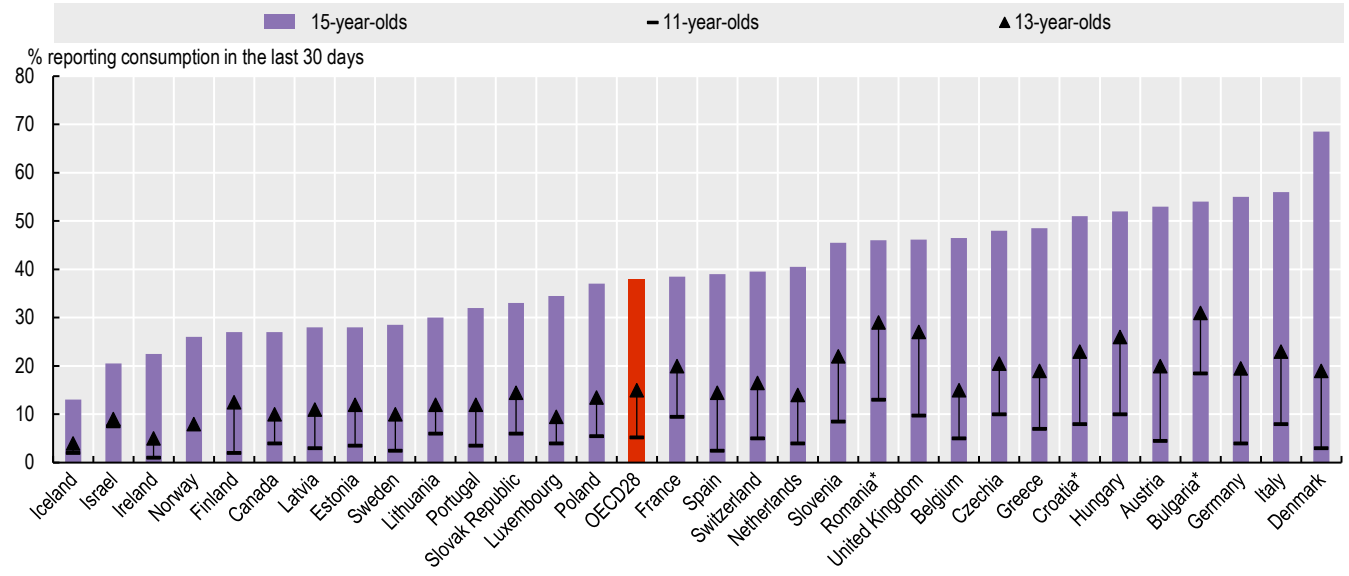
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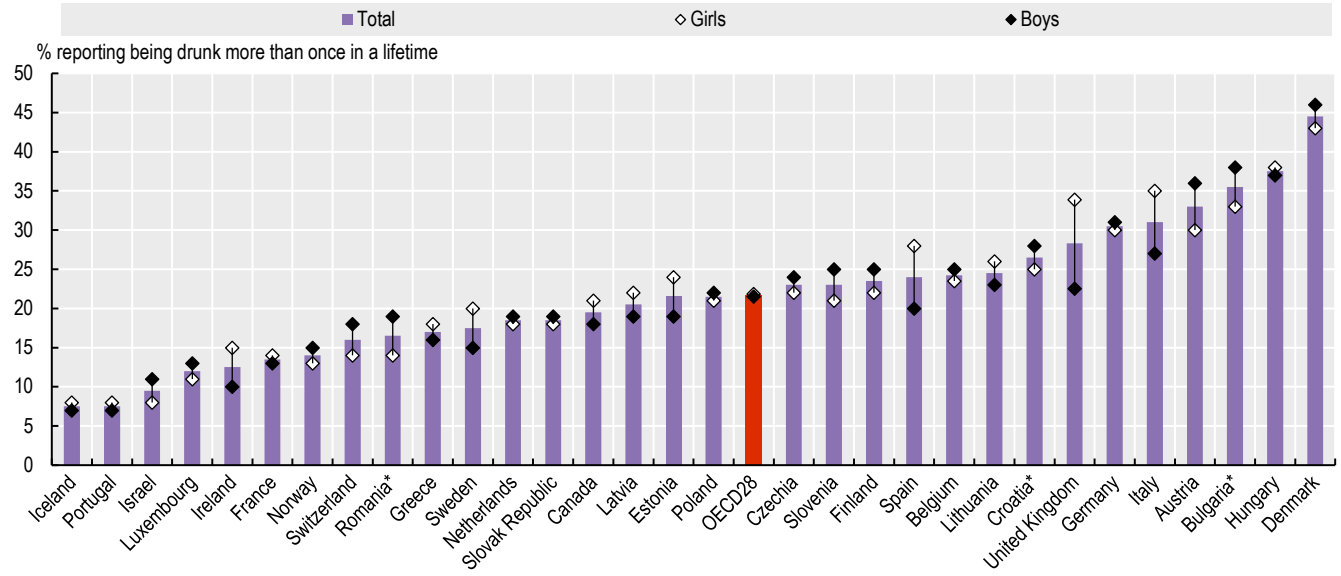
Figure 4.12. Alcohol consumption among adolescents, 2022



* Accession/partner country.
Source: HBSC Data Browser.

StatLink https://stat.link/a8fvgy

Figure 4.13. Repeated drunkenness among 15-year-olds, 2022



* Accession/partner country.
Source: HBSC Data Browser.

StatLink https://stat.link/2084ln

Nutrition and physical activity

A healthy and nutrient-balanced diet, which incorporates whole grains, fruit, vegetables, legumes and nuts, is essential for maintaining good health and reducing the risk of non-communicable diseases (NCDs). Consistently including vegetables in daily meals can help to maintain a healthy weight and lower the risk of cardiovascular disease, diabetes and certain types of cancer. Recommendations from the World Health Organization (WHO) suggest that adults should be eating at least 400 grammes – or five or more portions – of fruit and vegetables per day. Similarly, limiting intake of foods high in sugar, saturated and trans-fats, and sugar-sweetened beverages (SSBs) is essential to maintain a healthy diet. In 2024, the global economic cost attributed to unhealthy diets and NCDs was estimated at around USD 8.1 trillion (FAO, 2024[1]).

On average across 32 OECD countries, 59% of people aged 15 and over consumed vegetables each day in 2023. Countries with the highest rates of vegetable consumption were Korea, Australia and New Zealand, all of which recorded rates above 95% (Figure 4.14). Conversely, Luxembourg and Türkiye as well as accession country Romania were among the countries with the lowest rate of daily vegetable consumption (41% or below). In all countries except Mexico, women consistently exhibited higher rates of vegetable consumption compared to men. The largest gender gaps were observed in Germany, Finland, Luxembourg and Switzerland, with a difference of 18 p.p. or more.

In 2023, over 35% of people aged 15 and over in 9 OECD countries reported consuming SSBs during the previous day or night (Figure 4.15). SSB consumption rates were highest in Chile and Israel as well as accession/partner countries South Africa and Thailand (45% or above). They were lowest in Greece as well as accession/partner countries China, India and Indonesia (below 25%).

Engaging in regular physical activity has been shown to prevent a range of NCDs, improve cognitive functioning, and reduce symptoms of depression and anxiety. WHO guidelines on physical activity and sedentary behaviour indicate that adults should engage in at least 150 minutes of moderate-intensity aerobic physical activity, or at least 75 minutes of vigorous-intensity aerobic physical activity (or a combination of both) per week. They should also engage in muscle-strengthening activities at least twice a week and reduce the amount of time spent being sedentary.

In 2022, 30% of people aged 18 and over reported insufficient levels of physical activity across 38 OECD countries, covering activity at work, at home, for transport and during leisure time. This proportion varied from 11% in Sweden and the Netherlands to more than 50% in countries including Korea, Portugal, Japan and Costa Rica (Figure 4.16). A greater proportion of women (32%) than men (27%) reported insufficient level of physical activity on average across OECD countries. The gender gap was largest in Türkiye, Costa Rica and Chile as well as partner country India (with a difference of 16 p.p. or more).

Policy interventions aimed at improving population-level dietary habits and promoting regular physical activity have primarily consisted of public awareness and educational campaigns, nutrition labelling, and workplace- and community-based programmes. Some countries have taken action to redesign urban environments – including creating green spaces and prioritising areas for walking and cycling – to promote greater engagement in physical activity (OECD, forthcoming[2]).

Definitions and comparability

Vegetable consumption is defined as the proportion of people aged 15 and over who consume at least one portion of vegetables per day, excluding juice and potatoes, as reported in national health surveys. Data for New Zealand include potatoes. Data for Korea and New Zealand are derived from questions on the quantity of vegetables consumed each day (rather than frequency questions, e.g. over the past week). Values for these countries may therefore be overestimated. In some countries (e.g. Portugal), data exclude vegetable soup, which may underestimate consumption (see the weblink to metadata in the “Reader’s guide”).

The indicator on consumption of sugary soft drinks refers to the proportion of people aged 15 and over who consumed an SSB during the previous day or night. These include soda, energy drinks and sports drinks. The source of the data is the Global Diet Quality Project/Gallup World Poll.

The indicator on prevalence of insufficient physical activity among adults aged 18 and over refers to the proportion of the population that engages in less than 150 minutes of moderate-intensity physical activity per week, or less than 75 minutes of vigorous-intensity physical activity per week, or equivalent. The source of the data is the WHO Global Health Observatory (crude estimates). These estimates are based on self-reported physical activity, and cover activity at work, at home, for transport and during leisure time, and therefore estimates may differ from national sources.

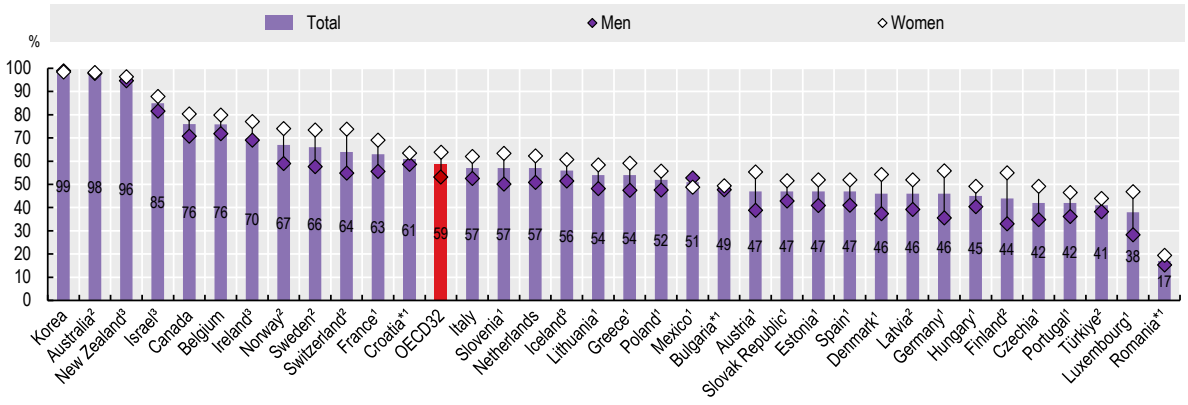
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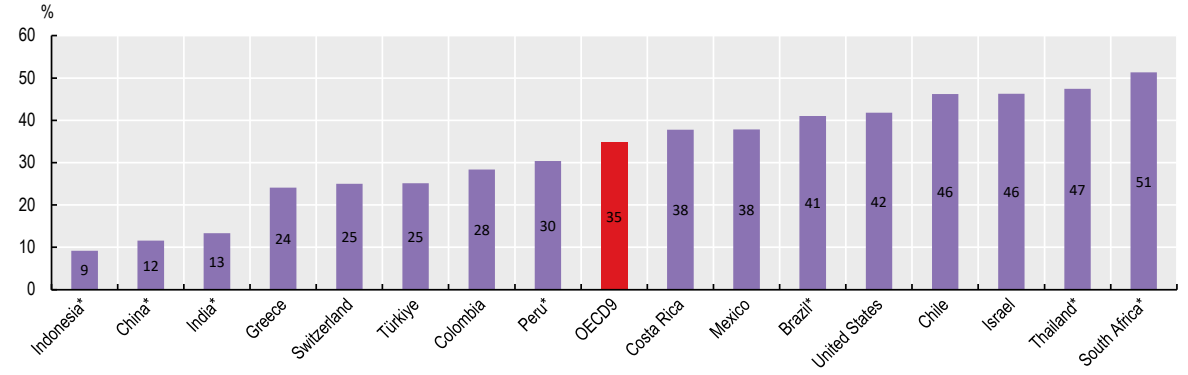
Figure 4.14. Daily vegetable consumption among people aged 15 and over, 2023 (or nearest year)



1. 2019-2020 data. 2. 2021-2022 data. 3. 2024 data. * Accession/partner country.
Source: OECD Health Statistics 2025.

StatLink https://stat.link/by8j19

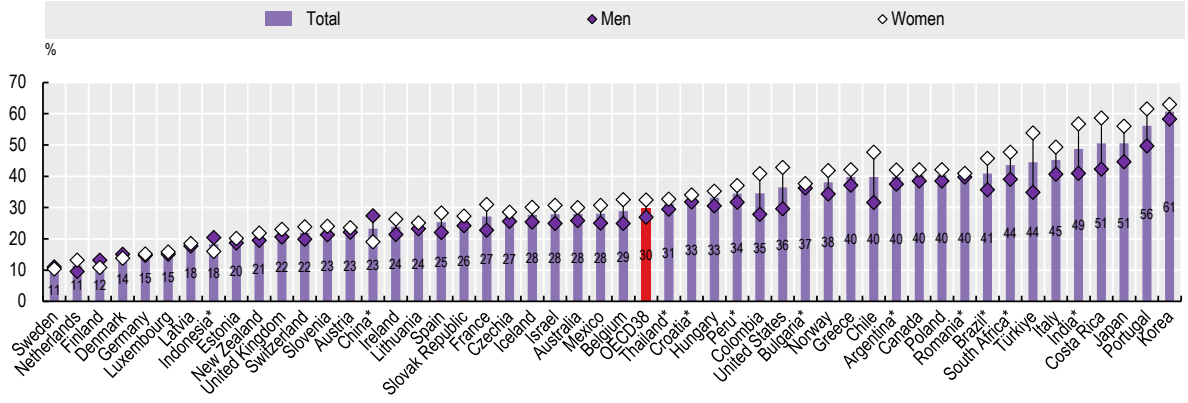
Figure 4.15. Daily consumption of sugary soft drinks among people aged 15 and over, 2023 (or nearest year)



* Accession/partner country.
Source: Global Diet Quality Project (2023), https://www.dietquality.org/.

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Figure 4.16. Insufficient physical activity among adults, 2022



* Accession/partner country.
Source: WHO (2022[3]), Global Health Observatory.

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Nutrition and physical activity among adolescents

Nutrition and physical activity are at the heart of a healthy lifestyle, and are associated with health outcomes during childhood and adulthood. A healthy diet and regular physical activity can reduce the risk of developing chronic conditions such as obesity, type 2 diabetes and cardiovascular conditions. Global recommendations for children and adolescents include daily intake of fruit and vegetables (with quantity varying by age, such as at least 400 grammes for those aged 10 and over), and engaging in at least one hour of moderate-to-vigorous physical activity each day as well as vigorous and strengthening activities at least three days a week (WHO, 2023[1]; WHO, 2020[2]).

On average across OECD countries, the proportion of adolescents reporting at least one hour of moderate-to-vigorous physical activity daily has remained globally unchanged since 2014, with only 15% of 15-year-olds meeting these daily guidelines (Figure 4.17). During this period, the proportions of adolescents achieving physical activity recommendations have increased in seven OECD countries and declined (by over 3 p.p.) in four OECD countries. In 2022, over 20% of adolescents met the recommended levels of physical activity in Canada, Finland and Hungary, compared to less than 10% in Italy and Israel.

An overview of physical activity trends among adolescents aged 11, 13 and 15, reveals persistent disparities between girls and boys across all age groups and over time. The proportion of boys achieving physical activity recommendations is 1.6 times higher than that of girls on average across all three periods.

Eating habits have generally improved over time. On average across OECD countries, the share of adolescents who do not eat vegetables daily decreased from 68% to 64% between 2014 and 2022 (Figure 4.18). More than half of OECD countries reported a decline (by over 3 p.p.) in not consuming vegetables over this period; however, in half of OECD countries, more than two-thirds of adolescents still do not eat vegetables daily.

Prevalence rates of daily consumption of SSBs among adolescents have decreased over time in 22 out of 28 OECD countries. Countries including the Netherlands, Poland and Spain exhibit the largest decreases. In 2022, 13% of adolescents reported daily consumption of SSBs, compared to 18% in 2014 on average across OECD countries (Figure 4.19). However, prevalence rates have increased in a few countries – notably in Finland, where the proportion of adolescents consuming SSBs daily has doubled since 2014, while remaining among the lowest across OECD countries.

To address unhealthy lifestyles, OECD countries have implemented a range of policy interventions focussed on improving health information and education, increasing healthier choices, and restricting the promotion of unhealthy choice options. In 2019, a vast majority of OECD countries had a school-based programme in place to educate children on nutrition and/or physical activity, and 24 OECD countries had set mandatory nutrition guidelines for food providers in schools (OECD, 2019[3]). Enabling healthier lifestyles for children and adolescents requires a multi-setting approach that extends beyond schools, to include local communities and public spaces. For example, the Netherlands introduced the National *Jongeren op Gezond Gewicht* (JOGG) initiative in 2010 – a multisectoral, community-based strategy aimed at creating healthier environments for children and adolescents. Evaluations show that JOGG can effectively improve children's health behaviours and contribute to reducing overweight and obesity rates (OECD, 2022[4]). Several countries have taken steps to limit children's and adolescents' exposure to unhealthy food marketing. Recently, the United Kingdom introduced legislation to restrict advertising of foods high in fat, sugar and salt on television during certain hours of the day as well as online. This measure aims to improve children's diet and help prevent diet-related chronic conditions, such as obesity.

Definitions and comparability

Data come from the HBSC study (available at https://data-browser.hbsc.org/). Since 1993/94, the HBSC survey has collected data every four years on physical activity and nutritional habits among adolescents aged 11, 13 and 15 years old across European countries and several other countries. Data for Belgium refer to the unweighted average of the French- and Flemish-speaking regions. Data for the United Kingdom refer to the weighted average for England, Scotland and Wales. The data presented focus specifically on those aged 15.

Moderate-to-vigorous physical activity refers to exercise undertaken for at least an hour each day that increases the heartbeat and sometimes leaves a child out of breath. Nutrition data refer to not consuming any vegetables daily and of daily consumption of sugary soft drinks. Survey questions on fruit and vegetable intake do not explicitly exclude juices, soups or potatoes.

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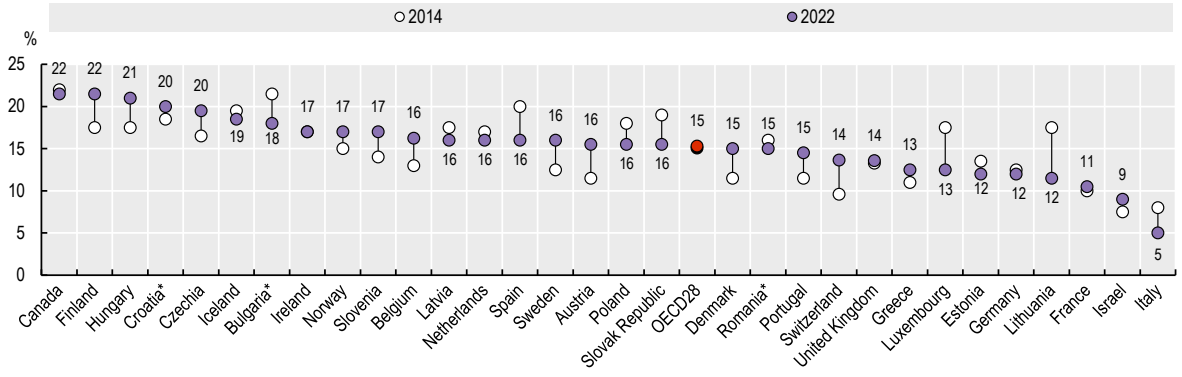
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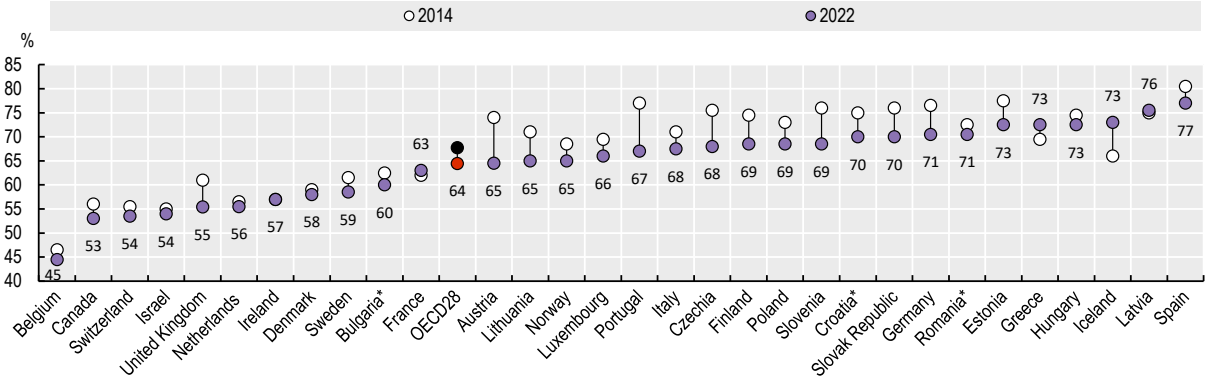
Figure 4.17. Share of 15-year-olds reporting at least one hour of moderate-to-vigorous physical activity daily, 2022 and 2014



* Accession/partner country.
Source: HBSC Data Browser.

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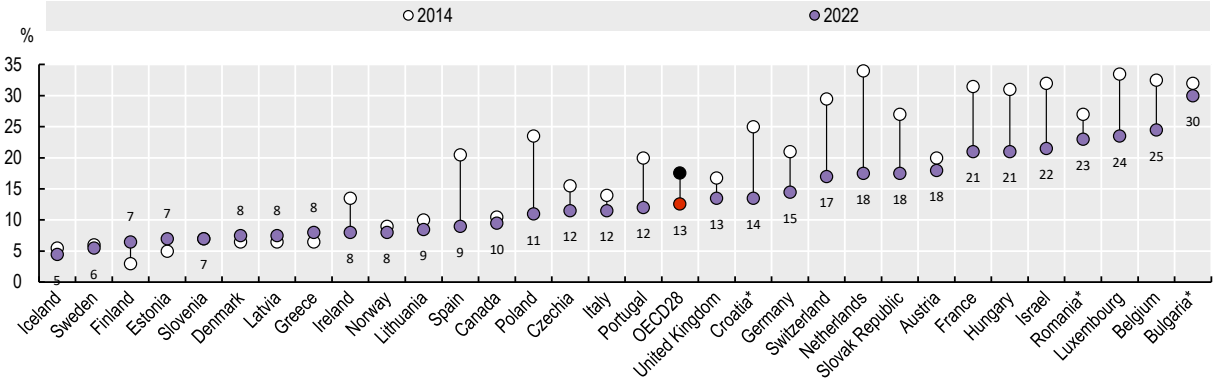
Figure 4.18. Share of 15-year-olds not consuming any vegetables daily, 2022 and 2014



* Accession/partner country.
Source: HBSC Data Browser.

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Figure 4.19. Share of 15-year-olds consuming sugary soft drinks daily, 2022 and 2014



* Accession/partner country.
Source: HBSC Data Browser.

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Overweight and obesity

Overweight and obesity are among the leading risk factors of the growing NCD burden globally. Individuals who are overweight or obese have a higher risk of developing type 2 diabetes, cardiovascular diseases, fatty liver disease, certain forms of cancer, and dementia. The burden of obesity on life years is considerable. Projections indicate that by 2050 there will be around 92 million premature deaths from obesity-related diseases in OECD, G20 and European Union (EU) countries (OECD, 2019[1]). Obesity rates correlate with socio-economic gradients, placing lower-income individuals at higher risk – partly due to the exposure to obesogenic environments that encourage consumption of energy-dense foods, trans-fats and saturated fats, and sedentary lifestyles.

Across 32 OECD countries that collect self-reported body height and weight data, obesity rates have increased over the past two decades. Between 2003 and 2023, the proportion of the population with obesity increased from 13% to 19% on average across OECD countries (Figure 4.20). The countries that experienced the highest growth in obesity rates over this period are Chile, Finland and the United States as well as accession country Brazil (exceeding a 10 p.p. difference). Conversely, the countries with the lowest increases (a 1-2 p.p. difference) are Czechia, Iceland, Portugal and Spain. Obesity rates increased rapidly between 2013 and 2023 in Australia, Chile, Finland, the Netherlands and Norway, with faster growth than during 2003-2013.

More than half of people aged 15 and over in OECD countries were overweight or obese in 2023. On average across 32 OECD countries with self-reported height and weight data available, 54% of the population aged 15 and over were overweight or obese, and 19% were obese in 2023 or in the latest available year (Figure 4.21). Men were more likely than women to be overweight or obese in all countries, except in Chile where the gender difference is minimal. The gender gap was particularly large in Czechia, Germany, Iceland, Korea, Luxembourg and Switzerland as well as accession country Bulgaria, averaging around 18-20 p.p.

Measured height and weight data provide a more accurate and reliable indication of the rates of overweight and obesity across countries despite an incomplete data set. Across the 13 OECD countries with measured data, 60% of people aged 15 and over were overweight or obese, and 26% were obese in 2023 or in the latest available year (Figure 4.22). In 11 OECD countries, over 50% of those aged 15 and over were overweight or obese. In countries including Finland, Mexico and the United States, this proportion reached 70% or more. Conversely, in Japan and Korea, less than 40% of the population was overweight or obese. Across countries, men consistently tended to be more likely to be overweight or obese compared to women, with a few exceptions like Mexico and accession country Peru. The gender gap was particularly wide in Canada, Hungary, Ireland and Korea.

OECD Member countries have made increasing policy efforts to address the growing public health concern associated with overweight and obesity. Recognising that obesity accounts for approximately 8% of total health expenditure and 3.3% of gross domestic product (GDP) across OECD countries, countries have stressed the necessity for urgent intervention (OECD, 2019[1]). Some of the most effective and widely used initiatives consist of mass media and educational campaigns, nutritional labelling, taxes on energy-dense food and sugary soft drinks, and regulatory agreements with the food industry aimed at improving the nutritional value of products. Equally important to note is the rapid advance of novel obesity drugs, such as glucagon-like peptide-1 receptor agonists (GLP-1 RAs). Originally developed for diabetes, these drugs have proven effectiveness for weight reduction and potential benefits for obesity-related comorbidities, though their long-term effects are not yet known. An increasing number of OECD countries are considering their inclusion as part of national obesity management strategies (OECD, forthcoming[2]).

Definitions and comparability

Overweight is defined as having an abnormal or excessive accumulation of fat, which presents a risk to health. The most frequently used measure is body mass index (BMI), which is a single number that evaluates an individual's weight in relation to height (dividing weight in kilogrammes by height in metres squared). Based on WHO classifications, adults over the age of 18 with a BMI greater than or equal to 30 are defined as being obese, and those with a BMI greater than or equal to 25 as being overweight (including obesity). The method for calculating BMI is the same for men and women and for adults of all ages.

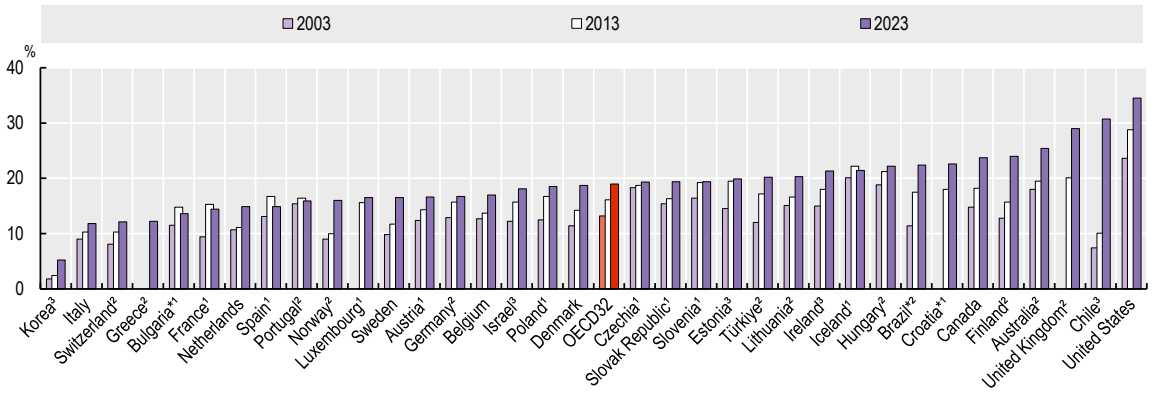
BMI data can also be collected using self-reported estimates of body height and weight. While BMI estimates based on self-reported data are easy to obtain and calculate, making it a useful tool for studying weight status at the population level, these estimates are typically lower and less reliable than those based on measured data. Data refer to 2023 or the nearest available year back to 2019 (see the weblink to metadata in the "Reader's guide"). Most countries report data for the population aged 15 and over, but there are some exceptions (see the weblink to metadata in the "Reader's guide").

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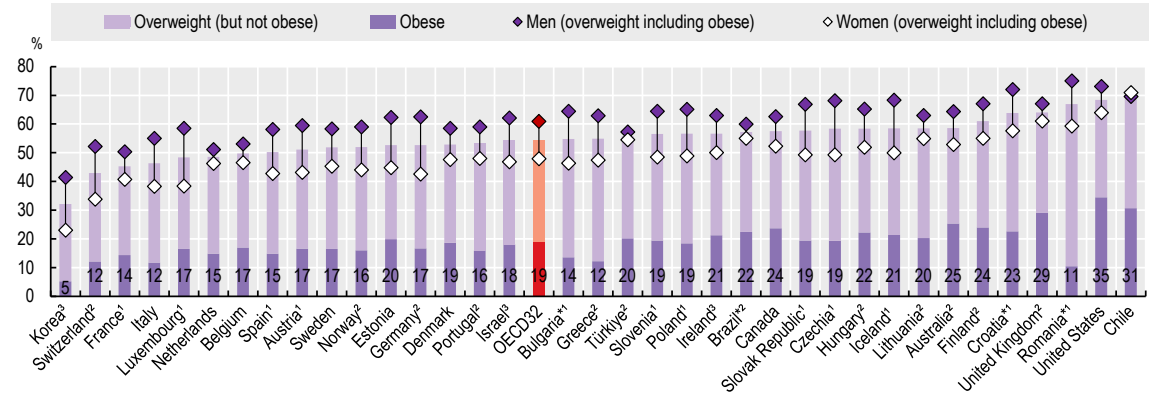
Figure 4.20. Trends in self-reported obesity rates among people aged 15 and over



1. Latest data from 2019-2020. 2. Latest data from 2021-2022. 3. Latest data from 2024. * Accession/partner country.
Source: OECD Health Statistics 2025.

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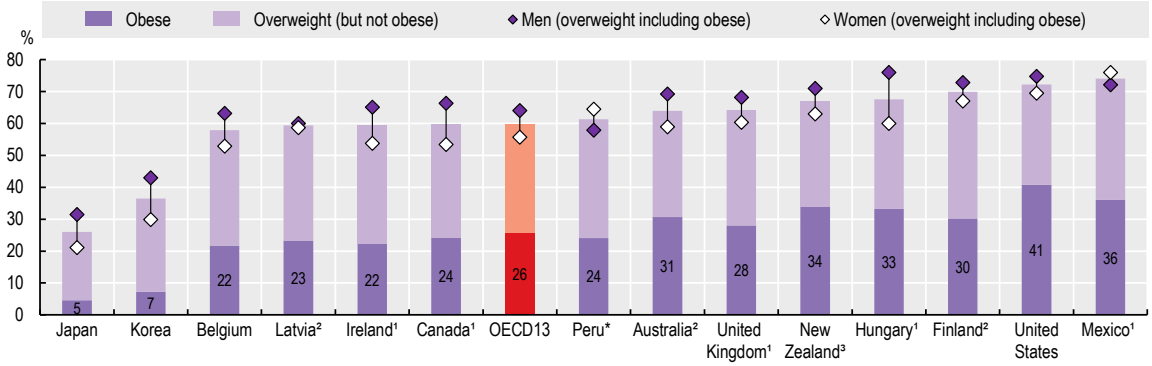
Figure 4.21. Self-reported overweight and obesity rates among people aged 15 and over, 2023 (or nearest year)



1. 2019-2020 data. 2. 2021-2022 data. 3. 2024 data. * Accession/partner country.
Source: OECD Health Statistics 2025.

StatLink https://stat.link/nkiamc

Figure 4.22. Measured overweight and obesity rates among people aged 15 and over, 2023 (or nearest year)



1. 2019-2020 data. 2. 2021-2022 data. 3. 2024 data. * Accession/partner country.
Source: OECD Health Statistics 2025.

StatLink https://stat.link/fkobnq

Overweight and obesity among adolescents

Overweight and obesity place a heavy burden on the health of children and adolescents. They are well-established risk factors for many chronic conditions – such as insulin resistance and respiratory diseases – and can be responsible for reducing life expectancy, as adverse health impacts often continue into adulthood. In recent decades, many countries have seen a rise in child and adolescent overweight and obesity rates, notably driven by changes in health behaviours – particularly poor dietary patterns and insufficient physical activity (OECD, 2019[1]).

In 2022, one in five 15-year-olds were either overweight or obese on average across OECD countries (Figure 4.23). The lowest rates were observed in the Netherlands and Denmark, where 14-15% of adolescents were overweight or obese. In contrast, the highest rates were seen in Greece, Canada and Hungary, with 25% or more of adolescents considered either overweight or obese. A marked gender difference exists: overweight and obesity are significantly more prevalent among boys (25%) than girls (16%) across all countries. Substantial gender disparities exist in some countries: the rate of overweight or obesity was at least 50% higher among boys than girls in 5 out of 27 countries.

Over time, overweight and obesity rates have increased in most countries. Between 2014 and 2022, nearly 50% of OECD countries observed an increase (by over 3 p.p.) in adolescent overweight or obesity, with the highest increases in Austria and Lithuania as well as accession country Croatia. On average across countries, between 2014 and 2022, prevalence of adolescent overweight and obesity increased from 22% to 25% in boys, and from 13% to 16% in girls.

Adolescent overweight and obesity are influenced by social determinants – particularly the socio-economic status of the family. In 2022, children and adolescents from least affluent families experienced higher rates of overweight and obesity compared to those from the most affluent families. Notable disparities persist: across OECD countries, overweight and obesity among 11-, 13- and 15-year-olds was 60% higher in the least affluent families (Figure 4.24). Countries with the largest disparities include Denmark and Belgium as well as accession country Bulgaria, where overweight and obesity prevalence was at least twice as high in the least affluent compared to the most affluent families. However, Denmark and Belgium also have lower-than-average overall prevalence of overweight and obesity.

To address adolescent overweight and obesity, many countries have opted for a range of strategies aimed at improving diet and physical activity and encouraging healthier lifestyles. In response to rising obesity rates, Ireland implemented the Obesity Policy and Action Plan 2016-2025, which consists of multi-sectoral actions – including restrictions on marketing of unhealthy foods and drinks to children, involving the commercial sector notably through food reformulation, carrying out family-focussed awareness campaigns and community-based health promotion programmes, and reinforcing primary healthcare for childhood obesity prevention and management (Department of Health, 2016[2]). France has gradually implemented a regional programme called "*Mission : retrouve ton cap*", which provides overweight and obese children and adolescents with free healthcare services and nutritional and psychology support for up to two years (Assurance Maladie, 2023[3]).

Definitions and comparability

The data come from the HBSC study (available at https://data-browser.hbsc.org/). Since 1993/94, the HBSC survey has collected self-reported data every four years on the height and weight of children and adolescents aged 11, 13 and 15 years old across European countries and several other countries. Data for Belgium refer to the unweighted average for French- and Flemish-speaking regions. Data for the United Kingdom refer to the weighted average for England, Scotland and Wales. BMI is calculated by dividing the body weight in kilogrammes by the square of the height in metres. The classification of overweight and obesity is determined using cut-off points based on the WHO growth reference for age (http://www.who.int/tools/growth-reference-data-for-5to19-years).

The indicator of socio-economic status is based on the Family Affluence Scale, which asks children and adolescents about material assets in their household.

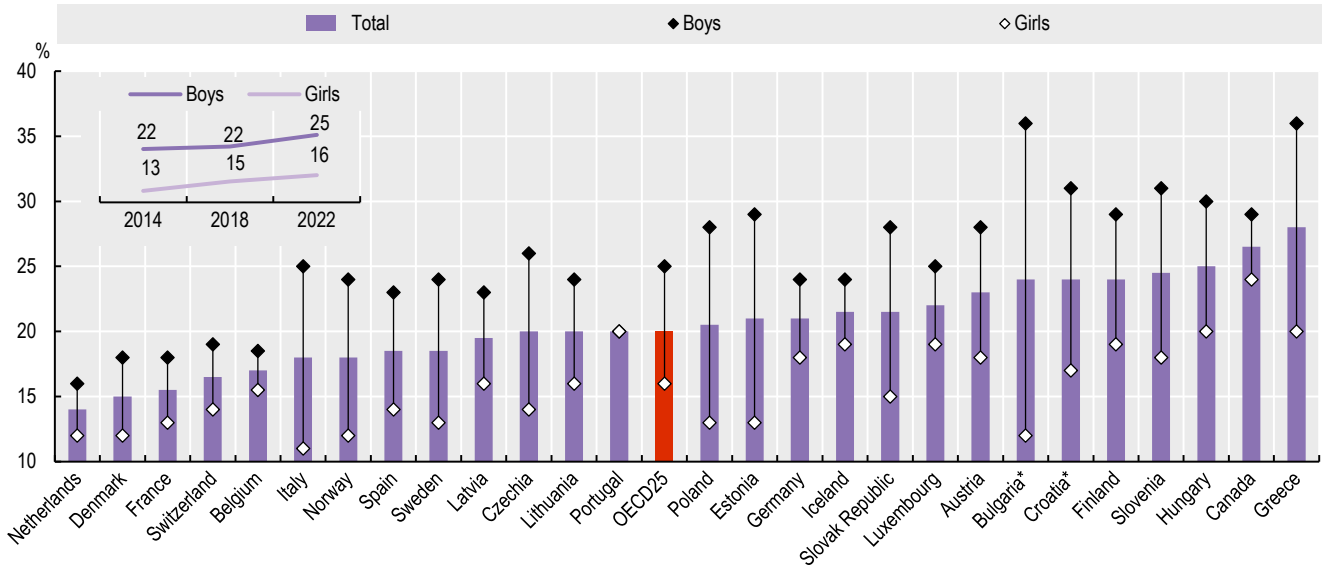
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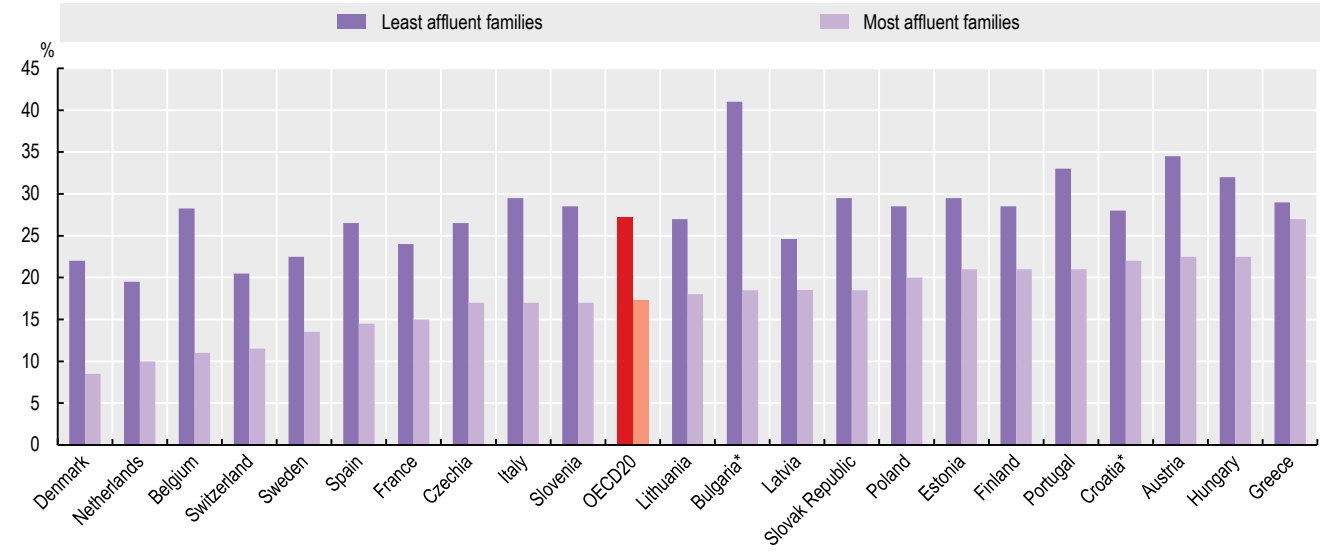
Figure 4.23. Self-reported overweight and obesity rates among 15-year-olds, 2022



* Accession/partner country. The values for boys and girls are the same in Portugal.
Source: HBSC Data Browser.

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Figure 4.24. Self-reported overweight and obesity rates among adolescents by family affluence, 2022



Note: In the survey, adolescents comprise 11-, 13- and 15-year-olds. * Accession/partner country.
Source: HBSC Data Browser.

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Environment and health

Climate change is one of the biggest challenges for present and future generations. It is linked to many different types of environmental distress, including air pollution, rising temperatures and extreme weather events. Across OECD countries, climate change is already affecting population health and well-being, and will increasingly put pressure on health systems in the years ahead. Air pollution represents a major cause of death and disability. Projections have estimated that outdoor air pollution may cause between 6 million and 9 million premature deaths a year worldwide by 2060, and may cost 1% of global GDP as a result of sick days, medical bills and reduced agricultural output (OECD, 2015[1]).

On average across OECD countries, populations were exposed to 11.2 microgrammes of fine particulate matter ($PM_{2.5}$) per cubic metre in 2020 (Figure 4.25). Only one country – Finland – had average levels of $PM_{2.5}$ pollution below the WHO air quality guidelines target of 5 microgrammes per cubic metre in 2020. Exposure to ambient outdoor particulate matter pollution declined between 2010 and 2020 in most OECD countries, by an average of 24%, although it increased in three OECD countries over this period (Australia, Chile and Japan). While policies to reduce pollution have led to some important reductions in deaths caused by air pollution in many OECD countries, exposure to ambient particulate matter remains a major environmental and public health concern: it was responsible for an estimated 4.1 million premature deaths in 2019, globally (GBD, 2019[2]).

In addition to the consequences of climate change for health outcomes, health systems themselves play an important role in greenhouse gas (GHG) emissions. New OECD analysis suggests that in 2018, healthcare-related emissions in OECD countries represented 4.4% of overall GHG emissions across the entire economy on average, amounting to more than 960 million tonnes of carbon dioxide-equivalent (CO_2-e) emissions (Figure 4.26). On average across OECD countries on a per capita basis, 523 kilogrammes of CO_2 -e emissions were related to healthcare in 2018. This average masks a 15-fold variation across countries: from 1 430 kilogrammes of CO_2-e emissions in the United States to 95 kilogrammes in Colombia.

Across the OECD and beyond, countries are increasingly recognising the role the health sector can play in reducing its environmental footprint, including its GHG emissions (OECD, 2025[3]). Transforming healthcare delivery to reduce GHG emissions – such as by promoting policies that reduce low-value care – could help to drive down GHG emissions while also helping to reduce waste in the system. National and cross-country initiatives to decarbonise supply chains and introduce green procurement standards for healthcare products and services are emerging.

Definitions and comparability

Fine particulate matter ($PM_{2.5}$) refers to tiny solid or liquid particles of less than 2.5 microgrammes in diameter, which can become airborne through combustion, industrial operations or natural processes. Transportation, industrial activities, power generation, agriculture and household heating represent key sources of $PM_{2.5}$ emissions. Data on air pollution come from the OECD Environment Directorate's dataset on air pollution exposure. Underlying data for the OECD estimates come from Global Burden of Disease air pollutant data (available at https://doi.org/10.1021/acs.est.5b03709) and Global Human Settlement Layer population data (available at https://ghsl.jrc.ec.europa.eu/data.php). The indicator on mean population-weighted exposure to ambient particulate matter can be interpreted as the annual average exposure of the average resident.

Greenhouse gas emission estimates for the health sector presented in Figure 4.26 are based on a "top-down" model that combines data from the OECD's Inter-Country Input Output (ICIO) table, the environmental extension to the ICIO table, and the JHAQ data collection on health expenditure (Doucet et al., 2025[4]). Seven families of greenhouse gases are included in this model: CO_2, methane (CH_4), nitrous oxide (N_2O), chlorofluorocarbons (CFCs), hydrofluorocarbons (HFCs), perfluorocarbons (PFCs), sulphur hexafluoride (SF_6), and nitrogen trifluoride (NF_3), with results expressed in CO_2-equivalent emissions. The model generates an estimate of the emissions related to healthcare demand for the population, with emissions allocated based on the residence of the healthcare consumer. Emissions included in the model comprise those occurring in the various health facilities themselves but also those generated in the supply of energy to facilities, emissions generated during the production of inputs used by health facilities, and the entire supply chain.

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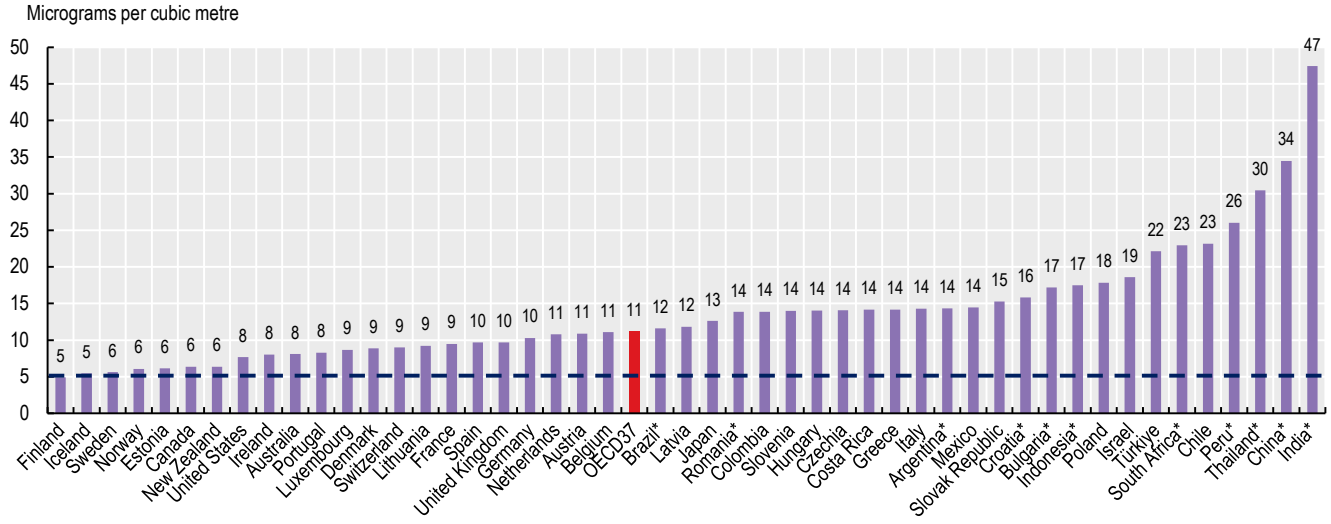
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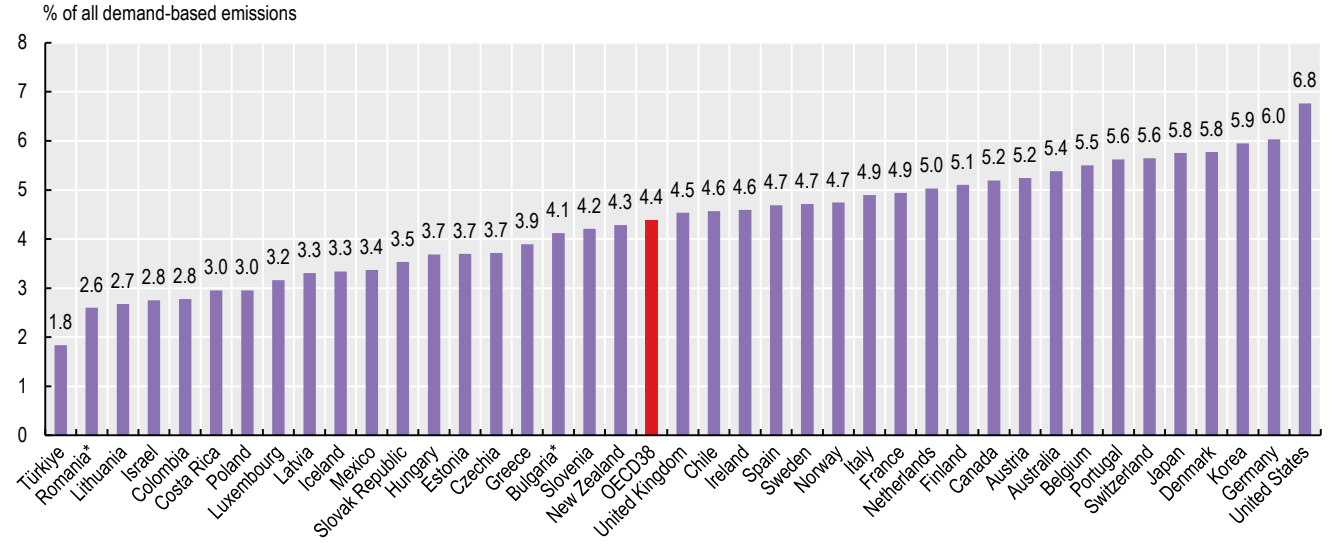
Figure 4.25. Mean population-weighted exposure to ambient particulate matter ($PM_{2.5}$), 2020



* Accession/partner country. Dashed line refers to the WHO air quality guidelines target.
Source: OECD Environment Statistics, 2025.

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Figure 4.26. Share of all greenhouse gas emissions related to healthcare demand, 2018



* Accession/partner country.
Source: Doucet et al. (2025[4]), "Measuring greenhouse gas emissions in the health sector: A new approach to model GHG emissions combining (JHAQ) health expenditure data and the multi-regional inter-country input-output (ICIO) tables", https://www.doi.org/10.1787/4d15c6ef-en; OECD (2025[3]), *Decarbonising Health Systems Across OECD Countries*, https://www.doi.org/10.1787/5ac2b24b-en.

StatLink https://stat.link/vds79j



5 Access and coverage

Population coverage for healthcare
Unmet needs for healthcare
Extent of healthcare coverage
Financial hardship and out-of-pocket expenditure
Waiting times
Physical access to services
Consultations with doctors
Hospital beds and occupancy
Hospital activity
Hip and knee replacement
Ambulatory surgery

Population coverage for healthcare

The share of a population covered for a core set of health services offers an initial indicator of access to care and financial protection. Most OECD countries have achieved universal or near-universal coverage for a core set of health services, which usually include consultations with doctors, tests and examinations, and hospital care (Figure 5.1). National health services or social health insurance have typically been the financing schemes for achieving universal health coverage. A few countries (such as the Netherlands and Switzerland) have achieved universality through compulsory private health insurance – supported by public subsidies and strong regulation on the scope and depth of coverage.

Population coverage for core services remained below 95% in four OECD countries in 2024, and was below 90% in Mexico and accession country Romania. In the United States, the share of uninsured people decreased following the Affordable Care Act, and about 25 million people were uninsured in 2023. Uninsured people tend to be working-age adults with lower education or income levels. In Ireland, although coverage is universal, fewer than half of the population are covered for the cost of all general practitioner (GP) services, but new eligibility measures introduced since 2023 have increased the proportion covered.

Beyond population coverage rates, satisfaction with the availability of quality health services offers further insight into effective coverage. The Gallup World Poll collects data on citizens' satisfaction with health and other public services. While contextual and cultural factors influence survey responses, the poll allows citizens' opinions to be compared based on the same survey question. Satisfaction with the availability of quality health services averaged 64% across OECD countries in 2024 (Figure 5.2). Swiss citizens were most likely to be satisfied (89%), while those in Greece, Türkiye, Hungary, Italy, Chile and Colombia were least likely to be satisfied (lower than 50%). While satisfaction levels have decreased on average across OECD countries over the past decade, this masks wide cross-country variation: Türkiye experienced the largest decline in satisfaction of 30 percentage points (p.p.), while Canada, France and New Zealand also had declines of over 20 p.p. Conversely, in Chile and Estonia satisfaction levels increased by 10 p.p. or more.

In many countries, citizens can purchase additional health coverage through voluntary private health insurance. This can cover any cost-sharing left after basic coverage (complementary insurance), add further services (supplementary insurance), or provide faster access or a wider choice of providers (duplicate insurance). Among 29 OECD countries with recent comparable data, nine had additional private insurance coverage for over half of the population in 2024 (Figure 5.3). Complementary insurance to cover cost-sharing is widely used in Belgium (97% of the population). Israel and the Netherlands had the largest supplementary health insurance market (over 80% of the population). Duplicate private health insurance was most widely used in Australia and Ireland. Over the last decade, the population covered by additional private health insurance has increased in 16 of 29 OECD countries with comparable data, with large increases in Belgium and Denmark (over 15 p.p.). In Slovenia, a major policy reform in 2024 replaced its complementary insurance with a new compulsory healthcare contribution as part of its social health insurance system.

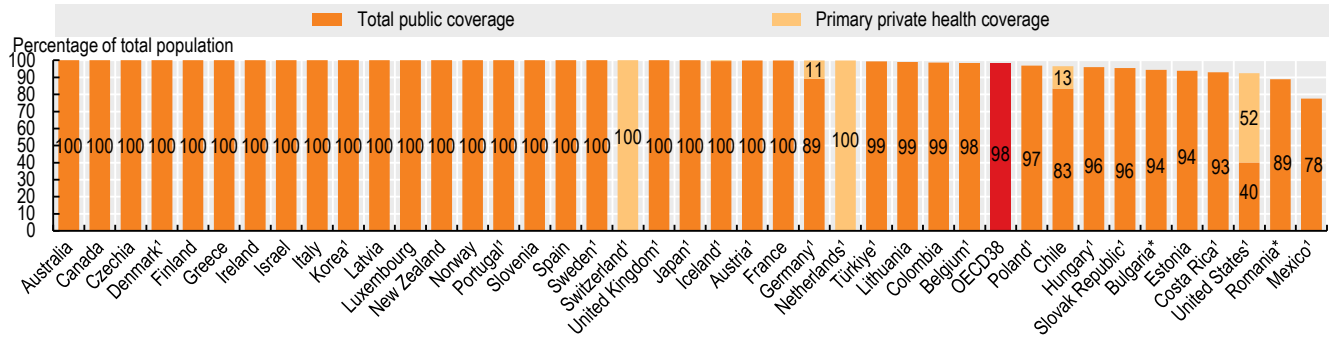
Definition and comparability

Population coverage for healthcare is defined here as the share of the population eligible for a core set of healthcare services – whether through public programmes or primary private health insurance. The set of services is country-specific, but usually includes consultations with doctors, tests and examinations, and hospital care. Note that this measure of coverage, whilst important, does not by itself guarantee access (see later sections in this chapter for data on unmet needs, financial protection and waiting times) Public coverage includes both national health systems and social health insurance. National health systems are largely financed from general taxation, whereas in social health insurance systems, financing typically comes from a combination of payroll contributions and taxation. In both, financing is linked to ability to pay.

Primary private health insurance refers to insurance coverage for a core set of services and can be voluntary or mandatory by law, for some or all of the population. Additional (secondary) private health insurance is always voluntary, with insurance premiums generally not income-related, although the purchase of private coverage may be subsidised by the government. In France, since 2016 subscription to an employer-provided complementary health insurance has been mandatory for almost all private sector employees. Voluntary health insurance numbers therefore now only include private individual complementary contracts and subsidised complementary health insurance for low-income households.

Data from the Gallup World Poll used in Figure 5.2 are generally based on a representative sample of at least 1 000 citizens in each country aged 15 and over. Respondents were asked: "In the city or area where you live, are you satisfied or dissatisfied with the availability of quality healthcare?"

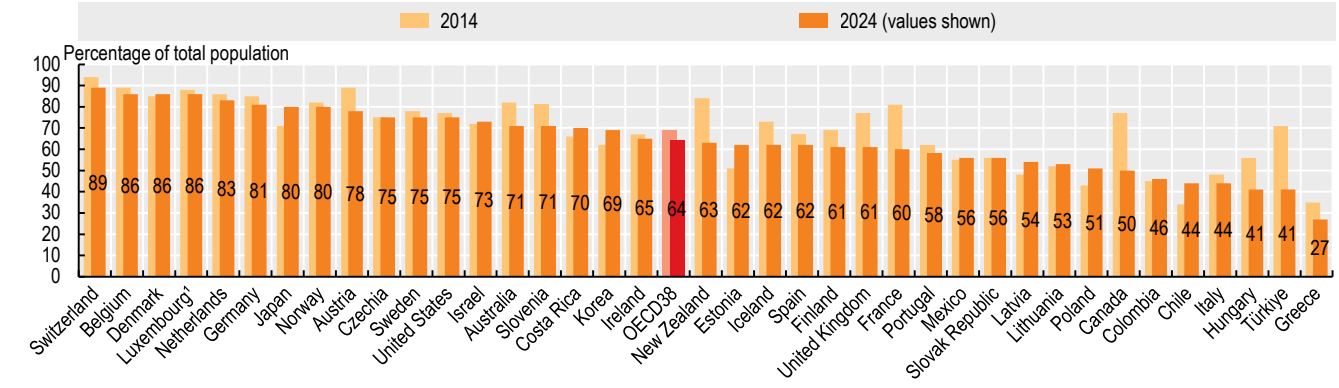
Figure 5.1. Population coverage for a core set of services, 2024 (or nearest year)



1. 2021-2023 data. * Accession/partner country.
Source: OECD Health Statistics 2025.

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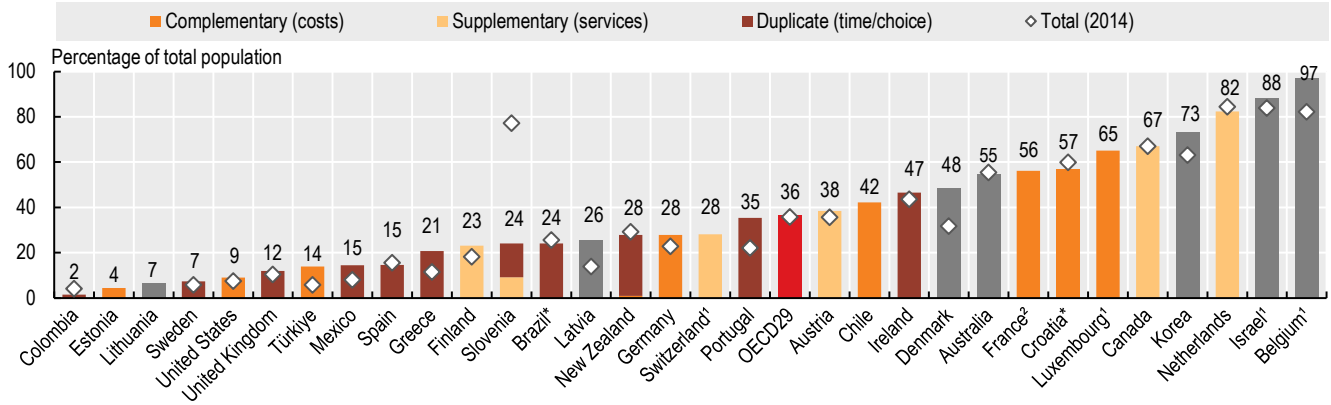
Figure 5.2. Population satisfied with availability of quality healthcare in area where they live, 2024 and 2014



1. Latest data from 2023.
Source: Gallup World Poll 2023 (database).

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Figure 5.3. Voluntary private health insurance coverage by type, 2023-2024 and 2014 (or nearest year)



Note: Data show additional (secondary) voluntary private insurance. They exclude primary private insurance coverage, which exists in Chile, Germany, Switzerland and the United States. Grey bars indicate total coverage across multiple types of insurance. 1. Latest data from 2022. 2. Latest data from 2019. * Accession country.
Source: OECD Health Statistics 2025.

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Unmet needs for healthcare

A fundamental principle underpinning all health systems across OECD countries is to provide access to high-quality care for the whole population, irrespective of their circumstances. Yet access can be limited for several reasons, including limited availability or affordability of services. Policies therefore need to ensure an adequate supply and distribution of health workers and healthcare services throughout the country, and address any financial barriers to care (OECD, 2019[1]).

On average across 28 OECD countries with comparable data, only 3.4% of the population reported that they had unmet medical care needs due to cost, distance or waiting times in 2024 (Figure 5.4). However, over 8% of the population reported unmet care needs in Latvia (8.4%), Estonia (8.5%), Finland (8.6%), Canada (9.1%) and Greece (12.1%), while in Germany, the Netherlands and Czechia, fewer than 1% of the population reported unmet needs for medical care. The main reason cited for unmet needs for medical care in most countries was waiting times, with 2.3% of people reporting this issue in 2024, on average across OECD countries. In Latvia, Estonia and Finland, more than 5% of the population cited waiting times as a barrier. Cost was also cited as an important barrier to access, and was the main reason for unmet needs in Greece, Latvia and France, with at least 2% of people reporting this issue in 2024. Distance to travel was also cited as a barrier, but less frequently than waiting times or cost.

In all OECD countries analysed, socio-economic disparities are significant (Figure 5.5). The burden of unmet needs for medical care falls disproportionally more on people in the lowest income group than those in the highest income group. People in the lowest income quintile were 2.5 times more likely to report unmet medical care needs than those in the highest quintile in 2024, on average across 28 OECD countries. The income gradient was largest in Greece, Latvia and Finland, with a difference of over 8 p.p. in the population reporting unmet needs between the lowest and highest income quintiles. In Greece, more than one in six people in the lowest income quintile reported unmet medical care needs, and in Estonia, Finland and Latvia this proportion reaches more than one in ten people in the lowest income quintile.

Reported unmet needs are generally larger for dental care than for medical care (Figure 5.6). This reflects the fact that dental care is less well covered by public schemes than medical care in most OECD countries, so people often have to pay out of pocket or purchase additional private health insurance (see section on “Extent of healthcare coverage”). More than 8% of people in Greece, Latvia and Iceland reported unmet dental care needs in 2024, compared to fewer than 1% in Germany, Hungary and the Netherlands, as well as accession country Croatia. In all countries analysed, the burden of unmet needs for dental care falls disproportionately on people with lower incomes. This was most evident in Greece, Latvia and Portugal, where more than 15% of people in the lowest income quintile reported forgoing needed dental care in 2024, compared to 5% or fewer in the highest quintile.

Unmet needs for medical care and dental care have increased in many OECD countries following the pandemic. In OECD countries analysed, unmet medical care needs across the entire population rose from 2.7% in 2019 to 3.4% in 2024. For dental care, unmet needs increased from 3.8% in 2019 to 4.1% in 2024. The main reason for the increase in unmet needs for medical and dental care were long waiting times. This is especially notable in Finland, Lithuania, Ireland, Greece, Spain and France, where unmet medical care needs due to waiting times increased by 1.4 p.p. or more since 2019. Some of these countries have introduced initiatives to reduce waiting times. Greece, for example, launched the Unified Digital List of Surgeries in 2024, to centralise state hospital surgery waiting lists into a single electronic platform, enabling real-time monitoring. In Spain, the National Health System established the Working Group on Waiting Lists (Grupo de Trabajo sobre Listas de Espera) to standardise management and reporting of waiting lists across the autonomous communities.

Definition and comparability

Questions on unmet healthcare needs are included in the EU Statistics on Income and Living Conditions (EU-SILC) survey compiled by Eurostat. People are asked whether in the previous 12 months they ever felt they needed medical care or dental care but did not receive it, followed by a question on why the need for care was unmet. The data presented here focus on three reasons: healthcare was too expensive, the distance to travel was too far, or waiting times were too long. Comparable data for Canada come from the Canadian Income Survey. Note that some other surveys of unmet needs (for example, the European Health Interview Survey) report higher rates of unmet needs. This is because such surveys exclude people without healthcare needs, while the EU-SILC survey considers the total population surveyed. In addition, the rate of unmet needs is sensitive to how the questions are worded, which can explain cross-survey differences.

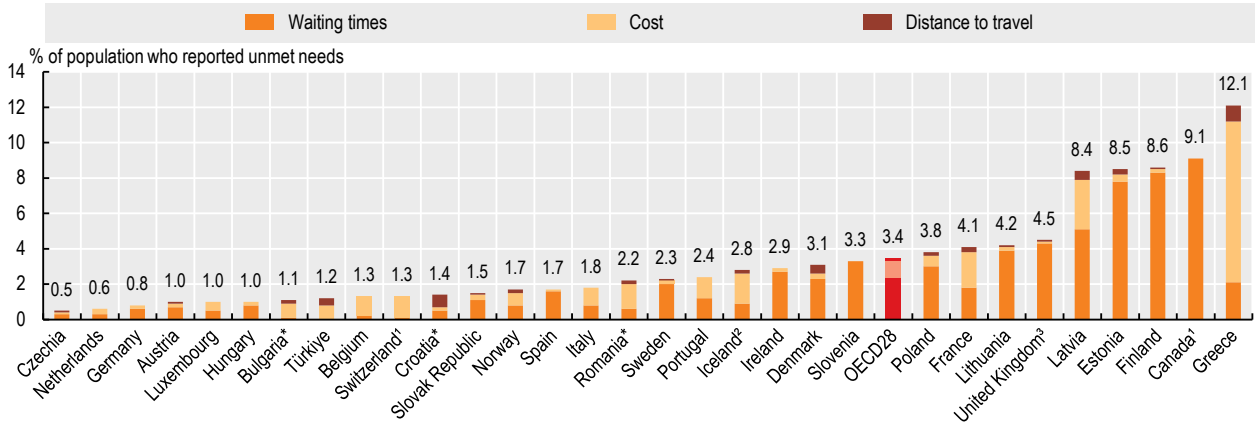
In comparing across countries, cultural factors may affect responses to questions about unmet healthcare needs. There are also some variations in the survey questions across countries: while most countries refer to both a medical examination and treatment, the question in some countries (Czechia and Spain) only refers to a medical examination or a doctor consultation, resulting in lower rates of unmet needs.

Income quintile groups are computed based on the total equivalised disposable income attributed to each household member. The first quintile represents the 20% of the population with the lowest income, and the fifth quintile the 20% of the population with the highest income.

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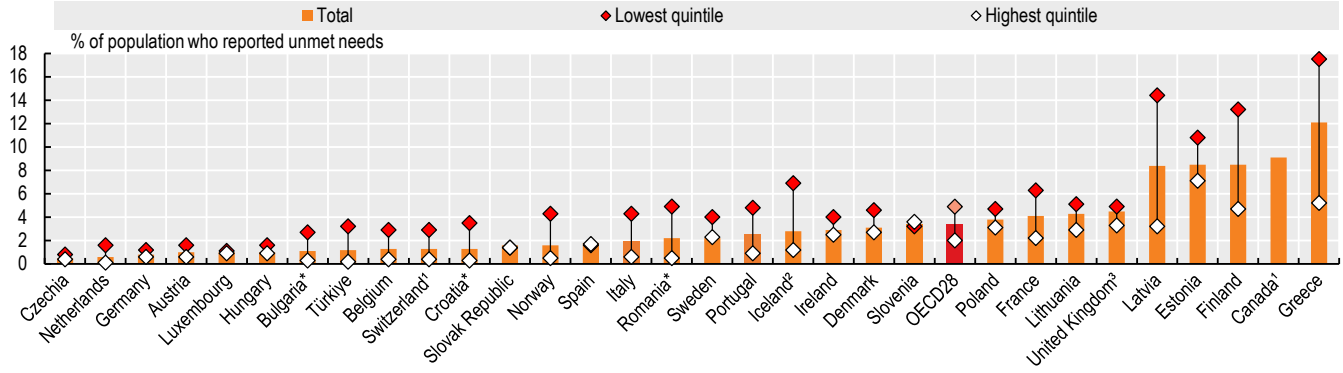
Figure 5.4. Population reporting unmet needs for medical care, by main reason, 2024



Note: Data for Canada are not broken down by reason. * Accession/partner country. 1. 2023 data. 2. 2020 data. 3. 2018 data.
Source: Eurostat, based on EU-SILC and the 2023 Canadian Income Survey.

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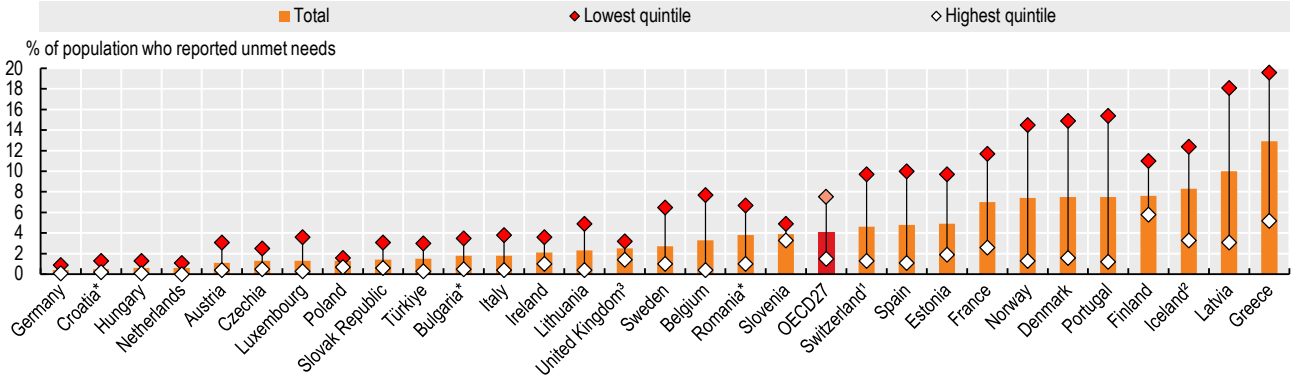
Figure 5.5. Population reporting unmet needs for medical care, by income level, 2024 (or nearest year)



* Accession/partner country. 1. 2023 data. 2. 2020 data. 3. 2018 data.
Source: Eurostat, based on EU-SILC and the 2023 Canadian Income Survey.

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Figure 5.6. Population reporting unmet needs for dental care, by income level, 2024 (or nearest year)



* Accession/partner country. 1. 2023 data. 2. 2020 data. 3. 2018 data.
Source: Eurostat based on EU-SILC.

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Extent of healthcare coverage

In addition to the share of the population entitled to core health services, the extent of healthcare coverage is defined by the range of services included in a publicly defined benefits package and the proportion of costs covered. Differences across countries in the extent of coverage can be the result of specific goods and services being included or excluded in the publicly defined benefits package, different cost-sharing arrangements or some services only being covered for specific population groups in a country.

On average across OECD countries, around three-quarters of all healthcare costs were covered by government or compulsory health insurance schemes in 2023 (see section on "Health expenditure by financing scheme" in Chapter 7), but financial protection is not uniform across all types of healthcare goods and services. In nearly all OECD countries, inpatient services in hospitals were more comprehensively covered than any other type of care, with 89% of all costs borne by government or compulsory insurance schemes in 2023 (Figure 5.7). In many countries, patients have access to free acute inpatient care or only need to make a small copayment; as a result, coverage rates were near 100% in Sweden, Norway, Iceland and Estonia, as well as accession country Romania. In Greece and Korea, financial coverage for the cost of inpatient care from public sources was only around two-thirds of total costs.

Nearly four out of every five dollars spent (78%) on outpatient medical care in OECD countries were paid by government and compulsory insurance schemes. Financial coverage for outpatient care was under 60% in Latvia, Israel, Portugal, Italy and Korea. In Latvia and Portugal, patients are increasingly seeking alternatives to the public system through private providers, with significant increases in duplicative voluntary health insurance between 2013 and 2023 to cover these costs (see section on "Population coverage for healthcare"). In contrast, government and compulsory insurance schemes paid over 90% of these costs in Czechia, the Slovak Republic, Sweden, Germany, Denmark and the United Kingdom. In some of these countries, outpatient primary and specialist care are generally free at the point of service, but user charges may still apply for specific services or if non-contracted private providers are consulted. For example, in Czechia, almost all health services are free at the point of use, except for a small fee for out-of-hours outpatient care.

Public coverage for the cost of dental care is far more limited across OECD countries due to restricted service packages (frequently limited to children) and higher levels of cost-sharing. On average, less than one-third of dental care costs were borne by government schemes or compulsory insurance (Figure 5.7). Services with poor public coverage are targets for the involvement of financial and non-healthcare corporate actors in the ownership and operation of services. In recent years, the dental care sector has been notably affected by these actors. In Spain, for example, the share of practices run by dental service organisations (that handle the business side of dental practices) in dental markets doubled between 2015 and 2018 (Suzuki et al., 2025[1]).

Coverage for pharmaceuticals is also typically less comprehensive than for inpatient and outpatient care. The most generous coverage was found in France (83%), Germany (82%) and Ireland (79%). On the other hand, this share was less than two-fifths in Canada, Poland and Chile. In Canada, over one-third of all pharmaceutical spending was financed via voluntary health insurance schemes in 2023, while in Chile and Poland, out-of-pocket payments financed 65% of pharmaceutical spending or more (see section on "Pharmaceutical expenditure" in Chapter 9).

Definition and comparability

Healthcare coverage is defined by the share of the population entitled to services, the range of services included in a benefits package and the proportion of costs covered by government schemes and compulsory insurance schemes. Coverage provided by voluntary health insurance and other voluntary schemes such as charities or employers is not considered. The core functions analysed here are defined based on definitions in the System of Health Accounts 2011 (OECD/Eurostat/WHO, 2017[2]). Hospital care refers to inpatient curative and rehabilitative care (which is mainly provided in hospitals); outpatient medical care to all outpatient curative and rehabilitative care excluding dental care; and pharmaceuticals to prescribed and over-the-counter medicines, including medical non-durables. In some countries spending on dental care cannot be identified separately and is included under outpatient medical care.

Comparing the shares of the costs covered for different types of services is a simplification. For example, a country with more restricted population coverage but a very generous benefits package may display a lower share of coverage than a country where the entire population is entitled to services but with a more limited benefits package.

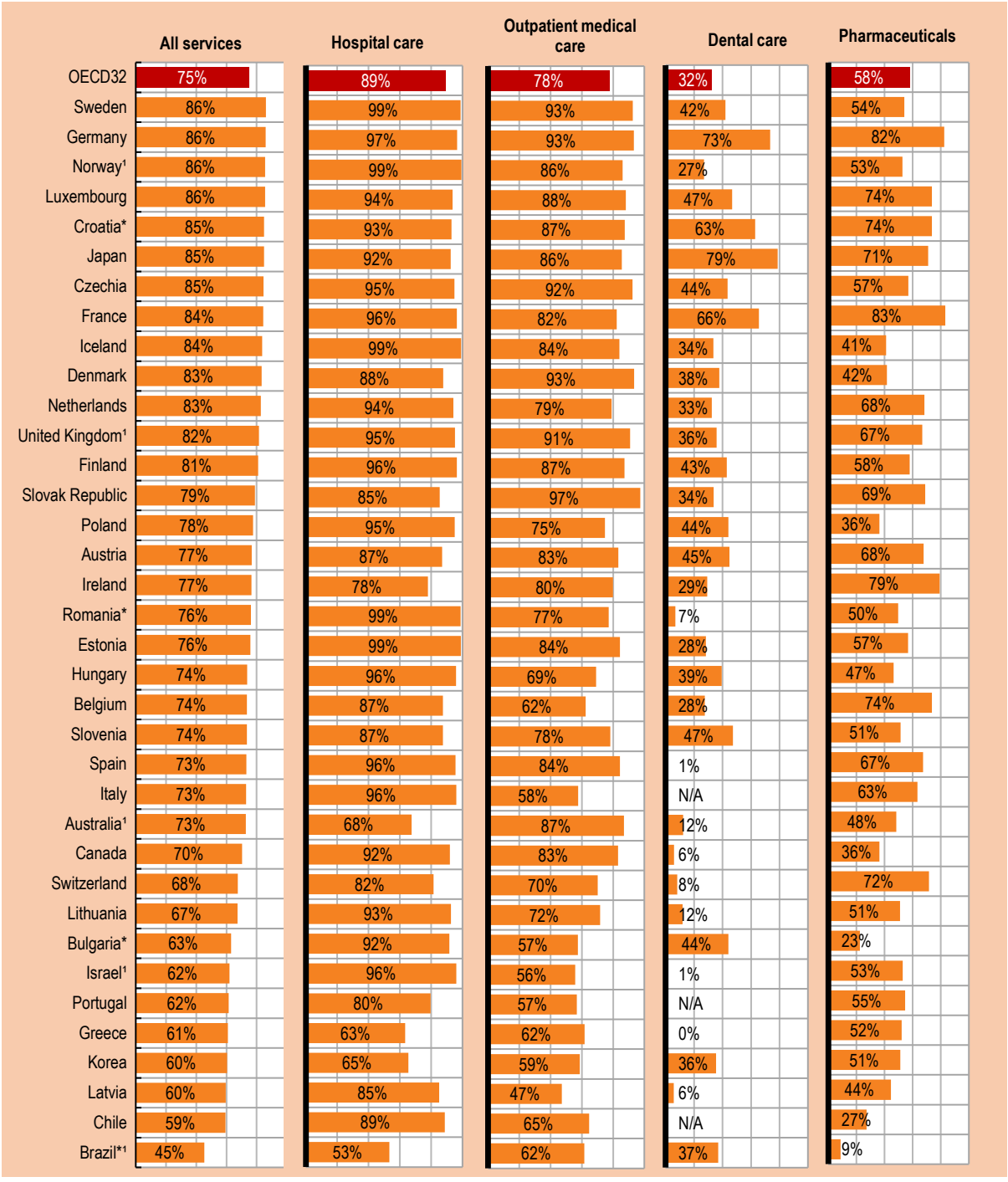
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Figure 5.7. Extent of financial coverage, 2023 (or nearest year)

Government and compulsory insurance spending as proportion of total health spending by type of care



Note: Coverage of pharmaceuticals for Israel calculated using spending on medical goods (non-specified by function). * Accession/partner country. 1. Latest available data from 2022.
Source: OECD Health Statistics 2025.

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Financial hardship and out-of-pocket expenditure

Health systems provide adequate financial protection when payments for healthcare do not cause people financial hardship. A lack of financial protection can reduce access to healthcare, undermine health status, deepen poverty, and exacerbate health and socio-economic inequalities. Poorer households and those who must pay for long-term treatment – such as medicines for chronic conditions – are particularly vulnerable. Whilst out-of-pocket (OOP) payments for healthcare often have a significant role in financing health systems, financial protection is weakened if a health system is over-reliant on OOP payments. On average across OECD countries, just under one-fifth of all spending on healthcare comes directly from patients through OOP payments (see section on "Health expenditure by type of financing" in Chapter 7).

The share of household consumption spent on healthcare provides an aggregate assessment of the financial burden of OOP expenditure. Across OECD countries in 2023, 3.2% of total household spending was on healthcare goods and services. The share was less than 2% in Poland, Luxembourg, Colombia and Türkiye, but stood above 5% in Switzerland, Korea and Chile (Figure 5.8).

Health systems in OECD countries differ in the degree of coverage for different health goods and services (see section on "Extent of healthcare coverage"). Pharmaceuticals and other medical goods are the main driver of household spending, accounting for 41% of OOP spending on health on average in 2023 (Figure 5.9). In Mexico, the Slovak Republic and Poland, pharmaceuticals accounted for over 60% of OOP spending. Outpatient care accounted for 22% of household spending on healthcare on average, but was especially high in Belgium (43%), Italy (48%) and Portugal (52%) where cost-sharing arrangements for outpatient care are common. Dental care represented 16% of OOP spending on health, and long-term care made up 13% in 2023. Inpatient care played only a minor role (8%) in the composition of OOP spending in OECD countries, except in Greece (34%), which reflects outlays for privately provided hospital services.

The indicator most widely used to measure financial hardship associated with OOP payments for households is the incidence of catastrophic spending on health (Cylus, Thomson and Evetovits, 2018[1]). This varies considerably across OECD countries, from fewer than 2% of households experiencing catastrophic health spending in Sweden, Slovenia, the United Kingdom, Ireland and the Netherlands, to over 10% of households in Lithuania, Latvia and Hungary (Figure 5.10). Across all countries, the poorest households (those in the lowest consumption quintile) are most likely to experience catastrophic health spending, even though many countries have put in place policies to safeguard financial protection.

The incidence of catastrophic spending is closely connected to a health system's reliance on OOP payments. Countries can reduce their reliance on OOP payments by increasing public spending on health; however, policy choices around coverage are also important. Population entitlement to publicly financed healthcare is a prerequisite for financial protection, but not a guarantee of it. Countries with a low incidence of catastrophic spending on health mitigate the negative impact of user charges through better copayment policies, for example via exemptions for people on low incomes and annual caps on payments. Moreover, ensuring that primary care is part of the benefits package is also likely to reduce financial hardship (WHO Regional Office for Europe, 2023[2]). For example, in Portugal the elimination of flat rate charges for primary care and publicly prescribed services may have contributed to the reduction of the incidence of catastrophic health spending in recent years.

Definition and comparability

OOP payments are expenditures borne directly by a patient where neither public nor private insurance cover the full cost of the health good or service. They include cost-sharing and other expenditure paid directly by private households, and should also ideally include estimations of informal payments to health providers. For countries that are not able to identify spending on dental care separately, this is typically reported under outpatient care, which affects the composition of OOP spending.

