ZURICH

The Value of Chronic Care

Closing the gap between life and health spans

Contents

Foreword

Living longer should mean better health, not just more years.

In many countries, the gap between how long people live and how well they live is widening.

Chronic diseases – hypertension, diabetes, cardiovascular disease, cancer, mental health conditions, to name a few – increasingly shape how hundreds of millions of people live, work, and plan for the future.

As life expectancy increases and lifestyles evolve, the impact of these conditions is rising. But these pressures do not play out in the same way everywhere. Countries with younger populations may experience low levels of chronic disease but face weaker health systems that struggle to respond as needs grow. In others, longer lives bring extended illness, heightening demands on even well-developed care systems.

Chronic diseases can play out over decades. Individuals require ongoing treatment and monitoring, while families shoulder additional caregiving responsibilities – increasing the need for financial resilience over longer periods of illness. Health care systems remain central to this response, but they are only one part of a broader ecosystem of prevention, treatment, protection, and support.

The Value of Chronic Care – the second report in Zurich's *The Value of Health & Wellbeing* series – examines two crucial questions: How prepared are countries to manage the chronic conditions that will define health in the decades ahead – and how must prevention and protection evolve in response?

Analyzing a decade of data for more than 200 conditions across 38 countries, the report brings together two distinct perspectives: the scale of chronic disease burden across populations, and the capacity, quality, and readiness of health systems in responding to it.

1 in 3

adults live with a long-standing illness or health problem

2023 data, OECD countries. OECD. Health at a Glance 2025: OECD indicators (2025)

While the index provides a benchmark of relative performance across countries, its purpose is to identify the patterns, tensions, and opportunities that shape how chronic disease care is delivered. Building a consistent, comparative view of these dynamics can help reveal how countries are adapting – an essential step toward building sturdier systems and more sustainable outcomes.

The data presented here, while numerical in form, reflects real people and real needs – our family, our friends, and our colleagues. The opportunity now is to stabilize how systems manage our health over time. It is our hope that this report informs and inspires efforts to help communities not only to live longer lives, but to live healthier ones.

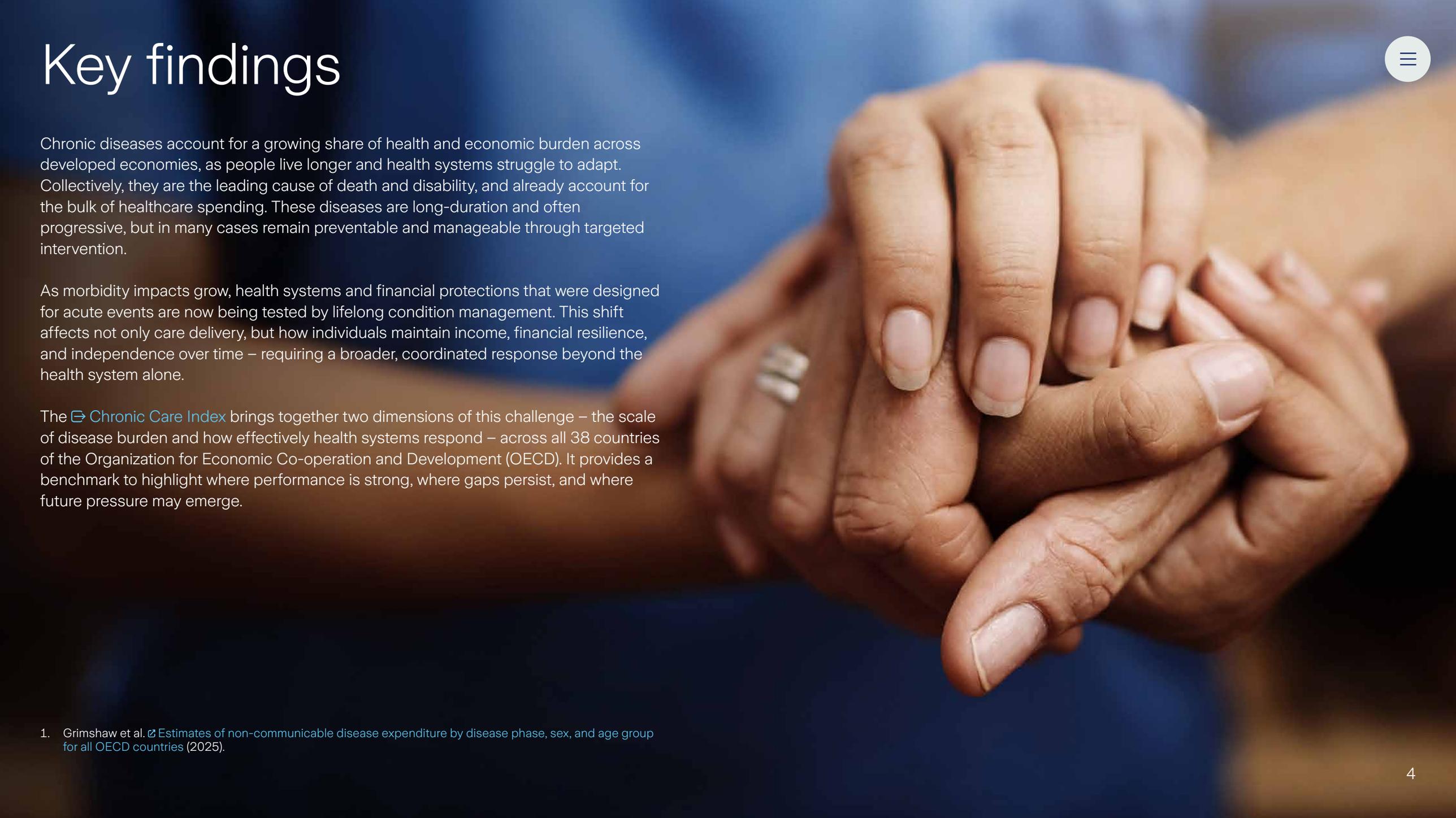
Alison Martin
CEO, Life, Health & Bank Distribution

Key findings

Chronic diseases account for a growing share of health and economic burden across developed economies, as people live longer and health systems struggle to adapt. Collectively, they are the leading cause of death and disability, and already account for the bulk of healthcare spending. These diseases are long-duration and often progressive, but in many cases remain preventable and manageable through targeted intervention.

As morbidity impacts grow, health systems and financial protections that were designed for acute events are now being tested by lifelong condition management. This shift affects not only care delivery, but how individuals maintain income, financial resilience, and independence over time – requiring a broader, coordinated response beyond the health system alone.

The Chronic Care Index brings together two dimensions of this challenge – the scale of disease burden and how effectively health systems respond – across all 38 countries of the Organization for Economic Co-operation and Development (OECD). It provides a benchmark to highlight where performance is strong, where gaps persist, and where future pressure may emerge.



1. Grimshaw et al. Estimates of non-communicable disease expenditure by disease phase, sex, and age group for all OECD countries (2025).

A widening gap between lifespans and health spans

Chronic disease is changing in an important way. In many OECD countries, fewer people are dying prematurely, but more are living for longer with illness, often for decades.

This means more time spent managing conditions, more pressure on health systems and households, and a growing need for ongoing support. It also shifts the challenge from short-term events to long-duration risk – with direct implications for prevention approaches and care costs, as well as income stability and long-term financial planning.

See Chronic disease burden.

Quality drives comparative performance

Capacity matters, but it does not fully explain the gap in performance. Large gaps remain in quality and readiness across countries – particularly in access, coordination, and continuity of care.

This creates an access gradient that directly impacts disease outcomes: Individuals facing financial or geographical barriers delay seeking diagnosis, struggle to maintain treatment, or rely on fragmented care. And where out-of-pocket costs are high, or protection is limited, this can lead to financial insecurity.

See Health system performance.

Resources alone do not guarantee outcomes

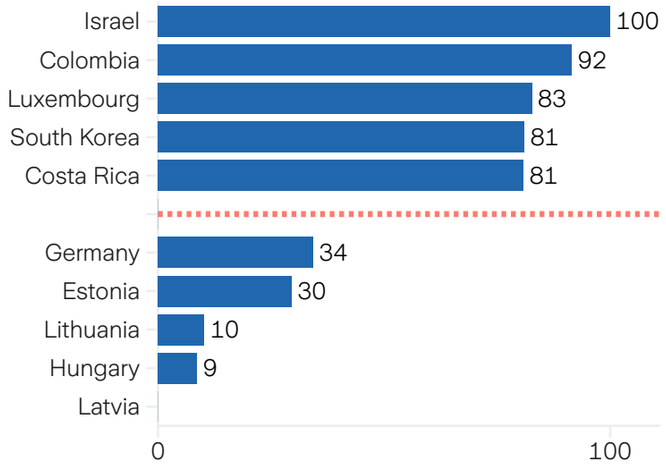
When disease burden and system performance are viewed together, a clearer picture emerges of how well countries are positioned to manage chronic conditions.

Demographics play a central role: countries with younger populations face rising pressure as populations age, while countries with older populations must find a way to maintain high performance under increasing demand. The result is two trajectories: one of prevention and preparation, and one of management.

See Chronic Care Index.

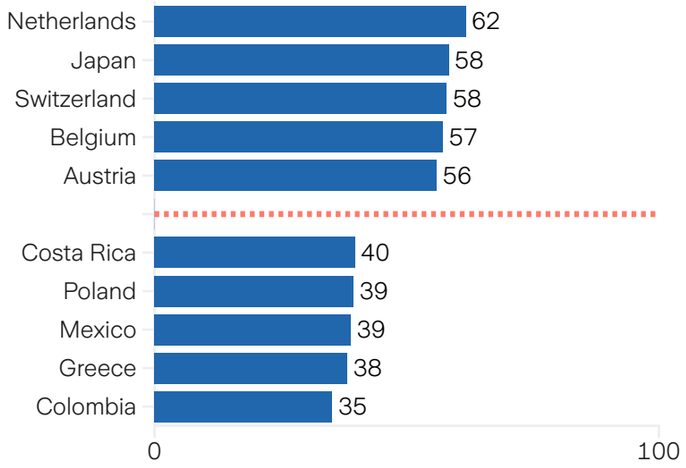
Scores: Chronic disease burden

Highest and lowest rankings



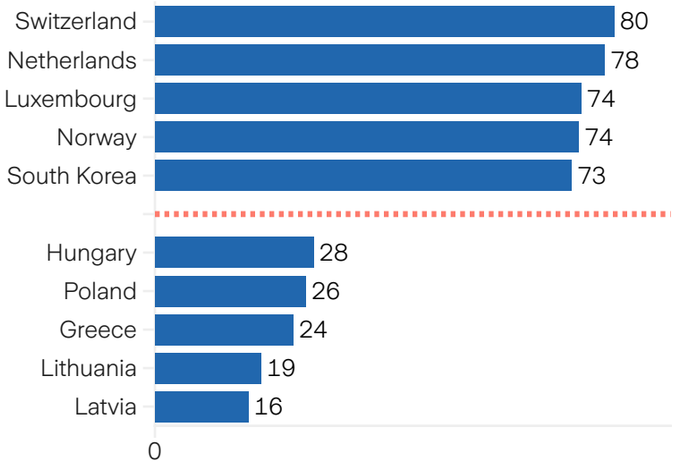
Scores: Health system performance

Highest and lowest rankings



Scores: Chronic Care Index

Highest and lowest rankings



Higher scores indicate stronger performance. Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

Acute care systems facing a chronic reality

These findings may arise from a structural gap: systems built for acute events that are now being tested by lifelong condition management.

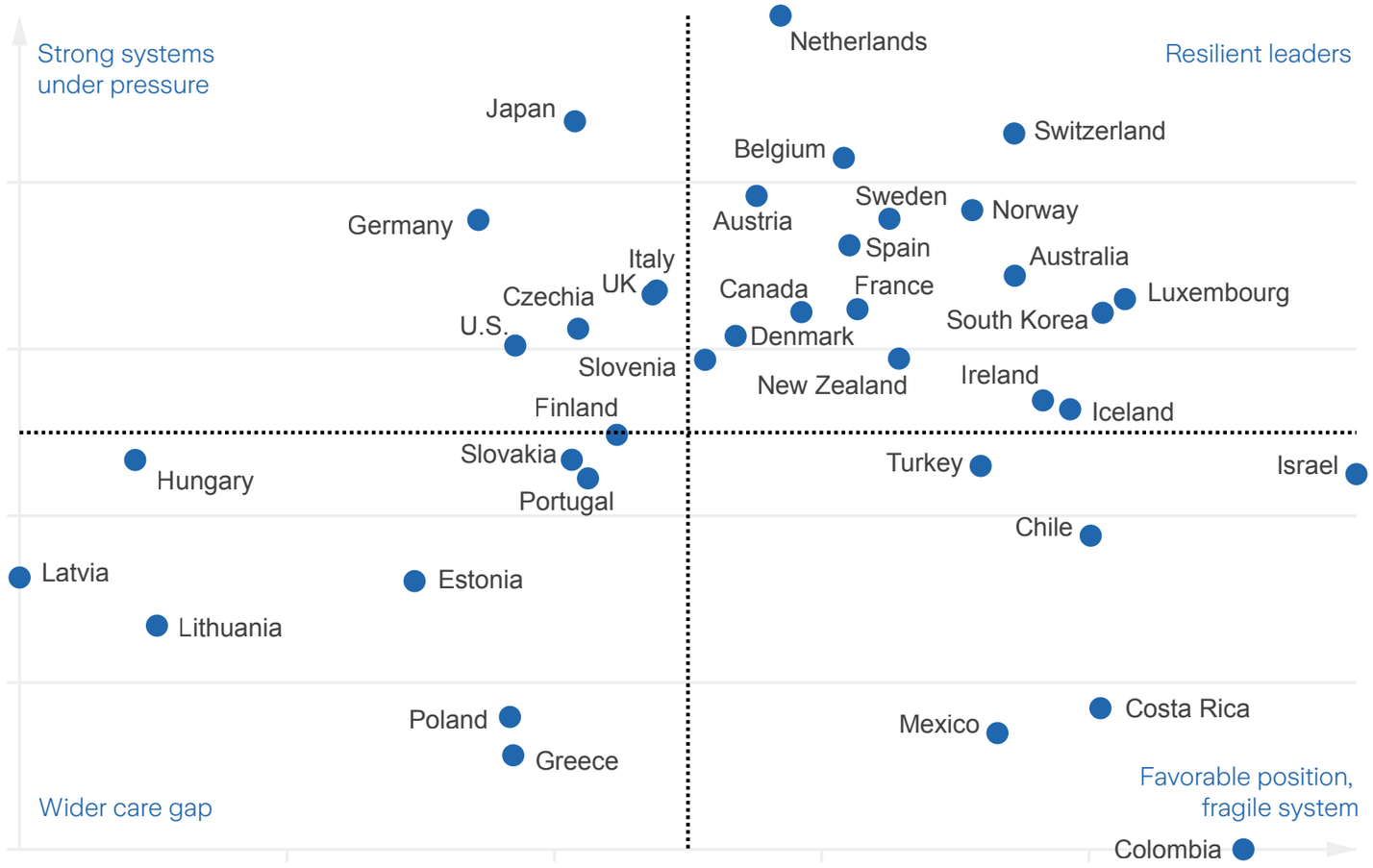
Countries that lead the Chronic Care Index – including Switzerland, the Netherlands, Luxembourg, Norway and South Korea – combine relatively low disease burden with strong health system performance, suggesting better management of both underlying risk factors and care delivery over time.

By contrast, lower-performing countries – such as Latvia, Lithuania, Greece, Poland, and Hungary – may face a wide care gap: a heavier burden of disease without the system infrastructure, quality, and readiness to manage it effectively. And when a country falls behind on both dimensions, catching up can become structurally more difficult.

Crucially, the findings show that performance is not simply a function of spending or system size, nor does aging alone predetermine high disease burden. Closing this care gap requires coordination across public health systems, employers, and insurers – with insurers contributing through earlier intervention to reduce risk, stronger protection for income and financial resilience, and services that help people navigate support over time.

Chronic Care Index

Chronic disease burden and Health system performance scores (0 – 100)



Higher scores indicate stronger performance. Health system performance scores have been rescaled here to better visualize relative positioning of countries. Refer to ⇨ Data and methodology for a full set of data sources, assumptions, and calculations.

Rebalancing risk: South Korea has a low disease burden despite a rapidly aging population, reflecting progress on behavioral risks. But rising metabolic risk is shifting the challenge toward earlier detection and long-term condition management.

Managing aging: Switzerland shows that aging populations don't have to mean worse outcomes. Strong coordination, high trust, and patient confidence support more consistent management of chronic conditions over time.

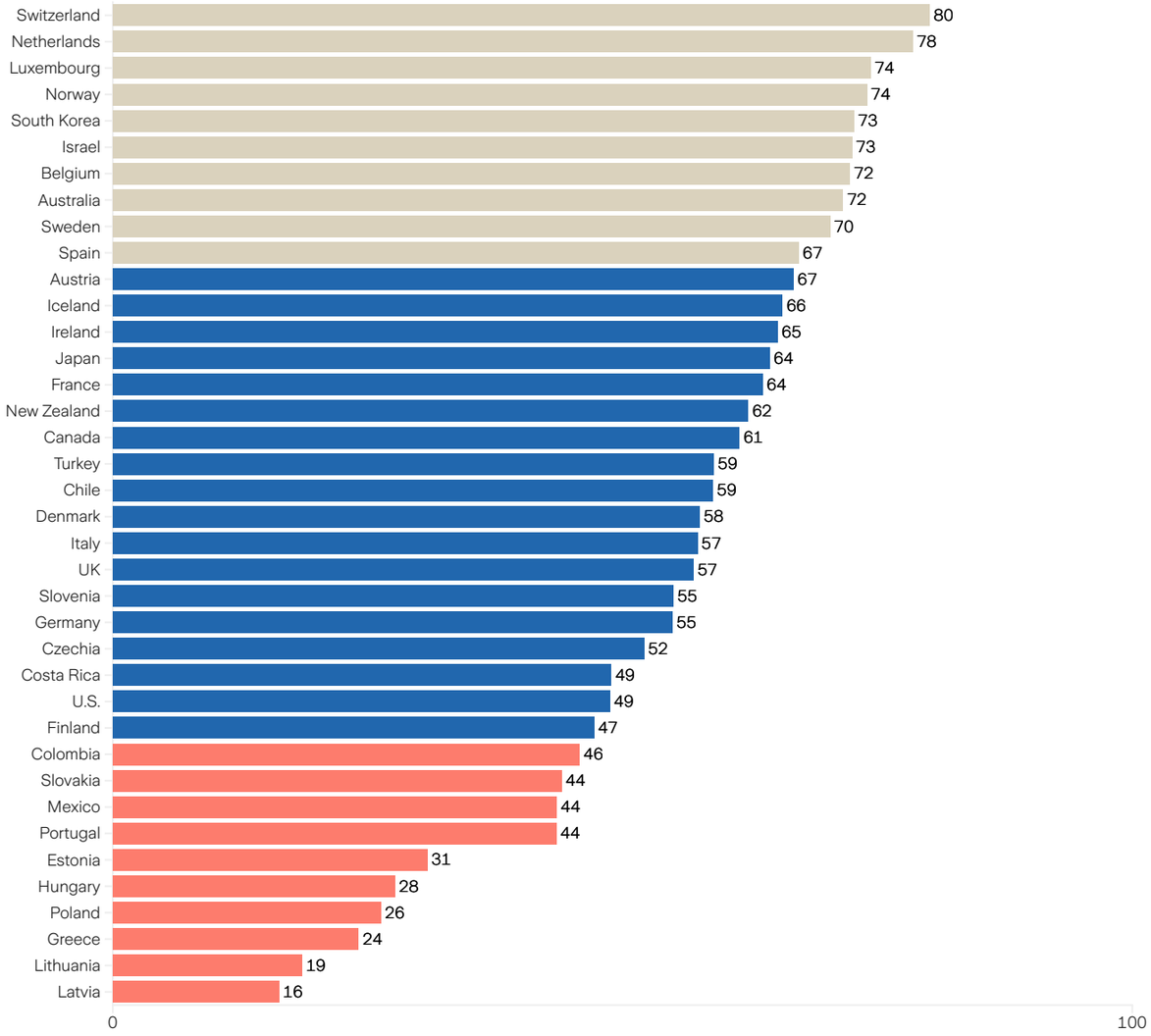
Access gap: The U.S. has some of the most advanced care available – but people do not access it evenly, which can lead to delays in diagnosis, inconsistent follow-up, and poorer control of chronic conditions.

Effectiveness gap: It is easier to enter care in Germany, but the bigger challenge is what happens next – care is not always well coordinated over time, making it harder to manage conditions consistently and avoid unnecessary escalation.

System design: The Netherlands shows how care design can influence disease burden, translating solid resources into consistent delivery through strong coordination and a clear focus on prevention and return-to-work support.

Scores: Chronic Care Index

0 – 100



Higher scores indicate stronger performance. Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

The next opportunity:
Closing the chronic care gap

Chronic conditions play out over decades. As people live longer with disease and disability, the value of chronic care will lie in how early and effectively countries organize, access, and sustain care, particularly through investment in prevention, integration, and shared responsibility:

1. **From management to prevention:**
   While treatment remains essential, acting earlier can reduce the likelihood that conditions develop into long-term disease, containing impacts on health, work, and financial stability. This is particularly important for conditions that can escalate over time, from cardiovascular disease and diabetes, to dementia and mental health disorders, reducing work capacity and driving long-term cost.

   Incidence and progression can be curbed by two sets of interventions: behavioral change targeting key risk factors, such as diet and physical activity; and identification and management of metabolic risk through screening and data.[2] As populations age, improvements in behavioral risks do not always coincide with reductions in underlying metabolic risk, meaning prevention must increasingly focus not only on reducing exposure, but on identifying, monitoring and managing risk earlier and more consistently over time.

   To support this, new models are emerging to expand access to risk assessment and screening, often delivered through employer-sponsored or insurance-linked platforms. This includes digitally-enabled risk profiling, condition-specific programs, and services that combine data, behavioral support, and clinical input over time. These models do not replace health systems, but extend their reach – enabling earlier identification of risk and more consistent support to sustain behavior change and manage conditions before they escalate.

2. **From fragmented interventions to integrated journeys:**
   Chronic care is not a single event, but a multi-year journey involving multiple touchpoints – primary care, specialists, employers, and other support providers. In many cases, a lack of integration can leave individuals and employers without a clear pathway through care. This can determine whether people receive timely, consistent care – or experience delays, costly duplication, and gaps in support.[3]

   The focus should now be on how these services connect: giving people a clear way into care, ensuring information flows between providers, and maintaining consistent follow-up as conditions evolve.

3. **From system performance to shared responsibility:**
   The scale and duration of chronic disease exceed what any single person or institution can manage alone. A shift is already underway toward shared responsibility across public systems, employers, and insurers.

   Employers play a key role in shaping the workplace environment and reaching working-age populations.[4] At the same time, insurers are central to delivering access to prevention, early detection, continuity of support and ongoing condition management, complementing public healthcare systems.

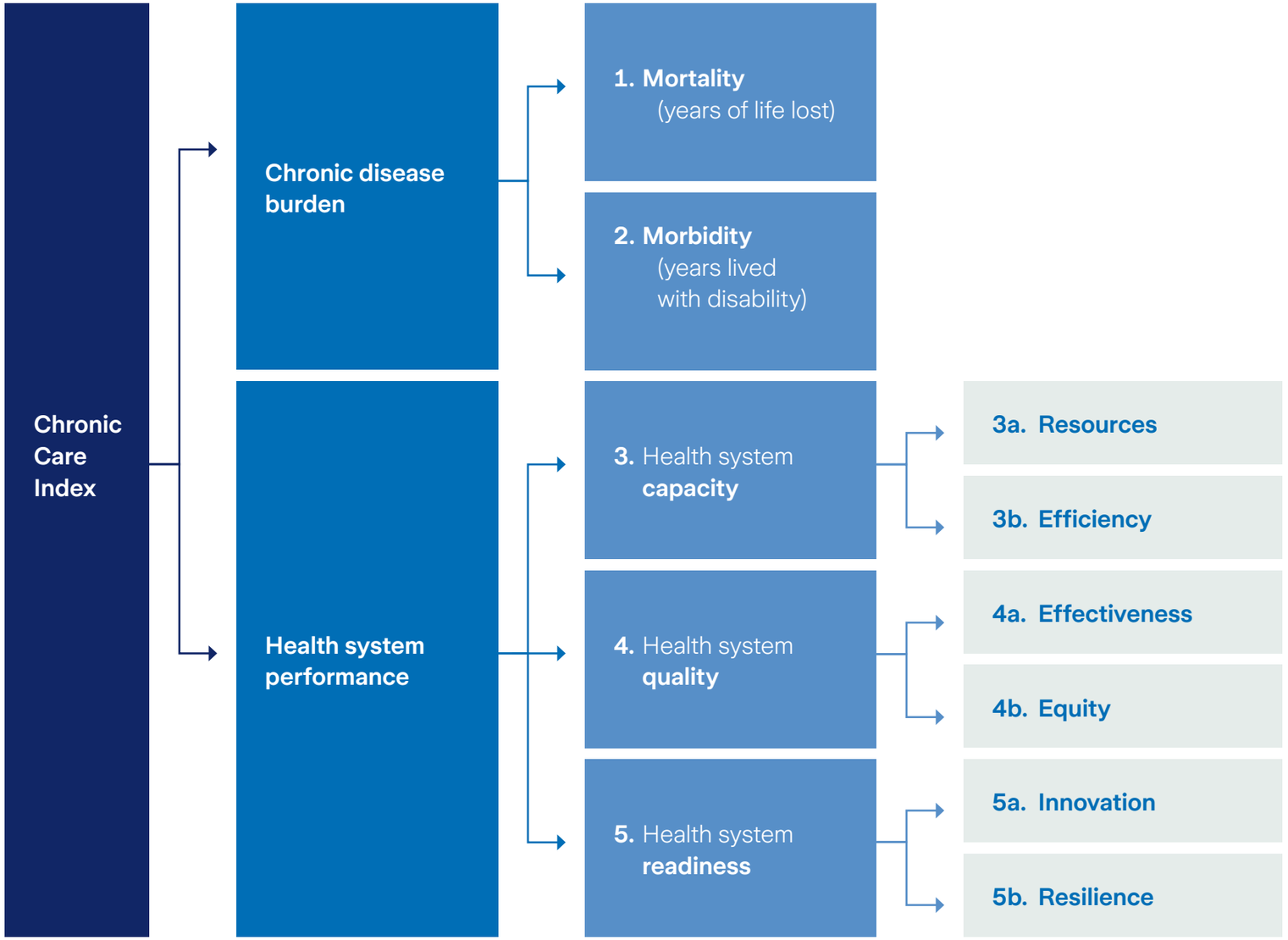
2. Riley-Gibson et al. A systematic review to determine the effect of strategies to sustain chronic disease prevention interventions in clinical and community settings (2025).
3. OECD. Integrating Care to Prevent and Manage Chronic Diseases (2023).
4. Virtanen et al. Effectiveness of workplace interventions for health promotion (2025).

How to read this report

The *Value of Chronic Care* is a comprehensive, data-driven index that measures and ranks how well health care systems are positioned in the face of a growing chronic disease burden.

Two primary dimensions are evaluated: the severity of chronic disease burden in terms of both mortality and morbidity; and the performance of health systems, considering capacity, quality, and readiness factors. Overall, dimension, pillar and indicator scores have a potential range from 0 – 100: higher scores indicate stronger performance.

The index enables direct comparison across all 38 member countries of the Organization for Economic Co-operation and Development (OECD).



What do we mean by chronic disease burden?

The definition of chronic disease used in this report is broad:[5] Conditions that require long-term care or ongoing treatment, and are a source of economic burden for patients, their families, and friends.

The Chronic disease burden dimension of the index covers more than 200 chronic conditions from more than 15 subsets of disease, captured in the Global Burden of Disease (GBD) study, published in 2025 using data to 2023.[6] This includes:

- **Communicable and nutritional diseases:** HIV/AIDS and select sexually transmitted infections; tuberculosis; certain tropical diseases, and nutritional deficiencies.
- **Non-communicable diseases,** such as neoplasms (cancers), cardiovascular diseases, chronic respiratory diseases, digestive diseases, neurological disorders, mental disorders, substance abuse disorders, diabetes and kidney diseases, skin and subcutaneous diseases, sense organ diseases, and musculoskeletal disorders.

We score a country's burden of chronic disease through fatal (Years of Life Lost, YLLs) and non-fatal (the Years Lived with Disability, YLDs) impacts.[7] These are combined into a composite measure: Disability-Adjusted Life Years (DALYs), a single figure that shows the overall impact of chronic disease.

To ensure comparability across countries and time periods, rates per 100,000 population were used to calculate scores.

What do we mean by health system performance?

The Health system performance dimension of the index measures the resources and capabilities of health care systems, through the lens of chronic disease treatment and management.

Country scores are derived from 30 indicators that measure three pillars of performance:

- **Capacity:** whether a health system can deliver care at scale, covering both resources (e.g., the availability of physicians) and efficiency measures (e.g., average length of hospital stay).
- **Quality:** whether care is effective (e.g., avoidable hospital admissions) and equitable (e.g., unmet needs).
- **Readiness:** whether a health system is positioned to respond to future challenges. This includes innovation (e.g. medical research expenditure) and resilience indicators (e.g., capital investment in health infrastructure).

5. Definitions of chronic disease vary. Refer to, for example: Bernell and Howard. Use your words carefully: what is a chronic disease? (2016); AIHW. Chronic disease (2025); CDC. About chronic diseases (2026); OECD. Does healthcare deliver? (2025); WHO. Noncommunicable diseases (2025).
6. Global Burden of Disease Collaborative Network. Global Burden of Disease Study 2023 (GBD 2023). Seattle, United States: Institute for Health Metrics and Evaluation (IHME), 2025.
7. One YLD represents one lost year of healthy life due to disability while one YLL represents one lost year of premature death.

Chronic disease burden

Chronic disease burden measures fatal and non-fatal impact associated with more than 200 chronic diseases across all 38 OECD countries.

Country scores are derived from total years of healthy life lost (DALYs), which captures both morbidity (YLDs) and mortality (YLLs).