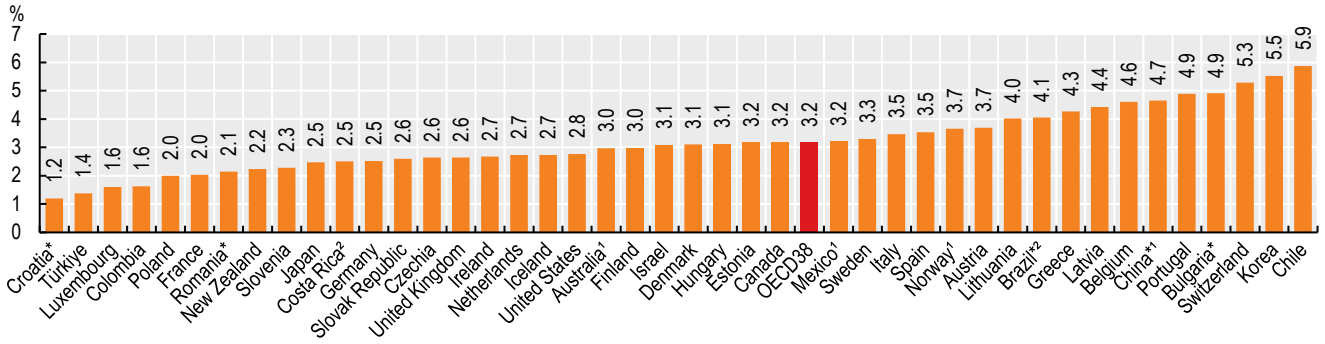
Catastrophic health spending is an indicator of financial protection used to monitor progress towards universal health coverage. It is defined here as OOP payments that exceed a pre-defined percentage of the resources available to a household to pay for healthcare. Household resources available can be defined in different ways, leading to measurement differences. In the data presented here, these resources are defined as household consumption minus a standard amount representing basic spending on food, rent and utilities (water, electricity, gas and other fuels). The threshold used to define households with catastrophic spending is 40%. Microdata from national household budget surveys are used to calculate this indicator.

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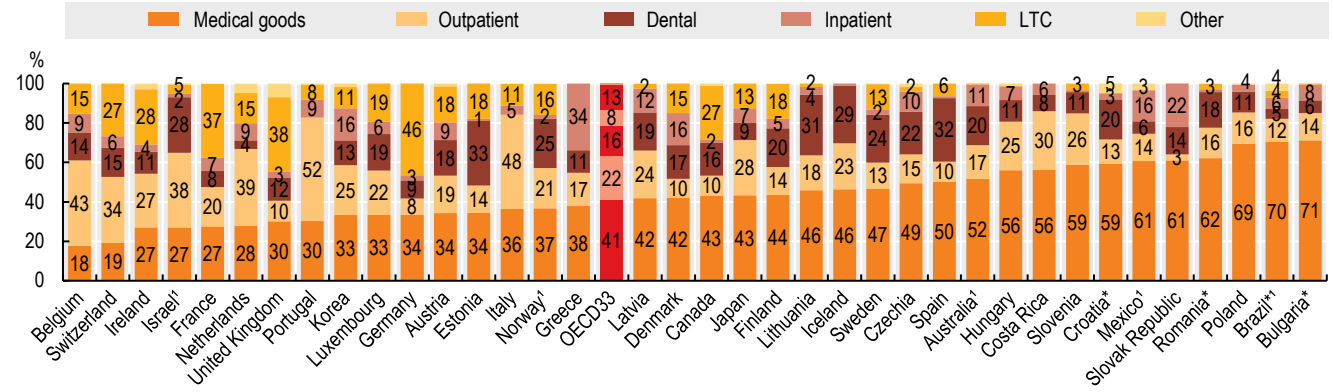
Figure 5.8. Out-of-pocket spending as a share of final household consumption, 2023 (or nearest year)



* Accession/partner country. 1. 2022 data. 2. 2021 data.
Source: OECD Health Statistics 2025, OECD National Accounts Database.

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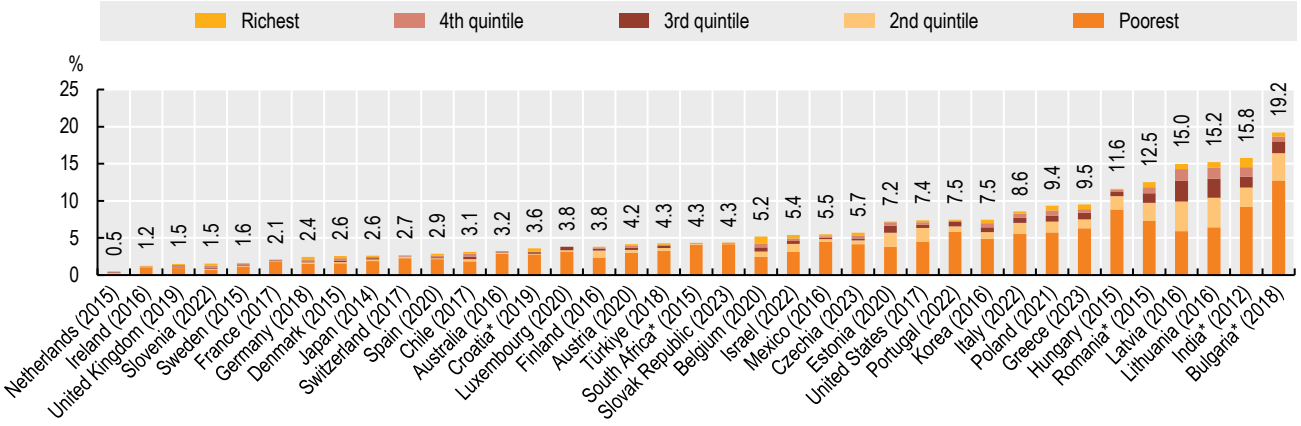
Figure 5.9. Composition of out-of-pocket spending on health, by type of service, 2023 (or nearest year)



Note: The "Medical goods" category includes pharmaceuticals and therapeutic appliances. LTC refers to long-term care. The "Other" category includes preventive care, administrative services and services unknown. * Accession/partner country. 1. 2022 data.
Source: OECD Health Statistics 2025.

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Figure 5.10. Share of households with catastrophic health spending by consumption quintile, latest year available



* Accession/partner country.
Source: WHO Regional Office for Europe 2023, UHC Watch 2025.

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Waiting times

Long waiting times for different types of healthcare have been a longstanding issue in a number of OECD countries. Postponing the expected benefits of treatment means that patients continue living with pain and disability for longer than they need to, and may worsen health outcomes for patients after the intervention.

Figure 5.11 and Figure 5.12 focus on two high-volume elective (non-emergency) surgical procedures: cataract and hip replacement surgery. For cataract surgery, in 2024 the share of patients waiting more than three months (Figure 5.11, left panel) ranged from less than 20% in Poland and Hungary, to over 70% in Finland and Norway (although waiting times in Norway are overestimated compared to other countries for this and other surgical procedures – see the "Definition and comparability" box). In terms of median number of days (Figure 5.11, right panel), this ranged from around 50 days or less in Spain, Poland, Hungary and Sweden, to 280 days in Slovenia.

Prior to the pandemic, most countries saw improvements in waiting times. Following large increases during the pandemic, waiting times have returned or started to return to pre-pandemic levels in most countries. However, in New Zealand and Slovenia, waiting times have continued to increase on both metrics since the pandemic. In recent years, Poland has seen considerable reductions in waiting times. These improvements were driven by increased funding through the National Health Fund for cataract, hip and knee replacement surgery since 2019.

For hip replacement surgery, the shares of patients waiting more than three months are broadly similar to those for cataract surgery, but median times are typically much longer (Figure 5.12). In 2024, median waiting times ranged from 67 days in Sweden and Spain, to over half a year in Hungary (209 days), Chile (313 days), Poland (343 days), and almost two years in Slovenia (667 days). Furthermore, waiting times have remained above pre-pandemic levels in more countries, with large increases observed in Slovenia. Poland is again an exception, with large reductions in waiting times compared to 2019. Knee replacement surgery figures (not shown) show similar trends to hip replacements, though waiting times on both measures are typically higher.

Across different types of elective surgery, research has shown that the volume of patients treated will often have to be substantially higher than recent levels to return fully to pre-pandemic levels, especially in light of growing demand due to population ageing (Siciliani and Lafortune, forthcoming[1]).

Commonwealth Fund Survey data provide complementary data on waiting times to see primary care providers (GPs or nurses) and specialists. Some OECD countries have maximum waiting time targets for primary care – typically between 24 hours and 7 days – alongside prioritisation of patients with severe conditions (OECD, 2020[2]). Yet on average across ten surveyed countries, almost one in five people (18%) reported waiting more than a week to see a GP or a nurse, and over half (57%) waited two days or longer, with waiting times longest in Canada, New Zealand and France (Figure 5.13, left panel). For specialists, on average just over half of respondents (52%) had to wait one month or longer for an appointment. In Canada and the United Kingdom, more than 10% reported having to wait for more than a year (Figure 5.13, right panel).

Definition and comparability

Two measures of waiting times for elective procedures are presented in this section: waiting times from specialist assessment to treatment, reporting data on the share of patients waiting more than three months; and waiting times of patients who are still on the list at a given point in time, showing the median number of days. Compared to the mean, the median is lower as it minimises the influence of outliers – patients with very long waiting times. Waiting times are overestimated in Norway because they start from the date a doctor refers a patient for specialist assessment for the treatment, whereas in other countries they start only when a specialist has assessed the patient and decided to add them to the waiting list for the treatment. Data come from administrative databases. Patients who refuse to receive the procedure on several occasions are generally removed from the list.

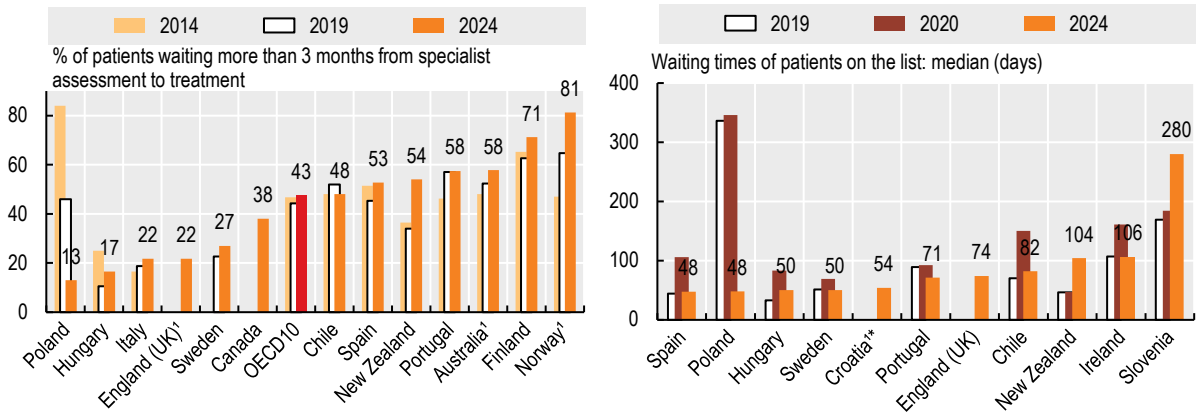
The Commonwealth Fund International Health Policy Survey asks respondents aged 18 and over how long they had to wait. For primary care, respondents were asked: "Last time you were sick or needed to see a doctor or a nurse, how quickly could you get an appointment?" For appointments with specialists, respondents were asked: "After you were advised to see or decided to see a specialist, how long did you have to wait for an appointment?" Irrelevant responses were excluded from the calculation. Note that these cross-country comparisons may be explained in part by differences in health system characteristics, but also the subjective nature of questions, and in some countries sample sizes were small.

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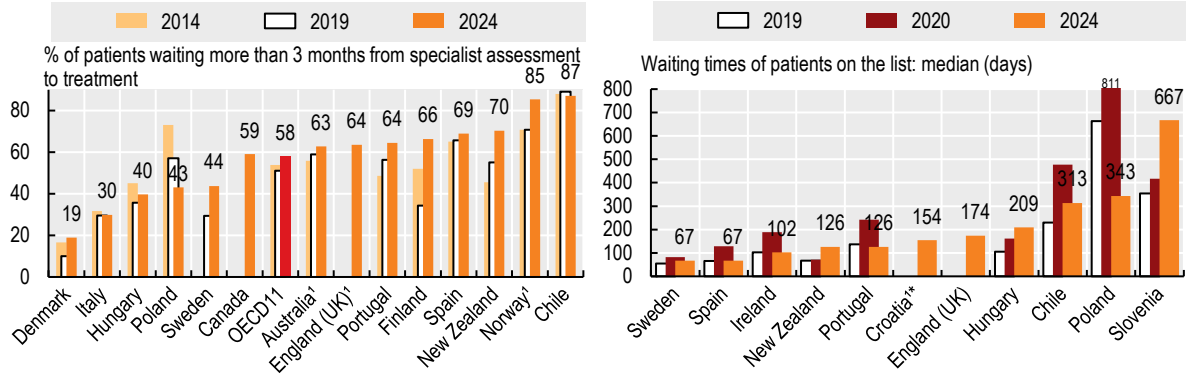
Figure 5.11. Waiting times for cataract surgery



Note: OECD average based on 10 countries with all years available. 1. Latest data from 2022-2023. * Accession/partner country.
Source: OECD Health Statistics 2025.

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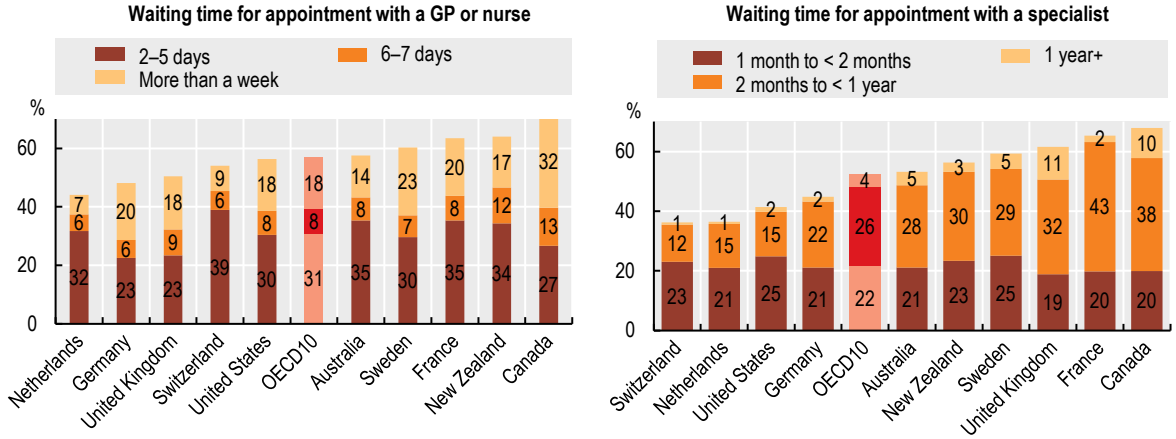
Figure 5.12. Waiting times for hip replacement surgery



Note: OECD average based on 11 countries with all years available. 1. Latest data from 2022-2023. * Accession/partner country.
Source: OECD Health Statistics 2025.

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Figure 5.13. Waiting times for appointment with a GP or nurse, or a specialist, 2023



Note: Data include teleconsultations and exclude visits to hospital emergency departments.
Source: Commonwealth Fund 2023 International Health Policy Survey.

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Physical access to services

People, wherever they live, should have sufficient access to health professionals and healthcare facilities. Yet shortages in certain regions can lead to unequal physical access to healthcare, which can lead to unmet needs (see section on "Unmet needs for healthcare"). Countries have tackled this issue for many years, in particular implementing policies to incentivise more doctors to work in remote and sparsely populated areas.

In terms of availability of doctors, on average across 18 OECD countries in 2023, there were 5.0 doctors per 1 000 population in metropolitan areas, compared to 3.2 per 1 000 in remote areas (Figure 5.14). In Lithuania, while there were 6.6 doctors per 1 000 population in metropolitan areas, there were only two doctors per 1 000 in remote areas. There were also two or less doctors per 1 000 population working in remote areas in Türkiye and Poland. In general, doctors were more evenly distributed across regions in Belgium, Japan and Korea.

In Portugal, where there was also a marked difference between metropolitan and remote areas, more disaggregated data show that doctors were mostly centralised in the metropolitan area of Lisbon, with much lower distribution in remote localities (see section on "Doctors (overall number and distribution) in Chapter 8). In order to address this accessibility issue, the Portuguese Government implemented various policies, including the launch of "More Doctors in 2024", which incentivises young medical professionals who choose to practise in hospitals in less densely populated areas with salary and housing incentives (OECD/European Observatory on Health Systems and Policies, 2023[1]). In Japan, where regional disparities in doctors are small, 16% of all medical students are from a regional quota scholarship programme. Recent research shows a higher retention rate among students from this programme, compared to other medical graduates. They are also more likely to work in rural hospitals afterwards, and less likely to specialise in urban-concentrated fields such as dermatology and ophthalmology (Matsumoto et al., 2021[2]).

Regarding physical access to hospitals, differences between rural areas and cities were also marked. On average across 14 OECD countries in 2023, while almost all the population living in cities were within a 45-minute drive of a hospital, 17% of the rural population had to drive more than 45 minutes to reach their nearest hospital (Figure 5.15). The difference was largest in Norway and Sweden, where almost everyone living in cities had easy physical access to a hospital, while among those living in rural areas, only 57% in Norway and 66% in Sweden were within 45 minutes' drive of a hospital. In Norway, accessibility issues are specifically highlighted for specialist appointments. For example, more than 80% of patients waited for more than three months for cataract surgery in 2024, which was the highest among 13 OECD countries with comparable data (see section on "Waiting times").

In Greece, even for those located in cities, 15% of the population lived far from a hospital, and this increased to 43% in rural areas. Indeed, Greece reported the highest share of the population reporting unmet needs due to distance to travel among 28 OECD countries, with costs and waiting times also important barriers (see section on "Unmet needs for healthcare"). Disparities were smallest in Czechia, France and Japan, where more than 98% of people in rural areas had access to hospitals nearby. In France, a system of hospital care at home (*l'hospitalisation à domicile*) enables patients to receive continued care at home, even for complex cases.

Definition and comparability

Regions are classified in two territorial levels. The higher level (Territorial level 2) consists of large regions corresponding generally to national administrative regions. These broad regions may contain a mix of metropolitan regions and more rural and remote areas. The lower level (Territorial level 3) is composed of smaller regions classified as metropolitan regions (defined as regions with a population of over 250 000), regions located near a metropolitan region, and more remote regions (defined as regions far from metropolitan areas and regions near small urban areas with a population of fewer than 250 000). All data on geographic distributions come from the OECD Regional Database, which includes data from the Eurostat Database for Territorial level 2.

The access to hospitals indicator was estimated using point of interest data, a 1-kilometre resolution population (GHS-POP 2020) and degree of urbanisation (GHS-SMOD 2020) grids and the Mapbox Isochrone API (OECD, 2024[3]). The indicator was calculated on whether a hospital was within reach of a 45-minute drive for each region.

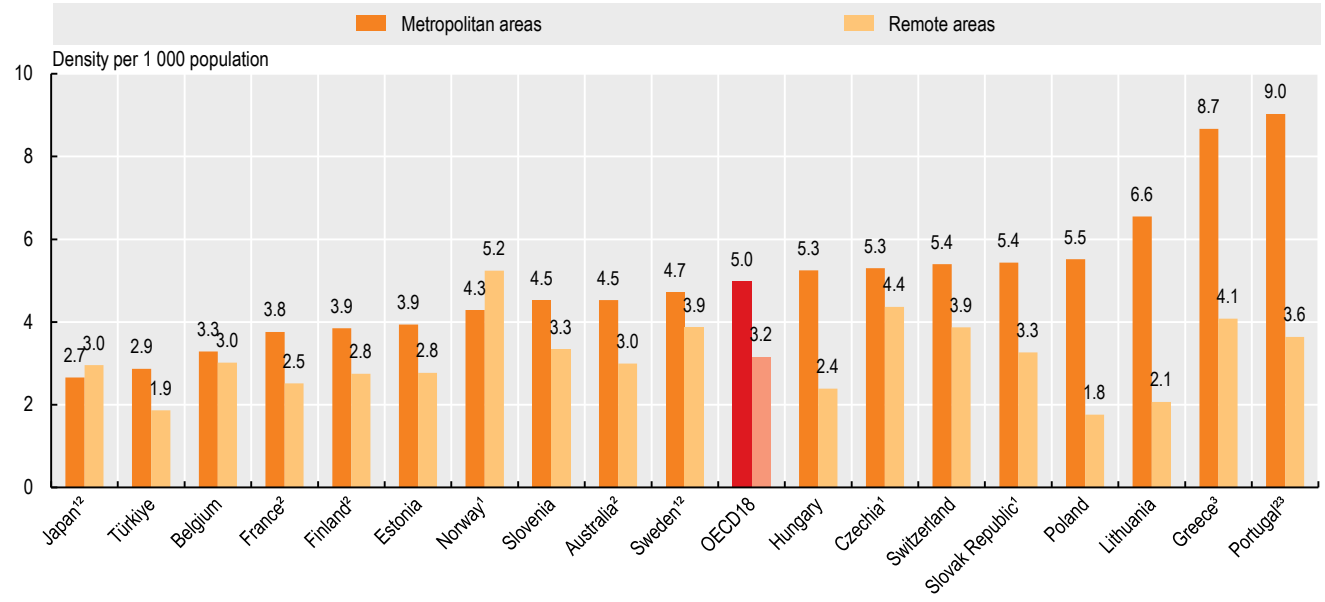
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OECD/European Observatory on Health Systems and Policies (2023), *Portugal: Country Health Profile 2023*, State of Health in the EU, OECD Publishing, Paris, https://doi.org/10.1787/069af7b1-en. [1]

Figure 5.14. Physician density, metropolitan and remote areas, 2023-2024 (or nearest year)

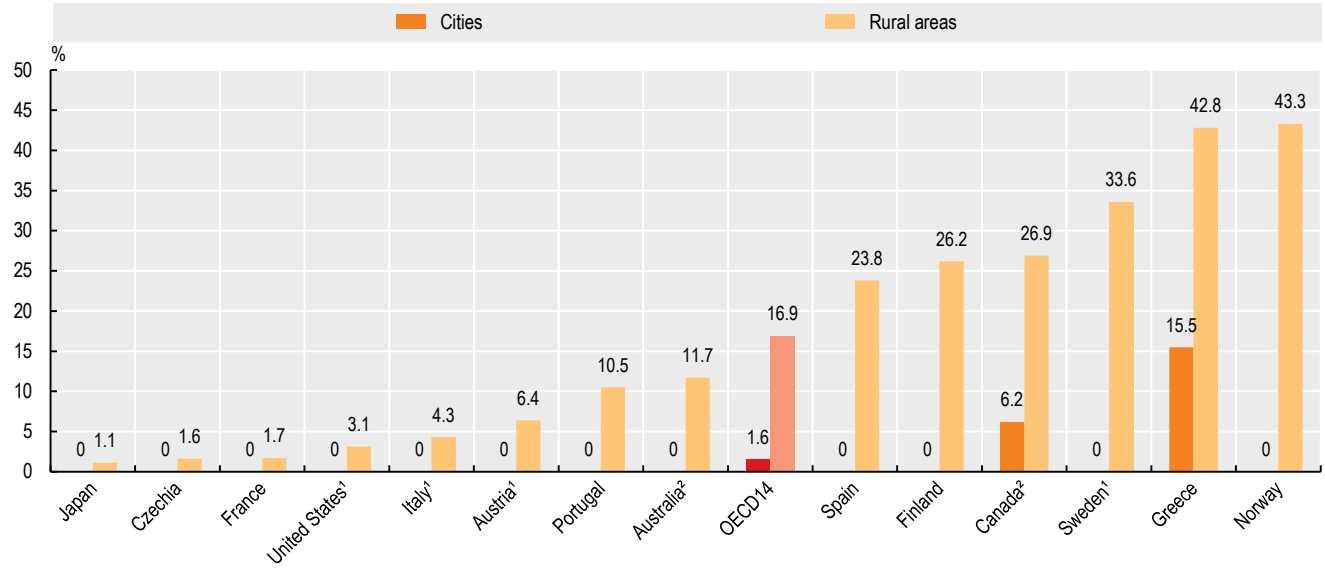


1. Data from the nearest region type used to fill missing data. 2. 2021-2022 data. 3. Data refer to all doctors licensed to practise, resulting in a large over-estimation of the number of practising doctors.
Source: OECD Regional Database 2025.

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Figure 5.15. People unable to reach a hospital within 45 minutes' drive, by locality, 2023

Access to hospitals in regions far from a functional urban area of 250K people or more (small regions, TL3) in 2023 by degree of urbanisation, population-weighted averages



1. 2020-2021 data. 2. 2018-2019 data.
Source: OECD Regional Database 2025.

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Consultations with doctors

Consultations with primary care doctors are for many people the most frequent contact with health services, and often provide an entry point for subsequent medical treatment. Consultations take place in doctors' clinics, community health centres, hospital outpatient departments or, in some cases, patients' own homes. Increasingly, teleconsultations are offered to patients, whereby consultations take place online, often through video calls.

In 2023, the average number of annual in-person doctor consultations per person among OECD countries ranged from fewer than 3 in Mexico, Costa Rica, Sweden and Greece to 18 in Korea (Figure 5.16). The OECD average was 6.5 consultations per person per year. In Canada, Finland, Sweden, the United Kingdom and the United States, the relatively low number of consultations can be explained in part by the enhanced role that nurses and other health professionals play in primary care – notably in management of patients with chronic diseases and in dealing with patients with minor health issues. This lessens the need for doctor consultations (Brownwood and Lafortune, 2024[1]).

The number of in-person consultations has decreased in 21 of 31 OECD countries since 2019. This can be attributed in part to increased use of teleconsultations in recent years. Indeed, in 2023, 13% of all doctor consultations were teleconsultations, on average across 22 OECD countries with comparable data (Figure 5.17). Teleconsultations comprised over 25% of all doctor consultations in Denmark, Estonia, Israel, Portugal and Sweden, but remained very low in Chile, Germany, Greece and Korea (see the section on "Data and digital" in Chapter 9 for trends in teleconsultations).

Provider payment methods and levels of co-payments have an impact on the number of doctor consultations. In some countries, doctors are paid predominantly by fee-for-service (as in Germany, Japan, Korea and the Slovak Republic). Such countries tend to have higher consultation rates than those countries where doctors are mainly paid by salaries or capitation (such as Denmark, Finland, Mexico and Sweden). Still, in the United States, doctors are paid mainly by fee-for-service, but consultation rates are relatively low. This may reflect in part the high co-payments faced by a large proportion of the population, which can cause patients to not consult a doctor because of the cost of care.

The number and type of doctor consultations can vary among different socio-economic groups. Wealthier individuals are more likely to see a doctor than individuals in the lowest income quintile, for a comparable level of need. Income inequalities in accessing doctors are much more marked for specialists than for GP consultations (OECD, 2019[2]).

Information on the number of doctor consultations per person can be used to estimate the annual number of (in-person) consultations per doctor. This indicator should not be taken as a measure of doctors' productivity, since consultations vary in length and effectiveness, and because it excludes services doctors deliver for hospital inpatients, as well as time spent on research and administration. Keeping these comparability issues in mind, the estimated number of consultations per doctor is highest in Korea, while Japan and Türkiye also reported high numbers of over 4 500 in 2023 (Figure 5.18). In Korea, this can be explained in part by short consultation times, allowing doctors to treat more patients per session, and seen by the government as a way of keeping waiting times low, with most patients able to receive primary medical care on the same day, even without an appointment. Numbers were lowest in Greece and Sweden. In Sweden, consultations with doctors in both primary care and hospital settings tend to be focussed on patients with more severe and complex cases.

Definition and comparability

In-person consultations with doctors refer to the number of face-to-face contacts with physicians, including both generalists and specialists. There are variations across countries in the coverage of different types of consultations – notably in outpatient departments of hospitals. Data come mainly from administrative sources, although in some countries (including Ireland, the Netherlands, New Zealand and Switzerland) they come from health interview surveys. Data from administrative sources tend to be more accurate (and higher) than those from surveys because of problems with recall and non-response rates.

Figures for the Netherlands exclude contacts for maternal and childcare. In Germany, data include only the number of cases of physician treatment according to reimbursement regulations under the country's social health insurance scheme (a case only counts the first contact over a three-month period, even if the patient consults a doctor more often, leading to an underestimation). Portugal and Spain exclude (all or part of) consultations at a private physician's office. Remote consultations cannot be distinguished and are included in a few countries (such as Austria from 2020, and Ireland, Japan, Latvia, the Netherlands, the Slovak Republic and Spain from 2019).

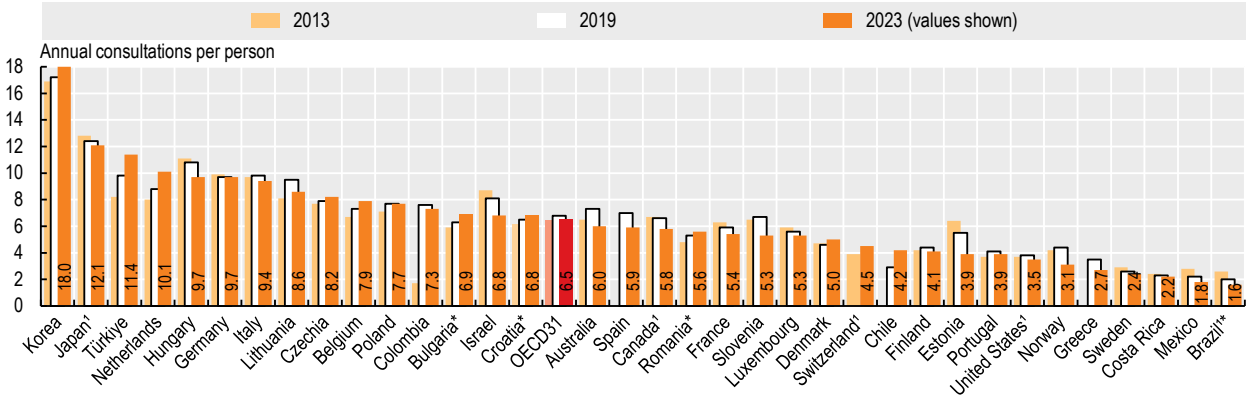
The breakdown between in-person consultations and teleconsultations was provided by 20 OECD countries. Teleconsultations cover remote consultations with both generalist and specialist medical practitioners. They cover all technologies used (notably phone or virtual calls), but Denmark excludes email consultations. Data cover public and private providers, except for Spain, which excludes consultations in a private physician's office, and Chile and Israel, which provide data for public providers only.

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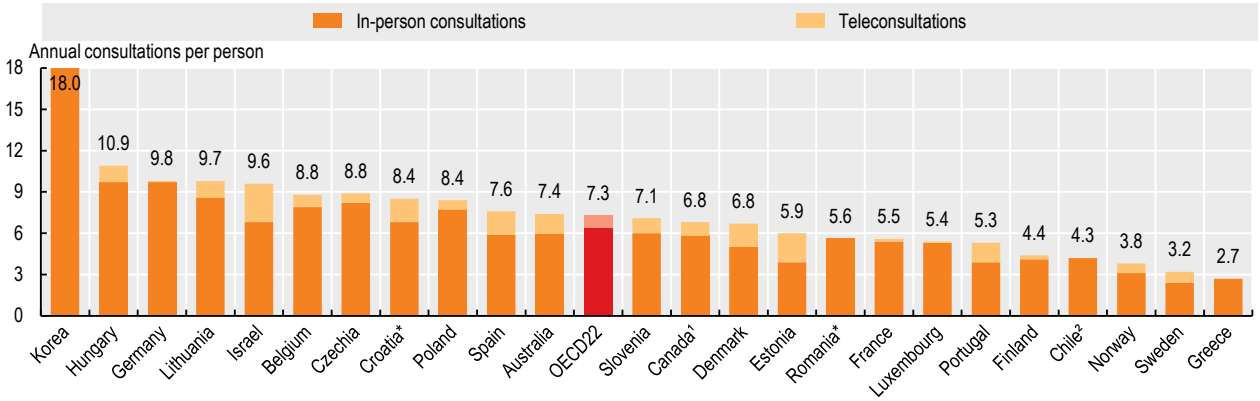
Figure 5.16. In-person doctor consultations per person, 2023, 2019 and 2013 (or nearest year)



1. Latest data from 2021-2022. In some countries, data from 2014-2015 used for earliest year, due to data breaks. * Accession/partner country.
Source: OECD Health Statistics 2025.

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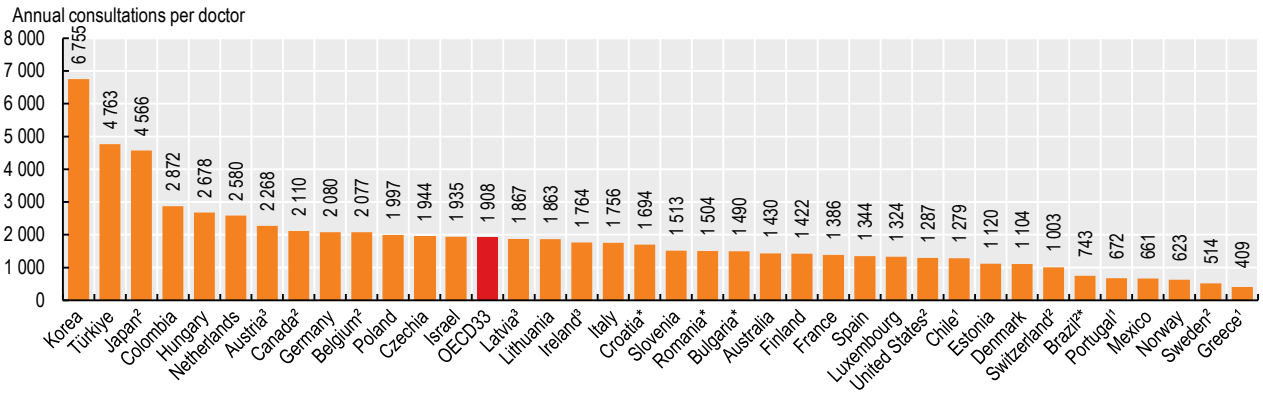
Figure 5.17. Doctor consultations, in-person vs. remote, 2023 (or nearest year)



1. 2022 data. 2. Public sector only. * Accession/partner country.
Source: OECD Health Statistics 2025.

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Figure 5.18. Estimated number of in-person consultations per doctor, 2023 (or nearest year)



1. Data for denominator include all doctors licensed to practise, results therefore may be an underestimate. 2. 2021-2022 data. 3. 2019 data. * Accession/partner country.
Source: OECD Health Statistics 2025.

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Hospital beds and occupancy

The COVID-19 pandemic highlighted the need to have sufficient hospital beds and flexibility in their use, to address any unexpected surge in demand for intensive care. Still, adequate staffing was more of a pressing constraint than bed numbers (OECD, 2023[1]). Further, a surplus of hospital beds may lead to overuse and therefore costs, as many patients can be treated effectively on a same-day basis in hospitals or primary healthcare facilities. Therefore, a balance needs to be found between ensuring sufficient bed capacity and value-for-money considerations.

Across OECD countries, there were on average 4.2 hospital beds per 1 000 population in 2023 (Figure 5.19). Rates were much higher in Korea (12.6 beds per 1 000) and Japan (12.5 per 1 000). Over two-thirds of OECD countries reported between 3 and 8 hospital beds per 1 000 population, with the lowest rates in Mexico, Costa Rica and Sweden.

Since 2013, the number of beds per capita has decreased in nearly all OECD countries, due in part to greater use of day care and reductions in the average length of stay. The largest decrease occurred in Finland, with a fall of over 50%, mainly affecting long-term care and psychiatric care beds. Reduced capacity of 1 bed or more per 1 000 population was observed in Austria, Lithuania, Luxembourg and the Netherlands, also due in part to long-term care and psychiatric care beds. In contrast, the number of beds increased strongly in Korea, with a significant number of these dedicated to long-term care.

Hospital bed occupancy rates offer complementary information to assess hospital capacity. High occupancy rates of curative (acute) care beds can be symptomatic of a health system under pressure. Some spare bed capacity is necessary to absorb unexpected surges in patients requiring hospitalisation. Although there is no consensus about the “optimal” occupancy rate, a rate of about 85% is often considered a maximum to reduce the risk of bed shortages (NICE, 2018[2]). In 2023, the average bed occupancy rate was 72%, but the rate was higher than 85% in 2 of the 29 OECD countries with comparable data: Ireland and Canada (Figure 5.20). Occupancy rates were comparatively low in Türkiye, Hungary and many central and eastern European countries. Compared to 2013, occupancy rates were lower in almost all OECD countries in 2023.

While general hospital bed capacity matters, intensive care unit (ICU) capacity is an essential resource in many health emergencies or other major crises, delivering care for critically ill patients, as demonstrated during the COVID-19 pandemic. Notwithstanding definitional differences, on average across 31 OECD countries there were 17 ICU beds per 100 000 population in 2023 (Figure 5.21). Numbers varied markedly from around 40 beds or more per 100 000 population in Czechia and Estonia to below 5 beds per 100 000 in New Zealand and Sweden. Compared to the pre-pandemic situation, most countries have increased ICU capacity.

Definition and comparability

Hospital beds include all inpatient beds that are regularly maintained and staffed and that are immediately available for use. They include beds in general hospitals, mental health and substance abuse hospitals, and other specialty hospitals. Beds in residential long-term care facilities are excluded. Data for some countries do not cover all hospitals. In the United Kingdom, data are restricted to public hospitals. Data for Sweden exclude private beds that are privately financed. Beds for same-day care may be included in some countries (such as Austria). Cots for healthy infants are included for a few countries (such as Canada and Poland).

The occupancy rate for curative (acute) care beds is calculated as the number of hospital bed-days related to curative care divided by the number of available curative care beds (multiplied by 365). This excludes day cases.

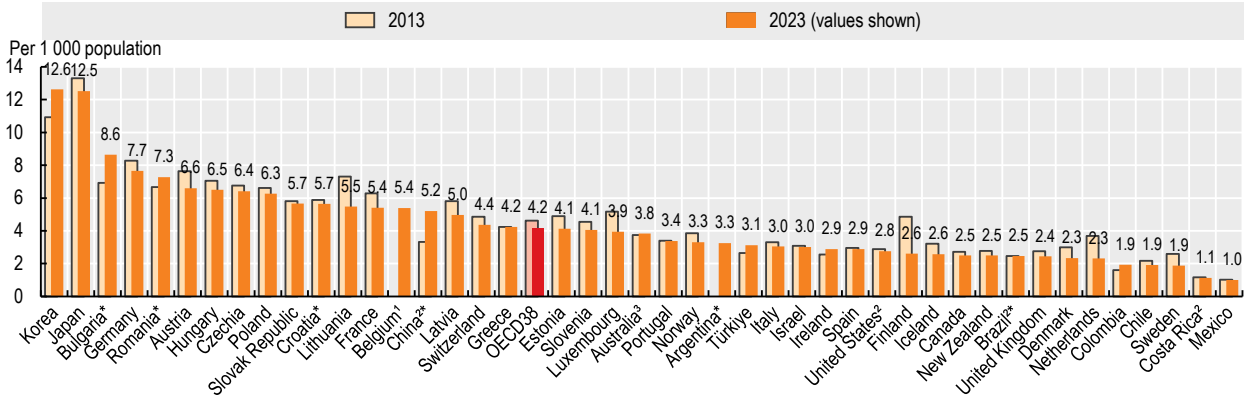
ICU beds are for critically ill patients who need intensive and specialised medical and nursing care, strong monitoring and physiological organ support to sustain life during a period of acute organ system insufficiency. ICU beds are classified by the level of care provided to the patient. Commonly, this falls into three levels, with Level 3 providing the most intense monitoring and Level 1 the lowest. The data on ICU beds cover the three levels, except in Finland, Ireland, Italy, the Netherlands and Spain, which include only critical care beds (Levels 2 and 3). The exact definition of intensive care beds varies across OECD countries, shaped by differences in regulations, specifying requirements such as the patient/nurse ratio, physical properties of the bed (including ventilators, monitoring equipment, infusion equipment and so on) and patient characteristics. The data in Figure 5.21 relate to adult ICU beds for most countries, but a few countries (such as Estonia, Iceland, Mexico and New Zealand) also include neonatal and paediatric ICU beds.

References

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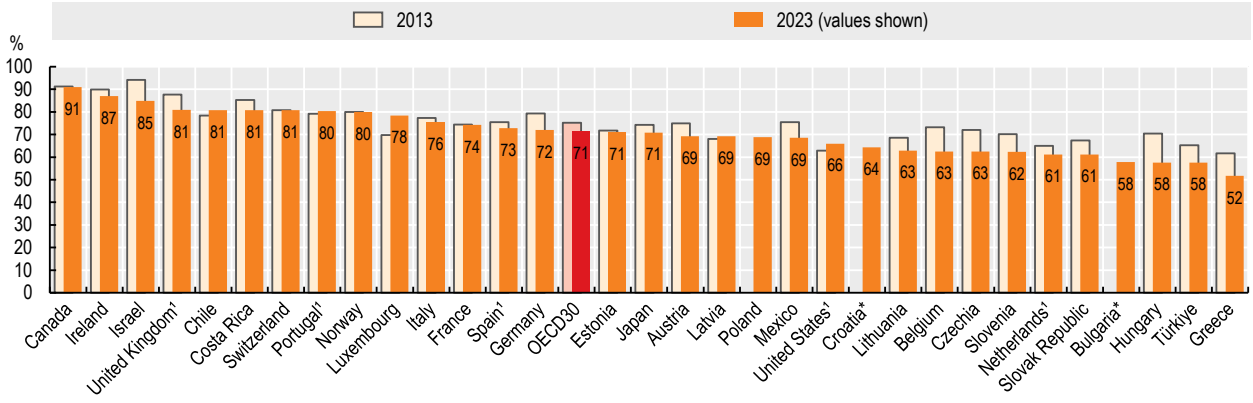
Figure 5.19. Hospital beds, 2023 and 2013 (or nearest year)



1. Data include only acute care and psychiatric hospitals. 2. Latest data from 2021-2022. 3. Latest data from 2016. * Accession/partner country.
Source: OECD Health Statistics 2025.

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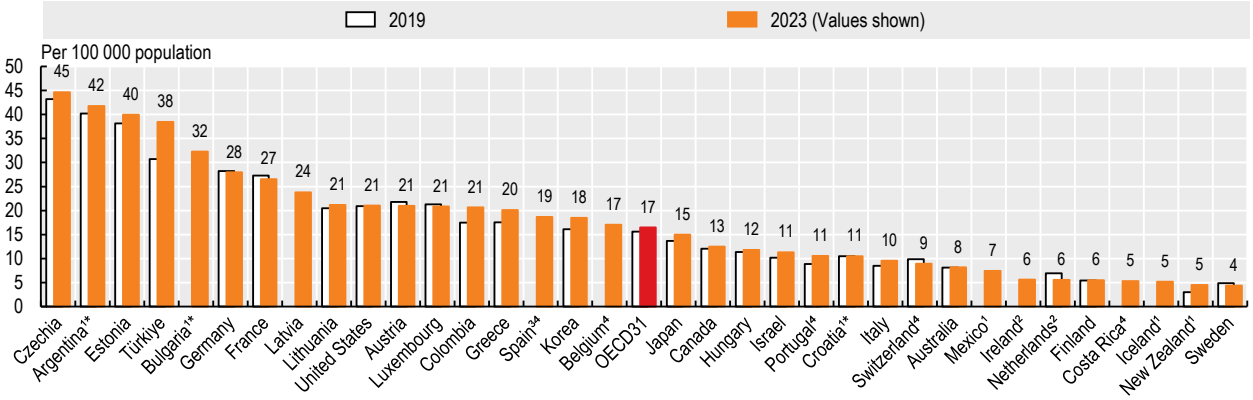
Figure 5.20. Occupancy rate of curative acute care beds, 2023 and 2013 (or nearest year)



1. Latest data from 2021-2022. * Accession/partner country.
Source: OECD Health Statistics 2025.

StatLink https://stat.link/0urtay

Figure 5.21. Adult intensive care beds, 2023 and 2019 (or nearest year)



1. Data include neonatal and paediatric ICU beds. 2. Data cover critical care beds only. 3. Data include post-anaesthetic reanimation units and paediatric ICU beds. 4. Latest data from 2022. * Accession/partner country.
Source: OECD Health Statistics 2025.

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Hospital activity

Hospital discharge rates – the number of patients who leave a hospital after staying at least one night – are a core indicator of hospital activity. Improving timely discharge of patients can help the flow of patients through a hospital, freeing up hospital beds and health worker time. Both premature and delayed discharges worsen health outcomes and increase costs: premature discharges can lead to costly readmissions; delayed discharges use up limited hospital resources.

On average across OECD countries, there were 128 hospital discharges for acute care per 1 000 population in 2023 (Figure 5.22). Rates were highest in Germany and Austria (over 200 per 1 000 population), and lowest in Mexico, Costa Rica, Canada, the Netherlands, Chile and Italy (fewer than 100 per 1 000 population). Among accession and partner countries, rates were also high in Bulgaria and China, and relatively low in Argentina and Brazil. In most OECD countries, the number of hospital discharges fell between 2019 and 2023.

The average length of stay in hospital is an indicator of efficiency in health service delivery. All else being equal, a shorter stay reduces the cost per discharge, and shifts care from inpatient to less expensive settings. Longer stays can be a sign of poor care co-ordination, resulting in some patients waiting unnecessarily in hospital until rehabilitation or long-term care can be arranged. At the same time, some patients may be discharged too early, when staying in hospital longer might have improved their health outcomes or reduced the chances of readmission.

In 2023, the average length of stay in hospital for acute care was 6.5 days across 36 OECD countries with comparable data (Figure 5.23). Türkiye and Mexico had the shortest hospital stays (4.7 days); Japan the longest (15.7 days). Since 2019, the average length of stay has decreased in most countries; the most significant declines occurred in Denmark and Belgium. However, average length of stay increased by over half a day on average in the United Kingdom and the United States.

Alongside these two core indicators of overall hospital activity, use of emergency care services is an important measure of frontline hospital services. Across 26 OECD countries with available data, there were an average 31 emergency department (ED) visits per 100 people annually in 2023 (Figure 5.24). Emergency care use was particularly high in Portugal and Spain, at over 65 ED visits per 100 people. While EDs provide a critical service, high use can be indicative of inappropriate and inefficient healthcare – notably if many patients attend EDs for non-urgent conditions that could be better managed in primary and community care settings. The Netherlands is an example of a country where GPs (through a system of co-operatives) provide acute care in out-of-office hours. The numbers of ED visits have been relatively stable since 2019, although they have declined in 10 of 26 countries with available data. The largest decreases were seen in Italy and Chile, while ED visits increased markedly in Iceland and Slovenia.

More disaggregated data (not shown) reveals further insights. On average across 16 OECD countries, 64% of ED visits resulted in discharges to home, 20% in admissions for inpatient care, and 16% in other outcomes including deaths. Most people arrived at EDs by their own means (self-presentation), with or without a referral from a healthcare professional, and 14% used dedicated emergency transport, such as ambulances.

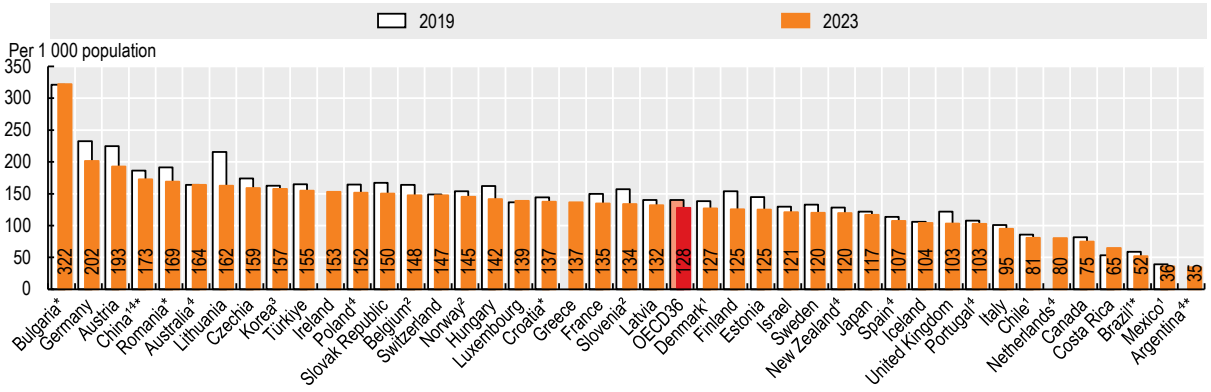
Definition and comparability

A discharge is defined as the release of a patient who has stayed at least one night in hospital. It includes deaths in hospital following inpatient care. Same-day discharges are excluded, with the exceptions of Chile, Japan and Norway, which include some same-day discharges. Healthy babies born in hospitals are excluded (or mostly excluded) from hospital discharge rates in several countries. These typically comprise around 3-10% of all discharges. Data only cover curative/acute care except for a few countries where they cover all inpatient cases, as indicated in the footnotes underneath the chart.

Average length of stay refers to the average number of days patients spend in hospital. It is generally measured by dividing the total number of days stayed by all inpatients during a year by the number of admissions or discharges. Day cases are usually excluded. Data only cover curative/acute care, except for a few countries where they cover all inpatient cases, as indicated in the footnotes underneath the chart. The exclusion of healthy babies born in hospitals from hospital discharge data in several countries results in a slight overestimation of the length of stay.

ED visits comprise both ambulatory and inpatient visits.

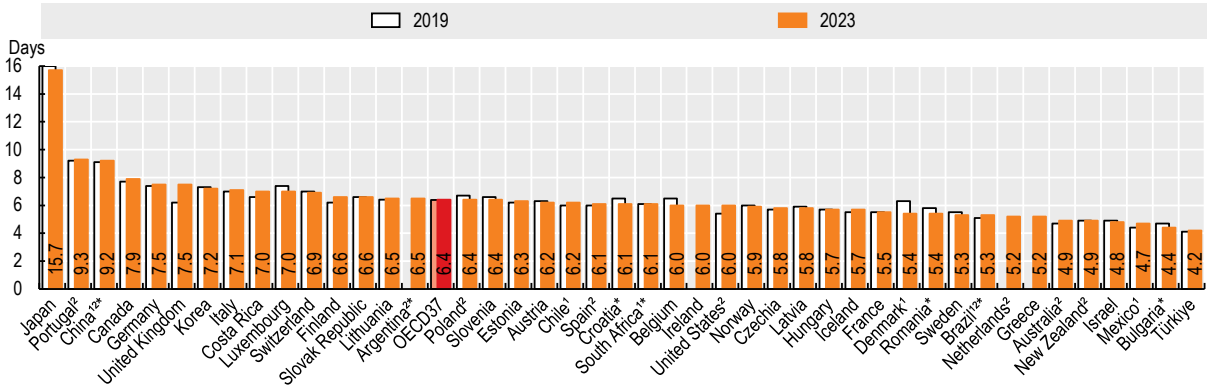
Figure 5.22. Hospital discharge rates, 2023 and 2019 (or nearest year)



Note: Data are discharges for curative (acute) care unless stated. 1. Data include total discharges for inpatient care. 2. Data exclude discharges of healthy babies. 3. Data exclude discharges from certain facility types. 4. Latest data from 2021-2022. * Accession/partner country.
Source: OECD Health Statistics 2025.

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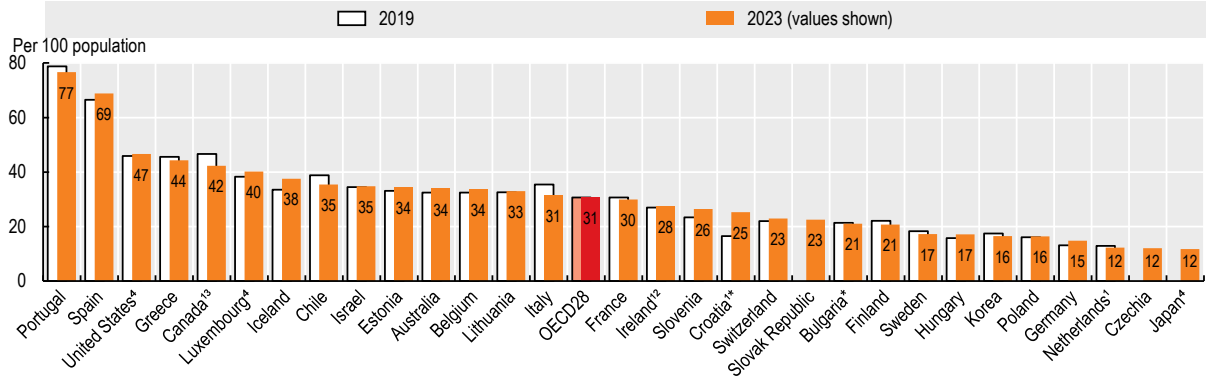
Figure 5.23. Average length of stay in hospital for curative (acute) care, 2023 and 2019 (or nearest year)



Note: Data are for curative (acute) care only unless stated. 1. Data include total average length of stay in hospital for inpatient care. 2. Latest data from 2021-2022. * Accession/partner country.
Source: OECD Health Statistics 2025.

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Figure 5.24. Emergency department visits, 2023 and 2019



1. Data do not include mental health hospitals. 2. Data do not include private hospitals. 3. Data cover Alberta and Ontario only. 4. Latest data from 2022. * Accession/partner country.
Source: OECD Health Statistics 2025.

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Hip and knee replacement

Hip and knee replacements are some of the most frequently performed and effective surgical procedures worldwide. The main indication for hip and knee replacement (joint replacement surgery) is osteoarthritis, which leads to reduced function and quality of life. Osteoarthritis is a degenerative form of arthritis characterised by the wearing down of cartilage that cushions and smooths the movement of joints – most commonly for the hip and knee. It causes pain, swelling and stiffness, resulting in a loss of mobility and function. Osteoarthritis is one of the ten most disabling diseases in developed countries. Worldwide, the WHO estimates show that about 528 million people have symptomatic osteoarthritis – an increase of 113% since 1990 (WHO, 2022[1]).

Age is the strongest predictor of the development and progression of osteoarthritis. It is more common in women, increasing after the age of 50, especially in the hand and knee. Other risk factors include obesity, physical inactivity, smoking, excessive alcohol consumption and injuries. While joint replacement surgery is mainly carried out among people aged 60 and over, it can also be performed on people at younger ages.

In 2023, Germany, Switzerland, Australia, Finland and Denmark had some of the highest rates for hip and knee replacement, among countries with available data (Figure 5.25). The OECD averages are 198 per 100 000 population for hip replacement, and 156 per 100 000 for knee replacement. Mexico, Colombia and Costa Rica have relatively low hip and knee replacement rates. Differences in population structure may explain part of this variation across countries, and age standardisation reduces it to some extent. Nevertheless, large differences persist, and research has shown that country rankings do not change significantly after age standardisation (McPherson, Gon and Scott, 2013[2]).

National averages can mask important variation in hip and knee replacement rates within countries. In Australia, Canada, Germany, France and Italy, a report analysing data from about ten years ago found that the rate of knee replacement was more than twice as high in some regions than others, even after age standardisation (OECD, 2014[3]). Alongside the number of operations, the quality of hip and knee surgery (see sections on “Safe acute care – surgical complications and handling of errors” and “Patient-reported outcomes in acute care” in Chapter 6) and waiting times are also critical for patients.

The number of hip and knee replacements per 100 000 population increased in all OECD countries over the past decade, except in New Zealand and Mexico (Figure 5.25). This aligns with the rising incidence and prevalence of osteoarthritis, caused by ageing populations and growing obesity rates in OECD countries. Increases were particularly substantial in Lithuania, Slovenia and Poland for hip replacement surgery (an increase of 90 or more procedures per 100 000 population); and Switzerland, Poland, Germany and Australia for knee surgery (an increase of 70 or more procedures per 100 000). While the volume of hip and knee replacements fell sharply during the pandemic (which led to increased waiting times), the latest data show that they have returned to pre-pandemic levels in most countries. However, in New Zealand, Luxembourg and Poland, number of surgeries were still lower in 2023 compared to 2019 for both hip and knee replacements.

Definition and comparability

Hip replacement is a surgical procedure in which the hip joint is replaced by a prosthetic implant. It is generally conducted to relieve arthritis pain or treat severe physical joint damage following hip fracture.

Knee replacement is a surgical procedure to replace the weight-bearing surfaces of the knee joint in order to relieve the pain and disability of osteoarthritis. It may also be performed for other knee diseases such as rheumatoid arthritis.

Classification systems and registration practices vary across countries, which may affect the comparability of the data. While most countries include both total and partial hip replacement, some countries only include total replacement. In Costa Rica, Mexico, New Zealand, Portugal and the United Kingdom, the data only include activities in publicly funded hospitals, thereby underestimating the number of total procedures presented here.

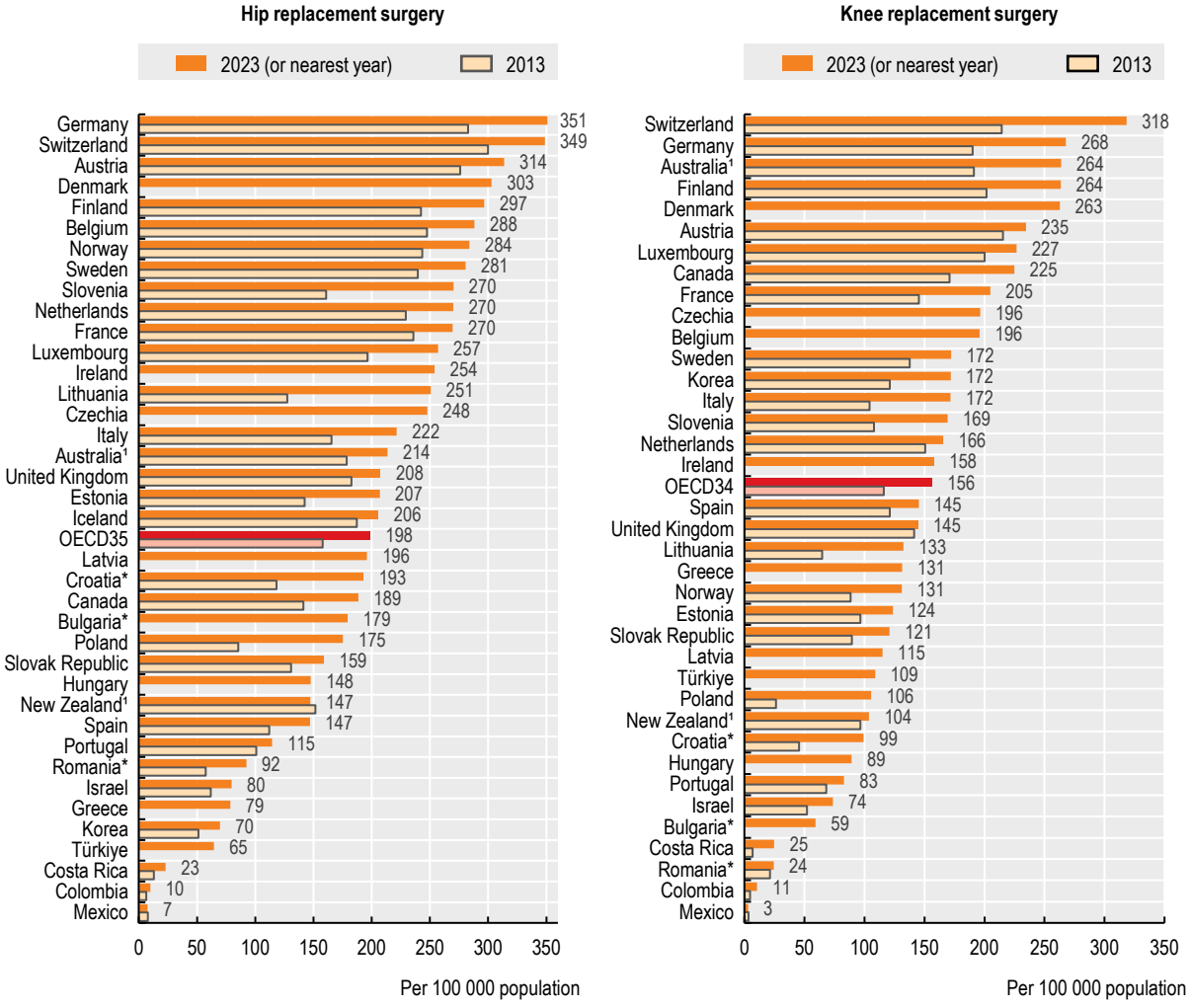
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Figure 5.25. Hip and knee replacement surgery, 2023 and 2013 (or nearest year)



1. Latest data from 2021-2022. In some countries, data from 2014-2015 used for earliest year, due to data breaks. * Accession/partner country.
Source: OECD Health Statistics 2025.

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Ambulatory surgery

Over the past few decades, the number of surgical procedures carried out on a same-day basis has increased markedly in OECD countries. Advances in medical technologies – in particular, the diffusion of less invasive surgical interventions – and better anaesthetics have made this development possible. These innovations have improved patient safety and health outcomes. Further, by shortening the treatment episode, ambulatory surgery can save important resources without any adverse effects on quality of care. It also frees up capacity within hospitals to focus on more complex cases or to reduce waiting lists. However, the impact of the rise in same-day surgery on overall health spending may not be straightforward, since the reduction in unit costs (compared to inpatient surgery) may be offset by overall growth in the volume of procedures performed. Any additional costs related to post-acute care and community health services following the interventions also need to be considered.

Cataract surgeries and tonsillectomies provide good examples of high-volume surgical procedures that are now mainly carried out on a same-day basis in many OECD countries.

Ambulatory surgery accounts for 90% or more of all cataract surgeries in most OECD countries with available data, other than in Mexico, Hungary, Greece and Germany. In several countries, nearly all cataract surgeries are performed as day cases; however, the rate is relatively low in Mexico and Hungary, with fewer than 75% performed as ambulatory cases. Ambulatory surgery is also low in accession countries Bulgaria and Romania, comprising under 50% of surgical procedures. While low rates may be explained in part by limitations in the data coverage of outpatient activities in or outside hospital, it may also reflect higher reimbursement for inpatient stays or constraints on the development of day surgery.

Tonsillectomies are one of the most frequent surgical procedures performed on children – usually those suffering from repeated or chronic infections of the tonsils, breathing problems or obstructive sleep apnoea due to large tonsils. Although the operation is performed under general anaesthesia, it is now carried out predominantly as ambulatory surgery in 14 of 33 OECD countries with comparable data, with children returning home the same day. However, the proportion of day cases is not as high as for cataract surgery, at 43% of tonsillectomies versus 95% of cataract surgeries on average across OECD countries with available data. Day tonsillectomy rates are relatively high in Finland, the Netherlands and Costa Rica (over 85% of cases) but remain lower than 5% of cases in five OECD countries, as well as in accession countries Bulgaria and Romania. In Slovenia, Hungary, Czechia and Austria, practically no tonsillectomies are performed as day cases. These large differences in the share of ambulatory surgery may reflect variations in the perceived risks of post-operative complications, or simply clinical traditions of keeping children in hospital for at least one night after the operation.

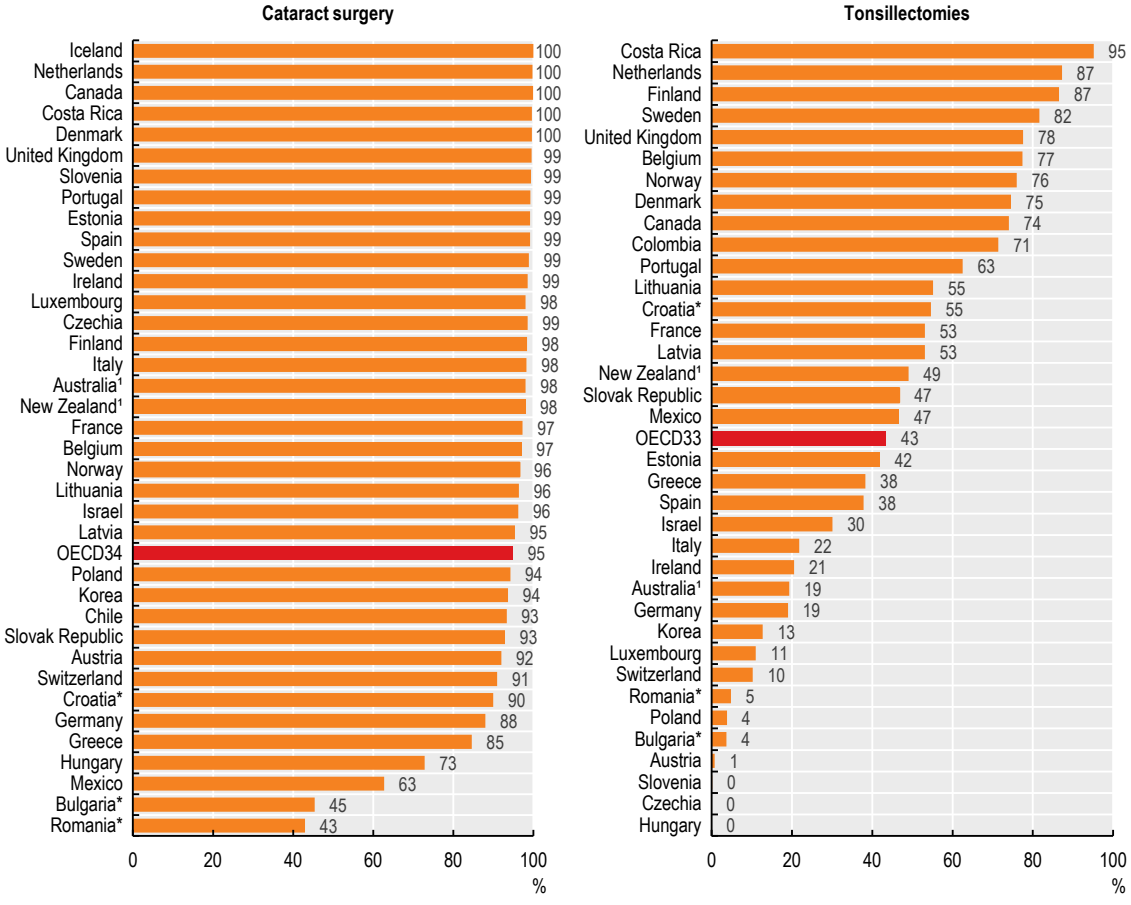
The number of cataract surgeries and tonsillectomies performed as ambulatory cases has grown significantly over time in many countries, including Austria, Lithuania, Luxembourg, France and Poland. In Poland, the share of cataract surgeries performed as day cases increased from only 27% in 2013 to 49% in 2018, then rapidly increased to 94% in 2023; in Lithuania, it increased from 35% to 96%. The share of tonsillectomies performed as ambulatory cases between 2013 and 2023 increased from 47% to 77% in the United Kingdom, while it increased from 22% to 53% in France. The share of same day procedures was largely unaffected by the pandemic for both cataract surgeries and tonsillectomies.

Definition and comparability

Cataract surgery consists of removing the lens of the eye because of the presence of cataracts partially or completely clouding the lens, and replacing it with an artificial lens. It is mainly performed on elderly people. Tonsillectomy consists of removing the tonsils – glands at the back of the throat. It is mainly performed on children.

The data for several countries do not include outpatient cases in hospital or outside hospital (patients who are not formally admitted and discharged), leading to some underestimation. In Costa Rica, Mexico, New Zealand, Portugal and the United Kingdom, the data only include cataract surgeries carried out in public or publicly funded hospitals, excluding any procedures performed in private hospitals.

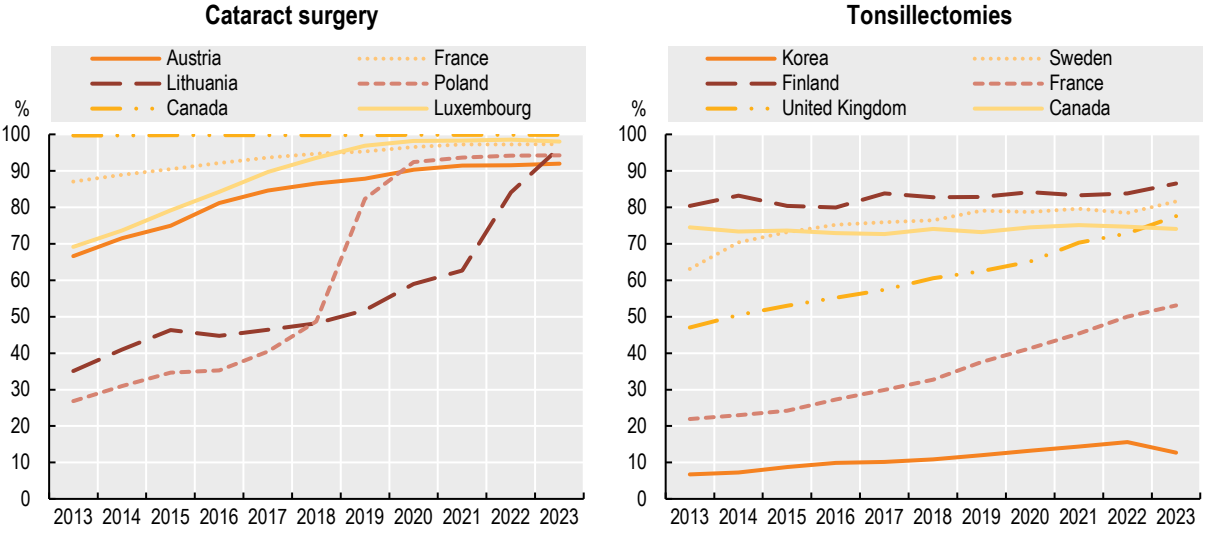
Figure 5.26. Share of surgical procedures carried out as ambulatory cases, 2023 (or nearest year)



1. 2021-2022 data. * Accession/partner country.
Source: OECD Health Statistics 2025.

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Figure 5.27. Trends in surgical procedures carried out as ambulatory cases, selected countries, 2013-2023



Source: OECD Health Statistics 2025.

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6 Quality and outcomes of care

Routine vaccinations
Cancer screening
Safe prescribing in primary care
Avoidable hospital admissions
Effective care for chronic conditions
Person-centredness of primary care
Safe acute care – workplace culture and patient experiences
Safe acute care – surgical complications and handling of errors
Mortality following acute myocardial infarction (AMI)
Mortality following ischaemic stroke
Care for people with mental health disorders
Patient-reported outcomes in hospital care
Integrated care

Routine vaccinations

Vaccination is one of the most effective public health interventions, offering substantial health and economic benefits by protecting against infectious diseases. Childhood vaccination against infectious diseases, such as diphtheria, tetanus and pertussis (DTP), measles and hepatitis B, has dramatically reduced morbidity and mortality worldwide. For older adults, who are at greater risk from influenza, vaccines provide critical protection, reducing severe illness, hospitalisations, and mortality, and mitigating seasonal pressures on health systems. High national coverage rates, however, may not be sufficient to stop disease spreading if vaccination rates are uneven across regions or among specific population groups. Hence, government action to ensure access to vaccines and garner trust and public confidence in the safety and efficacy of vaccination across all population groups is essential for the success of vaccination programmes.

Figure 6.1 shows vaccination coverage for DTP and measles. Across OECD countries, an average of 89% of children received the recommended measles vaccinations in 2024. Continued gaps in coverage of measles vaccine in specific population groups, including in countries with high coverage at the national level, are propelling outbreaks – measles incidence has reached its highest levels in recent decades in Europe (UNICEF/WHO, 2025[1]) – as well as increasing substantially in North and South America (WHO, 2025[2]). Public perceptions of the importance of vaccines for children declined during the COVID-19 pandemic in most OECD countries.

In 2024, only six OECD countries reached the minimum measles immunisation (two doses) level recommended by the World Health Organization (WHO) of 95% population coverage. Rates of immunisation for measles, which is often incorporated with rubella and/or mumps vaccination, were particularly low in Mexico (69%), Chile (73%) and Estonia (74%). Compared to pre-pandemic levels in 2019, measles vaccination rates have decreased on average in OECD countries by nearly 2 percentage points (p.p.) The decrease was particularly substantial in Chile (-18 p.p.), Estonia and Costa Rica (-15 p.p.), as well as in Poland, Lithuania, the Netherlands, Canada and OECD accession/partner countries Argentina and Romania, with drops of 8 p.p. or more.

Across OECD countries, an average of 93% of children received the recommended DTP vaccinations in 2024. However, more than one in five OECD countries did not meet the minimum immunisation level recommended by WHO for DTP (90%) in 2024, with particularly low rates in Mexico (78%) and Estonia (81%). OECD accession/partner countries including South Africa, Argentina, Romania, Peru and Indonesia also all had coverage of 80% or lower. Children's vaccination rates for DTP declined slightly on average (by less than 2 p.p.) between 2019 and 2024 in OECD countries, although Estonia and Czechia, as well as OECD accession/partner countries Indonesia and South Africa, had more substantial drops (-10 p.p. or more).

Influenza is a common seasonal infectious disease, which leads to 3-5 million severe cases worldwide each year, along with an estimated 650 000 deaths (WHO, 2019[3]). Annual vaccination is recommended for high-risk groups, including adults aged 65 and older. Figure 6.2 shows that the WHO's target influenza immunisation rate of 75% was only attained in Korea (85%), Mexico (83%), the United Kingdom and Denmark (78%) in 2023. Coverage was below 20% in Poland, Türkiye, the Slovak Republic, Latvia, Slovenia and Hungary, as well as OECD accession country Bulgaria.

Influenza vaccination rates for people aged 65 and over have increased over time, reaching 51% on average across OECD countries in 2024, from 46% in 2019. This reflects expansion of influenza vaccination campaigns and increased awareness. Still, coverage is lower than the high of 55% reached in 2021, which was facilitated by increased awareness of vaccination, and by the practice of co-administration of COVID-19 and influenza vaccines that increased access and convenience. Compared to 2019, increases were above 20 p.p. in Denmark and Norway. However, some countries had declines of more than 5 p.p., including Ireland, Israel and Hungary and OECD accession country Croatia.

Definition and comparability

Childhood vaccination refers to eligible children who have received the 2nd dose of measles-containing vaccine and three doses of combined diphtheria, tetanus and pertussis vaccine in a given year. These indicators are based on the vaccination policy in each country. The age of complete immunisation differs across countries, owing to different immunisation schedules.

Influenza vaccination rates refer to the number of people aged 65 and over who have received an annual influenza vaccination, divided by the total number of people aged over 65. In some countries, the data are for people aged over 60. Unless otherwise stated, the data shown for 2024 refer to the calendar year 2024 or to the flu season 2024/25.

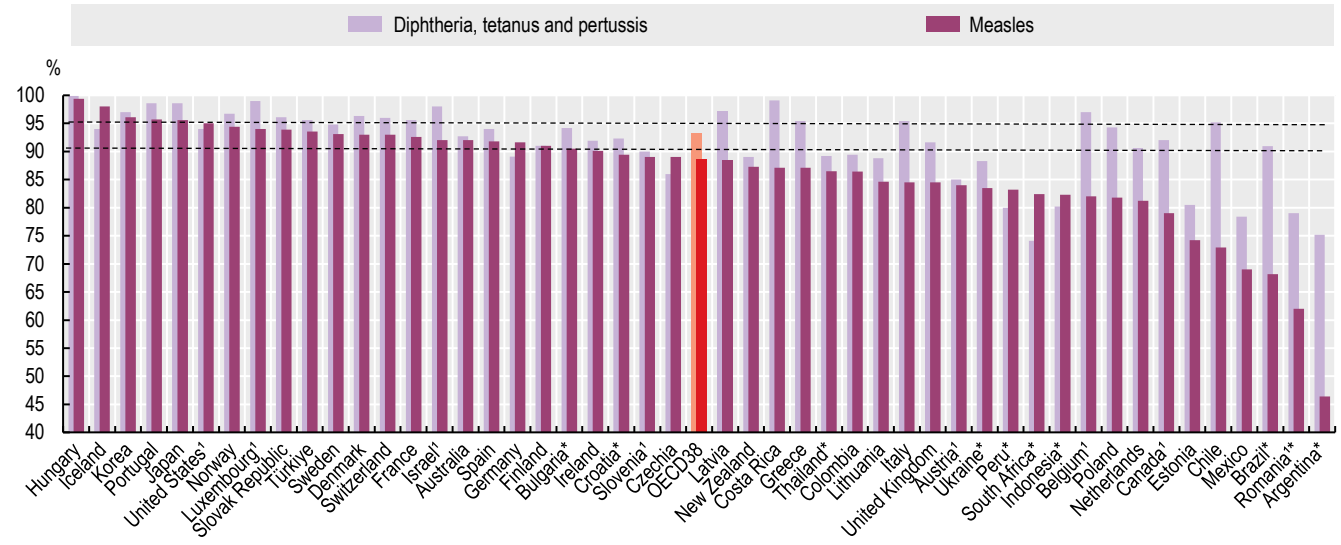
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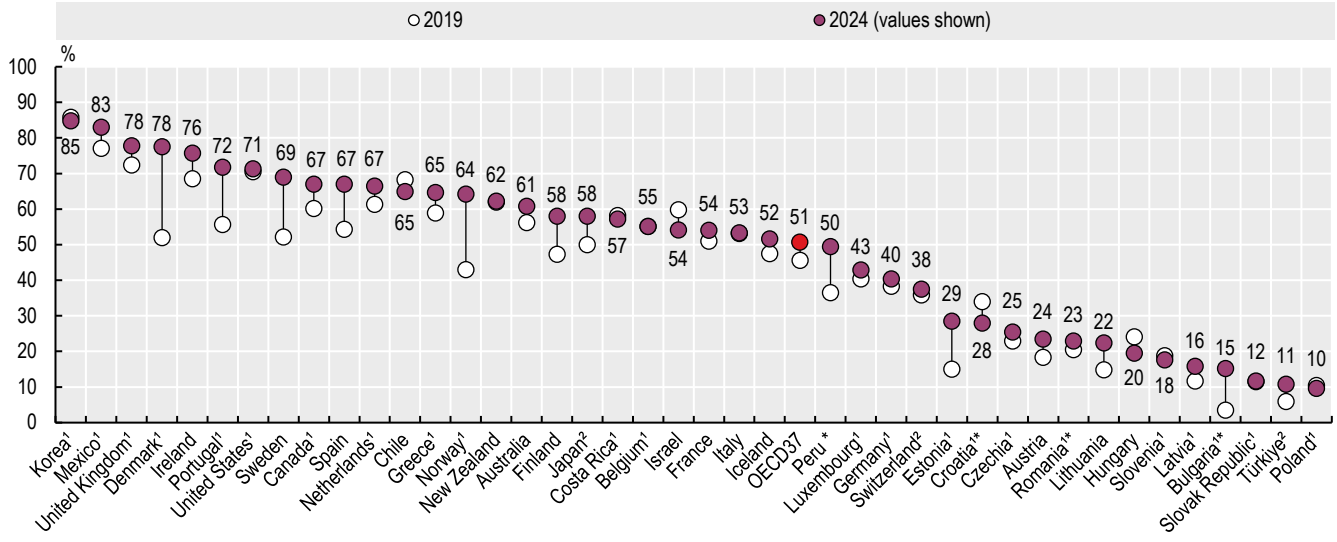
Figure 6.1. Percentage of eligible children who have received two doses of a measles-containing vaccine and three doses of the diphtheria, tetanus and pertussis vaccine, 2024 (or nearest year)



1. Data refer to estimates. Dotted lines indicate WHO minimum targets of 95% for measles and 90% for DTP. * Accession/partner country.
Source: OECD Health Statistics 2025.

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Figure 6.2. Percentage of population aged 65 and over vaccinated against influenza, 2024 and 2019 (or nearest year)



Note: Belgium's data exclude people in nursing homes. The Slovak Republic's data cover people aged 59+. 1. Latest data from 2023. 2. Latest data from 2022. * Accession/partner country.
Source: OECD Health Statistics 2025.

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Cancer screening

Early detection and diagnosis of cancer is vital to reduce cancer mortality at the population level and increase survival rates in people with cancer. Systematic screening of the target population for breast, cervical and colorectal cancer is considered an impactful and cost-effective measure to tackle the burden of cancer. Most OECD countries have programmes for target populations, but the population concerned for each cancer type, screening frequency and methods vary.

WHO recommends organising population-based mammography screening programmes for breast cancer in women based on age (WHO, 2014[1]). OECD countries commonly organise screening every two years for women aged 50-69, although some have expanded eligible age groups and are developing programmes to adapt screening to individual risk levels.

Figure 6.3 shows the proportion of women aged 50-69 who had a mammography examination in the two years preceding 2013 and 2023. The screening rate varies widely across OECD countries; for the latest period, it reached a high of 83% of the target population in Denmark and Sweden, and a low in Greece, Mexico and Costa Rica, where fewer than 25% of women aged 50-69 had a mammography examination during the previous two years. While the average breast cancer screening rate was similar in 2013 and 2023 across OECD countries, there were notable increases in Lithuania (by 21 p.p.) and Estonia (11 p.p.), following activities to increase access through investment in mammographs and geographical accessibility. Conversely, there have been notable decreases in the Netherlands and the United Kingdom (-10 p.p.) and Costa Rica (-9 p.p.). Data from the United Kingdom indicate increases in uptake in 2024, due to clearing of screening backlogs caused by the COVID-19 pandemic.

For cervical cancer, WHO recommends human papillomavirus (HPV) DNA detection tests for women from age 30 every 5-10 years. WHO's global strategy for elimination of cervical cancer recommends a 90% HPV vaccination coverage rate among girls by age 15, 70% coverage of cervical cancer screening at ages 35 and 45, and improvements in early diagnosis and treatment coverage (treating 90% of women with pre-cancer and managing 90% of women with invasive cancer) (WHO, 2021[2]). In OECD countries, cervical cancer screening is often provided every 3-5 years to women within the target age group. The target population and screening recommendations have changed in a number of countries following integration of HPV DNA testing as the primary screening test – commonly undertaken at five-year intervals – and HPV vaccination programmes (OECD, 2024[3]).

Figure 6.4 shows wide variation in the share of women screened for cervical cancer in line with national guidelines. In 2023, the highest rate was 78% in Sweden, followed by 75% in Switzerland and Czechia, while the lowest rates were in Poland (11%) and Costa Rica (4%), as well as OECD accession country Romania (6%). Costa Rica implemented opportunistic screening of eligible women and shifted to HPV DNA testing in 2024 in women aged 30-64. Although excluding some private hospitals, national estimates indicate 34% women aged 35-64 had a screening test in 2023.

Colorectal cancer is often highly treatable if detected early through routine screening, and many OECD countries have adopted nationwide screening programmes. Country guidelines typically recommend biennial faecal occult blood tests for people in their 50s and 60s, but some countries use other target age groups and methods, including colonoscopy examinations. Differences in recommended screening frequencies make comparisons of screening coverage across countries challenging.

Figure 6.5 shows coverage rates for colorectal cancer screening programmes based on national screening protocols. In 2023, proportions ranged from a high of 74% in Finland, followed by the United Kingdom (72%), the United States (68%) and the Netherlands (67%), to a low of 9% in Hungary. The Netherlands sends invitations, leaflets and test kits directly to eligible people, while Hungarians receive invitations only if their GP has joined the screening programme and recipients must order a test kit themselves (OECD, 2024[3]).

While cancer screening rates were generally increasing prior to the COVID-19 pandemic, they dropped in 2020-2021 due to pausing of programmes or delays in accessing health services. However, rates in most countries increased in 2023. Trends in screening uptake since the pandemic are the same for different types of cancer screening within the same country, suggesting a need for specific strategies to improve coverage – for example through greater awareness and accessibility of programmes (OECD, 2024[3]).

Definition and comparability

Screening rates are based on survey or programme data. Programme data are collected to monitor national screening programmes, capturing participation among the eligible population. For cervical and colorectal cancer, the differences between countries in target age groups, screening frequency and screening methods lead to variations in the data coverage reported across countries. Survey data may be affected by recall bias.

References

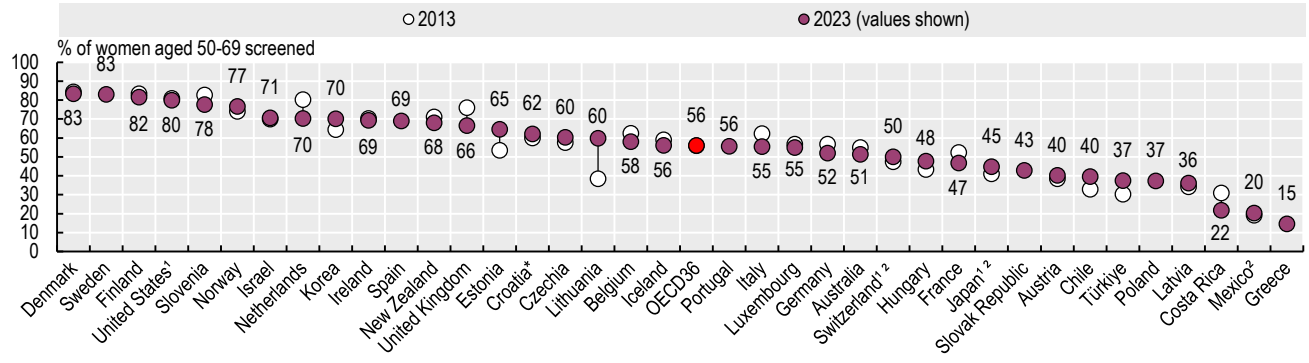
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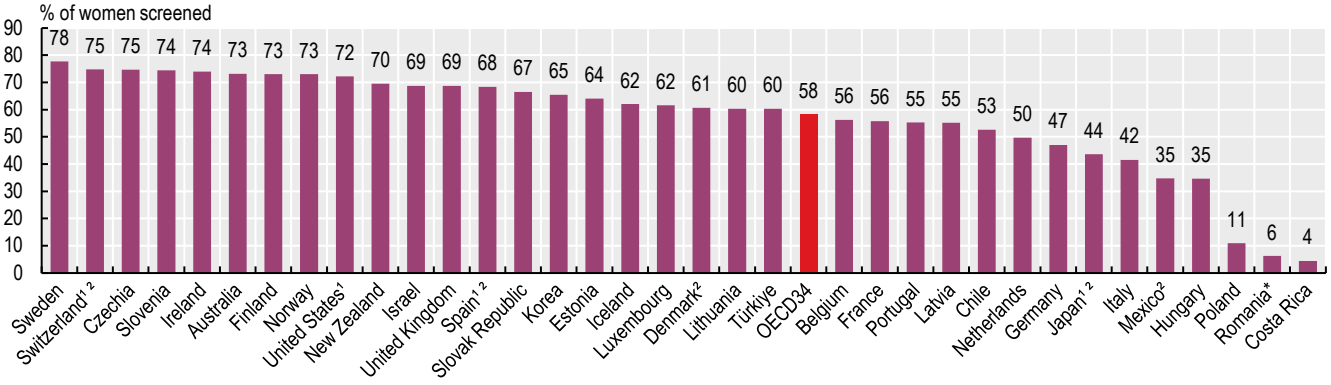
Figure 6.3. Mammography screening within the past two years, 2023 and 2013 (or nearest year)



Note: Programme data unless otherwise stated. Data for Iceland, Mexico and Türkiye refer to women aged 40-69, data for Israel to women aged 50-74 and data for Sweden to women aged 40-74. Data for the United Kingdom refer to England. 1. Survey data. 2. Latest data from 2020-2022. * Accession/partner country.
Source: OECD Health Statistics 2025, Direção-Geral da Saúde (2025[4]).

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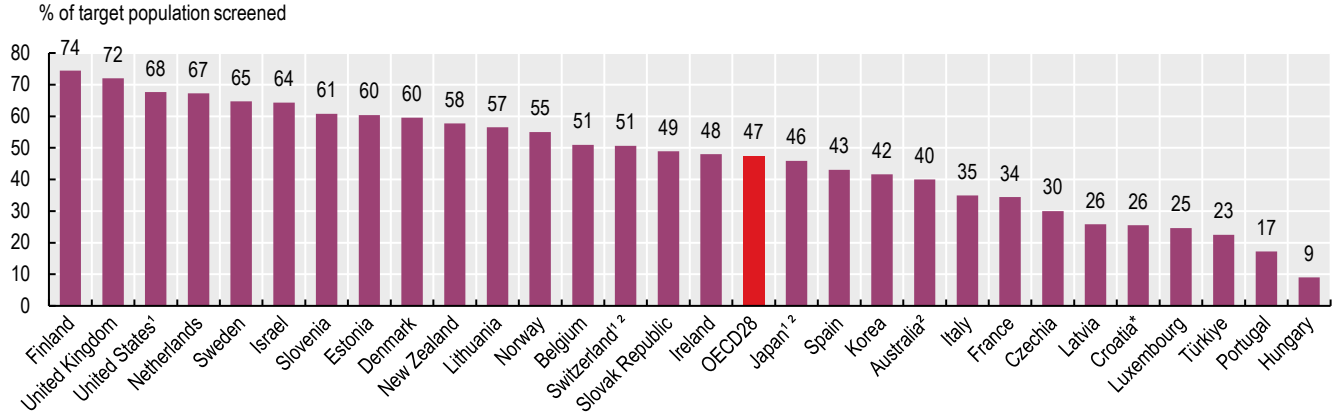
Figure 6.4. Cervical cancer screening coverage, 2023 (or nearest year)



Note: Programme data unless otherwise stated. Data for the United Kingdom refer to England. 1. Survey data. 2. Latest data from 2020-2022. * Accession/partner country.
Source: OECD Health Statistics 2025, Direção-Geral da Saúde (2025[4]).

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Figure 6.5. Colorectal cancer screening coverage, 2023 (or nearest year)



Note: Programme data unless otherwise stated. Data for the United Kingdom refer to England. 1. Survey data. 2. Latest data from 2022. * Accession/partner country.
Source: OECD Health Statistics 2025, Direção-Geral da Saúde (2025[4]).

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Safe prescribing in primary care

Safe prescribing of medicines can be used as an indicator of healthcare quality, complementing information on consumption and expenditure on pharmaceuticals (see also Chapter 9 on "Pharmaceuticals, technologies and digital health"). The overuse, underuse or misuse of prescription medicines can lead to serious consequences for the health of the patient and wasteful expenditure. This is the case for opioids and antibiotics, for example.

Antibiotics are prescribed for the treatment of bacterial infection, but their overuse or inappropriate prescription can drive rates of antimicrobial resistance, which is associated with increased mortality and healthcare costs across OECD countries (OECD, 2018[1]). Guidelines recommend that antibiotics should only be prescribed where clearly supported by clinical evidence. The total volume of antibiotics prescribed in the community setting has been validated as an indicator of safe and effective care, and countries try to reduce antibiotic prescribing in primary care to tackle antimicrobial resistance.

On average, 16 defined daily doses (DDDs) of antibiotics per 1 000 population were prescribed across OECD countries in 2023 – a slight reduction from 17 DDDs per 1 000 in 2013 (Figure 6.6). Finland reported the largest reduction in antibiotic prescribing over time, followed by Canada, Austria, Israel and Australia. The total volume of prescribed antibiotics in 2023 varied three-fold across OECD countries, with Sweden, the Netherlands and Austria reporting the lowest volumes per population per day, and Greece and Korea reporting the highest. The observed variation might be explained by differences in primary care prescribing guidelines and antimicrobial stewardship incentives, as well as attitudes and expectations regarding optimal treatment of infectious illness.

Opioids are used to treat acute pain, such as pain associated with cancer. However, over the last decade opioids have increasingly been used to treat chronic pain – despite the risk of dependence and addiction – leading to serious health risks. Opioid misuse accounted for an alarming epidemic of overdose deaths in some OECD countries, notably in the United States and Canada. Clinical prescribing guidelines are a stewardship effort aimed at reducing long-term opioid prescribing as a patient safety measure by promoting use of alternative pain medications and appropriate dosing strategies (OECD, 2019[2]).

Among 19 countries with available data, Iceland reported an overall volume of opioids prescribed twice the OECD average, at 33 DDDs per 1 000 adult population. Türkiye, Korea and Italy reported the lowest volumes, at 5 DDDs per 1 000 or lower (Figure 6.7). This wide variation can be explained in part by differences in clinical practice in pain management, as well as differences in regulation, legal frameworks for opioids, prescribing policies and treatment guidelines. The OECD average decreased by 4 DDDs per 1 000 population in 2023 compared to 2013. Estonia, Portugal and Spain all reported an increase of over 5 DDDs per 1 000.

Polypharmacy is the routine prescribing of multiple medications (often defined as more than five) for a patient. While polypharmacy may be justified for the management of multiple comorbidities, inappropriate polypharmacy – such as the use of inappropriate medications, overuse and duplication – is common (de Bienassis et al., 2022[3]). Risks associated with polypharmacy are substantial; they include medication-related harms, drug-drug or drug-disease interactions, falls, and cognitive impairment.

According to the OECD's Patient-Reported Indicator Surveys (PaRIS), on average across OECD countries, one in four primary care patients aged 45 and over with chronic conditions reported taking five or more medications (Figure 6.8). The proportion varied from 35% in Slovenia and 32% in Luxembourg and France to 18% in OECD accession country Romania and 14% in Wales (United Kingdom). In 8 of the 19 surveyed countries (Czechia, France, Luxembourg, Norway, Slovenia, Switzerland, the United States), 5% or more of patients were taking ten or more medications. Registry-based analyses of individuals aged 75 and older offer a valuable complement to self-reported data, revealing that up to half of this population is taking more than five medications concurrently (Section on "Safe long-term care" in Chapter 10). Rationalisation of polypharmacy in primary care can lead to more effective, patient-centred, safer prescribing, while reducing wasteful expenditure through deprescribing.

Definition and comparability

A DDD is the assumed average maintenance dose per day for a drug used for its main indication in adults. For instance, the DDD for oral aspirin equals 3 grammes – the assumed maintenance daily dose to treat pain in adults. DDDs do not necessarily reflect the average daily dose actually used in a given country. See http://www.whocc.no/atcddd.

The denominator for the indicator on the overall volume of antibiotics prescribed includes total population, while the denominator for the indicator on overall volume of opioids prescribed includes only the adult population with at least one prescription (aged 18 and over). Data for EU/EEA countries refer only to antibiotic consumption in the community setting and over-the-counter antibiotics are included for some countries.

Data on polypharmacy as reported by patients based on PaRIS refer to the proportion of people taking more than five medications on a regular or ongoing basis, as prescribed by a doctor or a nurse among those aged 45 and over with chronic conditions who visited their primary care practice in the past six months.

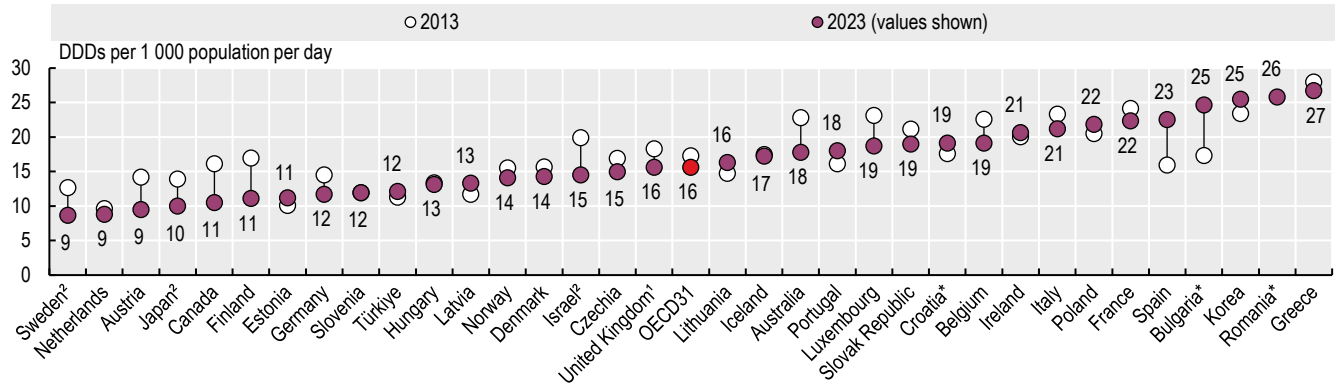
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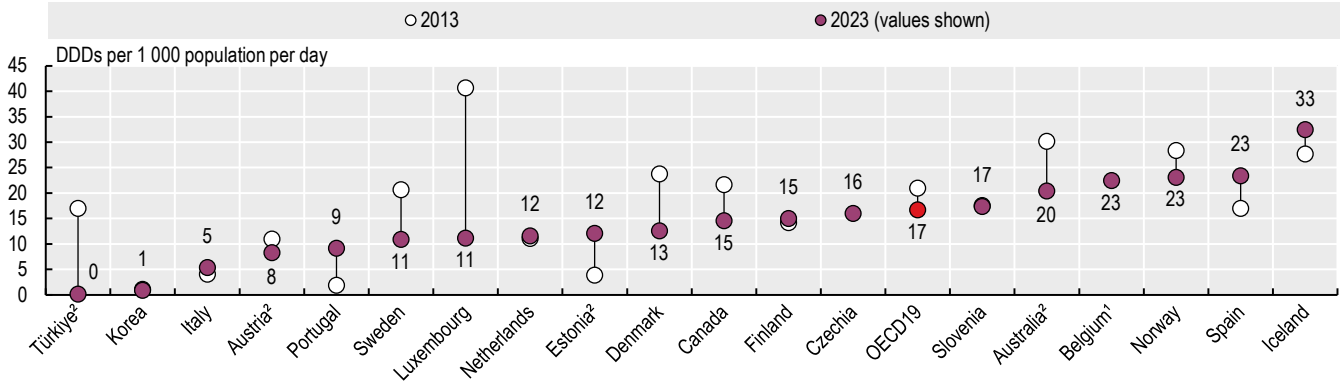
Figure 6.6. Total volume of antibiotics prescribed in the community setting, 2023 and 2013 (or nearest year)



1. Latest data from 2019. 2. Latest data from 2021. * Accession/partner country. Data refer to antibiotics prescribed in community setting only.
Source: European Centre for Disease Prevention and Control (ECDC) 2025 (for EU countries); ECDC 2021 (for the United Kingdom); OECD Health Statistics 2025.

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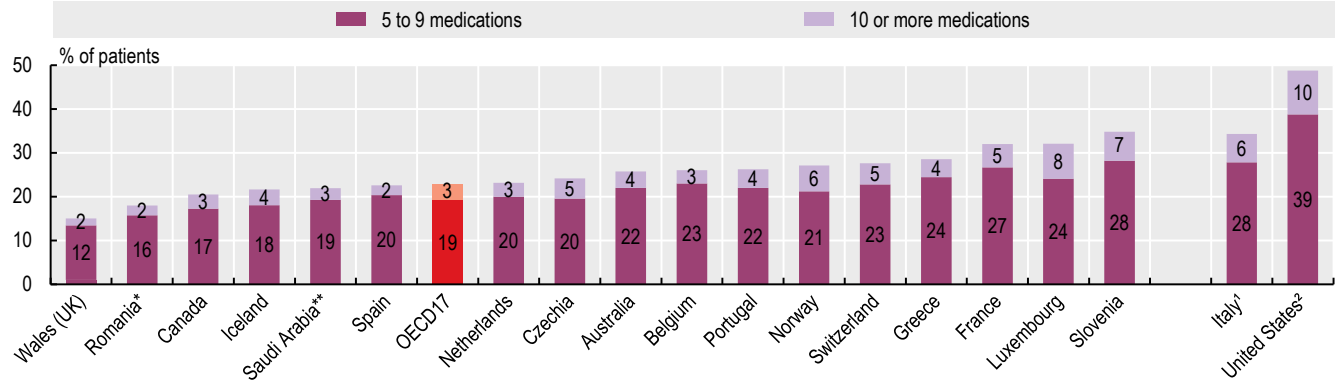
Figure 6.7. Total volume of opioids prescribed in the adult population, 2023 and 2013 (or nearest year)



1. Latest data from 2019. 2. Latest data from 2022.
Source: OECD Health Statistics 2025.

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Figure 6.8. Polypharmacy among primary care users with chronic conditions, 2024



1. Data for Italy refer to patients enrolled in outpatient settings for specialist visits in selected regions. 2. United States sample only includes people aged 65 and over.
* Accession/partner country. ** Participated in PaRIS survey.
Source: OECD PaRIS 2024 Database.

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Avoidable hospital admissions

Primary care is often people's first point of contact with health systems. Inadequate access to high quality primary care for conditions such as asthma, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF) and diabetes, can lead to hospital admissions that could have been avoided. Common to all four conditions is that the evidence base for effective treatment is well established, and much of it can be delivered by primary care. A high-performing primary care system, where accessible and high-quality services are provided, can reduce acute deterioration in people living with asthma, COPD, CHF and diabetes. For example, for diabetes, effective control of blood glucose levels through routine monitoring, dietary modification and regular exercise, and appropriate use of pharmaceuticals can reduce the onset of serious complications and the need for hospitalisation. Management of key risk factors such as smoking, blood pressure and lipid levels is also important in reducing complications. Hospital admissions for these conditions can be used as a marker of quality and access to primary care, with the proviso that very low admissions rates may also partly reflect reduced access to acute care.

Figure 6.9 shows that the combined hospital admission rates for asthma and COPD fell by 35% between 2013 and 2023 – now averaging 155 admissions per 100 000 population across OECD countries. Hospital admission rates ranged from fewer than 20 admissions per 100 000 in Costa Rica to over 250 admissions per 100 000 in Ireland, Australia, Denmark, the United Kingdom and Germany. As noted above, a component behind very low admissions relates to access, as Costa Rica has the lowest number of hospital beds per capita among OECD countries (see section on "Hospital beds" in Chapter 5).

Advances in cardiovascular disease (CVD) care and management, and progress in reducing CVD mortality, have led to increasing numbers of people living with chronic cardiovascular conditions, including CHF. Hospital admission rates for CHF varied 12-fold across OECD countries (Figure 6.10). As with asthma and COPD, Costa Rica had the lowest rate, while Poland and Lithuania reported a rate over twice the OECD average. The average admission rate across OECD countries fell by 16% between 2013 and 2023 – and it fell by over 30% in Austria, Belgium, Estonia, Italy and Portugal. Admissions for CHF increased in several countries over this period, including Iceland, Norway, the Slovak Republic, Switzerland and the United States. Patients can be supported in self-management activities to control clinical and behavioural risk factors and to manage their conditions (see section on "Effective care for chronic conditions") (OECD, 2025[1]).

Figure 6.11 shows that in 2023 there was a more than seven-fold variation in hospital admissions for diabetes across OECD countries. Italy, Iceland and the Netherlands reported the lowest rates, while the United States reported rates more than twice the OECD average, as did OECD accession country Romania. Although admissions for diabetes fell on average between 2013 and 2023 (from 151 to 111 per 100 000), a number of countries observed increases. Admissions for diabetes increased by more than 10% over this period in Israel, Latvia, Spain, Switzerland, the United Kingdom and the United States. Prevalence of diabetes and general access to hospital care may explain some of this variation. As with heart failure, ongoing control of diabetes usually involves a considerable amount of self-management; therefore, patient-centred care instruction and education are central to primary care of people with diabetes (OECD, 2020[2]).

Definition and comparability

The indicators are defined as the number of hospital admissions with a primary diagnosis of asthma or COPD or CHF among people aged 15 and over per 100 000 population. Diabetes hospital admission data are based on the sum of three indicators: admissions for short-term and long-term complications and for uncontrolled diabetes without complications. The indicator is based on a primary diagnosis of diabetes. Rates are age- and sex-standardised to the 2015 OECD population. Admissions resulting from a transfer from another hospital and where the patient dies during admission are excluded from the calculation, as these are considered unlikely to be avoidable.

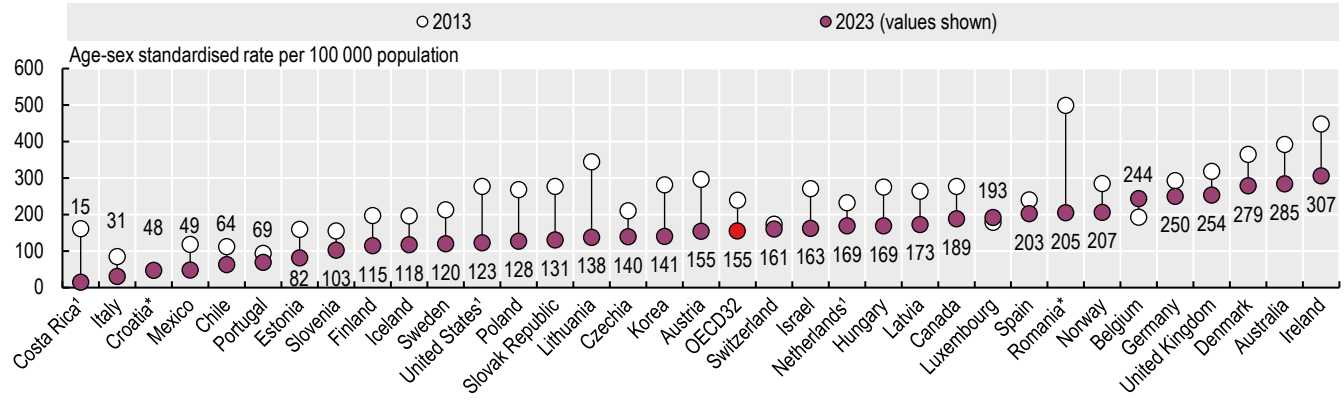
Disease prevalence and availability of hospital care may explain some, but not all, variations in cross-country rates. Differences in data definition, diagnostic and coding practices and indicator calculation methods between countries may affect comparability of data. For example, in many countries diabetes is coded as a secondary diagnosis, while a few countries code it as a primary diagnosis, and the exclusion of transfers cannot be fully implemented by some countries. Differences in data coverage of the national hospital sector across countries may also influence indicator rates.

References

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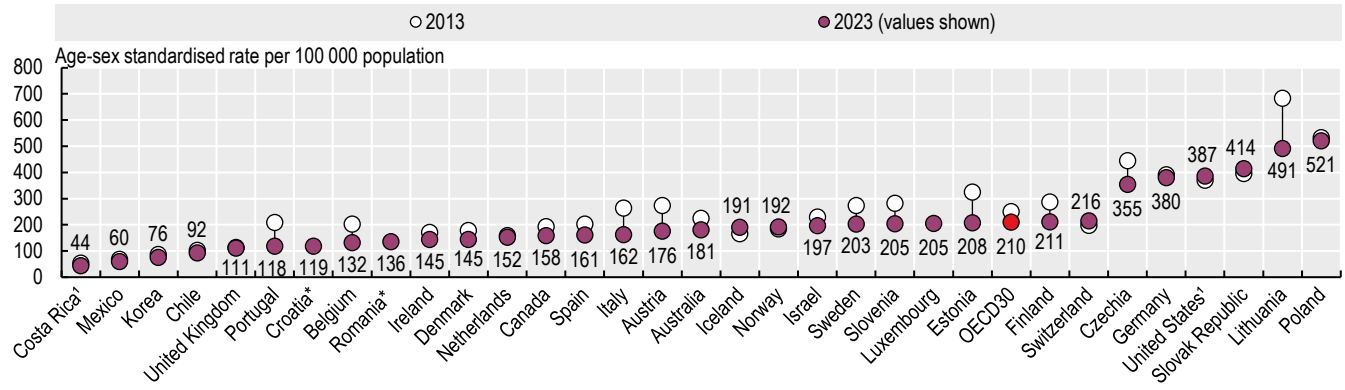
Figure 6.9. Asthma and chronic obstructive pulmonary disease hospital admissions in adults, 2023 and 2013 (or nearest year)



1. Latest data from 2021-2022. * Accession/partner country.
Source: OECD Health Statistics 2025.

StatLink https://stat.link/wtx3ho

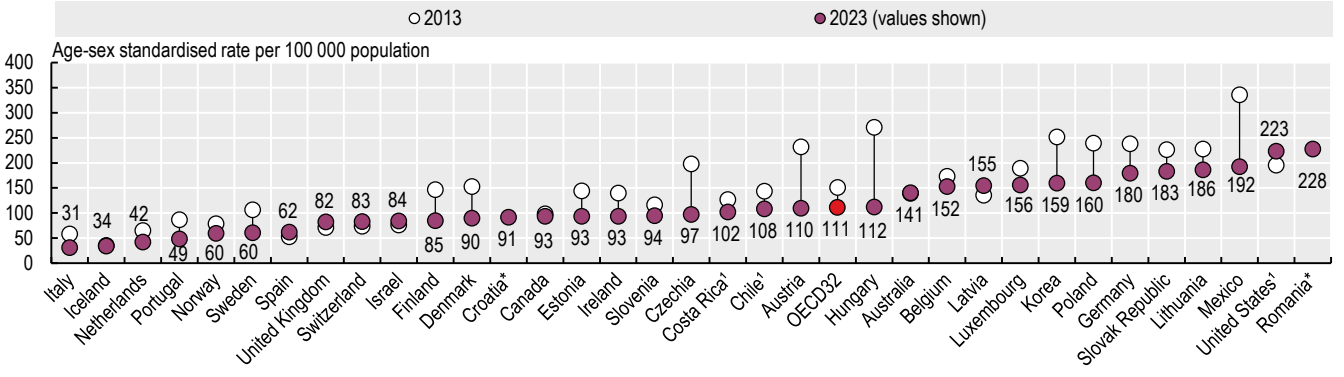
Figure 6.10. Congestive heart failure hospital admissions in adults, 2023 and 2013 (or nearest year)



1. Latest data from 2021-2022. * Accession/partner country.
Source: OECD Health Statistics 2025.

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Figure 6.11. Diabetes hospital admissions in adults, 2023 and 2013 (or nearest year)



1. Latest data from 2021-2022. * Accession/partner country.
Source: OECD Health Statistics 2025.

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Effective care for chronic conditions

Effective healthcare for individuals with chronic conditions can be improved through evidence-based clinical care, particularly as these patients have frequent interactions with their healthcare providers. However, as most of these people need to undertake ongoing self-management, supporting them in managing their health and well-being is also essential. This support includes guidance on healthy lifestyle choices and effective medication management. Integrated care of chronic conditions in primary care helps to prevent complications and avoidable hospital admissions.

One common chronic condition is diabetes – a leading cause of cardiovascular disease, blindness, kidney failure and lower limb amputation. In individuals living with diabetes and hypertension, angiotensin-converting enzyme inhibitors or angiotensin receptor blockers are recommended in most national guidelines as first-line anti-hypertensive medications to reduce blood pressure.

Figure 6.12 reveals broad consistency in the proportion of patients with diabetes on recommended antihypertensive medications in 2023, although Iceland, the Netherlands and Türkiye had rates at around 80% or lower. The average rate of antihypertensive prescribing increased by 4 p.p. from 2013 to 2023 across OECD countries with available data, reflecting improved adherence to clinical guidelines, with the improvement particularly notable in Finland.

Since the risk of amputations among diabetes patients can be reduced through effective diabetes management, the rate of hospital admissions for lower extremity amputation can indicate the long-term quality of diabetes care. Despite high adherence to clinical recommendations on prescribing in OECD countries, Figure 6.13 shows large international variation in rates of both major and minor lower extremity amputations among adults with diabetes. Iceland, Portugal, Italy, Korea and Sweden reported rates lower than 12 per 100 000 population, while Chile, Czechia, Slovenia and Germany reported rates higher than 40 per 100 000. Minor lower extremity amputations can be considered as treatment to prevent major lower extremity amputations, severe complications due to uncontrolled diabetes, but the rate of minor lower extremity amputations varies across countries, suggesting differences in timeliness and quality of primary care intervention for diabetes at an early stage. However, it should be noted that minor lower extremity amputations can be conducted in outpatient settings in OECD countries, which is common practice in Sweden, hence the rate of minor lower extremity amputations in hospital settings is relatively low, so caution is needed when interpreting cross-country variations in this indicator.

Self-management support, understood as empowering patients with the knowledge and skills to manage their conditions, is more effective when patients are actively involved in decisions about their own care. Results from OECD's PaRIS shows that at the primary care level, people are more confident in managing their health when doctors involve them in decision making and support them in taking a more active role in managing their health conditions (OECD, 2025[1]). Figure 6.14 shows that on average across OECD countries, while 70% of people without chronic conditions reported being confident to manage their own health, only 59% of people living with chronic conditions were confident in self-management. Confidence in self-management among people aged 45 and over with chronic conditions varied almost four-fold across surveyed countries, ranging from 92% in France to under 40% in Italy, Iceland and Greece.

Definition and comparability

The denominator of people with diabetes who are prescribed recommended antihypertensive medication is based on people with diabetes (i.e. who are long-term users of glucose-regulating medication) who also have one or more prescriptions from a range of medications often used in the management of hypertension in a specific year. The numerator is the number of people who have one or more prescriptions of an angiotensin-converting enzyme inhibitor or angiotensin receptor blocker. Any reported decrease in rates may be accounted for by an increase in the denominator of diabetes patients identified by prescribing data, due to increased prescription of glucagon-like peptide-1 (GLP-1) agonist medication for weight loss rather than for diabetes indication, identified in Denmark and Norway (see Chapter 9 on "Pharmaceuticals, technologies and digital health").

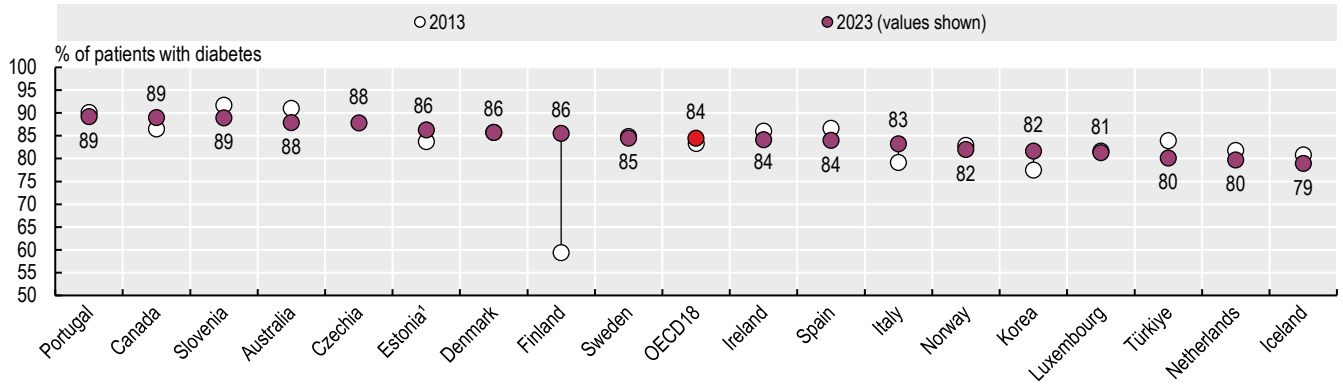
Major and minor lower extremity amputation in adults with diabetes is defined as the number of hospital discharges among people aged 15 years and over, with rates age- and sex-standardised to the 2015 OECD population. Major lower extremity refers to from hip to above ankle and minor lower extremity refers to from toe to ankle. These indicators refer to amputations in inpatient care settings while a varying degree of amputations, particularly minor lower extremity amputations, is undertaken in outpatient care settings across countries.

The indicator on confidence in self-management measures how confident respondents are in managing their own health and well-being, based on a question from the Person-Centred Co-ordinated Care Experience Questionnaire (P3CEQ) data instrument. The denominator for PaRIS data includes people aged 45 and over who visited their primary care practice in the past six months. The numerator includes people who reported being confident or very confident to manage their own health, as opposed to somewhat confident or not confident at all.

References

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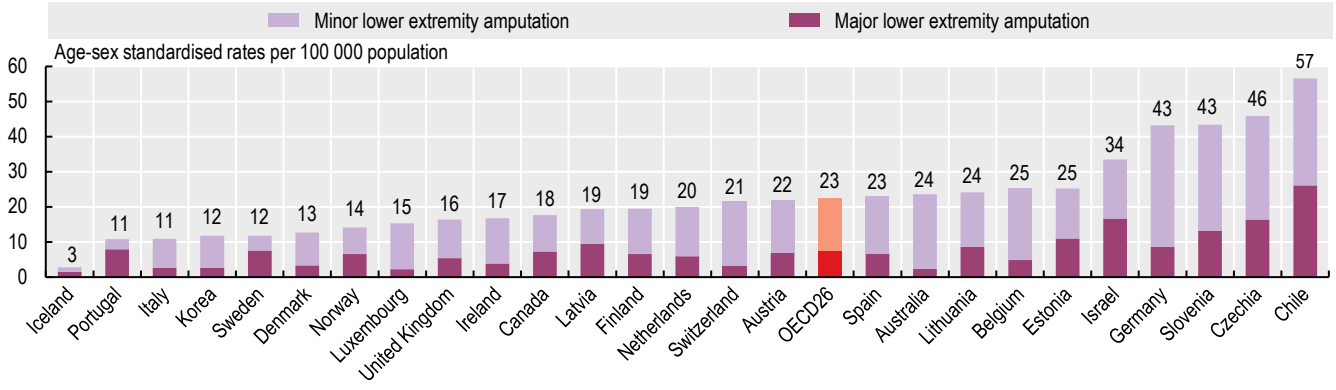
Figure 6.12. People with diabetes prescribed recommended antihypertensive medication, 2023 and 2013 (or nearest year)



1. Latest data from 2022.
Source: OECD Health Statistics 2025.

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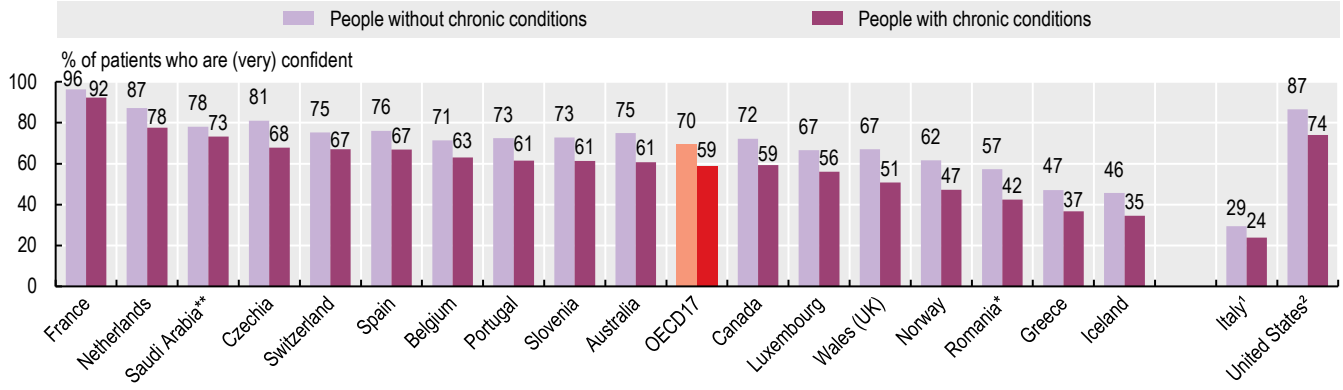
Figure 6.13. Major and minor lower extremity amputation in adults with diabetes, 2023 (or nearest year)



Source: OECD Health Statistics 2025.

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Figure 6.14. Primary care users who are confident in self-management, 2024



1. Data for Italy refer to patients enrolled in outpatient settings for specialist visits in selected regions. 2. United States sample only includes people aged 65 and over.
* Accession/partner country. ** Participated in the PaRIS survey.
Source: OECD PaRIS 2024 Database.

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Person-centredness of primary care

Incorporating people's voices is a core component of national and international efforts to improve quality of care (OECD, 2021[1]). Over the past decade, OECD countries have significantly expanded their use of patient-reported measures to inform healthcare policymaking. Several countries have collected and evaluated patient-reported experience measures (PREMs) and patient-reported outcome measures (PROMs), and have created channels for patient input to improve health system performance and person-centredness. A key initiative is the OECD's PaRIS – the world's largest international survey of people living with chronic conditions. It highlights cross-country differences in patient experiences, shedding light on variations in primary care quality and guiding efforts to strengthen primary care (OECD, 2025[2]).

PaRIS results show that people living with chronic conditions reported generally high levels of quality experienced in primary care. On average across OECD countries, 87% of patients with chronic conditions rated the care they received positively (good, very good or excellent), ranging from 97% in Switzerland to 69% in Portugal (Figure 6.15). Results were similar among people without chronic conditions. Analysis of PaRIS data shows that experienced quality is significantly associated with national health spending per capita and that more than 10% of variation can be attributed to country-level differences – such as national health policies and availability, accessibility and quality of healthcare services – as well as other factors beyond the health system.

Trust in healthcare professionals is a fundamental component of people-centred care, especially for those living with chronic conditions who require ongoing interaction with the health system. Across OECD countries, 78% of patients with chronic conditions reported trusting the last healthcare professional they saw, ranging from 88% in Switzerland to 57% in Greece (Figure 6.16). The average rate was higher than the average for trust in the healthcare system overall across OECD countries (62%) (OECD, 2025[2]). Patient perceptions of high-quality care, having a central point of contact, longer relationships with care professionals over time and seeing care professionals who schedule longer appointments, were all found to have a positive impact on trust.

When healthcare is "person-centred", it is tailored to the individual needs, preferences and values of the patient. Figure 6.17 (left panel) shows the proportion of patients who reported positive experiences of person-centred care, with scores above 12 on the P3CEQ person-centred care scale (0-24). On average across OECD countries, 87% reported positive experiences, ranging from 97% in Switzerland to 66% in Wales (United Kingdom). Improving continuity of information, reducing the need for patients to explain their situations repeatedly, and involving patients more fully in decision making are critical steps towards more people-centred care.

Primary care plays a crucial role in managing care for people with chronic conditions, making it a natural setting for implementing strategies and interventions to improve care co-ordination, such as medication reviews and self-management support. Figure 6.17 (right panel) shows the proportion of patients who reported positive experiences of care co-ordination, based on a score above 7.5 on the P3CEQ care co-ordination scale (0-15). The average across OECD countries was 59%, ranging from 81% in Switzerland to 22% in Wales (United Kingdom). Strengthening care planning, supporting medication reviews, and reinforcing continuous information sharing are key strategies to enhance co-ordination and better support people living with chronic conditions.

Definition and comparability

PaRIS results include data from 107 011 patients (aged 45+) linked to 1 816 primary care practices across 19 countries. All had used primary care in the past six months, and all results are age- and sex- standardised.

Experienced quality is an overall measure of how patients rate the care they have received over the past 12 months. It shows the percentage of primary care users who reported the experienced quality of care as "good", "very good" or "excellent" compared to "fair" or "poor". **Trust in healthcare professionals** refers to the degree to which patients have confidence and trust in the healthcare professional they saw or spoke to, with a positive outcome defined as responding "yes, definitely".

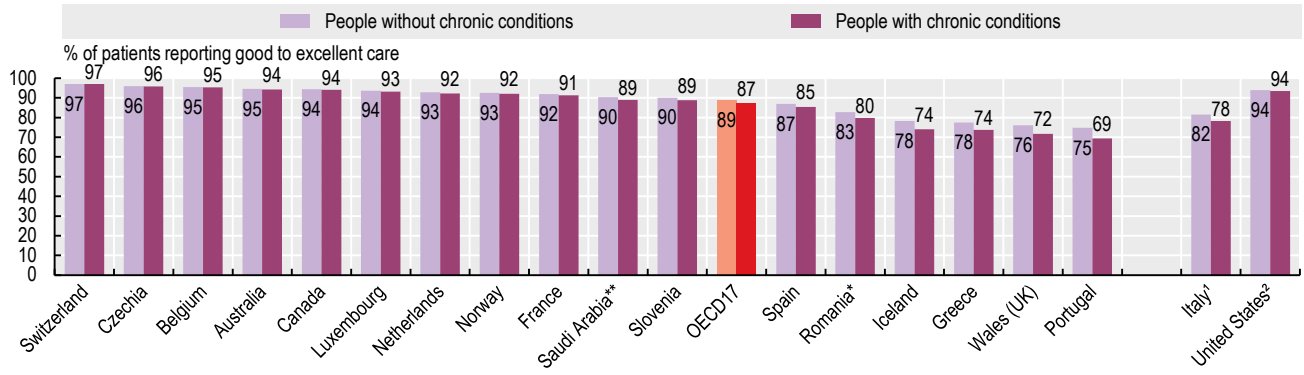
Person-centredness, the extent to which patients' health needs are managed holistically, ensuring that their preferences and needs are central to the care received, shows the percentage of patients reporting positive experience (scored 50% or more across eight questions, i.e. scale score ≥12 on the 24-point Person-Centred Co-ordinated Care Experience Questionnaire (P3CEQ) subscale). **Experienced co-ordination** – the extent to which patients experience seamless and continuous journey through different healthcare practices and settings – shows the percentage of patients reporting positive experience (scored 50% or more across five questions measuring care co-ordination, i.e. scale score ≥7.5 on the 15-point P3CEQ subscale).

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OECD (2021), *Health for the People, by the People: Building People-centred Health Systems*, OECD Health Policy Studies, OECD Publishing, Paris, https://doi.org/10.1787/c259e79a-en. [1]

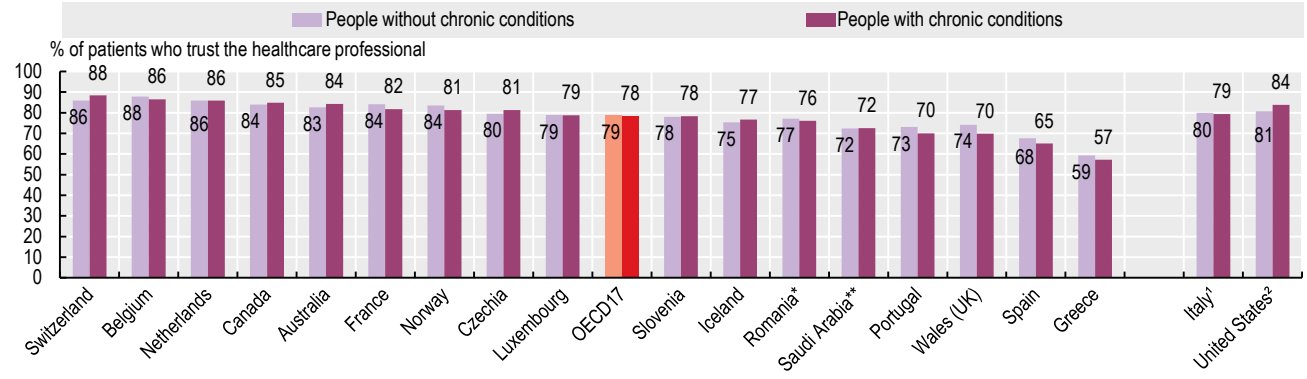
Figure 6.15. Experienced quality of primary care, 2024



1. Data for Italy refer to patients enrolled in outpatient settings for specialist visits in selected regions. 2. United States sample only includes people aged 65 years or older. * Accession/partner country. ** Participated in the PaRIS survey.
Source: OECD PaRIS 2024 Database.

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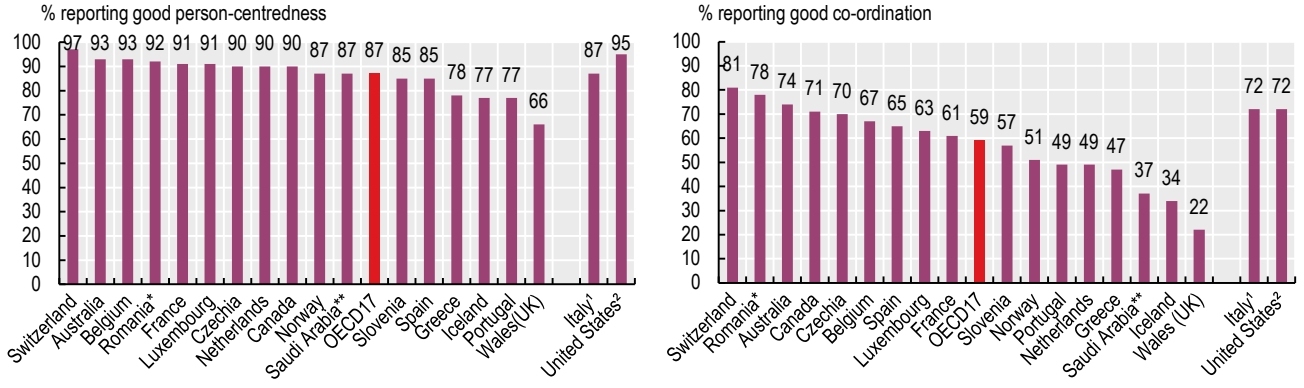
Figure 6.16. Trust in healthcare professionals among primary care users, 2024



1. Data for Italy refer to patients enrolled in outpatient settings for specialist visits in selected regions. 2. United States sample only includes people aged 65 and over.
* Accession/partner country. ** Participated in the PaRIS survey.
Source: OECD PaRIS 2024 Database.

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Figure 6.17. Person-centredness and experienced co-ordination among primary care users with chronic conditions, 2024



1. Data for Italy refer to patients enrolled in outpatient settings for specialist visits in selected regions. 2. United States sample only includes people aged 65 and over.
* Accession/partner country. ** Participated in the PaRIS survey.
Source: OECD PaRIS 2024 Database.

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Safe acute care – workplace culture and patient experiences

Measures of patient safety culture from the perspective of health workers can be used – along with patient-reported experiences of safety and traditional patient safety indicators (see section on "Safe acute care – surgical complications and handling of errors") – to give a holistic perspective of the state of safety in health systems.

A positive patient safety culture for health workers results in shared perceptions of the importance of safety, increased transparency and trust, and higher levels of shared responsibility, along with improved confidence in organisational and national safety initiatives. A growing body of research has found that a positive patient safety culture is associated with better health outcomes and patient experiences, as well as improved organisational productivity and staff satisfaction. Improved models of patient safety governance and investment in improving the patient safety culture have a substantial and lasting impact on outcomes (G20 Health & Development Partnership, 2021[1]).

Figure 6.18 and Figure 6.19 illustrate two domains of the Hospital Survey on Patient Safety Culture (HSPSC), which asks hospital staff to provide information on aspects of their work environment and whether they are conducive to good patient safety. Figure 6.18 shows staff perceptions of whether important patient care information is transferred across hospital units and during shift changes. Positive perceptions from staff on safety of handoffs and information exchange range widely across countries, with a difference of 25% p.p. (78% to 53%) for countries using HSPSC version 2.0. Countries using HSPSC version 1.0 typically observe lower levels of positive perceptions of handoffs and transitions due to the format of the survey questions – with values ranging from 53% to 36% of staff having a positive perception of patient safety in their hospital. Figure 6.19 shows that most hospital workers feel that staffing levels and the pace of work are not adequate for providing safe patient care. Across all staff types, positive perceptions on staffing and work pace are highest in Poland, Israel, Colombia, the United States and Latvia (50% or more with positive perceptions across different types). There is a clear disconnect between perceptions among management and frontline staff in most countries. On average, for OECD countries using HSPSC 2.0, only 44% of physicians and nurses in hospitals perceived staff levels and work pace to be safe, compared to 53% of management staff.

Patient perspectives are also critical to make health systems safer and more people-centred. According to data from the OECD PaRIS initiative, 25% of primary care users aged 45 and over reported having experienced an event or circumstance that could have resulted, or did result, in unnecessary harm to themselves, such as not getting an appointment when needed; receiving a wrong or delayed diagnosis or treatment; or experiencing problems with communications between healthcare professionals. Rates ranged from over 50% in Greece and Saudi Arabia, to under 10% in Czechia and Switzerland (Figure 6.20). The experience of an adverse event has a strong impact on deteriorating trust in both the professional and the healthcare system more broadly. Analysis of PaRIS data shows that people who have experienced an event or circumstance that could potentially cause them harm in healthcare are 1.6 times less likely to trust the healthcare system compared to those who have not experienced such an adverse event (45% compared to 70%). Likewise, trust in the person's last care professional is 1.4 times lower among people who have experienced an adverse event compared to those who have not (59% compared to 85%) (OECD, 2025[2]).

Definition and comparability

Health worker perceptions of patient safety are based on the assessment of workers in the hospital setting (including psychiatric hospitals) using the HSPSC, versions 1.0 and 2.0. There are differences in the average performance between HSPSC 1.0 and 2.0 – and scores generated using HSPSC 1.0 are normally lower. Several other differences may also influence the compatibility of data shown in Figure 6.18 and Figure 6.19. These relate primarily to differences in the scope and methods used in the patient safety culture measurement, including differences in the total number of survey respondents, types and number of participating hospitals, response rates and required vs. voluntary reporting (de Bienassis and Klazinga, 2024[3]). Careful interpretation of patient safety culture indicators is required because of these differences.

For information on sources and methods for PaRIS, see section on "Person centredness of primary care".

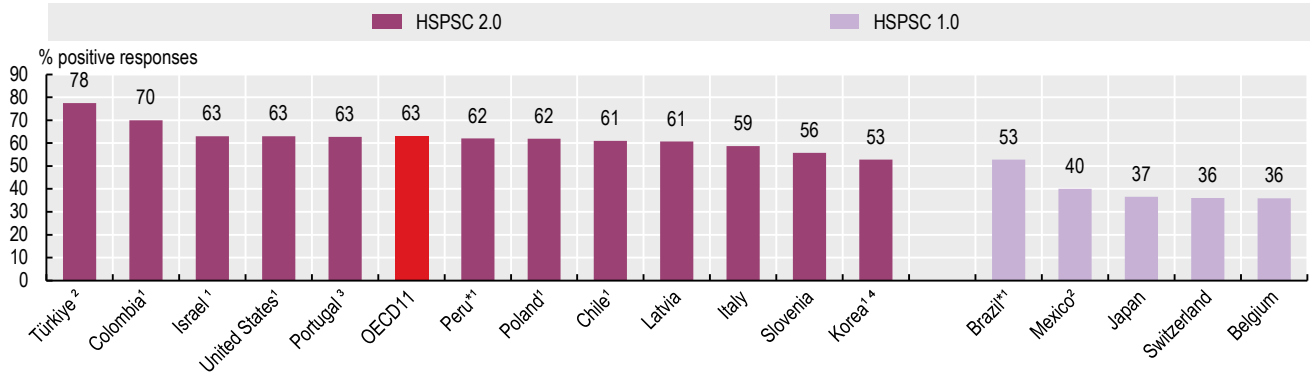
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OECD (2025), *Does Healthcare Deliver?: Results from the Patient-Reported Indicator Surveys (PaRIS)*, OECD Publishing, Paris, https://doi.org/10.1787/c8af05a5-en. [2]

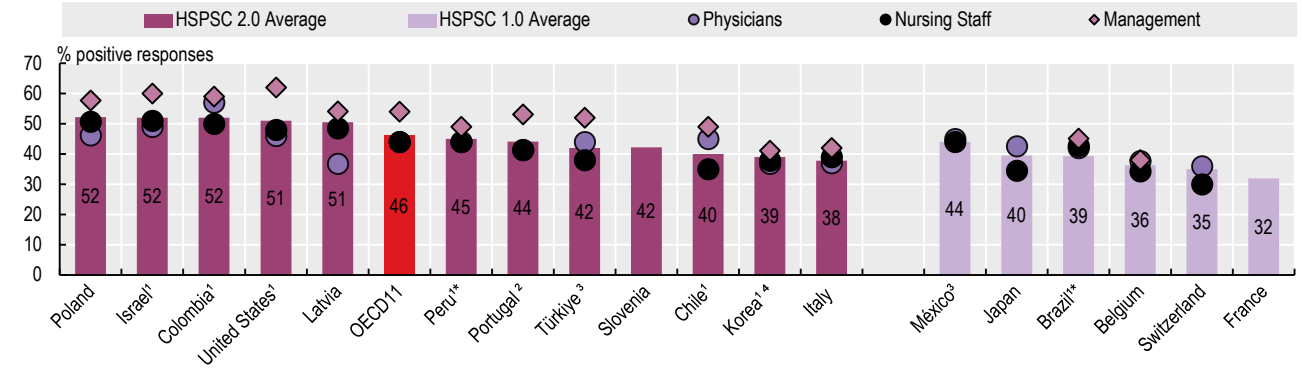
Figure 6.18. Health workers' perceptions of handoffs and information exchange, 2023 (or nearest year)



1. Latest data from 2020-2022. 2. Latest data from 2024. 3. Latest data from 2025. 4. Voluntary data submitted from 15 hospitals. * Accession/partner country.
Source: OECD Health Statistics 2025 and de Bienassis and Klazinga (2024[3]).

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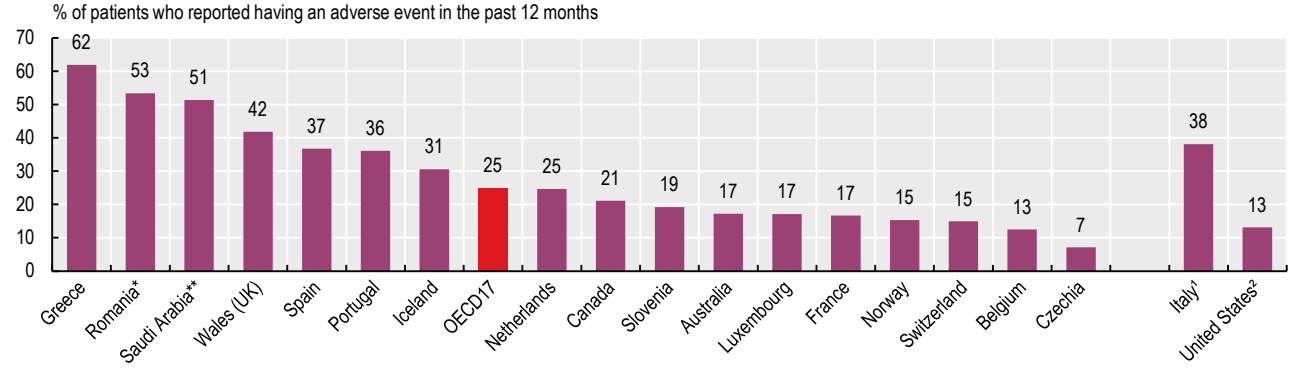
Figure 6.19. Health workers' perceptions of adequate staff levels and work pace, by job category, 2023 (or nearest year)



1. Latest data from 2020-2022. 2. Latest data from 2025. 3. Latest data from 2024. 4. Voluntary data submitted from 15 hospitals.* Accession/partner country.
Source: OECD Health Statistics 2025 and de Bienassis and Klazinga (2024[3]).

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Figure 6.20. Primary care users reporting that something went wrong over the course of their care in the last 12 months, 2024



1. Data for Italy refer to patients enrolled in outpatient settings for specialist visits in selected regions. 2. United States sample only includes people aged 65 and over.
* Accession/partner country. ** Participated in the PaRIS survey.
Source: OECD PaRIS 2024 Database.

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Safe acute care – surgical complications and handling of errors

Patient safety, relating to prevention of harm during healthcare activities, is a pressing issue with substantial social and economic costs in OECD countries. It is estimated that up to 13% of healthcare spending goes towards treatment of patients harmed during care, most of which could be avoided if appropriate safety protocols and clinical guidelines were adhered to (Slawomirski and Klazinga, 2022[1]). To achieve sustainable progress towards safe care and the goals of WHO's Global Patient Safety Action Plan 2021-2030, a focus on promoting patient safety cultures (see section on "Safe acute care – workplace culture and patient experiences") and improving both processes and outcomes (see section on "Patient-reported outcomes in acute care") is vital (WHO, 2021[2]).

Surgery for hip fracture is usually performed as an urgent/unplanned procedure. Early intervention within the first 48 hours can drastically improve patient outcomes and minimise the risk of complications. Time to surgery is influenced by many factors, including hospitals' surgical theatre capacity, staffing, flow and co-ordination, and targeted policy and organisational interventions – such as fast-track surgery pathways implemented in several high-performing countries like the Netherlands, Norway and Sweden.

Across OECD countries, nearly four out of five (79%) patients admitted for hip fracture underwent surgery within 48 hours in 2023, ranging from 98% in Norway to 44% in Latvia (Figure 6.21). The proportion of patients whose surgery was managed in a timely manner increased substantially between 2013 and 2023 in Italy (28 p.p.), Israel (18 p.p.) and Spain (11 p.p.), while rates decreased in Lithuania, the United Kingdom, Iceland and Latvia. During this period, Italy and Israel adopted this indicator within their national quality monitoring activities, helping to highlight the importance of timely intervention within the national context.

Severe tearing of the perineum during vaginal childbirth is a drastic adverse patient safety event that often requires surgical intervention and may lead to complications such as perineal pain and incontinence. Although prevention is not always possible, appropriate labour management and high-quality obstetric care can reduce the occurrence of tears.

Figure 6.22 shows that the incidence of traumas in vaginal births without instrumental assistance ranges from 0.5% and under in Poland, Lithuania, Costa Rica and Israel to over 3% in Canada, Iceland and Denmark. Differences across countries unrelated to surgical care quality – notably rates of caesarean sections, transparency and coding practices, and use of administrative versus obstetric registry data – influence obstetric trauma rates. Accurate and transparent monitoring is essential to improve patient safety, underscoring the importance of adequately recognising, capturing and addressing the true incident rates.

While administrative data are vital for monitoring patient safety, completeness and accurate recording of medical care and outcomes are dependent on healthcare workers' documentation when health incidents occur. A culture where workers feel they will be individually blamed for mistakes can discourage accurate reporting and inhibit individual and system performance. Although many countries are actively working to develop non-punitive, learning cultures that aim to improve patient safety by addressing system-level barriers to safe care (de Bienassis and Klazinga, 2024[3]), healthcare workers continue to give a low score to perceptions of fair response to error, with just over half of hospital care workers in OECD countries perceiving that they are treated fairly when they make mistakes and that there is a focus on learning from mistakes and supporting staff involved in errors at their workplace (Figure 6.23).

Definition and comparability

Figure 6.21 shows the proportion of patients aged 65 and over admitted to hospital with a diagnosis of upper femur fracture who had surgery initiated within two calendar days of admission. While cases where the hip fracture occurred during the admission should normally be excluded, countries where the time of admission and surgery is not comprehensively captured within hospital administrative data could have overestimated the rates.

The obstetric trauma indicator shows the rates of third- and fourth-degree tears, using International Classification of Diseases, tenth revision (ICD-10) codes O70.2-O70.3 in any field, after vaginal delivery where an instrument was not used (e.g. deliveries using forceps or vacuum extraction).

For information on sources and methods for healthcare workers' perceptions of response to error, see section on "Safe acute care – workplace culture and patient experiences".

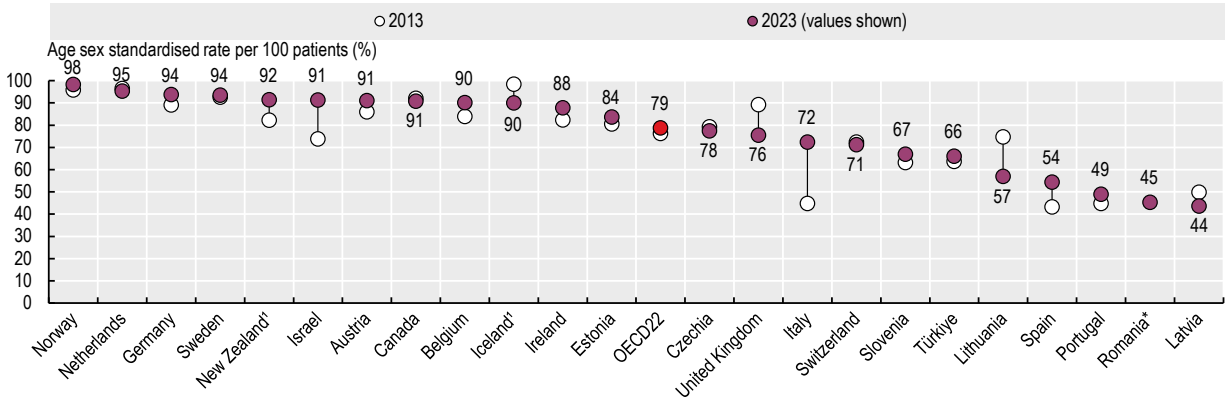
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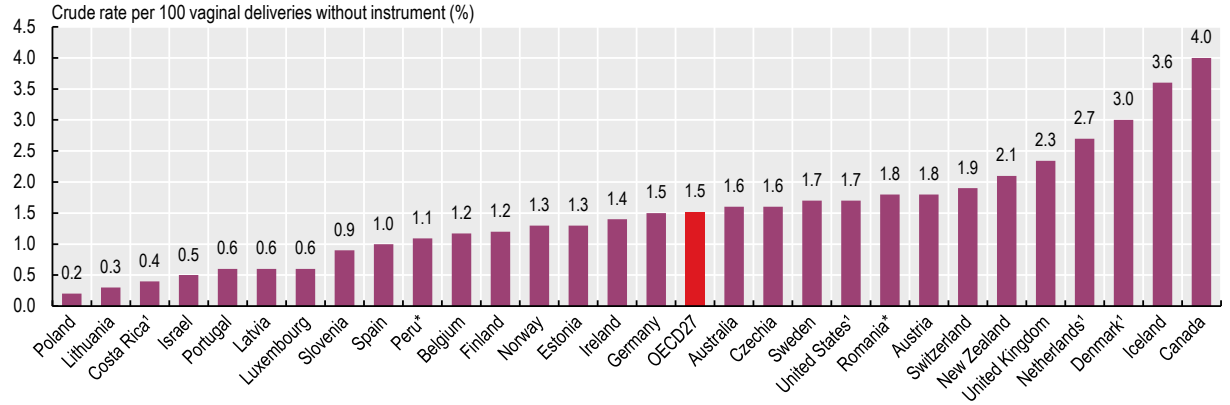
Figure 6.21. Hip fracture surgery initiation for patients aged 65 and over within two days of hospital admission, 2023 and 2013 (or nearest year)



1. Latest data from 2021-2022. * Accession/partner country.
Source: OECD Health Statistics 2025.

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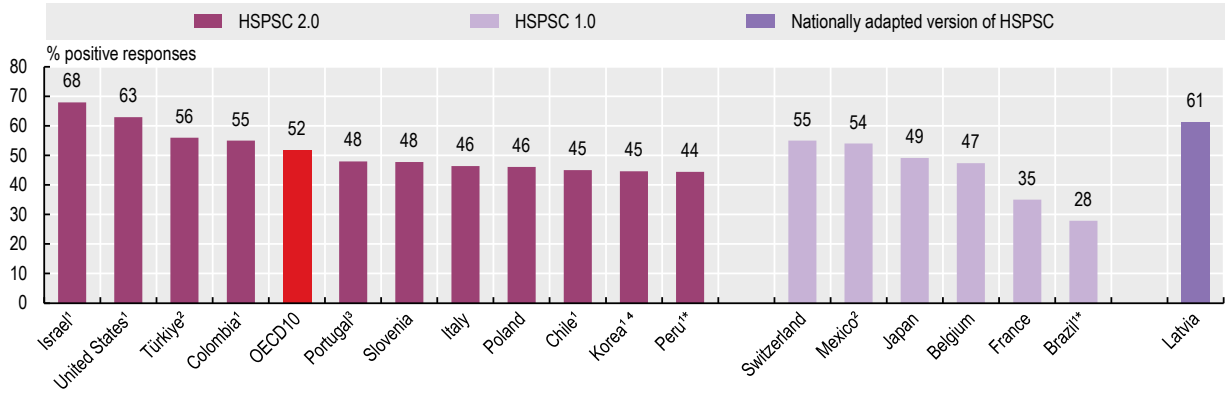
Figure 6.22. Obstetric trauma in vaginal delivery without instrument assistance, 2023 (or nearest year)



1. Latest data from 2020-2022. * Accession/partner country.
Source: OECD Health Statistics 2025.

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Figure 6.23. Healthcare workers' perceptions of fairness of response to error, 2024 (or nearest year)



1. Latest data from 2020-2022. 2. Latest data from 2024. 3. Latest data from 2025. 4. Voluntary data submitted from 15 hospitals. * Accession/partner country.
Source: OECD Health Statistics 2025 and de Bienassis and Klazinga (2024[3]).

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Mortality following acute myocardial infarction (AMI)

Mortality due to coronary heart disease has declined substantially over recent decades (see section on "Mortality from circulatory diseases" in Chapter 3). Reductions in smoking (see section on "Smoking and vaping" in Chapter 4) and improvements in treatment for heart diseases have contributed to this decline. Despite this progress, AMI (heart attack) remains one of the leading causes of death and the main cause of cardiovascular death in many OECD countries, highlighting the needs for further reductions in risk factors and care quality improvements (OECD/The King's Fund, 2020[1]; OECD, 2025[2]).

Metrics of 30-day mortality after hospital admission for AMI are reflective of processes of care, such as timely transport of patients and timely and effective medical interventions. As such, the indicator is influenced not only by the quality of acute care provided in hospitals – such as percutaneous coronary intervention (PCI) and coronary artery bypass graft surgery – but also by quality and timeliness of pre-hospital diagnosis and treatment including the use of automated external defibrillator (AED) and administration of medications, co-ordinated ambulance dispatch and efficient patient transportation to hospitals, and providing adequate diagnosis and treatment. Thirty-day mortality rates are also related to differences in patterns of hospital transfers, length of stay and AMI severity.

Figure 6.24 shows mortality rates within 30 days of admission to hospital for AMI using unlinked data – that is, only counting deaths that occurred in the hospital where the patient was initially admitted – among patients aged 45 and over. The lowest rates in 2023 were in Iceland, Norway, the Netherlands, Australia and Sweden (less than 4%) while the highest rates were in Mexico (23%) and Latvia (14%).

Figure 6.25. shows the same 30-day mortality rate but calculated based on linked data, whereby the deaths are recorded regardless of where they occurred after hospital admission (in the hospital where the patient was initially admitted, after transfer to another hospital or after being discharged). Based on these linked data, AMI mortality rates in 2023 ranged from 5% in Iceland and the Netherlands to 15% in Latvia.

Case fatality rates for AMI decreased substantially before the pandemic between 2013 and 2019 but there has been little improvement since 2019. Across OECD countries, the average rate fell from 8.2% to 6.7% for same-hospital deaths and from 10.7% to 8.9% for deaths in and out of hospital between 2013 and 2019 but in 2023 the average rate was 6.5% for same-hospital deaths (Figure 6.24) and 8.6% for deaths in and out of hospital (Figure 6.25.). However, there were a few exceptions: the 30-day mortality rate for AMI declined substantially in Japan, and a significant increase was observed in Türkiye and Poland since 2019. In Japan, a professional society responsible for certification of professionals and providers in cardiovascular interventions introduced a benchmarking mechanism for quality of PCI in 2018, and benchmarking results – covering 90% of PCI conducted in the country, are reported at the provider level to facilitate quality improvement (Saito et al., 2024[3]).

The mortality rate within 24 hours of hospital admission, which usually excludes deaths in the ambulance or hospital emergency department, was below 1.5 per 100 patients in Iceland, Canada and Australia but above 3.5 per 100 patients in Lithuania and Latvia in 2023 (Figure 6.26). Pre-hospital access to effective care is crucial for short-term outcomes for AMI patients. To ensure timely delivery of treatment, countries are increasingly allowing citizens to use an AED without prior training. Several OECD countries also overcame regulatory hurdles to allow non-medical pre-hospital staff to perform certain medical tasks such as diagnosis, prescription and administration of medicines. In Australia, ambulance officers can administer medications according to protocols, and their role has progressively increased in scope as has the sophistication of their training (OECD, 2025[2]; Putland, Morgan and Fujisawa, forthcoming[4]).

Definition and comparability

The case fatality rate measures the percentage of people aged 45 and over who die within 24 hours or within 30 days following hospital admission for a specific acute condition. For most countries, data refer to deaths after formal hospital admissions, excluding deaths in hospital emergency departments and prior to hospital arrival. Unlinked data include only deaths that occurred in the same hospital as the initial admission; linked data include deaths recorded regardless of where they occurred, including in another hospital or outside the hospital where AMI was first recorded. The linked-data-based method is considered more comprehensive and comparable than the rates based on unlinked data, and results in much lower variation between countries. However, it requires a unique patient identifier to link the data across the relevant datasets, which is not available in all countries. The results from this indicator are higher than for the same-hospital indicator.

Rates are age- and sex-standardised to the 2013 OECD population aged 45 and over admitted to hospital for AMI, using ICD-10 codes I21-I22.

References

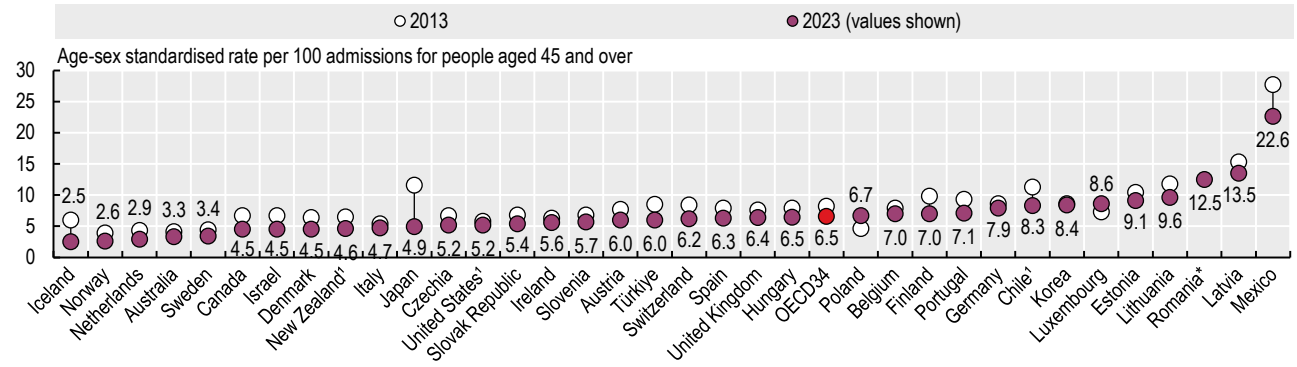
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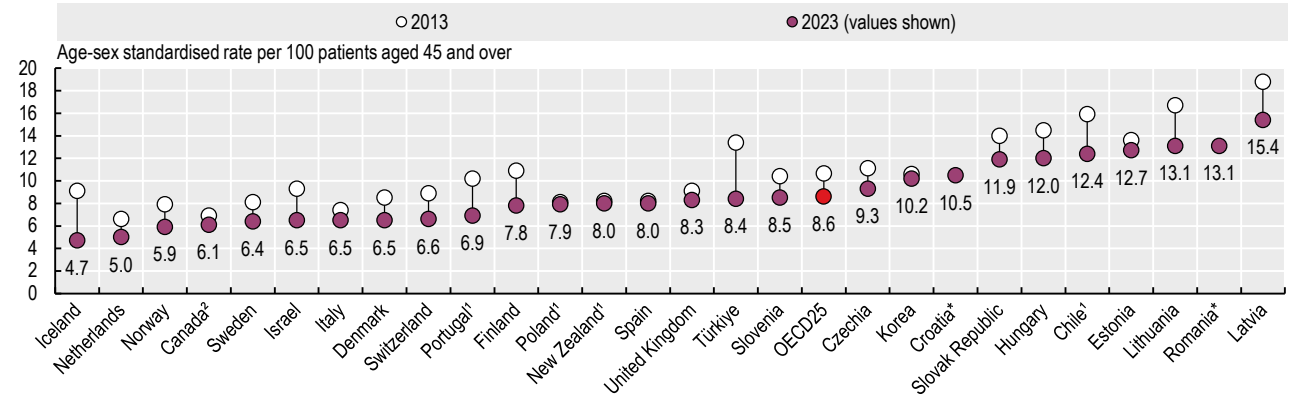
Figure 6.24. Thirty-day mortality after admission to hospital for acute myocardial infarction based on unlinked data, 2023 and 2013 (or nearest year)



1. Latest data from 2020-2022. * Accession/partner country.
Source: OECD Health Statistics 2025.

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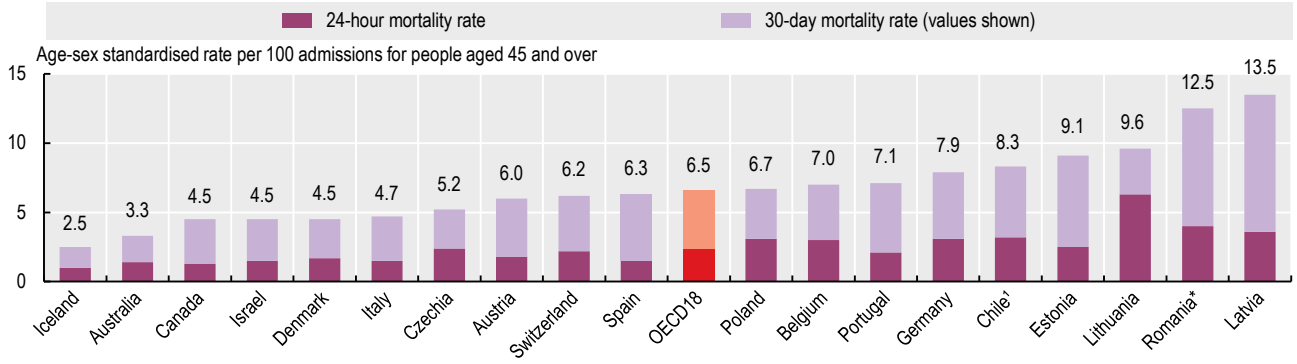
Figure 6.25. Thirty-day mortality after admission to hospital for acute myocardial infarction based on linked data, 2023 and 2013 (or nearest year)



1. Latest data from 2020-2022. 2. Data do not include deaths outside acute care hospitals. * Accession/partner country.
Source: OECD Health Statistics 2025.

StatLink https://stat.link/p4xa1m

Figure 6.26. Mortality within 24 hours and 30 days of admission to hospital for acute myocardial infarction based on unlinked data, 2023 (or nearest year)



1. Latest data from 2020-2021. * Accession/partner country.
Source: OECD Health Statistics 2025.

StatLink https://stat.link/fmzxkc

Mortality following ischaemic stroke

Stroke is a leading cause of death, accounting for 6% of all deaths across OECD countries in 2023 (see sections on "Main causes of mortality" and "Mortality from circulatory diseases" in Chapter 3). A stroke occurs when the blood supply to a part of the brain is interrupted, leading to necrosis (cell death) of the affected part. Of the two types of stroke, about 85% are ischaemic (caused by clotting) and 15% are haemorrhagic (caused by bleeding). Timely diagnosis is essential for time-sensitive treatment such as intravenous thrombolysis to remove or disperse blood clots and thrombectomy to remove a blood clot from a blood vessel.

Figure 6.27 shows the case fatality rates within 30 days of hospital admission for ischaemic stroke where death occurred in the same hospital as the initial admission (unlinked data). Figure 6.28 shows the case fatality rate where deaths are recorded regardless of where they occurred, including in another hospital or outside the hospital where the stroke was first recorded (linked data). The indicator using linked data is more comprehensive and comparable, but it requires a unique patient identifier and the capacity to link data – which are not available in all countries. The results from this indicator are higher than for the same-hospital indicator, as deaths are recorded regardless of where they occurred after hospital admission.

Across OECD countries, 7.7% of patients died within 30 days of hospital admission for ischaemic stroke in 2023, based on unlinked data (Figure 6.27). The case fatality rates were highest in Latvia, Mexico, Slovenia and Lithuania – all with mortality rates over 11%. Rates were lower than 4% in Japan, Korea and Norway. Low rates in Japan are due in part to efforts dedicated to improving the treatment of stroke patients, through systematic blood pressure monitoring, major material investment in hospitals and establishment of specialised stroke units so that almost all of the population have access to a primary stroke centre within 60 minutes by emergency motor vehicle (OECD, 2015[1]). In Norway, mobile stroke ambulances with on-board computed tomography scanners that can diagnose and treat acute ischaemic stroke are available; in 2023, 95% of stroke patients receive care at specialised stroke units (OECD, 2025[2]). On the other hand, in Latvia with a relatively high case fatality rate, only about half of stroke patients were treated in specialised stroke units in 2023.

Across 24 OECD countries that reported linked data, 12.1% of patients on average died within 30 days of being admitted to hospital for ischaemic stroke in 2023 (Figure 6.28). The mortality rate was highest (over 15%) in Latvia, Türkiye, Lithuania, Chile and Estonia, and lowest (under 8%) in Korea, Israel and Norway. Korea has attained low mortality rates through improvements in acute ischaemic stroke management, including an increased number of comprehensive stroke centres supporting high-quality care and thrombectomy, and expansions in health insurance coverage in relation to mechanical thrombectomy (Park et al., 2022[3]).

Treatment for ischaemic stroke has advanced dramatically over recent decades, with systems and processes now in place in many OECD countries to identify suspected ischaemic stroke patients and to deliver acute reperfusion therapy quickly. Improvement was notable before the pandemic between 2013 and 2019, when case fatality rates for ischaemic stroke decreased across OECD countries: on average, from 9.3% to 7.9% for unlinked data rates and from 13.4% to 12.1% for linked data rates (Figure 6.27 and Figure 6.28). However, as with AMI (see section on "Mortality following acute myocardial infarction (AMI)"), there has been little improvement in recent years, and mortality rates remained stable between 2019 and 2023.

Countries can improve the quality of stroke care further through timely transportation of patients, timely diagnosis, evidence-based medical interventions and access to high-quality specialised facilities such as stroke units. Advances in technology are leading to new models of care to deliver reperfusion therapy even more quickly and efficiently, whether through pre-hospital triage by telephone or administering the treatment in the ambulance (OECD, 2025[2]).

Definition and comparability

Case fatality rates are defined and unlinked and linked data are explained in the section on "Mortality following acute myocardial infarction (AMI)". Ischaemic stroke refers to ICD-10 codes I63-I64.

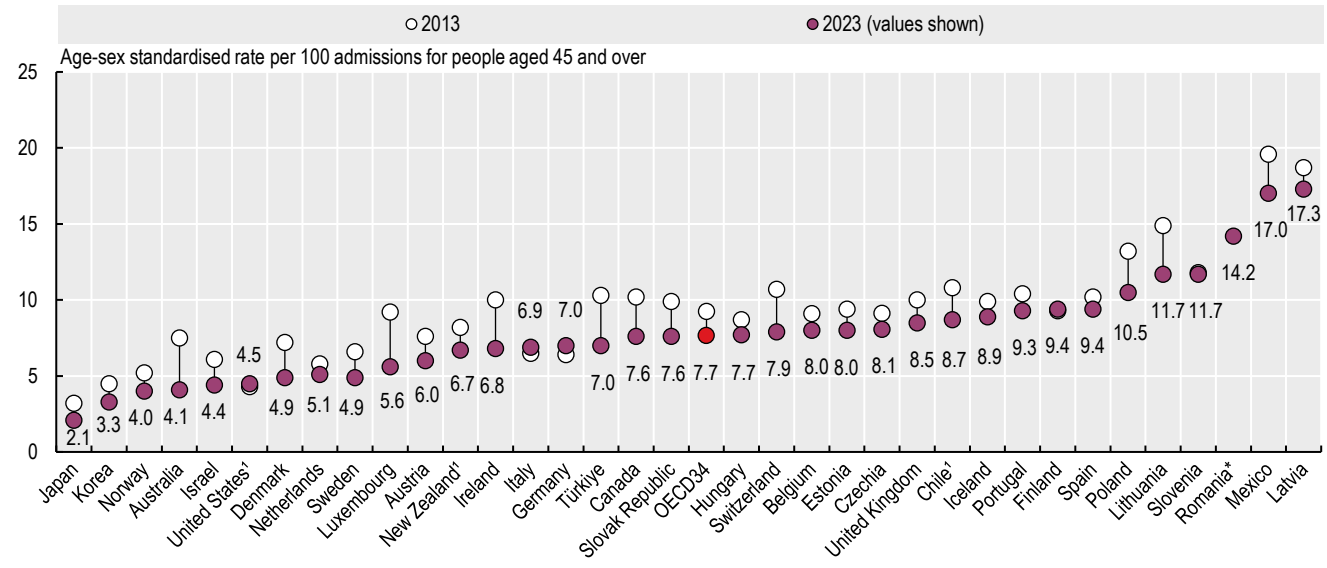
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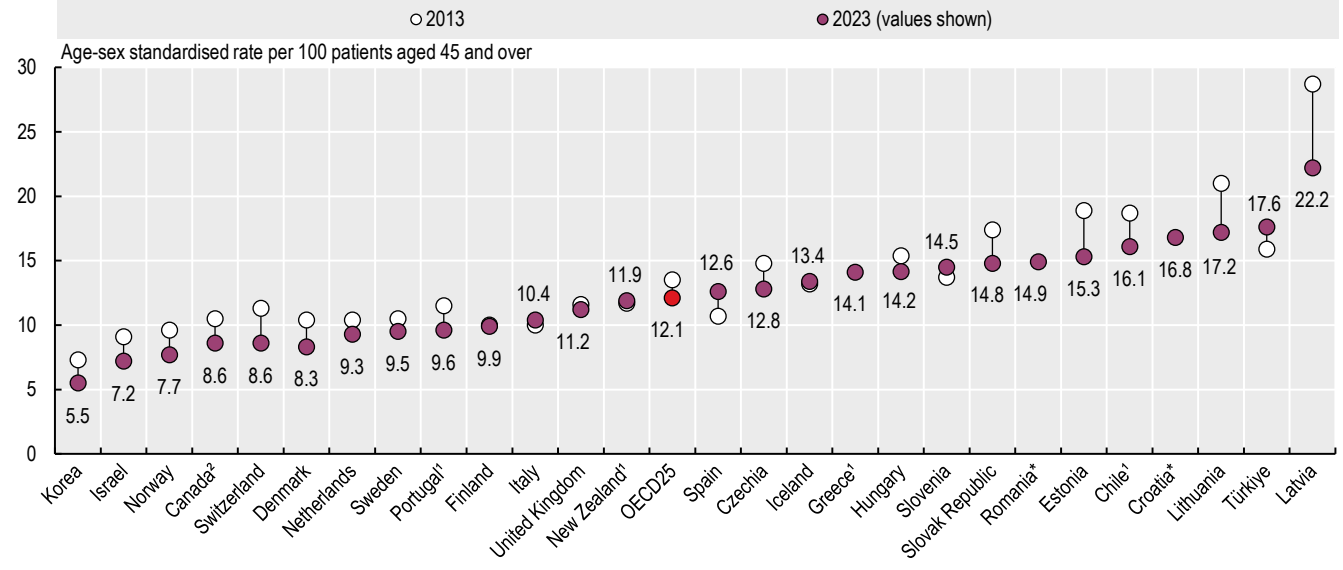
Figure 6.27. Thirty-day mortality after admission to hospital for ischaemic stroke based on unlinked data, 2023 and 2013 (or nearest year)



1. Latest data from 2021-2022. * Accession/partner country.
Source: OECD Health Statistics 2025.

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Figure 6.28. Thirty-day mortality after admission to hospital for ischaemic stroke based on linked data, 2023 and 2013 (or nearest year)



1. Latest data from 2020-2022. 2. Data do not include deaths outside acute care hospitals. * Accession/partner country.
Source: OECD Health Statistics 2025.