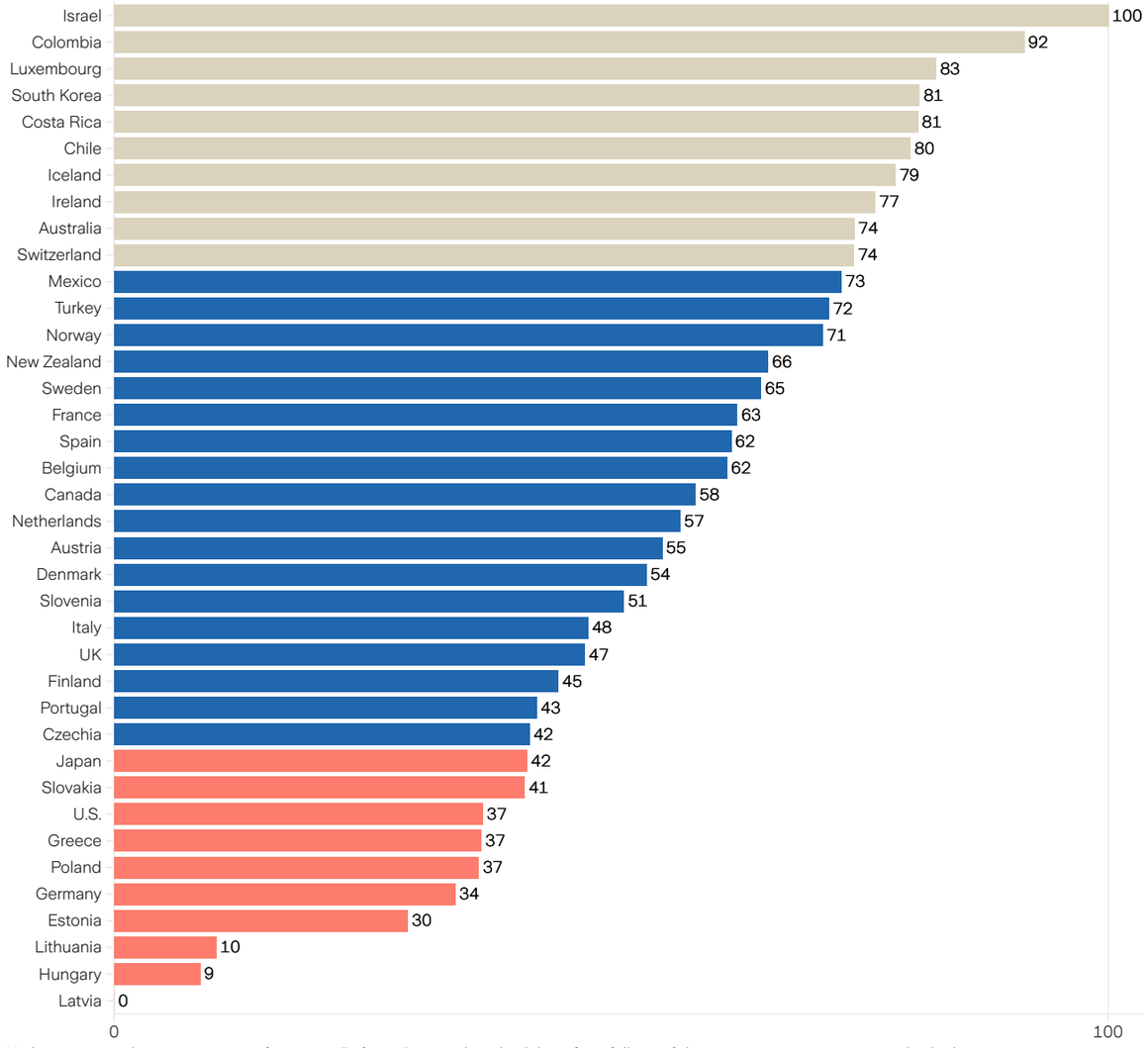
Future risk: Colombia ranks #2, with a low disease burden that largely reflects its demographic profile. Early signs of pressure are already emerging, with rising morbidity and mortality, narrowing the window for prevention and primary care to respond before demand accelerates.

Metabolic risk: Canada ranks #19 and is one of the few countries seeing both morbidity and mortality rise. As a super-aged country, it is also experiencing a shift in its risk profile – metabolic risks are increasing even as behavioral risks decline, placing greater weight on sustained disease management and support over time, including across working-age populations.

Mortality risk: Hungary ranks #37, with cardiovascular diseases accounting for nearly half (45%) of mortality impacts. While mortality rates have declined slightly, risk exposure remains elevated: high blood pressure dominates alongside rising metabolic risks, with prevention and risk reduction remaining key to further progress.

Scores: Chronic disease burden

0–100



Higher scores indicate stronger performance. Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

A widening gap between lifespans and health spans

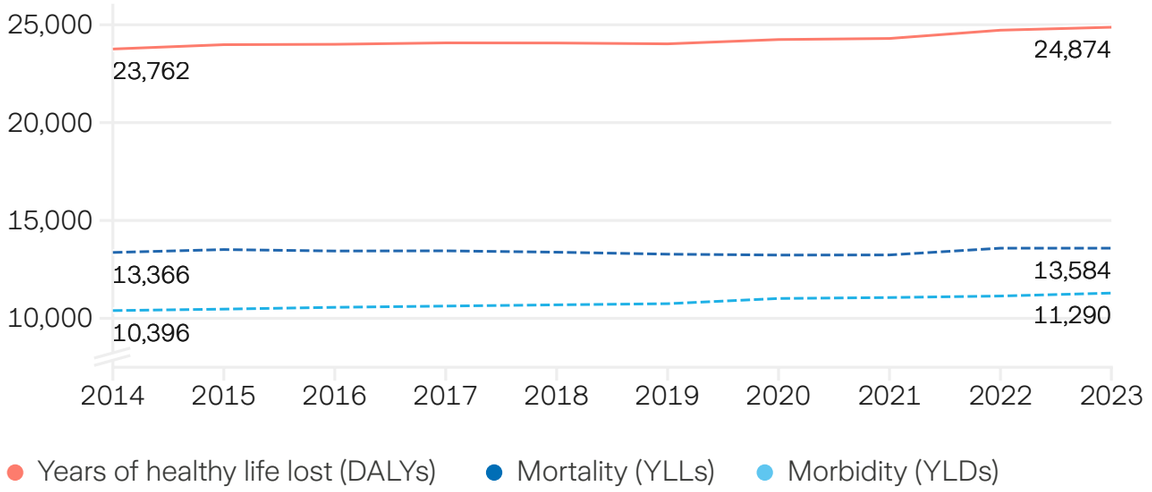
Chronic diseases – those that persist over long periods and require ongoing treatment – are a major strain on care systems across OECD countries. Longer lifespans have not been matched by equivalent improvements in population health.

The overall burden of chronic disease has risen slightly but steadily over the past decade, reflecting how people live, age, and receive care. A closer examination, however, reveals a shift in the nature of this burden. While both mortality and morbidity contribute to current trends, morbidity has grown more quickly over time. Although upticks in burden were visible during the COVID-19 pandemic, the underlying trajectory predates this.

These dynamics are particularly noticeable in countries with a lower overall disease burden, which perform well in aggregate terms but are also experiencing faster rates of morbidity growth. People may be living longer but survival gains are being accompanied by extended illness, increasing cumulative impacts on health systems, economies, and quality of life. This also changes the nature of related financial risk – moving from one-off events to sustained and uncertain exposure over time.

Chronic disease burden

Average DALYs, YLLs, and YLDs per 100,000 population across OECD countries, 2014 – 2023

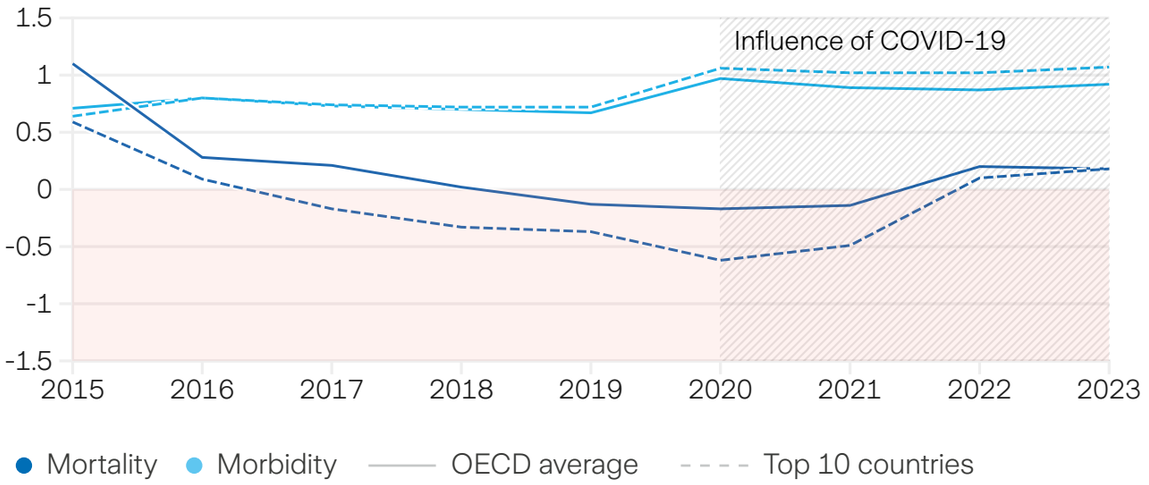


Primary source: IHME (2025).

Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

A morbidity-led burden

Average growth rates of morbidity and mortality impacts across OECD countries, 2014 – 2023



Primary source: IHME (2025).

Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

Morbidity- or mortality-led?

This trend is partially explained by two parallel dynamics: a slight drop in overall impact from conditions primarily associated with mortality, and a rising contribution from those associated with long-term morbidity.

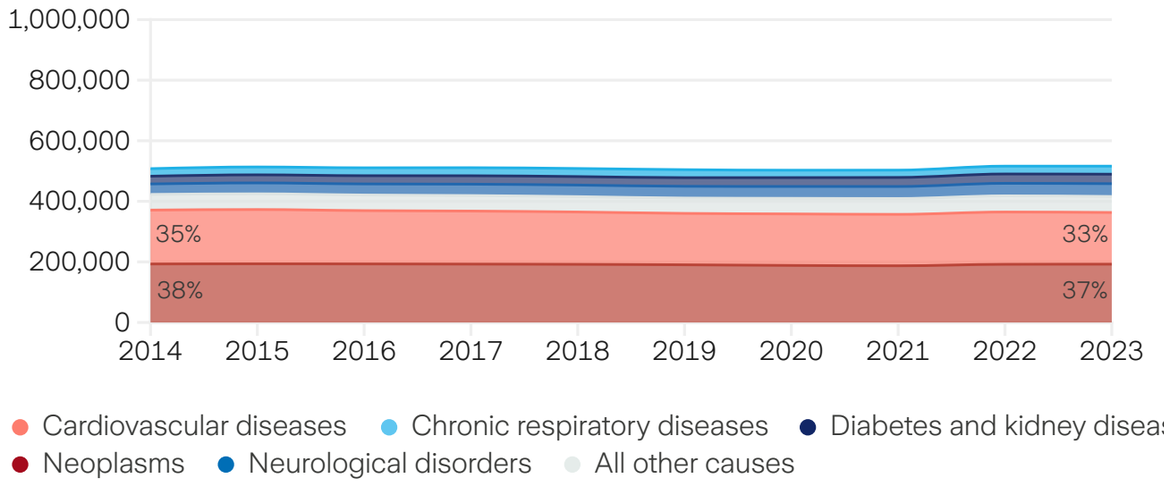
Neoplasms are the largest contributors to overall burden (21% of average DALYs per 100,000 population in 2023), driven predominantly by mortality (95% of associated DALYs). However, these impacts have slightly declined over time as survival rates improve. Cardiovascular disease, another high-mortality condition (86%) and major contributor to overall burden (21%), has also seen substantive drops in prevalence, and mortality and morbidity impacts over time.

In contrast, conditions characterized by long-term management – in particular mental health conditions and neurological diseases – have increased in morbidity impact and share of total burden (10% and 9%, respectively), reflecting higher prevalence. Musculoskeletal disorders also remain a significant contributor to morbidity and overall disease burden (9%). While reductions in mortality reflect important progress, increases in morbidity mean that conditions are becoming a decades-long problem, touching every dimension of a person's life: their health, their income, their independence, and their family's financial stability.

The economic profile of chronic disease is changing accordingly. Financial risk must be managed both at the point of diagnosis and over the course of long-term illness, with impacts no longer confined to retirement. As chronic disease extends into working life, it also shapes long-term financial planning, increasing the importance of both protection and savings planning to support extended periods of illness. Its effects extend beyond health systems alone – requiring a broader, more coordinated response across the institutions that shape people's health, work, and financial security.

Mortality burden by leading cause

Average YLLs per 100,000 population across OECD countries, 2014 – 2023

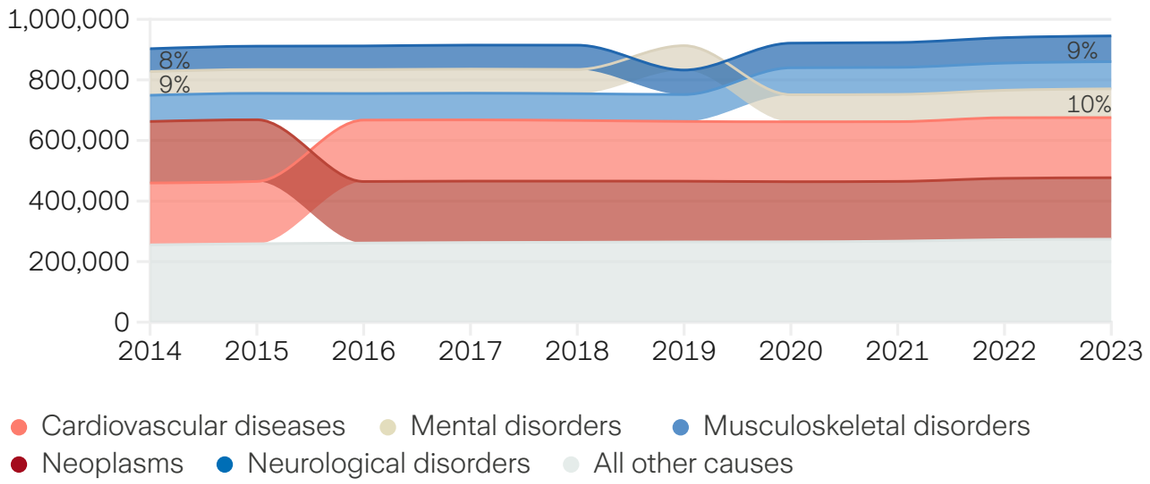


Primary source: IHME (2025).

Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

Morbidity burden by leading cause

Average YLDs per 100,000 population across OECD countries, 2014 – 2023



Primary source: IHME (2025).

Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

Spotlight

Dementia: Long-term care in practice

Dementia highlights a distinct aspect of the chronic care challenge, one defined by progressive loss of independence over time. As the condition advances, care shifts from clinical treatment to sustained support with daily living, often over many years.

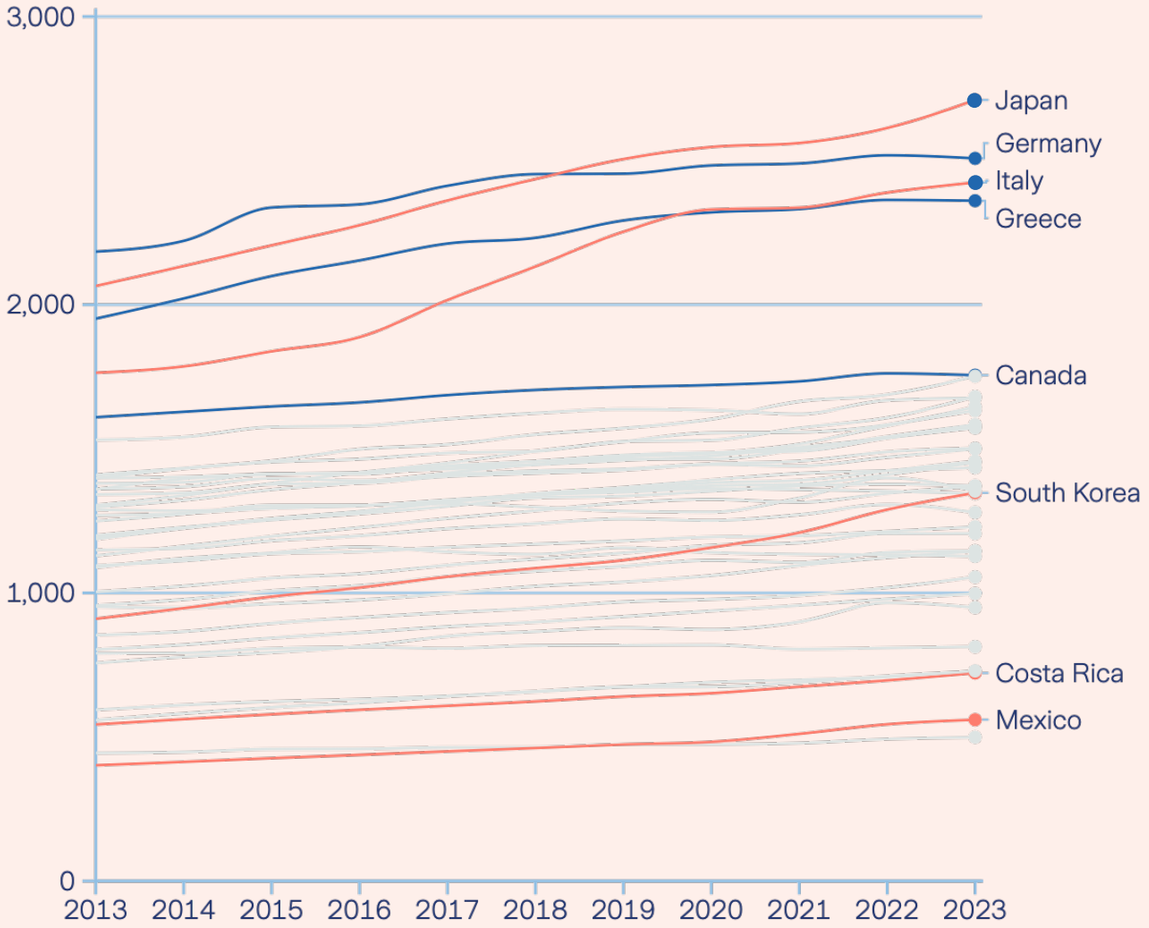
This creates a different model of care demand. Support increasingly sits outside hospitals and formal care settings, delivered through a combination of community services and informal caregiving. Families play a central role, often coordinating care, managing day-to-day needs, and absorbing the long-term impact on time, income, and wellbeing.

Coordinated, multi-component interventions – including caregiver education, case management, structured support programs, and community-based services – can help to maintain quality of life and reduce the burden on both individuals and those supporting them.[8] This can include approaches such as remote education and digital support for caregivers, structured care coordination, and access to services that enable people to remain at home for longer while maintaining connection to care.[9]

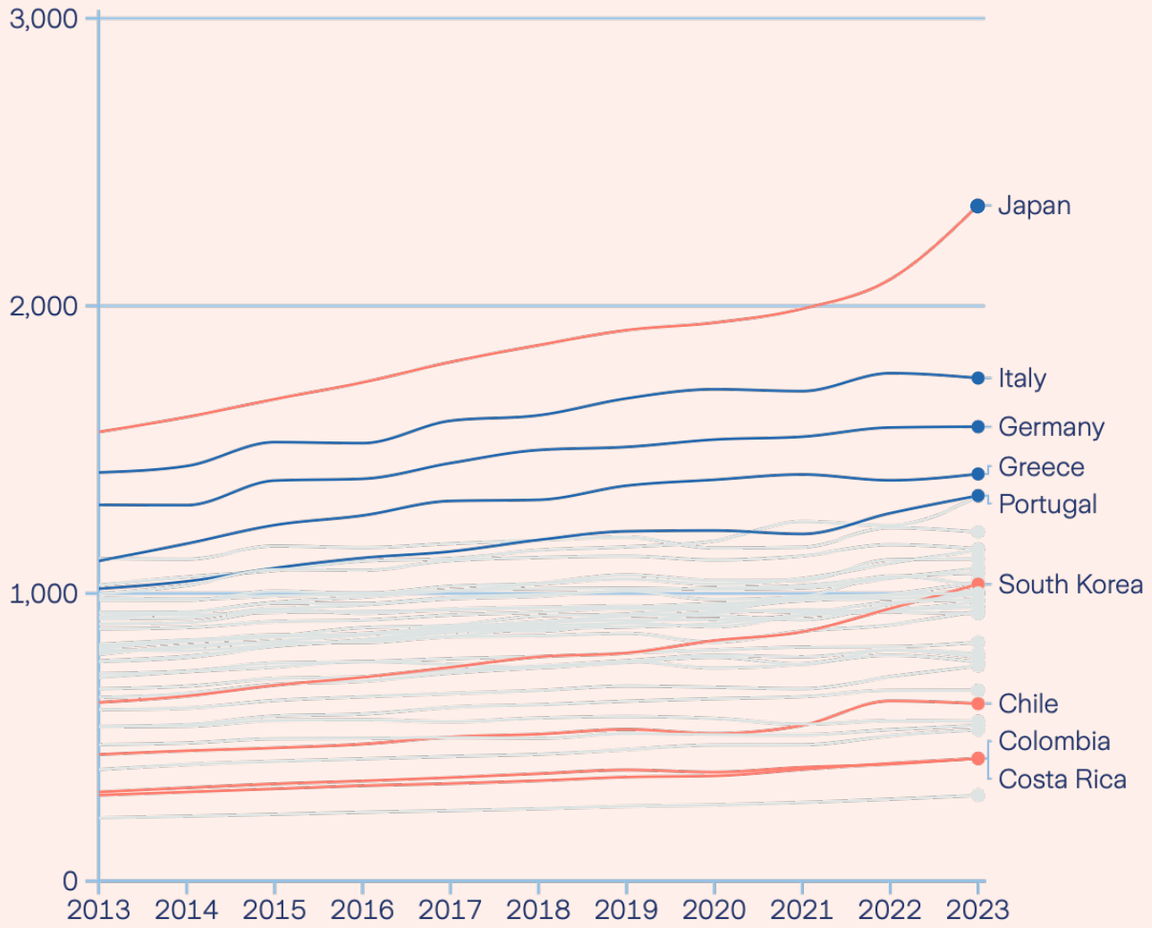
This also expands the role of protection and support systems beyond healthcare alone. Services that help people navigate care, access information, and address the financial and practical implications of long-term illness are becoming increasingly important alongside traditional medical treatment. These services extend to support for caregivers and family members, and transitions out of the workforce through financial protection and support services.

8. Encinas Monge et al. Interventions to Relieve the Burden on Informal Caregivers of Older People with Dementia: A Scoping Review (2024); Kwok et al. Multicomponent Intervention for Distressed Informal Caregivers of People with Dementia (2025).
9. Messina et al. Help-Seeking in Informal Family Caregivers of People with Dementia: A Qualitative Study with Support as a Case in Point (2022); WHO. Supporting informal long-term caregivers for older people (2024).

Alzheimer's disease and other dementias: Prevalence
Rate per 100,000 population, by OECD country, 2013 – 2023



Alzheimer's disease and other dementias: Years of healthy life lost
DALYs per 100,000 population, by OECD country, 2013 – 2023



High growth High volume

Primary source: IHME (2025). Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

Regional results: Where mortality still dominates

The shift toward morbidity has not been uniform across geographies. Patterns of disease burden vary significantly between countries, shaped by differences in underlying risk factors, health system performance, and population characteristics.

The lowest disease burden – or strongest performance in the index – can be found in two distinct sets of countries, both of which exhibit lower levels of mortality:

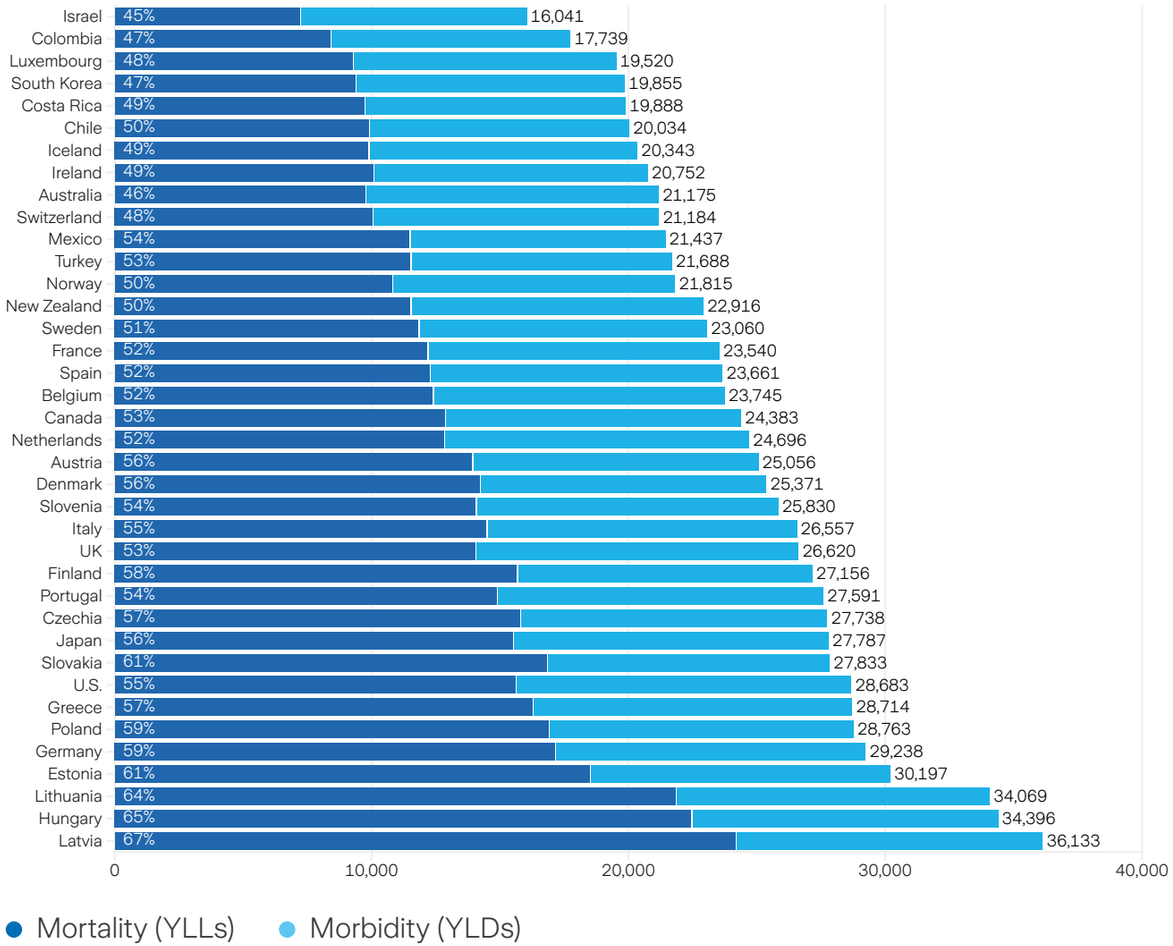
1. **"Younger" countries** where the burden has likely not yet peaked, such as Colombia, Chile, and Costa Rica.

2. **"Aging" countries**, such as South Korea, Luxembourg, and Australia, where lower disease scores point to more effective intervention and prevention of underlying risk factors (see Chronic Care Index).

But for countries with the highest disease burden – most notably in Eastern Europe – the chronic disease challenge remains, first and foremost, one of premature mortality. Nearly two-thirds of healthy life lost in these markets is still driven by early death from chronic conditions.

Chronic disease burden

Average YLDs and YLLs (%) and total per 100,000 population, 2023



Primary source: IHME (2025).

Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

Risk factors shape burden

Chronic disease outcomes are not determined by health systems alone. They reflect the distribution of underlying risk across populations, including metabolic, behavioral, and environmental factors. These risk profiles reflect not only current behaviors, but also the cumulative effects of prevention, policy, and demographic structure over time.

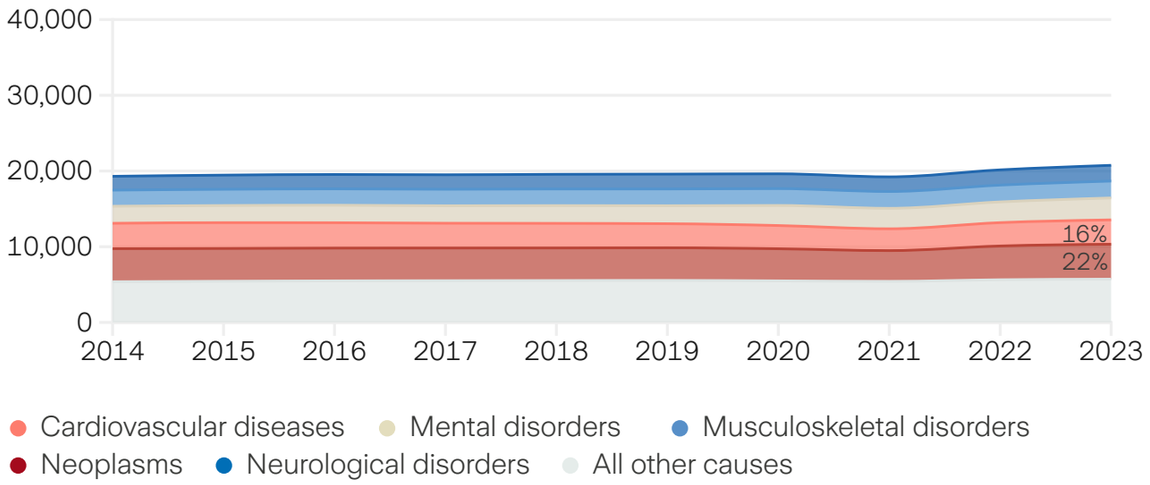
Countries with a higher disease burden (including Latvia, Lithuania, and Hungary) tend to face elevated exposure across multiple risk factors simultaneously – particularly high blood pressure, obesity, poor diet, tobacco use, and alcohol consumption. These risk factors are major drivers of the leading causes of premature death, particularly cardiovascular conditions and certain cancers, which dominate the case profile of lower-performing countries (together contributing to 54% of total healthy life lost in Hungary in 2023, versus 38% in Ireland, for example).

Differences in exposure also point to the role of prevention, early detection, and targeted intervention in shaping outcomes. Lower-burden countries, for example, tend to show lower overall exposure, reflecting the well-established understanding that chronic disease outcomes reflect not only the performance of health systems, but the distribution of modifiable risk factors within populations.

The clustering of countries by risk profile further reinforces this relationship, but also highlights its limits. Countries broadly fall into groupings defined by the distribution and intensity of behavioral, metabolic and environmental risks, but the alignment between risk exposure and disease burden is not uniform. Countries with broadly similar risk patterns can still experience different outcomes. For example, Switzerland and the UK sit within a comparable risk profile, yet rank 10th and 25th respectively on Chronic disease burden. This difference likely reflects not only variations in risk exposure, but how those risks accumulate over time and are managed through prevention, early

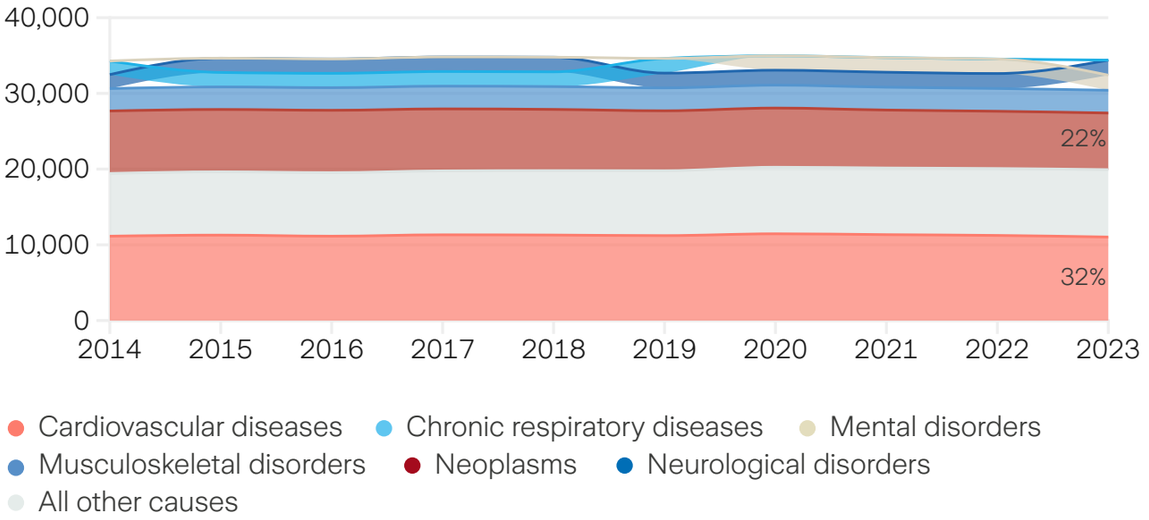
Ireland (#8): Total chronic disease burden by leading cause

Average DALYs per 100,000 population, 2014 – 2023



Hungary (#37): Total chronic disease burden by leading cause

Average DALYs per 100,000 population, 2014 – 2023



Primary source: IHME (2025). Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

detection and ongoing care – particularly where intervention occurs earlier in life, when long-term impacts on health, productivity, and cost can be most effectively shaped.

Importantly, there is no single dominant risk factor. Chronic disease burden reflects the combined effect of multiple risks, often interacting over long periods of time. Sustained improvements in outcomes therefore depend on addressing the full risk profile – across behavioral, metabolic, and environmental drivers – and adapting that response as the nature of risk evolves.

Risk characteristics across country clusters

Standarized DALYs per 100,000, 2023

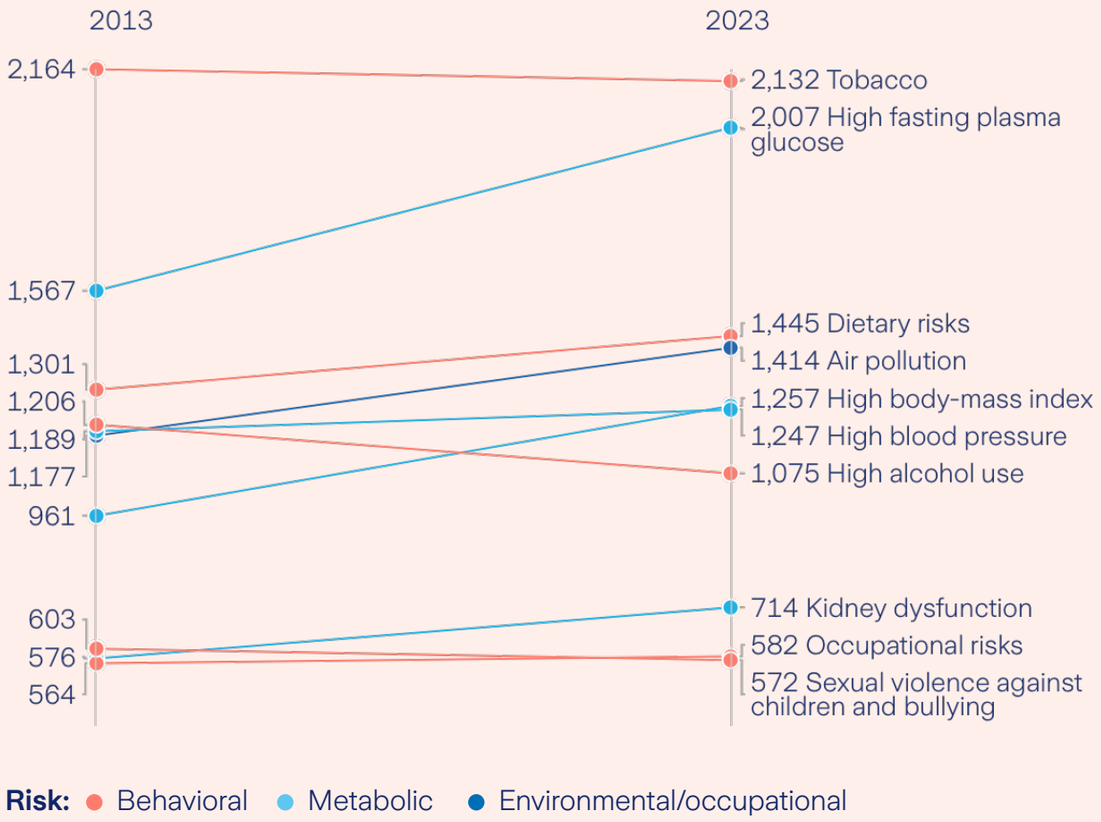
Risk factors	High multi-risk burden (e.g., 37 Hungary, 38 Latvia)	High burden (e.g., 32 Greece, 34 Germany)	Mid-range burden (e.g., 26 Finland, 29 Japan)	Mid-to-lower burden (e.g., 15 France, 19 Canada)	Low burden (e.g., 2 Colombia, 4 South Korea)	Outliers (11 Mexico, 31 U.S.)
Environmental and occupational risks						
Air pollution	1.68	0.42	0.15	-1.11	-0.81	-0.3
Non-optimal temperature	1.8	0.32	-0.21	-0.68	1.05	-0.2
Other environmental risks	1.86	0.4	-0.39	-0.61	-0.79	-0.5
Occupational risks	-0.03	0.1	0.72	1.42	-0.97	-1.2
Behavioral risks						
Child and maternal malnutrition	1.22	0.27	-1.04	-1.33	0.77	0.1
Tobacco	1.49	0.86	-0.17	-0.25	-1.17	-0.8
High alcohol use	1.84	0.44	-0.5	-0.56	-0.86	-0.4
Drug use	-0.22	-0.37	-0.67	-0.24	-0.51	2
Dietary risks	1.76	0.54	-0.44	-0.72	-0.92	-0.2
Intimate partner violence	-0.52	-0.93	-0.58	0.15	0.02	1.9
Sexual violence against children and bullying	-0.84	-0.87	-0.69	0.4	0.31	1.7
Unsafe sex	1.05	-0.38	-0.88	-1	-0.19	1.4
Low physical activity	1.66	0.4	0.18	-0.62	-1.23	-0.4
Metabolic risks						
High fasting plasma glucose	0.51	0.43	0	-0.99	-1.31	1.4
High systolic blood pressure	1.76	0.56	-0.18	-0.68	-0.88	-0.6
High body-mass index	1.21	0.55	-0.41	-0.93	-1.24	0.8
Kidney dysfunction	1.31	0.09	-0.44	-0.97	-1.03	1
High LDL cholesterol	1.81	0.36	-0.37	-0.65	-0.84	-0.4

Primary source: IHME (2025).

DALYs in this case capture the burden of chronic diseases only. Positive values mean higher-risk attributable burden than the average. Outliers have a uniquely high risk from drug abuse and interpersonal violence. Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

South Korea: From behavioral to metabolic risk

South Korea: Leading risk factors for healthy life lost
DALYs per 100,000 population and overall ranking, 2013 – 2023



Primary source: IHME (2025).

DALYs in this case capture the full burden of disease, not just chronic conditions. Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

Countries that actively manage behavioral and metabolic risks can outperform what demographic structure alone would predict.

South Korea is an illustrative case. It is now a super-aged society, with more than 20% of the population aged 65 and over,[10] and yet it ranks 4th on Chronic disease burden. This performance strengthens further when age-standardized (Regional results: Age matters), where South Korea ranks 1st, indicating that outcomes are not simply the product of favorable demographics but of more effective management of risk over time.

Part of this reflects a sustained policy response. South Korea's National Health Plan 2030 (HP2030) sets out a multi-sector framework spanning smoking, alcohol, nutrition, physical activity, cardiovascular disease, and obesity, with an explicit goal of extending healthy life expectancy.

Policy action has focused on major behavioral risks – particularly tobacco and alcohol – by tightening advertising and packaging controls, expanding cessation support, and strengthening public health campaigns. Both remain leading contributors to total disease burden (#1 and #7, respectively), but are also among the few risk factors to have declined over the past decade, with estimated contributions falling by 32 and 131 DALYs per 100,000 population, respectively.

At the same time, metabolic risks are moving in the opposite direction. High fasting plasma glucose and high body-mass index have seen the largest increases in contribution to disease, rising by 440 and 296 DALYs per 100,000 population, respectively, over the same period.

10. IMF. Republic of Korea Selected Issues (2025); Statista. Aging population in South Korea (2025).

South Korea's approach integrates continuous surveillance and early intervention to respond to this evolving risk profile. Large-scale national health surveys track changes in diet, activity, and metabolic health, enabling earlier detection and more targeted policy responses over time,[11] creating a feedback loop between data and intervention, and supporting more adaptive management of chronic disease risk.

This is further complemented by targeted chronic disease management programs, such as national initiatives for hypertension and diabetes, which combine education, counseling, nutrition and exercise support, alongside reminder systems to improve adherence and continuity of care. These programs focus on slowing progression and reducing complications, particularly for conditions where risk factors cannot be fully reversed.

Overall, South Korea's experience shows that higher burden is not an inevitable consequence of aging. Instead, outcomes reflect how effectively countries manage risk over time, combining prevention, regulation, and sustained disease management as the nature of that risk evolves.

11. Korea Disease Control and Prevention Agency. Utilization of national health survey results (accessed May 2026).

The next opportunity:
From management to prevention

As the contribution of morbidity continues to grow, the gap between life and health spans is widening – reshaping how disease is experienced and how it must be managed. Chronic disease is not only a health issue, but an economic one: Countries with higher burdens face increased healthcare costs, reduced workforce participation, and greater financial strain on households and public systems.

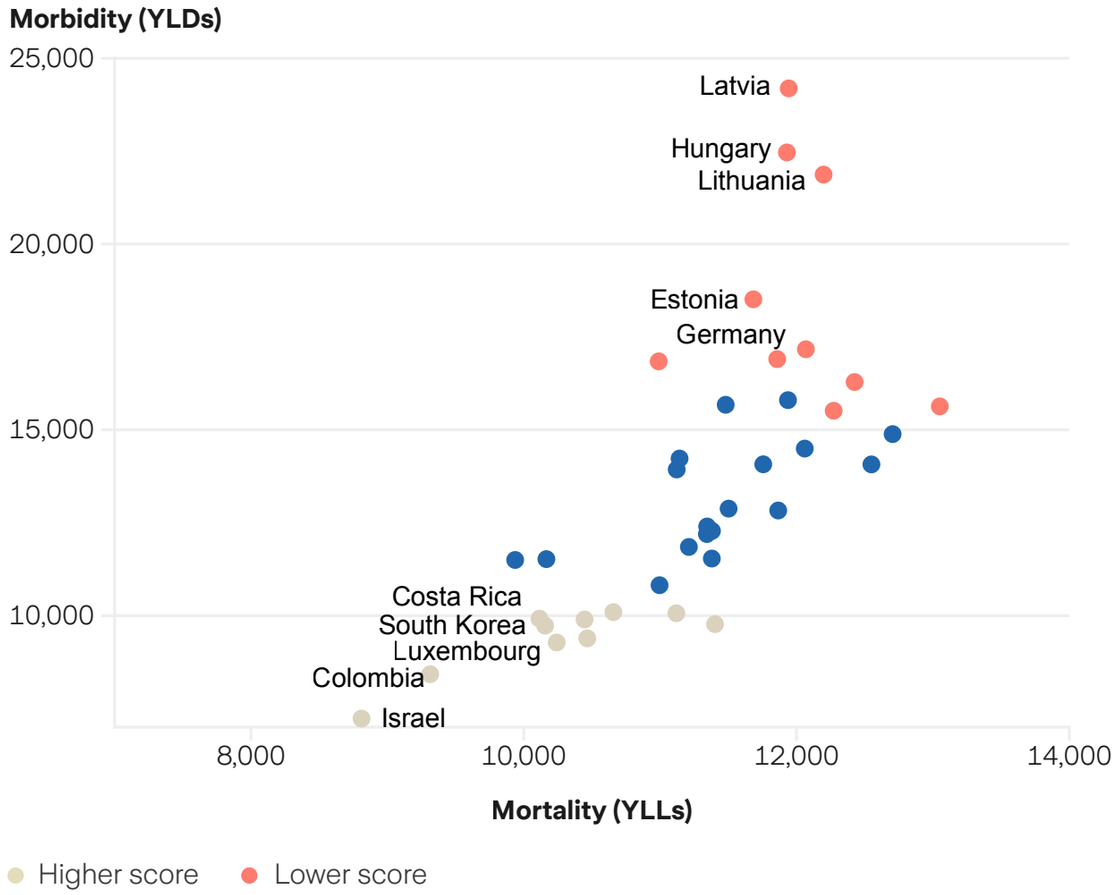
Understanding where burden falls – whether in premature mortality or prolonged morbidity – is critical to aligning prevention strategies, care systems, and financial protection with the realities people face, from acute needs to long-term income, disability, and care-related risks.

In higher-burden countries, some chronic diseases continue to persist in ways that higher-performing countries have been able to prevent or delay. Reducing mortality in these settings depends not only on treatment capacity but on addressing the underlying drivers of risk, including behavioral factors such as diet and physical activity, environmental exposures, and broader social determinants.

In lower-burden countries, the rise in morbidity likely means the long-term management of complex, often overlapping conditions, not just acute events. Comorbidity is common, with individuals experiencing multiple conditions simultaneously. Alongside a shifting condition profile, this intensifies clinical complexity and resource requirements, and calls for sustained investment in long-term disease management, mental health support, and age-related care.

Across both contexts sits a critical lever: prevention. Without a fundamental rebalancing of investment toward upstream prevention – behavioral interventions, screening, early diagnosis, and sustained lifestyle support – the cost of chronic disease and extended morbidity will continue to rise for households, employers, and protection systems.

Chronic disease burden by mortality and morbidity
YLLs and YLDs per 100,000 population



Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

Prevention remains underweighted in many systems. It often focuses on vaccines and screening, with broader lifestyle intervention – where much of chronic disease risk sits – falling outside formal care. In the UK, for example, only 5 percent of health expenditure is directed toward preventive measures.[12] Medical education devotes minimal time to nutrition and lifestyle, despite their role in the chronic conditions that dominate health spending.[13]

Prevention is also not evenly distributed: Those most exposed to risk are often the hardest to reach, particularly where environments reinforce unhealthy choices through the availability and marketing of poor-quality food, sedentary work and lifestyles, and limited access to healthier alternatives. The result is a system that is extraordinarily good at rescuing people once they are sick but focuses far less on helping them stay well.

Behavioral interventions, such as improvements in nutrition and physical activity, remain fundamental in reducing the incidence of chronic disease.[14] However, risk also reflects long-term exposure, aging, and prior health status – meaning improvements in behavioral risks, such as tobacco and alcohol, are not necessarily matched by reductions in underlying metabolic risk.

Prevention therefore cannot rely on reducing current exposure alone. It depends on sustained behavioral interventions combined with earlier identification, monitoring and ongoing management of metabolic risk. This includes consistent access to screening and support that is maintained over time, rather than delivered as one-off interventions.

Narrowing the gap requires shifting earlier in the pathway, where outcomes can be more effectively influenced. This is where the role of employers and supporting ecosystems becomes more pronounced: workplace health initiatives, preventive screenings, and targeted interventions can improve early detection and support ongoing management, particularly where chronic disease is a driver of long-term absence and workforce exit. Increasingly, employers and insurers are embedding prevention within employee benefits frameworks – combining digital tools, behavioral support, and access to specialist care to enable earlier and more sustained intervention.

In the UK alone, more than **2 million** people are economically inactive due to long-term health conditions and another **300,000** leave the workforce each year.

Sources: Gov.UK. Keep Britain Working: Final report (2026); The Health Foundation. Towards a healthier workforce (2024).

12. Office of National Statistics. Healthcare expenditure, UK Health Accounts: 2023 and 2024 (2025).
13. Crowley et al. Nutrition in medical information: a systematic review (2019); Albin et al. There and Back Again: A Forty-Year Perspective on Physician Nutrition Education (2024).
14. Riley-Gibson et al. A systematic review to determine the effect of strategies to sustain chronic disease prevention interventions in clinical and community settings (2025).

Diabetes: A gateway condition

Diabetes mellitus (diabetes)[15] is a particularly illustrative case of how chronic disease burden is evolving: rising prevalence, in some cases earlier onset, and extended duration across a set of interconnected and progressive conditions. It impacts between 11 (Israel and Iceland) and 28 percent (Japan) of the population across OECD countries but its impact extends well beyond its direct effects.

Diabetes functions as a multiplier of health risk. It is closely linked to a constellation of interrelated cardiometabolic risk factors – including high fasting plasma glucose, obesity, high blood pressure, and poor diet – that are shared across multiple chronic conditions. As a result, those at risk of diabetes are often also at risk of related conditions, from cardiovascular and kidney diseases to neurological complications. A single diagnosis can therefore set off a cascade of secondary health issues, increasing both the complexity and duration of care.

Improvements in treatment mean that more people are living longer with diabetes, often over several decades. While this reflects significant clinical progress, it also increases the number of years spent managing the disease and its complications.

High costs of emerging therapies – including the new generation of GLP-1-based weight-loss and diabetes medications – currently limits broad access in many markets, though wider availability, including lower-cost alternatives as patents expire, could influence outcomes and downstream complications over time.

A diagnosis of diabetes can therefore shape health, work, and financial outcomes over many years, making diabetes disproportionately costly relative to its prevalence, due to its impact on workforce participation, income stability, and long-term financial security.

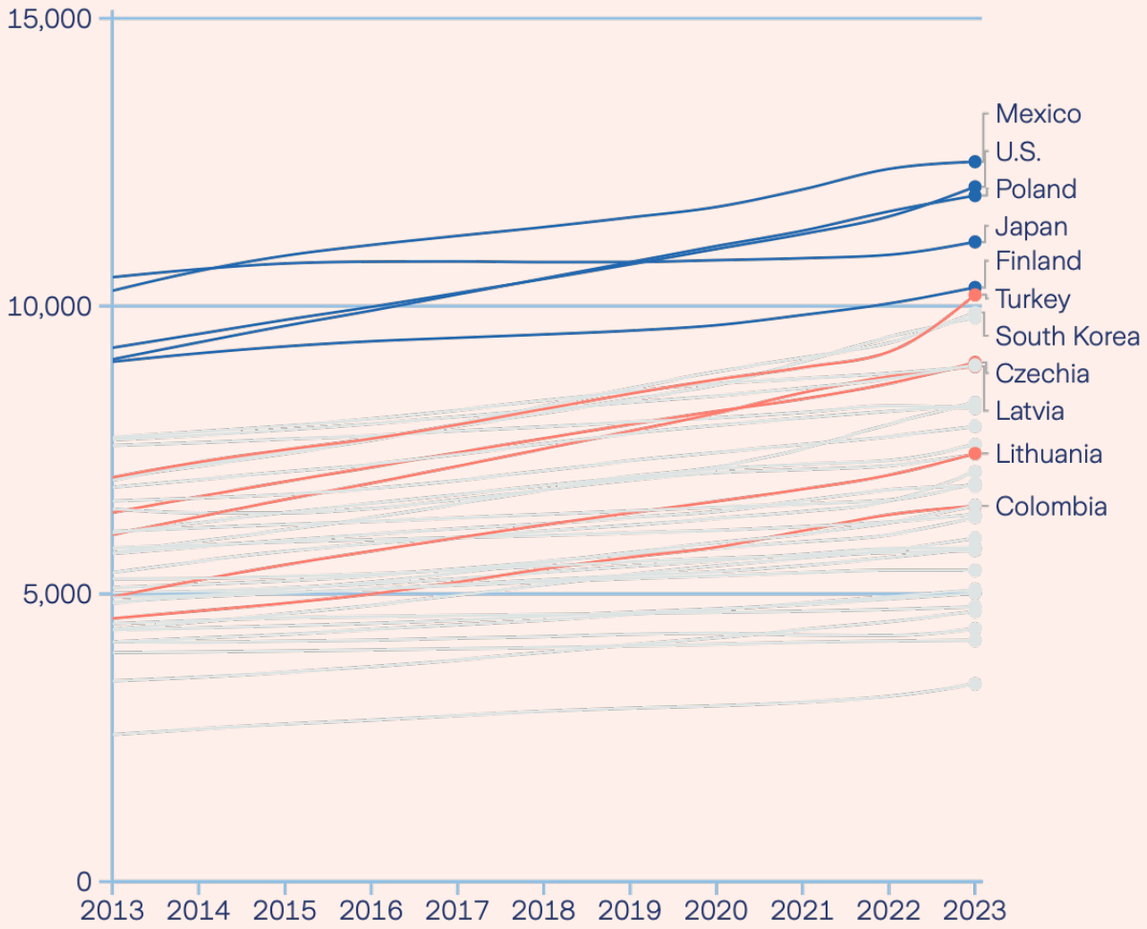
Despite well-established risk pathways, prevention remains uneven. Many of the key risk factors to diabetes are shaped by environmental, social, and behavioral conditions that can be difficult to change through individual action alone.

This is prompting greater focus on coordinated and timely intervention, proactive disease management, and forms of financial protection that reflect the long-term nature of chronic disease risk. This includes more targeted, condition-specific interventions where earlier screening and ongoing monitoring, coaching, and behavioral support can reduce progression and complications over time, helping to limit duration and cost.

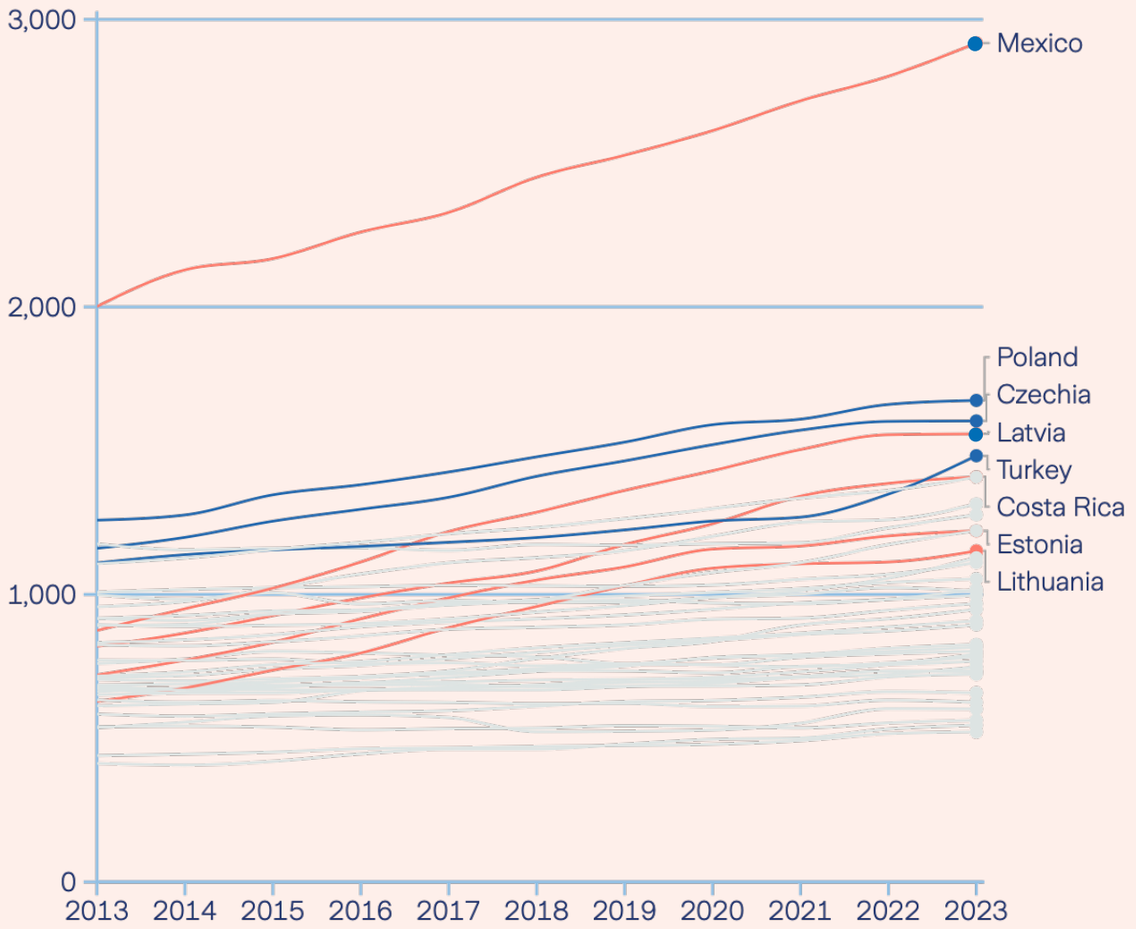
The challenge is not only to treat individual diseases, but to manage the wider system of risk factors and long-term care needs that underpin them – and to ensure that prevention, protection, and support mechanisms evolve in step with this changing reality.

15. A chronic condition in which the body cannot produce enough insulin or effectively use the insulin it produces, encompassing both Type 1 and Type 2.

Diabetes mellitus: Prevalence
Rate per 100,000 population, 2013 – 2023



Diabetes mellitus: Years of healthy life lost
DALYs per 100,000 population, by country, 2013 – 2023



High growth High volume

Primary source: IHME (2025). Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

Health system performance

Health system performance measures the resources and capabilities of health care systems across the 38 OECD countries, through the lens of chronic disease treatment and management.

Country scores are derived from 30 indicators that measure three key dimensions: Capacity (resources and efficiency); Quality (effectiveness and equity); and Readiness (innovation and resilience).

Continuity: Spain ranks #9, driven by strong Quality (#4). High levels of trust, care coordination and patient confidence point to a system that is more navigable and consistent over time, supported by primary care and universal coverage.[16]

16. European Observatory on Health Systems and Policies. Spain: health system review 2024 (2024).

Reach: The UK ranks #12, supported by high Readiness (#3), but constrained by mid-range Capacity (#15) and lower Quality (#22). Gaps in access and avoidable admissions suggests that care does not consistently reach people early enough, although reforms are shifting services into neighborhood settings and expanding primary and community-based care.[17]

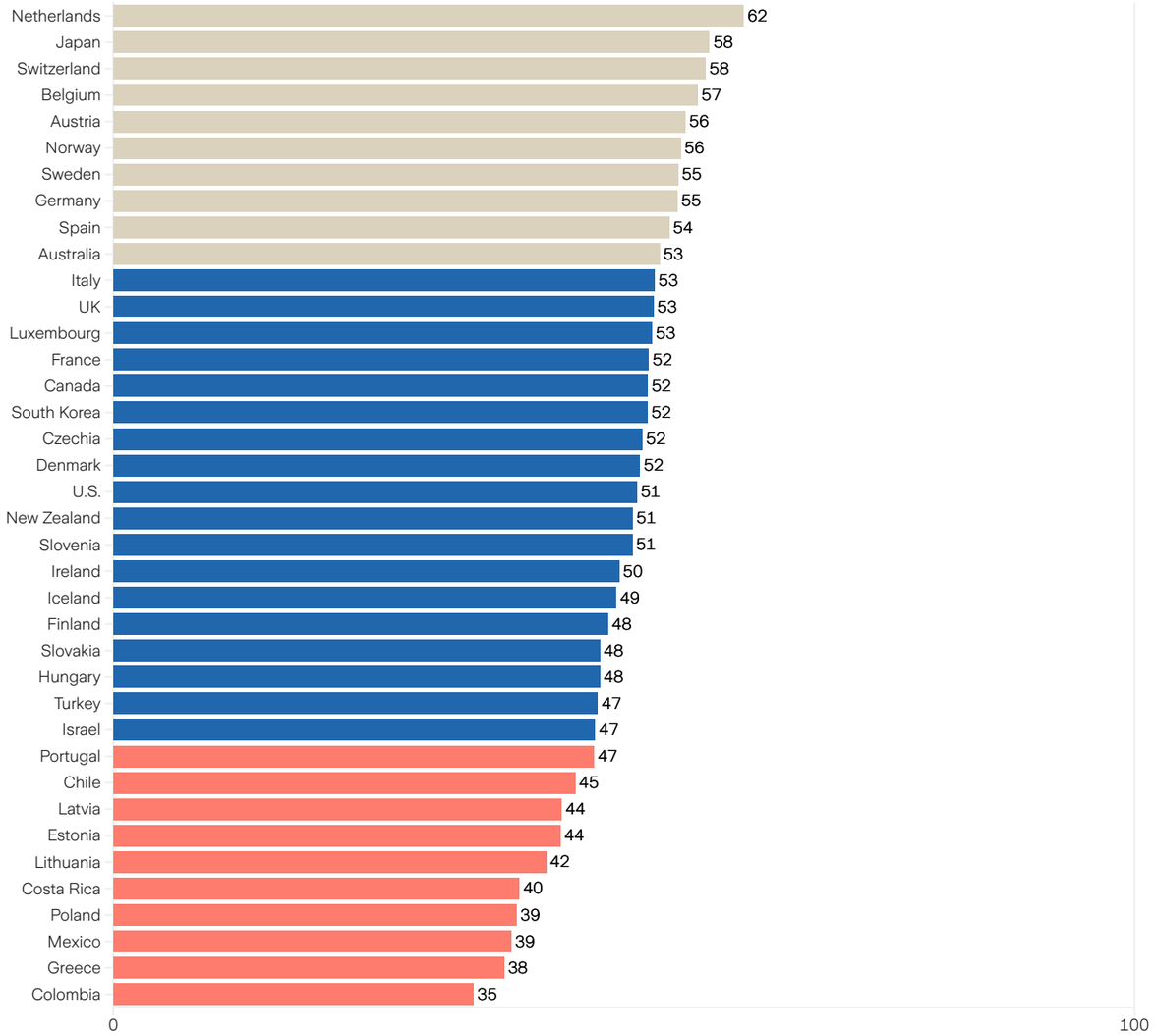
17. Department of Health and Social Care. PM launches new era for NHS with easier care in neighbourhoods (2025).