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Care for people with mental health disorders

The burden of mental illness is substantial, affecting one-in-two people at some point in their lives (see section on "Mental Health" in Chapter 3). Since the pandemic, the prevalence of severe mental illnesses has risen and remains above pre-pandemic levels in most OECD countries. The economic costs of mental health disorders are estimated to be over 4.2% of gross domestic product, covering direct treatment costs and indirect costs from lower employment and reduced productivity (OECD, 2021[1]). High-quality, timely care can improve outcomes and reduce suicide and excess mortality for people with mental health disorders.

Rates of death by suicide after hospital discharge can indicate the quality of care in the community following hospitalisation, and co-ordination between inpatient and community settings. Across OECD countries, suicide rates among patients who had been hospitalised in the previous year ranged from 1.4 per 1 000 patients in the United Kingdom to 6.9 per 1 000 patients in Korea in 2023 (Figure 6.29). Differences in suicide rates may also reflect differences in access to mental health care and the severity of conditions treated in inpatient settings, as hospital discharges vary widely across countries. Between 2013 and 2023, suicides after hospital discharge increased in Chile, Czechia, the Slovak Republic, Slovenia and Korea; but decreased in Finland, Denmark, Latvia, Canada, Lithuania, Sweden, Israel and Iceland. In Finland, suicide prevention has been a policy priority, as part of its National Mental Health Strategy and Suicide Prevention Agenda, which aims to increase resources for mental health services in primary care and to strengthen co-ordination between primary care and specialised care (OECD/European Observatory on Health Systems and Policies, 2023[2]).

An "excess mortality" value greater than one implies that people with mental health disorders face a higher risk of death than the rest of the population. Figure 6.30 shows that across OECD countries, mortality rates are over four times higher for people with schizophrenia and over twice as high for people with bipolar disorder, compared to the general population. In 2023, excess mortality ranged from 2.1 in Lithuania to 6.5 in Norway for people with schizophrenia, and from 1.4 in Lithuania to 4.3 in Korea for people with bipolar disorder. Over the past decade, excess mortality among people with severe mental illness has risen in most countries, except for bipolar disorder in Sweden and schizophrenia in Chile. One study found that increases in excess mortality among people with schizophrenia during the pandemic were driven by fewer admissions for somatic diseases and reduced access to and effectiveness of non-COVID acute care for people with schizophrenia compared to patients without severe mental disorders (Boyer et al., 2022[3]).

Patient-reported experience measures (PREMs) help to capture the quality of care provided to individuals living with mental health conditions. These metrics are increasingly used in mental health care to understand people's experience of health services and provision of people-centred care (de Bienassis et al., 2022[4]). Figure 6.31 shows whether service users felt as involved in treatment decisions as they wanted, both in inpatient mental health settings and among those using community services. The share of inpatient mental health service users reporting that they felt involved in their treatment decisions ranged from 50% in Japan to 83% in Türkiye. In community mental health settings, the lowest share was in Japan (75%), and the highest shares were in Türkiye (96%) and Portugal (89%).

Definition and comparability

Suicide within one year of discharge is established by linking patients discharged following hospitalisation, with a principal diagnosis or secondary diagnosis codes of mental health and behavioural disorders (ICD-10 codes F10-F69, F90-99), and suicide recorded in death registries (ICD-10 codes X60-X84). If secondary diagnosis codes are not equally important, a principal diagnosis or first two listed secondary diagnosis codes of mental health and behavioural disorders are used. For Slovenia, 2013 data are based only on principal diagnoses, for Israel both 2013 and 2023 data are based on only principal diagnoses, and in Korea, 2013 and 2023 data refer to people with principal diagnosis or first listed secondary diagnosis code.

The numerator for excess mortality is the overall mortality rate for people aged 15-74 diagnosed with schizophrenia or bipolar disorder. The denominator is the overall mortality rate for the general population in the same age group. The relatively small number of people with schizophrenia or bipolar disorder dying in any given year can cause substantial variations in this indicator from year to year.

Mental health PREMs are based on the assessment of inpatient and community mental health service users. Data refer to people aged 16 and over with a principal diagnosis of mental health and behavioural disorders. Cross-country comparisons of mental health PREMs should be made with caution due to variations in survey instrument. Data for Belgium refer to Flanders; for France to Paris; and for Australia to Victoria, Queensland and New South Wales.

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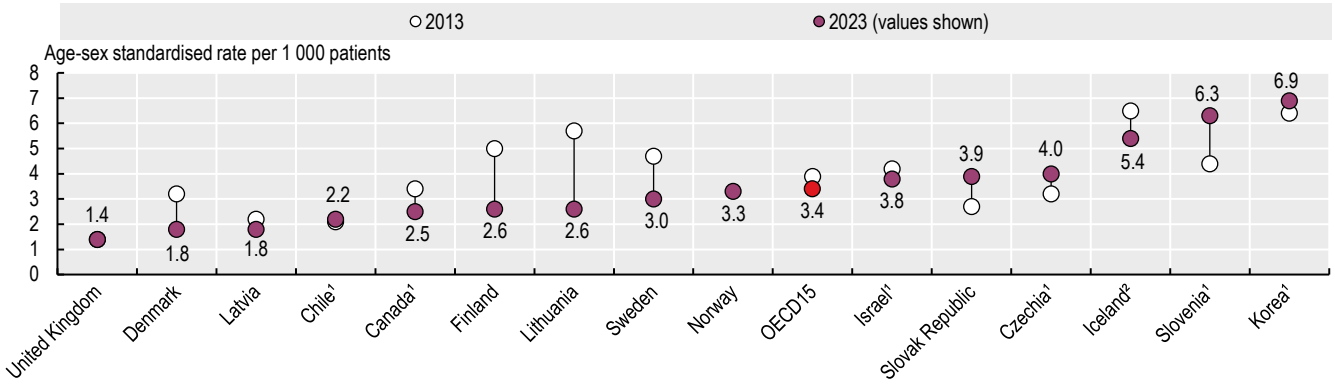
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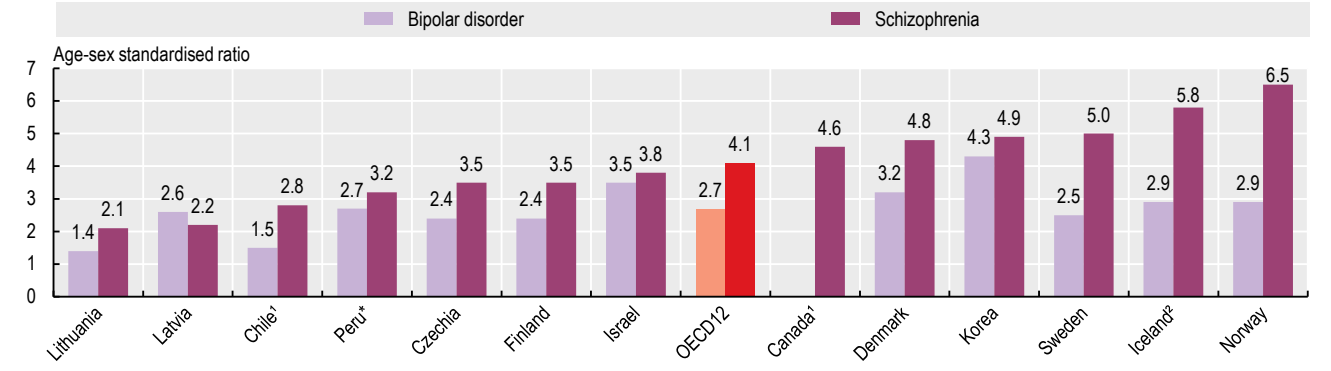
Figure 6.29. Suicide following hospitalisation for a psychiatric disorder, within one year of discharge, 2023 and 2013 (or nearest year)



1. Latest data from 2021-2022. 2. Data use three-year average.
Source: OECD Health Statistics 2025.

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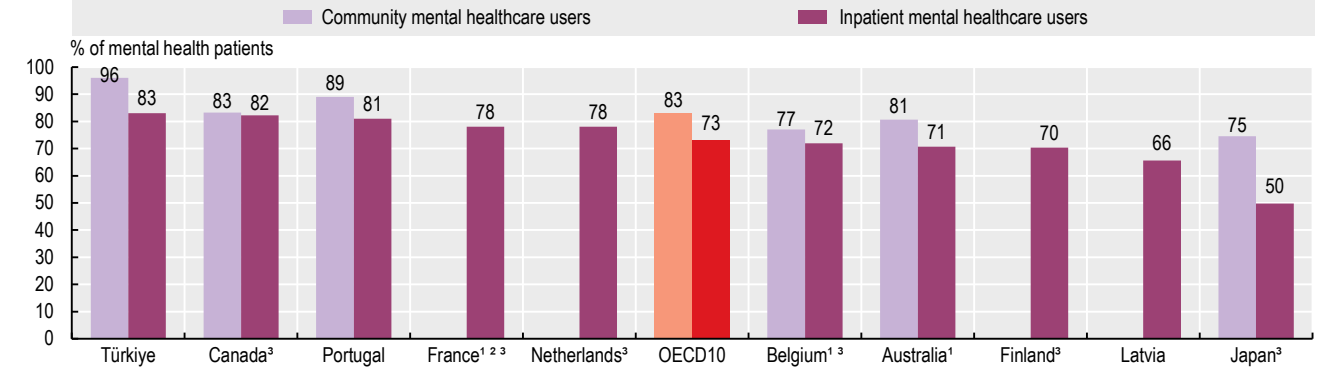
Figure 6.30. Excess mortality from bipolar disorder and schizophrenia compared to the general population, 2023 (or nearest year)



1. Latest data from 2022. 2. Data use three-year average. * Accession/partner country.
Source: OECD Health Statistics 2025.

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Figure 6.31. Inpatient mental health service users involvement in treatment decisions, 2023 (or nearest year)



1. Sampling covers only part of country, as detailed in definition and comparability box. 2. Sample less than 500. 3. Latest data from 2020-2022.
Source: OECD Health Statistics 2025 and de Bienassis et al. (2022[4]).

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Patient-reported outcomes in hospital care

Patient-reported outcome measures (PROMs) have become essential tools to inform improvements in healthcare quality and ensure people-centred care (see section on "Person centredness of primary care"). PROMs are often used as an indicator of the quality of care, including for acute care such as hip and knee replacement surgery. They are used to monitor and promote delivery of patient-centred care as they provide information on outcomes from the patient's perspective, including, for example whether the care they received was aligned with their individual goals and needs. Given the increasing use of PROMs to assess the quality of care in recent years, the number of people responding to PROMs requests in relation to hip and knee replacement surgery has increased across countries (Kendir et al., 2022[1]).

Figure 6.32 shows changes between the pre-operative and post-operative scores on the Oxford Hip Score (OHS) scales reported by patients after elective hip replacement surgery for osteoarthritis, which are available in joint replacement registries across OECD countries. Figure 6.33 shows changes between the pre-operative and post-operative scores reported by patients using the Oxford Knee Score (OKS) after elective knee replacement surgery for osteoarthritis. Figure 6.34 shows quality of life of patients measured by the EuroQol 5-Dimensional tool (EQ-5D) covering mobility, self-care, usual activities, pain/discomfort and anxiety/depression before and after hip or knee replacement surgery.

Changes from pre-operative to post-operative scores show that, on average, patients reported improvements in their conditions and in their quality of life after operations. For hip surgery, post-operative OHS increased substantially in all countries. Finland recorded the highest post-operative score, from 23 to 45, while Germany is the only country that remained below 40, with a post-operative score of 37 (Figure 6.32). For knee replacement surgery, all countries also reported post-operative gains, with a pre-operative OKS range of 19-25 increasing to 36-41 after surgery (Figure 6.33). Finland again showed the highest post-operative score at a score of 41. In relation to quality of life, for hip replacements, EQ-5D scores rose from a range of 0.26-0.59 before surgery to 0.77-0.90 after surgery; for knee replacements, scores improved from a range of 0.49-0.66 before surgery to 0.68-0.88 after surgery (Figure 6.34).

The extent of improvements (i.e. the average change between pre- and post-operative scores) was similar between men and women for specific health conditions and quality of life for both types of operations. However, women had lower pre- and post-operative scores for the conditions related to the operation and overall quality of life in all countries for both types of surgery. This highlights the need for healthcare systems to consider how diseases manifest and progress differently in men and women, and to ensure that care responds appropriately to these differences (see Chapter 2).

It should be noted that variations in post-operative scores reflect not only cross-country differences in the quality of hip and knee replacement surgery but also other factors beyond the healthcare received – notably, differences in socio-demographic and clinical characteristics of patients reporting PROMs. Caution is therefore needed when interpreting variations across countries. While international comparability of data remains limited for a few countries, more countries have been making efforts to measure the quality of care for people undergoing hip and knee replacement surgery from the perspective of patients. Examples include recent national- level hip and knee PROMs data collections in Norway and Slovenia.

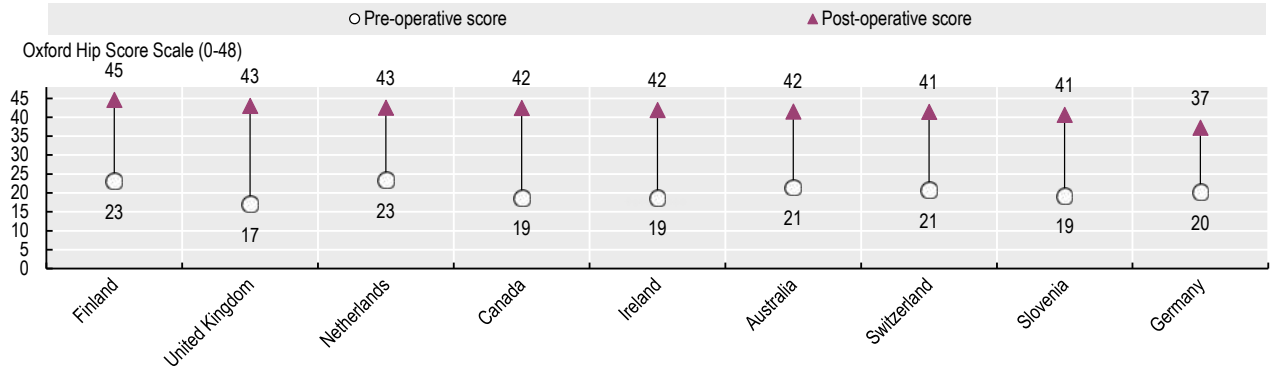
Definition and comparability

PROMs results are based on data from national or subnational arthroplasty registries in countries using data on adult patients undergoing elective hip or knee replacement surgery with a principal diagnosis of osteoarthritis, who completed an Oxford Hip/Kness Score (OHS/OKS) questionnaire, and/or an EuroQol 5-Dimensional tool (EQ-5D), both before and after operations. The OHS/OKS is among the most common disease-specific PROMs used for hip and knee replacement surgery. The EQ-5D is also frequently used to assess general quality of life of patients. A higher score denotes better outcomes on all these scales. Post-operative scores for Australia, Ireland and England (United Kingdom) are measured six months after the surgery, while others refer to 12 months after surgery. In all measures, data for Canada refer to Alberta, Manitoba and Ontario, data for Germany refer to Dresden, and data for Switzerland refer to Geneva. Sample size for Germany for the OHS and the OKS is below 600 patients.

References

Kendir, C. et al. (2022), "International assessment of the use and results of patient-reported outcome measures for hip and knee replacement surgery: Findings of the OECD Patient-Reported Indicator Surveys (PaRIS) working group on hip and knee replacement surgery", *OECD Health Working Papers*, No. 148, OECD Publishing, Paris, https://doi.org/10.1787/6da7f06b-en. [1]

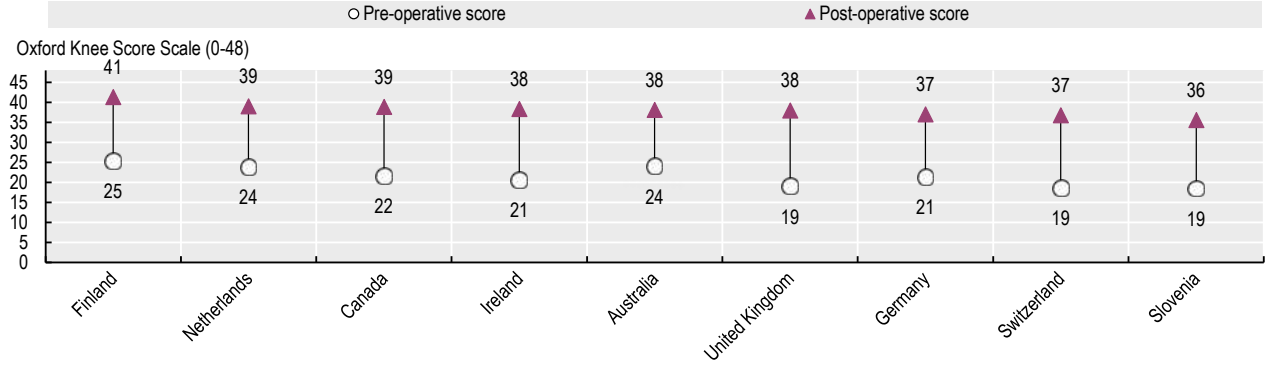
Figure 6.32. Patient-reported outcomes before and after hip replacement surgery, disease-specific measure, 2024 (or nearest year)



Note: Data for Canada refer to Alberta, Manitoba and Ontario; data for Germany refer to Dresden; and data for Switzerland refer to Geneva.
Source: OECD Health Statistics 2025.

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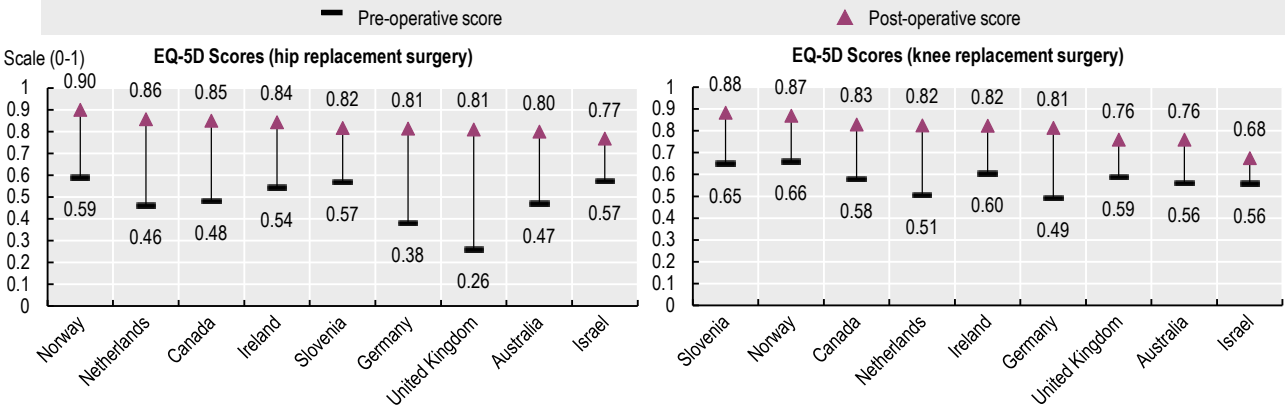
Figure 6.33. Patient-reported outcomes before and after knee replacement surgery, disease-specific measure, 2024 (or nearest year)



Note: Data for Canada refer to Alberta, Manitoba and Ontario; data for Germany refer to Dresden; and data for Switzerland refer to Geneva.
Source: OECD Health Statistics 2025.

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Figure 6.34. Patient-reported quality of life before and after hip and knee replacement surgery, generic measure, 2024 (or nearest year)



Note: Data for Canada refer to Alberta, Manitoba and Ontario; data for Germany refer to Dresden; and data for Switzerland refer to Geneva.
Source: OECD Health Statistics 2025.

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Integrated care

When patients with chronic conditions receive care from multiple providers across different healthcare settings, fragmented services can lead to poor health outcomes, unmet needs, excessive service use and higher costs. On average across OECD countries, based on PaRIS data, only 59% primary care users living with chronic conditions reported good care co-ordination, with results ranging from 22% in Wales (United Kingdom) to 81% in Switzerland. In response, many countries are developing new models of care to better integrate services – aiming to enhance population health, improve patient experience, reduce costs, support healthcare professionals' well-being and promote health equity (OECD, 2023[1]).

Optimal integration across levels of care for patients with stroke and chronic heart failure (CHF) reduces unnecessary hospital readmissions and mortality, while improving adherence to appropriate prescribing (Barrenho et al., 2022[2]). Among patients discharged from hospital, indicators such as readmission rates, mortality and compliance with prescription guidelines serve as key measures of how effectively health systems deliver integrated care.

Figure 6.35 presents the share of patients experiencing adverse outcomes within one year of discharge for ischaemic stroke and CHF in 2023. There is substantial cross-country variation in both the level and type of post-discharge outcomes. For stroke patients, on average across OECD countries,15% died and 23% were readmitted within a year, resulting in a combined adverse outcome of 38%. The Netherlands (31%) and Iceland (33%) reported the lowest overall rates, while Czechia (54%) and Denmark (48%) recorded the highest, with particularly high share of mortality and readmissions unrelated to the initial stroke. In nearly all countries, readmissions for conditions other than the original diagnosis account for the largest proportion of post-discharge events.

For CHF, the burden of post-discharge adverse events is consistently higher than for stroke. Iceland reported the lowest overall rate at 24%. In contrast, Norway (71%) and Czechia (69%) recorded the highest, with both mortality and readmissions exceeding the OECD averages. These findings point to opportunities to strengthen transitional care pathways and enhance continuity in chronic disease management.

Between 2013 and 2023, the share of patients who died or were readmitted within a year after discharge declined in most countries for both CHF and stroke. On average across OECD countries, adverse outcome rates fell by about 6 p.p. for CHF and 5 p.p. for stroke. Iceland showed the greatest improvement in both, with CHF rates dropping from 32.6% to 23.1% and stroke rates from 35.3% to 23.2%. Switzerland also saw substantial declines. These trends suggest progress in post-discharge care, with most countries maintaining or improving performance. However, several countries experienced worsening trends, particularly in CHF outcomes. Norway saw a rise in all-cause mortality within one year of discharge – from 23.3% in 2017 to 27.8% in 2023. Canada and Czechia also reported modest but consistent increases in post-discharge mortality, raising concerns about care co-ordination and primary care capacity.

Patients recovering from ischaemic stroke should receive antihypertensive and antithrombotic medications as part of secondary prevention after hospital discharge. Receiving at least one prescription within 18 months serves as an indicator of how well care is integrated between hospital and community settings (Barrenho et al., 2022[2]). Figure 6.36 shows wide variation in prescribing rates across countries: antihypertensives ranged from 68% in the Netherlands to 83% in Sweden, while antithrombotics ranged from 31% in OECD accession country Croatia to 94% in Sweden. Sweden's strong performance is likely to reflect effective information transfer across care levels and comprehensive diagnosis documentation (Dahlgren et al., 2017[3]).

Definition and comparability

Indicators refer to people aged 45 and over admitted for a non-elective (urgent) episode of care due to a first-time event of ischaemic stroke or CHF. A first-time event (index episode) was defined as no prior hospital admission for the same condition within the past five years. The year assigned to each indicator corresponds to the year of the index episode, with data capturing outcomes over the following 365 days for mortality and readmissions, and 548 days for prescriptions. Data are nationally representative for all countries. Rates are age- and sex-standardised. Integrated care indicators require linking of hospital records, death registries, and prescription or reimbursement claims using unique patient identifiers.

Definitions of acute, urgent care vary across countries. Most define it as hospital admission via emergency/unplanned care or care requiring immediate curative intervention.

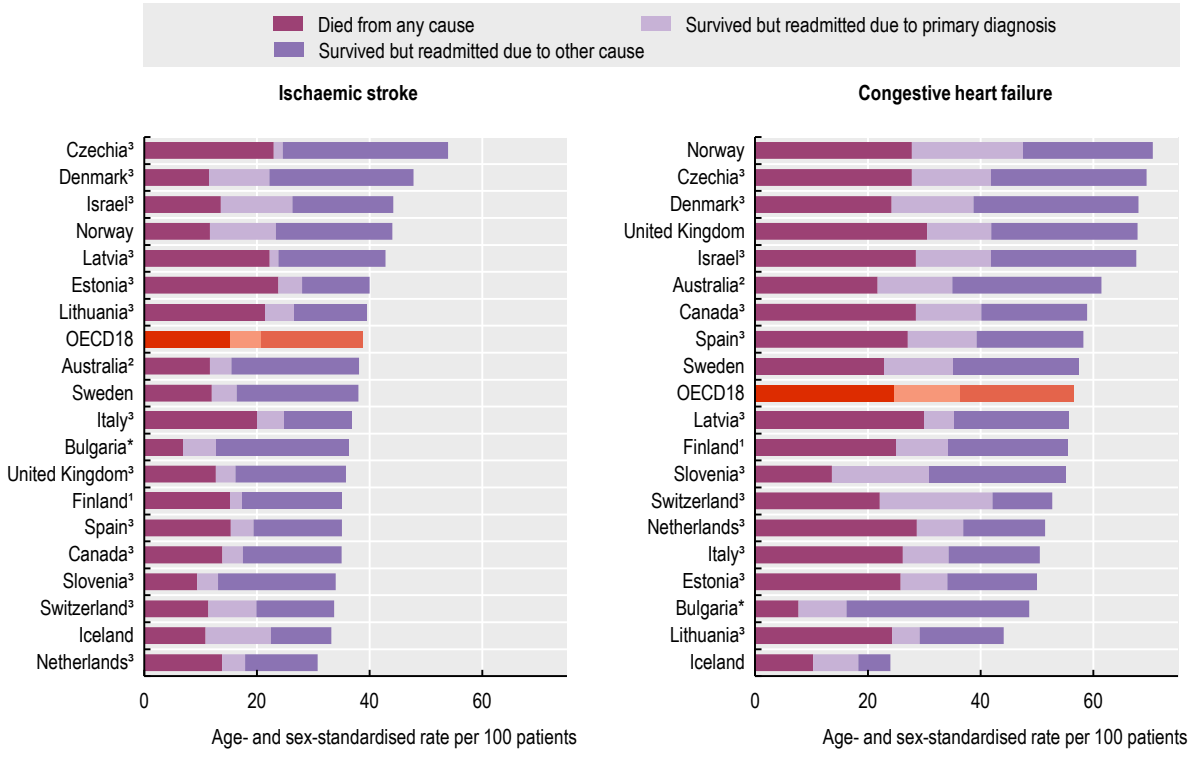
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Barrenho, E. et al. (2022), "International comparisons of the quality and outcomes of integrated care: Findings of the OECD pilot on stroke and chronic heart failure", *OECD Health Working Papers*, No. 142, OECD Publishing, Paris, https://doi.org/10.1787/480cf8a0-en. [2]

Dahlgren, C. et al. (2017), "Recording a diagnosis of stroke, transient ischaemic attack or myocardial infarction in primary healthcare and the association with dispensation of secondary preventive medication: a registry-based prospective cohort study", *BMJ Open*, Vol. 7/9, p. e015723, https://doi.org/10.1136/bmjopen-2016-015723. [3]

OECD (2023), *Integrating Care to Prevent and Manage Chronic Diseases: Best Practices in Public Health*, OECD Publishing, Paris, https://doi.org/10.1787/9acc1b1d-en. [1]

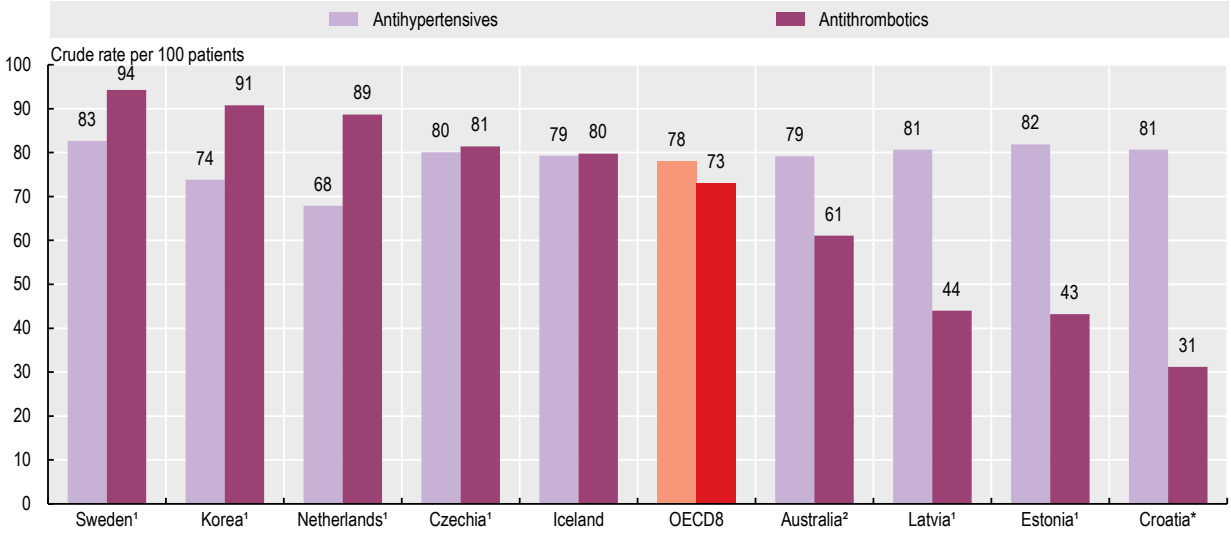
Figure 6.35. Patients with adverse outcomes within one year of discharge after ischaemic stroke and congestive heart failure, 2023 (or nearest year)



1. Latest data from 2018. 2. Latest data from 2019. 3. Latest data from 2020-2022. * Accession/partner country.
Source: OECD Health Statistics 2025.

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Figure 6.36. Patients receiving at least one antihypertensive and antithrombotic prescription in the 18 months following discharge after ischaemic stroke, 2023 (or nearest year)



1. Latest data from 2021-2022. 2. Latest data from 2019. * Accession/partner country.
Source: OECD Health Statistics 2025.

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7 Health expenditure

Health expenditure in relation to GDP
Health expenditure per capita
Prices in the health sector
Health expenditure by financing scheme
Public funding of health spending
Health expenditure by type of service
Health expenditure on prevention and primary healthcare
Health expenditure by provider
Capital expenditure in the health sector
Spending on crisis preparedness and critical care capacities
Health spending projections

Health expenditure in relation to GDP

The resources that a country allocates to healthcare compared to the size of the overall economy vary over time due to differences in both the growth of health spending and overall economic growth. During the 1990s and 2000s, OECD countries generally saw health spending outpace the rest of the economy, leading to an almost continual rise in the health expenditure-to-gross domestic product (GDP) ratio. After the volatility of the 2008 economic and financial crisis, this share remained relatively stable, as growth in health spending broadly matched overall economic performance across the OECD. In recent years, the COVID-19 pandemic and the cost-of-living and energy crisis led to further adjustments in this ratio.

In 2024, OECD countries are estimated to have allocated around 9.3% of their GDP to health on average (Figure 7.1). This was above the ratio seen in 2023 but remained somewhat below the peak of 2020 and 2021, when the share jumped to 9.6%. However, the 2024 ratio was still significantly above the pre-pandemic level of 2019, when OECD countries were dedicating around 8.8% of their GDP to health – a figure that had remained relatively stable since 2013. In 2024, the United States spent by far the most on health, equivalent to 17.2% of its GDP – and well above Germany, the next highest spender (at 12.3%). These are followed by a group of around 15 countries that all allocated 10-12% of their GDP to healthcare. In many of the Central and Eastern European OECD countries, as well as in the newer OECD Member countries in Latin America, spending on health represented between 6-9% of their GDP. Finally, Mexico and Türkiye spent less than 6% of their GDP on health.

An analysis of trends in per capita health spending and GDP over the past 20 years highlights two major shocks: the 2008 economic and financial crisis and the impact of COVID-19 in 2020 (Figure 7.2). While OECD economies sharply contracted in 2009, health spending growth was briefly maintained before slowing to near zero between 2010 and 2012 as measures were introduced to contain public spending. This was followed by a return to moderate growth. In 2020, widespread lockdowns and other public health measures severely restricting economic activity sent many OECD economies into freefall, while health spending soared. Russia's war on Ukraine, the energy crisis, and supply chain disruptions later led to high inflation and slower-than-expected growth in 2022 and 2023. As countries moved beyond the acute phase of COVID-19, real per capita health spending declined on average by 2.5% in 2022 and stagnated in 2023. However, in 2024, health spending began to return to pre-pandemic growth rates, with per capita expenditure estimated to have increased by more than 3% in real terms.

Trends in the health expenditure-to-GDP ratio over this period translate into a distinct pattern with significant step increases in 2009 and 2020, and a period of stability in between (Figure 7.3). Italy and the United Kingdom, for example, closely followed this trend, with the latter showing an even more pronounced jump in 2020 and maintaining elevated levels through 2024. In contrast, Italy's ratio has gradually declined since the pandemic peak, falling below pre-pandemic levels. Germany has seen a rather continual increase in the share of GDP over time. Throughout the period, the United States allocated by far the highest proportion of their economic output to health among all OECD countries, exceeding 17% in 2024 after peaking at 18.5% in 2020. Despite the various shocks, health spending as a share of GDP in Korea has seen a near continual and steady increase throughout the last 20 years until 2022, when the share peaked at 8.8% before declining slightly.

Definition and comparability

Expenditure on health gives a measure of the final consumption of health goods and services (i.e. current health expenditure) (OECD/Eurostat/WHO, 2017[1]). This includes spending by all types of financing arrangements on medical services and goods, population health and prevention programmes, as well as administration of the health system. The split of spending combines government and compulsory financing schemes, the latter including private insurance of a mandatory nature. Due to data limitations, private voluntary insurance in the United States is included with employer-based private insurance, which is currently mandated under the Affordable Care Act.

GDP is the sum of final consumption, gross capital formation and net exports. Final consumption includes goods and services used by households or the community to satisfy their individual needs. It includes final consumption expenditure of households, general government and non-profit institutions serving households.

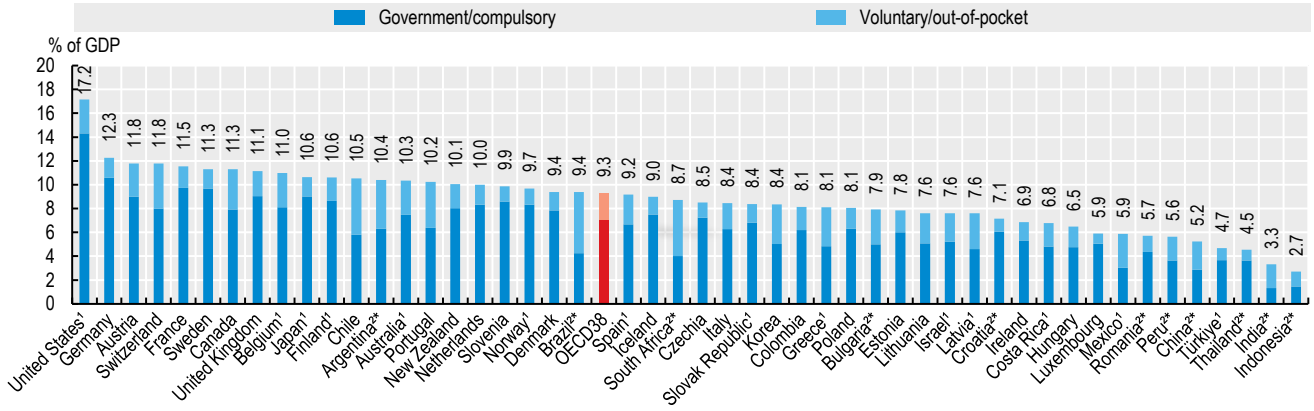
In countries such as Ireland and Luxembourg, where a significant proportion of GDP refers to repatriated profits and is thus not available for national consumption, Gross National Income (GNI) may be a more meaningful measure than GDP. However, for consistency, GDP is maintained as the denominator for all countries. The aggregate indicator Actual Individual Consumption (AIC) is used as temporal deflator to calculate health spending growth in real terms.

Note that data for 2024 are based on provisional figures provided by countries or preliminary estimates made by the OECD Secretariat.

References

OECD/Eurostat/WHO (2017), *A System of Health Accounts 2011: Revised edition*, OECD Publishing, Paris, https://doi.org/10.1787/9789264270985-en. [1]

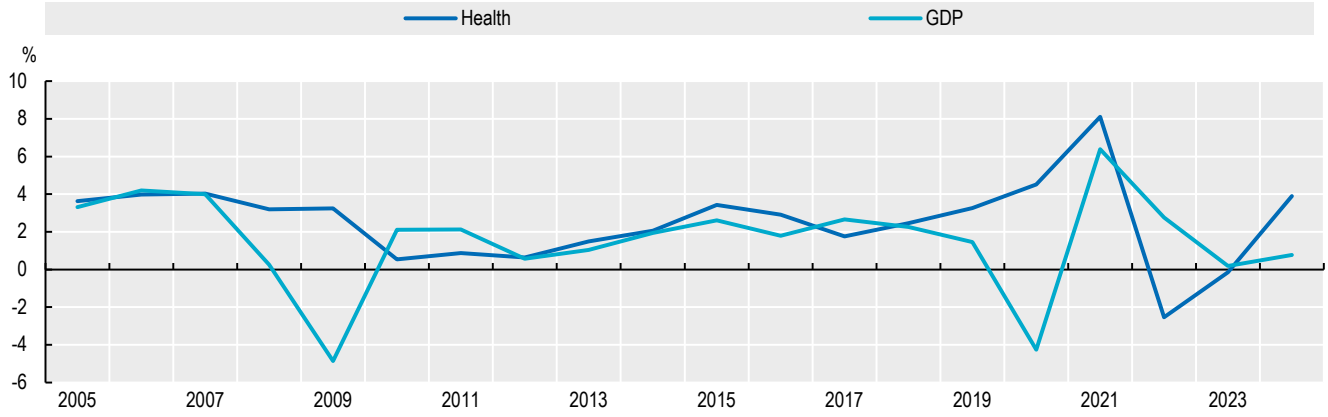
Figure 7.1. Health expenditure as a share of GDP, 2024 (or nearest year)



1. OECD estimate for 2024. 2. 2022-2023 data. * Accession/partner country.
Source: OECD Health Statistics 2025; WHO Global Health Expenditure Database.

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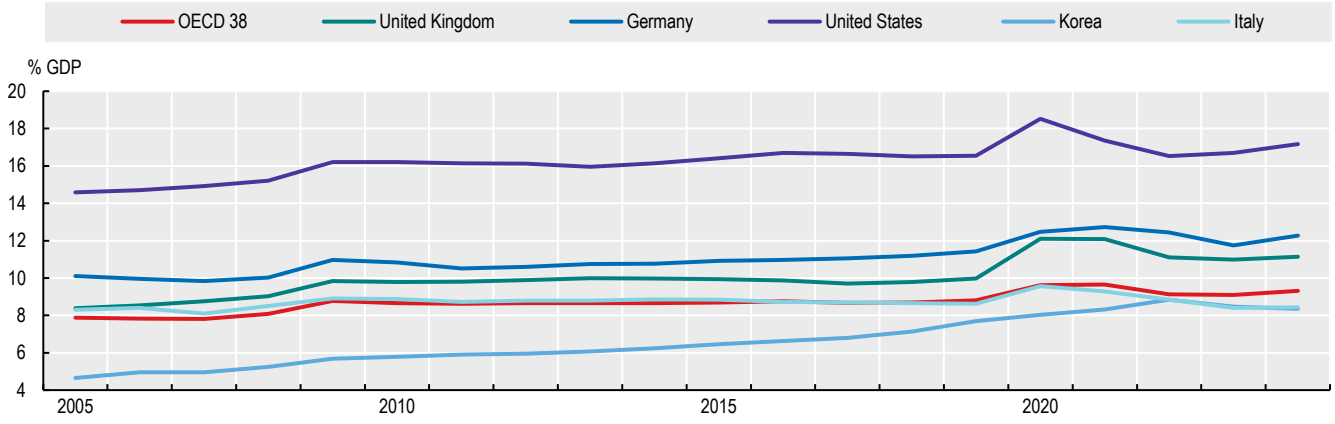
Figure 7.2. Annual real growth in per capita health expenditure and GDP, OECD average, 2006-2024



Source: OECD Health Statistics 2025.

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Figure 7.3. Health expenditure as a share of GDP, selected countries, 2006-2024



Source: OECD Health Statistics 2025.

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Health expenditure per capita

The level of per capita health spending – which captures both individual and population healthcare needs – and how this changes over time depends on a wide range of demographic, social and economic factors, as well as the financing and organisational arrangements of a country's health system.

In 2024, average health spending in OECD countries was estimated to stand at nearly USD 6 000 per capita (when adjusted for differences in purchasing power). The United States was the highest spender – reaching the equivalent of over USD 14 880 per person, or 2.5 times the OECD average (Figure 7.4). Switzerland, Norway and Germany followed, with per capita health spending of around two-thirds of the level of the United States (USD 9 300-10 000). After that, a further group of Western European countries, as well as Australia and Canada, all spent between USD 7 000 and USD 8 500 per person. Spending levels broadly decreased across Southern, Central and Eastern European countries to the Latin American OECD Member countries, with spending in Mexico (USD 1 590) at around a quarter of the OECD average. Health spending in accession/partner countries Indonesia and India was less than USD 500 per capita.

Figure 7.4 also shows the split of health spending based on the type of healthcare coverage, either organised through government health schemes or compulsory insurance, or through voluntary arrangements such as private voluntary health insurance or direct payments by households (see section "Health expenditure by financing schemes"). On average, about three-quarters of all health spending is financed through government or compulsory insurance schemes across OECD countries.

In the years leading up to the COVID-19 pandemic, annual per capita spending on healthcare grew by an average of 2.7% across OECD countries (Figure 7.5). In the Baltic countries, Korea and Poland, average annual spending growth during 2014-2019 was between 5% and 8%, while in France, Italy, Finland, Luxembourg and the Netherlands annual increases were much more moderate at less than 1% on average.

Between 2019 and 2024, average annual per capita spending growth in OECD countries took place at a similar rate (2.5%) than during the pre-pandemic period, but with substantial year-on-year differences. Across the OECD, annual growth in real terms was 5% in 2020 and peaked at 8% in 2021 as governments mobilised funds to slow down and tackle the effects of the COVID-19 pandemic. With countries transitioning out of this health emergency, health spending contracted by around 2.5% on average in OECD countries in 2022. It stagnated in 2023 before returning to robust growth at above 3% per capita in 2024 (Figure 7.2). Some of the recent trajectory can be explained by economic and geo-political challenges that affected countries' ability to fund any additional spending on health in 2022 and 2023, as well as high inflation rates that were often eroding nominal spending increases (Mueller, Penn and Morgan, 2024[1]).

Trends in health spending growth diverged markedly across countries and regions between 2019-2024 as the impact of the COVID-19 pandemic and the cost-of-living and energy crises differed between health systems. In Japan and Denmark, for example, the real level of health spending per capita stagnated when comparing 2019 and 2024. While both countries recorded high spending growth in 2021 (8%), this was followed by a subsequent drop of a similar magnitude in the subsequent year(s), resulting in a compound zero growth rate. On the other hand, Türkiye and Poland saw particularly high increases in health spending between 2019 and 2024, with average annual real growth of 8-10%. Slovenia, the Slovak Republic and Chile also recorded robust growth during this period, at around 4-5% on average. Latvia followed a very particular spending trajectory – with an astounding real-term spending increase of 30% in 2021, followed by substantial cuts in the two subsequent years, resulting in a compound annual growth rate close to 3%. In contrast, many countries in Western and Northern Europe, such as France, Italy, Spain, Belgium and Sweden, saw only modest annual spending growth at around 1% on average – similar to or below pre-pandemic period growth.

Definition and comparability

See section "Health expenditure in relation to GDP" for a definition of current expenditure on health.

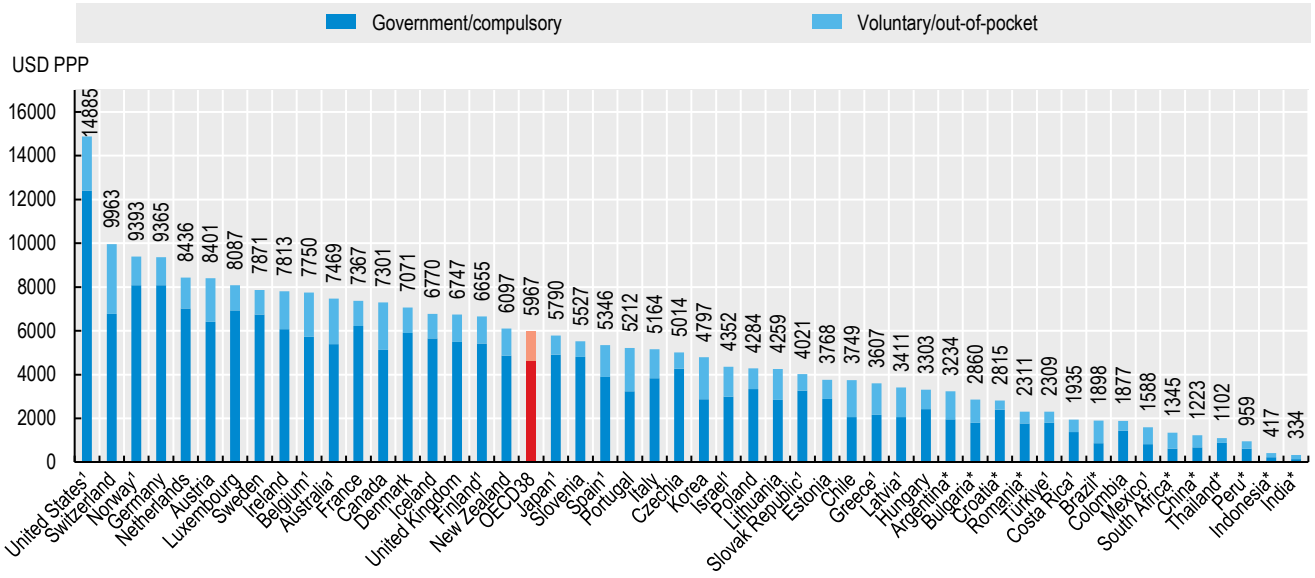
To compare spending levels between countries, per capita health expenditures are converted to a common currency (USD) and adjusted to take account of the difference in purchasing power of the national currencies. AIC Purchasing Power Parities (PPPs) are used as the most available and reliable conversion rates. For the calculation of growth rates in real terms, AIC deflators are used for all countries, where available.

Note that data for 2024 are based on provisional figures submitted by the country or estimated by the OECD Secretariat.

References

Mueller, M., C. Penn and D. Morgan (2024), "Examining the latest trends in health spending: Are we heading back to a time of austerity?", in *Fiscal Sustainability of Health Systems: How to Finance More Resilient Health Systems When Money Is Tight?*, OECD Publishing, Paris, https://doi.org/10.1787/880f3195-en. [1]

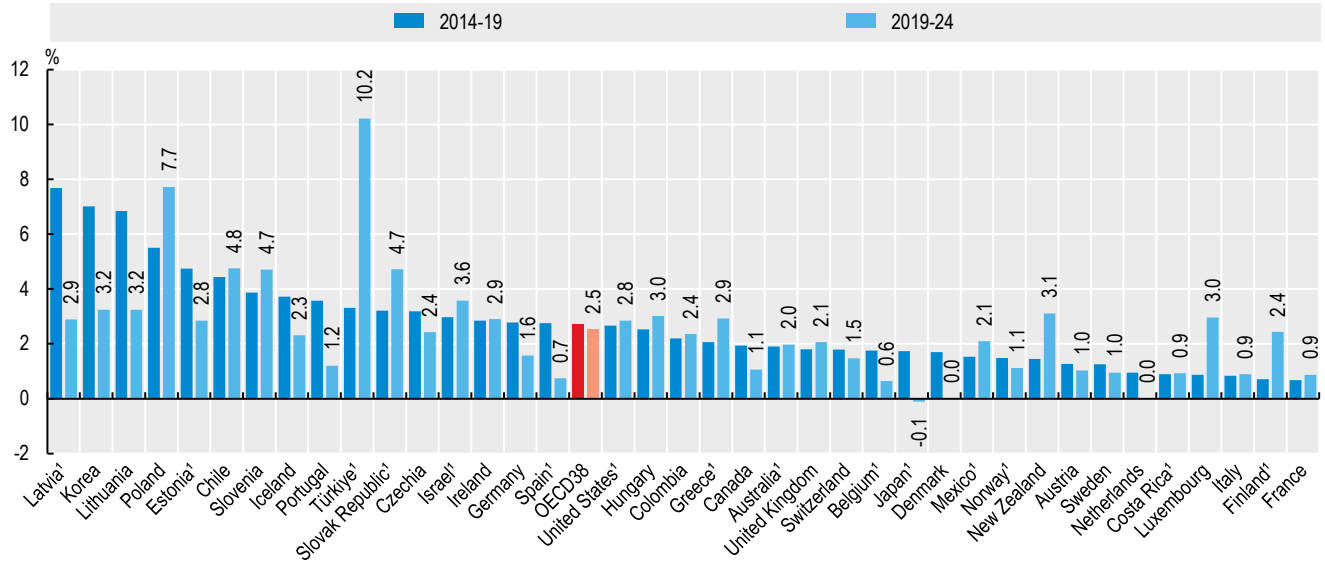
Figure 7.4. Health expenditure per capita, 2024 (or nearest year)



1. OECD estimates for 2024. * Accession/partner country.
Source: OECD Health Statistics 2025; WHO Global Health Expenditure Database.

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Figure 7.5. Annual growth in health expenditure per capita (real terms), 2014-2019 and 2019-2024



1. Based on OECD estimates for 2024. Growth rates and time periods may have been adjusted to take account of breaks in series.
Source: OECD Health Statistics 2025.

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Prices in the health sector

Cross-country comparisons of health spending reflect both differences in the prices of healthcare goods and services, and the amount ("volume") of care individuals consume. Breaking down health spending into these two components helps policymakers better understand the drivers of spending variation.

Achieving this requires spending data to be expressed in a common currency, and the choice of conversion method can strongly influence the results and their interpretation. One option is to convert local currencies using market exchange rates, but these are often volatile. Moreover, exchange rates may be unsuitable for predominantly non-traded sectors like healthcare, as they fail to capture the real domestic purchasing power of currencies. A more appropriate method is to use PPPs, which take account of price level differences at the level of the whole economy, for industries, and for specific spending aggregates (OECD/Eurostat, 2007[1]). Due to their widespread availability, AIC PPPs – which include all goods and services consumed by households – are commonly used as conversion rates for health spending (see section "Health expenditure per capita"). However, using AIC PPPs means that the resulting price levels reflect not only differences in healthcare volume and price but also any variations in the prices of healthcare goods and services relative to prices of all other consumer goods and services across countries.

Figure 7.6 presents health-specific price levels based on a standardised basket of healthcare goods and services across OECD countries. The same set of healthcare items costs 55% more than the OECD average in Iceland, and 52% more in Switzerland and the United States – the countries reporting the highest prices. Australia and Israel also exhibit relatively high healthcare prices. By contrast, countries including France, Slovenia and Spain have lower price levels, with the same healthcare basket costing roughly two-thirds of the OECD average. Türkiye records the lowest healthcare prices among OECD countries, at just 18% of the average.

By removing the price component from health spending, it is possible to estimate the quantity of healthcare goods and services ("the volume of healthcare") consumed by the population. These volumes vary less than overall health expenditure across countries (Figure 7.7). The United States continues to have the highest per capita healthcare use, with volumes about 50% above the OECD average. In contrast, Mexico and Costa Rica report the lowest volumes, at around one-fifth of the average. Differences in healthcare volume per person are shaped by factors such as the population's age and disease profile, how healthcare services are organised and delivered, the extent of pharmaceutical use, and barriers to access that may result in lower utilisation of care.

Prices in the health sector are closely linked to overall price levels in the economy. However, unlike internationally traded goods – which tend to converge in price across countries – services like healthcare are mostly produced locally. In wealthier countries, higher wages often drive up service costs, including healthcare. When comparing health-specific and economy-wide price levels relative to the OECD average, variation in healthcare prices is usually greater (Figure 7.8). Generally, countries with low overall prices have even lower healthcare prices, and vice versa. Still, this pattern does not apply universally. In Denmark, for example, general price levels are relatively high, but healthcare prices remain below the OECD average. This may reflect policy decisions to regulate healthcare prices.

Definition and comparability

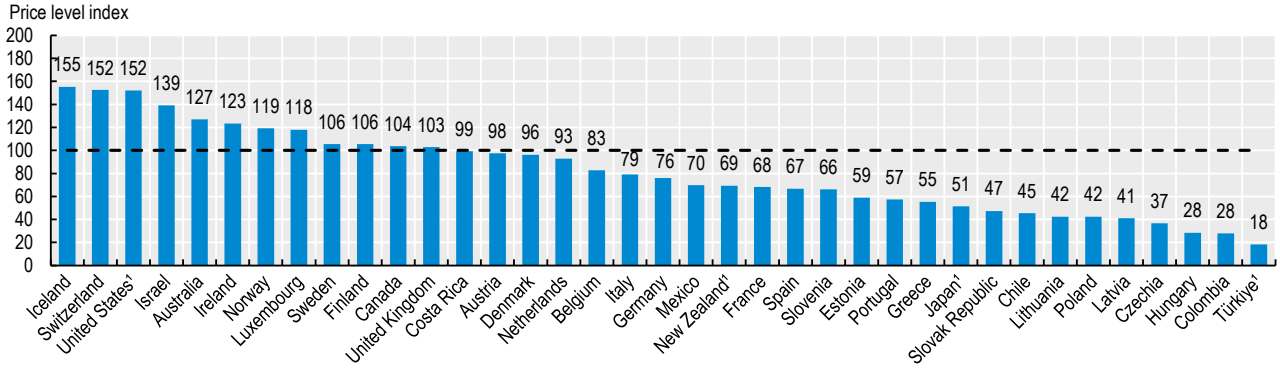
PPPs are conversion rates that show the ratio of prices in national currencies of the same basket of goods and services in different countries. Thus, they can be used as both currency converters and price deflators. When used to convert expenditure to a common unit, the results are valued at a uniform price level and should reflect only differences in the volumes of goods and services consumed.

To assess differences in health volumes health-specific PPPs are required. Eurostat and the OECD calculate PPPs for GDP and some 50 product groups, including health, on a regular basis. Recently, a number of countries have worked towards output-based measures of prices of healthcare goods and services. This methodology has been used to produce both health and hospital PPPs, which are now incorporated into the overall calculation of GDP PPPs. Such PPPs can be used to calculate health price level indices to compare price levels and volumes across countries. These indices are calculated as ratios of health PPPs to exchange rates and indicate the number of units of a common currency needed to purchase the same volume.

References

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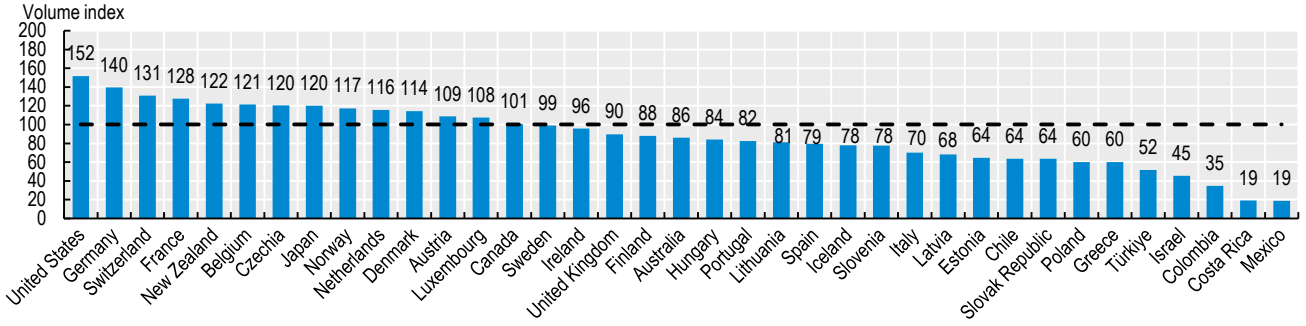
Figure 7.6. Comparative price levels in the health sector, 2023 (OECD average = 100)



1. For hospitals, PPPs are estimated predominantly by using salaries of medical and non-medical staff (input method).
Source: OECD Statistics 2025.

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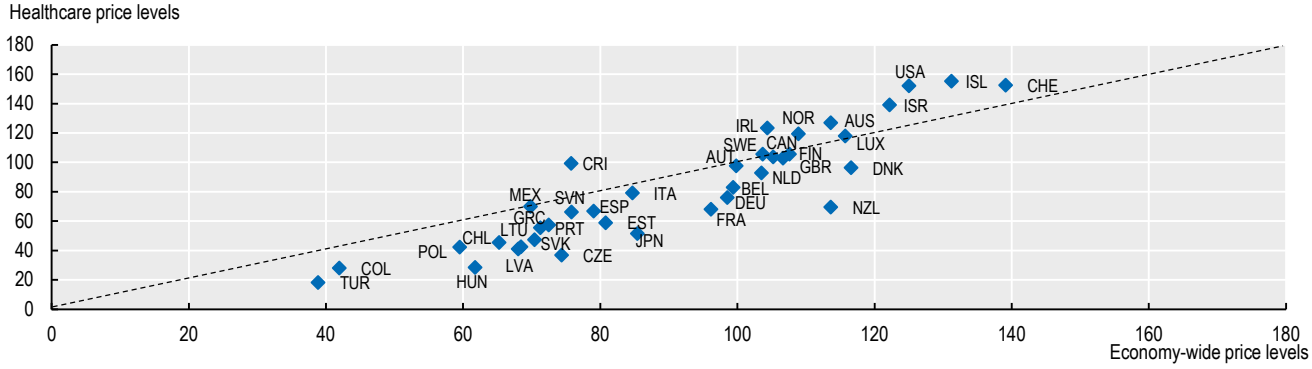
Figure 7.7. Estimated healthcare volumes per capita, 2023 (OECD average = 100)



Note: Volumes are calculated using the PPPs for Health.
Source: OECD Health Statistics 2025 and OECD Secretariat estimates.

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Figure 7.8. Healthcare price levels compared to economy-wide price levels, 2023 (OECD average = 100)



Sources: OECD Health Statistics 2025 and OECD Secretariat estimates.

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Health expenditure by financing scheme

Individuals or groups of the population obtain healthcare through a variety of financing arrangements. Government financing schemes – on a national or sub-national basis or for specific population groups – entitle individuals to healthcare based on residency and form the principal mechanism to cover healthcare costs in close to half of OECD countries. The other main method of financing is some form of compulsory health insurance (managed through public or private entities). Direct spending by households (out-of-pocket spending) can constitute a significant part of overall health expenditure. Finally, voluntary health insurance, in its various forms, can also play an important funding role in some countries.

Compulsory or automatic coverage, through government schemes or health insurance, forms the bulk of healthcare financing in OECD countries. Taken together, three-quarters of all healthcare spending in 2023 was covered through these types of mandatory financing schemes (Figure 7.9). Central, regional or local government schemes in Sweden, Norway, Iceland, Denmark and the United Kingdom accounted for 80% or more of national health spending. In France, Germany, Luxembourg and Japan, more than three-quarters of spending was covered through a type of compulsory health insurance scheme. In the United States, federal and state programmes covered around 28% of total health spending in 2023, while another 55% of expenditure was classified under compulsory insurance schemes, covering a mix of public arrangements and private health insurance considered compulsory under the Affordable Care Act.

Out-of-pocket payments financed just under one-fifth of all health spending in 2023 in OECD countries, with this share broadly increasing as GDP decreases. Households had to bear more than one-third of all healthcare costs directly in Mexico, Chile, Latvia and Greece. In partner country India, nearly half of all health spending is made out-of-pocket. By contrast, in France and Luxembourg, out-of-pocket spending accounted for less than 10% of total health expenditure. Voluntary health insurance only covered 5% of all healthcare costs across the OECD but financed more than one-tenth of all total health budget in Slovenia, Canada, Ireland, Israel, although Slovenia abolished complementary voluntary health insurance in 2024 (OECD/European Observatory on Health Systems and Policies, forthcoming[1]). In accession/partner countries Brazil (27%) and South Africa (45%), voluntary health insurance accounted for much larger shares of total health expenditure.

The spending trajectory of the various financing schemes has seen some important changes with the onset of the COVID-19 pandemic and the cost-of-living and energy crises (Figure 7.10). In the years preceding the COVID-19 pandemic (2017-2019), per capita spending by government schemes and compulsory health insurance grew annually by between 3-4%. This was outpaced by growth of voluntary health insurance spending (5.6% per year) but much stronger than growth of out-of-pocket payments (1.3%).

The pandemic led to a substantial acceleration in spending by government schemes. During 2019-2021, government spending increased by 26% per year on average across OECD countries, as significant resources were mobilised to track the virus, expand health system capacity, provide subsidies to health providers and eventually roll out vaccination campaigns. By contrast, spending growth of compulsory health insurance schemes remained largely unchanged compared to the pre-pandemic period, while spending by voluntary health insurance stagnated. In many countries, non-urgent elective surgery and dental treatment (two popular areas for voluntary insurance coverage) were postponed during peak waves of COVID-19 infections.

The most recent period (2021-2023) saw the phasing out of additional COVID-19 spending across OECD countries, resulting in a substantial drop in government financing (-11% per year). Moreover, the war in Ukraine, the energy crisis and a high inflationary environment led governments to reconsider their post-pandemic priorities. In contrast, spending by voluntary health insurance rebounded, growing by over 5% per year as demand for elective and privately financed services resumed. On the other hand, out-of-pocket spending stagnated.

Definition and comparability

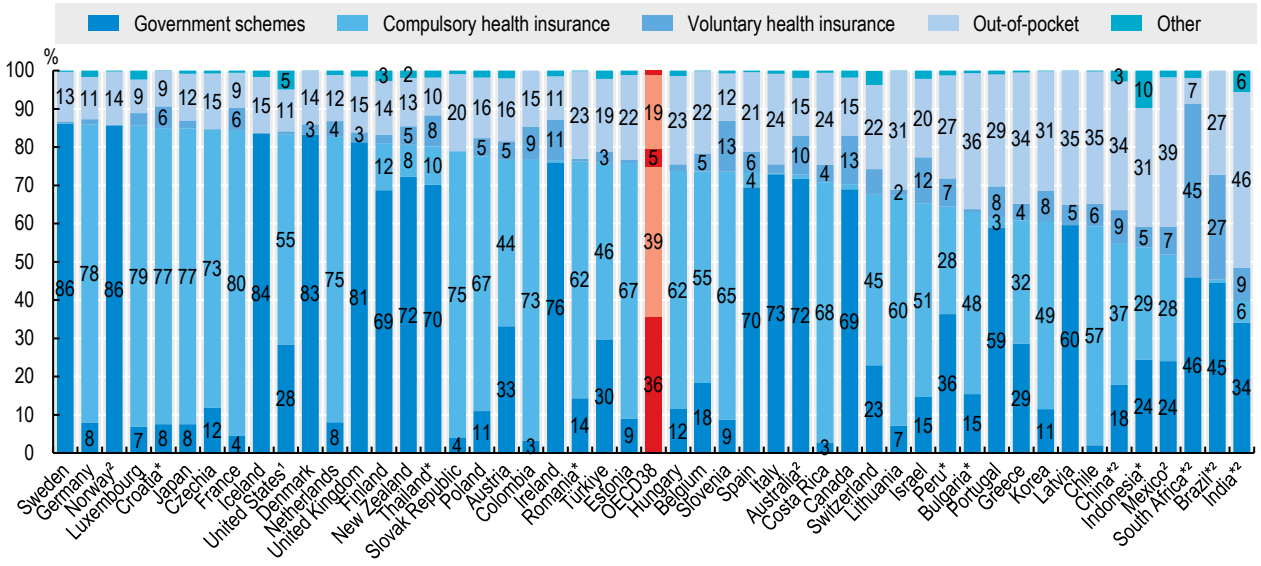
The financing of healthcare can be analysed from the point of view of financing schemes (financing arrangements through which health services are paid for and obtained by people, e.g. social health insurance), financing agents (organisations managing the financing schemes, e.g. social insurance agencies) and types of revenues of financing schemes (e.g. social insurance contributions). Here, "financing" is used in the sense of financing schemes as defined in the *System of Health Accounts 2011* (SHA) (OECD/Eurostat/WHO, 2017[2]) and includes government schemes, compulsory health insurance, voluntary health insurance and private funds such as households' out-of-pocket payments, non-governmental organisations (NGOs) and private corporations. Out-of-pocket payments are expenditures borne directly by patients. They include cost-sharing and, in certain countries, estimations of informal payments to healthcare providers.

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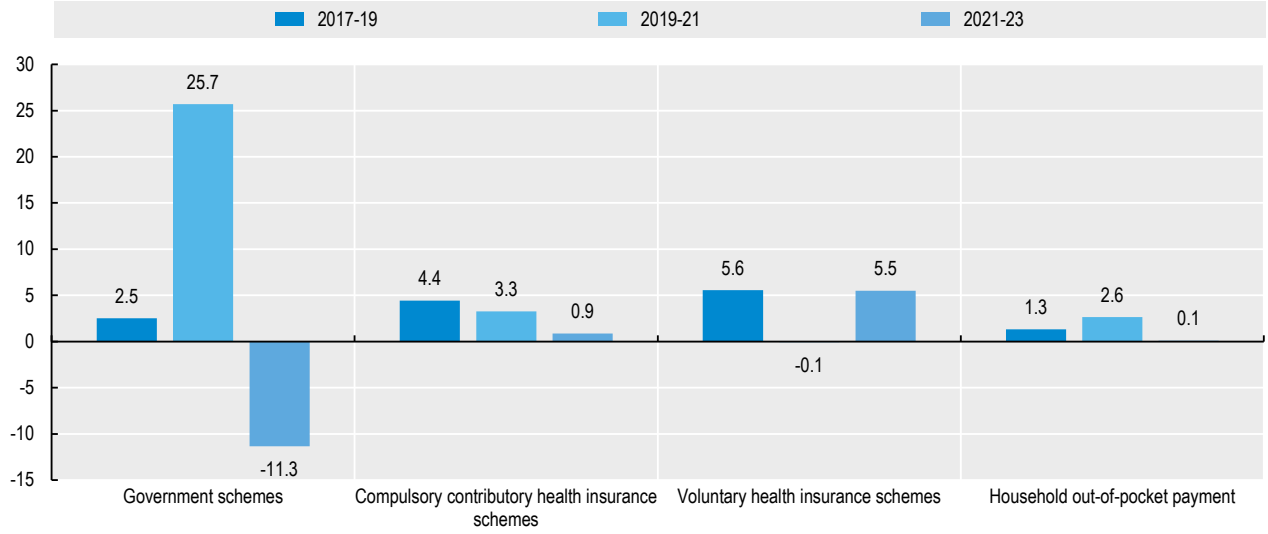
Figure 7.9. Health expenditure by type of financing, 2023 (or nearest year)



Note: "Other" refers to financing by NGOs, employers, non-resident schemes and unknown schemes. 1. All spending by private health insurance companies reported under compulsory health insurance. 2. 2022 data. * Accession/partner country.
Source: OECD Health Statistics 2025.

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Figure 7.10. Annual growth in per capita health expenditure by type of financing (real terms), OECD average, 2017-2019, 2019-2021, and 2021-2023



Source: OECD Health Statistics 2025.

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Public funding of health spending

While financing schemes purchase healthcare on behalf of individuals and the population, the revenues to fund this expenditure can originate from different sources. Most funding for government schemes comes from general government revenues (such as taxation), which are channelled through the budget process. However, governments might also contribute to social health insurance by covering the contributions of specific population groups or providing general budget support to insurance funds. Individuals may purchase private health insurance, but part of their premium may be paid by the employer, or it may be subsidised by the government. Individuals also finance care directly, using household income to pay for services in their entirety or as part of a cost-sharing arrangement. Other health financing schemes (such as non-profit or enterprise schemes) can receive donations or generate income from investments or other commercial operations. Finally, revenues can also come from non-domestic sources.

Public funding can be defined as the sum of government transfers and all social contributions. In 2023, public sources financed on average 72% of healthcare spending in OECD countries (Figure 7.11). Where government financing schemes are the principal financing mechanism, as in Norway and Sweden, government transfers fund 85% or more of healthcare expenditure. In other countries such as Costa Rica, Poland and Germany, the majority of public funding refers to social insurance contributions – payable by employers and employees – which financed close to two-thirds of all healthcare spending in 2023. In some countries, a disconnect between public funding on the one hand and government and compulsory insurance spending on the other hand can be observed. While government and compulsory spending accounted for 83% of all health spending in the United States and 68% in Switzerland, the corresponding shares of public funding were only 54% and 33%. This discrepancy is due to the important role of compulsory private insurance which is not part of public expenditure in these countries.

Governments fund a range of public services, and healthcare is competing for resources with many other sectors including education, defence, and housing. The level of public funding on health is determined by factors such as the type of health system in place, the demographic of the population, shifting budget priorities, and economic conditions. Health spending accounted for an average of 15.1% of total government expenditure across OECD countries in 2023, an increase of 1 percentage points (p.p.) compared to 2013 (Figure 7.12). During the initial phase of the pandemic, many OECD countries were able to increase the public resources available to healthcare substantially. As a result, the share of government expenditure dedicated to health increased, peaking at 15.6% in 2021. However, 2022 saw new economic and geopolitical challenges. Russia's war on Ukraine disrupted global energy markets and fuelled inflationary pressures, while many countries dealt with growing fiscal deficits. These constraints limited their ability to expand or even maintain healthcare spending, with the share of government expenditure dedicated to health declining in 2022 and 2023 on average across OECD countries.

Many OECD countries have a system of compulsory health insurance – either social health insurance or through private coverage – but there is substantial diversity in the composition of revenues for these types of schemes (Figure 7.13). The importance of government transfers as a source of revenue can vary significantly. On average, around two-thirds of financing is based on social contributions (or premiums) – primarily split between employees and employers – but around a quarter comes from government transfers, either on behalf of certain groups (such as those of low incomes or unemployed people) or as general support. Government transfers fund two-thirds of the social health insurance system in Chile, and over 50% of all their revenues in Hungary and Israel. Meanwhile, in Slovenia, Poland and Costa Rica, the role of government transfers in funding compulsory insurance schemes is marginal, with social insurance contributions representing at least 90% of all revenues of these schemes.

Definition and comparability

Health financing schemes have to raise revenues to pay for healthcare for the population they are covering. In general, financing schemes can receive transfers from the government, social insurance contributions, voluntary or compulsory prepayments (e.g. insurance premiums), other domestic revenues, and revenues from abroad (e.g. as part of development aid).

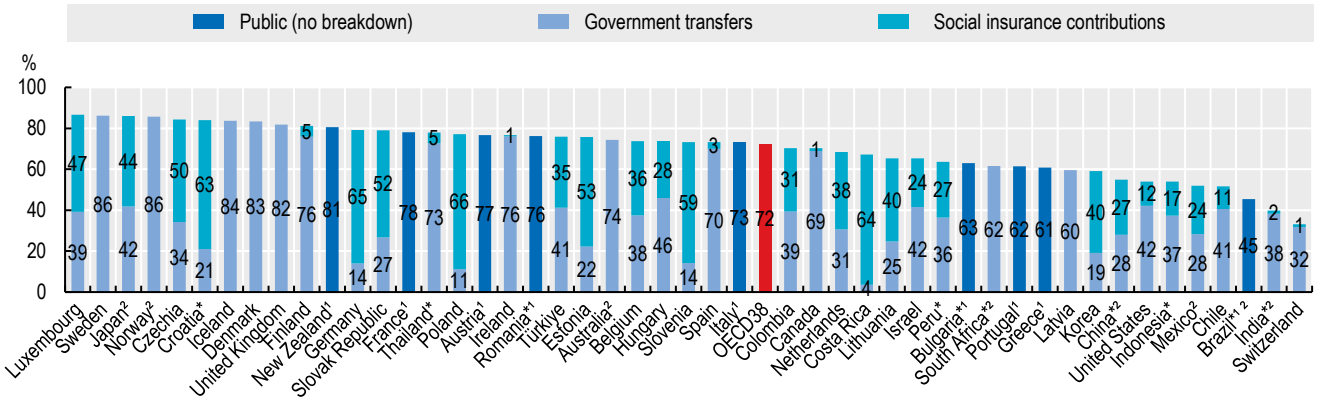
Revenues of a financing scheme are rarely equal to expenses in any given year leading to a surplus or deficit of funds. In practice, most countries use the composition of revenues per scheme to apply on a pro-rata basis to the scheme's expenditure thus providing a picture of how spending was financed in the accounting period.

Total government expenditure is as defined in the System of National Accounts. Using the methodology of SHA (OECD/Eurostat/WHO, 2017[1]), public spending on health is equal to the sum of transfers from government and social insurance contributions. In the absence of information from the revenue side, the sum of spending by government financing schemes and social health insurance is taken as a proxy.

References

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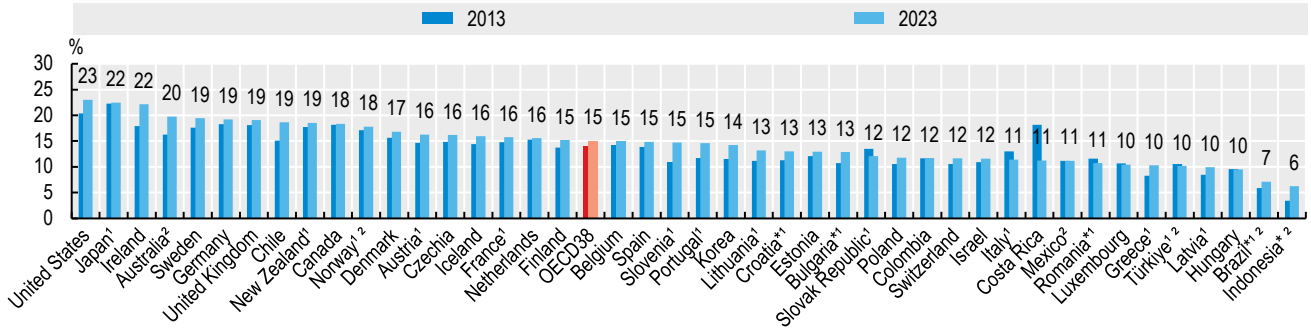
Figure 7.11. Health expenditure from public sources as a share of total health expenditure, 2023 (or nearest year)



1. Public is estimated by summing up spending by government schemes and social health insurance. 2. 2022 data. * Accession/partner country.
Source: OECD Health Statistics 2025.

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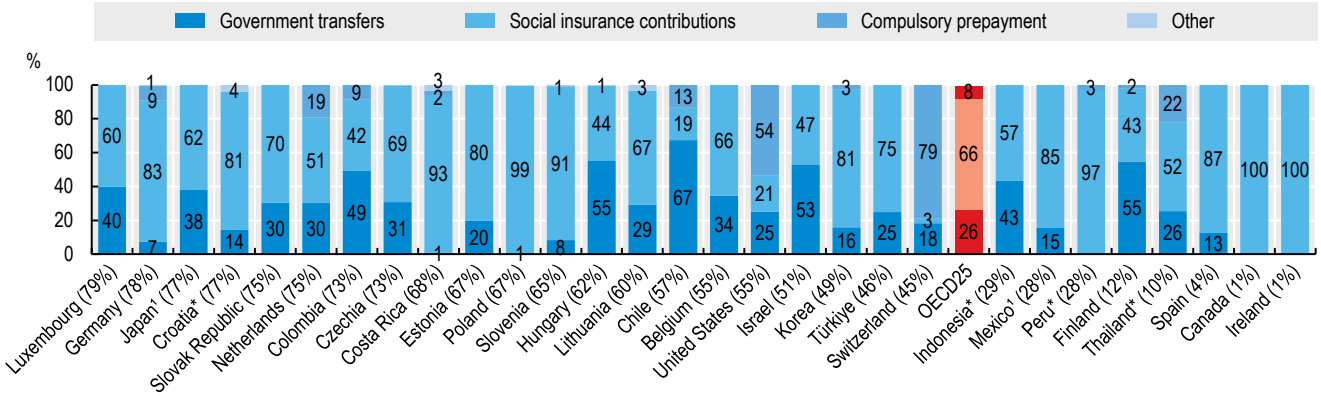
Figure 7.12. Health expenditure from public sources as a share of total government expenditure, 2013 and 2023 (or nearest year)



1. Public funding is estimated by summing up spending by government schemes and social health insurance. 2. Latest data from 2020-2022. * Accession/partner country.
Source: OECD Health Statistics 2025, OECD National Accounts Database.

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Figure 7.13. Financing sources of compulsory health insurance, 2023 (or nearest year)



Note: Numbers in brackets indicate the contribution of compulsory health insurance to total health expenditure. “Other” includes other domestic revenues and direct foreign transfers. 1. 2022 data. * Accession/partner country.
Source: OECD Health Statistics 2025.

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Health expenditure by type of service

A variety of factors, from disease burden and system priorities to organisational aspects and costs, determine the allocation of resources across the various types of healthcare services. For all OECD countries, curative and rehabilitative care services make up the bulk of health spending. These are primarily delivered through inpatient and outpatient services – accounting for over three-fifths of all health spending in 2023 (Figure 7.14). Medical goods (mostly pharmaceuticals) made up a further 18%, followed by long-term care services, consuming one in seven dollars of the health budget on average. Preventive care, together with administration and overall governance of the health system, account for the remaining 7% of health spending.

In 2023, Greece, Poland and Costa Rica reported the highest share of total health spending allocated to inpatient services, at around 40% – much above the OECD average of 28%. At the other end of the scale, many of the Nordic countries, Canada and the Netherlands had a much lower proportion of spending on inpatient services – at around 20%. Outpatient care forms a broad category covering generalist and specialist outpatient services, dental care, as well as homecare and ancillary services. Taken together, in 2023, spending on outpatient care services accounted for around 45% of all health spending in Israel, Portugal and Estonia compared to an OECD average of 33%. Given the relative importance of inpatient care delivery, Greece allocated a comparably low proportion on outpatient services, at only around one-fifth of all health spending.

The third largest health spending category is medical goods. Differences in prices for international goods such as pharmaceuticals tend to show less variation across countries than for locally produced services. As a result, spending on medical goods in countries with lower incomes often accounts for a more elevated share of health spending relative to services. For example, in 2023, expenditure on medical goods represented around 30% of all health spending in the Slovak Republic and Greece. By contrast, these shares were much lower in Norway, the Netherlands and the United Kingdom, accounting for only one-tenth of health spending.

The share of health spending dedicated to long-term care has been increasing continuously over recent decades and now stands at 14% on average. However, this figure hides significant differences across OECD countries. In countries with formal arrangements such as Norway, Sweden and the Netherlands, nearly 30% of all health spending was on long-term care services in 2023. However, a more informal long-term care sector exists in many Southern, Central and Eastern European and Latin American countries, where spending on long-term care is much lower – typically around 5% or less.

In recent years, the various public health and economic shocks had an impact on health spending patterns in many countries, resulting in notable differences in the spending trajectory across services (Figure 7.15). In the pre-pandemic period (2017-2019), variation in annual per capita spending growth across OECD countries was relatively limited, ranging from around 1% for pharmaceuticals to between 3-4% for outpatient care, long-term care, prevention and administration. The pandemic triggered an acceleration of spending growth across all healthcare functions. Between 2019 and 2021, annual spending growth for inpatient care and pharmaceuticals nearly doubled (to 4.3% and 2.7%, respectively), driven by expenses for additional staff and input costs as well as spending on protective equipment such as face masks. Spending on preventive care increased by over 50% per year, with countries dedicating significant resources to testing, tracing, surveillance, and public information campaigns related to the pandemic and the roll-out of the vaccination campaigns. At around 8% annually, spending on health system administration also recorded strong growth between 2019 and 2021. Some of this increase can be explained by the additional resources required to manage national COVID-19 responses strategies. The period 2021-2023 saw a widespread unwinding of additional COVID-19 spending, which affected all health services. Moreover, many OECD countries struggled with high inflation and the energy and cost-of-living crises, and health budgets had to increasingly compete with other priorities again. As a result, annual spending growth turned negative for most services in this period in many countries, with long-term care being a notable exception.

Definition and comparability

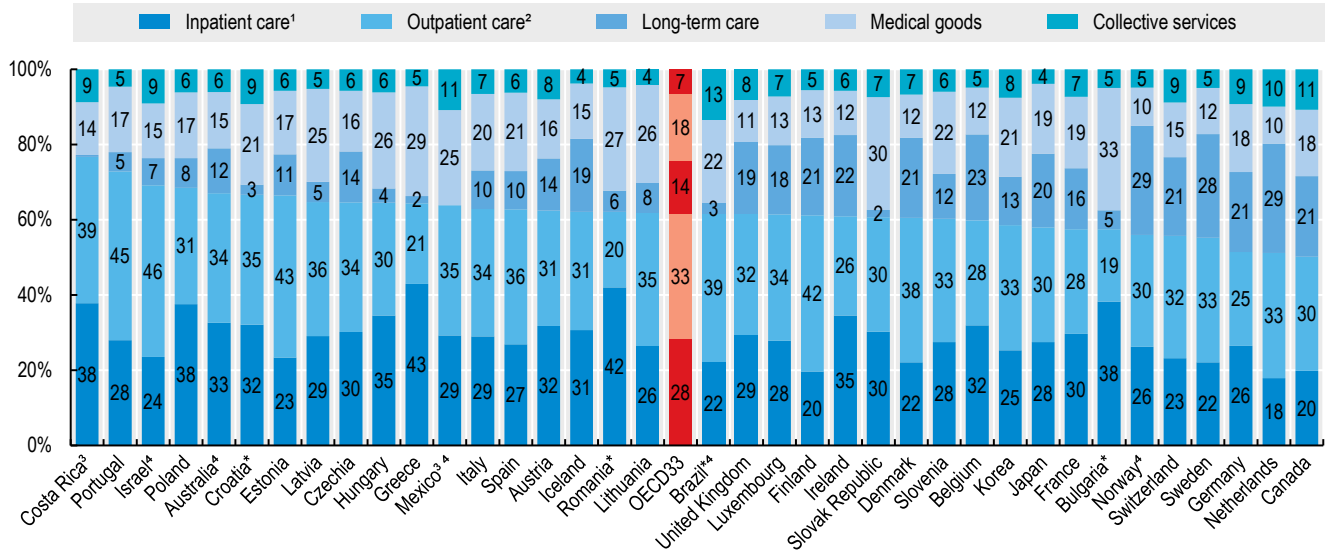
SHA (OECD/Eurostat/WHO, 2017[1]) defines the boundaries of the healthcare system from a functional perspective, with healthcare functions referring to the different types of healthcare services and goods. Current health expenditure comprises personal healthcare (curative care, rehabilitative care, long-term care, ancillary services and medical goods) and collective services (prevention and public health services as well as administration – referring to governance and administration of the overall health system rather than at the health provider level). Curative, rehabilitative and long-term care can also be classified by mode of provision (inpatient, day care, outpatient and home care).