Capacity: Portugal ranks #29, with very low Capacity (#35) despite relatively strong Quality (#12) and equity (#7). Delivery remains constrained by efficiency and long-term care capacity, even as reforms reorganize services into integrated Local Health Units that combine primary, hospital and community care to improve coordination over time.[18]

18. European Observatory on Health Systems and Policies. Portugal: health system summary 2024 (2025).

Scores: Health system performance

0 – 100



Higher scores indicate stronger performance. Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

Quality drives comparative performance

Across OECD countries, health system performance varies substantially. It is tempting to attribute these differences to resource gaps – fewer beds, fewer clinicians, lower spending – but results point to a more nuanced picture.

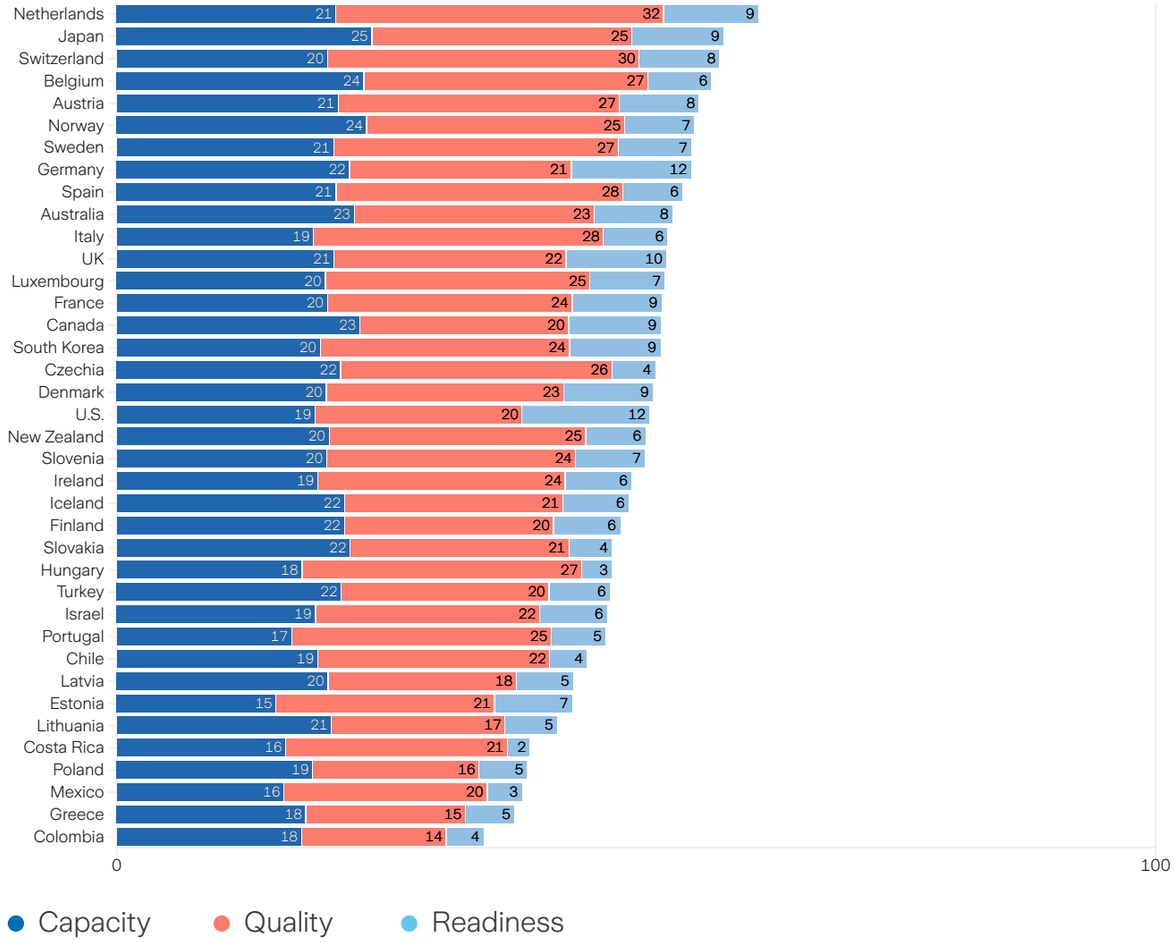
Capacity matters, but it does not fully explain the gap in performance. Capacity scores are more tightly clustered than other dimensions (with a 22-point spread in unweighted scores), suggesting that many systems in this analysis operate within a broadly similar range of resources.

By contrast, Quality and Readiness show greater variation (41 and 67 points, respectively). The largest differences between countries therefore sit less in how much care systems can provide and more in how well that care is delivered – and whether it reaches people consistently and equitably over time.

Several European countries, alongside Japan, sit at the top of the ranking, combining solid Capacity scores with stronger performance on Quality and Readiness. At the other end of the spectrum, some countries with comparatively low underlying disease burden – including Colombia and Costa Rica – nonetheless record weaker system performance, suggesting that disease outcomes may be shaped more by demographic or epidemiological factors than by system performance alone.

Health system performance scores by pillar

Overall scores (0 – 100)



Primary source: IHME (2025).

Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

Regional results:
Effective or equitable?

The Quality pillar of the index is particularly important for chronic conditions. These diseases are not episodic. Outcomes depend on continuity, early intervention, coordination across providers, and the patient's ability to manage their condition over time.

The gap between countries on Quality reflects two distinct, but closely related, sub-pillars: effectiveness and equity.

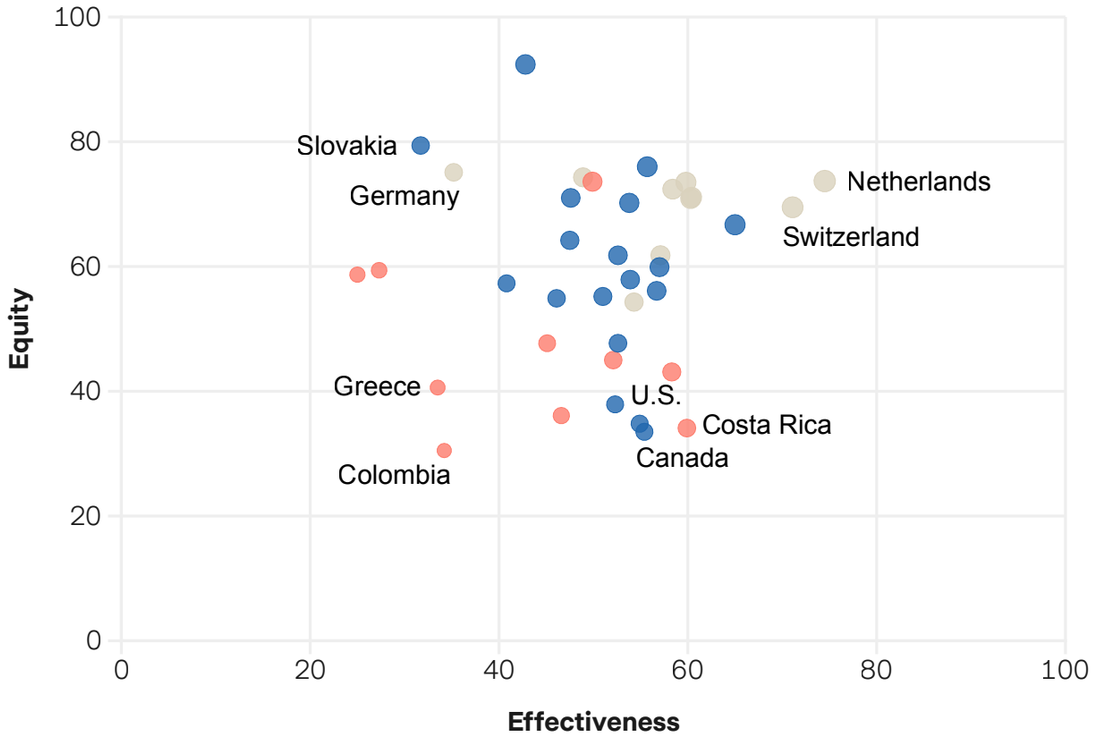
In some countries, such as the U.S., Canada, and Costa Rica, the primary constraint sits in equity. Care exists – and can even be high-performing in some cases – but is not consistently accessible. For chronic conditions, this could result in delayed diagnosis, uneven follow-up, and higher rates of preventable deterioration.

In other countries, including Germany and Slovakia, the constraint sits more clearly in effectiveness. These are systems that broadly reach patients, but may not prevent avoidable escalation, which can mean repeated exacerbations, unnecessary hospitalization, and weaker long-term condition management.

The widest care gaps emerge where both effectiveness and equity are weak. In countries such as Colombia and Greece, limited access and inconsistent delivery combine, increasing the risk of unmanaged progression and long-term burden.

Managing chronic disease is not simply a matter of increasing system inputs. The U.S. spends more, innovates more, and scores highly on patient experience, yet healthy life lost to chronic disease has still risen by over 10% over the past decade. The larger – and possibly harder – task is improving how care is delivered, ensuring that it is both effective in managing conditions over time and accessible across populations.

Health system performance: Equity vs. Effectiveness
Scores (0 – 100)

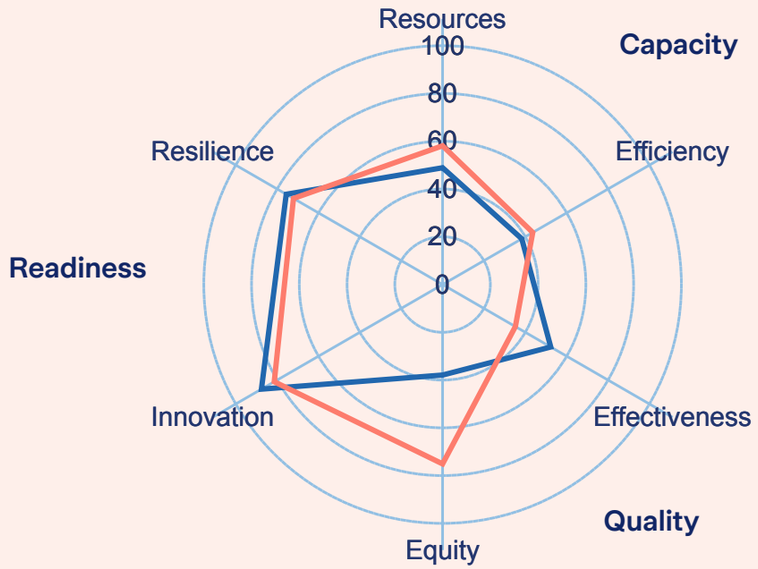


Health system performance: Higher score Lower score

Equity and Effectiveness are two sub-pillars of Quality in Health system performance. Higher scores indicate stronger performance. Scores (0–100) for the three pillars (Capacity, Quality and Readiness) are calculated individually and then combined using weighted inputs to produce the overall Health system performance score. Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

U.S. vs. Germany: Future readiness – at the cost of current delivery?

Health system performance by capacity, quality, and readiness
Scores (0 – 100)



● U.S. (#19) ● Germany (#8)

Higher scores indicate stronger performance. Refer to ⇨ Data and methodology for a full set of data sources, assumptions, and calculations.

Strength in one pillar does not compensate for weakness in another.

The world's largest economy and Europe's largest economy have much in common on paper. Both spend heavily on healthcare. Both rank in the top two globally on Readiness – investing more in health system innovation, R&D, and capability than almost any other country. Both carry a high chronic disease burden, ranking in the bottom quartile (Germany 34th, the U.S. 31st).

But beneath these similarities, results reveal two fundamentally different models of weaker performance – in how effectively that capability translates into accessible, consistent care.

The U.S. demonstrates a system with high capability for those within it, but limited reach beyond it. It ranks at or near the top on Readiness, innovation, and patient-reported effectiveness measures – including trust, care coordination, self-management confidence, and person-centered care. For those able to access the system, performance is among the strongest in the OECD.

However, this capability is unevenly distributed. Equity ranks near the bottom (#33), alongside weak efficiency (#31) as part of relatively low Capacity (#29). Despite the highest level of healthcare spending, indicators such as workforce availability and infrastructure remain comparatively weak. The result is a system that can deliver exceptional care – but does so unevenly.

In comparison, Germany has built a system that reaches its population. It ranks highly in Readiness and equity, and is comparatively stronger in Capacity. The infrastructure exists. The funding is there. Access is broad.

But overall Quality is held back by weaker effectiveness (#33). Germany has the infrastructure to manage chronic disease, but this does not appear to consistently translate into optimal outcomes. Patients enter the system readily; whether that care is delivered in a coordinated and effective way is more variable.

In the U.S., the gap is between capability and access. In Germany, it is between access and effectiveness. But which system translates into more consistent results?

Over the past decade, Germany's disease burden has remained broadly stable (5% total growth in DALYs between 2014 – 23), suggesting that its system is containing demand even where outcomes could improve.

The U.S., by contrast, has seen its chronic disease burden increase more rapidly (12%), despite higher levels of spending and innovation. This is partially due to an uptick in behavioral and substance-related diseases, shaped by drivers that sit outside the reach of traditional healthcare delivery.

These two experiences show that high levels of investment and innovation alone cannot solve a design problem: a system oriented toward episodes rather than journeys, toward treatment rather than management. What differentiates higher-performing systems is the ability to translate capacity and capability into care that is both effective and consistently accessible over time.

The access gap

For individuals living with chronic disease – and for the families, employers, and systems that support them – what matters most is whether they can access the care they need, when they need it, without financial strain.

Access is not defined by availability alone, but by affordability and geography. These challenges are reflected in weaker Quality scores, which capture higher levels of unmet medical need (particularly among lower-income groups), alongside higher effective costs of care and lower provider availability in underserved areas.

The result is an access gradient that shapes disease outcomes directly. Those most at risk of chronic disease are often the least able to access consistent care. Where barriers exist, people delay seeking diagnosis, struggle to maintain treatment, or rely on fragmented care, while individuals with greater financial or social resources are more likely to receive preventive services, early diagnosis, continuous care, and coordinated support. One person living with diabetes may have access to a GP, an endocrinologist, a dietitian, and a digital health platform – while another relies on an overstretched public clinic with a six-week waiting list.

The financial dimension reinforces this divide. Chronic disease is rarely a one-off cost. Management often spans decades, involving ongoing medication, specialist care and diagnostics, alongside, in some cases, reduced earning capacity. Where out-of-pocket costs are high, or protection is limited, this can lead to financial insecurity.

The next opportunity:
From fragmented intervention to integrated journeys

At its core, the chronic care challenge is one of navigation as much as availability. Chronic conditions that now dominate health and economic burden cannot be managed through isolated interventions or one-off payments. They require support that reflects how these conditions unfold: over years and often decades.

For individuals managing long-term conditions, the question is not only whether services exist, but whether they can move through the system in a coherent way – from diagnosis, to treatment, to ongoing management. In many systems, this journey is fragmented, with multiple providers, access points, and funding structures that are poorly connected.

This fragmentation becomes more pronounced as conditions evolve. A single diagnosis can lead to a chain of care needs – spanning treatment, specialist intervention, and longer-term support – often across different parts of the system. Managing this trajectory effectively requires coordination, not just access.

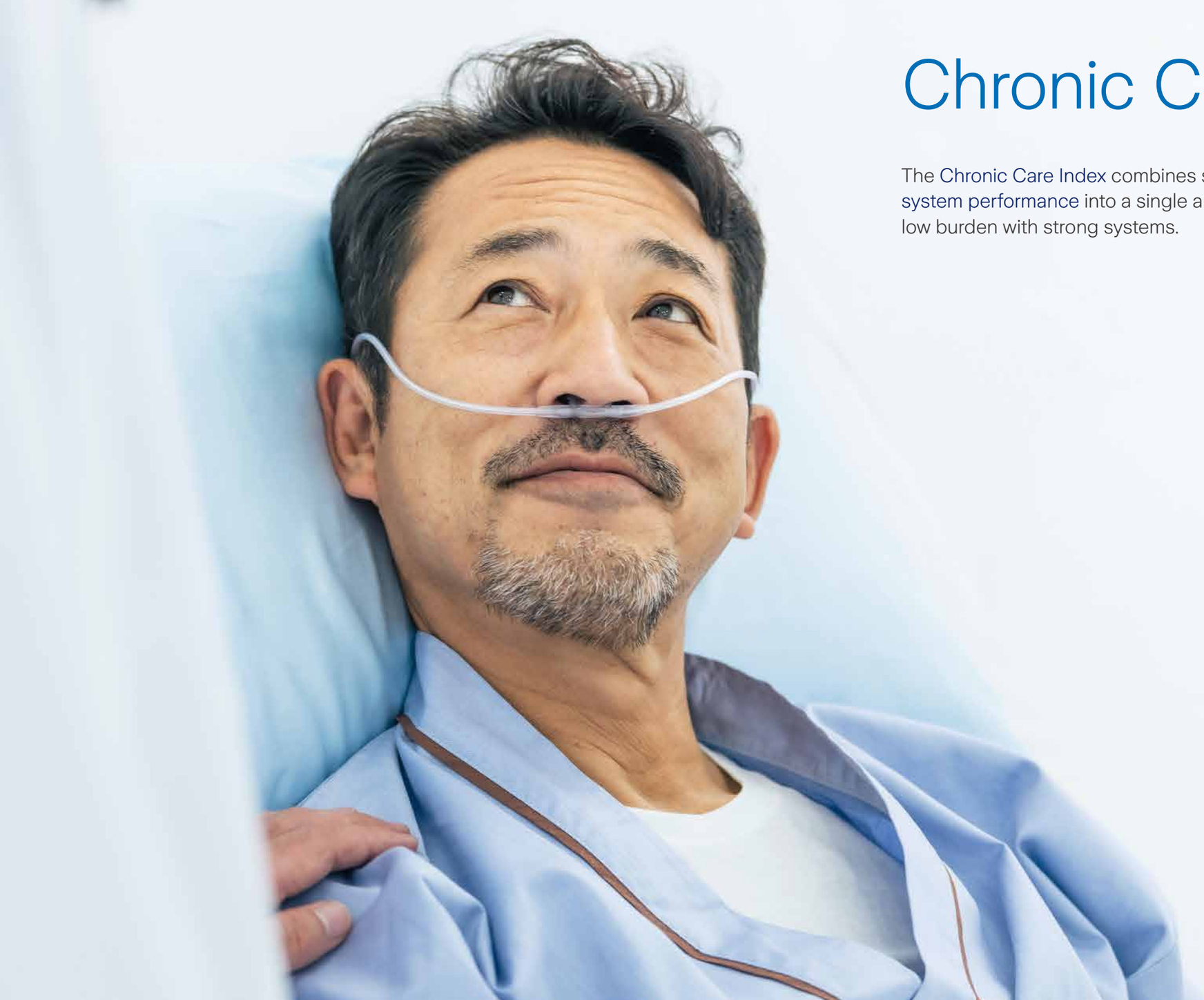
Few care systems are consistently organized around sustained, long-term management: They were designed to fix people, not to accompany them through 30 or 40 years of disease and disability. For chronic diseases, where progression is gradual and care is continuous, this creates a mismatch between how systems are designed and how care is needed.

Support is changing in response. Financial protection is increasingly complemented by services that improve access, coordination, and navigation over time. In some cases, this is being addressed through integrated platforms that bring together access to care, expert support, and health services into a single-entry point for employees. These range from virtual care, second medical opinions, and specialist pathways to preventive support such as screening, dietetic advice, and digital tools that support remote monitoring and ongoing management.

For individuals, this begins to shift the experience of care: from navigating disconnected services to accessing more coordinated pathways, often through a single point of entry supported by insurers, employers or platform providers. For employers, it addresses a persistent gap – not a lack of provision, but a lack of integration, with no clear “front door” through which employees can access and manage care.

Improving chronic care requires not only expansion, but redesign – connecting and streamlining services to support individuals over time.[19]

19. OECD. Integrating Care to Prevent and Manage Chronic Diseases (2023).



Chronic Care Index

The Chronic Care Index combines scores for Chronic disease burden and Health system performance into a single analytical framework – rewarding those that combine low burden with strong systems.

Resilient leader: Australia ranks #8, combining relatively low mortality with strong system performance. As morbidity rises, outcomes increasingly depend on how well systems sustain care over time, with a shift toward integrated, multidisciplinary models focused on managing multimorbidity and maintaining function and independence.[20]

20. Australian Government Department of Health, Disability and Ageing. National Strategic Framework for Chronic Conditions (2026); Australian Government Department of Health, Disability and Ageing. Chronic Conditions Prevention and Integrated Care Grants Program (2026).

Sustained performance: France ranks #15, combining a moderate disease burden with a comparatively capable system. Reforms are strengthening primary care, shifting decision-making locally, and changing provider payment to encourage integration, but workforce shortages and fragmented delivery continue to limit how consistently care is sustained over time.[21]

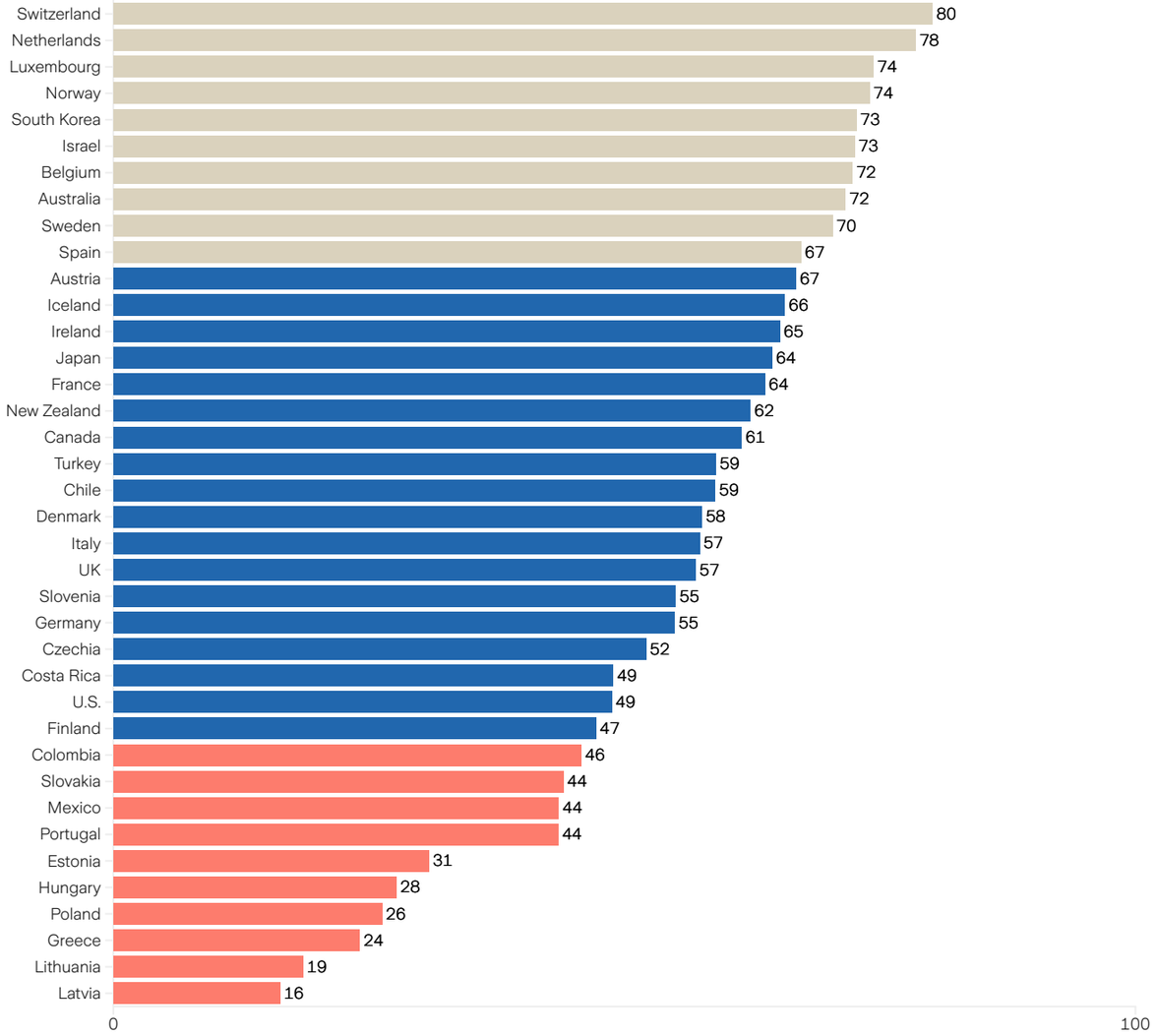
21. Or et al. France: health system review 2023 (2023).

Favorable position, fragile system: Mexico ranks #31, combining relatively low disease burden with weaker system performance. Recent reforms are expanding access, with a focus on free services, medicines, infrastructure, and staffing, but uneven continuity and capacity leave the system less prepared to absorb rising demand as populations age – particularly for those outside formal employment structures.[22]

22. Unger-Saldaña et al. Improving health system performance in Mexico (2023); Gobierno de México. Programa Institucional de Servicios de Salud del IMSS-Bienestar 2023–2024: Avance y Resultados Enero 2023 – Junio 2024 (2024).

Scores: Chronic Care Index

0 – 100



Higher scores indicate stronger performance. Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

Resources alone do not guarantee outcomes

The real story is not in chronic disease burden or health system performance in isolation, but in the relationship between them.

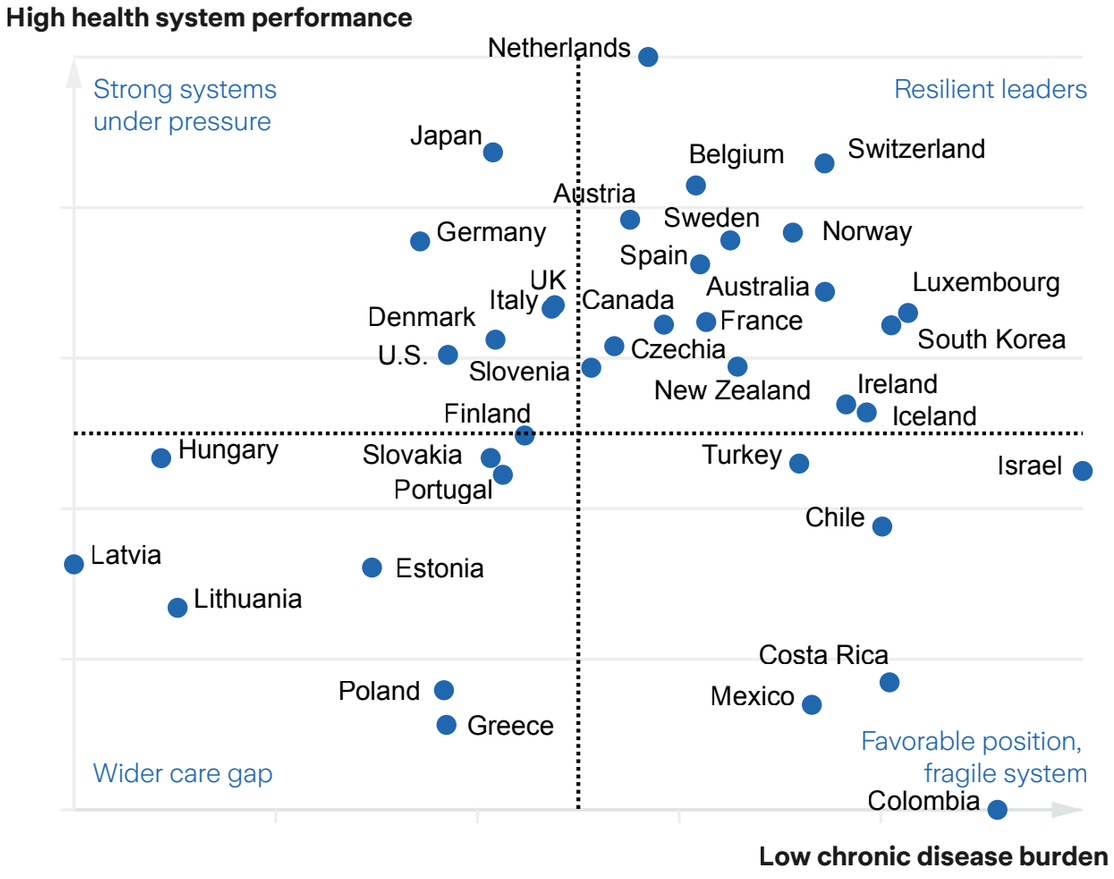
Countries that lead the Chronic Care Index – Switzerland, the Netherlands, Luxembourg, Norway, South Korea – perform strongly across both dimensions, or combine exceptional performance in one with solid outcomes in the other.

Plotting these two dimensions together reveals four profiles, which show not just who performs well, but also points to why – and where pressure is most likely to rise next:

- **Resilient leaders:** These countries lead the overall index, benefiting from both a relatively low chronic disease burden and a well-equipped health system – with results pointing to more effective prevention and care.
- **Strong systems under pressure:** Countries with capable systems managing higher levels of disease burden, highlighting the limits of treatment without sufficient progress on prevention and risk reduction.
- **Favorable position, fragile system:** Countries with relatively low burden but weaker system performance, often reflecting demographic or epidemiological advantage that may not be sustained.
- **Wider care gap:** Countries carrying a heavy burden of disease but lacking the system infrastructure, quality, and readiness to manage it effectively.

Importantly, once a country falls behind on both dimensions, catching up becomes structurally more difficult, as gaps in prevention, access, and co-ordination reinforce each other.