For the calculation of growth rates in real terms, AIC deflators are used.

References

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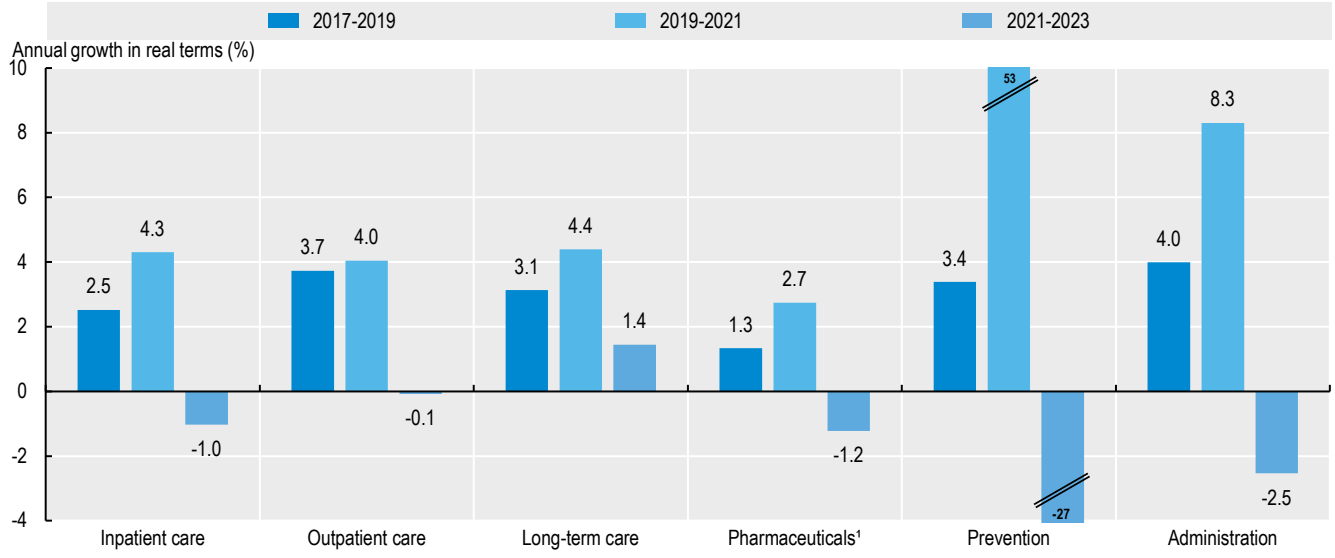
Figure 7.14. Health expenditure by type of service, 2023 (or nearest year)



Note: Countries are ordered by curative-rehabilitative care as a share of current expenditure on health. 1. Curative-rehabilitative care in inpatient and day care settings. 2. Includes home care and ancillary services. 3. Medical goods financed by government and compulsory schemes are included under inpatient or outpatient care. 4. 2022 data. * Accession/partner country.
Source: OECD Health Statistics 2025.

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Figure 7.15. Annual growth in health expenditure for selected services (real terms), OECD average, 2017-19, 2019-2021, and 2021-23



1. Includes spending on medical non-durables such as face masks.
Source: OECD Health Statistics 2025.

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Health expenditure on prevention and primary healthcare

Effective primary healthcare (PHC) is the cornerstone of an efficient, people-centred, and equitable health system. Strengthening PHC has been identified as an effective way to improve care co-ordination and health outcomes and reduce wasteful spending, by limiting unnecessary hospitalisations and associated costs in hospitals and other parts of the health system. However, in many OECD countries, PHC has not yet fully realised this potential.

In 2023, PHC represented 14% of all health spending on average across OECD countries, ranging from 10% or less in Switzerland, the Netherlands, Luxembourg and the Slovak Republic to around 20% in Lithuania, Estonia and Finland (Figure 7.16). Compared to a decade ago, this share has remained largely unchanged, indicating that spending on PHC has been growing in line with overall health spending. Thus, this suggests that PHC has by and large not been the main focus of targeted investment in the health sector.

Regarding its composition, half of PHC spending across OECD countries is on general outpatient care services, with a little over a third related to dental care. Prevention services and home visits by general practitioners (GPs) and nurses make up a smaller proportion of spending on PHC, although services related to prevention activities may often be hard to distinguish from general outpatient consultations. Spending on general outpatient care provided by ambulatory providers was particularly high in Costa Rica, Poland and Mexico, reaching up to 14% of overall health spending. In Austria, Canada, Germany, France, Luxembourg and Switzerland, spending on general outpatient care was much lower overall, accounting for 4% or less of health spending.

In Lithuania and Estonia, the large share of PHC in overall health spending can be explained by spending on dental care. In both countries, dental care accounts for around 10% of their total health budget – twice the OECD average. This compares with the Netherlands, Costa Rica, Mexico, Poland and the United Kingdom where dental care spending represents only around 3% of total health spending.

Total spending on prevention (referring to services and public health interventions provided by ambulatory care providers and in other setting) has remained relatively stable at 3% of overall health spending across OECD countries in the decade leading to the pandemic – but increased significantly with the onset of the COVID-19 crisis. By 2021, this share had climbed to 6% (Figure 7.17). This increase was particularly pronounced in Denmark, the United Kingdom, Austria and Japan, where the proportion of health spending attributed to preventive care was 7-8 p.p. above the share seen in 2013, reflecting substantial investments in public health measures related to fighting the spread of the COVID-19 pandemic. However, much of the pandemic-induced spending growth in 2021 was related to time-limited, emergency COVID-19 measures rather than long-term planned investments into population health. With public health emergency measures phased out after the acute phase of the pandemic, the share of preventive spending dropped and reached pre-pandemic levels by 2023, ranging from 6-7% of total health spending in Canada and the United Kingdom to less than 3% in Poland, Belgium, Iceland, France, Switzerland, Portugal and Japan. The fact that the position of prevention and public health in overall health budgets has not changed much after the experience of the COVID-19 pandemic may suggest that health systems remain similarly vulnerable to a major health crisis. It also indicates that additional spending on preventive care is still needed to strengthen countries' health system resilience and their agility to respond to pandemics and other evolving threats (OECD, 2023[1]).

Definition and comparability

International comparisons of what is spent on PHC have to date been largely absent due to the lack of a commonly accepted definition and an appropriate data collection framework. Working with data and clinical experts and international partners, OECD has developed a methodological framework to estimate PHC spending (Mueller and Morgan, 2018[2]).

Estimates are based on data submitted using the SHA framework (OECD/Eurostat/WHO, 2017[3]). The following functions are first identified as basic care services:

- General outpatient curative care (e.g. routine visits to a GP or nurse for acute or chronic treatment)
- Dental outpatient curative care (e.g. regular control visits as well as more complex oral treatment)
- Home-based curative care (mainly referring to home visits by GPs or nurses)
- Preventive care services (e.g. immunisation or health check-ups)

Where basic care services are provided by ambulatory healthcare providers such as medical practitioners, dentists, ambulatory healthcare centres and home healthcare service providers, this may be considered as a proxy for PHC. It should be stressed that this proxy measure is a simplified approach to operationalise a complex multi-dimensional concept.

Comparability for this indicator is still limited and depends on countries' capacity and methods used to distinguish between general outpatient and specialist services.

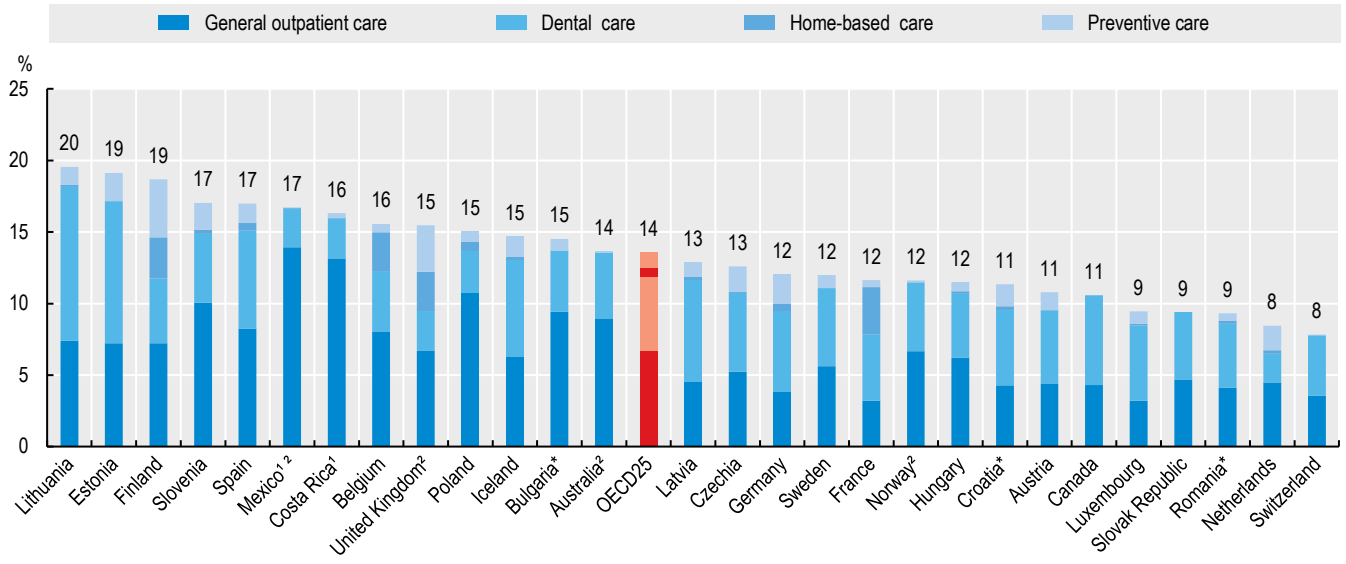
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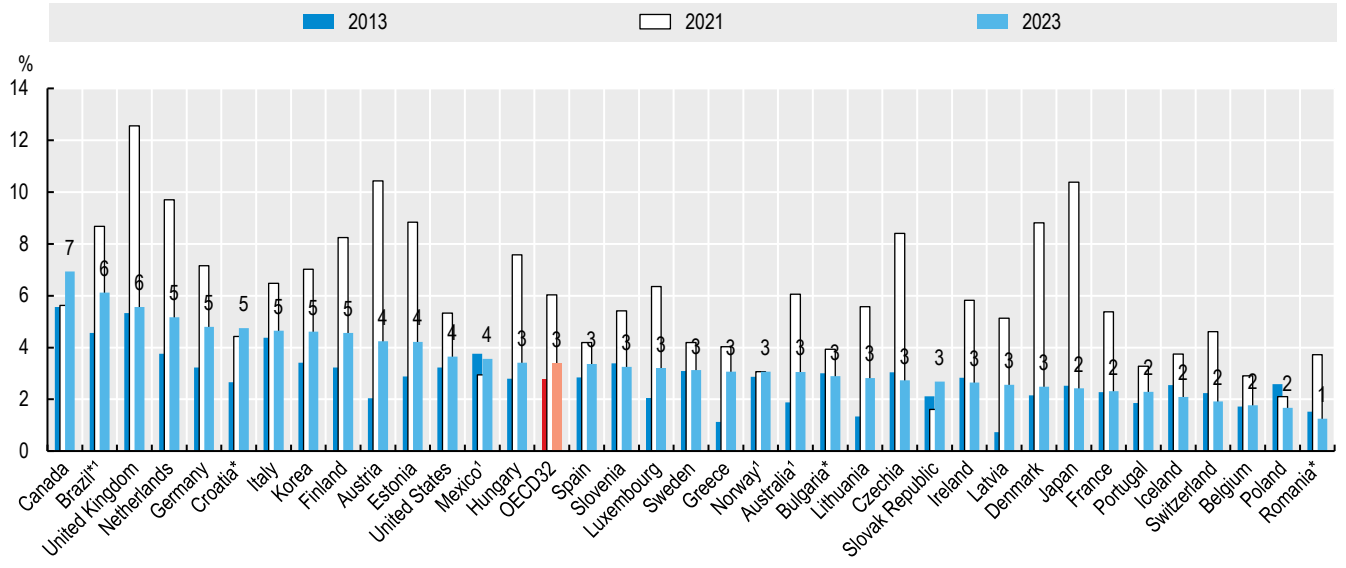
Figure 7.16. Spending on primary healthcare services as a share of current health expenditure, 2023 (or nearest year)



1. Spending on general outpatient care can include pharmaceuticals. 2. 2022 data. * Accession/partner country.
Source: OECD Health Statistics 2025.

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Figure 7.17. Spending on prevention as a share of current health expenditure, 2013, 2021 and 2023 (or nearest year)



1. 2022 data. * Accession/partner country.
Source: OECD Health Statistics 2025.

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Health expenditure by provider

Healthcare is delivered by a wide variety of health providers, ranging from hospitals and medical practices to ambulatory facilities and retailers, which can affect the expenditure patterns for different goods and services. Analysing health spending by provider can be particularly useful when considered alongside the functional breakdown of health expenditure (see section "Health expenditure by type of service"), giving a fuller picture of the organisation of health systems.

The organisational differences in healthcare delivery across OECD countries can be substantial, resulting in wide variation in the distribution of health spending across providers. At 39%, activities delivered in hospitals accounted for the largest proportion of health system funding across OECD countries. This average was largely exceeded in Türkiye and Costa Rica, where hospital activities received half or more of all financial resources, as well as in accession countries Indonesia and Thailand (Figure 7.18). On the other hand, Canada, Germany and Mexico spent less than 30% of the total health budget on hospitals.

After hospitals, the largest provider category is ambulatory providers. This covers a wide range of facilities with most spending related to either medical practices including GPs and specialists (as in Austria, France and Germany) or ambulatory healthcare centres (as in Finland, Ireland and Sweden). Across OECD countries, care delivered by ambulatory providers accounts for around a quarter of all health spending on average. Within this, around two-thirds of all spending relates to GP and specialist practices and ambulatory healthcare centres, and roughly one-fifth relate to dental practices. Overall, every third health dollar was spent on ambulatory providers in Belgium, Mexico, Finland, Luxembourg and the United States but this share was below 20% in Türkiye, Greece and the Slovak Republic.

Other main provider categories include retailers (mainly pharmacies), which accounted for one-sixth of all health spending across OECD countries and residential long-term care facilities (mainly providing inpatient care to dependent people), to which 9% of the total health spending can be attributed. The latter provider group plays a much more central role in the health systems in the Netherlands, Sweden and Finland than elsewhere.

Across OECD countries, there is wide variation in the range of activities that may be performed by the same category of provider, reflecting differences in the organisation of health systems. These cross-country differences are most pronounced in the hospital sector (Figure 7.19). Although inpatient curative and rehabilitative care define the primary activity of hospitals, they can also be important providers of outpatient care in many countries – for example, through accident and emergency departments, specialist outpatient units, or laboratory and imaging services. In Finland and Denmark, outpatient care accounts for more than half of hospital expenditure, since specialists typically receive patients in hospital outpatient departments. In Germany and Greece, on the other hand, hospitals are generally mono-functional, with the vast majority (around 90%) of spending dedicated to the provision of inpatient care services, and very little outpatient and day care spending. Over recent decades, many countries have shifted some inpatient services to day care departments aiming to achieve potential efficiency gains and a reduction in waiting times. As a result, day care services account for 15% or more of all hospital expenditures in Belgium, Ireland and Portugal.

Definition and comparability

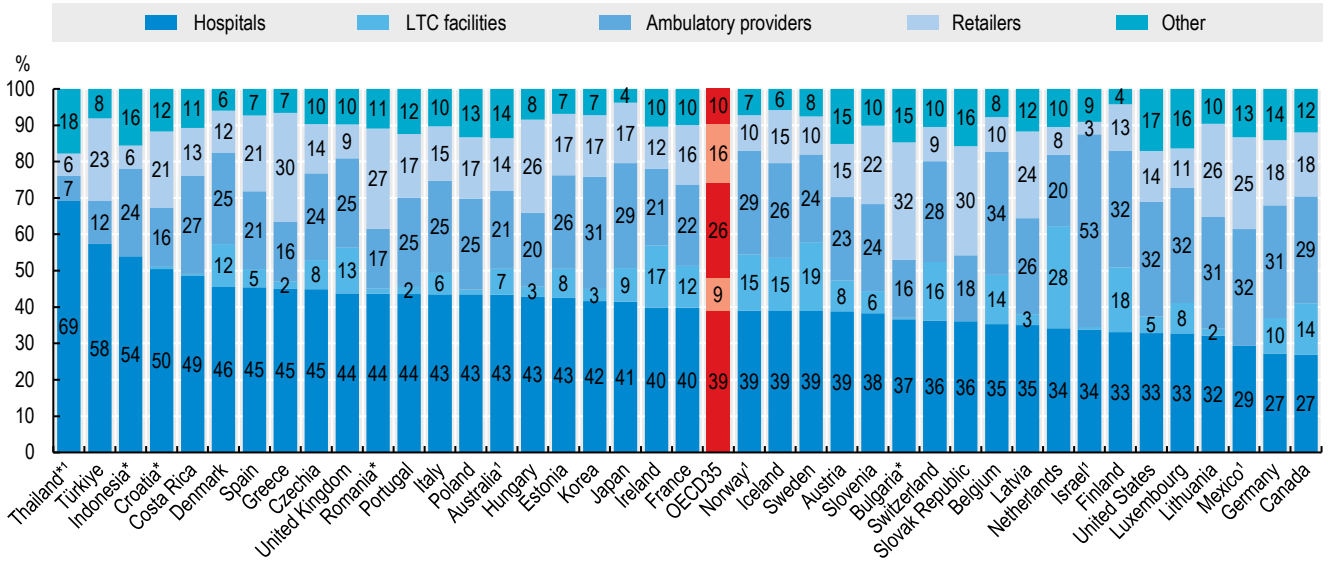
The universe of healthcare providers is defined in SHA (OECD/Eurostat/WHO, 2017[1]) and encompasses primary providers – i.e. organisations and actors that deliver healthcare goods and services as their primary activity – as well as secondary providers for which healthcare provision is only one among a number of activities.

The main categories of primary providers are hospitals (acute, psychiatric and specialised), residential long-term care facilities, ambulatory providers (practices of GPs and specialists, dental practices, ambulatory healthcare centres, providers of home healthcare services), providers of ancillary services (e.g. ambulance services, laboratories), retailers (e.g. pharmacies), and providers of preventive care (e.g. public health institutes). Secondary providers include residential care institutions whose main activities might be the provision of accommodation but that provide nursing supervision as secondary activity, supermarkets that sell over-the-counter medicines, or facilities that provide healthcare services to a restricted group of the population such as prison health services. Secondary providers also include providers of health system administration and financing, and households as providers of home healthcare. Health facilities are classified into a provider category based on their principal activity.

References

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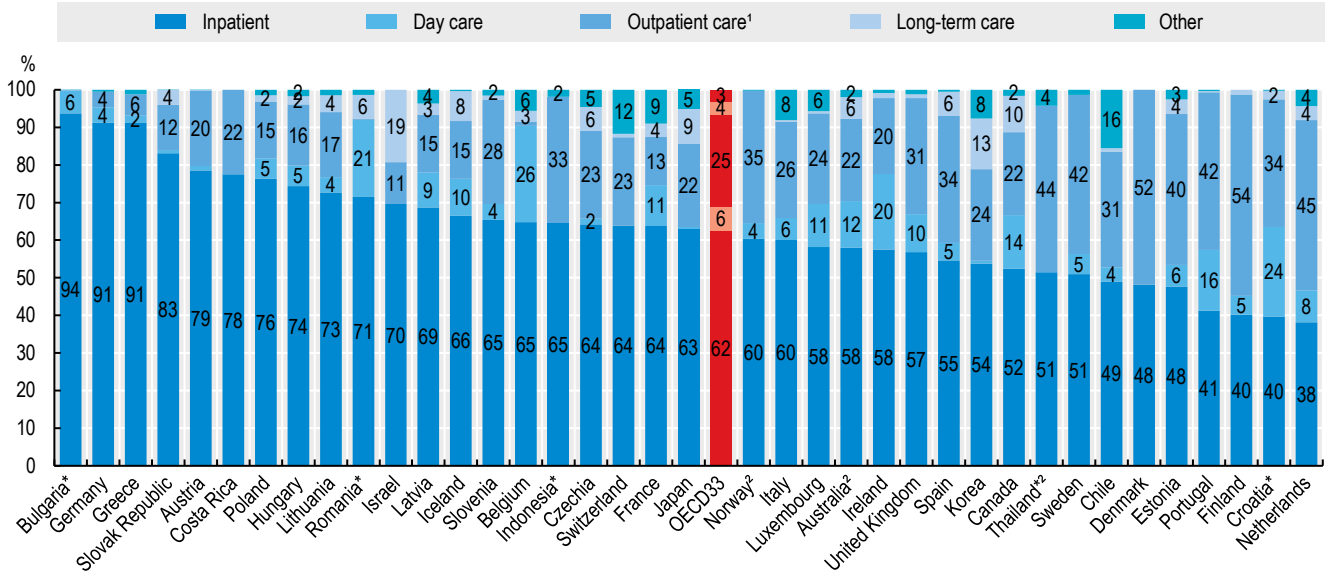
Figure 7.18. Health expenditure by provider, 2023 (or nearest year)



Note: "Other" includes ancillary service providers (e.g. patient transport and laboratories); health system administration, public health and prevention agencies; households in cases where they provide paid long-term care (LTC); and atypical providers, where healthcare is a secondary economic activity. 1. 2022 data. * Accession/partner country.
Source: OECD Health Statistics 2025.

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Figure 7.19. Hospital expenditure by type of service, 2023 (or nearest year)



Note: "Other" includes preventive care activity; pharmaceuticals if dispensed to outpatients; and unknown services. 1. Includes ancillary services. 2. 2022 data. *Accession/partner country.
Source: OECD Health Statistics 2025.

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Capital expenditure in the health sector

While human resources are critical to the health and long-term care sector, physical infrastructure and technology also play a central role in the delivery of effective health services. Investments in new healthcare facilities, equipment and digital technologies directly influence the ability of health systems to respond to both routine and emergency healthcare demands. Having adequate equipment – particularly in intensive care settings – is essential to avoiding dangerous delays in care. Beyond sufficient facilities and technical equipment, ensuring strong digital infrastructure is increasingly vital for both real-time crisis response and long-term health system performance. Investing in capital is thus fundamental to strengthening resilience across the health sector.

By its nature, capital investment tends to fluctuate annually, greatly influenced by short-term macroeconomic conditions, political priorities and legacy infrastructure. Consistent underinvestment can lead to the gradual deterioration of facilities and technology, ultimately requiring more costly remedial spending down the line.

Between 2021 and 2024, average annual capital expenditure on health across OECD countries remained at around 0.6% of GDP – compared to average current health spending of more than 9% of GDP over the same period (see section "Health expenditure in relation to GDP"). During this period, Germany recorded the highest annual level of capital investment, at 1.2% of GDP, followed by a group of countries each investing around 0.9% (Figure 7.20). One of these (Latvia) saw a doubling of capital spending compared with pre-pandemic levels. Under its National Recovery and Resilience Plan, backed by European Union funding, capital support was provided to modernise hospitals and healthcare providers while investment in information and communication technology (ICT) within healthcare accelerated. Of the G7 countries, Japan at 0.9% and the United States at 0.8% remained above the OECD average, while France, Italy and the United Kingdom all invested below the average at 0.4-0.5% of GDP. At the low end of the spectrum, annual capital spending represents only 0.2-0.3% of GDP in several OECD countries. Ireland, for example, has seen a continued period of low capital investment, although there are signs that this may be changing (Sicari and Sutherland, 2023[1]).

The breakdown of capital spending in the health sector reveals that, on average across OECD countries, construction accounted for the largest share (around half), followed by machinery and equipment, and then intellectual property products such as databases and software (Figure 7.20). The allocation of capital funds varies by country. For instance, Finland – with the backing of the European Investment Bank has embarked on a number of ongoing hospital construction projects, whereas others (including Japan, Latvia, and Portugal) have focussed more on equipment and machinery. While overall investment in the Netherlands is at a similar level to Finland's, the focus has been more in allocating funds to digital infrastructure projects (OECD, 2022[2]).

Over the last decade, capital investments in the health sector across OECD countries have gradually trended upwards (Figure 7.21). Australia's capital spending as a share of GDP has also increased over the period, albeit with variation year on year. Both the United States and Canada maintained generally stable capital spending over the same period, with a slight convergence more recently. In Europe, incentivised by its funding models, Germany has consistently invested at a high level in health infrastructure and capital. On the other hand, after the United Kingdom experienced a clear decline in investment through the mid-2010s, there has been a notable increase in recent years – even if the level remains below the OECD average.

Definition and comparability

Gross fixed capital formation (GFCF) in the health sector is measured by the total value of the fixed assets that health providers have acquired during the accounting period (less the value of the disposals of assets) and that are used repeatedly or continuously for more than one year in the production of health services. The breakdown by assets includes infrastructure (e.g. hospitals and clinics), machinery and equipment (e.g. diagnostic and surgical machinery, ambulances and ICT equipment), and software and databases.

GFCF is reported under the National Accounts by industrial sector according to the International Standard Industrial Classification (ISIC) Rev. 4 using section Q: Human health and social work activities. It is also reported by a small number of countries under the SHA framework (OECD/Eurostat/WHO, 2017[3]). The ISIC section Q is generally broader than the SHA boundary for healthcare. For reasons of comparability and availability, preference has been given to measures of GFCF under the National Accounts.

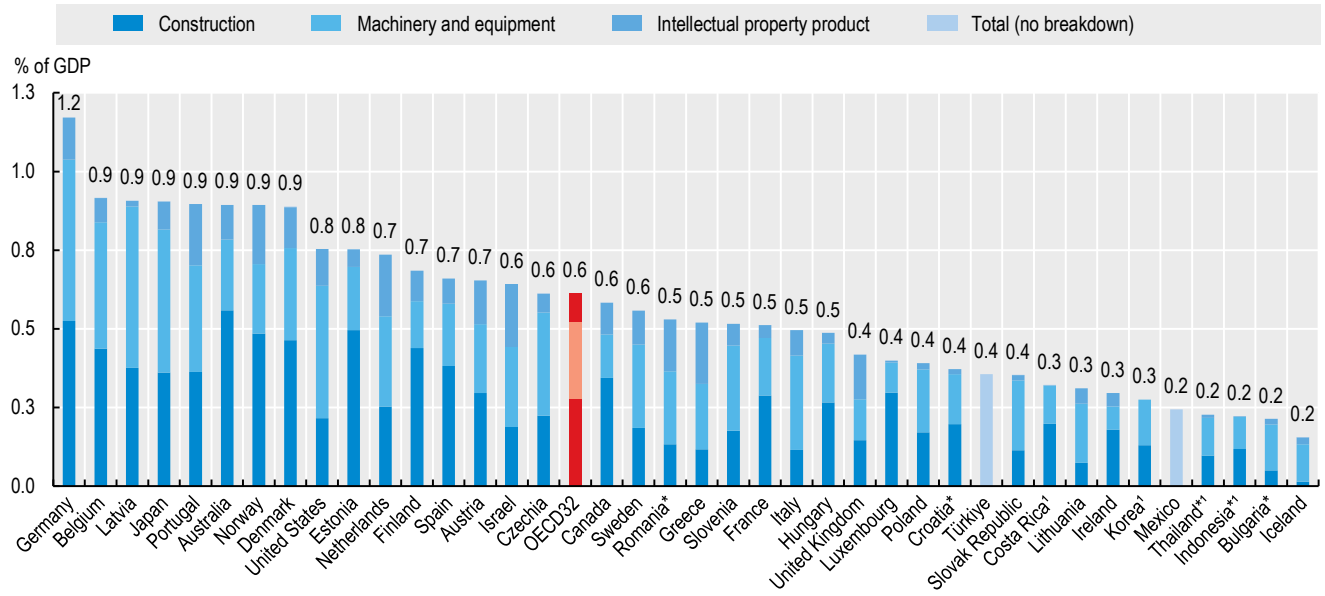
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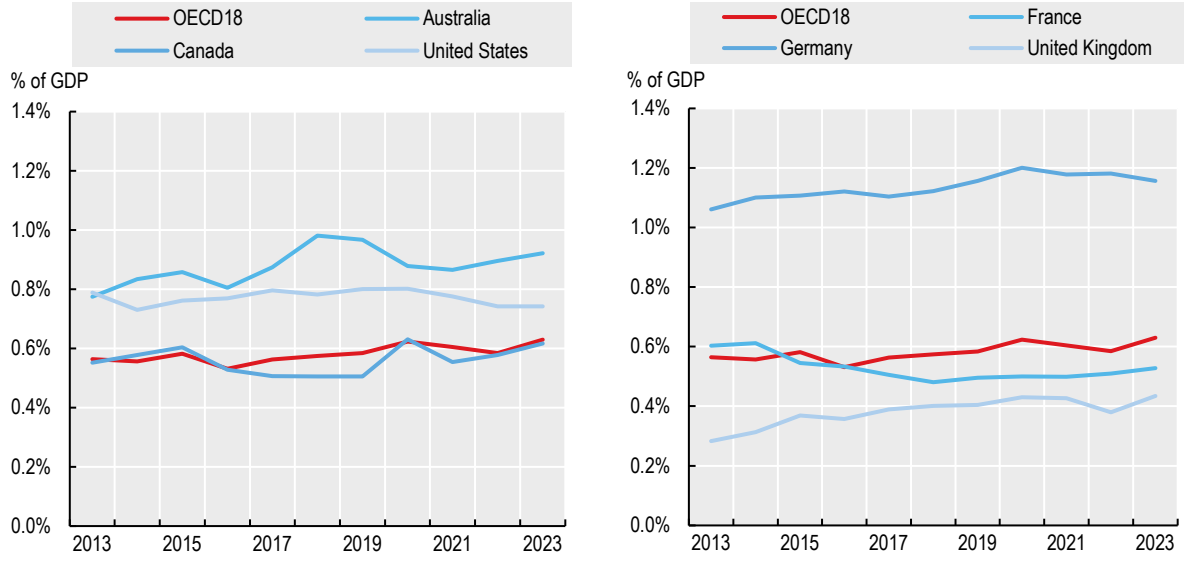
Figure 7.20. Annual capital expenditure in health and social work as a share of GDP, average 2021-2024 (or nearest year) by type of asset



1. Refers to GFCF of health providers under the SHA. * Accession/partner country.
Source: OECD National Accounts Database, OECD Health Statistics 2025.

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Figure 7.21. Trends in capital expenditure as a share of GDP, OECD and selected countries, 2013-2023



Source: OECD National Accounts Database, OECD Health Statistics 2025.

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Spending on crisis preparedness and critical care capacities

The rationale for spending on crisis preparedness and critical care capacities to respond to global health threats is clear. The COVID-19 pandemic resulted in millions of lives lost and triggered the deepest global recession in decades. Current estimates indicate a 2-3% annual probability of a pandemic with transmission and mortality characteristics similar to COVID-19 – suggesting that a pandemic of this scale could occur approximately once every 50 years (G20/World Health Organization/World Bank, 2024[1]).

OECD estimates indicate that OECD countries spent an average of USD 101 per capita on prevention, preparedness, and response (PPR) in 2023, including, for example, on certain immunisation programmes, disease surveillance, and national laboratory systems (Figure 7.22). The United States was the highest spender at USD 279 per capita, followed by Germany at USD 209. Latvia, Mexico, and Costa Rica reported the lowest levels of per capita spending on PPR at below USD 40 in 2023. Between 2013 and 2019, PPR spending declined as a share of overall health expenditure, with annual per capita spending on PPR growing by an average of 2.4% – slightly below the 2.5% growth rate of total health spending. However, several countries – including Korea, Lithuania, and Estonia, as well as accession countries Bulgaria and Romania – increased their PPR spending by more than 60% over this period.

Driven by emergency COVID-19-related expenditures, PPR spending accelerated between 2019 and 2023, increasing by 6% annually on average. Spending peaked dramatically in 2021, at nearly USD 140 per capita on average across OECD countries. Spending in Japan temporarily reached more than USD 300 per capita in 2021, and over USD 200 in Australia, Denmark, Germany, Switzerland, the United Kingdom and the United States.

Scaling up crisis preparedness and critical care capacity within OECD countries alone is insufficient to combat global health threats without parallel efforts across all health systems, but levels of investment are very uneven. In 2022, high-income countries (predominantly OECD countries) spent approximately five times more (USD 96) on a per capita basis than the average upper-middle-income country (USD 18), and significantly more than lower-middle-income (USD 5.5) and low-income (USD 3.7) countries (Figure 7.23). In high-income countries, public sources accounted for 85% of spending on PPR, with the remaining 15% financed through private sources. On the other hand, over 60% of PPR spending in low-income countries and more than 45% in lower-middle-income countries was financed through external sources in 2022.

A main source of external financing for health is official development assistance (ODA), government aid that supports a range of activities in the healthcare sector including PPR, but also infrastructure, primary healthcare, and health system strengthening. In 2023, OECD countries of the Development Assistance Committee (DAC) committed nearly USD 15 billion in bilateral ODA to health in developing countries (Figure 7.24). The United States was by far the largest donor in absolute terms, contributing over USD 7.5 billion, followed by Japan and the United Kingdom. As a share of their Gross National Income (GNI), DAC countries allocated an average of 0.02% to health, with Luxembourg Sweden, and Norway committing 0.04% or more of their GNI.

However, ODA is at a critical juncture. The COVID-19 pandemic had a profound impact on both public health and economic stability worldwide. Rising demands from competing development priorities are putting pressure on limited ODA resources, and evolving geopolitical dynamics are reshaping the aid commitments of traditional donors. Announced cuts from major donors mean DAC countries' net ODA for health is projected to fall by 6% in 2024 and 14-29% in 2025 (OECD, 2025[2]). This has direct implications for the beneficiary countries concerned, but also brings new risks for global health security.

Definition and comparability

The SHA framework does not yet include a category on PPR. A proxy measure of PPR spending has been developed, based on an OECD and WHO mapping of health accounts classifications with the Joint External Evaluation Tool of the International Health Regulations (Penn et al., 2025[3]).

Data on ODA are obtained from the Creditor Reporting System. Bilateral aid represents flows from official government sources directly to the recipient country. Data refer to the 32 OECD countries that are members of the OECD DAC. ODA to health refers to health and population services.

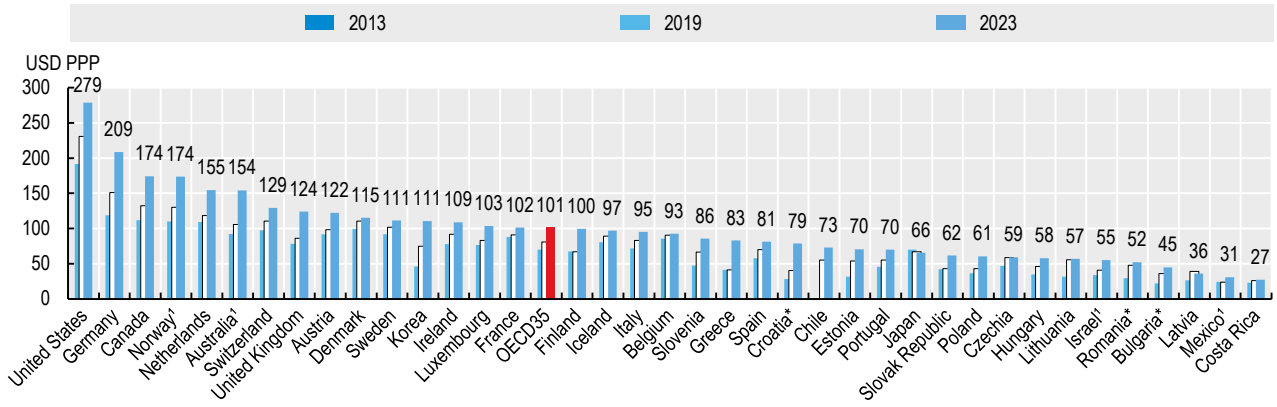
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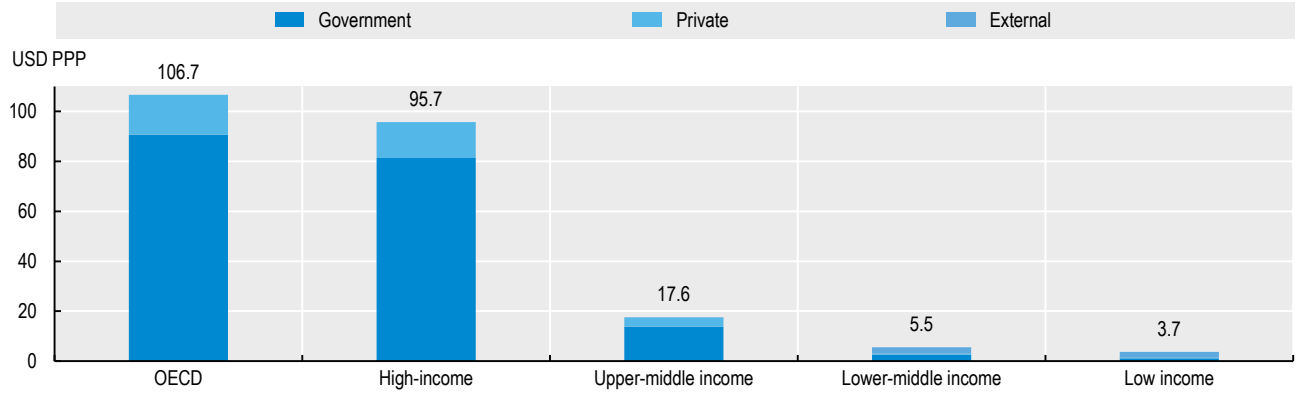
Figure 7.22. Estimated domestic spending on prevention, preparedness and response per capita, 2013, 2019 and 2023



Note: Data for Chile missing for 2013. 1. Latest data from 2022. * Accession/partner country.
Source: OECD Health Statistics 2025.

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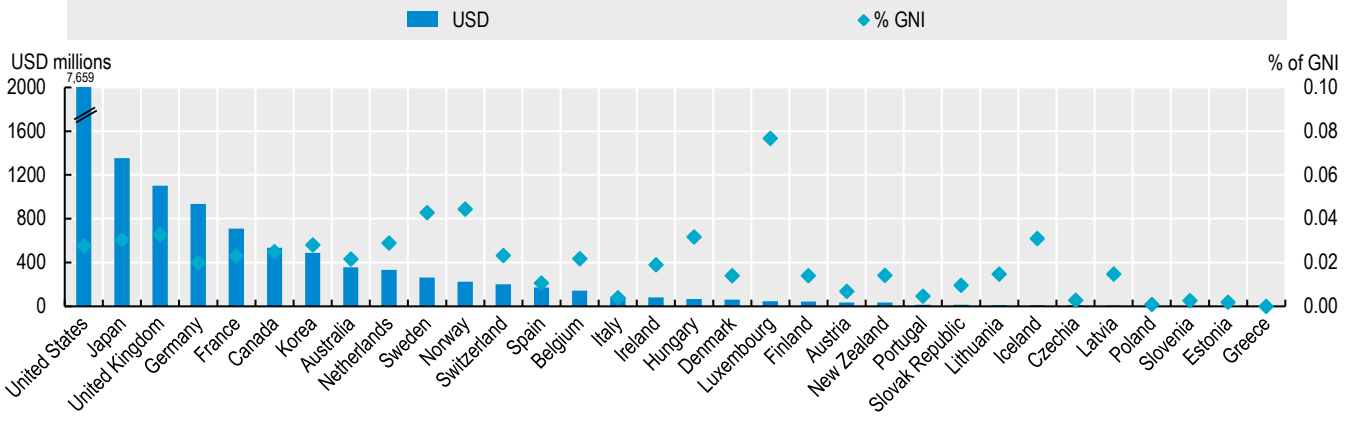
Figure 7.23. Estimated spending on prevention, preparedness and response per capita, by country income group, 2022



Sources: WHO Global Health Expenditure Database, OECD Health Statistics 2025.

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Figure 7.24. Bilateral ODA commitments for health, 2023



Source: Creditor Reporting System, OECD-DAC statistics. World Development Indicators.

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Health spending projections

Tracking long-term budgetary constraints through forward-looking projections enables decision makers to anticipate and plan for future financial demands in the health and long-term care sectors. With three-quarters of health spending in OECD countries financed from public sources on average, forecasting the evolution of this expenditure is crucial for fiscal sustainability.

The OECD projection model focusses on current public health spending – defined to include both government-financed schemes and compulsory health insurance. It uses a component-based approach, disaggregating projections by five-year age groups and attributing changes to four key drivers: income growth, productivity constraints, demographic changes, and technological innovation (OECD, 2024[1]).

From 2024 to 2045, per capita public health spending across OECD countries is projected to grow at an average annual rate of 2.6% under the base scenario. This represents a slowdown from the historical rate of 2.9% between 2001 and 2023 (Figure 7.25). Country-specific projections vary significantly. Public health spending per capita is projected to grow by over 3.5% annually in Costa Rica and Korea, both with strong GDP growth forecasts. In contrast, Austria and Germany are projected to see annual growth below 2%.

While health spending tends to mirror the shape of GDP growth, other cost drivers typically push spending above GDP trends, particularly under the "cost pressure" scenario. This partial decoupling is consistent with previous OECD analysis, which found that economic fluctuations explained less than half of the slowdown in health spending from 2005 to 2013, with policy decisions accounting for the rest (Lorenzoni et al., 2018[2]).

Given that public health spending is expected to grow faster than overall economic growth, public health spending as a share of GDP across OECD countries is projected to rise by 1.5 p.p., reaching 8.4% by 2045 in the base scenario (Figure 7.26). Increases of around 3 p.p. or more are expected in Iceland, New Zealand and Norway, while slight declines are projected in Greece, Latvia, Lithuania and Poland. Scenario analysis shows that public health spending as a share of GDP is projected to grow by around 1 p.p. under the "cost control" scenario and by 1.7 p.p. under the "cost pressure" scenario (Figure 7.27, left panel). In per capita terms, average annual growth under the base scenario is estimated at 2.6%, compared to the 2.7% "cost pressure" growth and 2.3% estimated under the "cost control" scenario (Figure 7.27, right panel).

In summary, the OECD model highlights the importance of policy choices in shaping future public health spending. While spending is expected to rise both in per capita terms and as a share of GDP, proactive planning and transformational policies will be critical to managing pressures and ensuring sustainable, high-performing health systems.

Definition and comparability

The "base" policy scenario assumes policies remain unchanged from those before the pandemic but assumes a linear increase in the productivity in the health sector up to 10% by 2045 as compared to the general economy, which reflects historical trends. The base scenario also models healthy ageing through a reduction in expenditure, on average, for survivors.

Two additional policy scenarios are modelled:

The "cost control" scenario estimates the extent to which effective cost containment policies can offset health spending drivers. It assumes a linear increase of up to 20% in productivity in the health sector by 2045, and a linear decrease of 10% by 2045 in the income elasticity of health spending (compared to no change in the base scenario) – reflecting that as countries become richer, health systems become more efficient and health outcomes improve. It also assumes that all life expectancy gains translate into years in good health over time, therefore lowering healthcare expenditure for survivors compared to the base scenario.

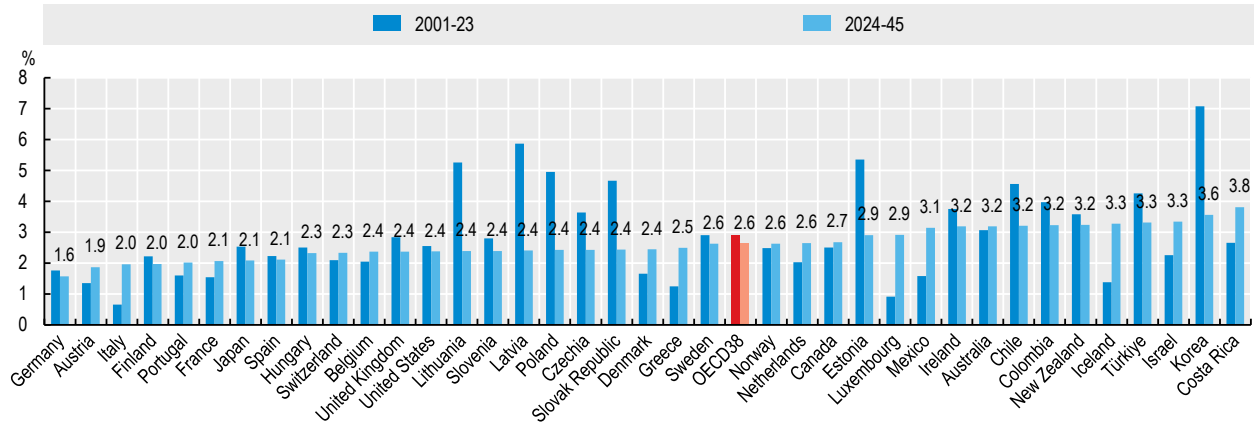
The "cost pressure" scenario assumes a linear increase in income elasticity up to 10% by 2045 and constant productivity. Here, ineffective cost-containment policies, combined with rising expectations on healthcare, lead to the introduction of expensive new technologies, with insufficient consideration of their cost-effectiveness. While in this scenario quality of care may increase, such gains will come with considerable cost pressures.

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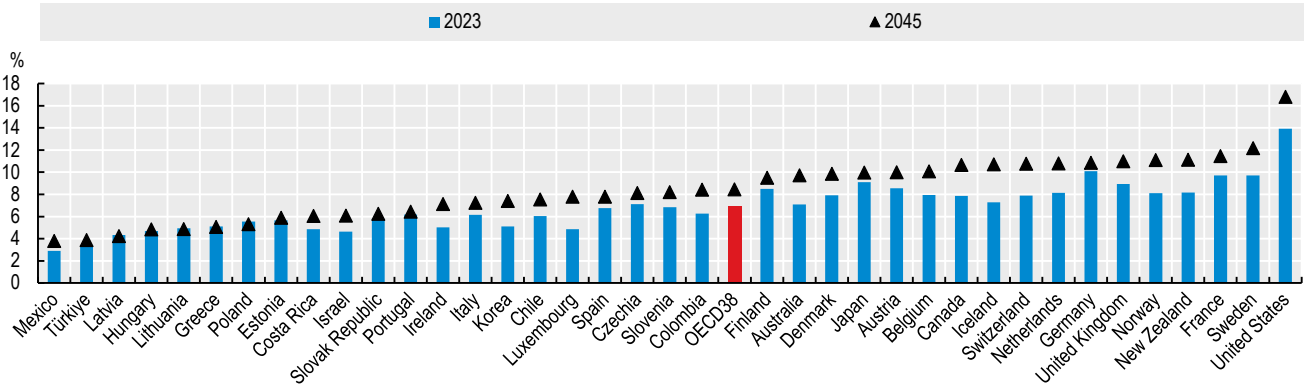
Figure 7.25. Observed and projected annual growth in per capita health spending from public sources (real terms), 2001-2023 and 2024-2045



Source: OECD Secretariat estimates.

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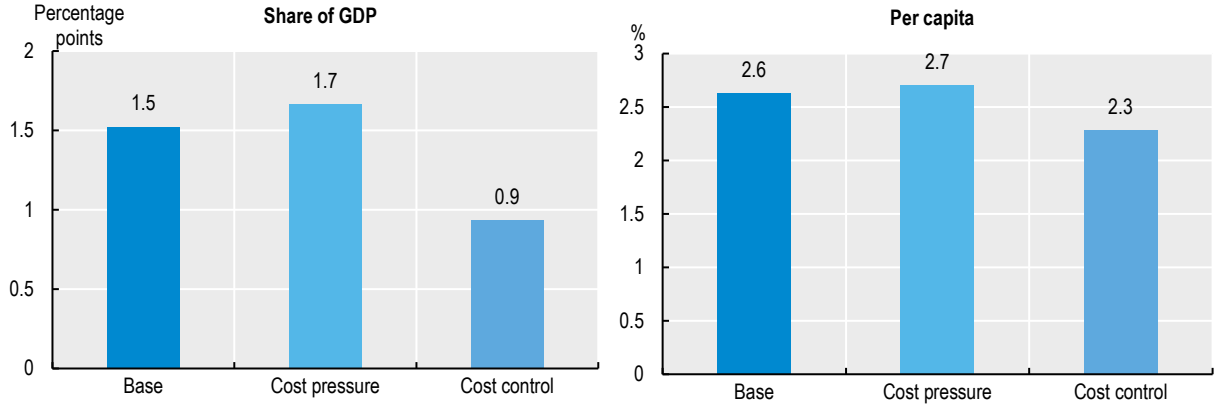
Figure 7.26. Observed and projected health spending from public sources as a share of GDP



Source: OECD Secretariat estimates.

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Figure 7.27. Projected increase of health spending from public sources in 2045 under different projection scenarios (OECD average)



Source: OECD Secretariat estimates.

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8 Health workforce

Health and social care workforce
Doctors (overall number and distribution)
Doctors (by age, gender and category)
Remuneration of general practitioners
Remuneration of specialists
Nurses
Remuneration of nurses
Hospital workers
Medical graduates
Nursing graduates
International migration of doctors
International migration of nurses

Health and social care workforce

Driven by ageing populations, rising incomes and greater expectations, the health and social care sectors employ more workers now than at any time in history in most OECD countries. In 2023, about one in every nine jobs (10.9%) was in health or social care, up from one in ten jobs (10.1%) in 2013 (Figure 8.1). In Nordic countries and the Netherlands, over 16% of all jobs are in health and social care. Between 2013 and 2023, the share of health and social care workers increased particularly rapidly in Türkiye, Chile and Korea, although it remained lower than the OECD average in these three countries.

Job numbers in the health and social care sector increased much more rapidly than in other sectors over the past few decades. On average across OECD countries, employment in health and social work increased by 30% between 2013 and 2023 – twice the rate of overall employment growth (Figure 8.2).

In most OECD countries, over 75% of workers in the health and social care sector are women (Figure 8.3). While women's jobs tend to be concentrated more in lower-skilled and lower-paid occupations, slightly more than half of all doctors on average across OECD countries in 2023 were female (see section on "Doctors by age, gender and category").

In most countries, hospitals are the largest employer of health and social care workers, employing about a quarter of all workers in this sector (see section on "Hospital workers"). Nurses make up the largest category of health and social care workers in most OECD countries, accounting for approximately 20-25% of all workers. Personal care workers (including healthcare assistants and nursing aides in hospitals and nursing homes) also account for a relatively large share of workers in the sector.

Population ageing, technological change and rising incomes are expected to continue to boost demand for health and social care workers in the coming years. This is confirmed by national projections that forecast substantial employment growth in the health sector in the years ahead. For example, in the United States, the Bureau of Labor Statistics projects that employment in the healthcare and social assistance sector will grow more rapidly than in any other sector of the economy between 2023 and 2033, with a growth rate of over 10% over this decade, more than twice the projected employment growth rate in the economy as a whole. In Canada, the healthcare sector is also projected to post the largest increases in employment over the next decade. The demand for social care (long-term care) workers is also projected to increase strongly, mainly due to population ageing (OECD, 2023[1]).

As the share of older people continues to grow and the working-age population to shrink in most OECD countries, it will become increasingly challenging to continue to increase the number and share of the working-age population employed in health and long-term care without crowding out employment in other sectors of the economy and curtailing overall economic growth. For example, in Norway, where more than one in five people are already employed in health and social care, a recent report concluded that there is little scope for the health sector to increase its share of the workforce without drawing talent away from other priority sectors of the economy (Healthcare Personnel Commission, 2023[2]). The report also advised against large-scale recruitment of health workers from abroad, stressing that reliance on foreign workers would introduce fragility into the system and be irresponsible from a global perspective. To meet the challenge of growing demand arising from population ageing, the Healthcare Personnel Commission recommended a multi-pronged strategy focussed on increasing productivity of existing human resources through increased task shifting, technology use and improved care integration.

Definition and comparability

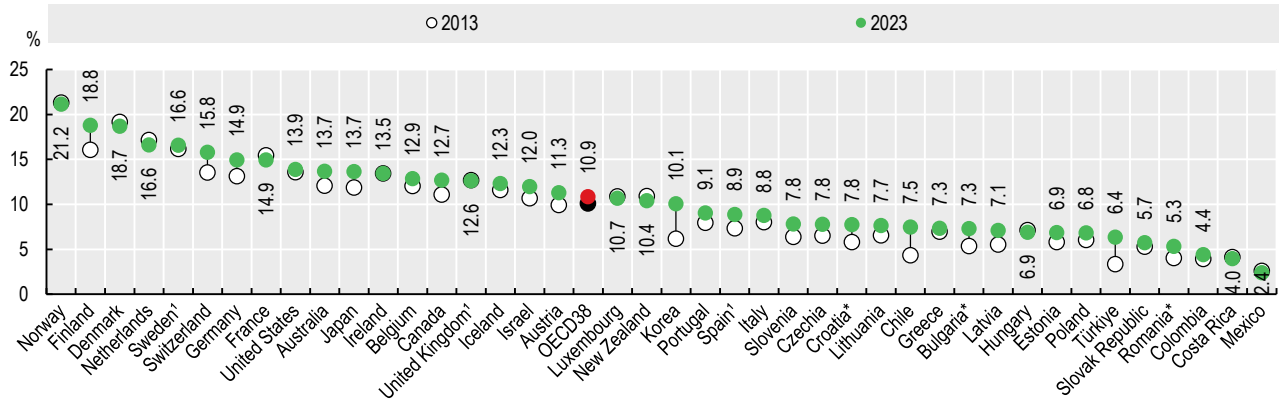
Health and social work is one of the economic activities defined according to the major divisions of the International Standard Industrial Classification of Economic Activities. Health and social work is a sub-component of the services sector, and is defined as a composite of human health activities, residential care activities (including long-term care) and social work activities without accommodation.

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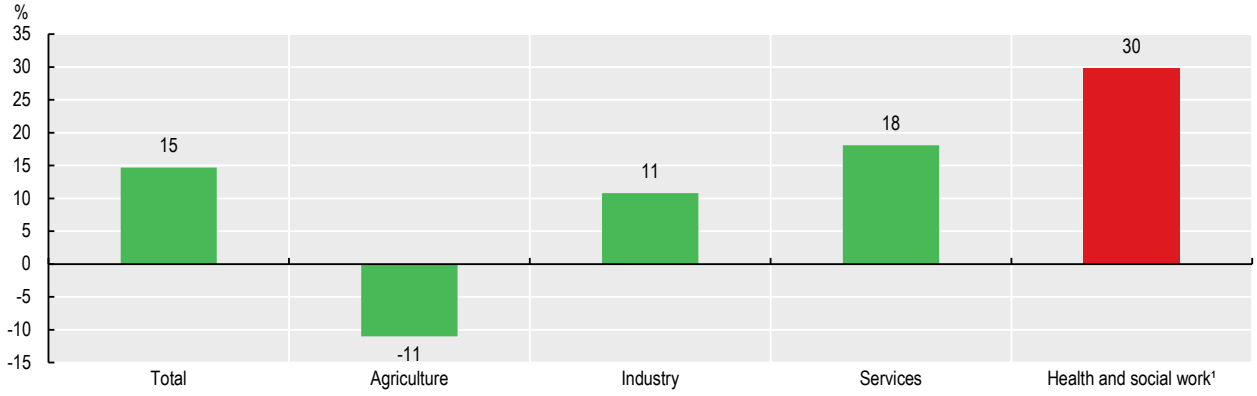
Figure 8.1. Employment in health and social work as a share of total employment, 2023 and 2013 (or nearest year)



1. Latest data from 2022. * Accession country.
Source: OECD National Accounts Database; OECD Annual Labour Force Statistics for Australia, Chile, Luxembourg and Türkiye.

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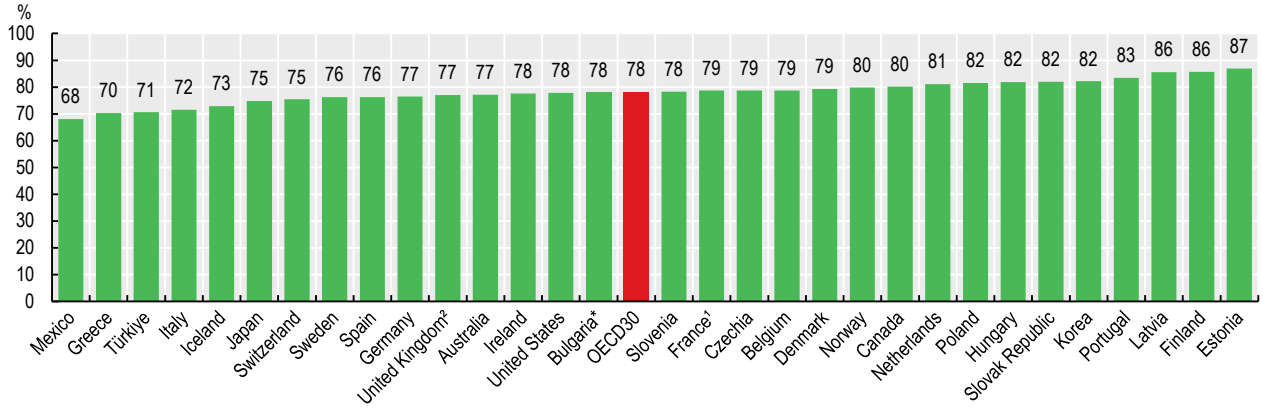
Figure 8.2. Employment growth by sector, OECD average, 2013-2023 (or nearest year)



1. Health and social work is classified as a sub-component of the services sector.
Source: OECD Annual Labour Force Statistics; OECD National Accounts Database for the United States.

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Figure 8.3. Share of women in health and social work, 2023 (or nearest year)



1. 2020 data. 2. 2024 data. * Accession country.
Source: OECD Annual Labour Force Statistics, complemented by national sources for Australia, France, Ireland, the United Kingdom and the United States.

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Doctors (overall number and distribution)

Access to medical care requires a sufficient number and proper distribution of doctors in all parts of the country. A shortage of doctors – either widespread or in specific regions – can lead to inequalities in access to care and unmet needs. In all OECD countries, the number of doctors has increased more rapidly than population size over the past decade, so that on average the number of doctors per 1 000 population rose from 3.3 in 2013 to 3.9 in 2023 (Figure 8.4). However, this does not mean that the shortage of doctors has decreased, given rising demand for healthcare, driven in part by population ageing.

In 2023, Greece, Portugal, Austria, Italy and Norway had the highest number of doctors among OECD countries, with 5.0 or more doctors per 1 000 population, although the numbers in Greece and Portugal are overestimated as they include all doctors licensed to practise (not just those actively practising). By contrast, the number of doctors was the lowest in Türkiye and Colombia, with 2.5 or fewer doctors per 1 000 population. Many non-European countries, notably Japan and Korea in Asia and Canada, Mexico and the United States in North America, also had relatively few doctors compared to the OECD average. Among OECD accession countries, Brazil and Peru had fewer doctors per population than any OECD country in 2023. While Argentina appears to have more doctors than the OECD average, the number is overestimated as it includes all doctors licensed to practise.

The growing number of doctors in OECD countries has been driven mainly by an increase in the number of students graduating from domestic medical schools (see section on “Medical graduates”). Long-held concerns about doctor shortages and the ageing of the medical workforce prompted many OECD countries to increase the number of students in medical schools several years ago (OECD, 2023[1]). In some countries, the immigration of foreign-trained doctors also contributed to the growth of available doctors (see section on “International migration of doctors”). A third factor is that in several countries more doctors are extending their careers beyond the previous standard retirement age (see section on “Doctors (by age, gender and category)”).

While the number of doctors per population has increased over the past decade in all countries, the average working hours of doctors has decreased in most countries, so the increase in the number of full-time equivalents (FTEs) has been more modest. Data from the European Union (EU) Labour Force Survey show that on average across EU countries, the working hours of male doctors fell from 44.3 hours per week in 2012 to 43.2 hours in 2022 (a reduction of 2.5%), while the working hours of female doctors fell slightly from 40.0 hours per week to 39.5 hours (a reduction of 1.2%) (OECD/European Commission, 2024[2]).

The density of doctors varies not only across but also within countries, and is generally greater in metropolitan regions, reflecting the concentration of specialised services and physicians’ preferences to practise in densely populated areas. In many countries, there is a particularly high concentration of doctors in national capital regions (Figure 8.5) (see also the section on “Physical access to services” in Chapter 5 on variations in doctor density between metropolitan and rural/remote areas).

Doctors may be reluctant to practise outside urban regions due to concerns about their professional life and social amenities. A range of policy levers can be used to influence the choice of practice location of physicians, including: 1) providing financial incentives for doctors to work in underserved areas; 2) increasing enrolment in medical education programmes of students from rural backgrounds or decentralising the location of medical schools; 3) regulating the choice of practice location of new doctors; and 4) reorganising service delivery to improve the working conditions of doctors in rural and other underserved areas (OECD, 2016[3]).

Definition and comparability

The data for most countries refer to practising doctors, defined as the number of doctors providing care directly to patients. In most countries, the numbers include interns and residents (doctors in training). Colombia, the Slovak Republic and Türkiye also include doctors who are active in the health sector even though they may not provide direct care to patients, adding another 5-10% of doctors. Chile, Greece, Portugal and Argentina report all physicians entitled to practise, resulting in an even larger overestimation of the number of practising doctors.

The geographic distribution is presented at Territorial Level 2. This consists of large regions corresponding generally to national administrative regions, which may contain a mix of metropolitan and more rural and remote areas.

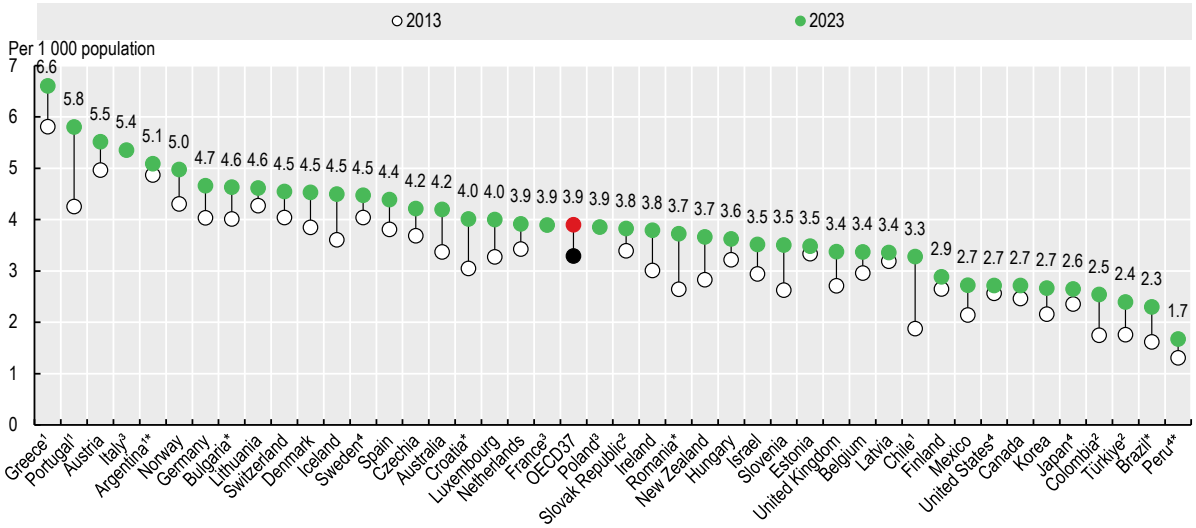
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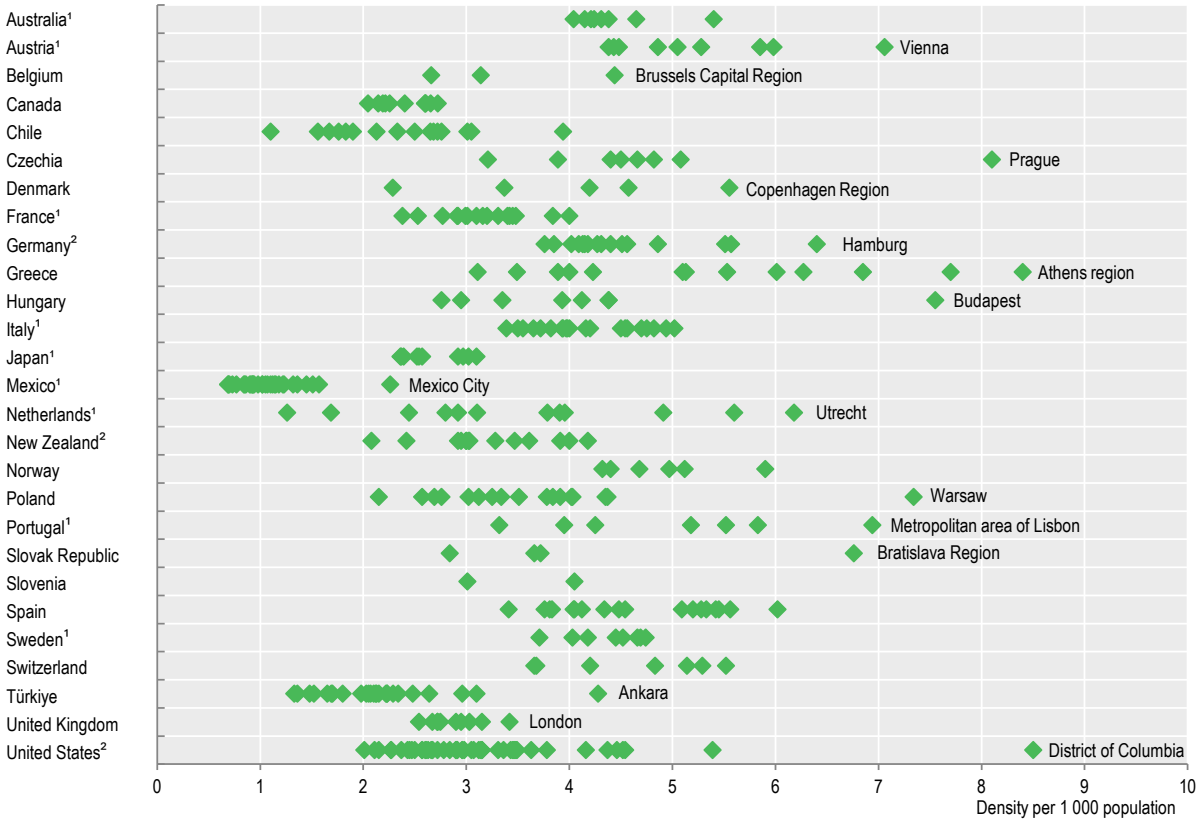
Figure 8.4. Practising doctors per 1 000 population, 2023 and 2013 (or nearest year)



1. Refers to all doctors licensed to practise, resulting in a large overestimation of the number of practising doctors. 2. Includes those working in the health sector as managers, educators, researchers, etc. (adding another 5-10% of doctors). 3. 2013 data not shown because of breaks in time series. 4. Latest data from 2021-2022.
* Accession country.
Source: OECD Health Statistics 2025.

StatLink https://stat.link/mzifb7

Figure 8.5. Doctor density by Territorial Level 2 regions, 2023 (or nearest year)



1. 2020-2022 data. 2. 2019 data.
Source: OECD Regional Database 2025 and Eurostat Database.

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Doctors (by age, gender and category)

The ageing of the medical workforce is a growing concern in many OECD countries. In 2023, nearly one-third (32%) of doctors across OECD countries were aged over 55. In nine OECD countries, this proportion reached 40% or more (Figure 8.6). Bulgaria, an OECD accession country, is facing the most pressing concerns, with more than half of physicians aged over 55. Latvia, Estonia, Italy and Hungary are the OECD countries with the highest proportion of doctors aged over 55, with at least 44% of doctors in this age group. However, the share of doctors aged over 55 has stabilised over the past decade in several countries, with the entry of many new young doctors into the profession offsetting the progressive retirement of the baby-boom generation of doctors.

Countries with a large share of doctors aged over 55 will need to train sufficient numbers of new doctors to replace those retiring over the next decade, while simultaneously implementing policies to encourage current doctors who are willing and able to continue working beyond the standard retirement age. Flexible work-to-retirement arrangements can play a key role in retaining experienced doctors in the workforce for longer. Indeed, the decision of many doctors to continue working beyond the standard retirement age has helped to avoid an exacerbation of shortages in many OECD countries over the past decade, as shown by the growing proportion of doctors aged over 65 in countries including Italy, Germany, France and Belgium.

Italy stands out, with over 20% of doctors aged 65 and over in 2023, foreshadowing substantial doctor attrition in the coming years. To mitigate the impact of this anticipated retirement wave on its health system, Italy has implemented measures to retain older physicians longer in the system while simultaneously boosting the training of new doctors in recent years. In 2024, legislation was passed to temporarily suspend the obligation for doctors employed by public facilities to retire at age 70, allowing them to remain active until they are 72. In addition, those who have retired since September 2023 can be readmitted to service within these limits.

The proportion of female doctors has increased in nearly all OECD countries over the past decade. For the first time in 2023, over half of all doctors on average across OECD countries were female. This proportion ranged from over 70% in Baltic countries (Latvia, Estonia and Lithuania) as well as accession country Romania to around 25% in Japan and Korea (Figure 8.7). The share of female doctors increased particularly rapidly over the past decade in Iceland, Norway, the Netherlands and Belgium. Female doctors generally tend to work more in general medicine and medical specialties like paediatrics, and less in surgical specialties. They also tend to work fewer hours than male doctors (about 10% less on average across EU countries, according to the EU Labour Force Survey), often reflecting uneven family responsibilities (OECD/European Commission, 2024[1]).

General practitioners (GPs) – also known as family doctors – represented about one-fifth (21%) of all doctors on average across OECD countries in 2023. This share ranged from over one-third in Canada, Finland and Belgium to just 6% of all doctors in Greece and Korea (Figure 8.8). However, the number of GPs is difficult to compare across countries, owing to variation in the ways doctors are categorised. For example, in the United States and Israel, general internal medicine doctors often play a role similar to that of GPs in other countries, yet they are categorised as specialists.

Many countries have taken steps to increase the number of training places in general medicine in response to concerns about shortages of GPs (see section on “Medical graduates”).

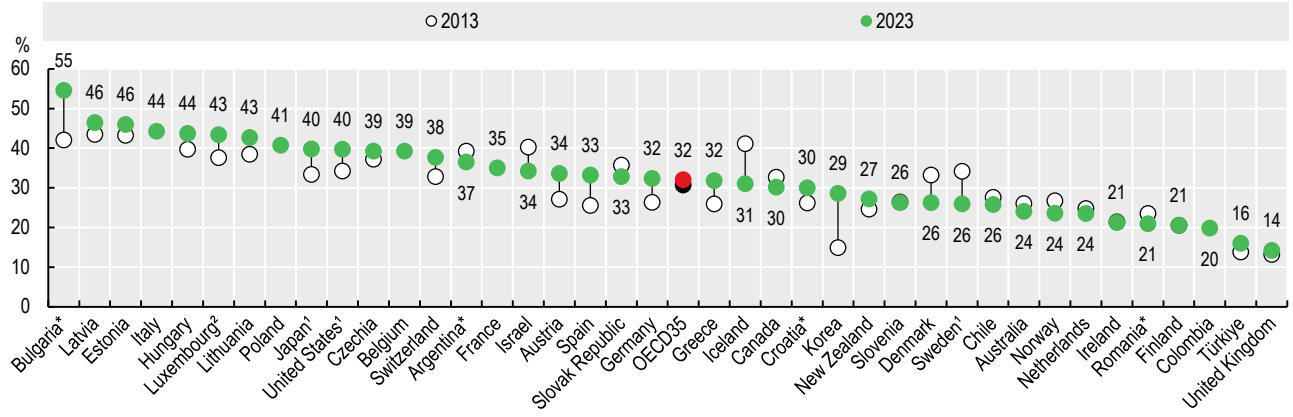
Definition and comparability

The data for most countries refer to practising doctors, defined as doctors providing care directly to patients. In some countries, the data are based on all doctors licensed to practise, not only those currently practising (Chile, Greece and Portugal; and also Israel and New Zealand for data on doctors by age and gender). Not all countries are able to report all their physicians in the two broad categories of specialists and generalists because specialty-specific data are not available for doctors in training or for those working in private practice. A distinction is made in the generalists category between GPs (family doctors) and non-specialist doctors working in hospitals or other settings, although this breakdown is not available for several countries (including Finland, Switzerland, Türkiye and the United Kingdom), possibly leading to an overestimation of GP numbers. In Switzerland, GPs include general internal medicine doctors and other generalists.

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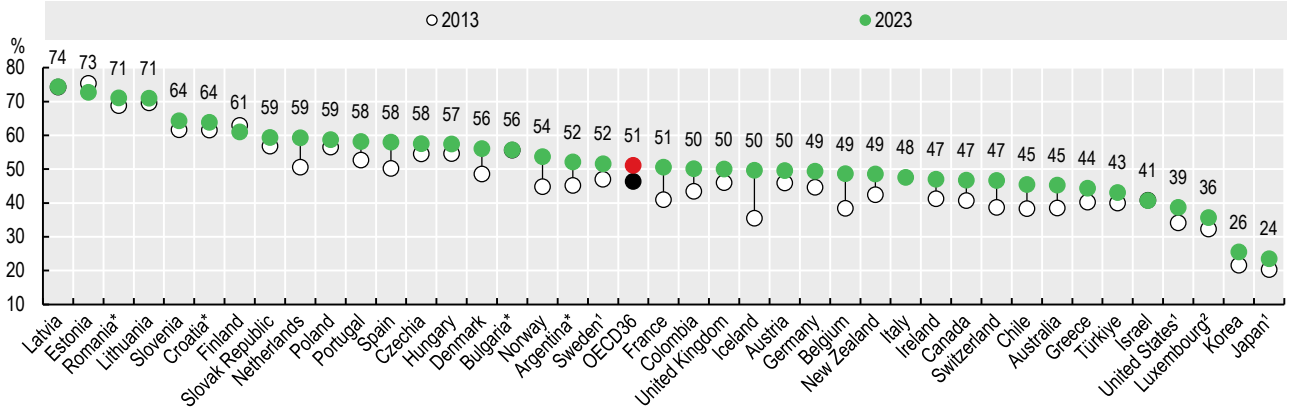
Figure 8.6. Share of doctors aged 55 and older, 2023 and 2013 (or nearest year)



1. Latest data from 2022. 2. Latest data from 2017. * Accession country.
Source: OECD Health Statistics 2025.

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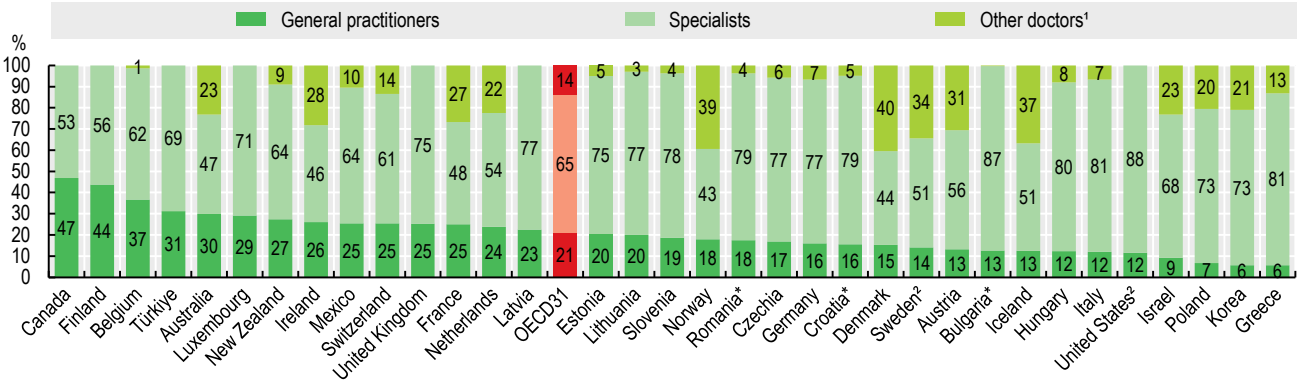
Figure 8.7. Share of female doctors, 2023 and 2013 (or nearest year)



1. Latest data from 2022. 2. Latest data from 2017. * Accession country.
Source: OECD Health Statistics 2025.

StatLink https://stat.link/oblpjk

Figure 8.8. Share of different categories of doctors, 2023 (or nearest year)



1. Includes non-specialist doctors working in hospitals and recent medical graduates who have not started specialty training. 2. Latest data from 2022. * Accession country.
Source: OECD Health Statistics 2025.

StatLink https://stat.link/cf6hqi

Remuneration of general practitioners

The level of remuneration of doctors is an important factor in the attractiveness of the medical profession, and how this differs across various medical specialties can be a criterion in deciding whether to pursue a career in general practice or in another speciality. Differences in remuneration levels of doctors (both GPs and specialists) across countries can also act as a "push" or "pull" factor when it comes to physician migration (OECD, 2025[1]). In many countries, governments can determine or influence the level and structure of remuneration of GPs and specialists by regulating their fees or by setting their salaries when doctors are employed in the public sector. A 2022 survey covering 10 OECD countries found that, in all countries, fewer than half of GPs were satisfied with their income (Commonwealth Fund, 2023[2]).

In all OECD countries, the remuneration of GPs is substantially higher than the average wage of all workers in the country, although it is lower than the remuneration of most specialists (see section on "Remuneration of specialists"). In 2023, salaried specialists in most countries earned between 1.5 and 2.5 times more than the average wage, while self-employed GPs in most cases earned between two and four times more (Figure 8.9; left panel). In countries where GPs can work as both self-employed and salaried doctors (and where remuneration data are available for both types of employment), the remuneration of self-employed GPs is generally higher.

The remuneration of GPs can also be compared based on a common currency (US dollars) adjusted for differences in purchasing power (Figure 8.9; right panel). In 2023, earnings of salaried GPs were at least three times greater in the Netherlands and Iceland than earnings of those working in Colombia and Mexico, while earnings of self-employed GPs in Germany, Switzerland and Austria were nearly or more than two times higher than earnings of those working in Israel, Australia and Denmark.

In many countries, the remuneration of GPs and specialists in real terms (adjusted for inflation) has increased over the past decade, most markedly in Hungary, Latvia and Lithuania, and also to a lesser extent in Poland and Estonia, catching up at least partly to remuneration levels of GPs and specialists in Western Europe. However, in some countries including Portugal, Canada and the Netherlands, the remuneration of both GPs and specialists fell in real terms between 2013 and 2023. Growth rates in many countries also differed between GPs and specialists (Figure 8.10). In some countries including Austria, Czechia and Spain, the remuneration of GPs has risen faster than that of specialists, thereby narrowing the income gap. By contrast, in Chile and Colombia, earnings of specialists have increased faster since 2013, thereby increasing the remuneration gap with GPs.

Definition and comparability

Remuneration of salaried doctors refers to average gross annual income, before deduction of social security contributions and income taxes. For self-employed doctors, remuneration refers to their total earnings excluding practice expenses, but including payable social security contributions and income taxes. Data are collected for both salaried and self-employed physicians. In some countries this distinction is blurred, since some salaried physicians are also allowed to treat private patients in a self-employed capacity, and some predominantly self-employed doctors can receive part of their remuneration through salaries.

International comparability of remuneration data for self-employed can be affected by variation in cost items included under practice expenses. In Germany, for example, immaterial expenses (e.g. "good will") related to the purchase of a practice are not included under practice expenses, potentially increasing remuneration figures. Different regulation of what can be claimed as practice expenses for tax purposes may also affect remuneration data. Remuneration levels, in particular for salaried doctors, may be underestimated in some countries as: 1) payments for overtime work, bonuses, other supplementary income or social security contributions are excluded in some countries; 2) incomes from private practices for salaried doctors are not always included; 3) informal payments are excluded; 4) data relate only to public sector employees in some countries, who tend to earn less than those working in the private sector; 5) physicians in training are sometimes included; 6) average remuneration is calculated based on head counts rather than full-time equivalents.

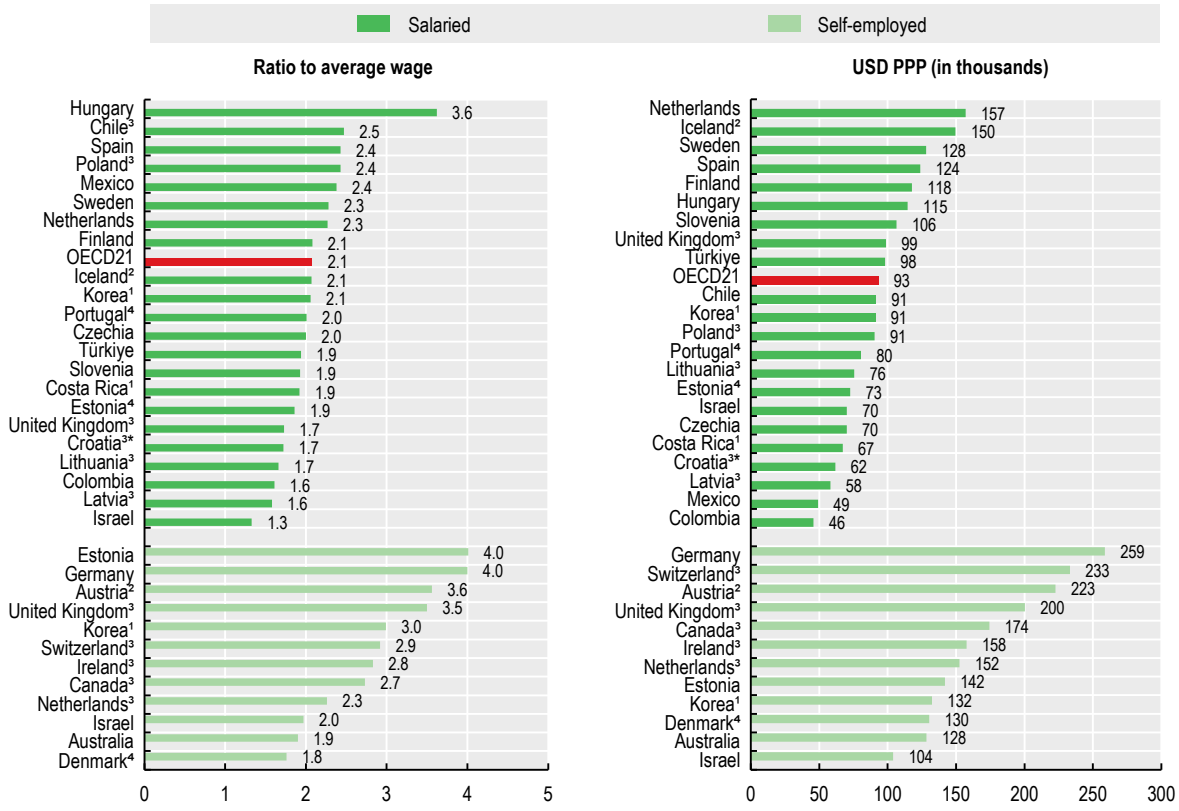
The remuneration of doctors is compared to the average wage of full-time employees in all sectors in the country. It is also compared across countries based on a common currency (US dollars), adjusted for differences in purchasing power by using the PPP for final consumption expenditure of private households.

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OECD (2025), *International Migration Outlook 2025*, OECD Publishing, Paris, https://doi.org/10.1787/ae26c893-en. [1]

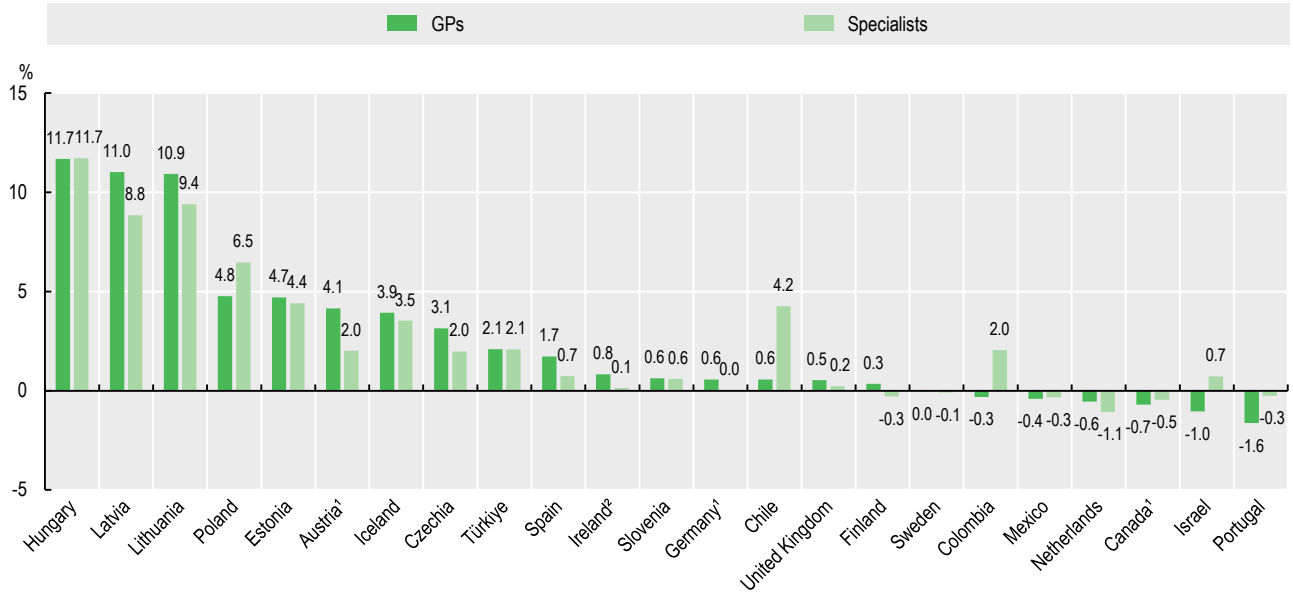
Figure 8.9. Remuneration of general practitioners, 2023 (or nearest year)



1. 2020 data. 2. 2021 data. 3. 2022 data. 4. 2024 data. * Accession country.
Source: OECD Health Statistics 2025.

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Figure 8.10. Average annual growth in remuneration of GPs and specialists (real terms), 2013-2023 (or nearest year)



1. Growth rate for remuneration of self-employed doctors only. 2. Data for Ireland relate to self-employed GPs (2022 latest year) and salaried specialists (2024 latest year).
Source: OECD Health Statistics 2025.

StatLink https://stat.link/suhbrk

Remuneration of specialists

Reflecting the very high level of qualifications of specialist doctors and the high workload of many of them, specialist doctors earn much more than the average national wage of all workers in all countries. Salaried medical specialists earn between two and five times more than the average worker, while self-employed specialists typically make around three to five times more. In Korea this difference is nearly seven times more (Figure 8.11; left panel). In nearly all countries where self-employed specialists coexist with salaried specialists, the self-employed earn much more than the salaried. The Netherlands is an exception, but this merely reflects the growing number of self-employed specialists practicing under a "director-shareholder business" status that provides an incentive to report low "usual wages" for tax reasons.

When comparing the remuneration of specialists in absolute terms based on a common currency (US dollars), and adjusted for differences in purchasing power and inflation, salaried specialists earn most in Ireland, where the new contracts for consultants that forgo the right to see private patients – effective in 2024 - led to an average income of more than USD 250 000 (Figure 8.11; right panel). Among the self-employed specialists, the highest earners are in Germany, Korea and Austria, making close to or more than USD 300 000. On the other hand, salaried specialists in Bulgaria take home the least among OECD and accession countries, and salaries for specialists in Mexico, Colombia, Greece and Costa Rica are also comparatively low (between USD 65 000-75 000). It is worth noting that while Mexican salaried specialists rank last based on this measure, their remuneration is above the OECD average when relating it to the existing average national wage in the country (Figure 8.11, left panel).

The level of income and how this differs across categories of doctors can be a criterion in deciding whether to pursue a career in general practice or in one of the various medical specialities. On average across OECD countries and specialties, specialists earn around 40% more than GPs. In Korea, the income of self-employed specialists was at least double that of self-employed GPs. In Switzerland, the difference between self-employed specialists and GPs was much smaller, at around 6%. Among salaried doctors, income of specialists is double that of GPs in Türkiye, Israel and Korea.

Calculating a generic average of the many different medical specialities hides important differences in the earning potential across the various disciplines, which can influence the career decisions of young doctors in training. While there are differences across OECD countries, some recurring patterns exist. On average, radiologists, anaesthesiologists and ophthalmologists are the highest earning specialists across OECD countries, earning around 60-80% more than GPs (Figure 8.12). On the other hand, income of paediatricians is typically either slightly below or above the level of GPs.

There are significant income gaps across specialties in some countries such as in Canada, where ophthalmologists on average make over three times more than GPs and over 75% more than general surgeons, while radiologists in Germany earn over two times more than GPs and paediatricians. In Israel, anaesthesiologists earn almost three times more than GPs. The gap is narrower in countries such as Portugal, where radiologists and ophthalmologists have incomes similar to those of GPs, while surgeons and anaesthesiologists make about 10% more than GPs.

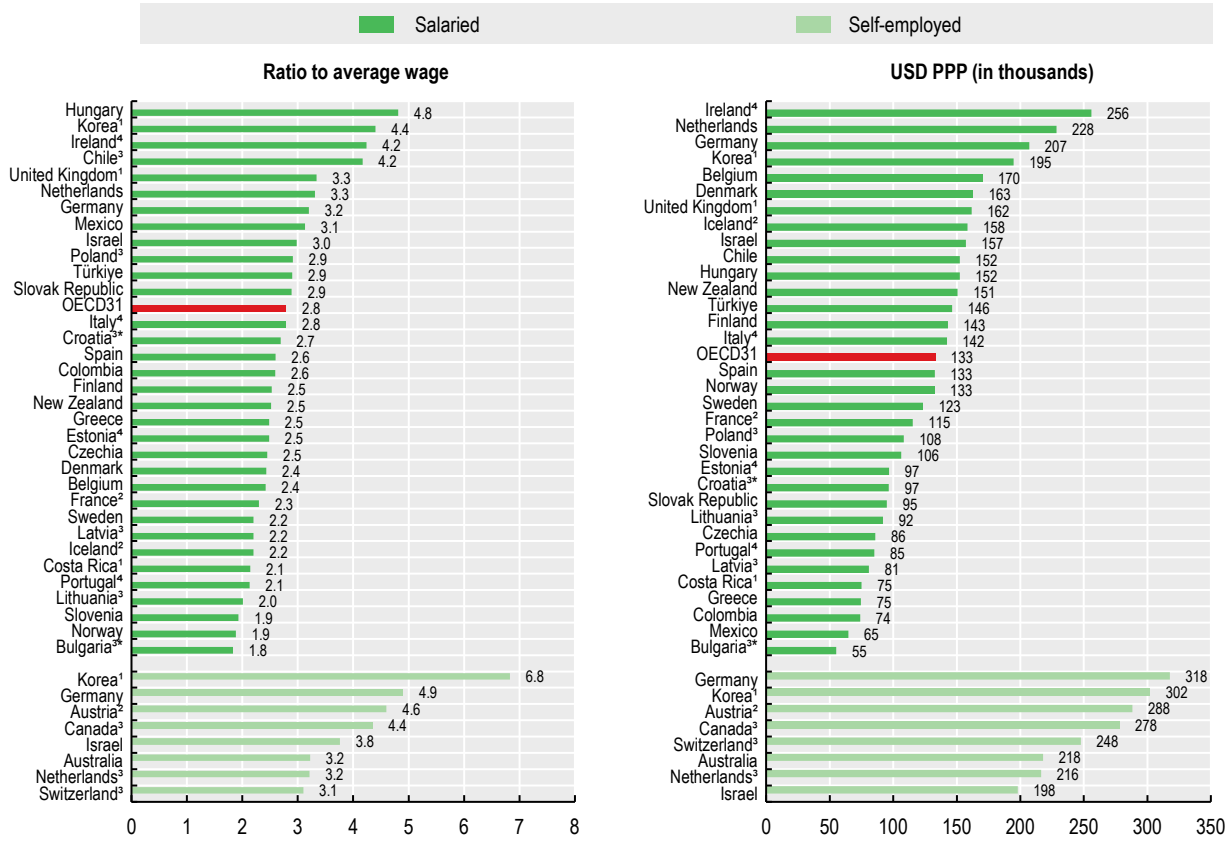
Various factors can contribute to explain the variation in levels of remuneration across countries and specialties, such as remuneration methods in general (such as salaries or fee-for-service for self-employed doctors), specific hourly or monthly wages, or fees for services paid and differences in workload (number of working hours).

Definition and comparability

There are a number of important data comparability issues across countries for both self-employed and salaried doctors – see the section on "Remuneration of general practitioners" for detailed information on factors that can limit comparability of remuneration data.

OECD's standard data collection includes remuneration data for all specialists combined, but a pilot data collection in 2025 has begun collecting data on the remuneration for a selected subgroup of specialties. Some comparability issues can arise due to different practices in countries when allocating groups of doctors to the various specialties.

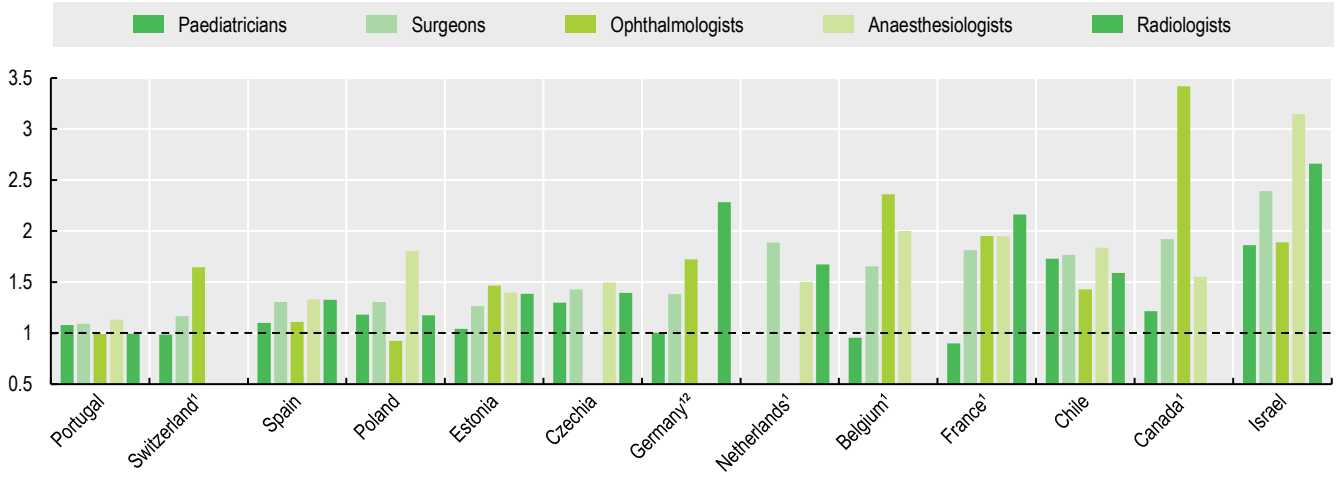
Figure 8.11. Remuneration of specialists, 2023 (or nearest year)



1. 2020 data. 2. 2021 data. 3. 2022 data. 4. 2024 data. * Accession country.
Source: OECD Health Statistics 2025.

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Figure 8.12. Remuneration of different categories of specialists compared to general practitioners, 2023 (or nearest year)



Notes: The dotted horizontal line represents parity with remuneration of GPs. 1. Data refer to self-employed specialists, 2. Radiologists include physicians with radiotherapy and nuclear medicine specialties (resulting in an overestimation). Countries are ordered based on average remuneration across specialties.
Source: National sources, OECD Pilot data collection 2025.

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Nurses

Nurses play a central role in the provision of healthcare and are the most numerous category of health workers in most OECD countries. While the majority of nurses are employed in hospitals, many also work in long-term care facilities or in the community. In 2023, there were 9.2 practicing nurses per 1 000 population on average across OECD countries, up from 8.1 in 2013. Nurse numbers in 2023 ranged from 3 per 1 000 population or fewer in Colombia, Türkiye and Mexico to over 15 per 1 000 population in Switzerland, Norway and Iceland (Figure 8.13). OECD accession countries have fewer nurses per population than the OECD average, although the number has increased significantly over the past decade in Romania, Croatia and Brazil, but not in Bulgaria.

The number of nurses per population has grown in most OECD countries over the past decade, although it has remained stable in some and has decreased slightly in a few countries (e.g. Iceland and Latvia). Increases have been particularly marked in Switzerland, Australia, Slovenia and Korea, driven largely by an expansion of new graduates from nursing education programmes (see section on "Nursing graduates"). In Switzerland, the growth can also be explained by a strong rise in the number of "associate professional nurses" with lower qualifications than "professional nurses". Indeed, over the past decade, the number of associate professional nurses in Switzerland increased by over 50% while professional nurse numbers increased by 20%.

In some countries, the recruitment of foreign-trained nurses has also played an important role. For example, foreign-trained nurses accounted for 92% of the overall growth in nurse numbers in Ireland between 2021 and 2024. They also accounted for over 80% of the growth in the number of nurses in the United Kingdom and New Zealand in recent years (see section on "International migration of nurses").

In several countries, many nurses reported a degradation of their working conditions during and after the COVID-19 pandemic, with a large proportion reporting job dissatisfaction and considering leaving their jobs (OECD, 2023[1]). Recent hospital staff surveys indicate that, on average across OECD countries with available data, a majority of nurses (56%) working in hospitals perceived staff levels and work pace to be unsafe (see section on "Safe acute care – workplace culture and patient experiences" in Chapter 6). Concerns about a "great resignation" of nurses and other health workers emerged in some countries in 2021, including the United States and the United Kingdom. However, recent data from the United Kingdom show some stabilisation there, with 10.1% of nurses and other workers in hospital and community care leaving the National Health Service between September 2023 and September 2024, down from 12.5% between September 2021 and September 2022 when leaver rates were at a peak. This improvement was supported by a specific programme to increase retention rates (NHS England, 2025[2]).

Nurses outnumber doctors in most OECD countries. On average, there are 2.5 nurses for every doctor. The ratio of nurses per doctor ranges from 1.2 or less in Colombia, Mexico, Türkiye and Latvia as well as accession country Bulgaria, to more than 4.0 in Japan, Finland, the United States and Switzerland (Figure 8.14). Several countries have moved forward in implementing more advanced roles for nurses to improve access to care and address shortages of doctors, including through roles such as "nurse practitioners" and "family and community nurses". More advanced practice nurses generally have more education and training (usually a master's degree) and are allowed to play greater roles in diagnosing illnesses and prescribing medications and other treatments, with or without the supervision of doctors. In the United States, the number of nurse practitioners increased more rapidly than the overall number of registered nurses between 2013 and 2023, and is projected to continue to grow strongly between 2023 and 2033. Evaluations of nurse practitioners in primary care in several countries show that these advanced practice nurses can improve access to services and reduce waiting times, while delivering the same quality of care as doctors for a range of patients, including those with minor illnesses and those needing routine follow-ups. These evaluations also find a high patient satisfaction rate (Brownwood and Lafortune, 2024[3]).

Definition and comparability

The number of nurses includes those providing services directly to patients ("practising") and in some cases also those working as managers, educators or researchers. In countries where nurses can hold different levels of qualifications and functions, the data include both professional nurses who have a higher level of education and associate professional nurses who have a lower level of education but are nonetheless recognised as nurses. Healthcare assistants (or nursing aides) who are not recognised as nurses are excluded (which represents a large category of workers in some countries including Spain and France). Midwives are excluded, except in some countries where they are included because they are considered specialist nurses or for other reasons (Australia, Ireland and Spain). Greece reports only nurses working in hospitals, resulting in an underestimation.

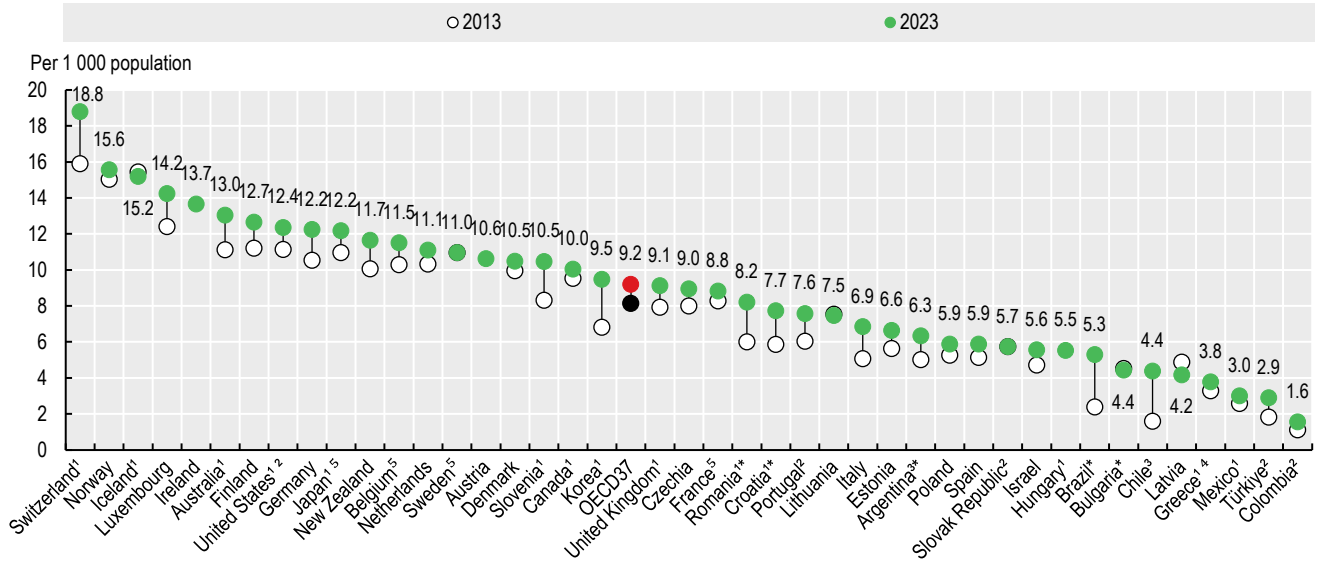
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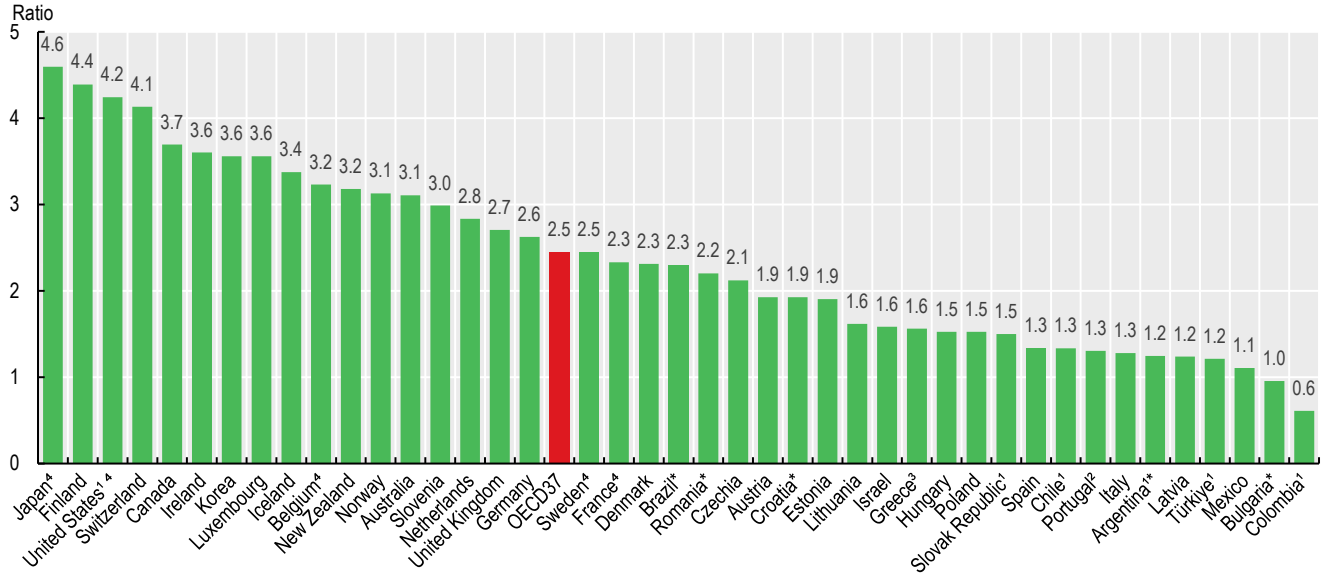
Figure 8.13. Practising nurses per 1 000 population, 2023 and 2013 (or nearest year)



1. Associate professional nurses with a lower level of qualifications make up more than 50% of nurses in Slovenia as well as accession countries Croatia and Romania; between 33% and 50% in Greece, Iceland, Korea, Mexico and Switzerland; and between 15% and 30% in Australia, Canada, Hungary, Japan, the United Kingdom and the United States. 2. Includes nurses working in the health sector as managers, educators, researchers and similar. 3. Includes all nurses licensed to practise. 4. Data only refer to nurses employed in hospitals. 5. Latest data from 2021-2022. * Accession country.
Source: OECD Health Statistics 2025.

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Figure 8.14. Ratio of nurses per doctor, 2023 (or nearest year)



1. For countries that have not provided data on practising nurses and/or practising doctors, numbers relate to the "professionally active" concept for both nurses and doctors (except Chile and Argentina, where numbers include all nurses and doctors licensed to practise). 2. Ratio underestimated (professionally active nurses/all doctors licensed to practise). 3. Data refer to nurses and doctors employed in hospitals. 4. Latest data from 2021-2022. * Accession country.
Source: OECD Health Statistics 2025.

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Remuneration of nurses

Whether nurses are paid adequately has been a contested topic for many years. The COVID-19 pandemic and, more recently, the cost-of-living crisis, have brought further attention to the income of nurses, with concerns about whether remuneration is sufficient to attract and retain nurses in the profession.

On average across OECD countries, the remuneration of hospital nurses in 2023 was 20% above the average wage of all employees. However, in Switzerland, the United Kingdom, Finland and Italy, nurses made less than the average worker, whereas in Mexico, Poland, Chile and Czechia, their income was at least 50% higher than the economy-wide average (Figure 8.15, left panel).

Figure 8.15 (right panel) compares the remuneration of hospital nurses based on a common currency (US dollars), adjusted for differences in purchasing power to provide an indication of the relative economic well-being of nurses across countries. In 2023, the income of nurses in Luxembourg was over three times higher than the income of those working in Mexico, Portugal, Bulgaria and Greece. In general, nurses in Central and Eastern and Southern European countries receive salaries below the OECD average, which may partly explain why many choose to migrate to other EU countries. Nursing income in the United States is higher than in most other OECD countries, which is one of the reasons why the United States is able to attract several thousand nurses from abroad every year (see section on “International migration of nurses”).

In most OECD countries, the remuneration of nurses increased in real terms in the years leading up to the pandemic. This was particularly the case in Central and Eastern European countries and the Baltic countries. In Poland, Latvia and Lithuania, nurses obtained pay rises averaging 9-11% per year in real terms in the years before the pandemic, thereby narrowing the gap with other EU countries (Figure 8.16). In Hungary, the Slovak Republic and Czechia, the annual increases stood at 6%. In contrast, the remuneration of nurses decreased in real terms by around 1% per year or more between 2013 and 2019 in Greece, Ireland and Portugal, a legacy of adjustment measures to reign in public spending in the wake of the financial and debt crisis.

Between 2019 and 2023, nurses saw their income increase in real terms in only around half of OECD countries. Nurses in Lithuania and Latvia continued to benefit from substantial pay increases per year (above or close to double digit). Annual salary growth was also robust in Poland, Hungary, the Slovak Republic, France and Estonia at above 4%. On the other hand, in New Zealand, Chile, Italy, the Netherlands and the United Kingdom, the salary of nurses fell in real terms by more than 1% annually.

Two conflicting trends can explain part of the variation in the pay trajectory of nurses over the 2019-2023 period. On the one hand, in many countries, a large proportion of nurses and other health workers received one-off COVID-19 “bonuses” in 2020 and 2021 in recognition of the frontline role they played during the pandemic. However, these bonuses frequently took the form of lump-sum payments and were not included in the regular wages (with Slovenia being one of the exceptions). On the other hand, moderate nominal wage increases were in many cases eroded by high inflation rates in the cost-of-living and energy crises, leading to negative real growth rates. Nurses were not the only occupation group affected by this phenomenon. In many countries, average real wages fell between 2021 and 2023 due to inflation (OECD, 2024[1]).

Definition and comparability

The remuneration of nurses refers to average gross annual income, including social security contributions and income taxes payable by the employee. In most countries, the data relate specifically to nurses working in hospitals, although in Canada they also cover nurses working in other settings. In some federal states, such as Australia, Canada and the United States, as well as in the United Kingdom, the level and structure of nurse remuneration is determined at the subnational level, which may contribute to variations across jurisdictions. Alternative data sources for the United Kingdom suggest that the average income of nurses is above (not below) the national average of all workers.

Data refer only to registered (“professional”) nurses in Canada, Chile, Ireland and the United States, resulting in an overestimation compared to other countries where lower-level (“associate professional”) nurses are also included. Data for New Zealand include all nurses employed by publicly funded district health boards, at all levels; they also include health assistants, who have a different and significantly lower salary structure than registered nurses.

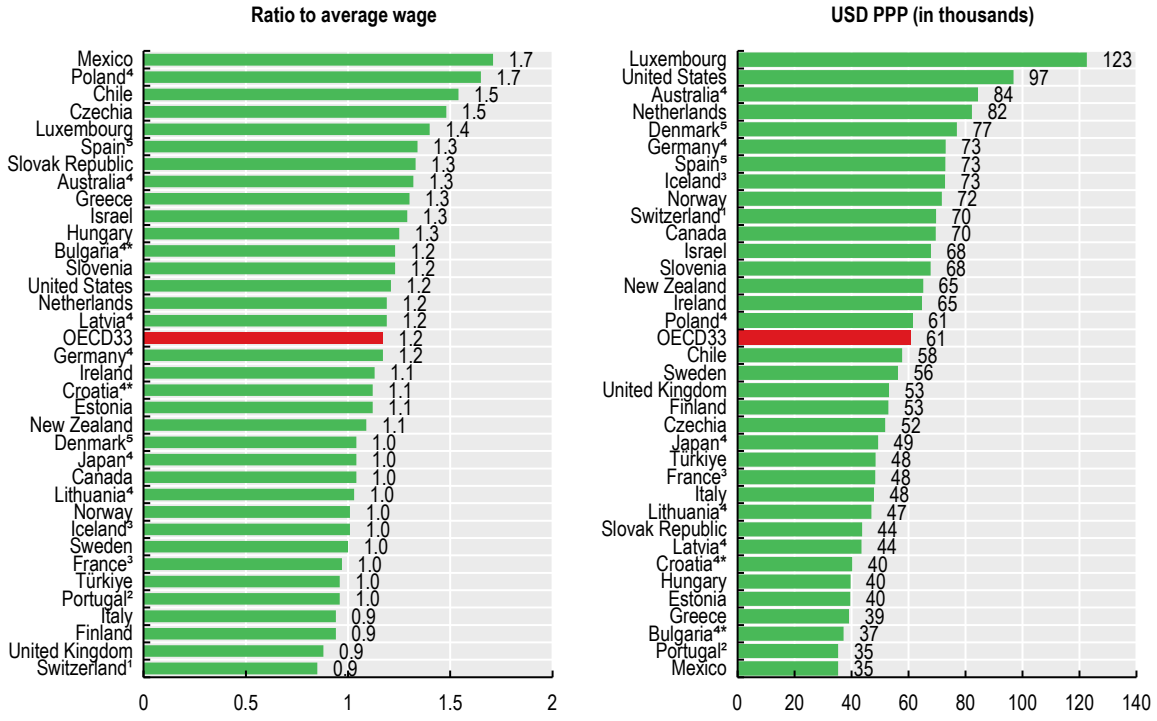
The data relate to nurses working full time. The data for some countries do not include additional income such as overtime payments. Informal payments, which represent a significant part of total income in some countries, are not reported.

The income of nurses is compared to the average wage of full-time employees in all sectors in the country. It is also compared across countries based on a common currency (USD) and adjusted for differences in purchasing power as well as inflation.

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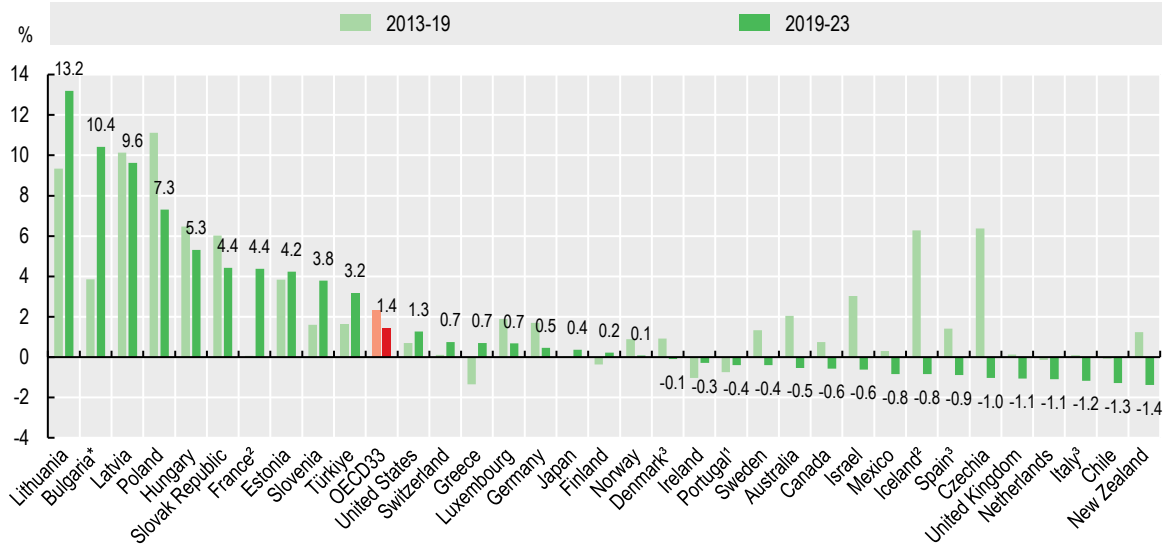
Figure 8.15. Remuneration of hospital nurses, 2023 (or nearest year)



1. Includes “associate professional” nurses with lower qualifications and revenues. 2. Includes only hospital nurses working in the National Health Service (public sector). 3. 2021 data. 4. 2022 data. 5. 2024 data. * Accession country.
Source: OECD Health Statistics 2025.

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Figure 8.16. Average annual growth in remuneration of hospital nurses (real terms), 2019-2023 and 2013-2019 (or nearest year)



1. Data include only hospital nurses working in the National Health Service (public sector). 2. The latest growth rate only covers 2019-2021. 3. The latest growth rate covers the period 2019-2024 (Denmark and Spain) and 2021-2024 (Italy).
Source: OECD Health Statistics 2025.

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Hospital workers

The number and composition of people working in hospitals in OECD countries varies depending on the roles and functions that hospitals play in health systems, as well as on how different types of support services in hospitals are provided and accounted for. The roles and functions of hospitals vary notably regarding the extent to which outpatient specialist services are provided in or outside hospitals. In most countries with universal health coverage funded by the tax system (national health service systems), outpatient specialist services are typically provided in public hospitals. This is the case, for example, in Portugal, Spain, the United Kingdom and Nordic countries, Portugal and Spain. In other countries such as Australia, Austria, Belgium, Canada, France, Germany, Switzerland and the United States, most outpatient services are provided outside hospitals. In some Central and Eastern European countries (such as Estonia and Slovenia), most outpatient specialist services are provided in public hospitals, whereas these are provided in public multi-specialty clinics in others (such as Poland) or in private solo practices (as in Czechia).

In 2023, the number of people working in hospitals relative to the overall size of the population was at least twice as high in Switzerland, the United Kingdom, Norway, Denmark, the United States, Iceland and France as in Mexico, Chile, Hungary and Korea (Figure 8.17).

In all countries, nurses represent the largest category of care providers in hospitals. Nurses and midwives account for over one-third (36%) of all hospital employment, on average across OECD countries. Doctors account for one in seven (14%) hospital workers on average across OECD countries, although in several countries this number underestimates the number of doctors who work at least part time in hospitals, since self-employed doctors with dual practices outside and in hospital are not counted.

Healthcare assistants (or nursing aides) accounted for about 10% of hospital workers on average across OECD countries, but there is wide variation across countries. Healthcare assistants accounted for over 20% of the hospital workforce in Portugal and Spain, and nearly 20% in France, while this category of workers is non-existent (or almost non-existent) in several other countries.

Other non-clinical staff account for about a quarter of all hospital workers on average across those OECD countries that are able to report these data. This share is particularly large in some countries. In the United States, 46% of people working in hospitals are non-clinical staff, and this proportion reaches 30% or more in Switzerland, Iceland, France and Türkiye. The large proportion of non-clinical staff has led to proposals in France to limit this share to no more than 25% of total hospital staff. The OECD data collection does not seek further information about different categories of non-clinical staff, but these may include at least three categories of workers: administrative staff, logistical staff (such as cleaning and catering staff), and IT and other technical support staff. It is important to bear in mind that some of the variations in the number and share of non-clinical staff across countries may be explained by the degree of externalisation of these services. In addition, the distinction between clinical and non-clinical staff may not always be clear-cut for certain categories of workers (such as medical-administrative assistants), limiting data comparability across countries.

Looking at trends over time for nurses (the most numerous category of clinical staff in hospitals), in several countries – including Canada, the United States, Mexico, Germany and Spain – the number of nurses working in hospitals increased steadily between 2013 and 2023, both before and after the pandemic. In Italy and the United Kingdom, there was no increase in the number of nurses working in hospitals between 2013 and 2017, but the number started to increase steadily from 2017 onward. By contrast, the increase was much more modest in France both before and after the pandemic (Figure 8.18).

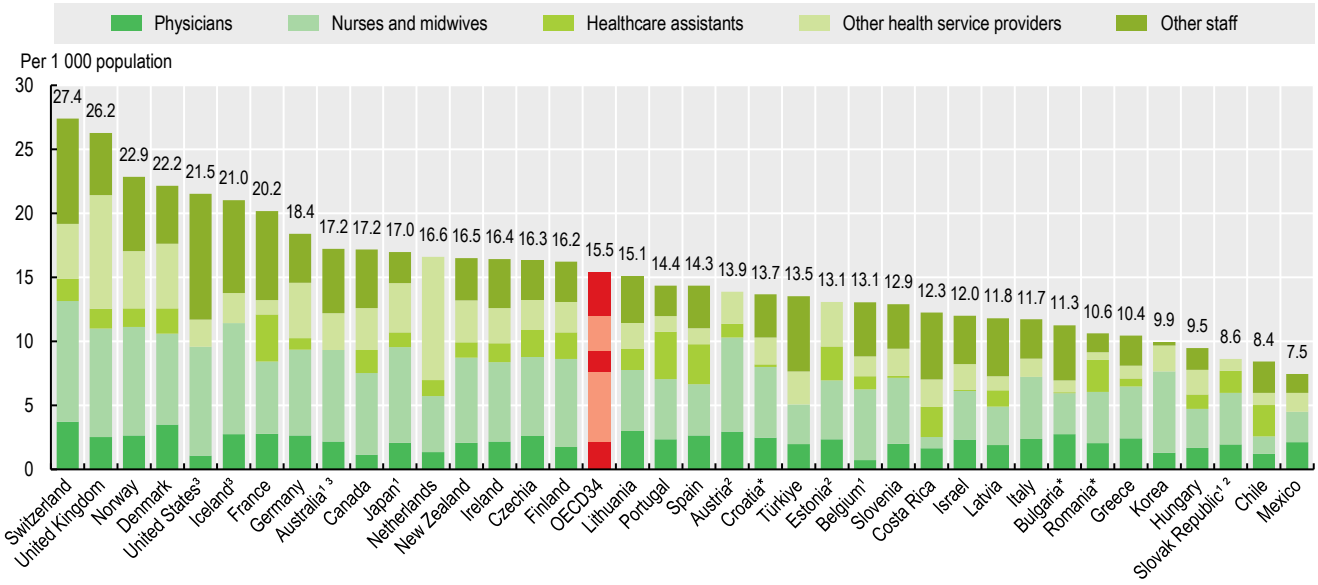
Definition and comparability

Hospital workers are defined as people working in hospitals, including wherever possible self-employed people under service contracts. In most countries, workers include both clinical and non-clinical staff. The data are reported in headcounts, although the OECD Health Database also includes data on FTE numbers for a more limited number of countries.

Many countries do not count all or some self-employed workers working in hospitals. Australia, Chile, Denmark, Ireland, New Zealand and the United Kingdom only report data on employment in public hospitals, resulting in an underestimation.

For comparisons across countries, the number of hospital workers is related to the overall population size in each country. Another option would be to relate the number of workers more specifically to the number of hospital beds or hospital bed-days to take into account some measure of hospital activity across countries, although this would not include activities that do not require hospitalisation (such as consultations, examinations and day care).

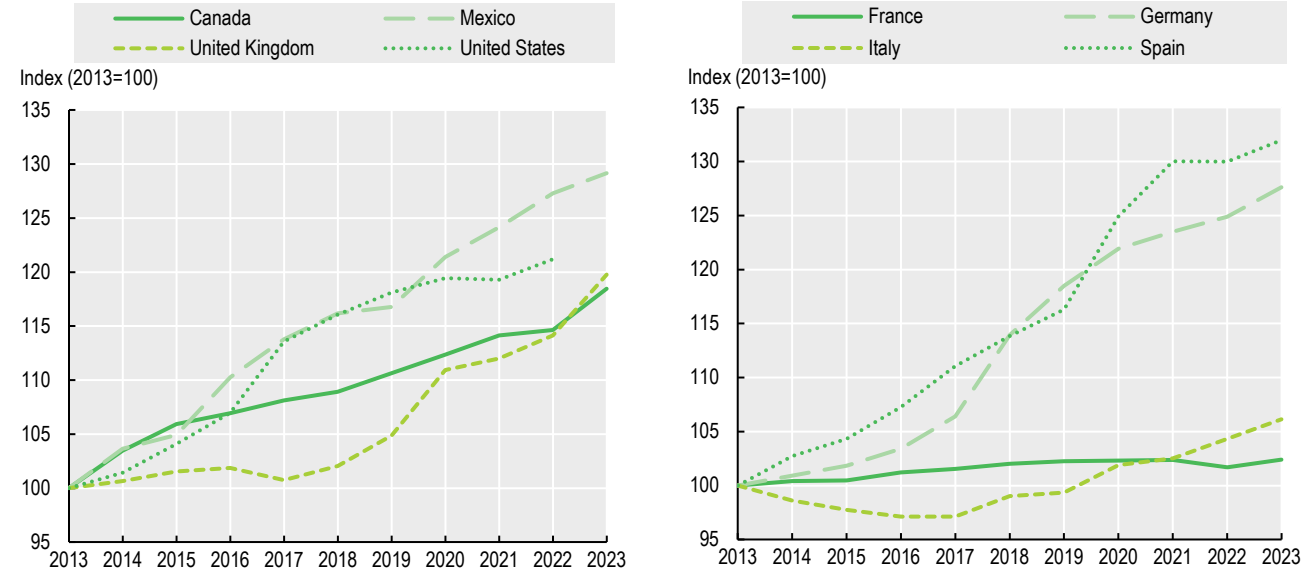
Figure 8.17. Hospital workforce per 1 000 population, 2023 (or nearest year)



1. Data refer to FTE workers (rather than headcount), resulting in an underestimation. 2. Data cover only clinical staff (healthcare providers), excluding other staff (administrative, technical, etc.), resulting in an underestimation. 3. Latest data from 2020-2022. * Accession country.
Source: OECD Health Statistics 2025.

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Figure 8.18. Growth in number of hospital nurses, selected OECD countries, 2013-2023



Note: Data cover nurses and midwives.
Source: OECD Health Statistics 2025.

StatLink https://stat.link/akrxvs

Medical graduates

The number of new medical graduates is a key indicator to assess the number of new entrants into the medical profession who will be available to replace retiring doctors and to respond to any current or future shortages. Numbers in any given year reflects decisions made a few years earlier related to student admissions, either through explicit *numerus clausus* policies (the setting of quotas on student admissions) or other decision-making processes.

Overall, the number of medical graduates across OECD countries increased by 75% between 2000 and 2023, rising from 93 000 in 2000 to 163 000 in 2023. In 2023, the number of new medical graduates in OECD countries ranged from fewer than 8 per 100 000 population in Israel, Canada, Korea and Japan, to more than 20 per 100 000 in Latvia, Ireland, Lithuania and Denmark (Figure 8.19).

Medical graduate numbers were even greater in Bulgaria and Romania, two OECD accession countries, mainly driven by a strong rise in the number of international medical students. Many medical schools in the Slovak Republic, Czechia, Hungary and Poland also attract a growing number of international medical students. In Ireland too, the high number of medical graduates is due to a large share of international medical students, who in recent years have made up about half of all students. Many of these international students in Irish medical schools come from Canada, the United States and the United Kingdom. For all these countries, in most cases, international students do not stay in the country after graduation. In Ireland, this results in a paradoxical situation where they need to import doctors trained in other countries to address doctor shortages (OECD, 2019[1]). In Israel, the low number of domestic medical graduates is compensated for by the high number of foreign-trained doctors (about 60% of all doctors). A large share of these foreign-trained doctors are Israeli-born doctors who have returned to Israel after completing their first degree abroad because of the limited number of places in Israeli medical schools (OECD, 2023[2]).

The number of medical graduates relative to the size of the population has increased in most OECD countries since 2013, in response to concerns about shortages of doctors. In many countries, this has been achieved through both the creation of new medical schools and the expansion of student intakes in existing medical schools. Korea is the only OECD country where the number of medical graduates relative to population size and the absolute number of graduates decreased at least slightly between 2013 and 2023, reflecting the fact that there was no increase in student admissions since 2006 and student dropout rates increased slightly. In February 2024, the former Korean government announced a plan to increase the number of medical students by two-thirds, but this was met with fierce opposition from junior doctors, who argued that resources should be used instead to improve working conditions and pay rates to make jobs in some core hospital departments and specialties more attractive (Min, 2024[3]).

Many OECD countries have increased not only the number of students admitted to medical schools, but also the number of medical graduates going into general medicine for their postgraduate internship/residency training to address specific shortages of general practitioners (OECD, 2023[4]). In 2023, the share of postgraduate training places in general medicine averaged 27% across 18 OECD countries with available data. It ranged from around 45% of all new residents in Canada, the United Kingdom and Belgium to less than 15% in Israel, Germany, Slovenia and Mexico (Figure 8.20). In France, since 2017 at least 40% of all postgraduate training places must be allocated to general medicine. In Belgium, the government announced in 2022 a plan to gradually increase the share of postgraduate training places allocated to general medicine from 39% in 2022 to 47% by 2028 (Vandenbroucke, 2022[5]). However, in many countries it has proved challenging to attract sufficient numbers of medical graduates to fill available training places in general medicine, given its lower perceived prestige and remuneration (see section on “Remuneration of general practitioners”).

Definition and comparability

Medical graduates are defined as students who have graduated from medical schools in a given year. They include both domestic and international students. Postgraduate internship/residency positions are training posts for medical graduates, offered across multiple specialty tracks, including general/family medicine. Occupied posts do not necessarily match positions offered, as not all posts are filled in many countries.

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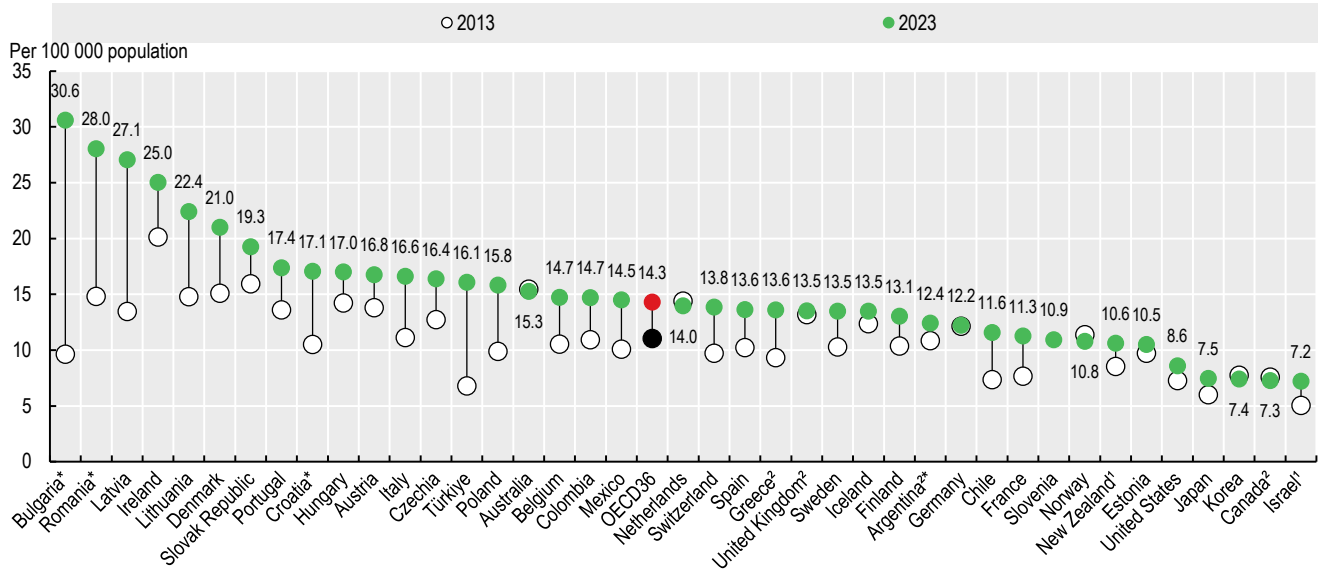
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Vandenbroucke, F. (2022), *Towards a New Deal for the (practice) general practitioner [Vers un New Deal pour le (cabinet de) médecin généraliste]*, https://vandenbroucke.belgium.be/fr/vers-un-new-deal-pour-le-cabinet-de-m%C3%A9decin-g%C3%A9n%C3%A9raliste. [5]

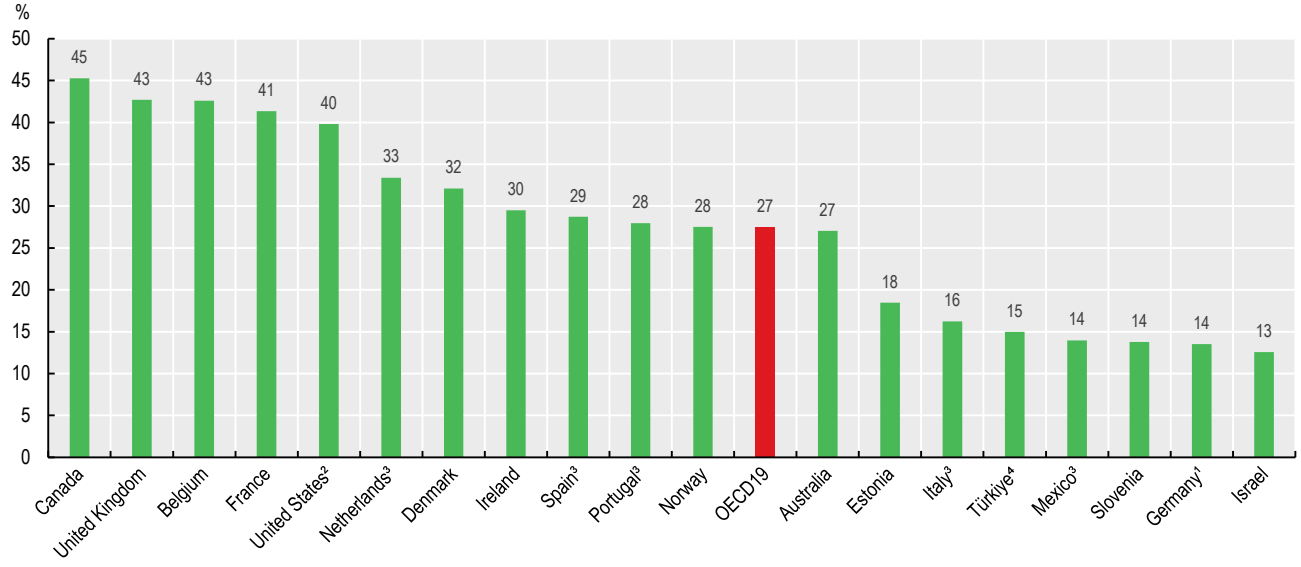
Figure 8.19. Medical graduates, 2023 and 2013 (or nearest year)



Note: A large number of medical graduates are international students in some countries (including Bulgaria, Romania, Latvia, Ireland, the Slovak Republic, Hungary and Czechia). 1. Data exclude international students, resulting in an underestimation. 2. Latest data from 2022. * Accession country.
Source: OECD Health Statistics 2025.

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Figure 8.20. Share of postgraduate training places in general medicine, 2023



1. Refers to students who have completed their specialisation (not those starting it). 2. General practice includes students in both family medicine and internal medicine. 3. Refers to positions opened, not places filled. 4. 2024 data.
Source: National sources.

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Nursing graduates

The number of new nursing graduates is a key indicator to assess the potential number of new entrants to the nursing profession to replace retiring nurses and respond to any current or future shortages. The number of nursing graduates in any given year reflects decisions made a few years earlier (about three years) related to student admissions, although graduation rates are also affected by student dropout rates.

The number of new nursing graduates increased in most OECD countries over the past decade. On average across OECD countries, the number of nursing graduates increased at a rate of about 1.7% per year, from approximately 544 000 in 2013 to 644 000 in 2023. By comparison, the number of medical graduates across OECD countries increased nearly twice as fast over the same period, at an average annual rate of 3.2%.

In 2023, the number of new nursing graduates ranged from no more than 10 per 100 000 population in Colombia and Luxembourg as well as accession country Bulgaria, to over 100 per 100 000 in Australia and Switzerland (Figure 8.21). In Luxembourg, the low numbers is offset by a large number of students who obtain their nursing degree in a neighbouring country, as well as Luxembourg's capacity to attract nurses from other countries through better pay and working conditions (see section on "Remuneration of nurses").

In those countries that have different levels of qualifications for different categories of nurses, the growth in graduation rate has varied between the shorter (typically more vocational) and the longer (typically university-based) programmes leading to more qualified positions. In Switzerland, the 45% increase in the number of new graduates between 2013 and 2023 has been driven mainly by a 50% increase in the number of graduates from "associate professional nurse" programmes which outpaced the 40% increase from "professional nurses" programmes. By contrast, in the United States, the 20% growth in the number of nursing graduates between 2013 and 2023 was driven entirely by an increase in the number of graduates from bachelor's degree programmes while the number of graduates from shorter practical/vocational nursing programmes decreased.

While in most countries numbers of nursing graduates have increased over time, large reductions were observed in the Slovak Republic. This reflects large falls between 2013 and 2020, but numbers have started to increase again since then. In Italy too, the number of nursing graduates decreased substantially between 2013 and 2023 (by over 20% in absolute numbers), mainly reflecting increasing student dropout rates.

While expanding the number of students starting and completing nursing education programmes is key to addressing current and future nurse shortages, the success of this strategy depends on young people's interest in the profession. According to the most recent OECD PISA surveys, the share of 15-year-olds expecting to become nurses declined in half of OECD countries, and the average across OECD countries dropped slightly, from 2.3% in 2018 to 2.1% in 2022 (OECD, 2024[1]). Declines were more marked in the United States, Canada, Ireland, Norway and Denmark. In contrast, Japan saw a significant rise and had the highest share of 15-year-old students expecting to become nurses. In several countries, including Poland, the Baltic countries, Hungary, Italy and Greece, fewer than 1% of 15-year-olds aspire to become nurses (Figure 8.22). One key reason for the overall low interest is that nursing remains a highly gendered profession: in most OECD countries, over 90% of 15-year-old students who expect to become nurses are girls (OECD, 2025[2]).

Definition and comparability

Nursing graduates are defined as students who have obtained a recognised qualification required to become a licensed or registered nurse. They include graduates from both higher-level (typically university) and lower-level (typically more vocational) nursing programmes in countries where these two types of programmes coexist (except in Canada and Greece). They exclude graduates from master's or doctorate degrees in nursing to avoid double-counting nurses acquiring further qualifications.

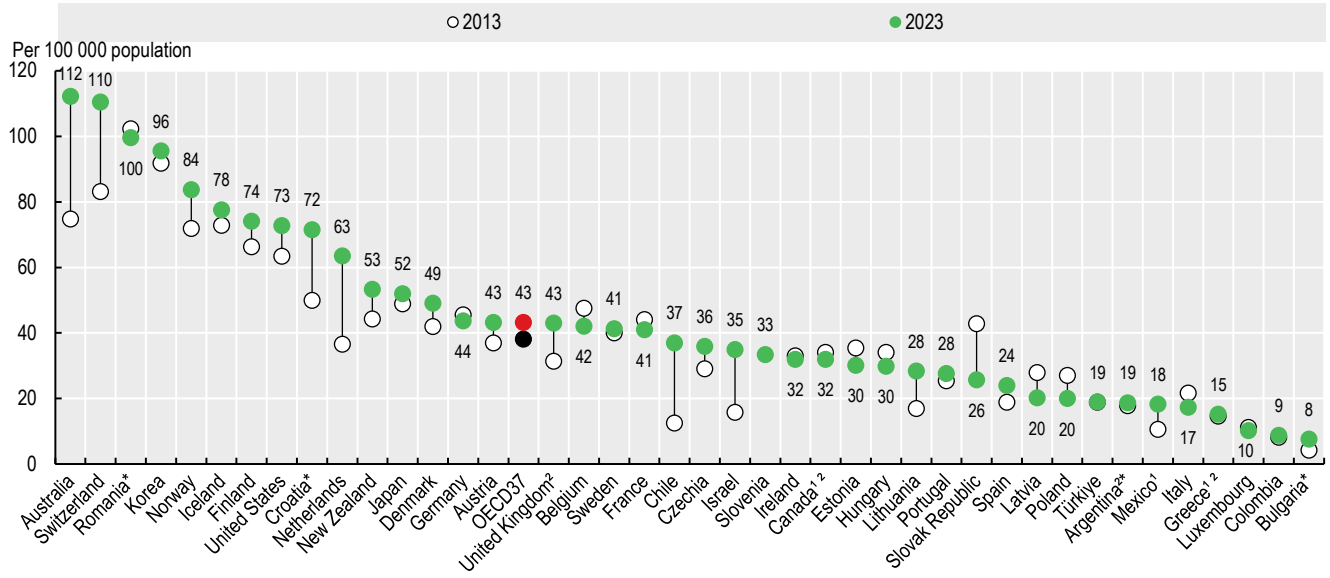
The data on the career aspirations of 15-year-old students from the OECD PISA survey are based on responses to the following question: "What kind of job do you expect to have when you are about 30 years old?". The responses to this open-ended question are subsequently coded based on the International Standard Classification of Occupations (ISCO-08).

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OECD (2024), *Fewer young people want to become nurses in half of OECD countries*, OECD Publishing, https://www.oecd.org/en/publications/fewer-young-people-want-to-become-nurses-in-half-of-oecd-countries_e6612040-en.html. [1]

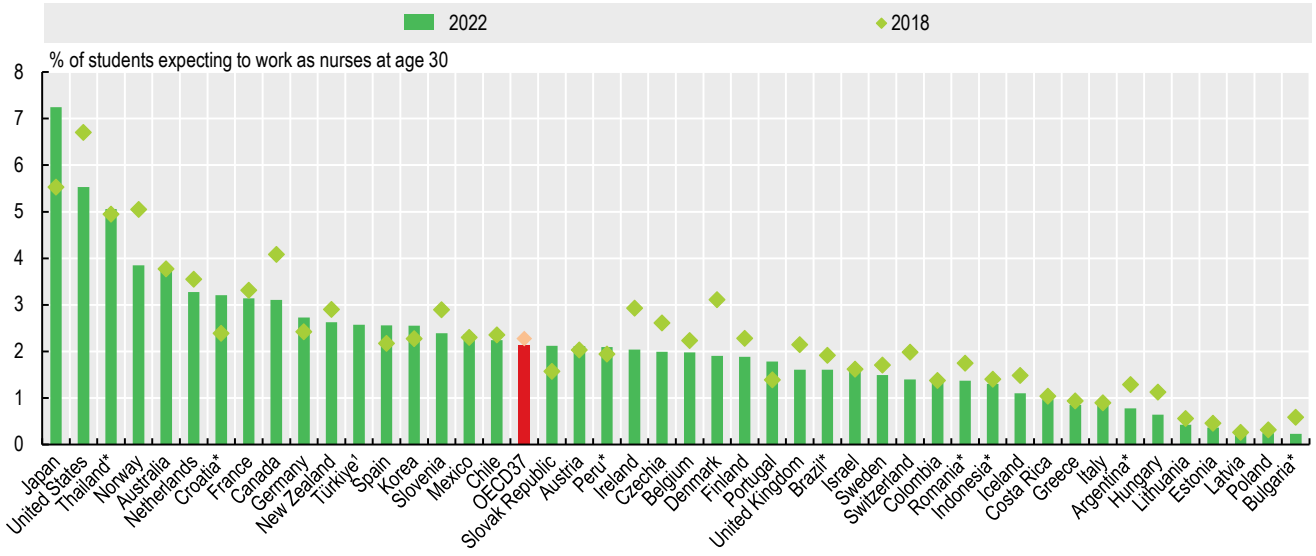
Figure 8.21. Nursing graduates, 2023 and 2013 (or nearest year)



1. Data include only professional nursing graduates. 2. Latest data from 2022. * Accession country.
Source: OECD Health Statistics 2025.

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Figure 8.22. Interest in a nursing career among 15-year-old students, 2022 and 2018



Notes: Luxembourg did not participate in the PISA 2022 survey. 1. Türkiye data for PISA 2018 are not included due to low reliability. * Accession country.
Source: OECD, PISA 2018 and 2022 Database.

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International migration of doctors

Many OECD countries turn to foreign-trained doctors to expand their medical workforce quickly and at relatively low cost. Although these recruits relieve immediate staffing pressures, they introduce greater uncertainty into workforce planning and can deepen shortages in countries of origin. In 2023, OECD Members employed more than 600 000 foreign-trained physicians, a rise of just over 50% since 2010. Their distribution is uneven: nearly three-fifths practise in only three destinations – the United States, the United Kingdom and Germany.

Foreign-trained doctors represented, on average, 20% of the medical workforce across OECD countries in 2023, up from 16% in 2010 (Figure 8.23). Their numbers rose faster than those of domestically trained physicians in almost every member country, pushing their share upwards. The proportion varied considerably in 2023, from 1% or lower in Lithuania and Italy to more than 40% in Switzerland, New Zealand, Ireland and Norway, and 59% in Israel. Growth between 2010 and 2023 was especially strong in Switzerland, where the absolute number of foreign-trained doctors doubled, and in Germany, where it tripled.

Many of these doctors are native-born citizens who obtained their first medical degree abroad before returning home for postgraduate training and practice. They account for 80% of foreign-trained physicians in Greece, 57% in Norway, 55% in Israel and 25% in Sweden. This pattern reflects the internationalisation of medical education and an expanding cross-border market for medical degrees (OECD, 2019[1]), rather than a one-way "brain drain". Ireland, however, presents a paradox: although it has become an international training hub, with about half of its medical students now coming from overseas, the country increasingly recruits fully trained doctors from abroad as many of its own graduates leave after graduation (OECD, 2025[2]).

Growing reliance on foreign-trained physicians has taken place alongside an expansion of domestic training capacity. Between 2010 and 2023, domestically trained doctors still made up most of the growth in physician numbers in most OECD Members (Figure 8.24). Yet in five countries foreign-trained doctors drove more than half of the increase – notably in Switzerland (86%), Norway (70%) and Ireland (57%). Across OECD countries, foreign-trained doctors accounted for roughly one-third of the total growth in physicians' numbers.

Annual inflows of foreign-trained doctors are highly volatile, shaped by factors ranging from geopolitical tensions and economic cycles to forced displacement, migration pathways, qualification-recognition rules and active recruitment campaigns. Even so, inflows to the main countries of destination have trended upwards and accelerated since the COVID-19 pandemic (Figure 8.25). The United Kingdom admitted more than 18 000 foreign-trained doctors in 2023, its highest annual intake on record and a three-fold increase from 2010. Ireland and Israel have seen equally large rises.

One of the major barriers to effective labour market integration of foreign-trained professionals, including doctors, is recognition of qualifications and licensing procedures. They can contribute to "brain waste", in which qualified workers are unable to practise, or work at a lower level than they have trained for. Canadian census data illustrate the scale of the problem: in 2021, 90% of Canadian-born and Canadian-trained doctors were practising medicine, whereas only 36% of foreign-born and foreign-trained doctors in the country held a medical post. Registered nurses show a similar, though narrower, disparity. Consequently, a sizeable pool of qualified doctors and nurses remains untapped despite ongoing workforce shortages, in part because lengthy bridging programmes and complex licensing procedures delay or prevent entry into practice (OECD, 2025[2]).

Migration policies for health professionals in OECD countries have long centred on shortage-occupation lists and bilateral training or skills-development agreements. Dedicated pathways tailored to health workers are now emerging, and temporary measures adopted during recent crises – most notably COVID-19 and displacement linked to the invasion of Ukraine – have prompted governments to test the capacity of existing systems and devise new strategies for attracting health workers. Although designed as temporary fixes, they have spurred broader interest in lasting reforms, in particular the introduction of temporary and conditional licences that ease labour-market entry for foreign-trained doctors (OECD, 2025[2]).

Definition and comparability

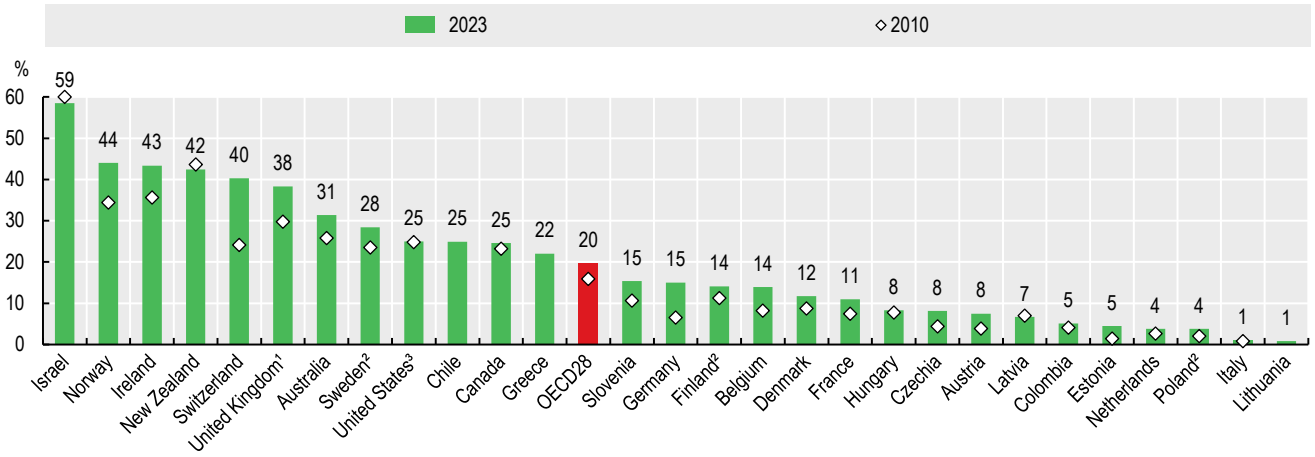
Foreign-trained doctors are defined as those who obtained their first medical degree abroad. They relate to the total stock of doctors working in OECD countries, as well as the annual inflows of these professionals. The OECD Health Database also includes data by country of origin. The data sources in most countries are professional registries or other administrative sources. The main comparability limitation relates to differences in the activity status of doctors. Some registries are updated regularly, making it possible to distinguish doctors who are actively working in health systems, while others include all doctors licensed to practise, regardless of whether they are still active. Data for Germany are based on nationality, not on the place of training.

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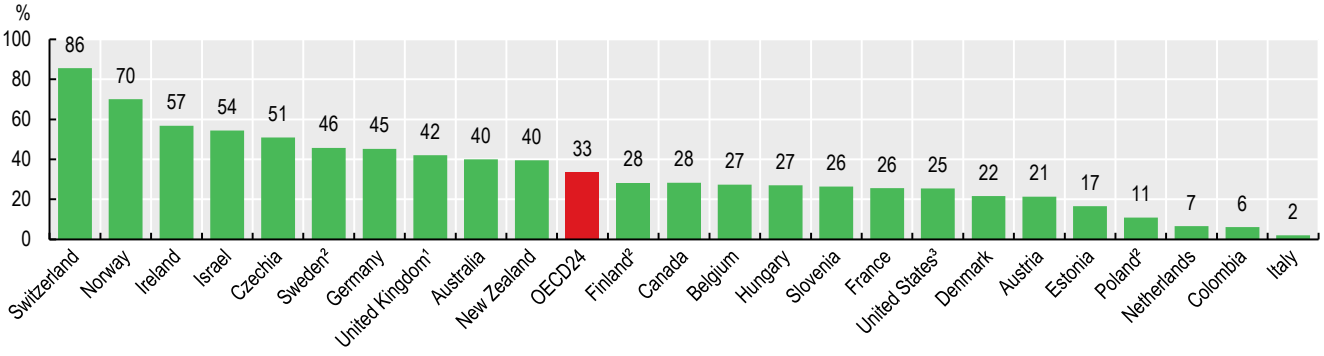
Figure 8.23. Share of foreign-trained doctors, 2023 and 2010 (or nearest years)



1. Latest data cover England and Wales only. 2. Latest data from 2022. 3. Latest data from 2024.
Source: OECD Health Statistics 2025.

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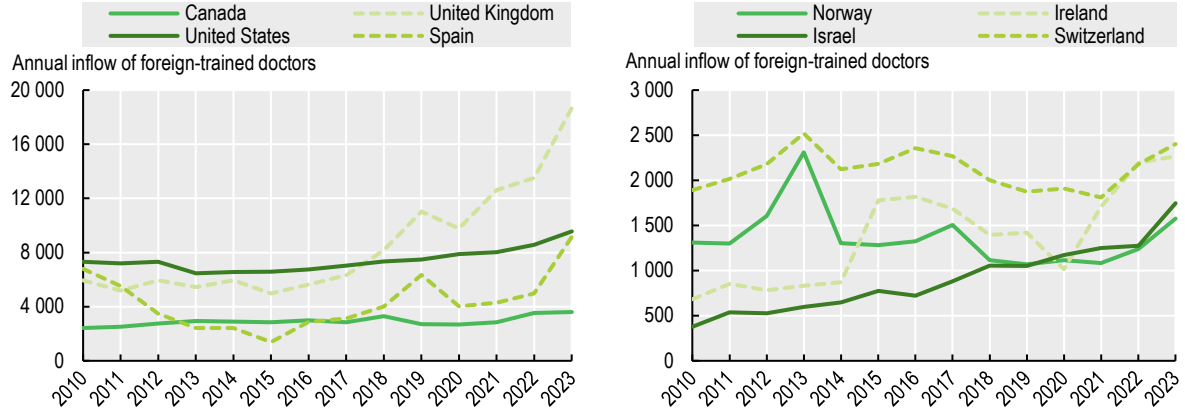
Figure 8.24. Contribution of foreign-trained doctors to physician workforce growth, 2010-2023 (or nearest years)



1. Latest data cover England and Wales only. 2. Latest data from 2022. 3. Latest data from 2024.
Source: OECD Health Statistics 2025.

StatLink https://stat.link/jmodve

Figure 8.25. Evolution of annual inflows of foreign-trained doctors, selected OECD countries, 2010 2023



Source: OECD Health Statistics 2025.

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International migration of nurses

OECD countries tend to rely less on foreign-trained nurses than doctors. In 2023, 8.8% of nurses were trained abroad (Figure 8.26), far below the 19.6% average for physicians Several factors help to explain the gap: nursing degrees are cheaper and shorter, recognition of foreign qualifications can be more difficult and more migrant nurses work in lower-level roles than what they were trained in their home country or leave the profession altogether.

Even so, the number of foreign-trained nurses has grown steeply across OECD countries, reaching more than 800 000 in 2023, an increase of 69% since 2010. The share rose in most OECD countries between 2010 and 2023. While the available time series for Ireland is more limited, the share of nurses educated abroad has increased from 47% in 2021 to 52% in 2023 (with a further increase to 54% in 2024). New Zealand, Switzerland and the United Kingdom also have a large and growing share of foreign-trained nurses. As with doctors, foreign-trained nurses are concentrated in a few large destination countries: the United States, the United Kingdom and Germany host over 60% of the total, and the 10 main destination countries together account for 92%.

Although reliance on foreign-trained for nurses is less pronounced than for doctors, foreign-trained nurses still accounted, on average, for one in five (21%) additional nurses in OECD countries between 2010 and 2023 (Figure 8.27). Their contribution was especially marked in the United Kingdom, where foreign-trained nurses represented 83% of the increase in the total number of nurses (increasing from 70 000 to 170 000 in absolute terms). They also contributed substantially to the rise in the number of nurses in Switzerland (58%), New Zealand (55%), Australia (33%), Germany (26%) and the Netherlands (26%). In Ireland where the time series is more limited, foreign-trained nurses made up 92% of the nursing workforce growth between 2021 and 2024.

When focussing on the place of birth instead of the place of training, the number of foreign-born nurses working in OECD countries more than doubled over the past two decades. The main countries of origin of nurses working in OECD countries in 2020/21 were the Philippines (about 270 000 nurses working in OECD countries), India (120 000), Poland (64 000) and Nigeria (54 000). To mitigate potential “brain drain” from countries of origin, the WHO Global Code of Practice on the International Recruitment of Health Personnel was adopted in 2010, promoting ethical recruitment and balancing the interests of sending and receiving countries while safeguarding migrant health workers’ rights. Its 2023 revision introduced the Health Workforce Support and Safeguards List of 55 countries facing the greatest workforce pressures, noting that active recruitment from these countries should be avoided unless accompanied by compensatory measures. In 2020/21, about 257 000 nurses working in OECD countries were born in one of these countries facing acute workforce pressures, with many of them coming from Nigeria (54 000), Haiti (35 800) and Ghana (21 400) (OECD, 2025[1]).

The annual inflows of foreign-trained nurses have risen in almost all major countries of destination since 2010 (Figure 8.28). While most of these countries recorded a dip in inflows in 2020-2021 during the COVID-19 pandemic, this was followed by sharp rebounds with higher yearly intakes than before the pandemic. The United Kingdom illustrates both intensive international recruitment efforts and a challenging new profile as a “stepping-stone” to other destinations. Arrivals of foreign-trained nurses grew seven-fold, from 3 000 to more than 21 000, between 2010 and 2023, but some of these foreign-trained nurses may move to other countries afterward. Applications for Certificates of Current Professional Status, which are required to register abroad, have increased sharply in recent years in the United Kingdom, with more than four-fifths destined for the United States, Australia or New Zealand (The Health Foundation, 2024[2]). This underlines the risks of relying heavily on international recruitment. Onward migration is neither new nor confined to the United Kingdom. For example, New Zealand has long seen foreign-born nurses depart for Australia under the Trans-Tasman Mutual Recognition Arrangement.

Definition and comparability

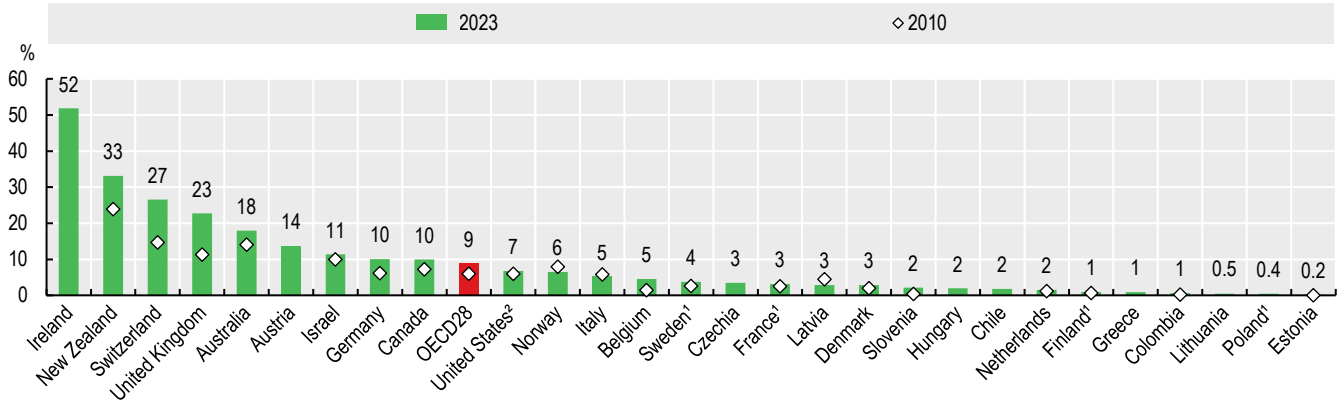
Foreign-trained nurses are defined as those who obtained their first nursing degree abroad. They relate to the total stock of nurses working in OECD countries as well as the annual inflows. The data sources in most countries are professional registries or other administrative sources. The main comparability limitation relates to differences in the activity status of nurses. Some registries are updated regularly, making it possible to distinguish nurses who are actively working in health systems, while others include all nurses licensed to practise, regardless of whether they are still active. Data for Germany are based on nationality, not on place of training. Data on foreign-born nurses come from the Database on Immigrants to OECD Countries (DIOC), which compiles information from national population censuses and labour force surveys, and includes breakdowns by country of origin.

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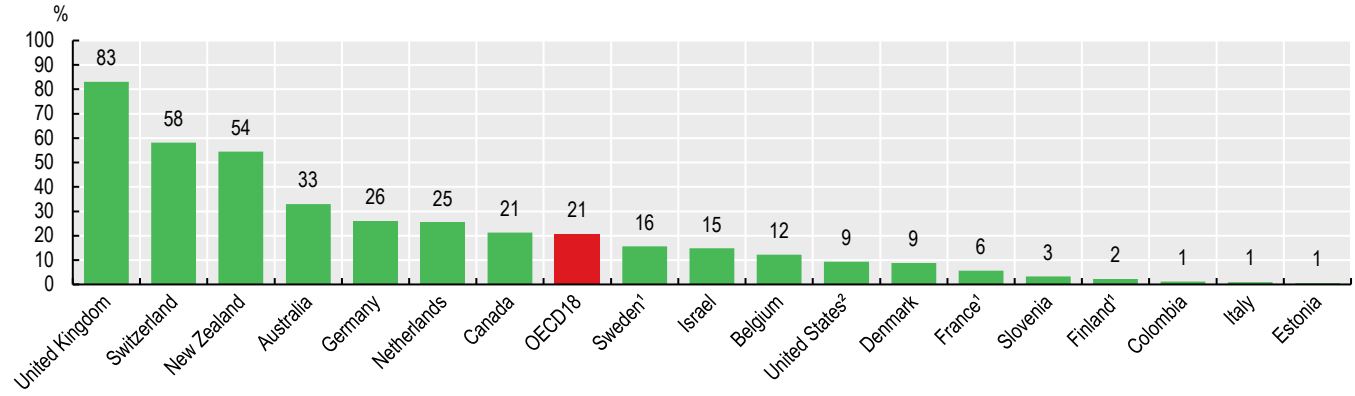
Figure 8.26. Share of foreign-trained nurses, 2023 and 2010 (or nearest years)



1. Latest data from 2021 or 2022. 2. Latest data from 2024.
Source: OECD Health Statistics 2025.

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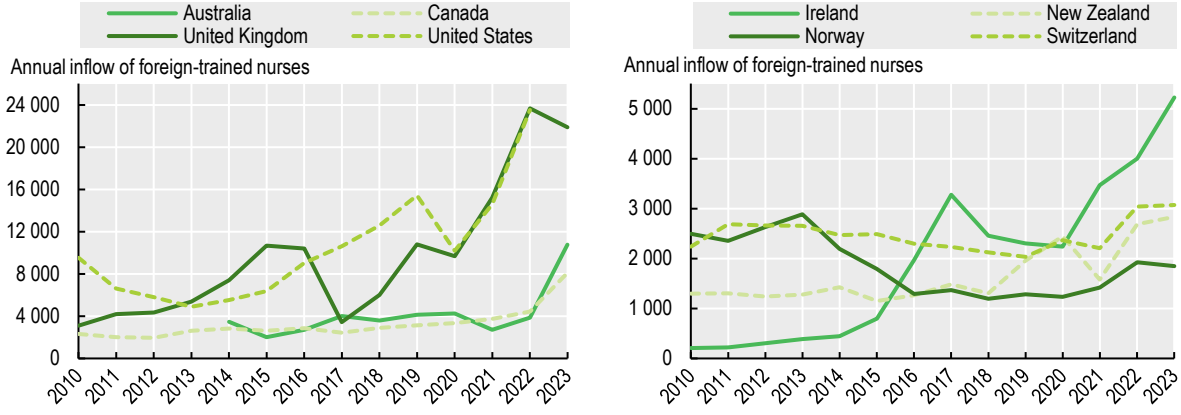
Figure 8.27. Contribution of foreign-trained nurses to nursing workforce growth, 2010-2023 (or nearest years)



1. Latest data from 2021 or 2022. 2. Latest data from 2024.
Source: OECD Health Statistics 2025.

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Figure 8.28. Evolution of annual inflows of foreign-trained nurses, selected OECD countries, 2010-2023



Source: OECD Health Statistics 2025.

StatLink https://stat.link/nfmbu0



9 Pharmaceuticals, technologies, and digital health

Pharmaceutical expenditure
Pharmacists and pharmacies
Pharmaceutical consumption
Generics and biosimilars
Diagnostic technologies
Data and digital
Pharmaceutical knowledge and innovation

Pharmaceutical expenditure

In 2023, retail pharmaceuticals – defined as those dispensed outside hospitals and other care facilities – accounted for around one-sixth of total health spending across OECD countries. This represented the third largest area of expenditure after spending on inpatient and outpatient services. However, growth in retail pharmaceutical spending over the past decade has generally fallen behind spending in other health services, reflecting continued efforts to manage costs, particularly through pricing policies and the expanded use of generics (see section on "Health expenditure by type of service" in Chapter 7).

Per capita expenditure on retail pharmaceuticals averaged USD 766 (adjusted for differences in purchasing power) in OECD countries in 2023 (Figure 9.1). The United States (USD 1 713) reported the highest per capita spending, at more than double the average, followed by Germany (USD 1 158) and Switzerland (USD 1 061). At the lower end, Denmark (USD 404), Chile (USD 455) and Estonia (USD 458) all spent below 60% of the OECD average. Variation can be due to differences in prescribing practices, the uptake of generics, and the regulatory frameworks in place. The relatively low spending in Denmark reflects widespread provision of medicines within hospital or ambulatory care settings, rather than through retail outlets. Prescription medicines accounted for more than 75% of total expenditure in most countries, with the rest going on over-the-counter medicines (OTC). Poland stands out as the only OECD country where OTC spending exceeded that of prescription medicines.

In terms of financing, governments and compulsory insurance schemes are the principal source of retail pharmaceutical funding, accounting for almost 60% of spending on average across OECD countries in 2023 (Figure 9.2). This share exceeded 80% in France and Germany where public or statutory schemes provide broad coverage for outpatient medicines. Out-of-pocket spending by households, including co-payments and direct purchases, accounts for much of the remaining cost, at around 38%, although it financed around two-thirds of spending in Chile and Poland. Only in a handful of countries does voluntary health insurance play any role in pharmaceutical spending. Canada is an outlier with a third of spending covered by private insurance. Complementary health insurance also accounted for almost a quarter of retail pharmaceutical spending in Slovenia, although from 2024 this is no longer available as a voluntary option for pharmacy or basic medical coverage.

Spending on retail pharmaceuticals provides only a partial view of total pharmaceutical expenditure. Medicines used in hospital and other non-retail settings are a growing component of overall pharmaceutical costs, driven in part by the introduction of high-cost therapies in areas such as oncology, immunology, and rare diseases. Across 15 OECD countries, non-retail pharmaceuticals accounted for 25% of total pharmaceutical expenditure in 2023, up from 21% in 2013 (Figure 9.3). The largest increases were observed in Portugal, Spain and Czechia, where hospital use of pharmaceuticals grew significantly. Denmark continued to report the highest share (49%) of non-retail spending, reflecting a longstanding practice in hospital-based dispensing. By contrast, Switzerland and Lithuania, recorded the lowest proportions at only around 6% of total pharmaceutical spending in 2023. A growing body of evidence, including recent analysis from the OECD (Morgan and Xiang, 2022[1]), highlights the need to account for both retail and hospital pharmaceutical expenditures when planning budgets and assessing long-term financial sustainability.