Chronic Care Index
Chronic disease burden and Health system performance scores (0 – 100)



Higher scores indicate stronger performance. Health system performance scores have been rescaled here to better visualize relative positioning of countries. Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

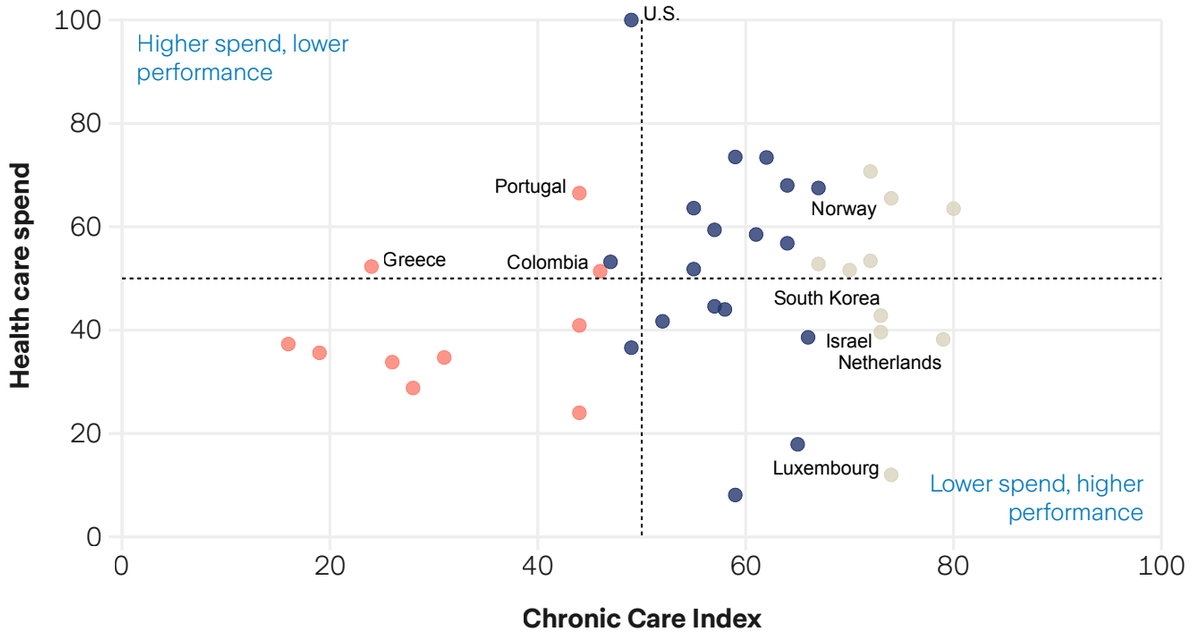
Notably, economic resources clearly help, but they do not guarantee strong performance. Some of the wealthiest economies sit in the middle of the ranking, while smaller or less wealthy countries outperform them.

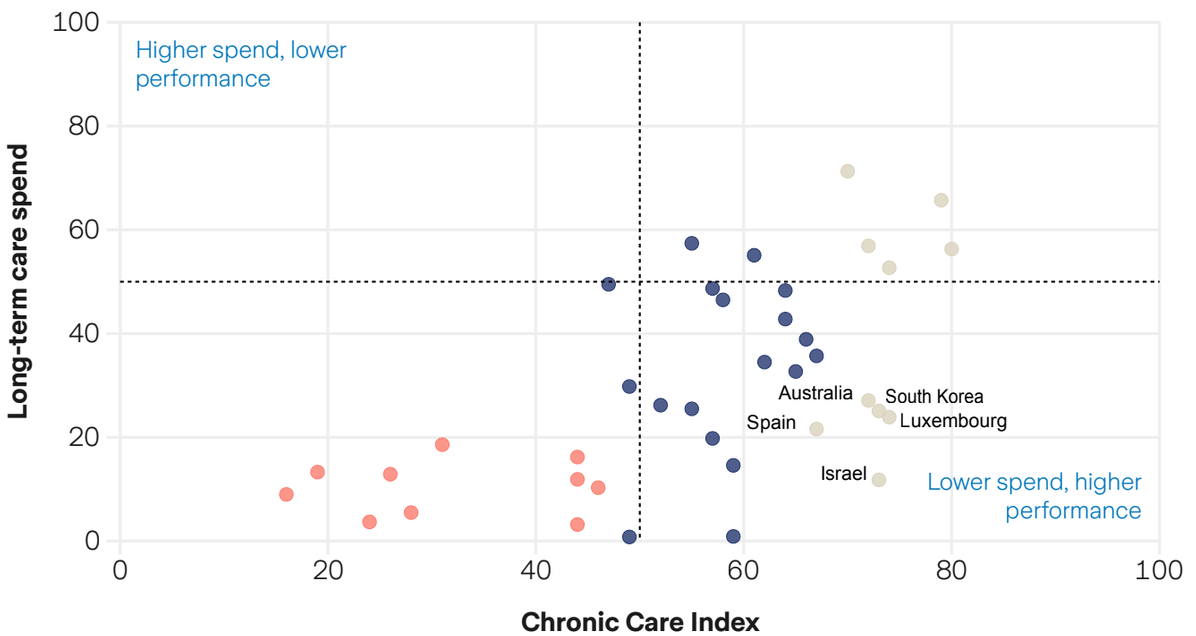
Higher health and long-term care spending are often associated with stronger overall scores. However, the relationship is far from consistent: countries with broadly similar spending levels can still perform very differently. For example, Portugal and Norway receive similar scores for health care spend, yet sit in different tiers when disease burden and overall health system performance are combined. Likewise, countries such as Luxembourg and South Korea show only moderate spending levels across both indicators, but achieve relatively strong outcomes on the composite index.

This further confirms the importance of how resources are deployed not just how much is available.

Higher spend does not guarantee stronger performance

Scores (0 – 100) for 3a.8 Total health expenditure as a share of GDP (%), 3a.9 Total long-term care expenditure as a share of GDP (%) and overall Chronic Care Index across OECD countries, 2014 – 2023





Chronic Care Index: Higher score Lower score

Higher scores indicate stronger performance. Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

Regional results: Age matters

These scores measure what a country faces today – but do not fully capture where it is headed.

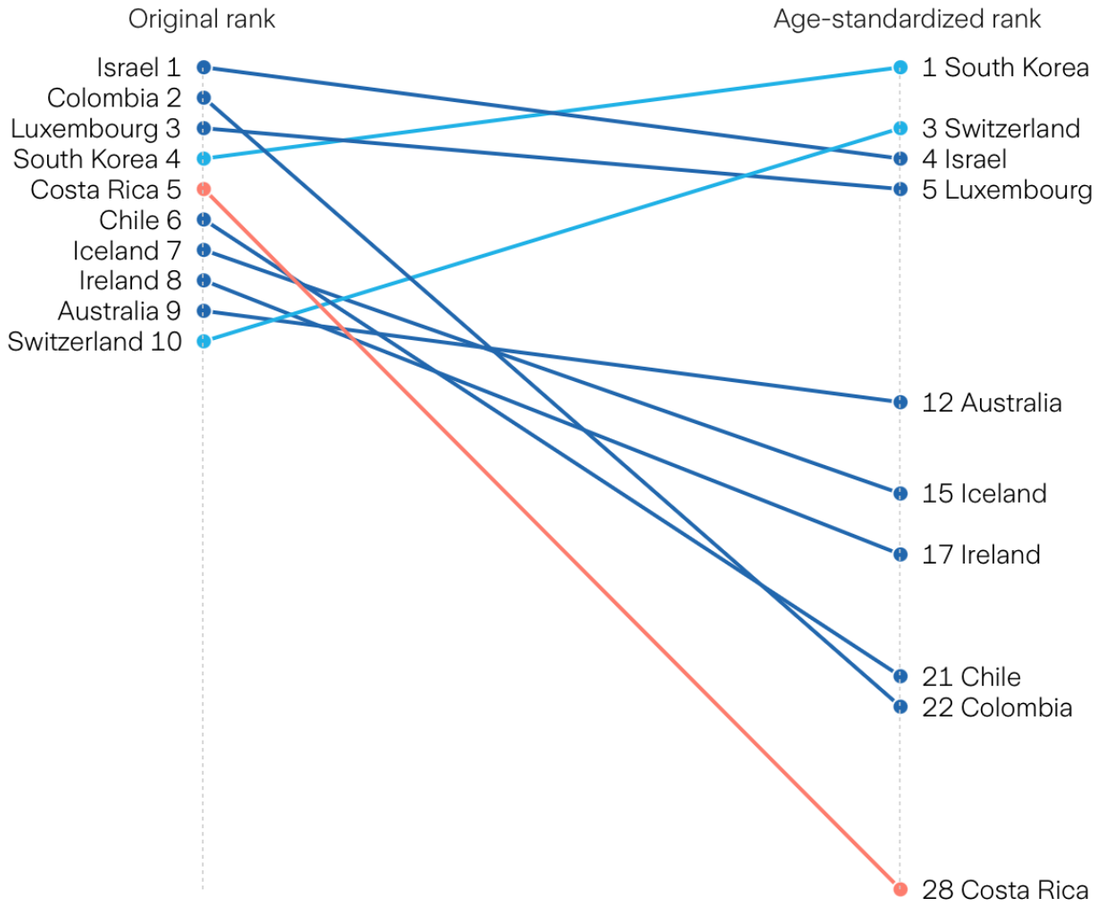
Age is the variable that turns a snapshot into a trajectory. Chronic disease is concentrated in older populations, meaning countries with younger populations will, all else being equal, report lower burden – regardless of underlying system performance or prevention effectiveness.

Colombia illustrates this dynamic clearly. It ranks near the top of Chronic disease burden yet records the weakest Health system performance score. When the data is age-standardized, Colombia falls significantly in the burden ranking, indicating that its current position reflects demographic advantage rather than system strength.

As populations age and risk factors intensify, that position may not hold. Countries such as Costa Rica and Chile show similar patterns – relatively low burden today, combined with systems that may be less prepared to absorb future demand. Health system capability, unlike disease burden, does not adjust quickly; it requires sustained investment over time.

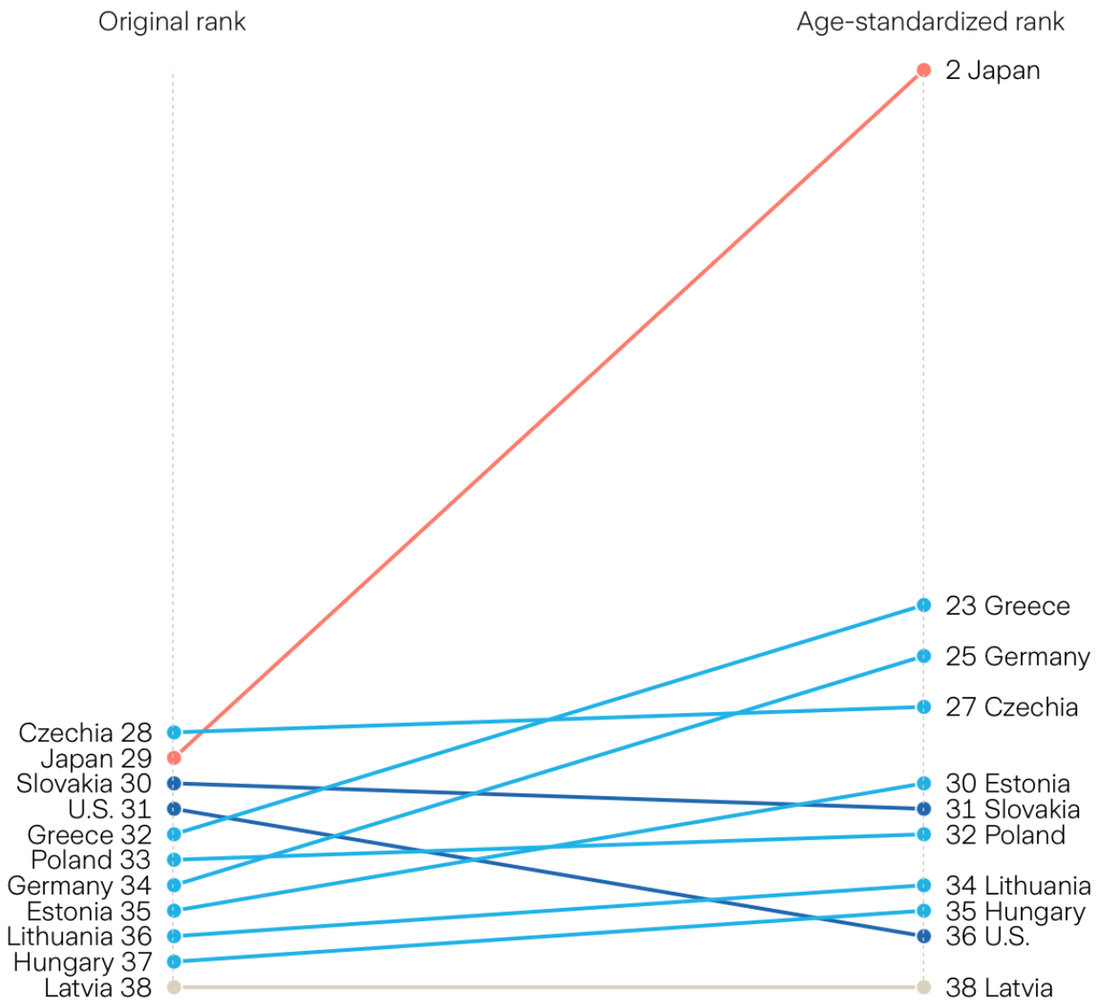
Chronic disease burden: Age-standardized ranking

Highest-ranking countries



Refer to Data and methodology for a full set of data sources, assumptions and calculations.

Chronic disease burden: Age-standardized ranking
Lowest-ranking countries



Refer to ⇨ Data and methodology for a full set of data sources, assumptions, and calculations.

Japan represents the inverse case. It performs strongly on Health system performance, yet scores lower on Chronic disease burden due to its advanced demographic profile, with a larger share of the population in higher-risk age groups. When adjusted for age, its ranking improves markedly, indicating that outcomes are driven more by population aging than underlying system weakness.

This shows that while demographic pressure raises burden, it is system performance that determines how effectively it is managed.

This interaction creates two distinct versions of the chronic care challenge:

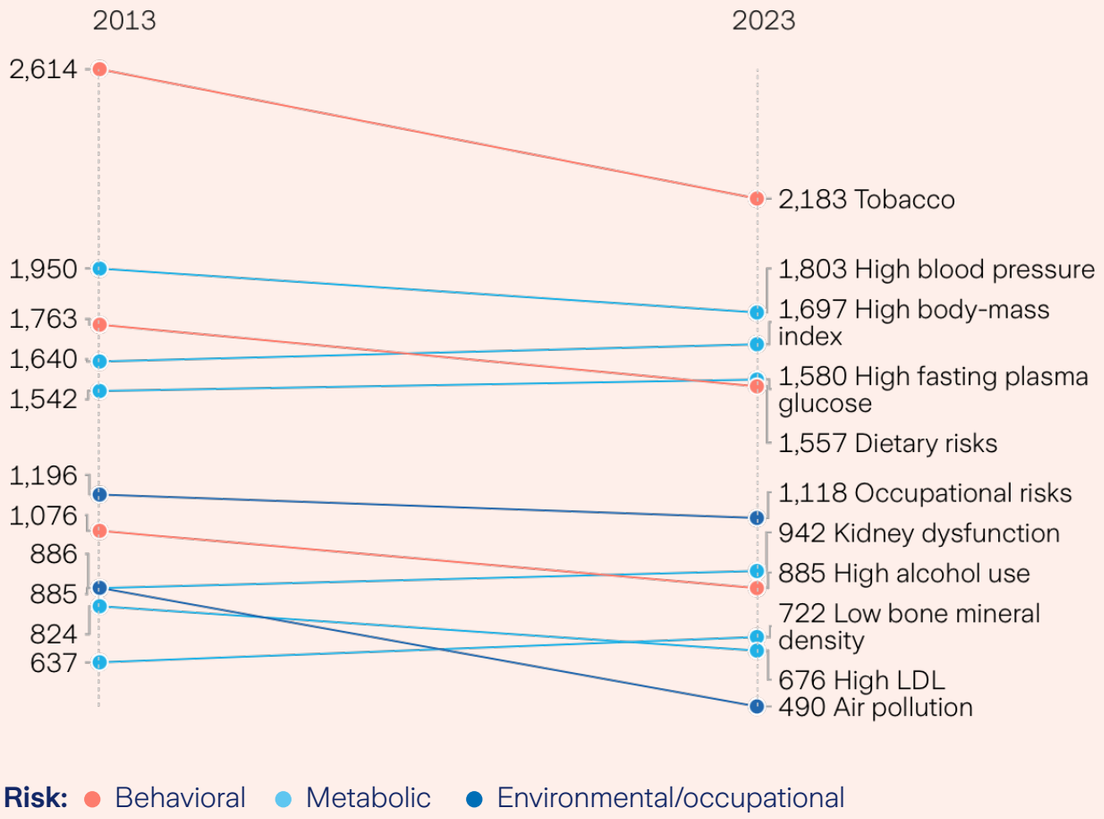
- **Already-aged populations:** Countries across Western Europe and East Asia are managing high levels of chronic disease today. Their challenge is in sustaining system performance – maintaining capacity, quality, and readiness to serve large populations living with multiple chronic conditions over long periods.

- **Still-young populations:** Countries earlier in the demographic transition face a different challenge: preparing for the burden that is coming. There is a window of opportunity to invest in prevention, system capacity, and long-term care, but that window is closing.

A country's position on the Chronic Care Index should therefore be understood as a starting point, not a fixed outcome. Countries with low burden today may face rapid increases as populations age, while those with higher burden may stabilize outcomes if systems are able to manage chronic disease – and related risk factors – effectively over time.

Switzerland: Outperforming aging

Switzerland: Leading risk factors for healthy life lost
Change in DALYs per 100,000 population and overall ranking, 2013 – 2023



Primary source: IHME (2025).

DALYs in this case capture the full burden of disease, not just chronic conditions.

Chronic disease outcomes are shaped not only by underlying risk, but by how effectively systems respond to that risk profile over time. Switzerland illustrates this interaction clearly.

It ranks first overall on the Chronic Care Index, combining a relatively low–moderate disease burden with some of the strongest health system performance across the OECD. Its performance on disease burden strengthens further when adjusted for age: Switzerland rises from 10th to 3rd, indicating that outcomes are achieved despite an older population profile.

As in other lower-burden countries, the underlying risk profile is shifting. Several major behavioral risks have declined over the past decade – most notably tobacco, dietary risks, and alcohol use – with reductions of 431, 206 and 191 DALYs per 100,000 population, respectively. At the same time, metabolic risks have increased in relative importance, though more gradually than other countries: high body-mass index (+57), high fasting plasma glucose (+38) and kidney dysfunction (+57) have all risen, while high blood pressure has declined (–146).

This pattern reflects a broader transition in chronic disease. As behavioral risks fall, a larger share of burden is driven by long-term metabolic exposure, where disease progression depends on sustained control over time.

What differentiates Switzerland is how this evolving risk is managed. Despite only mid-range Capacity (20th) and low efficiency (38th), it ranks 2nd on Quality, with particularly strong performance on the aspects of care most relevant to chronic conditions: continuity, coordination, and patient engagement. It ranks 1st across care coordination, person-centered care, primary care quality, and trust, and among the top countries for patient confidence in managing their own health.

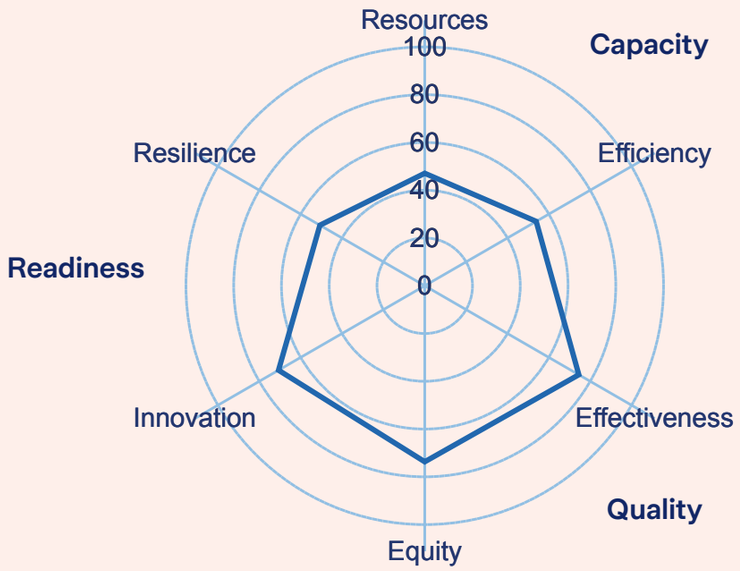
These factors are critical as metabolic risks rise. While behavioral risks can often be targeted directly through policy interventions, managing metabolic risk depends on both continued behavioral change and sustained care – ongoing monitoring, adherence to treatment, and coordination across multiple providers. Switzerland's system appears better equipped to deliver this type of care consistently, limiting progression, and preventing escalation even as underlying risk increases.

Prevention in this context is therefore reinforced through regular contact with the health system, supported by insurance-based access and complementary services that extend screening, specialist care, and long-term management beyond acute episodes.

Switzerland's experience demonstrates that even as risk profiles shift toward more complex, long-duration conditions, systems that deliver consistent, coordinated, and trusted care can contain the impact of that shift over time.

The Netherlands: A resilience leader

The Netherlands: Health system performance by capacity, quality, and readiness
Scores (0 – 100)



Higher scores indicate stronger performance. Refer to ⇨ Data and methodology for a full set of data sources, assumptions, and calculations.

The Netherlands offers a glimpse of what success looks like in the data, where system design, not just system spending, determines chronic care performance.

It ranks 1st overall in terms of Health system performance, but what distinguishes the Netherlands is not scale of spending or infrastructure – it ranks 13th on Capacity and 28th on health expenditure – but the outcomes it achieves with these resources.

On disease burden, it ranks 20th – mid-table, with overall impacts growing modestly (8% growth in DALYs from 2014 – 2023). But it records the highest effectiveness score, including among the lowest rates of avoidable hospital admissions. This contributes to the highest Quality score in the OECD, with patients reporting among the highest levels of trust in the health system. Similar to Switzerland, it also has the highest confidence in managing its own health – factors that can translate into a clearer, more navigable care experience for patients living with long-term conditions.

The Dutch system also embeds a structural incentive that most OECD countries lack: Employers are required to pay employees for up to two years of sickness absence and must develop structured return-to-work plans. This creates a clear financial and operational incentive for earlier intervention and active rehabilitation and is one factor that may contribute to stronger outcomes, alongside broader population health behaviors and system design.

The next opportunity:
From system performance to shared responsibility

Responsibility for the chronic care challenge cannot sit with any single actor. Individuals cannot manage it alone. Governments cannot fund it all. Health systems cannot deliver it all. Employers cannot absorb it all.

Instead, a shift is underway toward shared responsibility across institutions, visible in initiatives such as the UK's Keep Britain Working program and the Netherlands' employer-obligation model. Employers are increasingly at the frontline of health promotion and management. Warning signs are often first visible in the workplace – through absence, reduced performance, or shifts in behavior. This makes workplace systems, employer engagement, and employee benefits a key part of the chronic care response, particularly for conditions that develop and persist over long periods.[23] Supporting people to remain at work, or to return in a structured way, is not only an economic priority but can be a health outcome in itself.

This is where group protection and health services can act as the practical interface between prevention, access, and recovery. Insurers increasingly sit alongside employers and providers in the chronic care pathway – using longitudinal data, benefits infrastructure, and service partnerships to support earlier intervention and more coordinated care over time. For example, models in markets such as the UK and Spain combine access to specialist expertise, remote support, and navigation services alongside core protection. The benefits can be widespread: individuals experience better health outcomes, employers retain productive workforces, and governments face less long-term welfare pressure.

The chronic care challenge will unfold over decades, but the direction is already clear: from cure to prevention, from episodes of care to continuous management, and from isolated provision to coordinated support across systems. The countries best positioned to manage this future are those that adapt early – before the gap between demand and system capability widens.

23. Virtanen et al. Effectiveness of workplace interventions for health promotion (2025); Tsai et al. Moving Diabetes Prevention Programs to the Workplace (2024).

Country profiles

Australia

Australia ranks top 10, combining low mortality, rising morbidity, and strong system performance. Quality supports outcomes, though equity gaps and long-term care constraints remain.

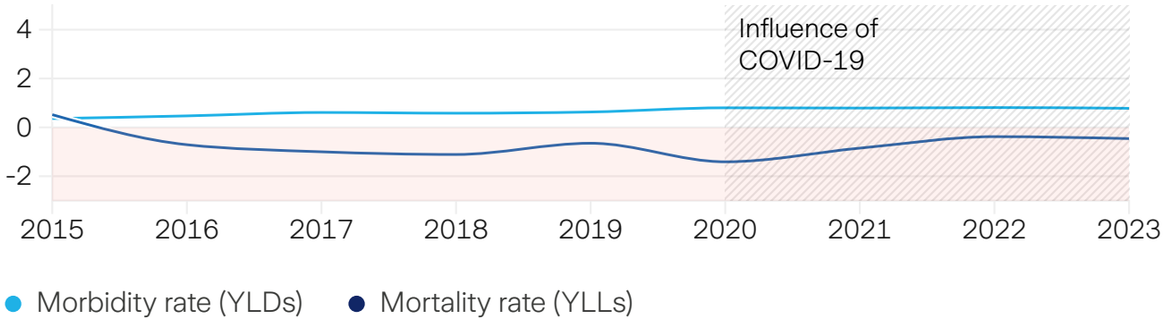
Chronic Care Index

Rank: 8

Chronic disease burden

Rank: 9

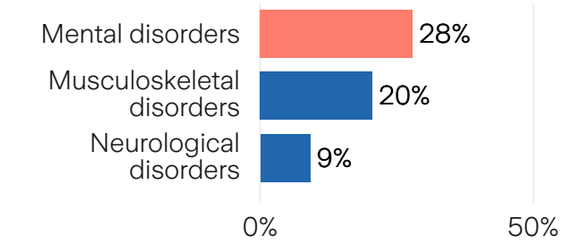
Average growth rates of morbidity and mortality, 2014-2023



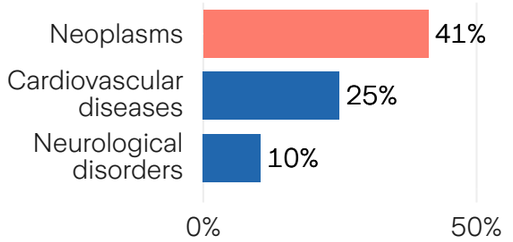
Disease burden by morbidity and mortality

Morbidity		Mortality	
Score:	39	Score:	85
Rank:	21	Rank:	6

By top condition

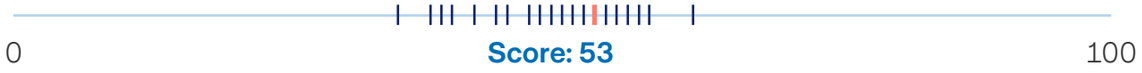


By top condition



Health system performance

Rank: 10



Performance by pillar, scores

Capacity:	54	Quality:	54	Readiness:	50
Resources:	56	Effectiveness:	54	Innovation:	53
Efficiency:	51	Equity:	54	Resilience:	48

Scores range from 0 to 100, with higher values indicating stronger performance.
Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

Chronic Care Index

Rank: 11

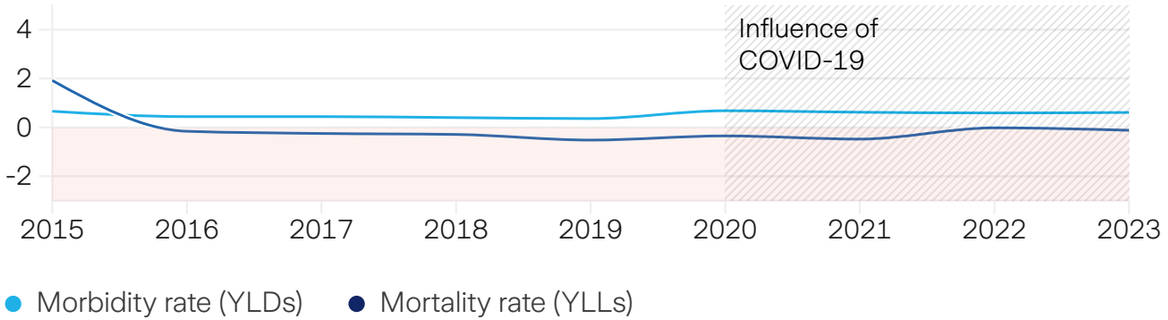
Austria

Austria ranks higher-mid tier, supported by strong system performance, particularly Quality. Moderate burden and weaker efficiency contribute to Capacity pressures.

Chronic disease burden

Rank: 21

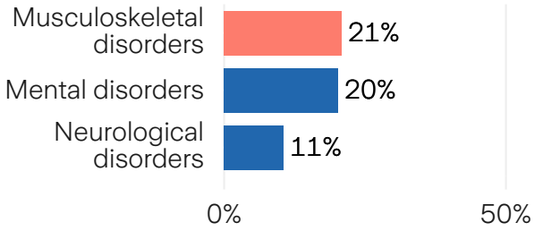
Average growth rates of morbidity and mortality, 2014-2023



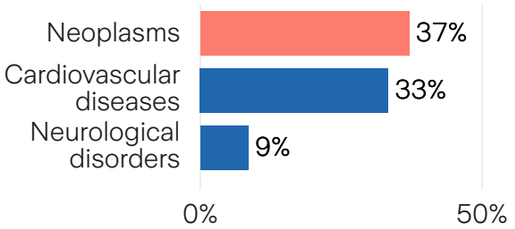
Disease burden by morbidity and mortality

Morbidity		Mortality	
Score:	45	Score:	60
Rank:	14	Rank:	21

By top condition



By top condition



Health system performance

Rank: 5

Performance by pillar, scores

Capacity:	50	Quality:	64	Readiness:	51
Resources:	52	Effectiveness:	58	Innovation:	38
Efficiency:	47	Equity:	72	Resilience:	64

Scores range from 0 to 100, with higher values indicating stronger performance.
Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

Belgium

Belgium ranks top 10, with moderate burden and strong system performance. Quality and Capacity support outcomes, amid weaker resilience and innovation scores.