Definition and comparability

Pharmaceutical expenditure covers spending on prescription medicines and self-medication (often referred to as OTC products). Some countries cannot report a breakdown, and their data may include medical non-durables (such as first aid kits, hypodermic syringes and facemasks). This typically leads to an overestimation by 5-10%, although during the COVID-19 pandemic this figure was probably higher. Retail pharmaceuticals are those provided outside hospital care, dispensed by a retail pharmacy or bought from a supermarket, and the prices should include wholesale and retail margins and value added tax (OECD/Eurostat/WHO, 2017[2]). Comparability issues exist regarding the administration and dispensing of pharmaceuticals for hospital outpatients. In some countries, the costs are included under curative care; in others, under pharmaceuticals.

Hospital and other non-retail pharmaceuticals include drugs administered or dispensed during an episode of hospital care or in another healthcare setting. The costs of pharmaceuticals consumed in hospitals and other healthcare settings are reported as part of the costs of inpatient or day-case treatment. Non-retail pharmaceuticals also include the costs of vaccines that are consumed as part of a vaccination campaign and that are not procured via retailers.

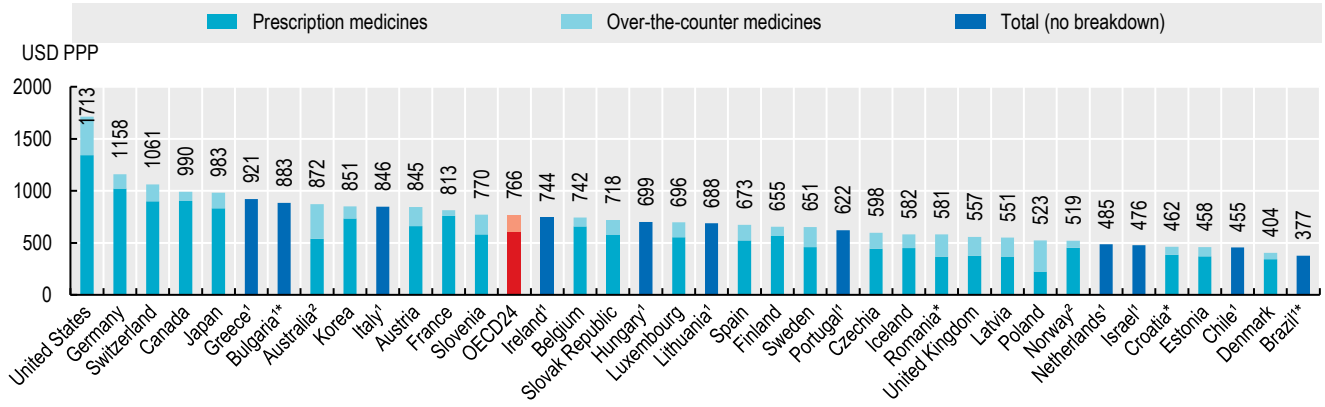
Total pharmaceutical spending refers to "net" spending: it is adjusted for rebates paid by manufacturers, wholesalers or pharmacies.

References

Morgan, D. and F. Xiang (2022), "Improving data on pharmaceutical expenditure in hospitals and other health care settings", *OECD Health Working Papers*, No. 139, OECD Publishing, Paris, https://doi.org/10.1787/6c0d64a2-en. [1]

OECD/Eurostat/WHO (2017), *A System of Health Accounts 2011: Revised edition*, OECD Publishing, Paris, https://doi.org/10.1787/9789264270985-en. [2]

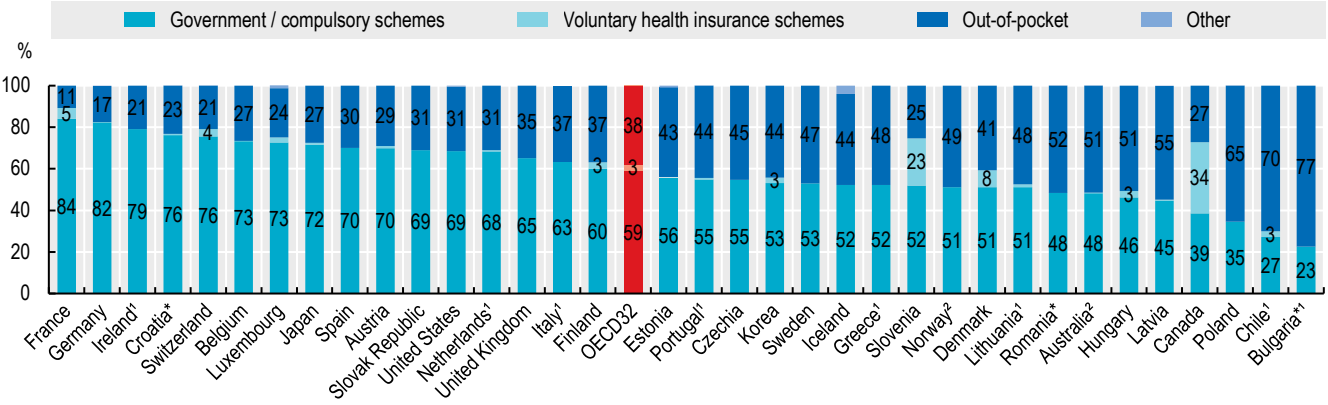
Figure 9.1. Expenditure on retail pharmaceuticals per capita, 2023 (or nearest year)



1. Includes medical non-durables. 2. 2022 data. * Accession/partner country.
Source: OECD Health Statistics 2025.

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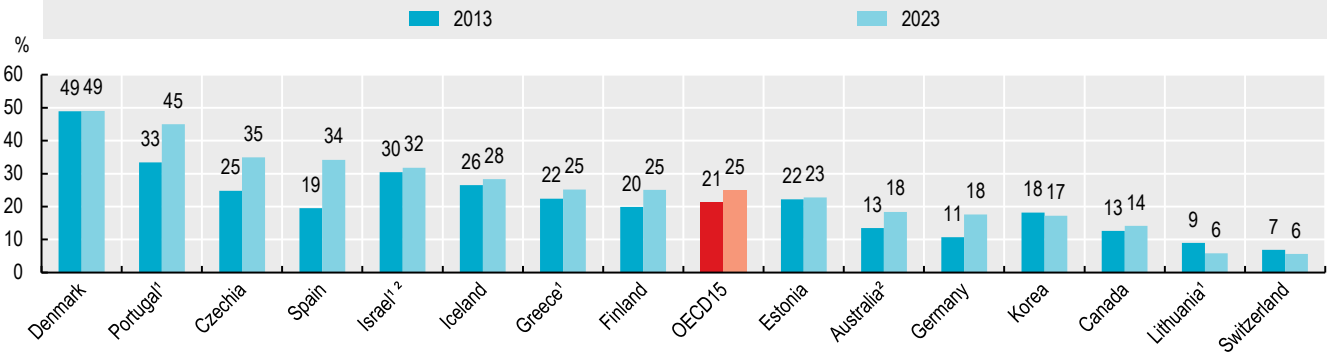
Figure 9.2. Expenditure on retail pharmaceuticals by type of financing, 2023 (or nearest year)



1. Includes medical non-durables. 2. 2022 data. * Accession/partner country.
Source: OECD Health Statistics 2025.

StatLink https://stat.link/gq278w

Figure 9.3. Non-retail pharmaceutical expenditures as a share of total pharmaceutical expenditure, 2023 and 2013 (or nearest year)



1. Includes medical non-durables. 2. 2022 data.
Source: OECD Health Statistics 2025.

StatLink https://stat.link/jv49fl

Pharmacists and pharmacies

Pharmacists are highly trained healthcare professionals whose main role is managing the distribution of medicines to consumers/patients and supporting their safe and efficacious use. Between 2013 and 2023, the average number of practising pharmacists per capita in OECD countries increased by 10%, to 86 pharmacists per 100 000 population (Figure 9.4). However, the density of pharmacists varied widely, ranging from a low of 18 per 100 000 in Colombia to 203 per 100 000 in Japan. Among OECD countries, the highest growth rate in pharmacist density between 2013 and 2023 was observed in Chile, where the number of pharmacists more than doubled.

Most pharmacists work in community pharmacies, but many also work in hospitals and industry, as well as in research and academic settings. In Canada, for example, in 2023 77% of practising pharmacists worked in community pharmacies, while 23% worked in hospitals and other healthcare facilities. In Japan, around 59% of pharmacists worked in community pharmacies in 2022, while around 19% worked in hospitals or clinics, and the remaining 22% in other settings.

The role of the community pharmacist has expanded in recent years. In addition to dispensing medications, pharmacists are increasingly providing a range of other healthcare services (such as vaccinations, medicine adherence and chronic disease management support, and home medication review), both in community pharmacies and as part of integrated healthcare provider teams. For example, in several Canadian provinces, the United Kingdom, many parts of the United States and in Australia, community pharmacists (with the required qualifications) are permitted to assess patients with certain minor conditions and independently prescribe them medications. The expansion of the authorised scope of practice of community pharmacists was accelerated in many countries in response to COVID-19 (OECD, 2021[1]), and in some cases, it has been maintained. In France, for example, some of the exceptional authorisations granted to pharmacists during the pandemic have since been made permanent, giving them an expanded role in renewing prescriptions, prescribing for minor conditions, and administering vaccines. In Scotland (United Kingdom), the Pharmacy First scheme allows pharmacists to manage common minor ailments (WPC, 2023[2]).

In 2023, the number of community pharmacies per 100 000 population ranged from 9 in Denmark to 102 in Greece, with an average of 29 across OECD countries with comparable data (Figure 9.5). For most countries there has not been much change over time, although one exception is Denmark, where community pharmacy density increased by 60% between 2013 and 2023. The variation in community pharmacy density across countries can be explained in part by differences in common distribution channels. For example, some countries rely more on hospital pharmacies to dispense medicines to outpatients. Denmark has fewer community pharmacies, but these are often large, and include branch pharmacies and subsidiary pharmacy units attached to a principal pharmacy. Denmark, along with a number of European countries (such as Austria, Belgium, Italy, Portugal and Spain) regulate the establishment of new pharmacies based on population or distance criteria. In Australia, with an average of around 23 community pharmacies per 100 000 population, the minimum distance between pharmacies is regulated. The range of products and services provided by pharmacies also varies between countries. In most European countries, for example, pharmacies also sell cosmetics, food supplements, medical devices and homeopathic products.

Definition and comparability

Practising pharmacists are defined as pharmacists who are licensed to practise and provide direct services to clients/patients. They can be either salaried or self-employed, and work in community pharmacies, hospitals or other settings. Assistant pharmacists and other employees of pharmacies are normally excluded.

In Ireland, the figures for 2023 onwards are obtained from self-declarations made to the Pharmaceutical Society of Ireland and refer to all individuals on their register who have indicated that they are patient-facing in the pharmaceutical industry (i.e. working in a community or hospital pharmacy).

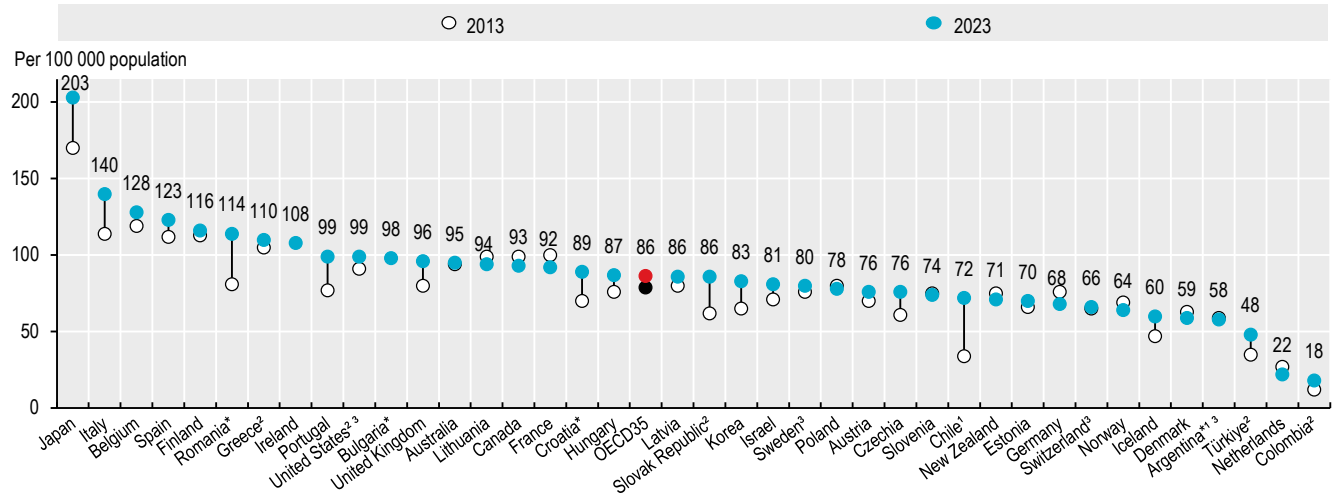
Community pharmacies are premises that, in accordance with local regulations and definitions, may operate as a facility for the provision of pharmacy services in community settings. The number of community pharmacies reported is the number of premises where medicines are dispensed under the supervision of a pharmacist.

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WPC (2023), *Sector Analysis Report 2023*, World Pharmacy Council, https://d2s3n99uw51hng.cloudfront.net/static/2023%20WPC%20Sector%20Analysis%20Report%20-%20Public%20Version.pdf (accessed on 9 July 2025). [2]

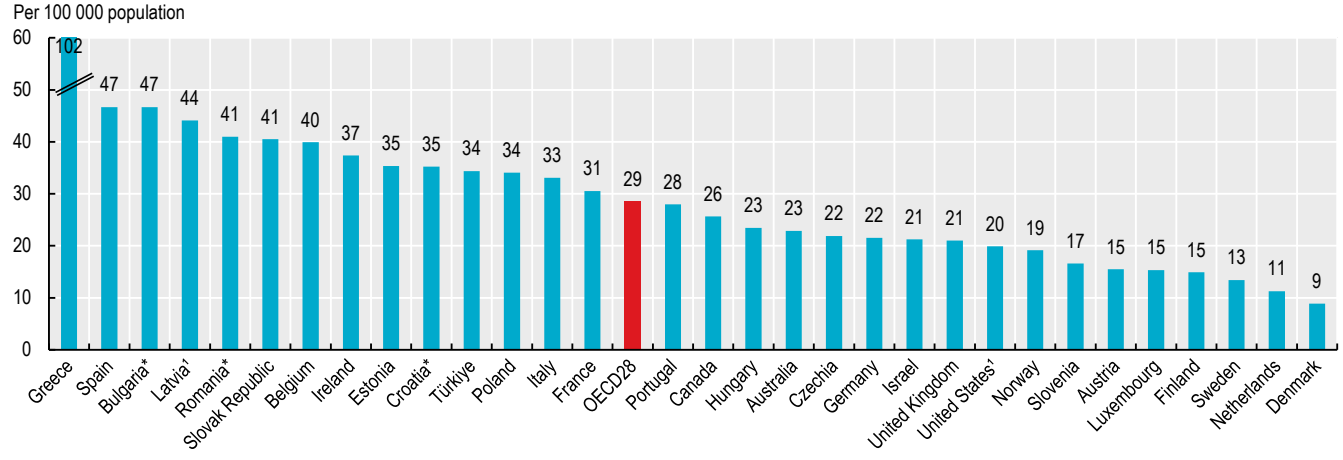
Figure 9.4. Practising pharmacists, 2023 and 2013 (or nearest year)



1. Includes all pharmacists licensed to practise. 2. Includes pharmacists working in the health sector as researchers, for pharmaceutical companies, etc. 3. Latest data from 2021-2022. * Accession/partner country.
Source: OECD Health Statistics 2025.

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Figure 9.5. Community pharmacies, 2023 (or nearest year)



1. 2020-2021 data. * Accession/partner country.
Source: Pharmaceutical Group of the European Union database, IQVIA or national sources for non-European countries.

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Pharmaceutical consumption

Pharmaceutical consumption has been increasing for decades, driven by a growing need for medicines to treat age-related and chronic diseases, and by changes in clinical practice. This section examines the consumption of four categories of medicines used in select chronic conditions: antihypertensives, lipid-modifying agents, antidiabetics and antidepressants (Figure 9.6). These medicines address illnesses for which prevalence has increased markedly across OECD countries.

Consumption of antihypertensive medicines in OECD countries increased by around 6% on average between 2013 and 2023, but grew by almost 50% in Chile. Consumption levels remain highly variable across OECD countries, reflecting differences in prevalence of hypertension and clinical practice.

Much greater growth was seen in the use of lipid-modifying agents, with consumption in OECD countries increasing by almost 65% between 2013 and 2023 on average. Denmark and Finland reported the highest levels of consumption per capita in 2023, while Türkiye recorded the lowest, highlighting a more than five-fold variation across OECD countries.

The use of antidiabetic medications also grew dramatically, by 50% over the same period and more than tripled in Canada and the Slovak Republic. Growth may be explained in part by the rising prevalence of diabetes, which is largely linked to obesity, and by the increasing use of certain A10 medicines for other indications such as obesity, heart failure, or kidney disease. In Canada, Drug Information System data from certain provinces – covering all dispensed prescriptions – documented a real surge in consumption, driven in part by increased prescribing of Semaglutide following its 2021 market authorisation for obesity, even though it was not publicly reimbursed for this indication. In the Slovak Republic, the increase was driven by physicians following clinical studies supporting the extension of A10 drug indications to cardiological and nephrological uses. In 2023, consumption of antidiabetic medicines was highest in the Slovak Republic and Canada, and lowest in Latvia, New Zealand and Austria, with more than a four-fold variation.

Consumption of antidepressant medicines increased by over 40% in OECD countries between 2013 and 2023, and more than doubled in Chile, Estonia, Korea and Latvia. As well as a potential increased burden of mental ill-health, this may also reflect improved recognition of mental health disorders, evolving clinical guidelines and availability of therapies, as well as longer-term prescribing (Bogowicz et al., 2021[1]; Madeira, Queiroz and Henriques, 2023[2]). Iceland and Portugal reported the highest level of consumption in 2023, at a rate around six times that of Latvia.

More recently, pharmaceutical consumption in each of these four categories increased by around 20-30% in OECD countries on average between 2019 and 2023, except for antihypertensive medicines, where consumption remained relatively stable. These consumption patterns may in part reflect differences in the burden of the disease since the COVID-19 pandemic – for example, the increased prevalence of anxiety and depression (see section on “Mental health” in Chapter 3).

Definition and comparability

The defined daily dose (DDD) is the assumed average maintenance dose per day for a medicine used for its main indication in adults. DDDs are assigned to each active ingredient in a given therapeutic class by international expert consensus. DDDs do not necessarily reflect the average daily dose actually used in a given country. They can be aggregated within and across therapeutic classes of the Anatomical Therapeutic Chemical (ATC) classification of the World Health Organization.

Antihypertensive medicine consumption refers to the sum of five ATC 2nd level categories, which may all be prescribed for hypertension (C02 – antihypertensives, C03 – diuretics, C07 – beta blocking agents, C08 – calcium channel blockers and C09 – agents acting on the renin-angiotensin system). ATC codes for other medicine classes are C10 – lipid-modifying agents, A10 – medicines used in diabetes and N06A – antidepressants. Comparisons of medicine consumption should be treated with caution as variations may reflect differences in both disease burden and clinical practice. Moreover, the same medicine can be used to treat multiple diseases, which may result in overreporting of consumption levels.

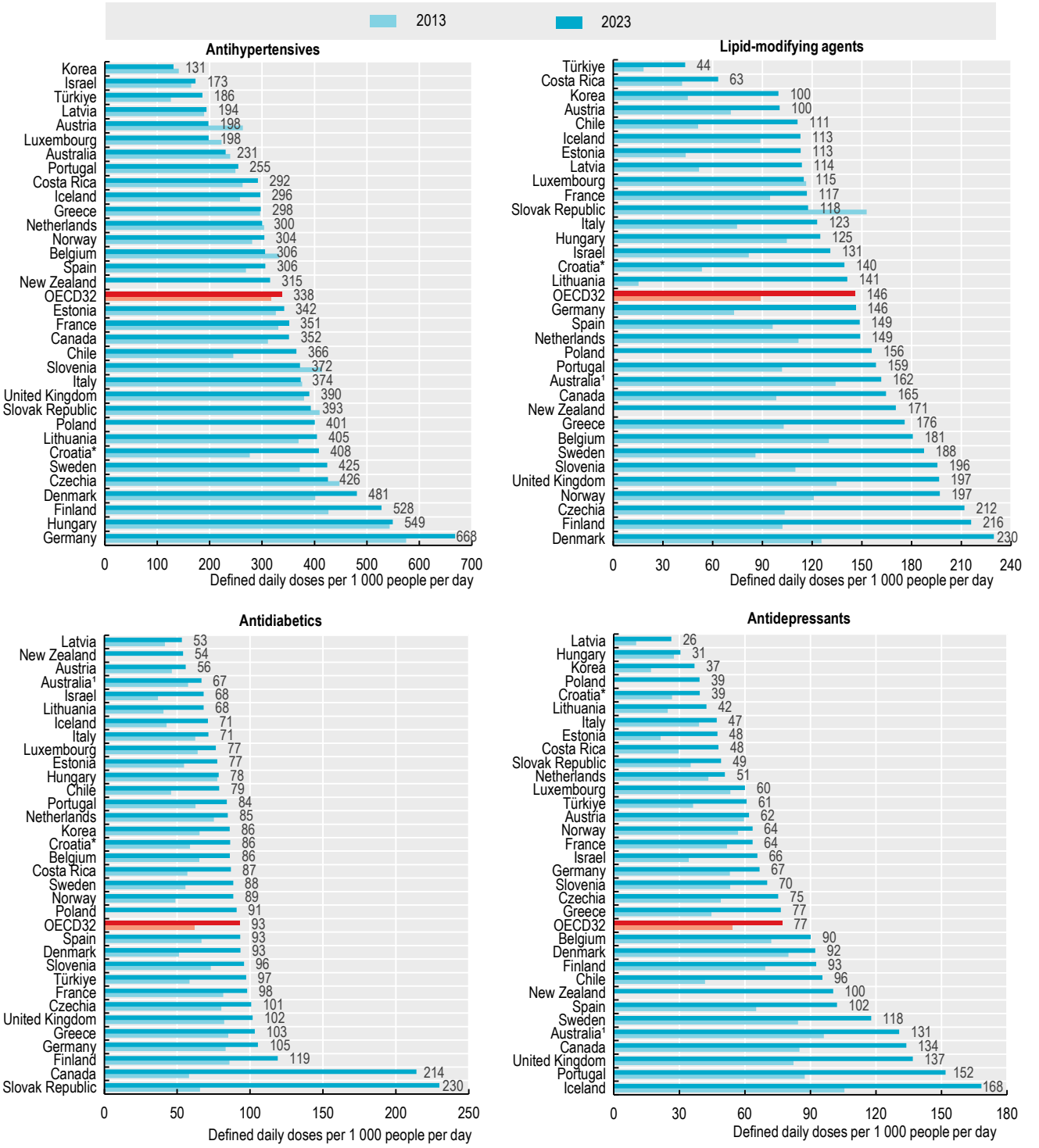
Data refer to outpatient consumption only, except for Chile, Costa Rica, Croatia, Czechia, Denmark, Estonia, Finland, France, Italy, Korea, Lithuania, Luxembourg (since 2021), Norway, the Slovak Republic, Spain (since 2018) and Sweden, where data also include hospital consumption. For Canada, only data from provinces for which population-level data were available were included (British Columbia, Manitoba and Saskatchewan). Data for Spain refer to inpatient and outpatient consumption for prescribed medicines covered by the national health system (public insurance), while data for Luxembourg refer to outpatient consumption and since 2021 also include medicines delivered only by hospitals. Data for Luxembourg are underestimated due to incomplete consideration of products with multiple active ingredients. Some countries have signalled that their current reporting does not include consumption of combination of products (e.g. New Zealand for antidiabetics). This might underestimate actual consumption.

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Figure 9.6. Consumption of medicines for selected chronic conditions, 2023 and 2013 (or nearest year)



1. Latest data from 2022. 2. See "Definition and comparability" box for a breakdown of ATC codes. 3. Data labels correspond to 2023 data. * Accession/partner country.
Source: OECD Health Statistics 2025.

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Generics and biosimilars

All OECD countries view generics and biosimilars as opportunities to increase efficiency in pharmaceutical spending, but many do not fully exploit their potential. In 2023, generics accounted for more than three-quarters of the volume of pharmaceuticals sold in Chile, Germany, the United Kingdom, the Netherlands, Canada, New Zealand and Latvia. Between 2013 and 2023, the volume of generics increased in most countries, with notable growth observed in Luxembourg, Japan and Greece (Figure 9.7). In value terms, generics accounted for 25% of the pharmaceutical market, on average, but over 50% in Chile and the United Kingdom (Figure 9.8).

Differences in market structures (notably the number of off-patent medicines) and prescribing practices explain some cross-country differences, but generic uptake also depends on policies (OECD, 2018[1]; Socha-Dietrich, James and Couffinhal, 2017[2]). For example, in Austria, generic substitution by pharmacists is not permitted; in Luxembourg, generic substitution by pharmacists is limited to selected medicines. In some countries, such as Ireland, generic penetration is low, but originators and generics may be priced at the same level.

Many countries have implemented incentives for physicians, pharmacists and patients to boost generic markets. For instance, Japan established a roadmap to increase generic uptake in 2013. Since then, the government has steadily raised its targets and implemented various measures, including incentives for hospitals and pharmacies. In Switzerland, pharmacists receive a fee for generic substitution; in France, pharmacies receive bonuses if their substitution rates are high. In many countries, third-party payers fund a fixed reimbursement amount for a given medicine, allowing the patient a choice of the originator or a generic, but with responsibility for any difference in price.

Biologicals are a class of medicines manufactured in, or sourced from, living systems such as microorganisms, or plant or animal cells. Many are produced using recombinant DNA technology. When such medicines no longer have market exclusivity, “biosimilars” – follow-on versions of these products – can be approved. The market entry of biosimilars creates price competition, thereby improving affordability and cost containment efforts.

From 2013 to 2023, biosimilars steadily gained market share in the accessible market across ten key therapy areas (see the “Definition and comparability” box). In 2013, biosimilars represented just 1% of the market volume, but by 2023, their share had increased to 22% across 25 countries This trend highlights the growing acceptance and integration of biosimilars into healthcare systems. In 2023, biosimilars accounted for more than one-quarter of the accessible market in selected therapy areas in countries including Italy, Spain, Sweden, Austria and Portugal (Figure 9.9).

Definition and comparability

A generic medicine is a pharmaceutical product that has the same qualitative and quantitative composition in active substances and the same pharmaceutical form as the reference product, and whose bioequivalence with the reference product has been demonstrated. Generics may be branded (generics with a specific trade name) or unbranded (identified using the international non-proprietary name and the company’s name).

Countries are requested to provide data for the whole of their respective markets. However, many countries provide data covering only the community pharmaceutical market or the reimbursed pharmaceutical market (see figure notes). The share of generic market expressed in value can be the turnover of pharmaceutical companies, the amount paid for pharmaceuticals by third-party payers or the amount paid by all payers (third-party and consumers). The share of the generic market by volume can be expressed in DDDs or as a number of packages/boxes or standard units.

A biosimilar medicinal product (a biosimilar) is a product granted regulatory approval by demonstrating sufficient similarity to the reference medicinal product (biological) in terms of quality characteristics, biological activity, safety and efficacy. Market share is calculated based on the accessible market, defined as the consumption volume (in treatment days) of originator biologics that have lost market exclusivity and the corresponding biosimilars. The accessible market includes three categories: reference medicines (originator biologics for which a biosimilar exists), non-referenced market (biologics that have lost patent protection but do not have an approved biosimilar), and biosimilars. Originator biologics that are still under patent protection are excluded from the accessible market. Volume sales are measured in treatment days, based on DDDs.

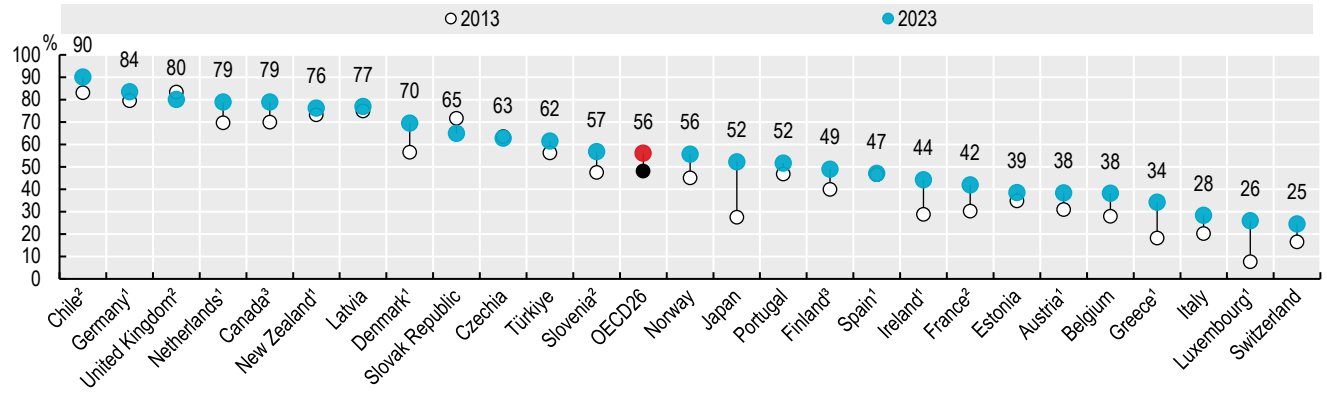
Analysis focusses on ten key therapy areas where biosimilar competition is most relevant and mature; human growth hormone, erythropoietin, granulocyte-colony stimulating factor, anti-tumour necrosis factor (anti-TNF) agents, fertility treatments (follitropin alfa), insulins, oncologic drugs, low-molecular-weight heparin, parathyroid hormone, and ophthalmologic drugs.

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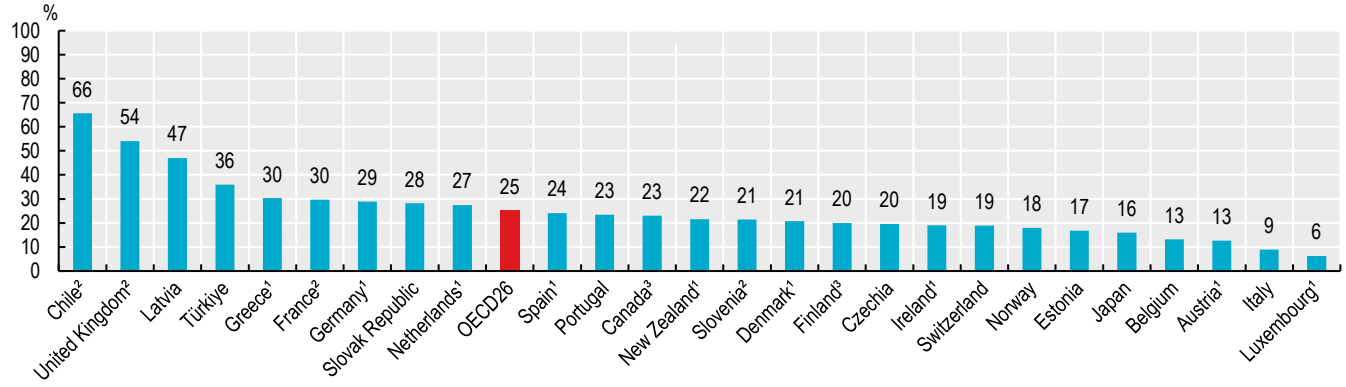
Figure 9.7. Share of generics in the pharmaceutical market by volume, 2023 and 2013 (or nearest year)



1. Reimbursed pharmaceutical market, i.e. the sub-market in which a third-party payer reimburses medicines. 2. Community pharmacy market. 3. Latest data from 2021-2022.
Source: OECD Health Statistics 2025.

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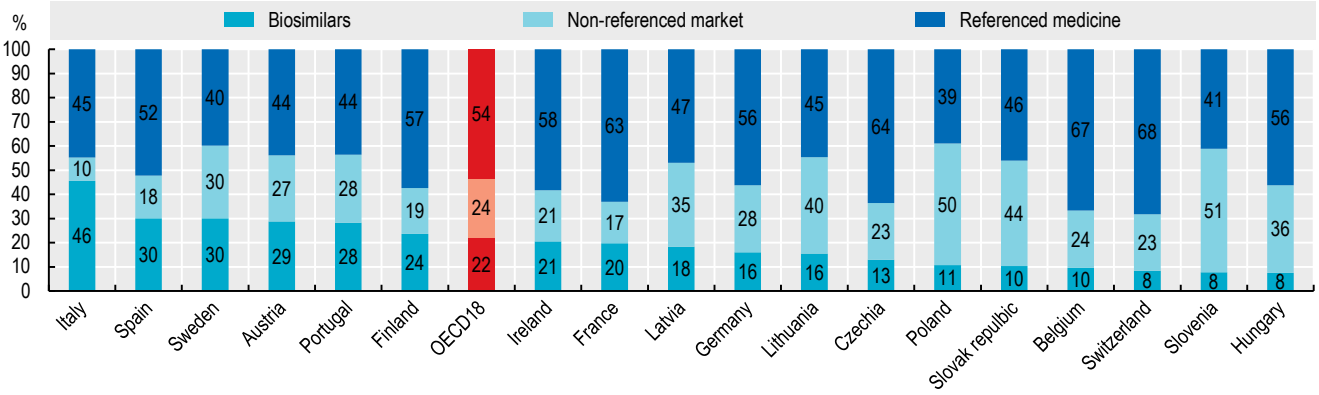
Figure 9.8. Share of generics in the pharmaceutical market by value, 2023 (or nearest year)



1. Reimbursed pharmaceutical market, i.e. the sub-market in which a third-party payer reimburses medicines. 2. Community pharmacy market. 3. 2022 data or earlier
Source: OECD Health Statistics 2025.

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Figure 9.9. Market share of biosimilars in biologic market in ten key therapy areas, 2023



Note: See "Definition and comparability" box for an explanation of "ten key therapy areas," "non-referenced market" and "referenced medicine."
Source: IQVIA MIDAS® 2023.

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Diagnostic technologies

Technologies play an important role in medical diagnoses: from physical examination and results processing and sharing, to accessing patients' health records, to the review of clinical histories. However, new technologies are acknowledged as a major cost driver in health systems (OECD, 2024[1]). This section presents data on the availability and use of three diagnostic imaging technologies: computed tomography (CT), magnetic resonance imaging (MRI) and positron emission tomography (PET). CT and MRI examinations (exams) both show images of internal organs and tissues, while PET scans show other information and problems at the cellular level.

There is no general guideline or international benchmark regarding the ideal numbers of CT scanners, PET scanners or MRI units. Too few units may lead to access problems in terms of geographical proximity or waiting times, while too many may result in overuse of these costly diagnostic procedures, with little if any benefit for patients.

Availability of CT and PET scanners and MRI units has increased rapidly in most OECD countries over the past few decades. Japan had by far the highest number of CT scanners and MRI units, and the third highest number of PET scanners per capita. Australia has the next highest number of CT scanners; the United States the second highest numbers of MRI units and PET scanners; and Denmark the highest number of PET scanners per capita (Figure 9.10). The combined numbers of these three diagnostic technologies were also substantially higher than the OECD average in Greece, Korea, and Italy; and much lower than the average in Colombia, Costa Rica and Mexico.

Data on use of diagnostic scanners are available for 31 OECD countries. Taken together, use of CT, MRI and PET diagnostic exams was highest in Luxembourg, Korea, Austria, France and Portugal, all of which had a combined total of over 370 exams per 1 000 population in 2023 (Figure 9.11). Use of these three diagnostic exams was lowest in Costa Rica and Finland; as well as accession countries Romania and Bulgaria. There are large variations in the use of CT scanners and MRI units, not only across but also within countries – for example, in Norway, a recent analysis revealed nearly 50% geographical variation in use of outpatient diagnostic imaging exams for the musculoskeletal system, as well as for the thorax, abdomen, and blood vessels, in 2019 (Hofmann and Gransjøen, 2022[2]).

Looking at trends over time, the number of CT and MRI exams per 1 000 population has continued to grow in several countries, including Australia, Belgium, France, Germany, Korea and Latvia (Figure 9.12). Between 2013 and 2023, the number of CT exams more than doubled in Korea and increased by more than 50% in Australia and Latvia. Similarly, numbers of MRI exams more than doubled in Korea and Latvia, increased by around 70% in France, and rose steadily in Belgium and Germany.

Clinical guidelines on MRI and CT exams exist in OECD countries to promote appropriate imaging and to enhance patient safety by avoiding unnecessary procedures. Previous studies have assessed the appropriateness of CT and MRI exams by comparing them against national guidelines or specific imaging referral criteria. For instance, a recent retrospective analysis conducted in Sweden evaluated the appropriateness of 13 075 MRI and CT examinations using the European Society of Radiology's guidance for appropriate imaging. The study found that 76% of MRI exams and 63% of CT exams were classified as appropriate according to this guideline (Ståhlbrandt et al., 2023[3]).

Definition and comparability

The data in most countries cover CT scanners, MRI units and PET scanners installed both in hospitals and the ambulatory sector, but coverage is more limited in some countries. Costa Rica, Portugal, Switzerland (for MRI units), Germany (for PET scanners) and the United Kingdom report equipment available in hospitals only. For Colombia, Costa Rica and the United Kingdom, the data only cover equipment in the public sector. For Australia and Hungary, the number of CT scanners, MRI units and PET scanners includes only those eligible for public reimbursement.

Similarly, CT, MRI and PET exams performed outside hospital are not included in Portugal, Switzerland and the United Kingdom, while exams performed in hospitals are not covered in Norway. In Australia, the data only include exams rendered on a "fee-for-service" basis for which Medicare benefits were paid, while in Korea and the Netherlands they only include publicly financed exams.

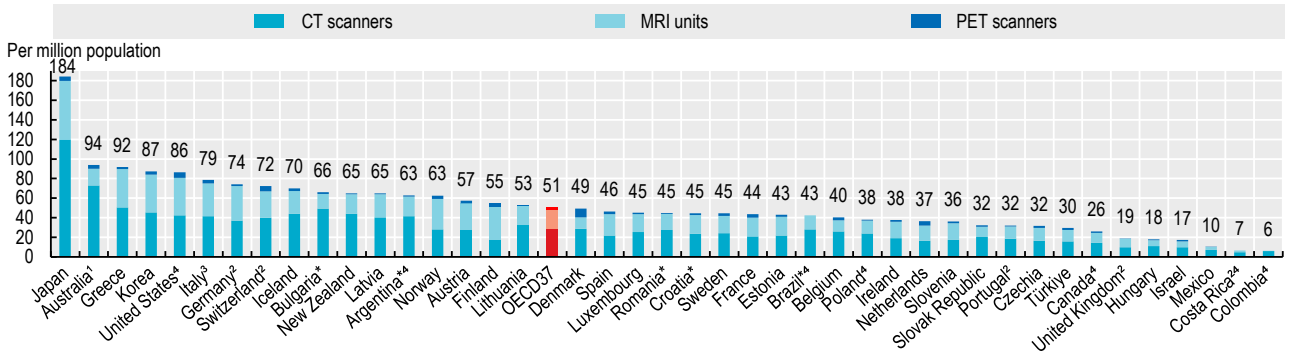
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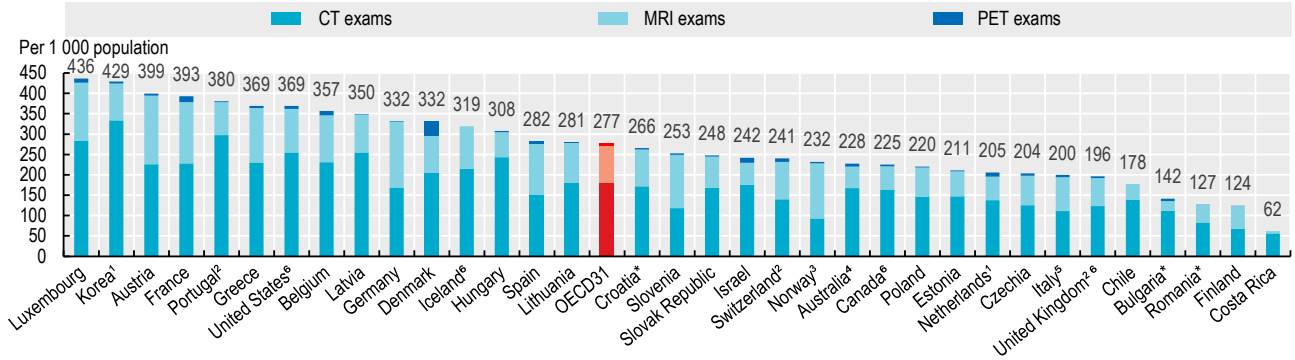
Figure 9.10. CT scanners, MRI units and PET scanners, 2023 (or nearest year)



1. Data include equipment eligible for public reimbursement only. 2. Data exclude equipment outside hospital (only for MRI units in Switzerland and only for PET in Germany). 3. Data for private hospitals not included. 4. 2022 data or earlier. * Accession/partner country.
Source: OECD Health Statistics 2025.

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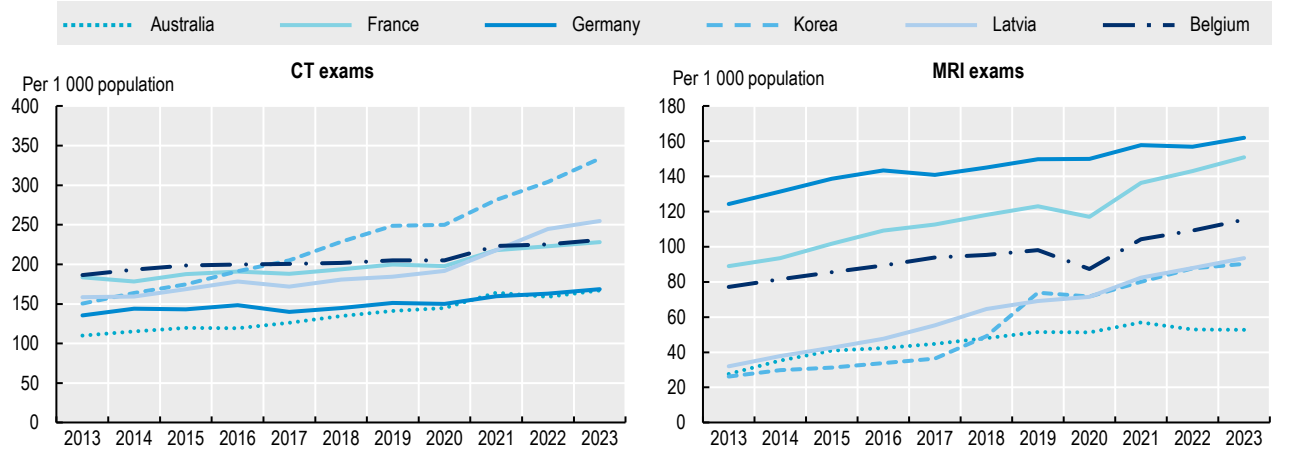
Figure 9.11. CT, MRI and PET exams, 2023 (or nearest year)



1. Data exclude privately funded exams. 2. Data exclude exams outside hospital. 3. Data include only exams outside hospital. 4. Data exclude exams on public patients. 5. Data for private hospitals not included. 6. 2022 data or earlier. * Accession/partner country.
Source: OECD Health Statistics 2025.

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Figure 9.12. Trends in use of diagnostic technologies, selected countries, 2013-2023



Note: Data for Korea exclude privately funded exams and data for Australia exclude exams on public patients.
Source: OECD Health Statistics 2025.

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Data and digital

Digitalising health systems relies on the availability of high-quality, interoperable data to deliver efficient, resilient, and equitable healthcare. Digital technologies such as telemedicine, electronic health records (EHRs), digital therapeutics and artificial intelligence (AI) are becoming widely used, enhancing continuity of care and accelerating the timeliness of delivery. Recognising their potential to reduce healthcare disparities, countries are continuing to expand health information infrastructure, and are making health data readily accessible to strengthen system resilience, improve performance, and facilitate cross-border co-operation (OECD, 2022[1]).

OECD countries have made progress in expanding access to EHRs. In 2024, the average availability of online digital health services reached 82%, an increase from 79% in 2023 among countries with comparable data. Only Belgium and Estonia currently provide full access to EHRs functions. Availability remains low in Ireland, where citizens have access to fewer than 30% of EHR core functionalities (Figure 9.13). Nevertheless, all countries improved EHR accessibility since 2022, with the highest increases in Czechia, France, Ireland, Portugal and the Slovak Republic. This progress reflects growing investment in data accessibility but ensuring interoperability across hospitals, general practices and other healthcare facilities remains challenging. Ensuring interoperability is not only a technical hurdle but also an organisational and governance challenge, as fragmented data systems reduce efficiency, hinder continuity of care, and limit the potential of advanced analytics and AI.

Building trust is essential to encourage the active use of digital health technologies. The 2024 Patient-Reported Indicator Surveys (PaRIS) survey highlights that older and less educated individuals are less confident in using digital tools to manage their health and report more difficulty understanding health information than younger and more-educated individuals. Across the surveyed OECD countries, the gap in digital health literacy between education levels exceeds 15 percentage in France, Iceland, Australia, the United States and Wales (United Kingdom), with those having lower education reporting significantly less confidence. By contrast, in Saudi Arabia and Slovenia, individuals with less education report higher confidence, and in Romania, Portugal and Belgium, the gap between groups is comparatively small (Figure 9.14).

During the COVID-19 pandemic, telemedicine was essential for delivering care. In 2019, remote consultations via phone or video averaged 0.5 per patient per year across OECD countries. By 2021, this more than doubled to 1.3 teleconsultations, with significant increases in Australia, Lithuania, Spain and Slovenia. However, by 2023, the rate of teleconsultations had stabilised to 1.0 per patient per year, reflecting a partial retreat from pandemic peaks while maintaining levels well above pre-pandemic baselines. Israel had the highest use in 2023 (2.8 teleconsultations per patient per year), while the largest post-pandemic drops occurred in Poland, Lithuania and Spain (Figure 9.15). After realising the benefits through the pandemic, health systems have expanded use of remote consultations, although financial, legal and operational barriers still exist (Keelara, Sutherland and Almyranti, 2025[2]). Sustaining telemedicine use will require not only addressing legal and financial barriers, but also adapting payment systems, strengthening broadband infrastructure, and embedding teleconsultations into mainstream care pathways.

Definition and comparability

Citizens' online access to EHRs is one of the indicators within the Digital Economy and Society Index (DESI) dashboard. The indicator is measured through two main components: i) the nationwide availability of online access to EHRs (via a patient portal or a patient mobile app), and ii) the percentage of individuals that have the ability to obtain or make use of their own minimum set of health-related data currently stored in public and private EHR systems (European Commission, 2025[3]).

The definition of digital health literacy includes having confidence in accessing and selecting high quality information sources and understanding and applying information obtained from digital sources. In PaRIS, the indicator for digital health literacy is an item of the eHealth Literacy Scale or eHEALS showing the percentage of primary care users aged 45 and over (very) confident in using health information from internet. Results are age- and sex-standardised across countries.

Teleconsultations cover remote consultations with generalist and specialist medical practitioners. They cover all technologies used (notably phone or virtual calls). While data on teleconsultations are broadly comparable across countries, some deviations exist. Denmark includes nurse consultations but excludes hospital outpatient teleconsultations; Germany only counts those reimbursed by statutory health insurance; Sweden includes text-based consultations, with regional variation in data extraction. Further minor differences relate to the inclusion of certain providers or settings in Estonia, Norway, Portugal and Spain.

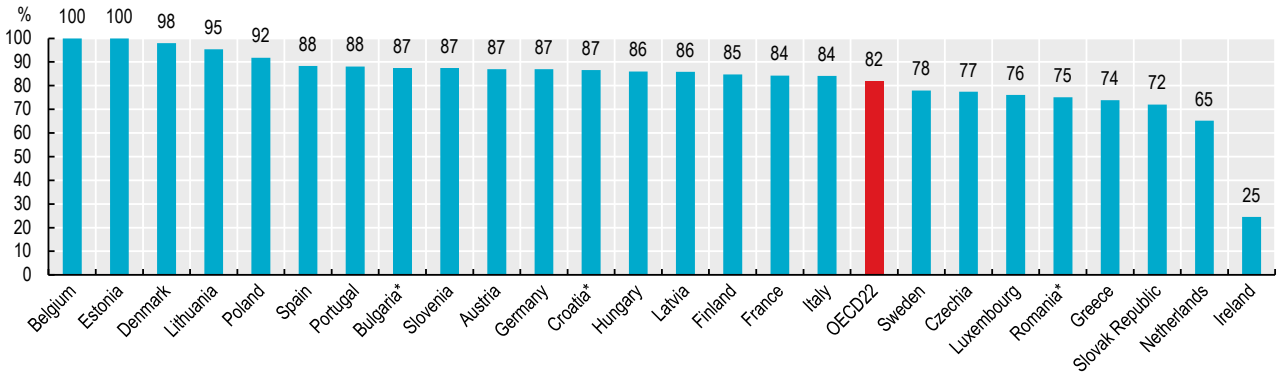
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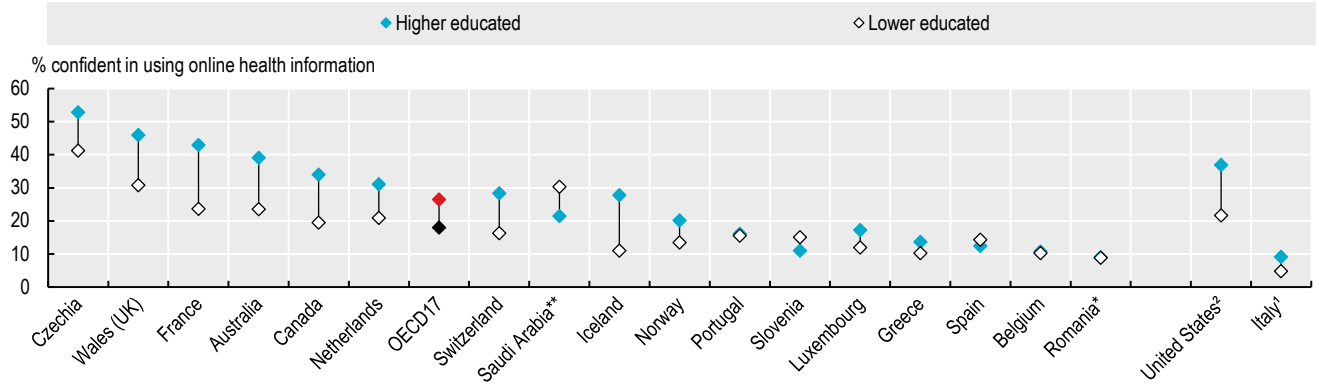
Figure 9.13. Access to electronic health records, 2024



Note: * Accession/partner country.
Source: Digital Economy and Society Index, European Commission 2025.

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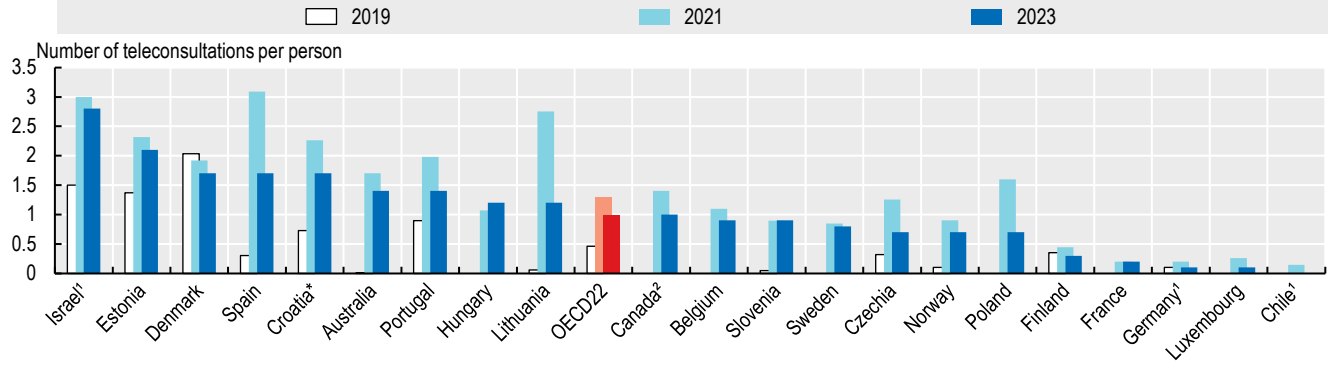
Figure 9.14. Digital health literacy scores by education among primary care users aged 45 and over, 2024



1. Data for Italy refer to patients enrolled in outpatient settings for specialist visits in selected regions. 2. United States sample only includes people aged 65 and over.
* Accession/partner country. **Participated in the PaRIS survey.
Source: OECD PaRIS 2024 Database.

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Figure 9.15. Doctor teleconsultations per person, 2023, 2021 and 2019



1. Public sector only. 2. Latest available data for Canada 2022. * Accession/partner country.
Source: OECD Health Statistics 2025.

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Pharmaceutical knowledge and innovation

Pharmaceutical research and development (R&D) is funded via a mix of private and public sources. Governments typically fund basic and early-stage research through budget allocations, research grants and public ownership of research and higher education institutions. The pharmaceutical industry funds R&D across all phases and most pre-registration clinical trials, but mostly contributes to translating and applying knowledge to develop products, with some support from R&D subsidies or tax credits.

In 2022, governments in the 35 OECD countries for which data are available collectively budgeted USD 73 billion for health-related R&D. While this figure goes beyond pharmaceuticals, it understates total government support, as it excludes most tax incentives and funding for higher education and publicly owned enterprises. The United States accounted for about two-thirds of the total (USD 49.5 billion) and devoted the largest share relative to GDP (Figure 9.16), followed by the United Kingdom (USD 3.7 billion) and Japan (USD 3.3 billion).

In the period 2010-2023, government-allocated budgets for health-related R&D in OECD countries increased by approximately 13% (in real terms), decreasing from a peak in 2020 during the COVID-19 pandemic (+24% since 2010). More specifically, in real terms, OECD countries collectively allocated USD 60 billion on average in the period 2010-2019, reaching a peak of USD 80 billion in 2020, and decreasing to an average of USD 72 billion in the period 2021-2023.

The pharmaceutical industry spent USD 129 billion on R&D in 2022, with the majority again spent in the United States (USD 103.9 billion). Business enterprise expenditure on R&D (BERD) in the pharmaceutical sector has increased by nearly 76% in real terms since 2010. Most of this growth occurred in OECD countries (+60% since 2010), specifically driven by the United States (69% of the OECD total). However, the non-OECD share is increasing. Notably, BERD in China increased from USD 5.0 billion in 2010 (in constant 2015 PPPs) to USD 23.4 billion in 2022 (+365%) – a higher growth rate than in any OECD country.

On average across OECD countries, the pharmaceutical sector accounts for about 8% of total BERD, although this share varies widely between countries (Figure 9.17). In half of OECD countries, business investment in pharma R&D represents less than 5%, while in Switzerland, Slovenia, Denmark and Belgium, the sector's share exceeds 20%, reflecting the significant role the pharmaceutical industry plays in their economies.

Actual R&D activity can be observed through the number of products or medicines in development by therapeutic class and indication of treatment. Between 2013 and 2023, the total number of product-indication combinations that were in active development worldwide more than doubled, to reach 41 370 (Figure 9.18), although this was driven in part by products with multiple indications. In terms of disease focus, product development priorities have not changed dramatically since 2013. Cancer has accounted for the largest share of product indications in development in every year since 2013 and has increased steadily – from 27% of all product-indication pairs in 2013 to 43% in 2023.

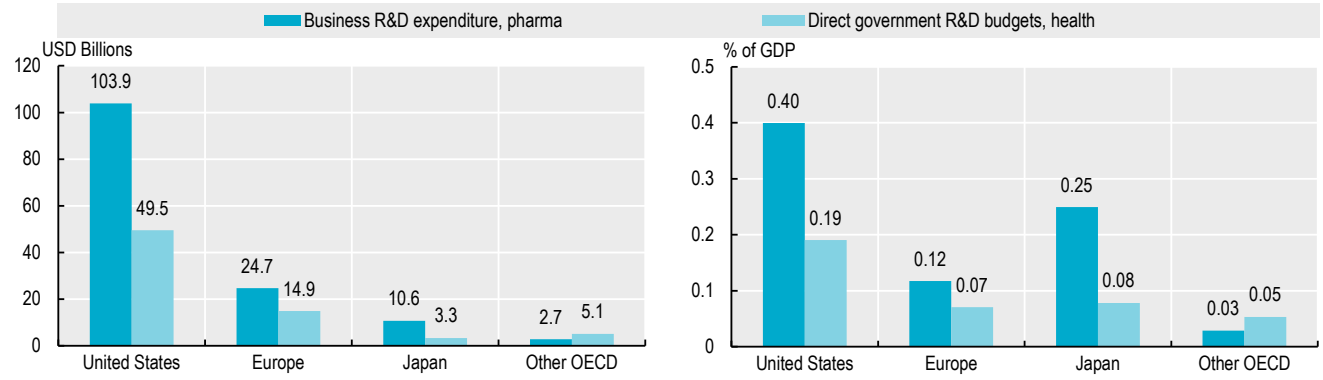
Definition and comparability

Government budget allocations for R&D (GBARD) capture R&D performed directly by the government and amounts paid to other institutions for R&D. Health-related R&D refers to GBARD aimed at protecting, promoting and restoring human health, including all aspects of medical and social care, but excluding spending by public corporations or general university funding subsequently allocated to health.

The OECD's Analytical Business Enterprise Research and Development (ANBERD) database provides annual data on BERD by industry. BERD covers R&D performed by corporations in the country where the activity occurs, regardless of funding source, and is collected by national statistical agencies following the Frascati Manual (with some variation in practice). BERD can be classified either by a firm's main activity (MA) or by the industry orientation (IO) of the R&D performed. The main activity approach assigns all of an enterprise's R&D to the industry of its primary line of business, ensuring consistency with other economic statistics such as value added. However, this can obscure the fact that diversified firms often conduct R&D for multiple industries. Industry orientation instead allocates R&D across the sectors in which it is intended to be applied, providing a more accurate picture of the economic focus of R&D efforts. For this reason, Figure 9.17 uses industry orientation data where available, as it better reflects the distribution of R&D across industries.

Figure 9.18 shows the number of product-indication pairs in active development, as identified in the proprietary AdisInsight database curated by Springer Nature. This database tracks commercial product development projects from discovery to market launch worldwide, based on publicly available information. Compared to *Health at a Glance 2023*, the figures have been adjusted to correct for duplicates and to reflect a refined health category classification.

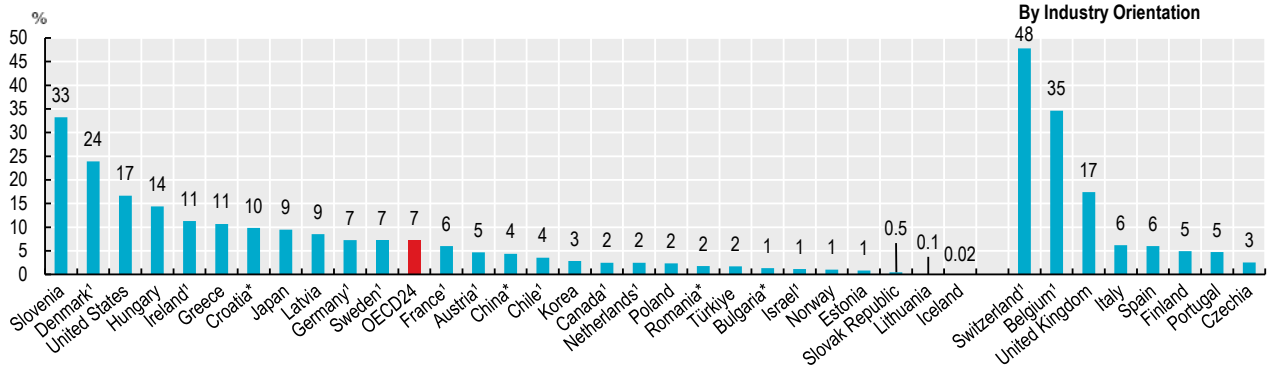
Figure 9.16. Business expenditure on pharmaceutical R&D and government budgets allocated to health-related R&D, 2022 or latest year available



Note: Europe includes 21 European Union Member States that are also OECD countries.
Source: OECD R&D Statistics.

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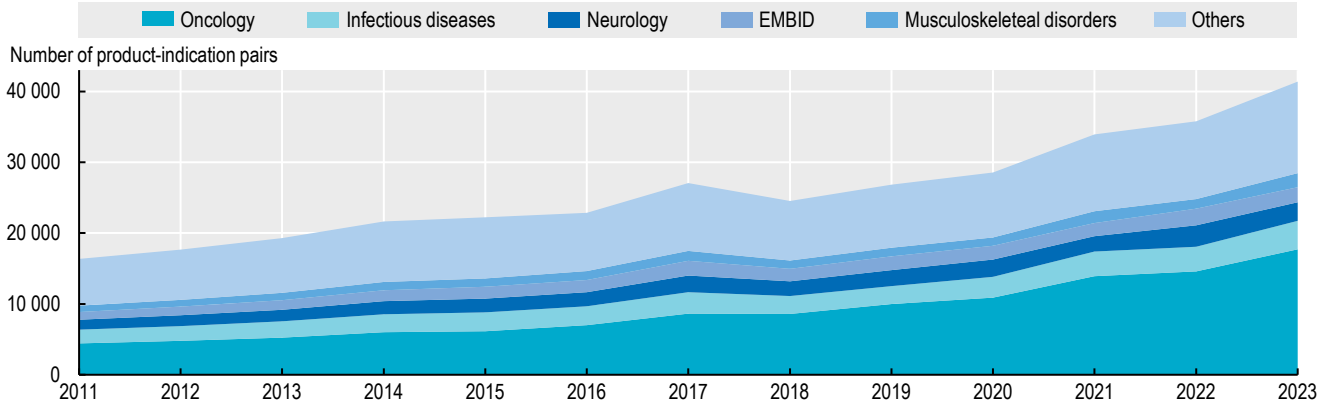
Figure 9.17. Pharmaceutical R&D as a share of business expenditure on R&D, 2022 or nearest year



1. 2020-2021 data. * Accession/partner country.
Source: Analytical Business Enterprise R&D by ISIC Rev.4 industry (ANBERD database). Office of National Statistics (ONS) for the United Kingdom.

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Figure 9.18. Top health categories for medicines in active development worldwide, 2013-2023



Note: Oncology includes malignant neoplasms; EMBID includes endocrine, metabolic, blood and immune disorders; infectious diseases also include parasitic diseases; musculoskeletal disorders includes musculoskeletal and connective tissue disorders.
Source: AdisInsight 2023.

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10 Ageing and long-term care

Demographic trends
Life expectancy and healthy life expectancy at older ages
Self-rated health and disability at age 65 and over
Dementia
Safe long-term care
Access to long-term care
Informal carers
Long-term care workers
Long-term care settings
Long-term care spending and unit costs
End-of-life care

Demographic trends

Over the past 50 years, the share of the population aged 65 and over has doubled on average across OECD countries, increasing from less than 9% in 1960 to 18.5% in 2023. Declining fertility rates and longer life expectancy (see section on "Life expectancy at birth" in Chapter 3) have meant that older people make up an increasing proportion of the population in OECD countries. Across the 38 OECD Member countries, more than 252 million people were aged 65 and over in 2023, including more than 67 million who were at least 80 years old. These demographic trends underscore the need for health systems to adapt and strengthen their capacity to meet the growing and evolving demands of an ageing population.

Across OECD countries, the share of the population aged 65 and over is projected to continue increasing in the coming decades, rising on average from 18.5% in 2023 to 26.4% by 2050 (OECD, 2024[1]) (Figure 10.1, left panel). In five countries (Korea, Japan, Greece, Portugal and Italy), the share of the population aged 65 and over is expected to exceed one-third by 2050. At the other end of the spectrum, the population aged 65 and over in Israel, Mexico, Australia, Colombia and Iceland will represent less than one-fifth of the population in 2050, owing to higher fertility and migration rates.

While the rise in the share of the population aged 65 and over across OECD countries is striking, the increase has been particularly rapid among the oldest group – people aged 80 and over. Between 2023 and 2050, the share of the population aged 80 and over is predicted to double on average across OECD countries – from 4.9% to 9.6% (OECD, 2024[1]) (Figure 10.1, right panel). At least one in ten people may be 80 and over in nearly half (18) of these countries by 2050, including five countries (Korea, Japan, Greece, Portugal and Italy) where more than one in eight people may be 80 and over.

While most OECD accession and Key Partner countries have a younger age structure than many Member countries, population ageing will nonetheless occur rapidly in the coming years, and sometimes at a faster pace than among OECD countries. In China, the share of the population aged 65 and over is likely to increase much more rapidly than in OECD countries – more than doubling from 14.3% in 2023 to 30.1% in 2050. The share of the Chinese population aged 80 and over is expected to rise even more quickly, increasing more than four-fold from 2.5% in 2023 to 10.3% in 2050. Brazil – whose share of the population aged 65 and over was slightly more than half the OECD average in 2023 – will see similarly rapid growth, with nearly 22% of the population projected to be aged 65 and over by 2050. The speed of population ageing has varied markedly across OECD countries, with Greece, Chile and Lithuania experiencing rapid ageing over the past three decades. In the coming years, Korea is projected to undergo the most rapid population ageing among OECD countries, with the share of the population aged 80 and over increasing almost fourfold – from below the OECD average in 2023 (4.4% versus 4.9%) to well above it (16.5% versus 9.6%) by 2050.

Despite the gains in healthy life expectancy seen in recent years (see section on "Life expectancy and healthy life expectancy at older ages"), health systems will have to adapt to meet the needs of an ageing population, which are likely to include greater demand for labour-intensive long-term care (LTC) and more integrated person-centred care. These trends are placing and will place significant pressure on countries' fiscal capacities to provide adequate LTC. Despite public benefits, out-of-pocket costs can be substantial in some countries, especially for those with severe care needs and low incomes. Eliminating these costs would require a 6% annual increase in LTC spending until 2050 (OECD, 2024[1]). It would also require investing in the people who provide care and support. The COVID-19 pandemic further exposed the workforce shortcomings of the LTC sector. While the total number of LTC workers has increased in a number of countries, it has not kept pace with population ageing (see section on "Long-term care workers"). These shortages are closely tied to poor job quality as care work is physically and emotionally demanding, often poorly paid and lacking in social recognition (OECD, 2023[2]). Addressing these challenges will require co-ordinated reforms across health, labour and social policy systems to build integrated and sustainable LTC systems.

Definition and comparability

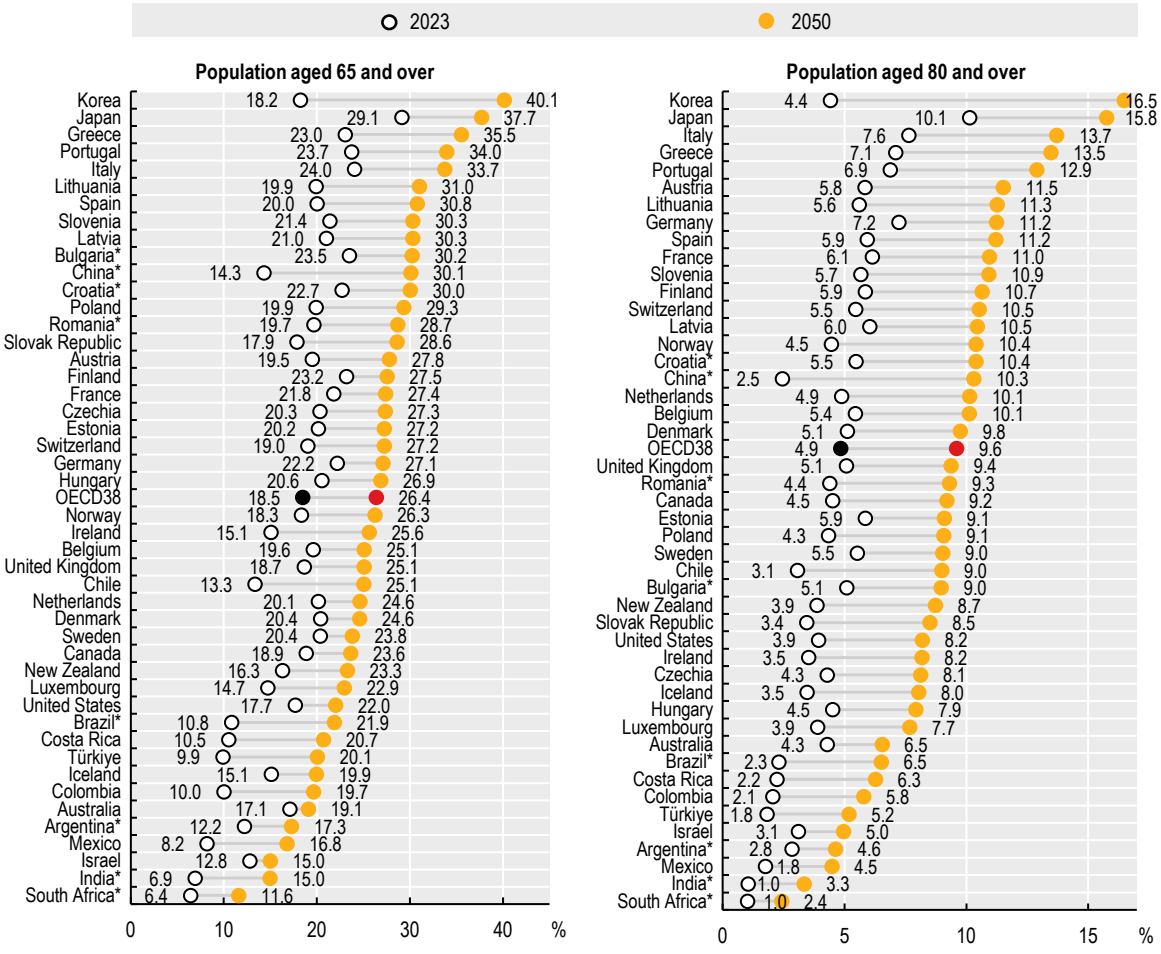
Data on population structure have been extracted from the OECD Historical Population Data and Projections (1950-2060) Database. The projections are based on the most recent "medium-variant" population projections from the United Nations World Population Prospects – 2022 Revision, complemented by national projections, Economic Commission for Latin American and the Caribbean population estimates and projections, and Eurostat population projections.

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OECD (2023), *Beyond Applause? Improving Working Conditions in Long-Term Care*, OECD Publishing, Paris, https://doi.org/10.1787/27d33ab3-en. [2]

Figure 10.1. Share of the population aged 65 and over and 80 and over, 2050 and 2023



* Accession/partner country.

Source: OECD Health Statistics 2025; OECD Historical Population Data and Projections Database, 2025.

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Life expectancy and healthy life expectancy at older ages

All OECD countries have experienced considerable gains in life expectancy at age 65 in recent decades. On average across OECD countries, people at age 65 in 2023 could expect to live a further 20 years (Figure 10.2). Life expectancy at age 65 increased by 6 years between 1970 and 2023, and by 2.8 years between 2000 and 2023, with all countries experiencing positive growth. Six countries (Korea, Ireland, Estonia, Slovenia, Portugal and Israel) enjoyed gains of at least 3.5 years between 2000 and 2023; five countries (the United States, Germany, Costa Rica, Hungary and Mexico) experienced an increase of less than 2 years over this time period.

Life expectancy at age 65 has continued to rise over the past decade, but the pace of improvement has slowed. Most countries saw gains of less than one year between 2013 and 2023. This overall deceleration partly reflects the lingering impact of the COVID-19 pandemic, which temporarily disrupted upward trends in many countries, but it also reflects slowing advances in cutting heart disease and stroke (see section on "Life expectancy at birth" in Chapter 3). Greece, Hungary, Germany, Austria and Finland recorded less than 0.3 years of growth, and Türkiye experienced negative growth. In contrast, 11 countries including Korea, Chile, Israel, Ireland and Lithuania experienced gains of over one year between 2013 and 2023. Japan, Spain, France and Switzerland continue to rank among the countries with the highest life expectancy at age 65 – with rates approaching or exceeding 22 years in 2023.

Life expectancy at age 65 is around 3.4 years higher for women than for men. This gender gap has not changed substantially since 2000, when life expectancy at age 65 was 3.5 years higher for women than men. Among OECD countries, life expectancy at age 65 in 2023 was highest for women in Japan (28.9 years) and for men in Israel (25.5 years). It was lowest for women in Mexico (20.2 years) and for men in Latvia (15.7 years).

While most OECD countries experienced gains in life expectancy at age 65 between 2013 and 2023, not all additional years are lived in good health. The number of healthy life-years at age 60 varies substantially across OECD countries (Figure 10.3). The World Health Organization (WHO) defines health-adjusted life expectancy as "the average number of years that a person can expect to live in 'full health' by taking into account years lived in less than full health due to disease and/or injury" (WHO, 2023[1]). On average across OECD countries, the number of healthy life-years expected at age 60 was 18.3 for women and 16.2 for men in 2021 – a noticeably smaller difference between men and women than that for general life expectancy at age 65. Japan, Korea and Spain report over 20 years of good health for women and Israel, Iceland and Japan over 18.7 for men. In contrast, healthy life expectancy is under 15.6 years for women in Mexico, Hungary, the Slovak Republic and Türkiye, and under 12.5 years for men in Latvia, Hungary, Lithuania and the Slovak Republic, indicating fewer years in good health. OECD accession/partner countries report the lowest levels. Women in South Africa, India and Indonesia live under 13 healthy years, while men fall below 12 in South Africa, Bulgaria, Indonesia, India and Romania.

Ensuring that gains in life expectancy translate into healthier years requires policy action. Recent OECD work shows that investing in prevention, health system adaptation, home care, and community-based care can improve health and longevity while also contributing to savings and economic growth (OECD, 2025[2]).

Definition and comparability

Life expectancy measures how long on average a person of a given age can expect to live if current death rates do not change. However, the actual age-specific death rate of any particular birth cohort cannot be known in advance. If rates are falling, as has been the case over recent decades in OECD countries, actual life spans will be higher than life expectancy calculated using current death rates. The methodology used to calculate life expectancy can vary slightly between countries. This can change a country's estimates by a fraction of a year. Data for life expectancy at age 65 come from Eurostat for European Union (EU) countries. For non-EU OECD countries the data come from OECD Health Statistics 2025, where the OECD Secretariat calculates life expectancy at age 65 for all OECD countries, using an unweighted average of life expectancy of men and women.

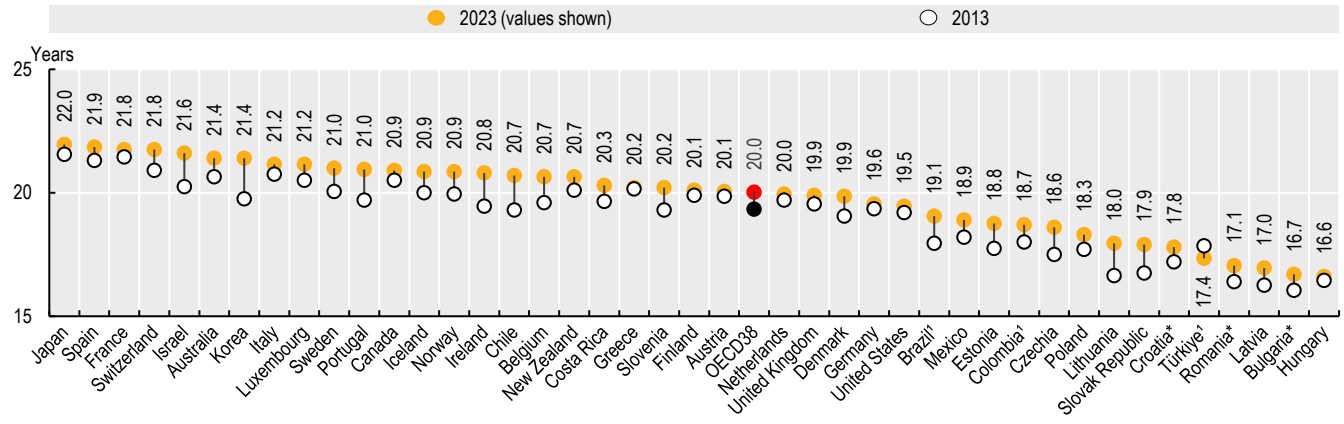
Healthy life-years at age 60 is defined as the average number of years in full health a person can expect to live based on current rates of ill-health and mortality. This indicator is calculated by the WHO Global Health Observatory and is released every five years. The latest data available are from 2021. Acknowledging the conceptual differences in the measures of healthy life expectancy between the EU and the WHO, this section refers to "good health" as a more general term to appeal to the broader audience.

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WHO (2023), *Healthy life expectancy (HALE) at birth*, https://www.who.int/data/gho/indicator-metadata-registry/imr-details/66. [1]

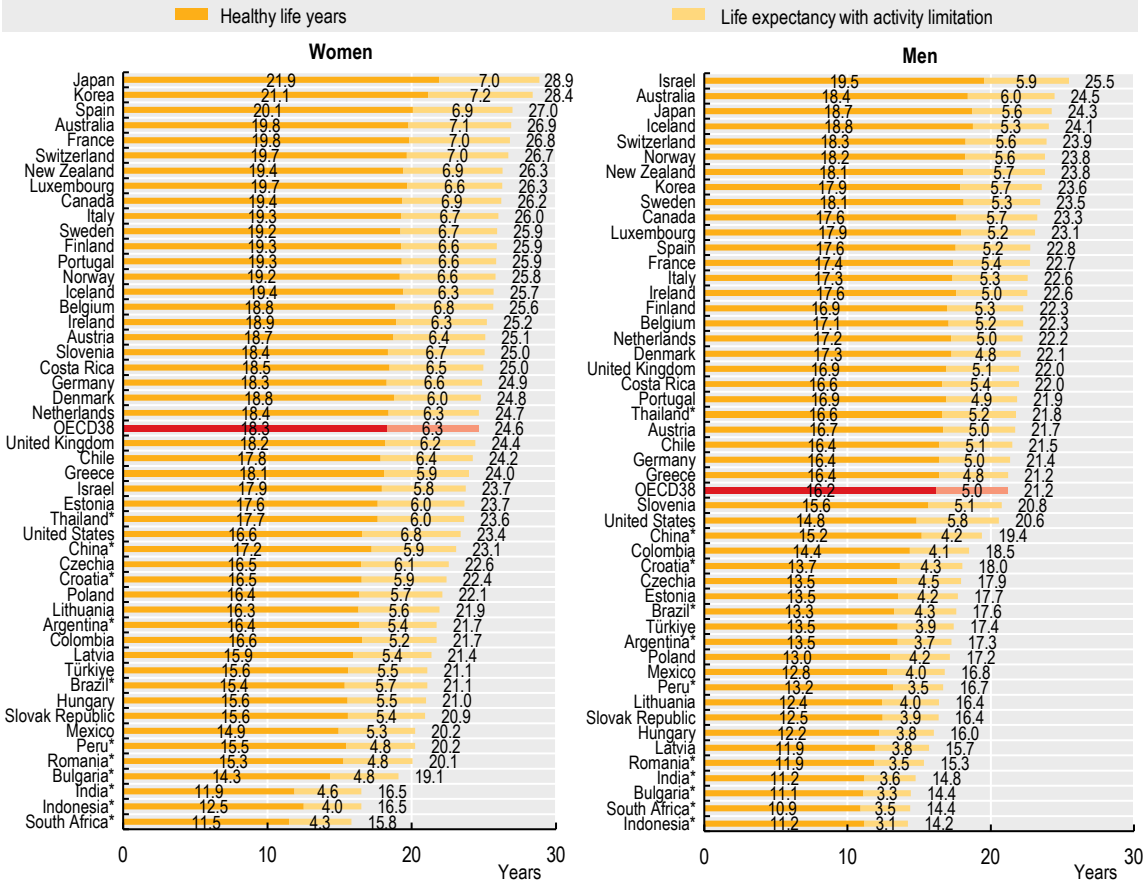
Figure 10.2. Life expectancy at age 65, 2023 and 2013 (or nearest year)



1. Latest data from 2020-2022. * Accession/partner country.
Source: OECD Health Statistics 2025, Eurostat 2025 for EU countries plus Iceland, Norway and Switzerland.

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Figure 10.3. Healthy life expectancy at age 60, 2021



* Accession/partner country.
Source: WHO Global Health Observatory 2025. Values may differ from national estimates.

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Self-rated health and disability at age 65 and over

Even as life expectancy at age 65 has increased across OECD countries, not all older adults (or those aged 65 and over) spend their remaining years in good health (see section on "Life expectancy and healthy life expectancy at older ages"). In all OECD countries with available data, more older people in the lowest income quintile rate their health as poor than those in the highest quintile (Figure 10.4). Across 24 OECD countries on average, one in four (22.8%) people in the lowest income quintile reported their health to be poor or very poor in 2024, compared to one in ten (9.7%) among those in the highest income quintile.

In ten countries, people in the lowest income quintile were at least two and a half times as likely as those in the highest quintile to report having poor or very poor health, while in five countries – Slovenia, Czechia, Estonia, the Netherlands and Lithuania – people in the poorest quintile were more than three times as likely to report living in poor health. In Switzerland, however, the lowest shares of older people reported being in poor health across OECD countries for both the lowest (7.1%) and highest (2.8%) income quintiles. In five countries (Finland, Italy, Luxembourg, Poland, Spain and the Slovak Republic), older adults in the poorest income quintile were less than twice as likely to report being in poor health.

Across 27 OECD countries in 2022, slightly more than one in five people aged 65 and over reported having at least some limitations in their activities of daily living (ADL) and instrumental activities of daily living (IADL): 19% reported some limitations and a further 3% reported severe limitations (Figure 10.5). Many of the countries reporting the highest rates of self-rated poor or very poor health also reported some of the highest rates of limitations in ADL/IADL. In Hungary, Portugal, Belgium and England (United Kingdom), more than 24% of adults aged 65 and over reported at least some limitations in ADL/IADL. In Korea, Ireland, and Luxembourg, less than 13% of adults in the same age group reported such limitations. In four countries – Japan, Spain, Lithuania and Portugal – more than 7% of adults aged 65 and over reported experiencing severe limitations in ADL/IADL. Overall, Japan, Portugal, Lithuania and Spain account for the highest levels of self-reported limitations in ADL/IADL, approaching or surpassing 30% in total.

In 2024, 83% of primary care users aged 65 and over with at least one chronic condition across 17 OECD countries reported their social functioning as good, very good, or excellent (Figure 10.6). The highest share was observed in Switzerland (92%), with seven other countries also reporting shares above 85% – France, Canada, the United States, Slovenia, Belgium, Luxembourg and Czechia. In contrast, fewer than 80% of older primary care users reported at least good social functioning in Spain, Wales (United Kingdom) and Italy, with the lowest share observed in Portugal (70%) and in accession country Romania (70.9%).

Definition and comparability

Figure 10.4 is based on the European Union Statistics on Income and Living Conditions (EU-SILC) data. Self-reported health reflects people's overall perception of their own health, including both physical and psychological dimensions. Perceived health status by income quintile is derived from the respondent's self-perceived health, which expresses a subjective assessment of his/her health. Data for income-based inequalities in perceived health status looked at the difference in the proportion of adults 65 and over reporting their health to be poor or very poor and excluding individuals who perceived their health status to be fair.

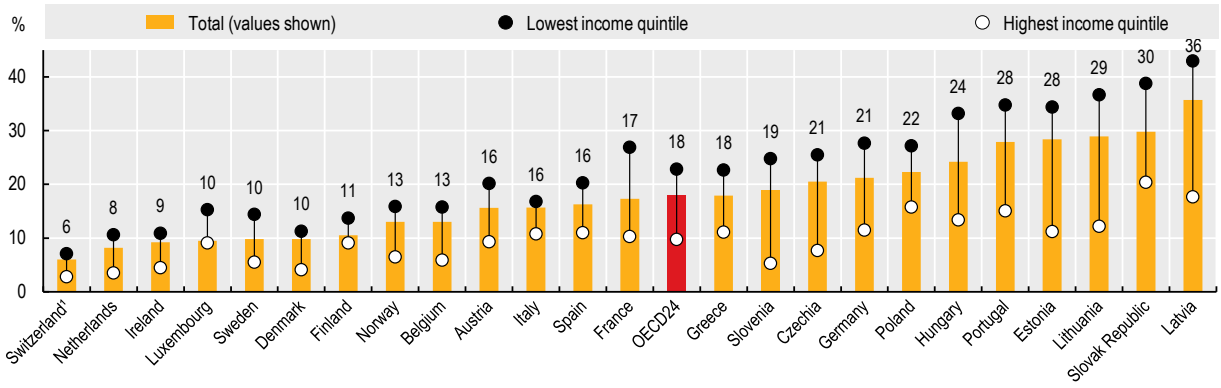
Limitations in daily activities assesses an individual's independence across both ADL and IADL. These limitations are classified into two groups: "some limitations", which refers to individuals presenting low or moderate care needs, and "severe limitations," for those exhibiting severe care needs. Assessment of these need levels is derived from the methodology used and described in OECD (2024[1]). It employs an average of two matching methods to align typical cases with self-reported difficulties in performing ADL and IADL. The microdata used are from multiple datasets, which prioritise the inclusion of ADL and IADL; however, some inherent differences in their definitions may exist. For a more detailed explanation see OECD (2024[1]).

Caution is required in making cross-country comparisons of perceived health status or social functioning, as people's self-assessments are subjective and can be affected by cultural factors. Perceived social functioning is based on responses to the question: "In general, please rate how well you carry out your usual social activities and roles," with answer options ranging from poor to excellent. Data come from the OECD Patient-Reported Indicator Surveys (PaRIS) 2024 survey, using the PROMIS® Scale v1.2 – Global Health item on social functioning. Comparability is somewhat limited for Italy, as different samples were used.

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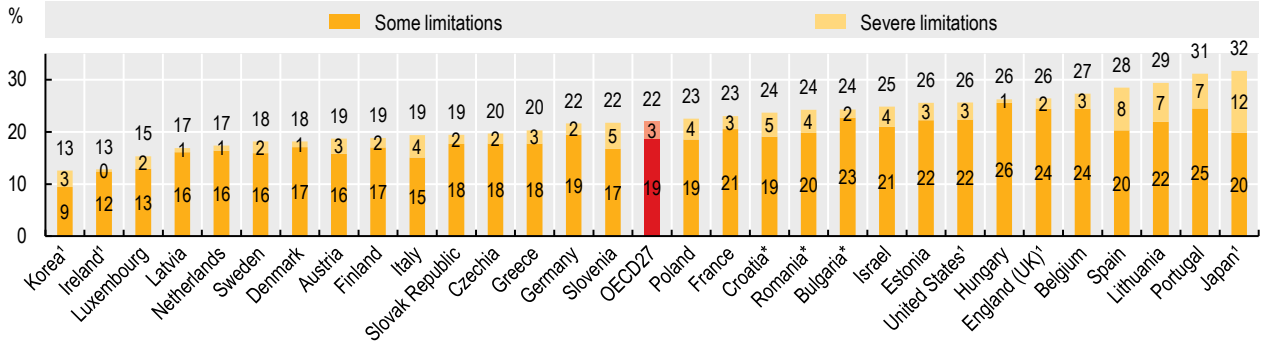
Figure 10.4. People aged 65 and over rating their health as poor or very poor, by income quintile, 2024 (or nearest year)



1. 2023 data.
Source: Eurostat, based on EU-SILC.

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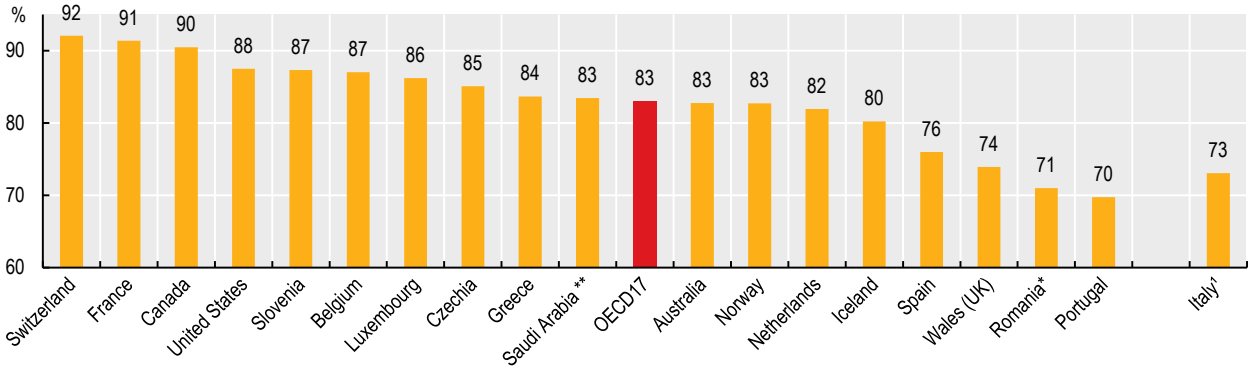
Figure 10.5. Activities of daily living and instrumental activities of daily living limitations in adults aged 65 and over, 2021-2022 (or nearest year)



1. 2017-2019 data. * Accession/partner country.
Source: SHARE wave 9 (2021-2022); ELSA, wave 9 (2019), for the United Kingdom; HRS (2018) for the United States; KLoSA (2018) for Korea; SSJDA (2017) for Japan, TILDA wave 5 (2018) for Ireland.

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Figure 10.6. Primary care users aged 65 and over with at least one chronic condition reporting their social functioning as good, very good or excellent, 2024



Note: Using data instrument PROMIS® Scale v1.2. See definition and comparability box for more information. * Accession/partner country. ** Participated in the PaRIS survey. 1. Data for Italy refer to patients enrolled in outpatient settings for specialist visits in selected regions.
Source: OECD PaRIS 2024 Database.

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Dementia

Dementia is a major global challenge of population ageing. It covers brain disorders including Alzheimer's disease, which progressively damages and kills brain cells, causing a gradual deterioration of a person's functional capacity and social relations. To date, there is no cure and disease-modifying treatments only slow progression of the condition at the risk of side-effects.

As countries age, the number of people living with dementia is also expected to increase. Across 19 OECD countries, 61 people per 1 000 population aged 65 and over were estimated to be living with dementia in 2023 (Figure 10.7), ranging from 24 per 1 000 population in Colombia to 122 per 1 000 in Japan – although differences in diagnostic rates, definitions and measurements hamper international comparability.

At least 24 of 29 OECD countries have stand-alone dementia plans aimed at improving the prevention, diagnosis and care delivered to people with dementia (OECD, forthcoming[1]). Dementia prevention remains a challenging area, although around 45% of dementia cases on the globe are subject to modifiable risk factors, such as chronic disease management (Livingston et al., 2024[2]). Early intervention can delay dementia's progression but requires early diagnosis. At least 23 OECD countries have diagnostic guidelines to support healthcare workers in recognising symptoms and in streamlining diagnostic pathways.

Recent progress in pharmaceutical research and development has raised new hope in dementia treatment. While these new medications aim at slowing down the progression of Alzheimer's disease, their non-negligible side-effects, unfavourable cost-effectiveness, limited clinical practices and significant administrative burden limit access to the drugs, leading countries to exercise caution in adopting them into healthcare systems. As of July 2025, donanemab (Kisunla) has been approved in Australia, Japan, Mexico, the United Kingdom and the United States, and lecanemab (Leqembi) has been approved in the European Union, Israel, Japan, Korea, the United Kingdom and the United States, with reimbursement status varying by country.

In treating mild to moderate dementia, multidimensional lifestyle interventions (such as the Finnish Geriatric Intervention Study to Prevent Cognitive Impairment and Disability (FINGER)), and non-pharmacological approaches (such as physical and music therapy) have shown promising results. However, the level of implementation differs across countries.

As the illness advances, many people with dementia experience behavioural and psychological symptoms. Non-cognitive symptoms should be managed with non-pharmacological methods first; short-term antipsychotics are recommended only when these fail and the risks of non-treatment outweigh potential harms.

However, inappropriate use of these drugs remains widespread, and reducing their overuse is a policy priority. Across 17 OECD countries, an average of 54 per 1 000 people aged 65 and over were prescribed antipsychotic medicines. In 2023, antipsychotic prescribing varied by a factor of almost six across these OECD countries, from just 16 prescriptions per 1 000 people aged 65 and over in Sweden to more than 90 prescriptions per 1 000 in Slovenia. Moreover, age-standardised rates of antipsychotic prescribing were 27% higher for women than for men across the 17 OECD countries (Figure 10.8).

Definition and comparability

The OECD is currently performing a pilot data collection on dementia to better understand variations in data reporting across OECD countries and to move towards internationally comparable data. Several OECD countries have built nationwide patient registries (e.g. England (United Kingdom) and Norway) and dementia registries (e.g. Sweden, forthcoming in Ireland) that facilitate identification of people who have been diagnosed with dementia.

Dementia prevalence data are collected from the pilot data collection and national sources. Some countries provide data based on estimates, while others use patient-registered data. These two approaches differ. Estimated data may overestimate prevalence, as they include projections based on population characteristics and assumptions. In contrast, registered data includes only officially diagnosed cases, which may understate the true number due to underdiagnosis or gaps in reporting.

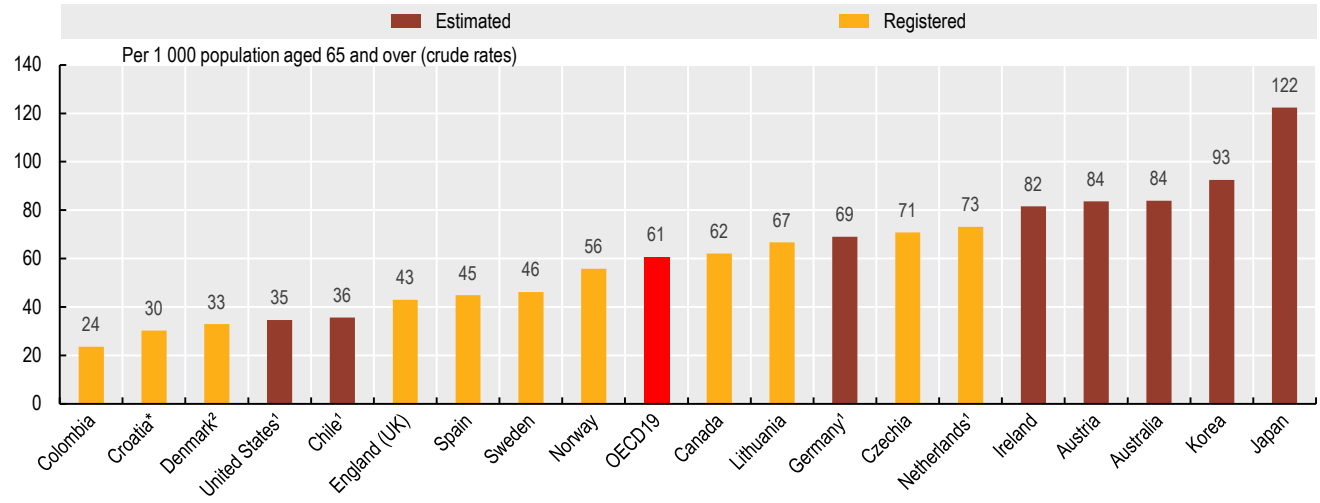
Antipsychotics are defined consistently across countries using the WHO Anatomical Therapeutic Chemical (ATC) classification. The numerator includes all patients on the medications register with a prescription for a drug within ATC subgroup N05A. The denominator is the total number of people on the register. Most countries are unable to identify which prescriptions relate to people with dementia, so the antipsychotics indicator covers all people aged 65 and over. Caution is needed when making inferences about the dementia population, since a higher rate of prescribing among all those aged 65 and over translates into more prescriptions for people with dementia. Nonetheless, measuring this indicator, exploring the reasons for variation and reducing inappropriate use can help to improve the quality of dementia care.

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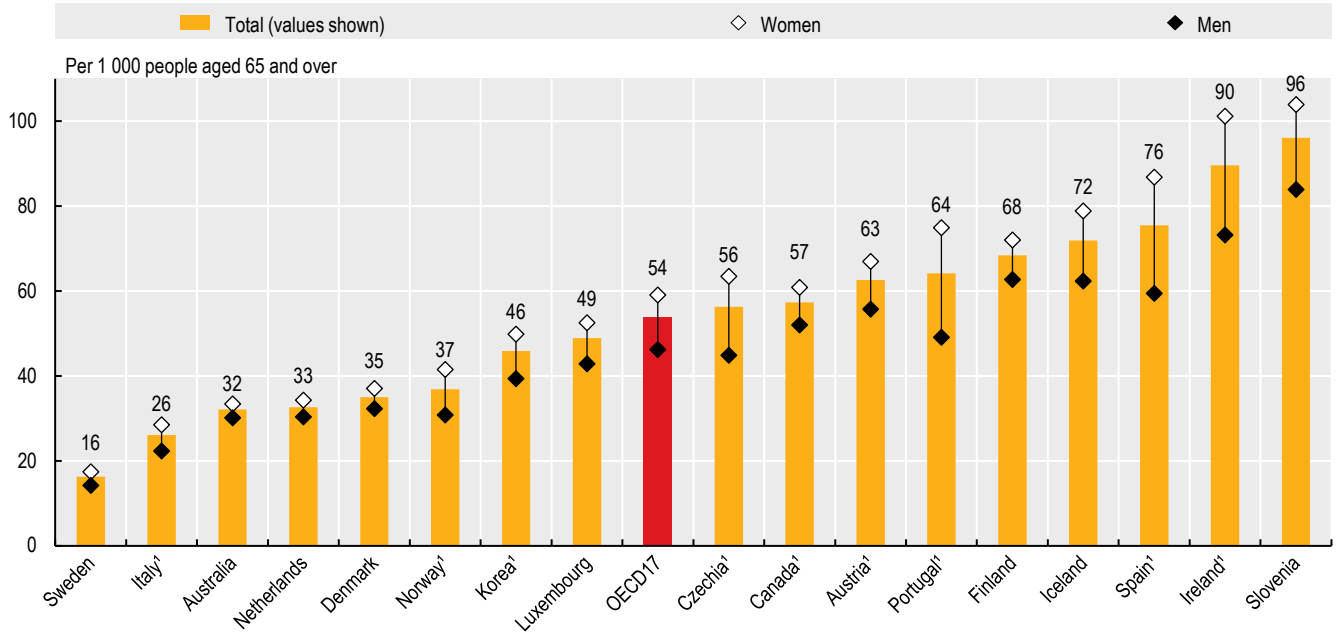
Figure 10.7. Estimated and registered dementia prevalence among people aged 65 and over, 2023 (or nearest year)



1. 2024-2025 data. Definitions vary across countries (see the "Definition and comparability" box). * Accession/partner country.
Source: Pilot data collection from OECD Healthcare Quality and Outcomes. National sources include: GÖG (Hg.) (2025), *Österreichischer Demenzbericht 2025* (Austria); Canadian Chronic Disease Surveillance System (CCDSS) (2025), Dementia, including Alzheimer's disease; Observatorio Social (2022), *Encuesta Discapacidad y Dependencia* (Chile); Danish Dementia Research Centre (2025), *Incidence and prevalence of dementia in Denmark*; Rommel, A. et al. (2025), "Dementia – Prevalence, trends and regional patterns in Germany. An analysis based on routine data from the statutory health insurance", *Journal of Health Monitoring*, Vol. 10/1; Ninomiya, T. et al. (2024), *A Study on the Prevalence and Future Projections of Dementia and Mild Cognitive Impairment* (Japan); Ministry of Health and Welfare (2025), *2023 National Survey on Dementia Epidemiology and Prevalence* (Korea); Ministerio de Salud (2023), *Base de Datos Clínicos de Atención Primaria* (Spain); and Kramarow, E. (2024), "Diagnosed dementia in adults age 65 and older: United States", *National Health Statistics Reports*, no. 203.

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Figure 10.8. Antipsychotic prescribing rates, 2024 (or nearest year)



Note: Data include both people with and without dementia. 1. 2023 data.
Source: OECD Health Statistics 2025.

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Safe long-term care

The LTC sector faces growing demand for expert care due to ageing populations with complex conditions and functional needs. Ensuring safety is not only about preventing harm but also about promoting trust, quality of life and effective delivery of care.

A major concern for LTC safety is healthcare-associated infections (HAIs) caused among other things by antibiotic-resistant bacteria. HAIs are generally considered to be preventable with standard infection prevention and control measures, but can still adversely affect older adults living in LTC facilities (OECD/WHO, 2022[1]). Across 16 OECD countries, 3.2% of LTC facility residents had at least one HAI in 2023-2024 (Figure 10.9). The reported prevalence was high in Portugal, Spain and the Netherlands (over 5%).

The use of benzodiazepines also comes with safety risks. For older people, most guidelines advise complete avoidance of benzodiazepines because of the associated risks of dizziness, confusion and falls. Even so, benzodiazepines continue to be prescribed for older adults for anxiety and sleep disorders. Long-term use of benzodiazepines can lead to adverse events (overdoses), tolerance, dependence and dose escalation. Long-acting (as opposed to short-acting) benzodiazepines are further discouraged for older adults because they take longer for the body to eliminate (OECD, 2017[2]).

Benzodiazepine use declined across 18 OECD countries, with chronic use dropping from 33 to 27 per 1 000 people aged 65 and over in 2013-2023, on average (Figure 10.10, left panel). In 2023, figures ranged from below 1 in Italy to 92.8 in Iceland. Iceland saw the largest decline (34 fewer patients per 1 000 population) but remained the top user. Luxembourg and Estonia showed slight increases. For long-acting benzodiazepines, the OECD average fell from 64 to almost 42 per 1 000 in 2023 (Figure 10.10, right panel). Italy and Finland had relatively low rates, at less than 5 per 1 000 population, while the rates exceeded 90 in Spain, Korea and Estonia. Korea, Estonia and Iceland recorded the largest declines in long-acting benzodiazepine use. Spain had the highest use and was the only country to increase by 7 per 1 000 between 2013 and 2023. The variation is partly due to different reimbursement and prescribing policies, disease prevalence and treatment guidelines.

Owing to multimorbidity and complex care needs, older patients often take multiple medications for extended periods. Although there are justifiable cases of polypharmacy, inappropriate use increases the risk of adverse drug events, medication errors and harm – leading to falls and episodes of confusion and delirium. Across 16 OECD countries, the share of adults aged 75 and over taking at least five medications has increased by 2.6 percentage points (p.p.) from 2014 to 2024. Türkiye, Denmark and Austria reported the lowest rates in 2024, at less than 30%, while Australia reported the highest rates at 77%, followed by Portugal, Korea, Italy and Ireland at more than 63% (Figure 10.11). These large variations are explained in part by the establishment of targeted polypharmacy initiatives in some countries, including related reimbursement and prescribing policies. Over time, the Netherlands experienced the largest decline of 6.3 p.p. in polypharmacy, followed by Australia and Denmark. In contrast, Türkiye and Slovenia both experienced an increase of 8 p.p.

Definition and comparability

Data on HAIs are from the point prevalence survey (PPS) of healthcare-associated infections and antimicrobial use from the European Centre for Disease Prevention and Control (2025[3]). The crude HAI prevalence indicates the percentage of LTC facility residents with at least one active HAI detected on the day of the PPS over the total number of eligible residents on the day. Caution is advised due to variations in the methodology in some countries, LTC facility participation and sample representativeness.

Data on trends in benzodiazepines for chronic and long-acting use, and data on the proportion of people aged 75 and over taking more than five medications concurrently, are collected throughout the OECD Healthcare Quality and Outcomes data collection biannually. Denominators comprise the population aged 65 and over with at least one prescription for benzodiazepines for chronic and long-acting use, and the population aged 75 and over with at least one prescription for the proportion of the population taking more than five medications concurrently, rather than the general population. Further information on sources and methods is available in the OECD Data Explorer. See the “Definition and comparability” box in the section on “Safe prescribing in primary care” in Chapter 6 for additional details regarding the definition and comparability of prescription data across countries.

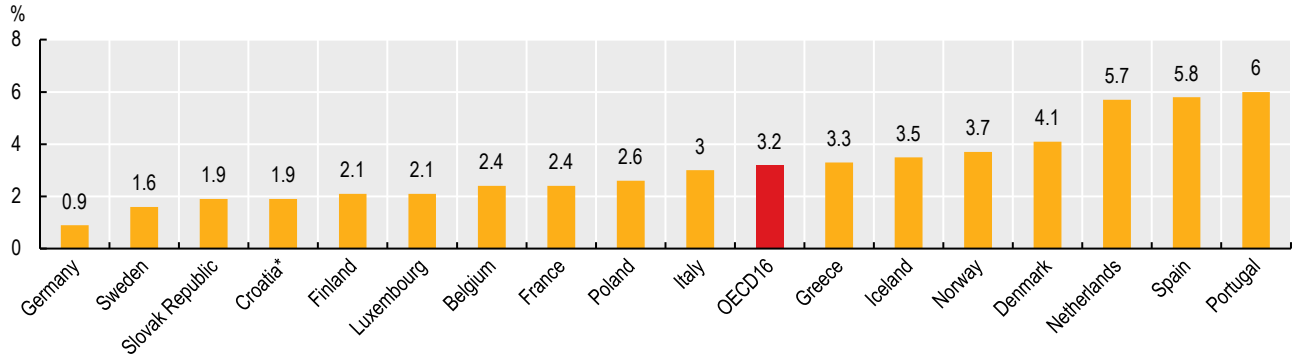
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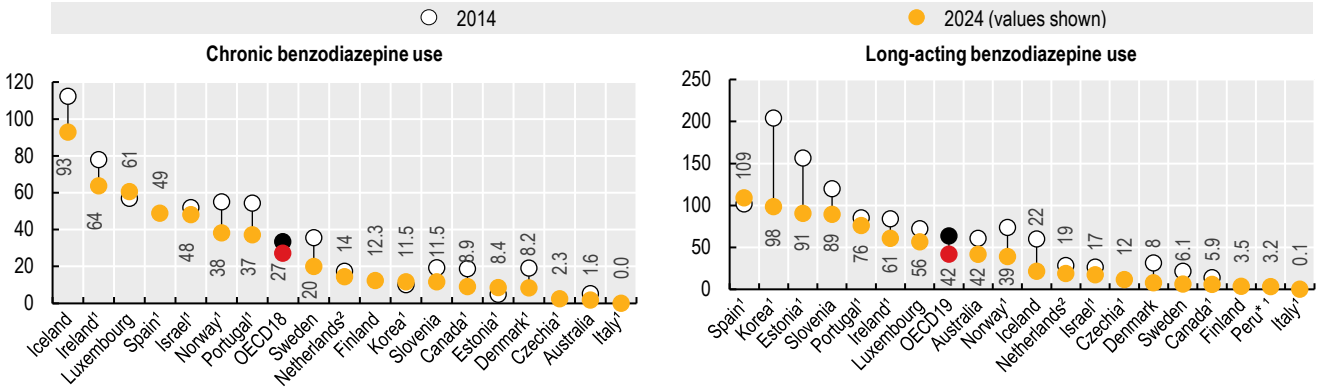
Figure 10.9. Prevalence of healthcare-associated infections per 100 residents in long-term care facilities, 2023-2024



* Accession/partner country.
Source: European Centre for Disease Prevention and Control (ECDC).

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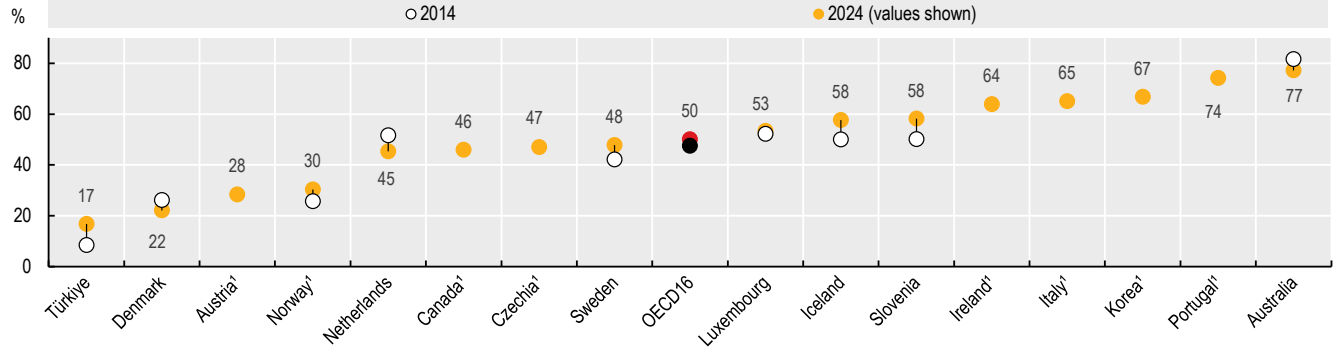
Figure 10.10. Benzodiazepine use per 1 000 patients aged 65 and over, 2024 and 2014 (or nearest year)



1. Latest data from 2021-2023. 2. Data for 2018 instead of 2014. * Accession/partner country.
Source: OECD Health Statistics 2025.

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Figure 10.11. People aged 75 and over taking more than five medications concurrently, 2024 and 2014 (or nearest year)



1. Latest data from 2023.
Source: OECD Health Statistics 2025.

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Access to long-term care

Across 31 OECD countries, an average of 12% of people aged 65 and over received LTC, either at home or in LTC facilities, in 2023 (Figure 10.12). In four OECD countries (Lithuania, Israel, Switzerland and Germany) more than one in five of the population aged 65 and over received LTC services. Cultural norms around the degree to which families look after older people may also affect the use of formal services (see section on "Informal carers"). On average, the share of LTC beneficiaries aged 65 and over slightly increased by 1 p.p. from 11% in 2013. It increased by more than 8 p.p. in Lithuania, Germany, Israel and Spain, while a drop of 2% or more was observed in the Netherlands, New Zealand, Denmark and Hungary.

Many people in need of LTC wish to remain in their homes for as long as possible. In response to these preferences, many OECD countries have developed services to support home-based care for older adults. Between 2013 and 2023, the proportion of LTC recipients who received care at home across 23 OECD countries increased slightly, from 66% to 70% (Figure 10.13). Increases were particularly large in Germany, Korea, Spain and Switzerland.

Changes in needs assessment and eligibility criteria contribute to some of the changes in the share of LTC beneficiaries since the 2010s (Llena-Nozal, Araki and Killmeier, 2025[1]). In 2017, Germany expanded the definition of LTC needs to expand support for people with cognitive impairments, which improved the accessibility of LTC insurance benefits. Spain has added an additional care level since 2015, to expand support to people with moderate dependency to have access to public benefits. On the other hand, a 2015 reform in the Netherlands transferred some responsibilities for LTC provision to local authorities, contributing to a substantial decrease in residential care recipients. In New Zealand, the provision of home care was effectively rationed, as home care providers limited the supply of services to manage operational costs and absorb wage increases under the Pay Equity Settlement, which mandated legal pay rises for care workers to address longstanding gender-based pay disparities.

Even where people live with limitations in ADL and IADL, they may not always receive sufficient formal LTC support. Among people aged 65 and over across 22 European countries, 47% of individuals living at home with at least one ADL/IADL limitation – and two in five (38%) people living with three or more ADL/IADL limitations – reported that they either did not receive sufficient informal LTC help, or did not receive formal LTC support (Figure 10.14).

Definition and comparability

LTC recipients are defined as people receiving LTC from paid providers and unpaid providers who receive cash allowances, as well as those receiving other public benefits granted to support people with LTC needs. LTC can be delivered in facilities (institutions) or at home. LTC institutions refer to nursing and residential care facilities that provide accommodation and LTC as a package. LTC at home is defined as people who receive most of their care at home. Home care also applies to the use of institutions on a temporary basis, community care and day care centres, and specially designed living arrangements.

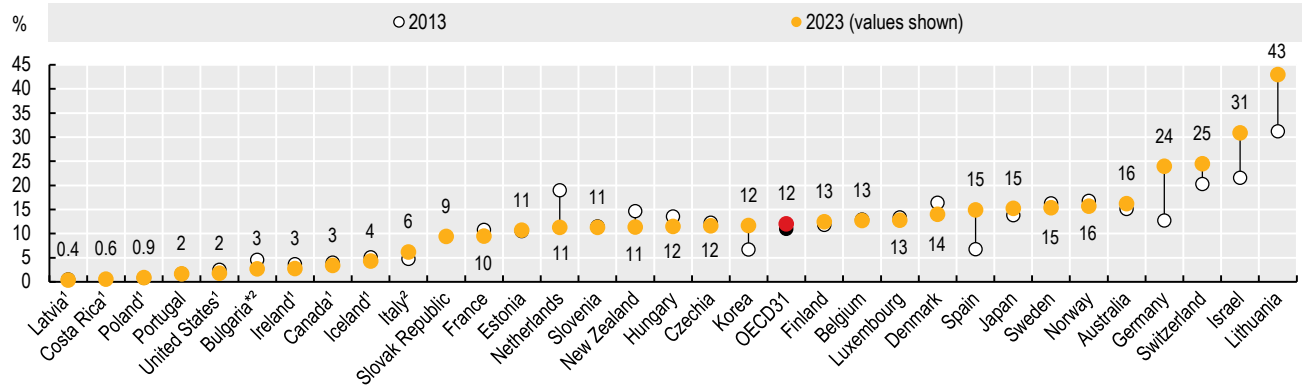
Data for Canada, Costa Rica, Iceland, Ireland, Latvia, Poland and the United States are only available for people receiving LTC in institutions, so the total number of recipients is underestimated. For Japan, the actual number of LTC recipients aged 65 and over are estimated from the Statistics of Long-Term Care Benefit Expenditures (Ministry of Health, Labour and Welfare) and divided by the corresponding populations from the Population Estimates as of 1 October (Statistics Bureau of Japan). For the Netherlands, LTC services by local municipalities (*Wmo*) are not included and so the use of home care is underestimated. For the Slovak Republic, even though data were available for LTC recipients at home in 2021, only data for institutions were used to ensure comparability with 2011.

Data on LTC services can be challenging, and there are some known limitations of the figures. Data for some countries refer only to people receiving publicly funded care, while other countries include people who are paying for their own care. Because data on people receiving care outside public systems are more difficult to collect and may be underreported, figures for countries that rely more heavily on privately funded care may be artificially low. In Portugal, private institutions supported by Social Security are not included, and thus the uptake of LTC services is underreported. For the indicator on unmet LTC needs, the data relate to the population aged 65 and over, based on wave 9 of the Survey of Health, Ageing and Retirement in Europe (SHARE), referring to 2021 and 2022. While there is no internationally accepted definition of unmet LTC needs, SHARE facilitates the estimation of the share of older people reporting limitations in ADL and IADL who did not receive formal home care or sufficient informal care.

References

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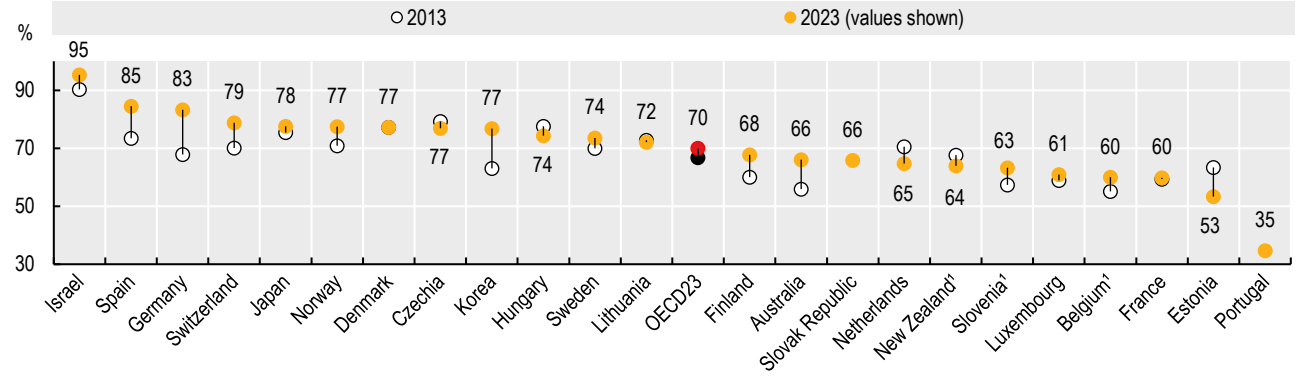
Figure 10.12. People aged 65 and over receiving long-term care, 2023 and 2013 (or nearest year)



Note: Data refer to both institutional and home care recipients, unless otherwise stated. 1. Data for institutional care only. 2. Data for home care only. Latest data from 2020-2022 for Belgium, Costa Rica, New Zealand, Slovenia and the United States; and 2015 for Czechia. * Accession/partner country.
Source: OECD Health Statistics 2025, complemented by national sources.

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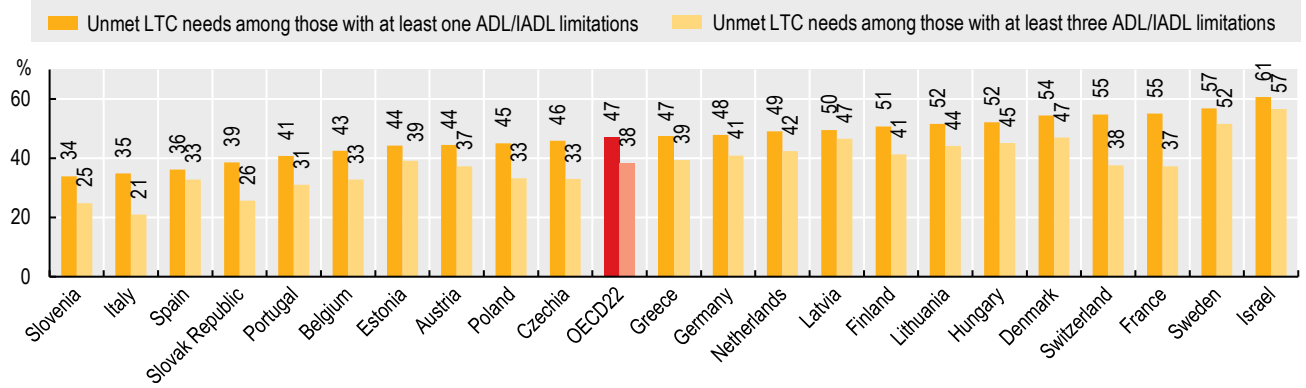
Figure 10.13. Long-term care recipients aged 65 and over receiving care at home, 2023 and 2013 (or nearest year)



1. Latest data from 2020-2022.
Source: OECD Health Statistics 2025, complemented by national sources.

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Figure 10.14. Unmet long-term care needs among people living at home aged 65 and above with some limitations in activities of daily living, 2021-2022



Source: SHARE wave 9 (2021-2022).

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Informal carers

Informal carers are a major source of care for people with LTC needs across OECD countries. Among 19 OECD countries analysed, about 60% of older people reported receiving only informal care (Rocard and Llena-Nozal, 2022[1]). Informal care is provided by family members, friends and people in social networks to individuals who need support with everyday tasks. Due to the informal nature of care, comparable data are difficult to obtain. The data discussed in this section stem from international and national surveys. There are differences in the definition of informal care across these surveys, which affects the comparability of the data (see the "Definition and comparability" box).

Across OECD countries, more than one in eight (13%) people aged 50 and over provided informal care, ranging from 5% in Latvia to more than 20% in Austria and Belgium (Figure 10.15). On average, 6.3% of survey respondents across these countries indicated that they provide informal care on a daily basis, compared to 6.9% providing care on a weekly basis. The percentage share of those providing daily care was highest in Belgium and Germany (9.4%), and lowest in Latvia and Sweden (3%). Among OECD countries, the share of those providing weekly care was highest in Belgium (14.8), and lowest for Latvia (2%).

Informal carers are predominantly women. Across 26 OECD countries, 61% of informal carers were women, ranging from 53% in Spain to 73% in Latvia (Figure 10.16). The share of women was particularly high in Latvia, Lithuania and Greece, where more than 70% of daily informal carers were women. Across OECD accession countries (Croatia, Bulgaria and Romania), 60% or more of informal carers are women.

On average across 24 OECD countries, 11% of daily carers reported being employed or self-employed (outside the informal care they also provide), ranging from more than one-third in the United Kingdom (40%) and Portugal (36%) to a low of 10% or fewer in Luxembourg and the Slovak Republic (Figure 10.17).

Intense provision of informal care is associated with negative effects on mental health and labour market participation, such as a reduction of hours worked and earlier retirement. The estimated impact of informal caregiving and labour market attrition on economic growth reaches 0.5% in annualised terms (Barszczewski et al., forthcoming[2]). About two-thirds of OECD countries have introduced policies to support informal workers and to alleviate the burden of informal care – such as cash benefits paid to carers, those in need of care or both. In addition, about half of OECD countries offer some form of paid leave for informal carers, although this does not necessarily make up for forgone wages. The degree to which countries can depend on informal care as a dominant provider of LTC is likely to decline in the future. Demand for LTC will increase due to population ageing and subsequent increases in LTC needs (see section on "Demographic trends'"). At the same time, declines in family size, increases in geographical mobility and increasing female labour market participation are leading to reductions in the supply of informal carers. Countries will therefore have to expand their formal LTC sectors to compensate for unmet care needs.

Definition and comparability

Informal carers are defined as people providing any help to older family members, friends and people in their social network, living inside or outside their household, who require help with everyday tasks. The data presented here relate only to the population aged 50 and over and are based on national surveys for Australia (Survey of Disability, Aging and Carers – SDAC), the United Kingdom (English Longitudinal Study of Ageing – ELSA) and the United States (Health and Retirement Survey – HRS), and an international survey for European countries (SHARE).

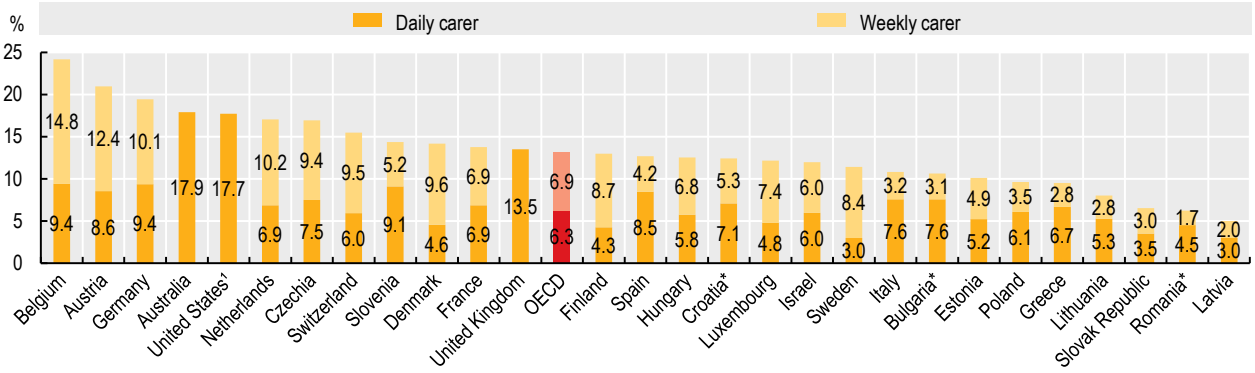
Questions about the intensity of care vary between surveys. In SHARE, carers are asked about how often they provided care in the last year; this indicator includes people who provided care at least weekly. It is important to highlight that the COVID-19 pandemic might have made people recognise their role and identify as informal caregivers. Questions in HRS and SDAC are less comparable with SHARE. Carers in HRS are included if they provided more than 200 hours of care in the last year. In SDAC, a carer is defined as a person who provides any informal assistance, in terms of help or supervision, to people with disabilities or older people (65 and over). The assistance must be ongoing, or likely to be ongoing, for six months or more. People caring for disabled children are excluded in European countries but included in data for the United States and Australia. However, the United States data only include those caring for someone outside their household, while Australia considers all informal carers together (and only primary carers). As a result, data for Australia and the United States may not be comparable with other countries' data

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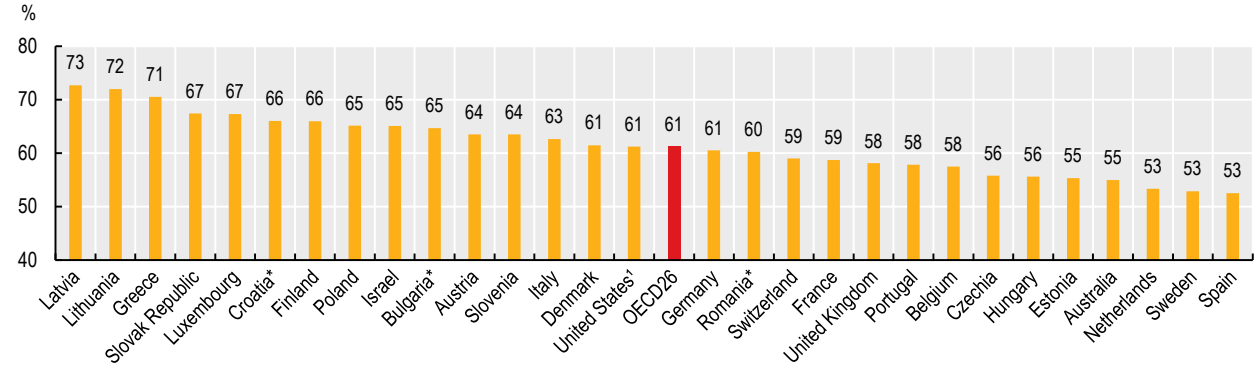
Figure 10.15. People aged 50 and above providing informal care, 2021-2022 (or nearest year)



Note: The definition of informal carers differs between surveys (see the "Definition and comparability" box). Data for the United Kingdom, Australia, the United States refer to informal carers in general. 1. 2018-2019 data. * Accession/partner country.
Source: SHARE wave 9 (2021-2022); SDAC (2022) for Australia; Census-based statistics (2021) for the United Kingdom; HRS wave 14 (2018-2019) for the United States.

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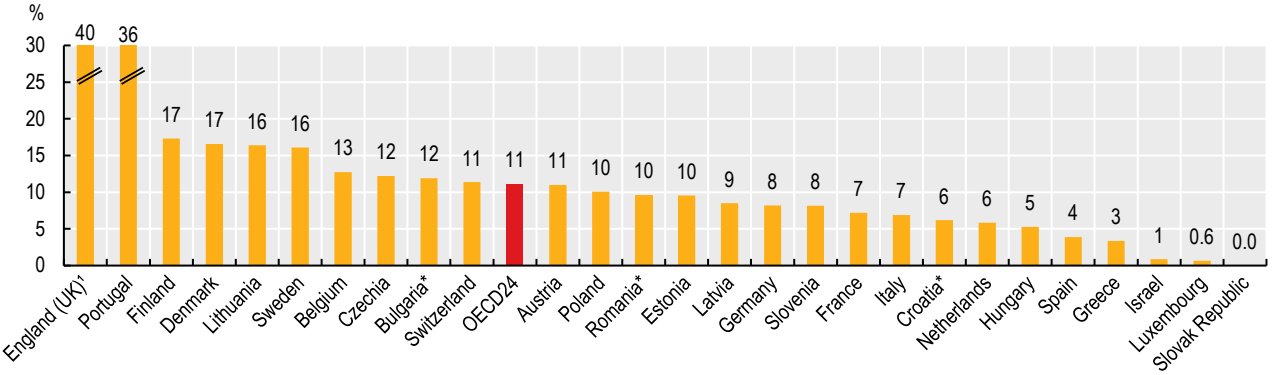
Figure 10.16. Share of informal daily carers who are women, 2021-2022 (or nearest year)



1. Latest data from 2018-2019. * Accession/partner country.
Source: SHARE wave 9 (2021-2022), SDAC (2018) for Australia; Census-based statistics (2021) for the United Kingdom; HRS wave 14 (2018-2019) for the United States.

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Figure 10.17. Share of informal daily carers that also work, 2021-2022 (or nearest year)



1. 2018-2019 data. * Accession/partner country.
Source: SHARE wave 9 (2021-2022); ELSA wave 10 (2021-2023) for the United Kingdom.

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Long-term care workers

All OECD countries offer some degree of formal LTC to assist people in need of care in their daily activities. Care is provided by LTC workers, who are defined as paid staff – typically nurses and personal carers – providing care and/or assistance to people limited in their daily activities at home or in institutions, excluding hospitals. The demand for LTC workers will keep rising in the years to come due to population ageing and changing patterns of informal care.

Despite this increasing demand, the average number of LTC workers remained stable at 5 per 100 people aged 65 and over between 2013 and 2023, among the 31 OECD countries for which data were available, ranging from a high of 13.0 in Norway to a low of 0.2 in Greece (Figure 10.18). Korea, Türkiye and Spain each saw an increase of more than 1 LTC worker per 100 people aged 65 and over from 2013 to 2023. Conversely, notable reductions in the number of LTC workers per 100 people aged 65 and over were observed in the United States, Denmark, Estonia and Belgium.

The LTC sector is constantly facing difficulties in attracting talent and meeting growing demand due to poor working conditions – including low wages, high physical and mental risks, non-standard employment contracts and low recognition (OECD, 2023[1]). Non-standard employment is common in the LTC sector (Figure 10.19). In 31 OECD countries that reported data, more than one in three LTC workers, on average, were in part-time employment, with significantly higher shares working in part-time arrangements in Australia (91%), the Netherlands (74%) and Korea (69%). Moreover, one in six LTC workers across 28 OECD countries worked on a fixed-term contract basis. This was particularly common in Australia and Portugal, as well as accession countries Bulgaria and Croatia, where again more than a third of the LTC workforce works under fixed-term contracts.

Amid labour shortages, the importance of migrant workers is rising in the LTC sector. Across 26 European OECD countries, the share of foreign-born LTC workers increased from 14% in 2014 to 21% in 2024 (Figure 10.20). Four out of ten LTC workers in Luxembourg, Sweden, Ireland and Switzerland were foreign-born, whereas very few workers were foreign-born in many Central and Eastern European countries. Moreover, the LTC workforce had a higher share of foreign-born workers than the overall workforce in two-thirds of the countries – particularly among countries with a higher share of foreign-born workers.

Educational and training requirements are particularly low for personal care workers. For example, there is no qualification requirement for LTC workers in Greece, Iceland, the United Kingdom and the United States (Llena-Nozal, Barszczewski and Rauet-Tejeda, 2025[2]) A mismatch between education and skills needed – such as specific geriatric training, health monitoring and co-ordinating care – can negatively affect the quality of care delivered. Beyond low salaries and employment instability, limited access to training and education and career prospects might lower the attractiveness of the LTC profession (OECD, 2020[3]).

Definition and comparability

Data in this section are based on headcounts. LTC workers are defined as paid workers who provide care at home or in institutions (outside hospitals), providing assistance as qualified nurses or personal care workers. Nurses include both professional and associate professional nurses – International Standard Classification of Occupations 2008 (ISCO-08) classifications 2 221 and 3 221. Personal care workers (ISCO-08 classifications 5 321 and 5 322) include various categories of workers, who may be called different names in different countries.

Collecting comparable data for personal care workers is challenging due to limited accreditation. OECD countries often have mandatory accreditation for those working in institutional care, but this is less the case for those in home care (Llena-Nozal, Barszczewski and Rauet-Tejeda, 2025[2]). Data from OECD Health Statistics 2025 exclude nurses working in administration but may include family members or friends who are employed under a formal contract by the care recipient, an agency or public and private care service companies.

Data from OECD Health Statistics 2025 are based on the European Union Labour Force Survey (EU-LFS) for Belgium, Bulgaria, France, Iceland, Italy, Lithuania, Poland, Romania and Türkiye in Figure 10.18. For LTC workers on fixed-term contracts in Figure 10.19, Japan's data are added from the 2022 Survey on Long-Term Care Workers (Care Work Foundation of Japan) and Korea's data from the Long-Term Care Survey (Ministry of Health and Welfare, Korea Institute for Health and Social Affairs). For Korea, contract workers are treated as fixed-term workers. Data from the EU-LFS are used in Figure 10.20.

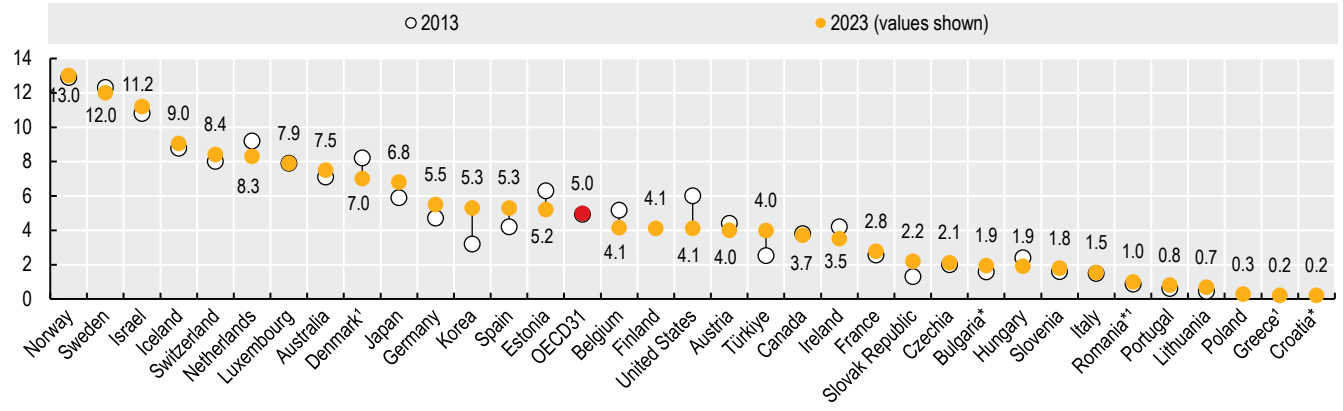
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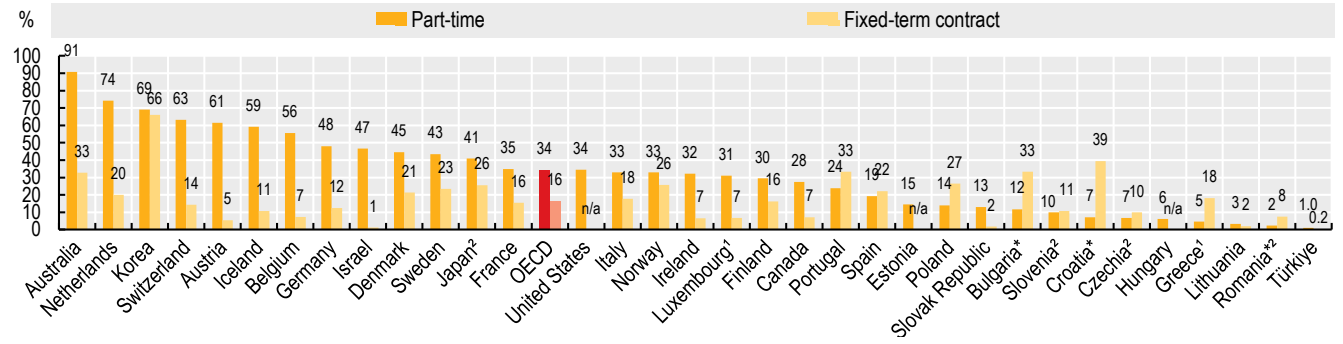
Figure 10.18. Long-term care workers per 100 people aged 65 and over, 2023 and 2013 (or nearest year)



1. Latest data from 2021-2022. * Accession/partner country.
Source: OECD Health Statistics 2025.

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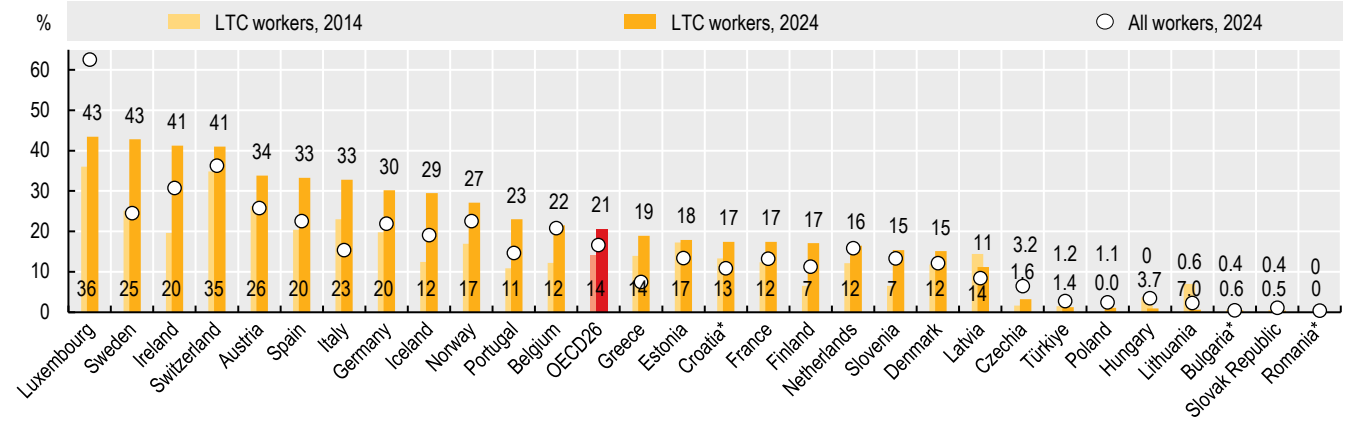
Figure 10.19. Share of long-term care workers who work part time or on fixed-term contracts, 2023 (or nearest year)



1. 2021-2022 data. 2. 2021-2022 data for part time. 3. 2022 data for fixed-term contract. * Accession/partner country.
Source: OECD Health Statistics 2025, complemented by national sources.

StatLink https://stat.link/2zkpe1

Figure 10.20. Share of long-term care workers who are foreign-born, 2024 and 2014



Note: Data refer to those aged from 20 to 64. * Accession/partner country.
Source: European Union Labour Force Survey (Eurostat).

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Long-term care settings

Many people receiving LTC wish to remain at home for as long as possible, and most countries have taken steps in recent years to support this preference and promote community and home-based care. However, depending on individual circumstances, a move to LTC facilities may eventually be the most appropriate option. It is therefore important that countries retain an appropriate level of residential LTC capacity. The number of beds in LTC facilities and in LTC departments in hospitals offers a measure of the resources available for delivering LTC services to individuals outside their home.

Across 34 OECD countries, there were an average of 41 beds per 1 000 people aged 65 and over in 2023 (Figure 10.21). The vast majority of beds – 40 per 1 000 – were located in LTC facilities, while just 3 beds per 1 000 were located in hospitals. The proportion of LTC beds in hospitals exceeded 10% of all LTC beds in just four OECD countries: Greece (68%), Korea (52%), Czechia (20%) and Israel (16%). Among OECD countries reporting both facility-based and hospital-based LTC beds, the number of beds available per capita varied enormously, with a more than seven-fold difference between the highest and lowest. Luxembourg, the country with the highest number of beds, reported almost 79 beds per 1 000 people aged 65 and over, compared to fewer than 3 beds per 1 000 in Greece.

Between 2013 and 2023, OECD countries reduced the number of LTC beds in facilities by an average of 5 beds per 1 000 people aged 65 and over. In some cases, the number of LTC beds per 1 000 people 65 and over may have fallen even as the absolute number of beds increased, as population ageing outpaced the growth in beds. However, the change in the number of beds in facilities varied significantly between OECD countries. Over the decade, nine countries reduced the ratio of LTC beds by about 10 or more. In contrast, in Italy and Japan the number of LTC beds increased by more than 2.5 per 1 000 people aged 65 and over between 2013 and 2023. These substantial changes were driven by policy changes over the period. In the Netherlands, declines were driven by major LTC reforms in 2015, aiming at de-institutionalising care (Llena-Nozal, Araki and Killmeier, 2025[1]). Although the number of LTC beds in OECD accession/partner countries is below the OECD average, they have recorded the largest increases from 2013 to 2023 – notably Argentina and Croatia with increases of 17 and 12 beds per 1 000 people 65 and over, respectively.

Approximately two in three LTC beds were owned by private facilities across 21 OECD countries in 2023 (Figure 10.22). The share of privately owned LTC beds exceeded 90% of the total LTC beds in nine countries, including the Netherlands and New Zealand with only private beds. In contrast, LTC beds were predominantly owned by public facilities in Norway (92%) and Latvia (92%). Variation in LTC bed ownership across countries may be attributable to many institutional factors, including public policy and regulations. Countries with centralised health and social care systems (e.g. Norway, Latvia) are more likely to maintain LTC provision publicly than countries with more market-oriented systems, which outsource LTC provision to private entities while retaining regulatory oversight, as is the case in the Netherlands.

Developing and applying models of care that respect residents' wishes and promote dignity and autonomy is a critical aspect of high-quality care. This includes ensuring that staff working in LTC facilities are appropriately trained, and that facilities receive the support they need to deliver high-quality care, reduce high turnover and facilitate the recruitment and retention of high-quality care workers (see section on "Long-term care workers").

Definition and comparability

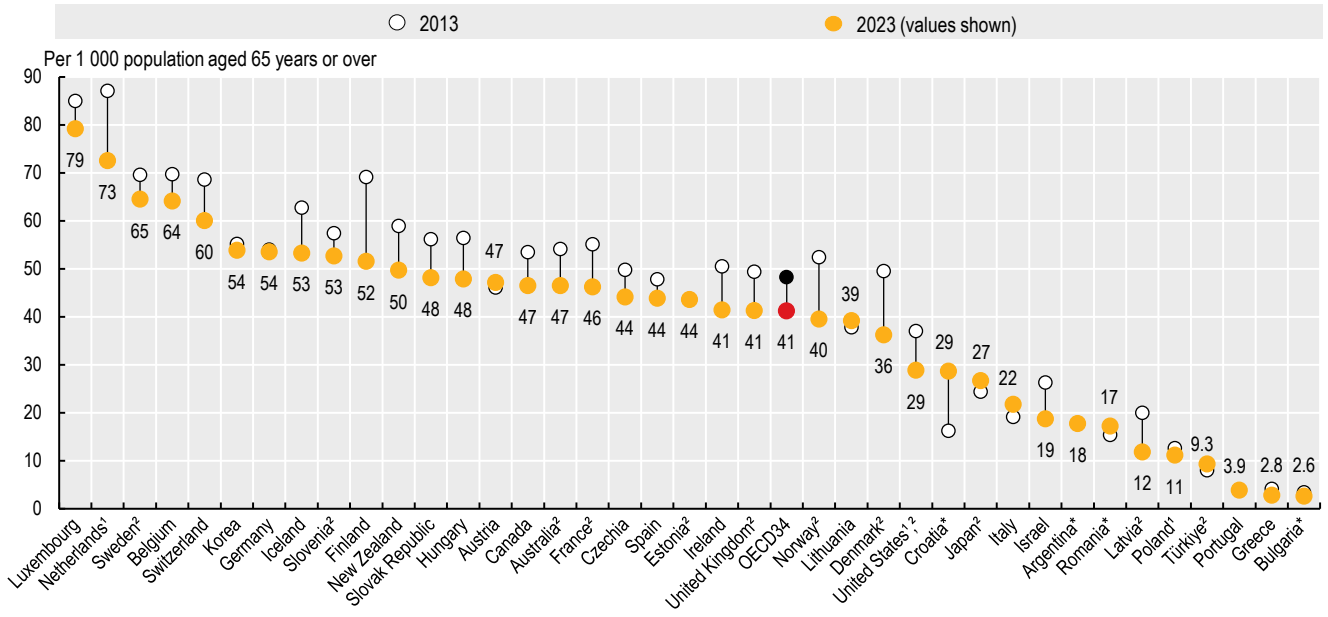
LTC facilities refer to nursing and residential care facilities that offer accommodation and LTC as a package. They include specially designed facilities or hospital-like settings where the main service component is LTC for people with moderate to severe functional restrictions. They do not include beds in adapted living arrangements for those who require help while maintaining a high level of autonomy and self-control. For international comparisons, they should also not include beds in rehabilitation centres.

However, there are differences in data coverage between countries. Several countries only include beds in publicly funded LTC facilities, while others also count private facilities (both for-profit and not-for-profit). Some countries also include beds in treatment centres for addicted people, psychiatric units of general or specialised hospitals, and rehabilitation centres.

References

Llena-Nozal, A., S. Araki and K. Killmeier (2025), *Needs assessment and eligibility criteria in long-term care: How access is managed across OECD countries*, OECD Health Working Papers No. 181, https://doi.org/10.1787/461811c4-en. [1]

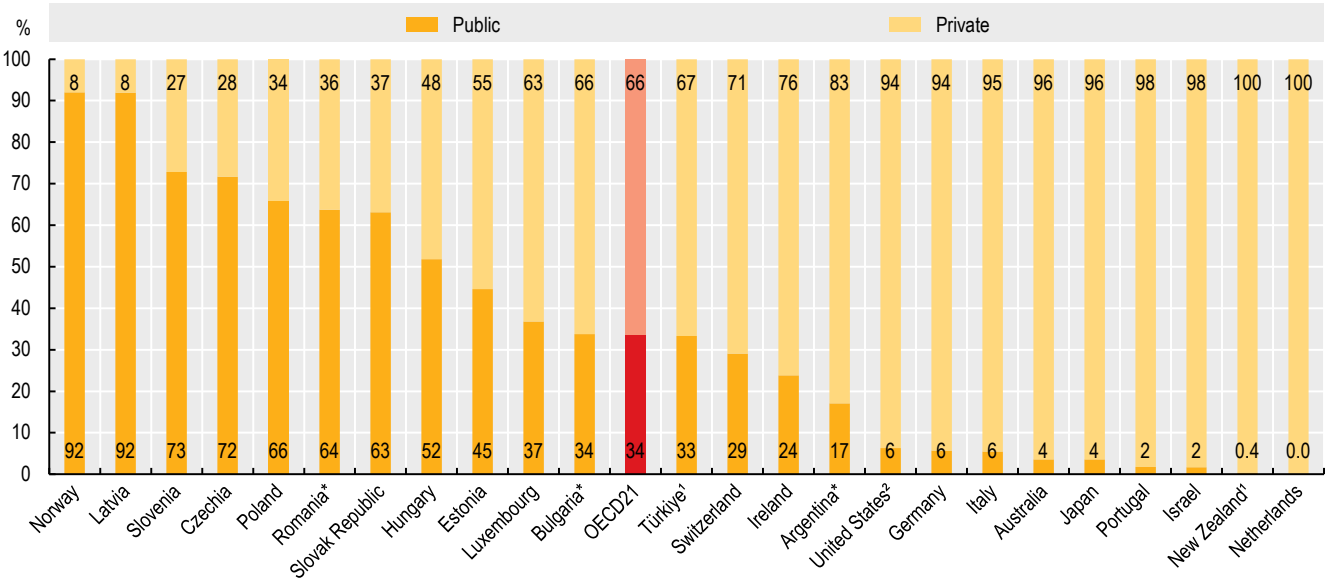
Figure 10.21. Long-term care beds in institutions and hospitals, 2023 and 2013 (or nearest year)



1. Latest data from 2021-2022. 2. Data only include beds in institutions. * Accession/partner country.
Source: OECD Health Statistics, 2025.

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Figure 10.22. Long-term care beds by ownership, 2023 (or nearest year)



1. 2024 data. 2. 2022 data. * Accession/partner country.
Source: OECD Health Statistics 2025.

StatLink https://stat.link/k16myn

Long-term care spending and unit costs

Over the last decade, LTC spending has been outpacing overall health spending in most OECD countries (see section on "Health expenditure by type of service" in Chapter 7). Population ageing will lead to more people needing ongoing health and social care, rising incomes increase expectations of quality of life in old age, the supply of informal care is likely to shrink, and productivity gains are difficult to achieve in such a labour-intensive sector. Amid these cost pressures, LTC spending is projected to increase annually by 2.6% until 2050 across OECD countries (OECD, 2024[1]).

In 2023, 1.8% of gross domestic product (GDP) was allocated to LTC (including both the health and social component) across OECD countries (Figure 10.23). At 4.1% of GDP, the highest spender was the Netherlands, followed by the Nordic countries of Sweden (3.7%), Finland (3.2%) and Denmark (3.2%), as well as Belgium (3.1%). In contrast, Greece, Chile and Costa Rica, as well as accession/partner countries Bulgaria, Romania, Brazil, Croatia and Peru spent less than 0.5% of GDP on provision of LTC services. This variation partly mirrors differences in the population structure, but mostly reflects the stage of development of formal LTC systems – as opposed to more informal arrangements based mainly on care provided by unpaid family members. Some level of underestimation may exist for those countries unable to record spending on social LTC. Across OECD countries, four out of five dollars spent on LTC come from public sources.

Across OECD countries, around half of health and social LTC spending in 2023 occurred in nursing homes (Figure 10.24). In most OECD countries, these providers account for the majority of LTC spending. On average, around one-sixth of all LTC spending was used for professional (health) care provision at home. Other LTC providers include hospitals, households – if a care allowance exists that remunerates the informal provision of such services – and LTC providers with a clear social focus. These service providers each account for around 10% of total LTC spending across OECD countries. The importance of these modes of provision varies widely across countries, reflecting differences in the organisation of LTC and policy priorities.

On a more micro level, the cost of LTC can be prohibitive for older people – especially for those who have more severe needs and/or have lower income and wealth – and thus unaffordable and inaccessible without public benefits and services (OECD, 2024[1]). The cost of home care for an older individual with severe needs is estimated at 292% of the median income of older people on average across 22 OECD countries and subnational areas, whereas the estimated cost of institutional care stands at 211% (Figure 10.25). Home care costs exceed four times an older individual's median income in Finland (754%), Czechia (668%), Sweden (576%), Japan (425%), Tallin (Estonia) (496%) and Vienna (Austria) (400%). While institutional care is less expensive than home care in 12 out of 22 OECD countries and subnational areas, its cost is higher than the median income of those aged 65 and over in every OECD Member country and accession/partner country with available data.

Public social protection systems are therefore critical in ensuring that older people have access to adequate care without falling into poverty or financially burdening family members. For example, the estimated cost of home care is high in Finland, but its LTC social protection scheme is estimated to cover 97% of the cost of home care for people with severe needs, leaving an out-of-pocket expense equivalent to 22% of median income among those aged 65 and over. In other words, the cost of home care falls drastically from 754% to 22% of median income, ensuring affordability and accessibility for older people in need of LTC.

Definition and comparability

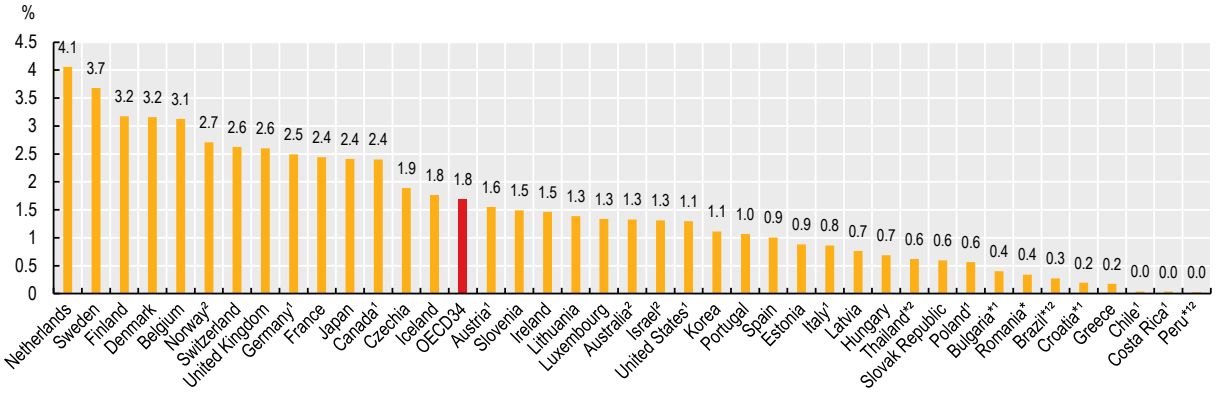
LTC spending comprises both health and social services provided to LTC-dependent people who need care on an ongoing basis. Based on the System of Health Accounts 2011, the health component of LTC spending relates to nursing care and personal care services (help with ADL). It also covers palliative care and care provided in LTC institutions (including boarding costs) or at home. LTC social expenditure primarily covers help with IADL. Progress has been made in improving the general comparability of LTC spending in recent years, but some variation in reporting practices remains between the health and social components of LTC. In some countries, social LTC is (partly) included under health LTC; in others, only health LTC is reported. There is also some variation in the comprehensiveness of reporting for privately funded LTC expenditure.

LTC institutions refer to nursing and residential care facilities that provide accommodation and LTC as a package. They are specially designed institutions where the predominant service component is LTC for dependent people with moderate to severe functional restrictions. An older person with severe needs is defined as someone who requires 41.25 hours of care per week. A detailed description of their needs can be found in OECD (2024[1]).

References

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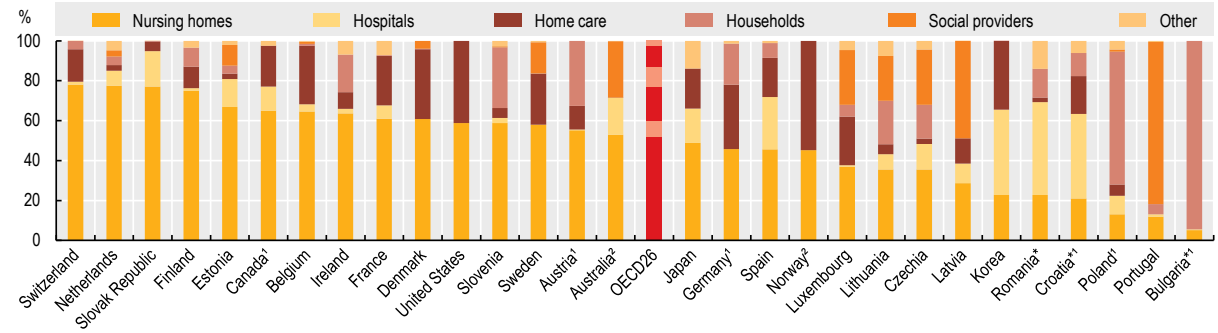
Figure 10.23. Total long-term care spending as a share of gross domestic product, 2023 (or nearest year)



1. Countries not reporting spending for LTC (social). In many countries this component is therefore missing from total LTC, but in some countries it is partly included under LTC (health). 2. 2022 data. * Accession/partner country.
Source: OECD Health Statistics 2025.

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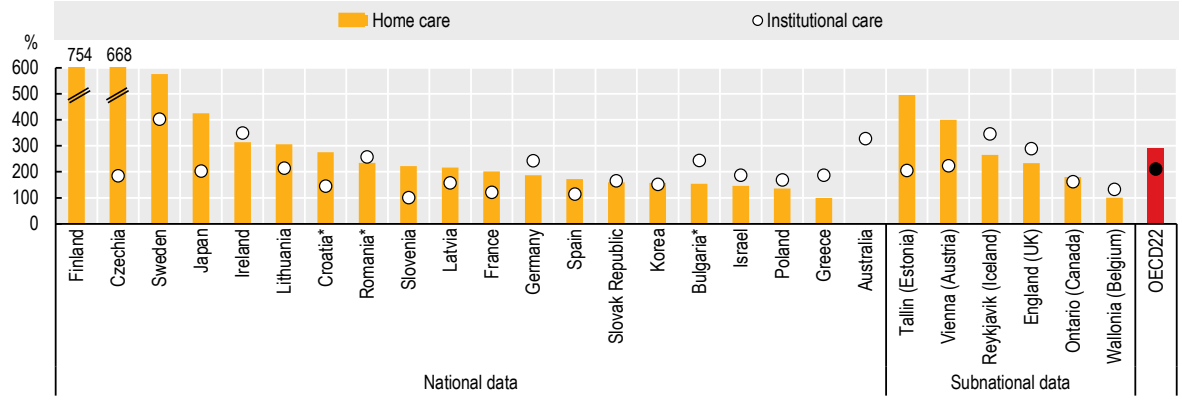
Figure 10.24. Total long-term care spending by provider, 2023 (or nearest year)



1. Countries not reporting social LTC. The category "Social providers" refers to providers where the primary focus is on help with IADL or other social care. 2. 2022 data. * Accession/partner country.
Source: OECD Health Statistics 2025.

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Figure 10.25. Costs of long-term care for people aged 65 and over with severe needs, as a share of median income, 2024-2025 (or nearest year)



Note: The OECD averages are based on both national and subnational data. Data are missing for Australia (home) and Finland (institution). * Accession/partner country.
Source: OECD Long-Term Care Social Protection Questionnaire (2025); OECD Income Distribution Database.

StatLink https://stat.link/kho4tn

End-of-life care

End-of-life care refers to the range of health and long-term care services people receive in the last phase of life, often defined as the final year before death (OECD, 2023[1]). It involves all the services providing physical, emotional, social and spiritual support to the dying person, including management of pain and mental distress. Emotional support and bereavement care for the dying person's family are also part of end-of-life care. Due to population ageing and increasing prevalence of chronic conditions across OECD countries, the number of people in need of end-of-life care is growing and is expected to reach 10 million people by 2050, up from 7 million in 2019.

End-of-life care can be delivered in hospitals, hospices, nursing homes and patients' homes. Although personal characteristics, beliefs and other cultural factors can influence preferences for care at the end of life, existing literature shows that most people would prefer to spend the end of their lives in their homes. A scoping review of end-of-life care studies found a clear preference for deaths at home among patients as well as patient families – up to 89% for patients and up to 84% for patient families (Pinto et al., 2024[2]).

However, fewer than half of those who need end-of-life care are currently receiving it, indicating a lack of adequate access (OECD, 2023[1]). Nearly half of deaths occurred in hospitals across 30 OECD countries in 2023, making hospitals the most common place of death (Figure 10.26). The Netherlands, Norway and Switzerland and accession country Peru record the lowest shares, with only around one-third of deaths or fewer happening in hospitals. This is linked to the role of nursing homes, hospices or other LTC facilities, which in the Netherlands and Switzerland represent the most prevalent place of death (OECD, 2023[1]). In Hungary, Japan, Iceland, Lithuania, Portugal, and Israel 60% of deaths or more were recorded at hospitals.

The share of deaths occurring in hospitals decreased between 2018 and 2023 in about 70% of the countries, with the largest reductions seen in Estonia (11 p.p.), Japan and Ireland (8 p.p.) and Denmark (7 p.p.). By contrast, it increased in a handful of countries including Latvia and Iceland, as well as accession country Romania. The COVID-19 pandemic might have contributed to a decline in the share of hospital deaths.

Across 17 OECD countries for which more detailed data on place of death are available, hospitals were the most common place of death, with an average of 47% of deaths taking place in hospitals in contrast to 22% of deaths recorded at home as of 2019-2020 (Figure 10.27). The Netherlands was the only country where home is the most common place of death. Deaths in LTC facilities and institutions were often observed in Sweden (40%), Switzerland (38%), Iceland (37%), the Netherlands (36%) and New Zealand (32%), whereas hospital death rates were the highest in Japan (75%), Czechia (64%), Estonia (63%), Israel (61%) and Lithuania (60%).

Mainstreaming end-of-life care into health policies and medical education, as well as ensuing access to essential medicines for pain and symptom management, remains a challenge. The Global Atlas of Palliative Care reports that the proportion of medical and nursing schools with mandatory palliative care teaching is 100% in only eight Asian-Pacific and European OECD countries (Austria, Finland, France, Ireland, Lithuania, Luxembourg, Japan and the United Kingdom).

Definition and comparability

Data on the share of deaths in hospitals refer to deaths happening for any cause of death, excluding external causes of mortality such as accidents and injuries – all International Classification of Diseases, tenth revision (ICD-10) codes except V00-Y99. Data refer to the years 2018 and 2023 or the nearest years available. Caution is needed in cross-country comparisons, as data might refer to different years. The share of deaths in hospitals has been calculated by the OECD Secretariat, based on the available data. Data for Korea exclude hospitals with long-term care beds, and therefore the incidence of hospital deaths is underestimated by nearly half. Data for the United Kingdom exclude Northern Ireland.

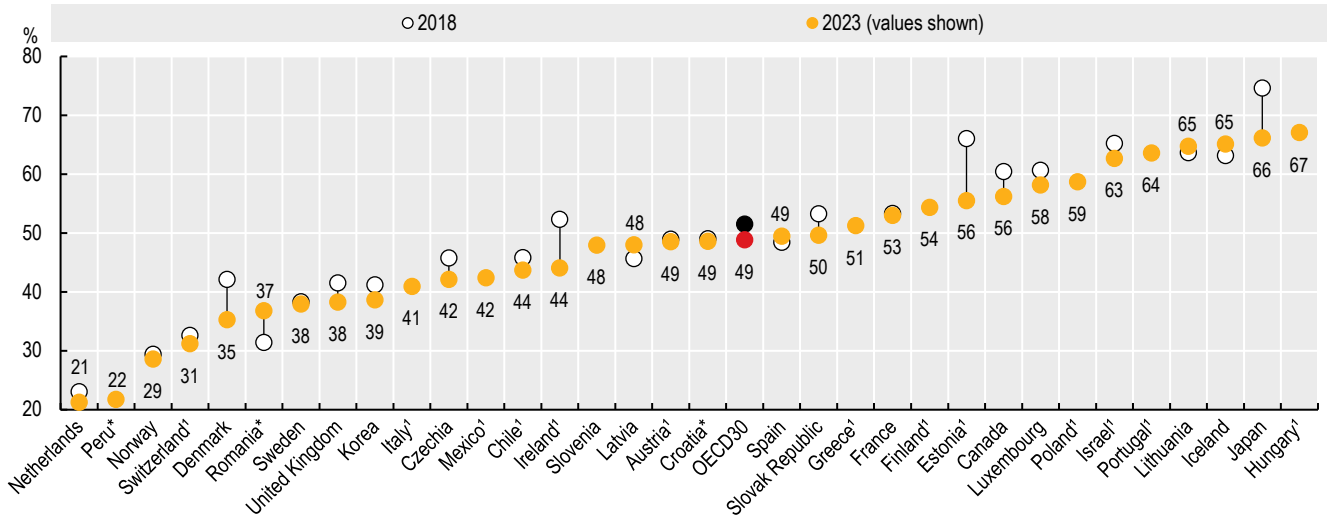
While end-of-life care encompasses the range of services provided to people at the end of life, palliative care is not necessarily limited to the very end of life, such as the final days or hours. Its scope has broadened to begin much earlier in the disease trajectory. Palliative care provides holistic support for people with a life-limiting illness from the time of diagnosis, through to death and bereavement, helping them live as well as possible until the end of life.

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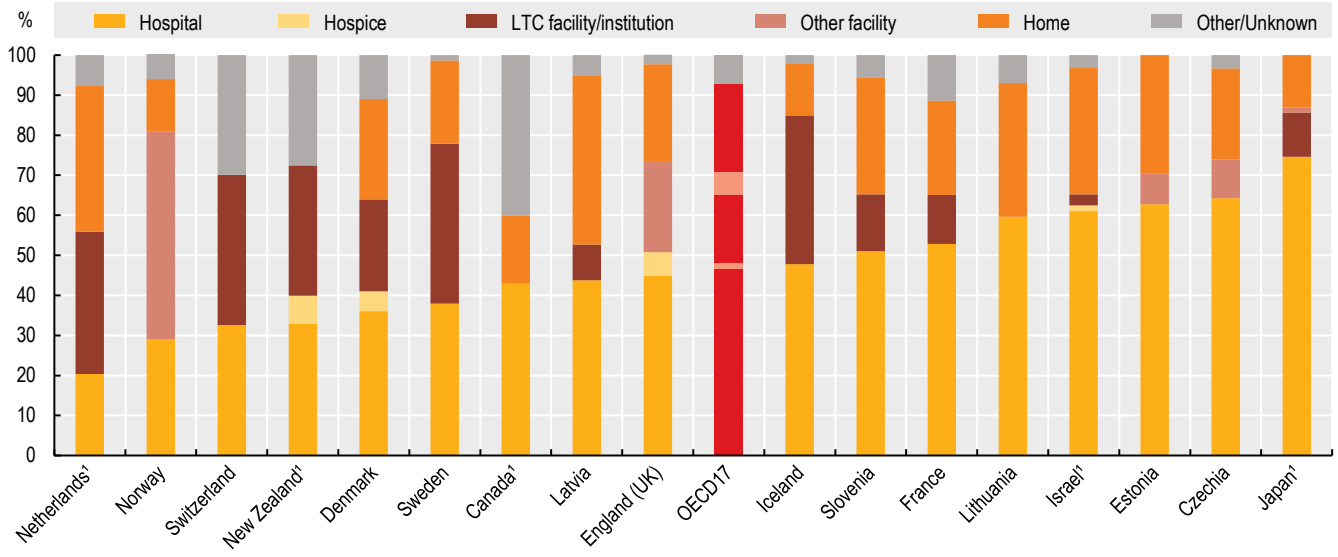
Figure 10.26. Share of deaths occurring in hospitals, 2023 and 2018 (or nearest year)



1. Latest data from 2021-2022. * Accession/partner country.
Source: OECD Health Statistics 2025; EOLinPLACE for Finland, Greece, Hungary, Mexico, Poland, Portugal; Institut national de la statistique et des études économiques (France).

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Figure 10.27. Place of death, 2019-2020 (or nearest year)



1. Data refer to 2017-2018.
Source: OECD (2023[11]); Institut national de la statistique et des études économiques (France).

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Health at a Glance 2025

OECD Indicators

Health at a Glance provides a comprehensive set of indicators on population health and health system performance across OECD Members, Key Partners and accession candidate countries. These indicators cover health status, non-medical determinants and risk factors, access to and quality of healthcare, health spending and health system resources. Analysis draws from the latest comparable official national statistics and other sources.

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