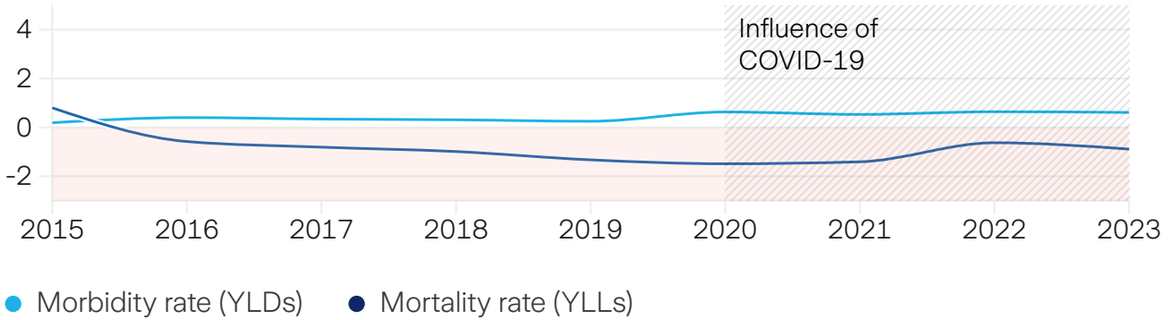
Chronic Care Index

Rank: 7

Chronic disease burden

Rank: 18

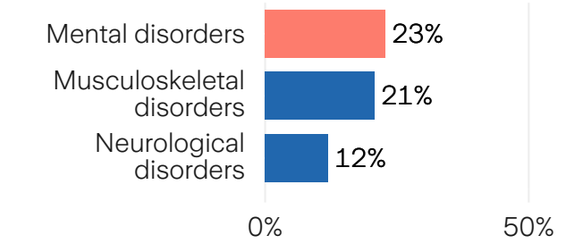
Average growth rates of morbidity and mortality, 2014-2023



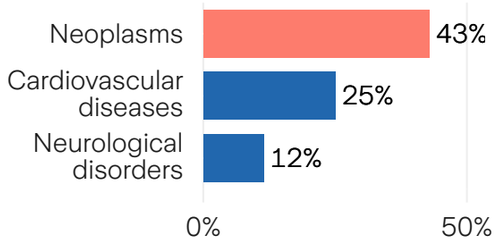
Disease burden by morbidity and mortality

Morbidity		Mortality	
Score:	40	Score:	70
Rank:	18	Rank:	18

By top condition



By top condition



Health system performance

Rank: 4

Performance by pillar, scores

Capacity:	56	Quality:	64	Readiness:	41
Resources:	62	Effectiveness:	60	Innovation:	38
Efficiency:	46	Equity:	71	Resilience:	43

Scores range from 0 to 100, with higher values indicating stronger performance.
Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

Chronic Care Index

Rank: 17

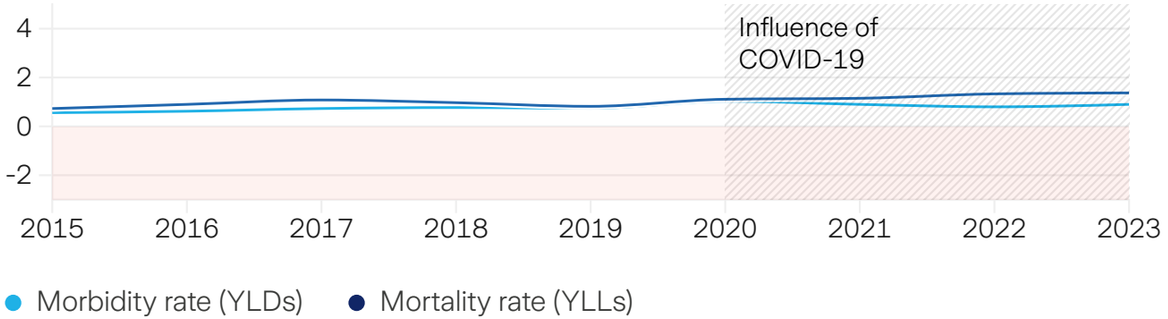
Canada

Canada ranks mid-table but exhibits growth in both morbidity and mortality. Strong Readiness partially offsets weaker Quality, which includes equity gaps.

Chronic disease burden

Rank: 19

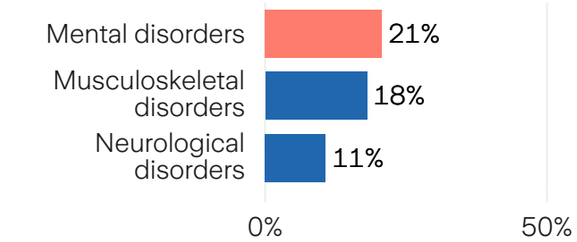
Average growth rates of morbidity and mortality, 2014-2023



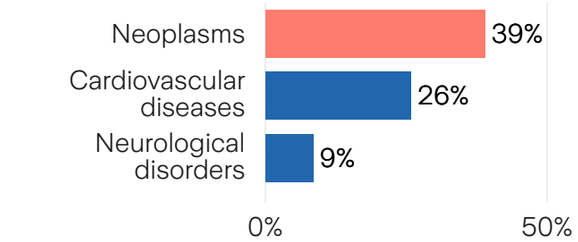
Disease burden by morbidity and mortality

Morbidity		Mortality	
Score:	37	Score:	67
Rank:	23	Rank:	20

By top condition



By top condition



Health system performance

Rank: 15

Performance by pillar, scores

Capacity:	55	Quality:	47	Readiness:	59
Resources:	48	Effectiveness:	55	Innovation:	52
Efficiency:	67	Equity:	34	Resilience:	66

Scores range from 0 to 100, with higher values indicating stronger performance.
Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

Chile

Chile ranks mid-table, combining low mortality with rising morbidity and weaker system performance. Lower Readiness and Quality limit longer-term capability.

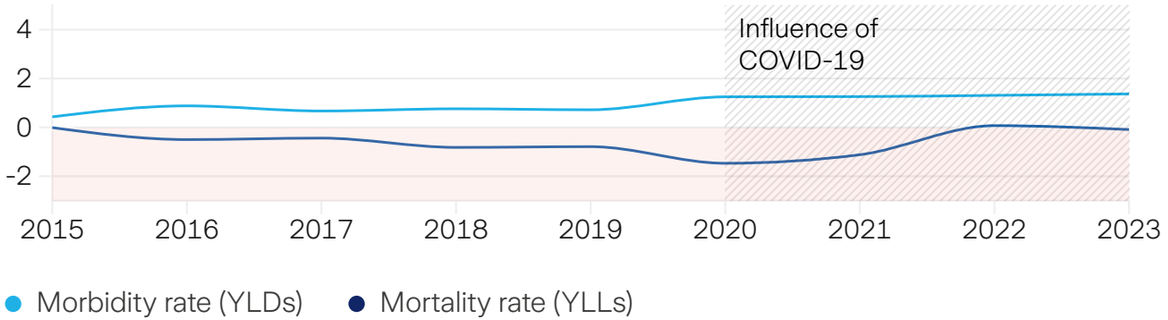
Chronic Care Index

Rank: 19

Chronic disease burden

Rank: 6

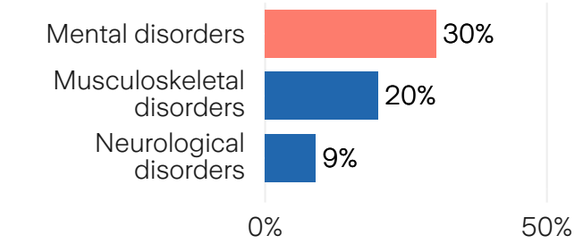
Average growth rates of morbidity and mortality, 2014-2023



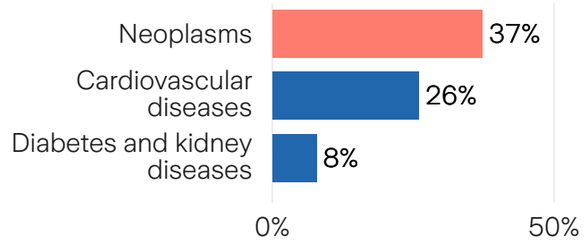
Disease burden by morbidity and mortality

Morbidity		Mortality	
Score:	69	Score:	84
Rank:	4	Rank:	8

By top condition



By top condition



Health system performance

Rank: 30

Performance by pillar, scores

Capacity:	**46**	**Quality:**	**53**	**Readiness:**	**24**
Resources:	40	Effectiveness:	58	Innovation:	4
Efficiency:	55	Equity:	43	Resilience:	43

Scores range from 0 to 100, with higher values indicating stronger performance.
Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

Colombia

Colombia ranks lower-mid tier, combining low burden with the weakest system performance. Low Quality and Readiness constrain outcomes, despite efficiency supporting Capacity.

Chronic Care Index

Rank: 29

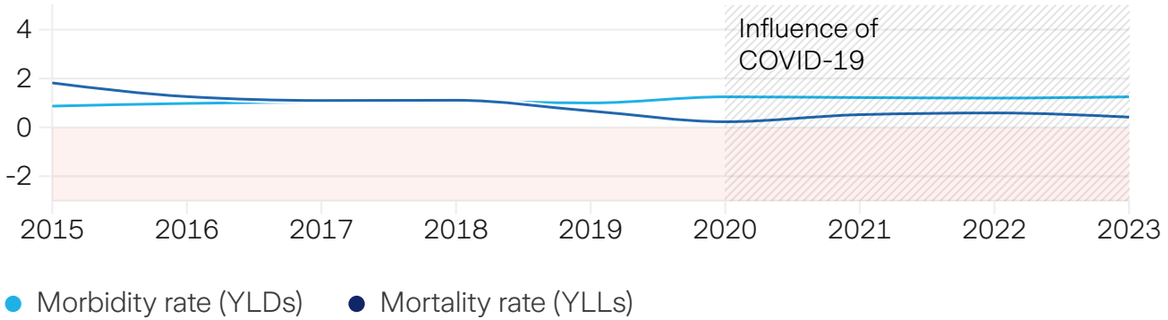
0 — Score: 46 — 100

Chronic disease burden

Rank: 2

0 — Score: 92 — 100

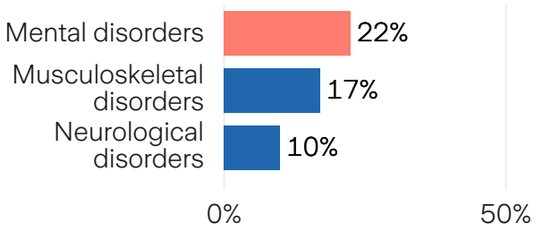
Average growth rates of morbidity and mortality, 2014-2023



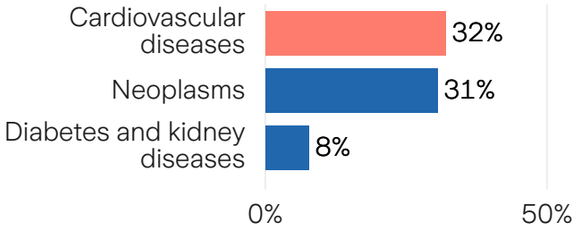
Disease burden by morbidity and mortality

Morbidity		Mortality	
Score:	88	Score:	93
Rank:	2	Rank:	2

By top condition



By top condition



Health system performance

Rank: 38

0 — Score: 35 — 100

Performance by pillar, scores

Capacity:	**42**	**Quality:**	**33**	**Readiness:**	**24**
Resources:	26	Effectiveness:	34	Innovation:	1
Efficiency:	68	Equity:	30	Resilience:	46

Scores range from 0 to 100, with higher values indicating stronger performance.
Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

Costa Rica

Costa Rica ranks lower-mid tier, combining low burden with weak system performance. Lower Readiness and equity constrain capability despite stronger effectiveness.

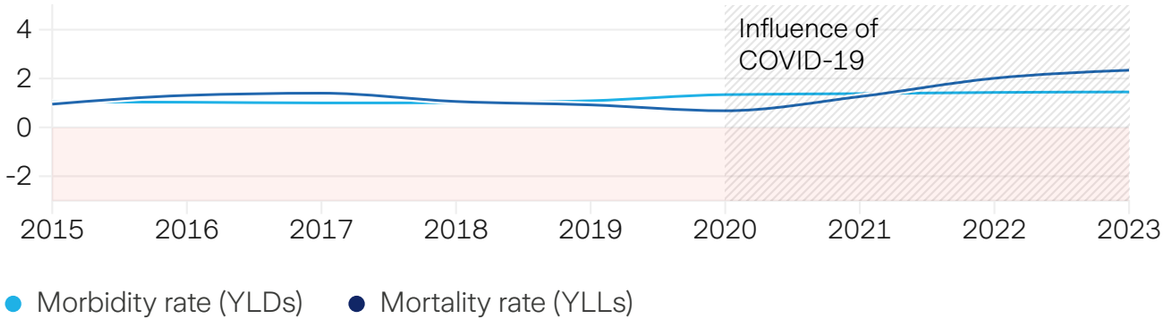
Chronic Care Index

Rank: 26

Chronic disease burden

Rank: 5

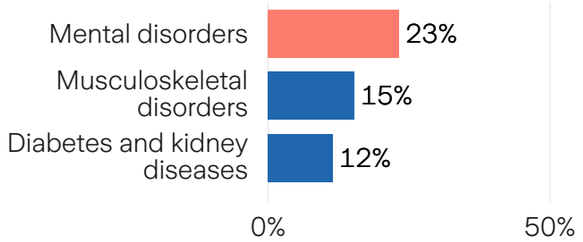
Average growth rates of morbidity and mortality, 2014-2023



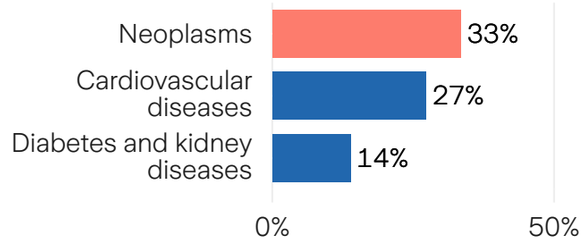
Disease burden by morbidity and mortality

Morbidity		Mortality	
Score:	68	Score:	85
Rank:	5	Rank:	5

By top condition



By top condition



Health system performance

Rank: 34

Performance by pillar, scores

Capacity:	38	Quality:	50	Readiness:	14
Resources:	32	Effectiveness:	60	Innovation:	9
Efficiency:	49	Equity:	34	Resilience:	19

Scores range from 0 to 100, with higher values indicating stronger performance.
Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

Czechia

Czechia ranks lower-mid tier, combining higher burden with moderate system performance. Strong Quality supports access, while weaker Readiness reflects lower innovation and resilience scores.

Chronic Care Index

Rank: 25

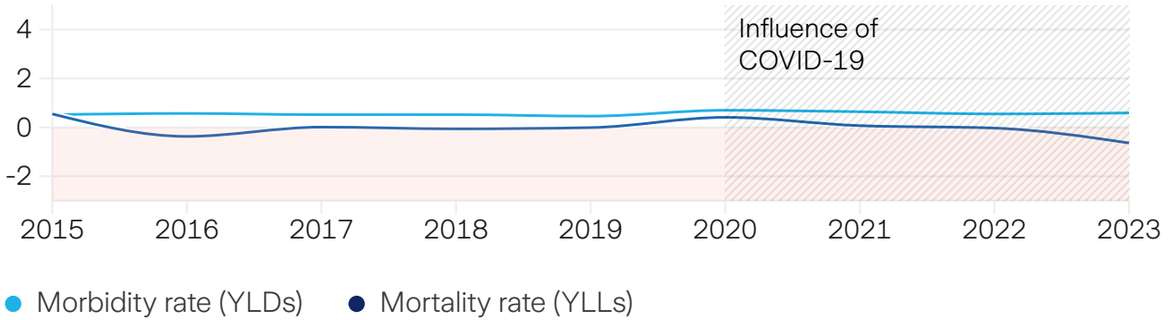
0 — **Score: 52** — 100

Chronic disease burden

Rank: 28

0 — **Score: 42** — 100

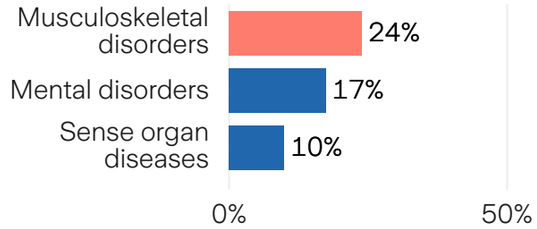
Average growth rates of morbidity and mortality, 2014-2023



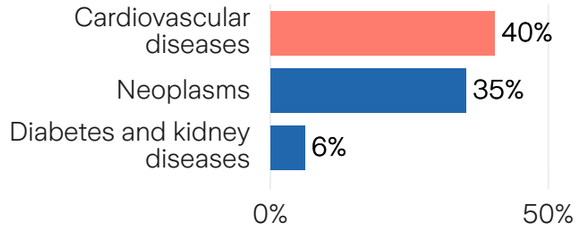
Disease burden by morbidity and mortality

Morbidity		Mortality	
Score:	26	Score:	49
Rank:	29	Rank:	30

By top condition



By top condition



Health system performance

Rank: 17

0 — **Score: 52** — 100

Performance by pillar, scores

Capacity:	**51**	**Quality:**	**61**	**Readiness:**	**28**
Resources:	45	Effectiveness:	43	Innovation:	8
Efficiency:	61	Equity:	92	Resilience:	47

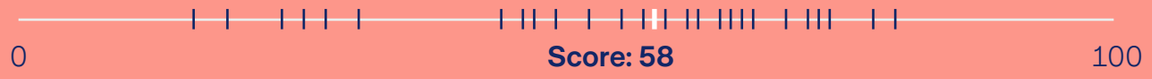
Scores range from 0 to 100, with higher values indicating stronger performance.
Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

Denmark

Denmark ranks mid-table, combining moderate burden with mid-range performance. Strong Readiness supports future capability, while Quality and Capacity are more mixed.

Chronic Care Index

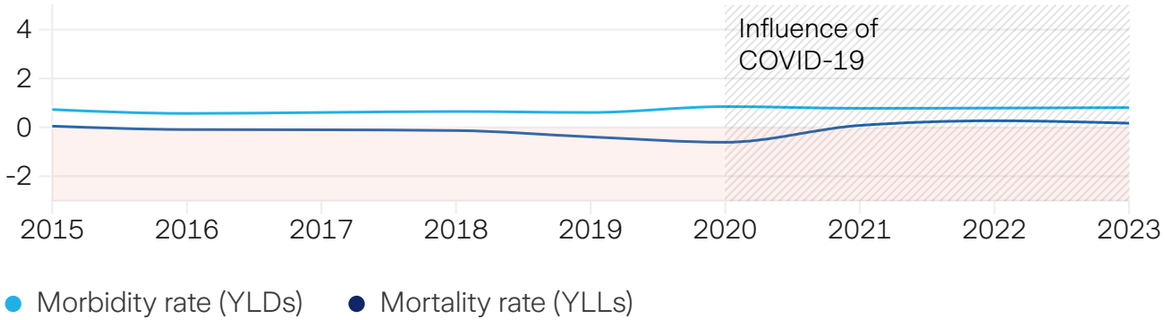
Rank: 20



Chronic disease burden

Rank: 22

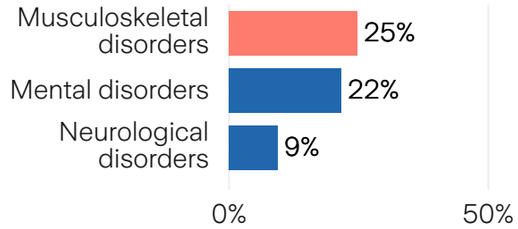
Average growth rates of morbidity and mortality, 2014-2023



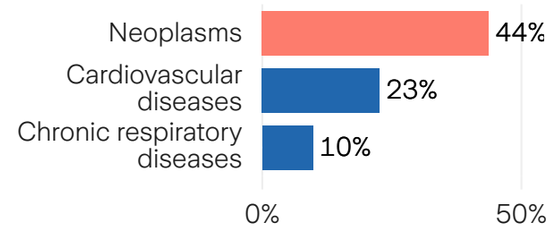
Disease burden by morbidity and mortality

Morbidity		Mortality	
Score:	45	Score:	59
Rank:	15	Rank:	24

By top condition

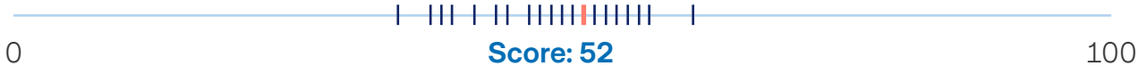


By top condition



Health system performance

Rank: 18



Performance by pillar, scores

Capacity:	**47**	**Quality:**	**54**	**Readiness:**	**57**
Resources:	46	Effectiveness:	47	Innovation:	60
Efficiency:	50	Equity:	64	Resilience:	55

Scores range from 0 to 100, with higher values indicating stronger performance.
Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

Estonia

Estonia ranks lower tier, combining higher burden with weaker system performance. Lower Capacity and Quality constrain delivery, though Readiness is supported by resilience scores.

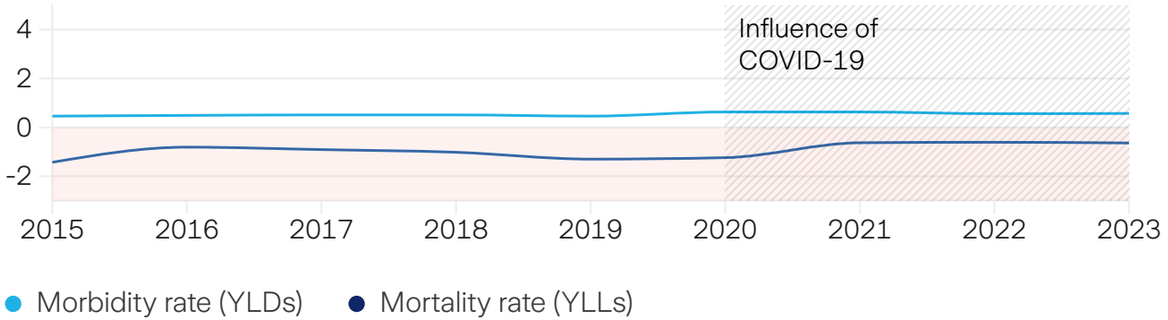
Chronic Care Index

Rank: 33

Chronic disease burden

Rank: 35

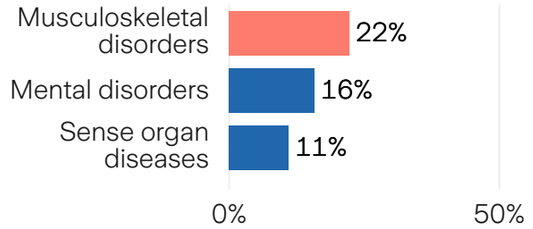
Average growth rates of morbidity and mortality, 2014-2023



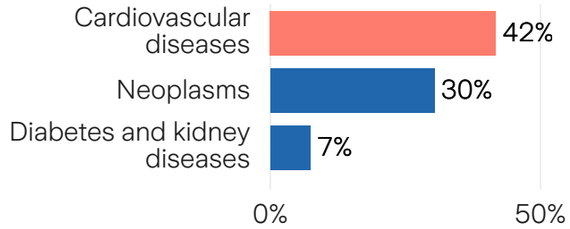
Disease burden by morbidity and mortality

Morbidity		Mortality	
Score:	32	Score:	33
Rank:	24	Rank:	35

By top condition



By top condition



Health system performance

Rank: 32

Performance by pillar, scores

Capacity:	**36**	**Quality:**	**49**	**Readiness:**	**50**
Resources:	39	Effectiveness:	52	Innovation:	21
Efficiency:	31	Equity:	45	Resilience:	78

Scores range from 0 to 100, with higher values indicating stronger performance.
Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

Finland

Finland ranks lower-mid tier, combining moderate burden with mid-range system performance. Strong Capacity supports provision, though weaker Quality, notably equity, limits outcomes.

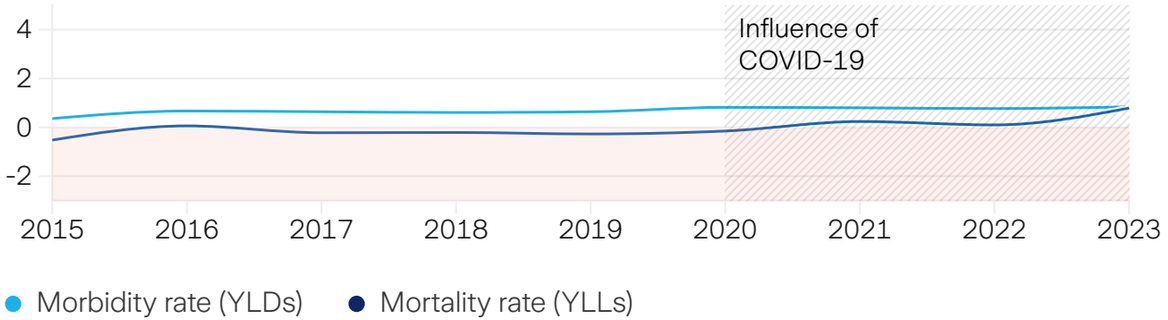
Chronic Care Index

Rank: 28

Chronic disease burden

Rank: 26

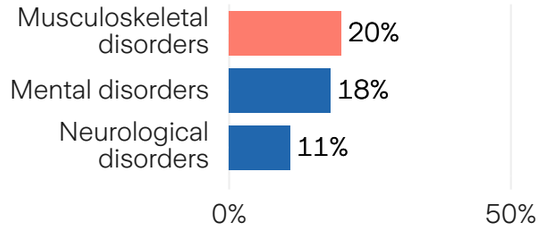
Average growth rates of morbidity and mortality, 2014-2023



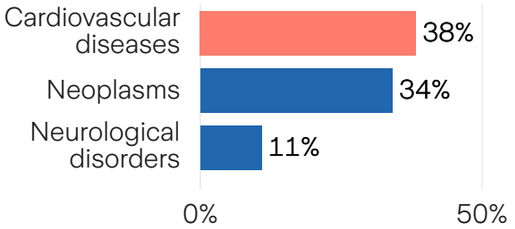
Disease burden by morbidity and mortality

Morbidity		Mortality	
Score:	37	Score:	50
Rank:	22	Rank:	29

By top condition



By top condition



Health system performance

Rank: 24

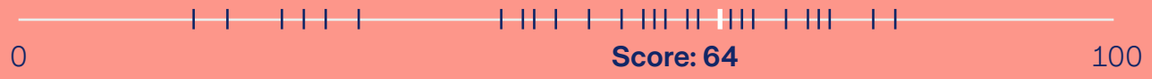
Performance by pillar, scores

Capacity:	52	Quality:	47	Readiness:	43
Resources:	55	Effectiveness:	55	Innovation:	36
Efficiency:	47	Equity:	35	Resilience:	49

Scores range from 0 to 100, with higher values indicating stronger performance.
Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

Chronic Care Index

Rank: 15



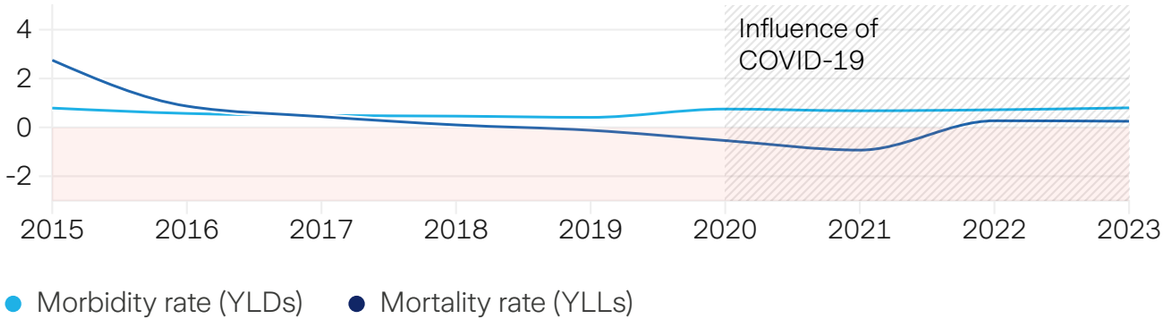
France

France ranks higher-mid tier, combining moderate burden with relatively strong system performance. Strong Readiness and resources scores offset lower efficiency.

Chronic disease burden

Rank: 16

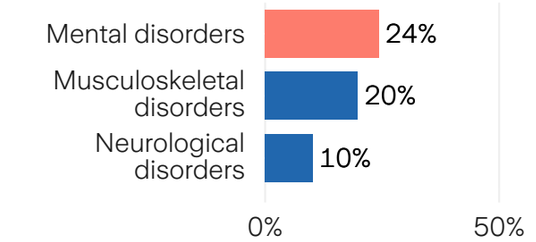
Average growth rates of morbidity and mortality, 2014-2023



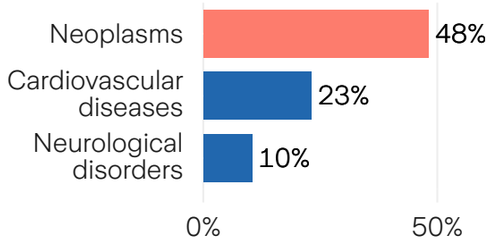
Disease burden by morbidity and mortality

Morbidity		Mortality	
Score:	40	Score:	71
Rank:	17	Rank:	16

By top condition



By top condition



Health system performance

Rank: 14

Performance by pillar, scores

Capacity:	48	Quality:	55	Readiness:	57
Resources:	54	Effectiveness:	54	Innovation:	59
Efficiency:	38	Equity:	58	Resilience:	55

Scores range from 0 to 100, with higher values indicating stronger performance.
Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

Chronic Care Index

Rank: 24

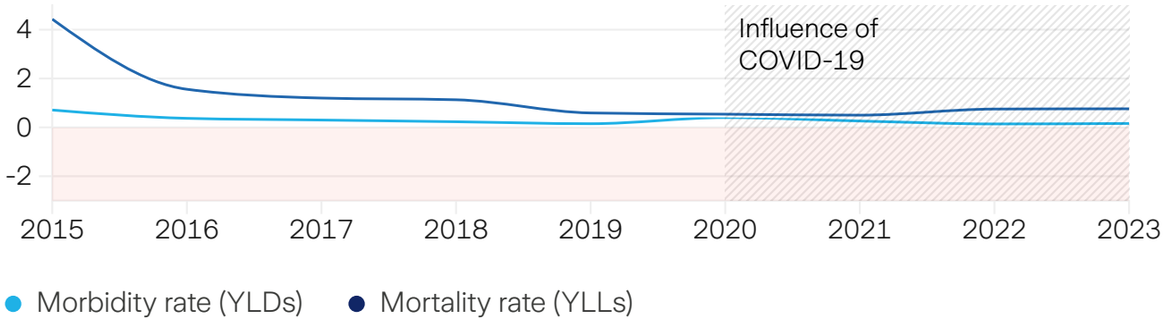
Germany

Germany ranks lower-mid tier, combining higher burden with strong system performance. Strong Readiness and Capacity support the system, though weaker effectiveness limits outcomes.

Chronic disease burden

Rank: 34

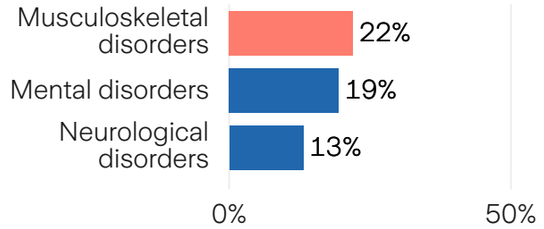
Average growth rates of morbidity and mortality, 2014-2023



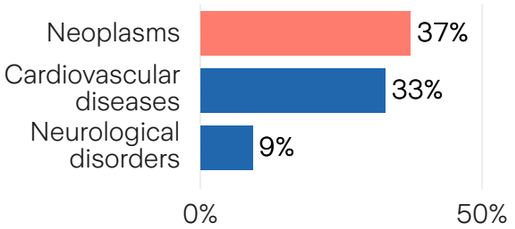
Disease burden by morbidity and mortality

Morbidity		Mortality	
Score:	23	Score:	41
Rank:	32	Rank:	34

By top condition



By top condition



Health system performance

Rank: 8

Performance by pillar, scores

Capacity:	**53**	**Quality:**	**50**	**Readiness:**	**77**
Resources:	58	Effectiveness:	35	Innovation:	81
Efficiency:	44	Equity:	75	Resilience:	72

Scores range from 0 to 100, with higher values indicating stronger performance.
Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

Chronic Care Index

Rank: 36

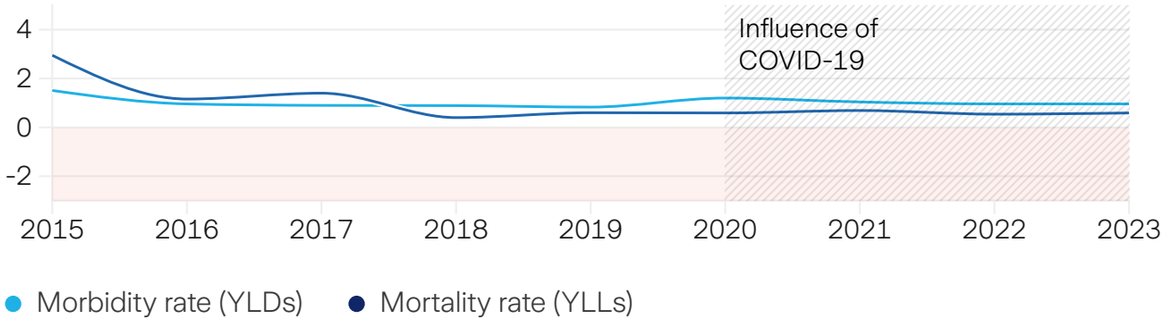
Greece

Greece ranks lower tier, combining higher burden with weak system performance. Quality and Readiness are low, while Capacity is limited by weak efficiency and resource gaps.

Chronic disease burden

Rank: 32

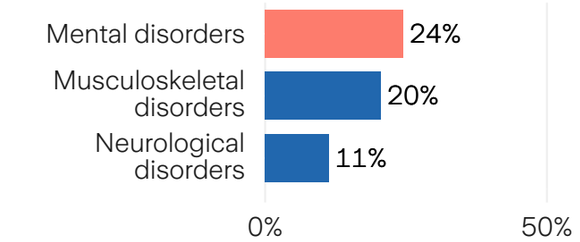
Average growth rates of morbidity and mortality, 2014-2023



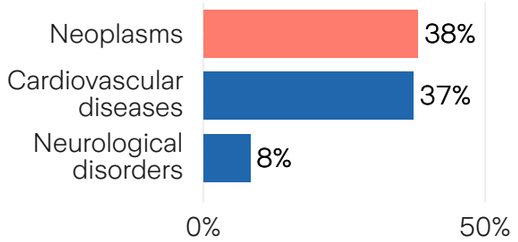
Disease burden by morbidity and mortality

Morbidity		Mortality	
Score:	15	Score:	47
Rank:	35	Rank:	31

By top condition



By top condition



Health system performance

Rank: 37

Performance by pillar, scores

Capacity:	43	Quality:	36	Readiness:	31
Resources:	41	Effectiveness:	33	Innovation:	22
Efficiency:	46	Equity:	41	Resilience:	41

Scores range from 0 to 100, with higher values indicating stronger performance.
Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

Hungary

Hungary ranks lower tier, combining higher burden with mid-range system performance. Strong Quality supports care, though weaker Capacity and Readiness reflect investment gaps.

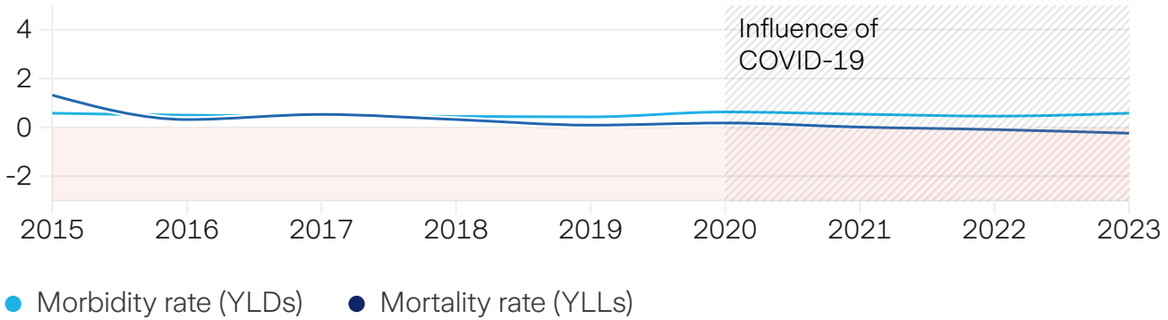
Chronic Care Index

Rank: 34

Chronic disease burden

Rank: 37

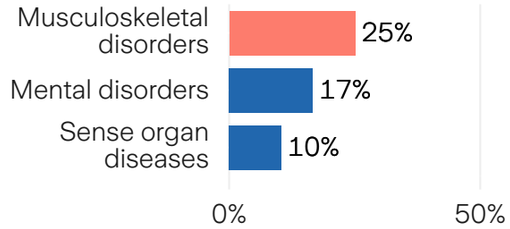
Average growth rates of morbidity and mortality, 2014-2023



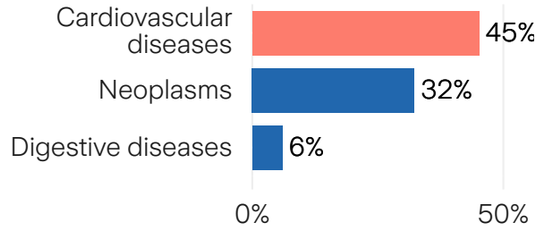
Disease burden by morbidity and mortality

Morbidity		Mortality	
Score:	26	Score:	10
Rank:	28	Rank:	37

By top condition



By top condition



Health system performance

Rank: 26

Performance by pillar, scores

Capacity:	42	Quality:	63	Readiness:	19
Resources:	33	Effectiveness:	56	Innovation:	8
Efficiency:	56	Equity:	76	Resilience:	31

Scores range from 0 to 100, with higher values indicating stronger performance.
Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

Chronic Care Index

Rank: 12

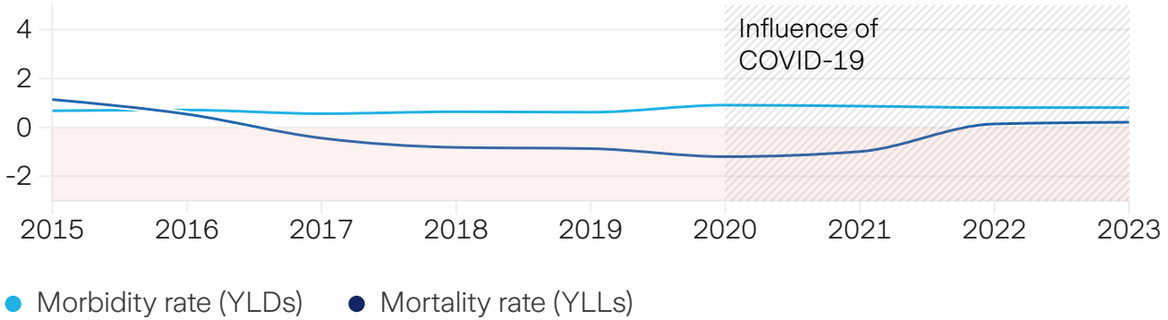
Iceland

Iceland ranks higher-mid tier, combining low mortality with moderate morbidity and mid-range system performance. Capacity is strong, though weaker Quality and Readiness limit consistency.

Chronic disease burden

Rank: 7

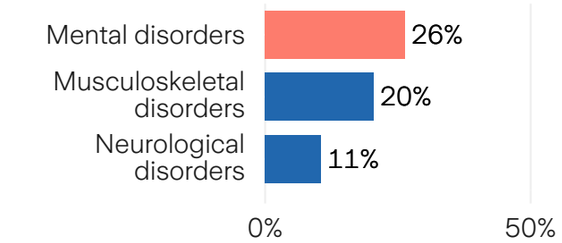
Average growth rates of morbidity and mortality, 2014-2023



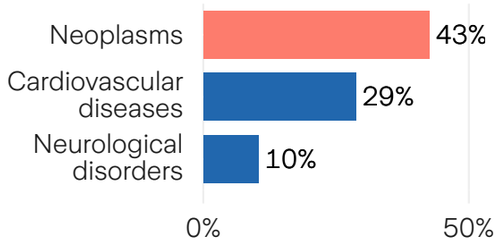
Disease burden by morbidity and mortality

Morbidity		Mortality	
Score:	61	Score:	84
Rank:	8	Rank:	7

By top condition



By top condition



Health system performance

Rank: 23

Performance by pillar, scores

Capacity:	52	Quality:	49	Readiness:	42
Resources:	50	Effectiveness:	46	Innovation:	40
Efficiency:	54	Equity:	55	Resilience:	44

Scores range from 0 to 100, with higher values indicating stronger performance.
Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

Chronic Care Index

Rank: 13

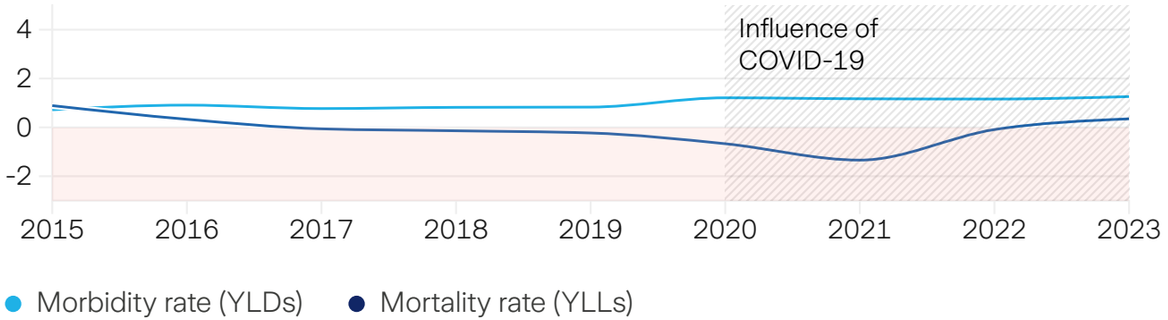
Ireland

Ireland ranks higher-mid tier, combining low burden with mid-range system performance. Strong equity supports outcomes, though Readiness is constrained by weaker resilience scores.

Chronic disease burden

Rank: 8

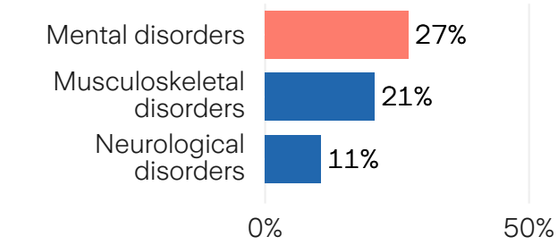
Average growth rates of morbidity and mortality, 2014-2023



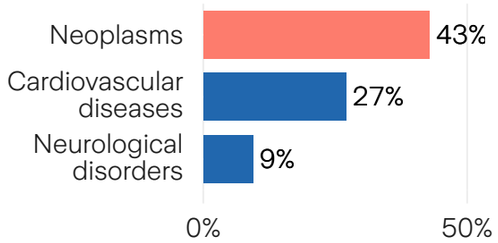
Disease burden by morbidity and mortality

Morbidity		Mortality	
Score:	56	Score:	83
Rank:	10	Rank:	10

By top condition



By top condition



Health system performance

Rank: 22

Performance by pillar, scores

Capacity:	46	Quality:	56	Readiness:	42
Resources:	41	Effectiveness:	53	Innovation:	58
Efficiency:	53	Equity:	62	Resilience:	27

Scores range from 0 to 100, with higher values indicating stronger performance.
Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

Chronic Care Index

Rank: 6

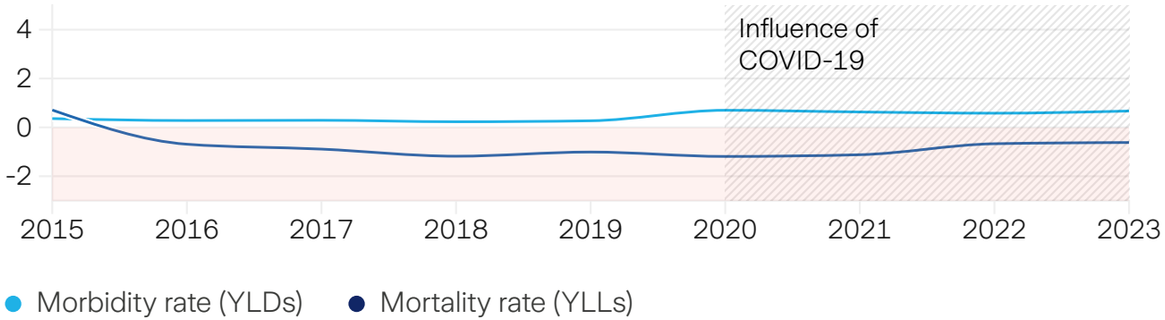
Israel

Israel ranks top 10, primarily due to a very low burden. Strong innovation contrasts with low resilience scores, while Capacity and Quality are limited.

Chronic disease burden

Rank: 1

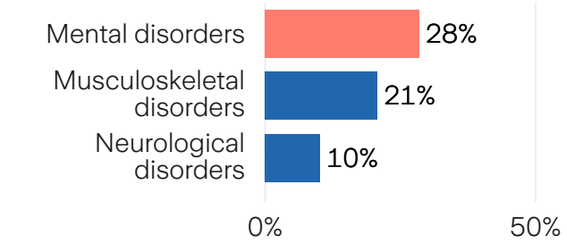
Average growth rates of morbidity and mortality, 2014-2023



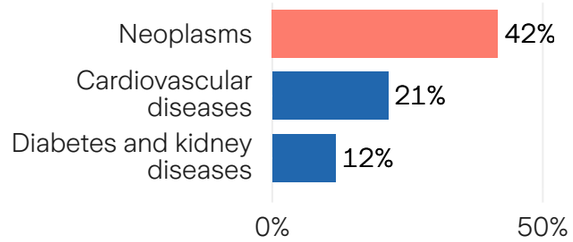
Disease burden by morbidity and mortality

Morbidity		Mortality	
Score:	100	Score:	100
Rank:	1	Rank:	1

By top condition



By top condition



Health system performance

Rank: 28

Performance by pillar, scores

Capacity:	45	Quality:	51	Readiness:	43
Resources:	39	Effectiveness:	53	Innovation:	65
Efficiency:	55	Equity:	48	Resilience:	22

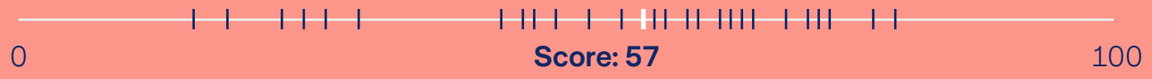
Scores range from 0 to 100, with higher values indicating stronger performance.
Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

Italy

Italy ranks mid-table, combining growth in both morbidity and mortality with strong system performance. Strong Quality partially offsets lower efficiency.

Chronic Care Index

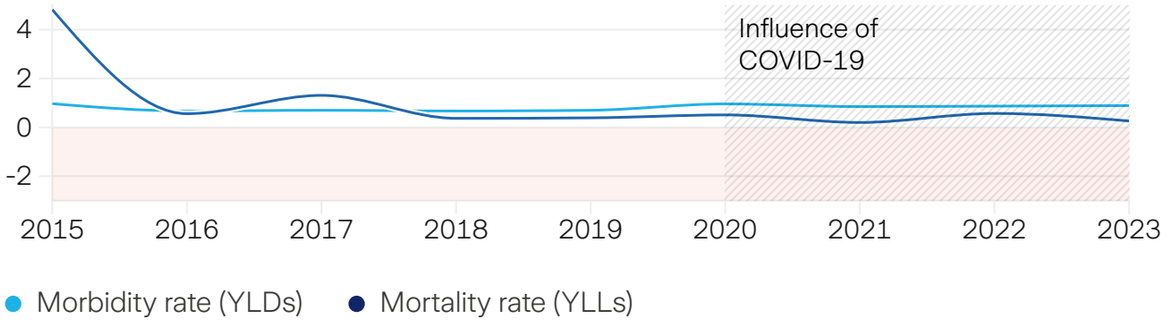
Rank: 21



Chronic disease burden

Rank: 24

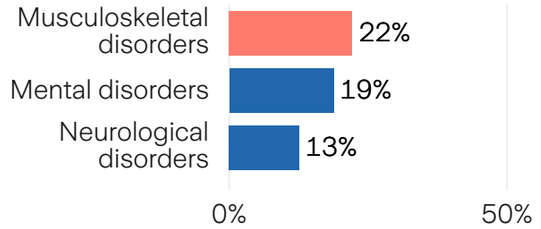
Average growth rates of morbidity and mortality, 2014-2023



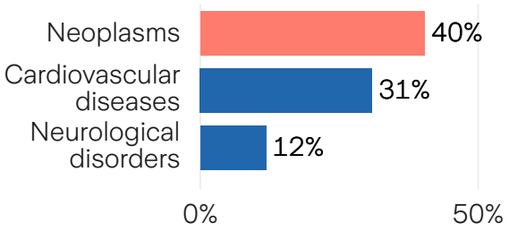
Disease burden by morbidity and mortality

Morbidity		Mortality	
Score:	23	Score:	57
Rank:	31	Rank:	25

By top condition



By top condition



Health system performance

Rank: 11

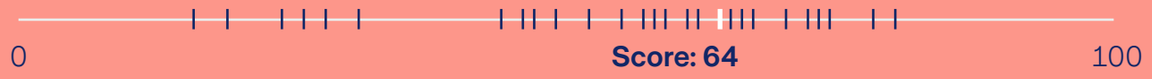
Performance by pillar, scores

Capacity:	45	Quality:	66	Readiness:	41
Resources:	53	Effectiveness:	65	Innovation:	35
Efficiency:	30	Equity:	67	Resilience:	48

Scores range from 0 to 100, with higher values indicating stronger performance.
Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

Chronic Care Index

Rank: 14



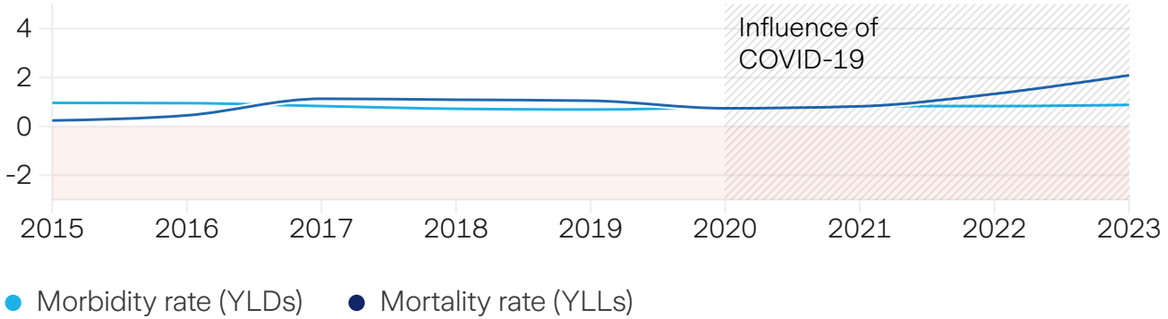
Japan

Japan ranks higher-mid tier, combining moderate mortality with higher morbidity and strong system performance. Capacity is strong, though effectiveness is more mixed.

Chronic disease burden

Rank: 29

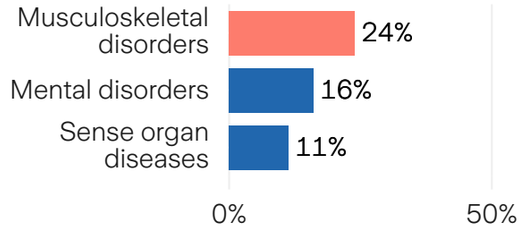
Average growth rates of morbidity and mortality, 2014-2023



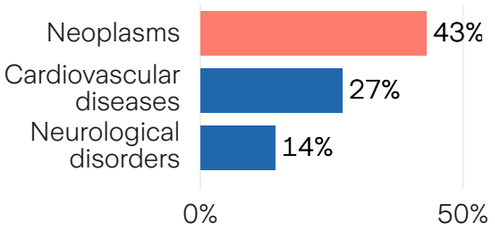
Disease burden by morbidity and mortality

Morbidity		Mortality	
Score:	18	Score:	51
Rank:	34	Rank:	27

By top condition



By top condition



Health system performance

Rank: 2

Performance by pillar, scores

Capacity:	58	Quality:	59	Readiness:	59
Resources:	62	Effectiveness:	57	Innovation:	72
Efficiency:	50	Equity:	62	Resilience:	45

Scores range from 0 to 100, with higher values indicating stronger performance.
Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

Chronic Care Index

Rank: 38

0 **Score: 16** 100

Latvia

Latvia ranks lower tier, combining high mortality and morbidity with weak system performance. Quality and Readiness are low, though Capacity benefits from strong efficiency.

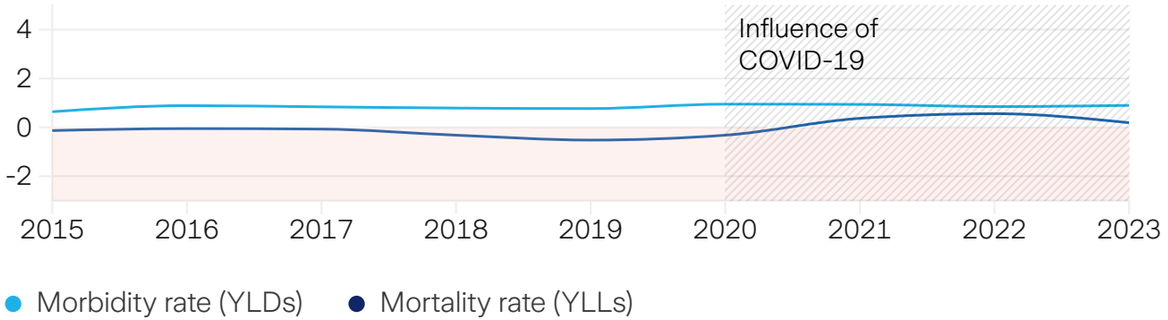
Chronic disease burden

Rank: 38

Score: 0

100

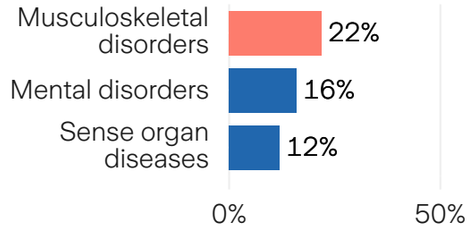
Average growth rates of morbidity and mortality, 2014-2023



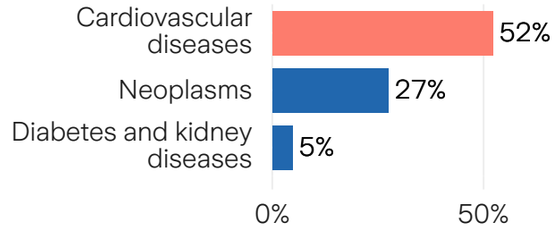
Disease burden by morbidity and mortality

Morbidity		Mortality	
Score:	26	Score:	0
Rank:	30	Rank:	38

By top condition



By top condition



Health system performance

Rank: 31

0 **Score: 44** 100

Performance by pillar, scores

Capacity:	**48**	**Quality:**	**43**	**Readiness:**	**36**
Resources:	36	Effectiveness:	47	Innovation:	8
Efficiency:	68	Equity:	36	Resilience:	65

Scores range from 0 to 100, with higher values indicating stronger performance.
Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

Lithuania

Lithuania ranks lower tier, combining high mortality and morbidity with weak system performance. Quality and Readiness are low, while Capacity is supported by moderate efficiency.

Chronic Care Index

Rank: 37

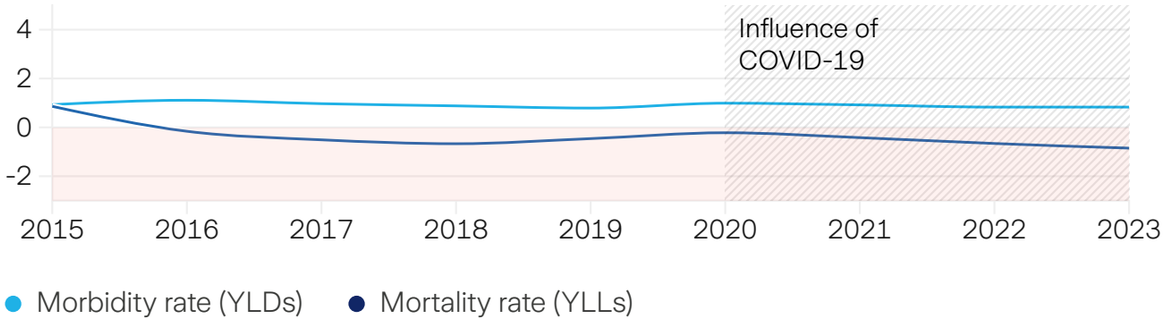
0 **Score: 19** 100

Chronic disease burden

Rank: 36

0 **Score: 10** 100

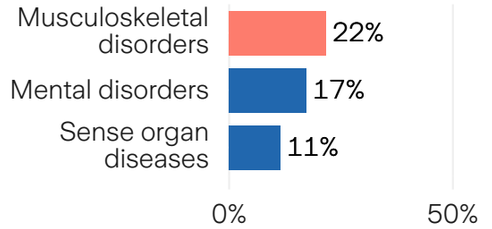
Average growth rates of morbidity and mortality, 2014-2023



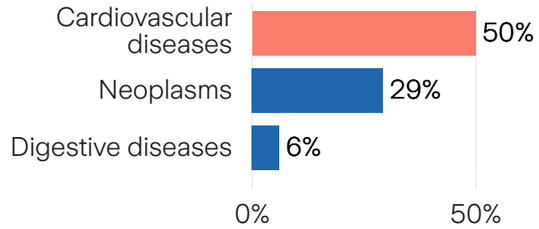
Disease burden by morbidity and mortality

Morbidity		Mortality	
Score:	20	Score:	14
Rank:	33	Rank:	36

By top condition



By top condition



Health system performance

Rank: 33

0 **Score: 42** 100

Performance by pillar, scores

Capacity:	**49**	**Quality:**	**39**	**Readiness:**	**33**
Resources:	47	Effectiveness:	27	Innovation:	19
Efficiency:	52	Equity:	59	Resilience:	48

Scores range from 0 to 100, with higher values indicating stronger performance.
Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

Luxembourg

Luxembourg ranks top 10, combining a notable drop in mortality with strong health performance. Strong Quality is supported by equity and trust, while Capacity is constrained by low efficiency.

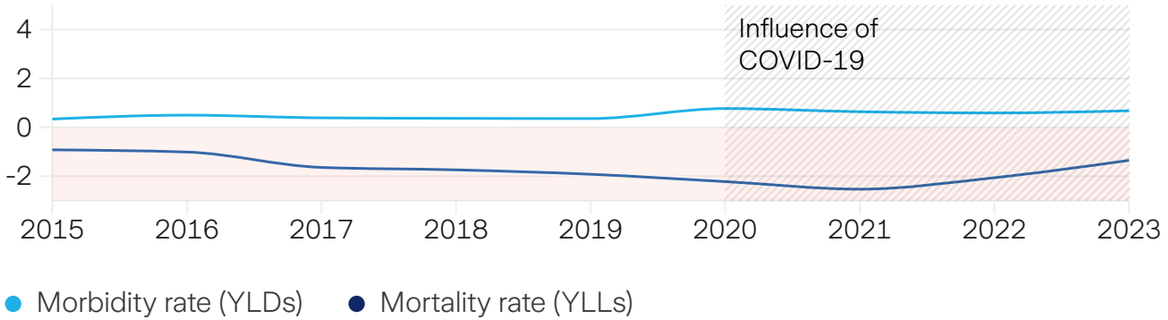
Chronic Care Index

Rank: 3

Chronic disease burden

Rank: 3

Average growth rates of morbidity and mortality, 2014-2023



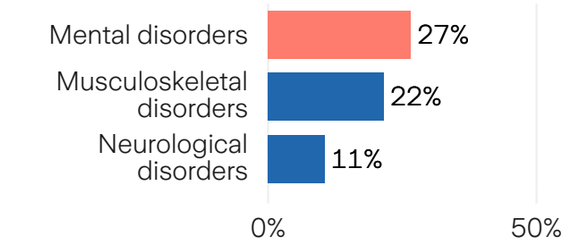
Health system performance

Rank: 13

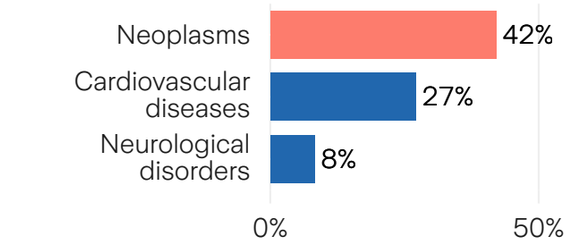
Disease burden by morbidity and mortality

Morbidity		Mortality	
Score:	66	Score:	88
Rank:	7	Rank:	3

By top condition



By top condition



Performance by pillar, scores

Capacity:	47	Quality:	60	Readiness:	48
Resources:	56	Effectiveness:	54	Innovation:	50
Efficiency:	33	Equity:	70	Resilience:	46

Scores range from 0 to 100, with higher values indicating stronger performance.
Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

Mexico

Mexico ranks lower tier, combining relatively low burden with weak system performance. Capacity and Readiness reflect limited resources and innovation, despite strong efficiency.

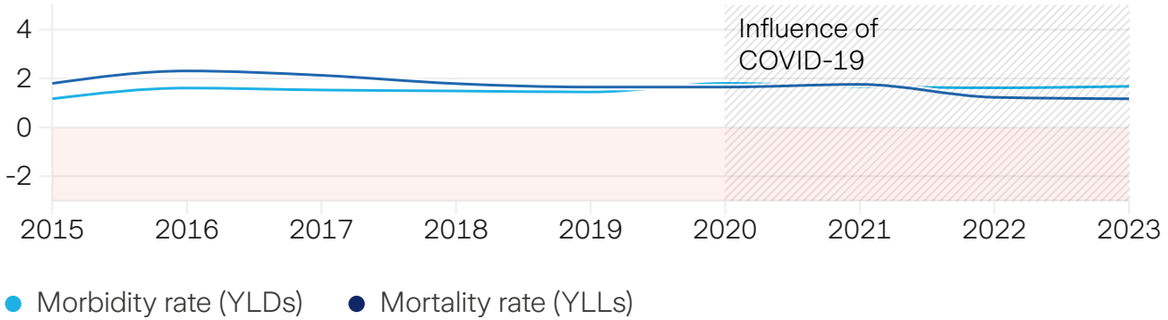
Chronic Care Index

Rank: 31

Chronic disease burden

Rank: 11

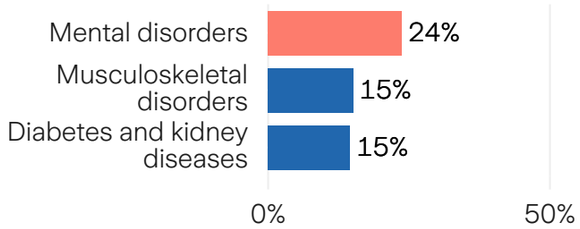
Average growth rates of morbidity and mortality, 2014-2023



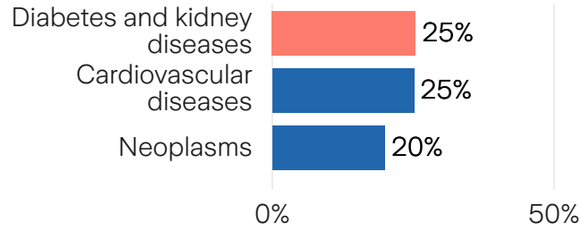
Disease burden by morbidity and mortality

Morbidity		Mortality	
Score:	73	Score:	75
Rank:	3	Rank:	12

By top condition



By top condition



Health system performance

Rank: 36

Performance by pillar, scores

Capacity:	38	Quality:	46	Readiness:	22
Resources:	24	Effectiveness:	45	Innovation:	6
Efficiency:	61	Equity:	48	Resilience:	38

Scores range from 0 to 100, with higher values indicating stronger performance.
Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

Chronic Care Index

Rank: 2

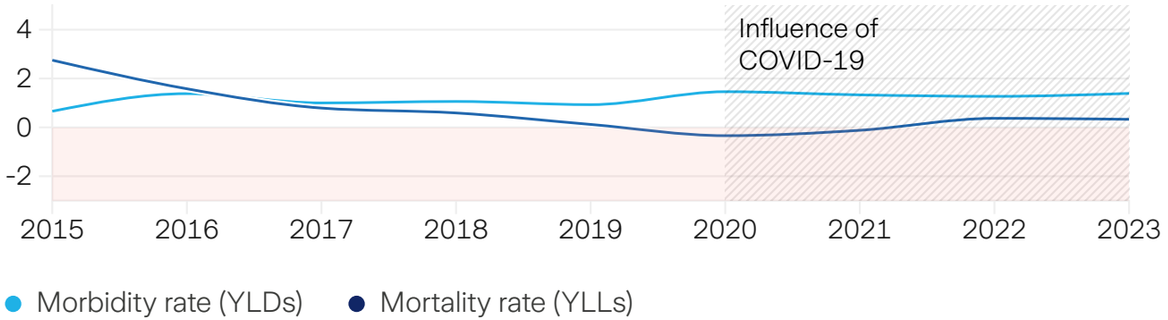
Netherlands

The Netherlands ranks top 10, combining moderate burden with very strong system performance. Exceptional Quality and high Readiness, though Capacity is more moderate.

Chronic disease burden

Rank: 20

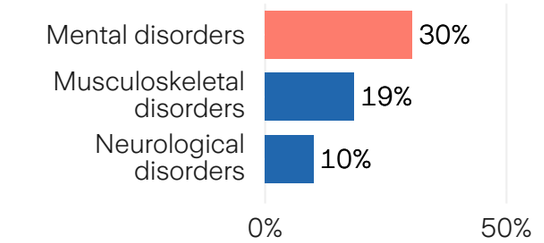
Average growth rates of morbidity and mortality, 2014-2023



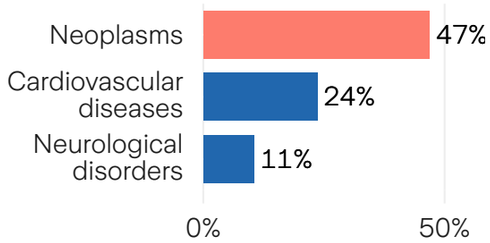
Disease burden by morbidity and mortality

Morbidity		Mortality	
Score:	28	Score:	67
Rank:	27	Rank:	19

By top condition



By top condition



Health system performance

Rank: 1

Performance by pillar, scores

Capacity:	50	Quality:	74	Readiness:	61
Resources:	47	Effectiveness:	75	Innovation:	71
Efficiency:	54	Equity:	74	Resilience:	51

Scores range from 0 to 100, with higher values indicating stronger performance.
Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

New Zealand

New Zealand ranks mid-table, combining moderate burden with mid-range system performance. Strong Quality, though Readiness reflects lower resilience and innovation scores.

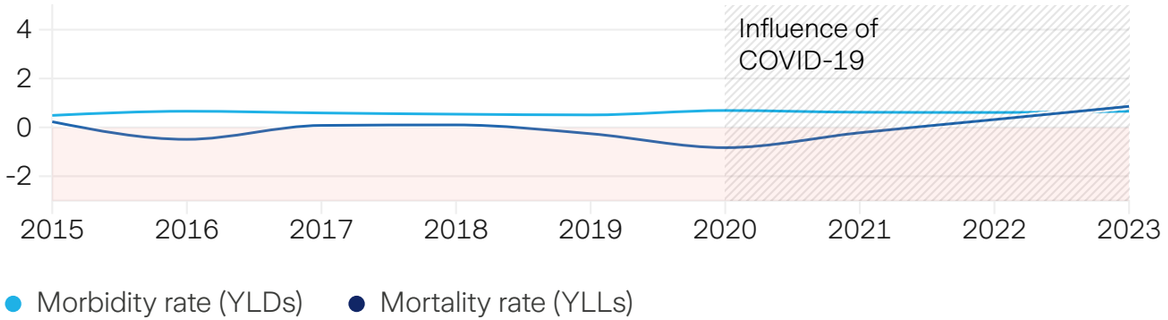
Chronic Care Index

Rank: 16

Chronic disease burden

Rank: 14

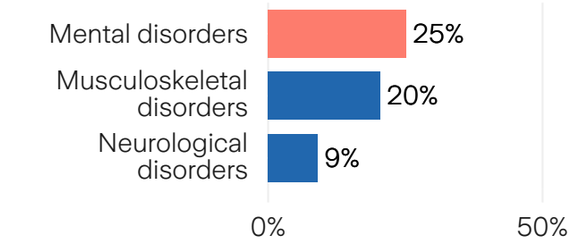
Average growth rates of morbidity and mortality, 2014-2023



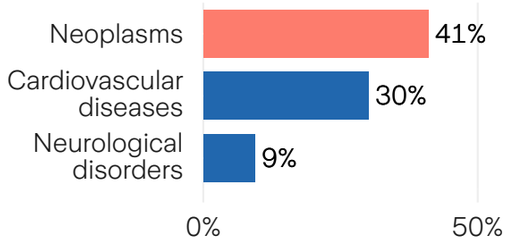
Disease burden by morbidity and mortality

Morbidity		Mortality	
Score:	39	Score:	75
Rank:	19	Rank:	14

By top condition



By top condition



Health system performance

Rank: 20

Performance by pillar, scores

Capacity:	48	Quality:	58	Readiness:	38
Resources:	51	Effectiveness:	57	Innovation:	33
Efficiency:	44	Equity:	60	Resilience:	43

Scores range from 0 to 100, with higher values indicating stronger performance.
Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

Chronic Care Index

Rank: 4

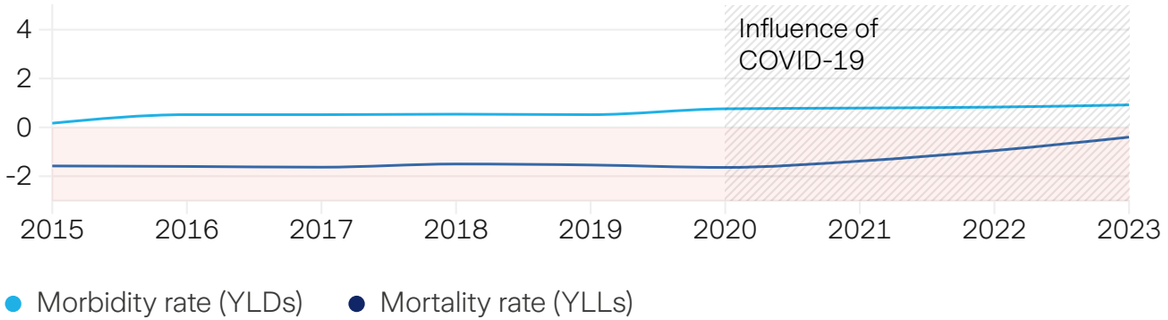
Norway

Norway ranks top 10, combining moderate burden with strong system performance. Strong Capacity, supported by resources, drives performance, while resilience scores are more limited.

Chronic disease burden

Rank: 13

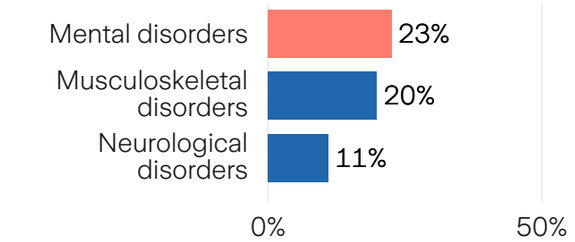
Average growth rates of morbidity and mortality, 2014-2023



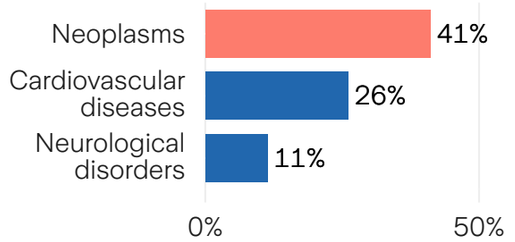
Disease burden by morbidity and mortality

Morbidity		Mortality	
Score:	48	Score:	79
Rank:	12	Rank:	11

By top condition



By top condition

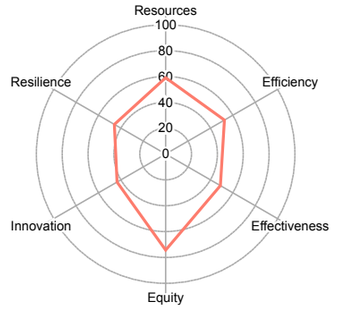


Health system performance

Rank: 6

Performance by pillar, scores

Capacity:	57	Quality:	58	Readiness:	45
Resources:	59	Effectiveness:	49	Innovation:	43
Efficiency:	53	Equity:	74	Resilience:	46



Scores range from 0 to 100, with higher values indicating stronger performance.
Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

Chronic Care Index

Rank: 35

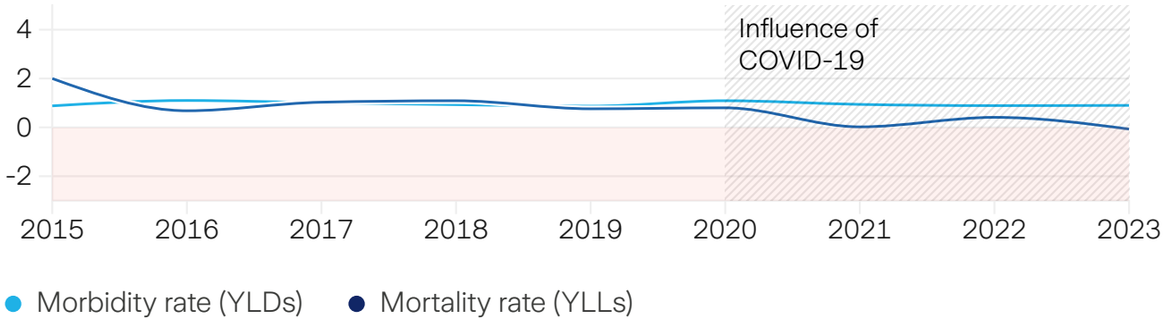
Poland

Poland ranks lower tier, combining high burden with weak system performance. Quality and Readiness are low, while Capacity is partly supported by stronger efficiency.

Chronic disease burden

Rank: 33

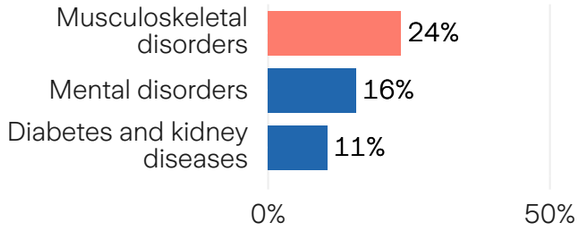
Average growth rates of morbidity and mortality, 2014-2023



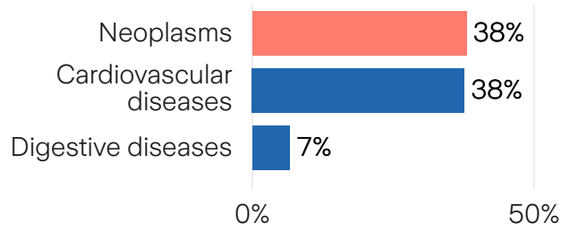
Disease burden by morbidity and mortality

Morbidity		Mortality	
Score:	28	Score:	43
Rank:	26	Rank:	33

By top condition



By top condition



Health system performance

Rank: 35

Performance by pillar, scores

Capacity:	44	Quality:	38	Readiness:	31
Resources:	36	Effectiveness:	25	Innovation:	16
Efficiency:	59	Equity:	59	Resilience:	45

Scores range from 0 to 100, with higher values indicating stronger performance.
Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

Portugal

Portugal ranks lower tier, combining moderate burden with uneven performance. Strong Quality contrasts with weak Capacity and Readiness, driven by low efficiency and innovation.

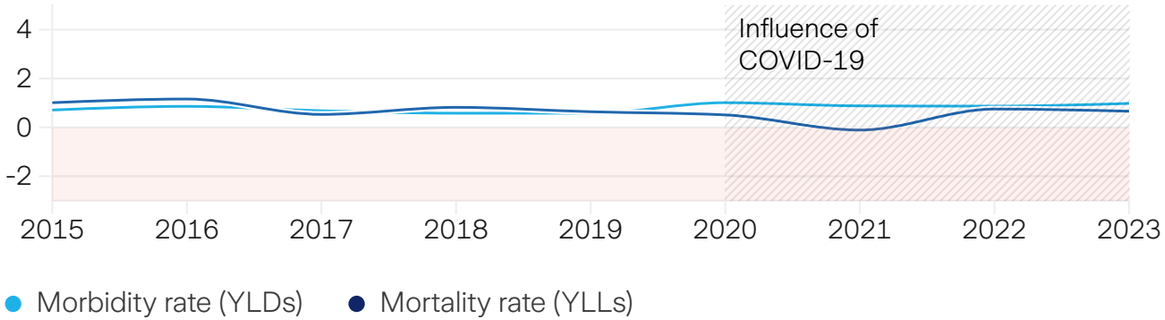
Chronic Care Index

Rank: 32

Chronic disease burden

Rank: 27

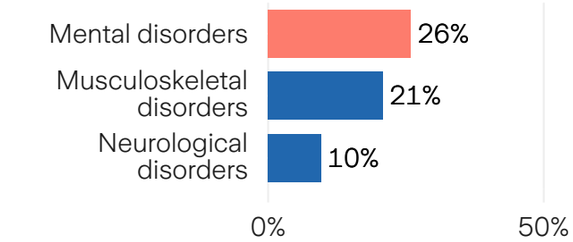
Average growth rates of morbidity and mortality, 2014-2023



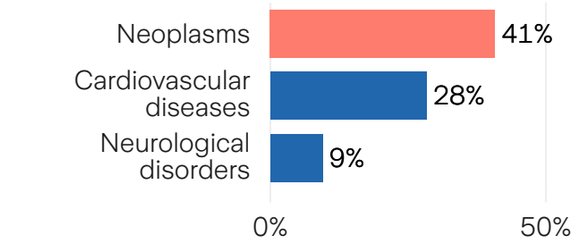
Disease burden by morbidity and mortality

Morbidity		Mortality	
Score:	8	Score:	55
Rank:	37	Rank:	26

By top condition



By top condition



Health system performance

Rank: 29

Performance by pillar, scores

Capacity:	40	Quality:	59	Readiness:	35
Resources:	42	Effectiveness:	50	Innovation:	14
Efficiency:	36	Equity:	74	Resilience:	56

Scores range from 0 to 100, with higher values indicating stronger performance.
Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

Slovakia

Slovakia ranks lower-mid tier, combining higher burden with uneven system performance. Strong Capacity, supported by efficiency, contrasts with weak Readiness driven by low innovation.

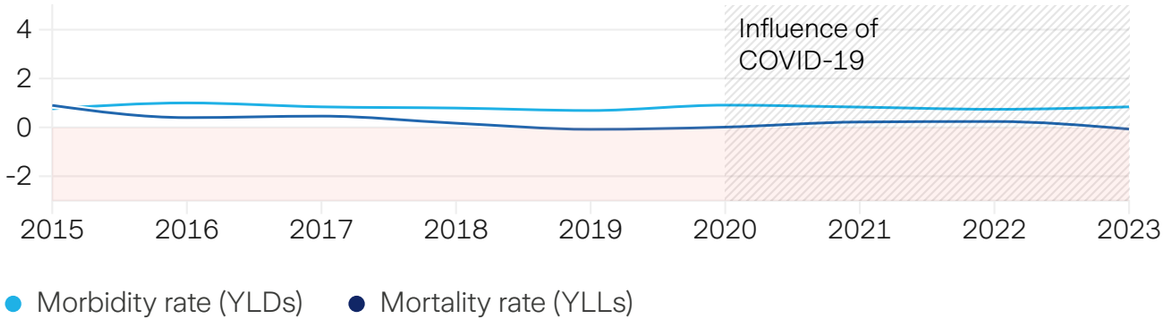
Chronic Care Index

Rank: 30

Chronic disease burden

Rank: 30

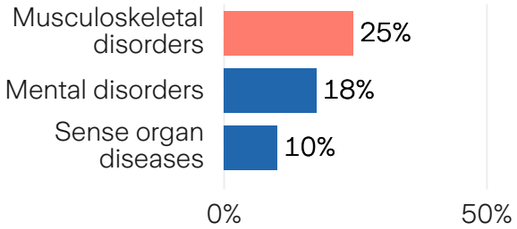
Average growth rates of morbidity and mortality, 2014-2023



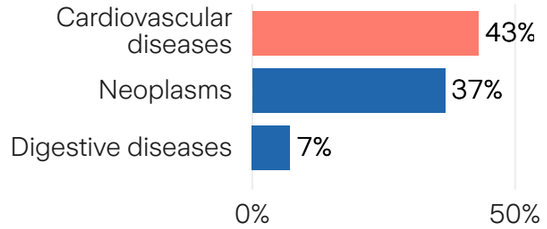
Disease burden by morbidity and mortality

Morbidity		Mortality	
Score:	49	Score:	43
Rank:	11	Rank:	32

By top condition



By top condition

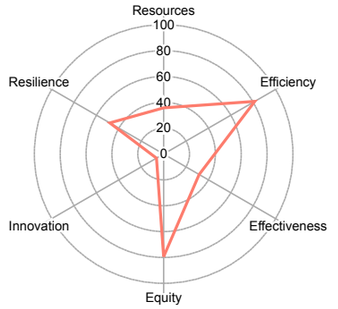


Health system performance

Rank: 25

Performance by pillar, scores

Capacity:	53	Quality:	50	Readiness:	27
Resources:	36	Effectiveness:	32	Innovation:	6
Efficiency:	81	Equity:	79	Resilience:	48



Scores range from 0 to 100, with higher values indicating stronger performance.
Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

Slovenia

Slovenia ranks mid-table, combining moderate burden with balanced system performance. Quality and Capacity are moderate, while Readiness reflects stronger resilience than innovation scores.

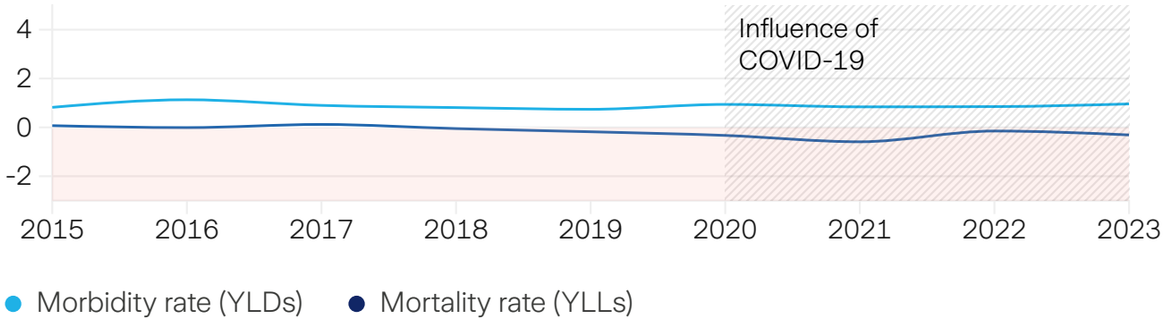
Chronic Care Index

Rank: 23

Chronic disease burden

Rank: 23

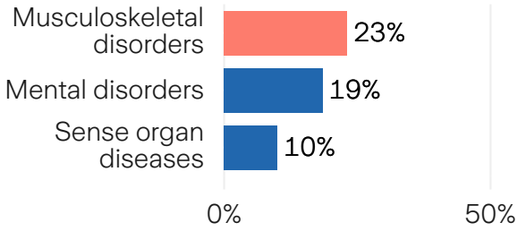
Average growth rates of morbidity and mortality, 2014-2023



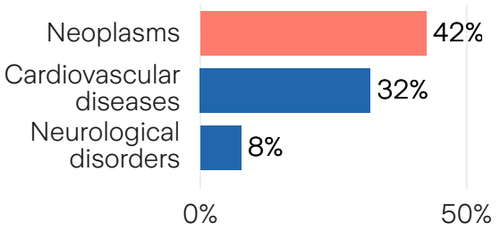
Disease burden by morbidity and mortality

Morbidity		Mortality	
Score:	31	Score:	60
Rank:	25	Rank:	23

By top condition



By top condition



Health system performance

Rank: 21

Performance by pillar, scores

Capacity:	48	Quality:	56	Readiness:	44
Resources:	44	Effectiveness:	48	Innovation:	27
Efficiency:	53	Equity:	71	Resilience:	61

Scores range from 0 to 100, with higher values indicating stronger performance.
Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

South Korea

South Korea ranks top 10, combining low burden with strong system performance. Strong Readiness reflects innovation, while Capacity and Quality remain moderate.

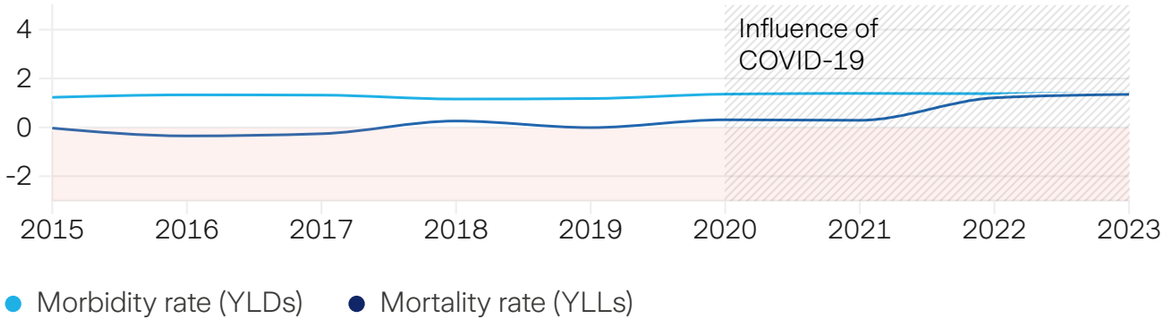
Chronic Care Index

Rank: 5

Chronic disease burden

Rank: 4

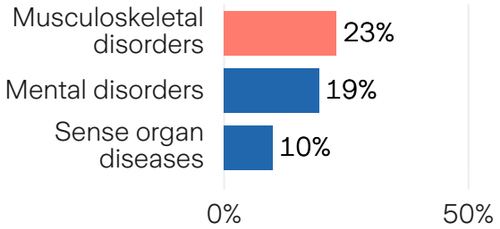
Average growth rates of morbidity and mortality, 2014-2023



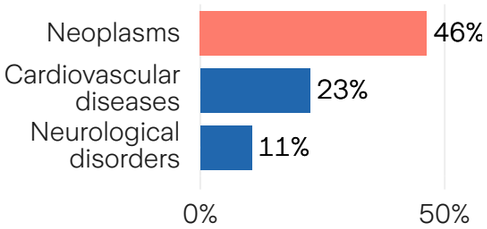
Disease burden by morbidity and mortality

Morbidity		Mortality	
Score:	61	Score:	87
Rank:	9	Rank:	4

By top condition



By top condition



Health system performance

Rank: 16

Performance by pillar, scores

Capacity:	46	Quality:	56	Readiness:	58
Resources:	45	Effectiveness:	57	Innovation:	70
Efficiency:	47	Equity:	56	Resilience:	47

Scores range from 0 to 100, with higher values indicating stronger performance.
Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

Chronic Care Index

Rank: 10

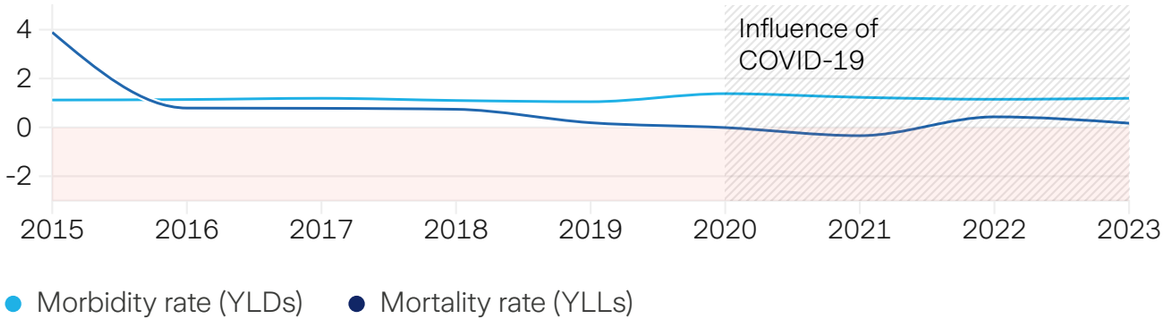
Spain

Spain ranks top 10, combining moderate burden with strong system performance. Strong Quality, while Readiness reflects lower innovation and resilience scores.

Chronic disease burden

Rank: 17

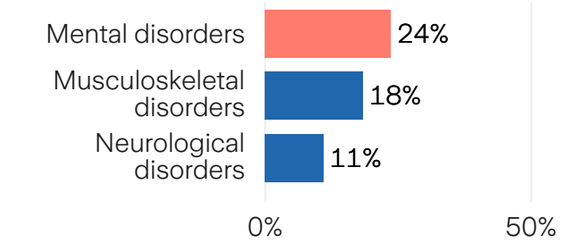
Average growth rates of morbidity and mortality, 2014-2023



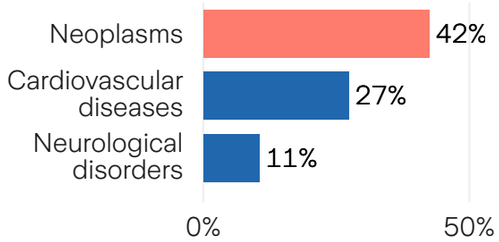
Disease burden by morbidity and mortality

Morbidity		Mortality	
Score:	39	Score:	70
Rank:	20	Rank:	17

By top condition



By top condition



Health system performance

Rank: 9

Performance by pillar, scores

Capacity:	50	Quality:	65	Readiness:	38
Resources:	50	Effectiveness:	60	Innovation:	32
Efficiency:	49	Equity:	74	Resilience:	44

Scores range from 0 to 100, with higher values indicating stronger performance.
Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

Sweden

Sweden ranks top 10, combining moderate burden with strong system performance. Strong Quality and resources support outcomes, while Capacity is constrained by low efficiency.

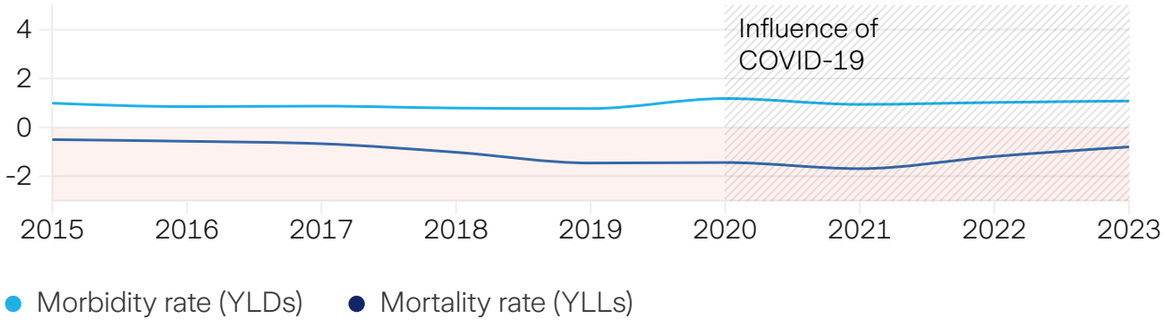
Chronic Care Index

Rank: 9

Chronic disease burden

Rank: 15

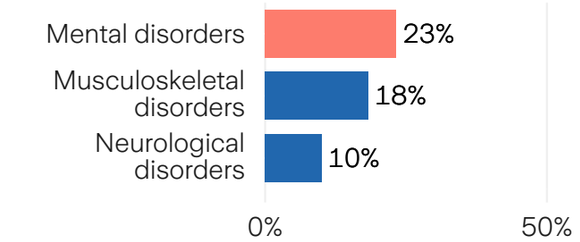
Average growth rates of morbidity and mortality, 2014-2023



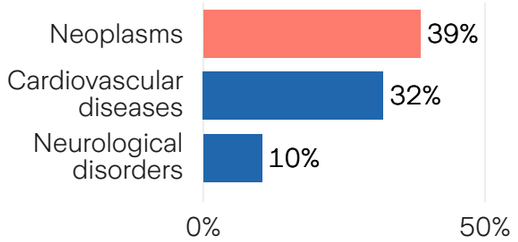
Disease burden by morbidity and mortality

Morbidity		Mortality	
Score:	43	Score:	73
Rank:	16	Rank:	15

By top condition



By top condition



Health system performance

Rank: 7

Performance by pillar, scores

Capacity:	49	Quality:	64	Readiness:	47
Resources:	59	Effectiveness:	60	Innovation:	45
Efficiency:	33	Equity:	71	Resilience:	49

Scores range from 0 to 100, with higher values indicating stronger performance.
Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

Chronic Care Index

Rank: 1

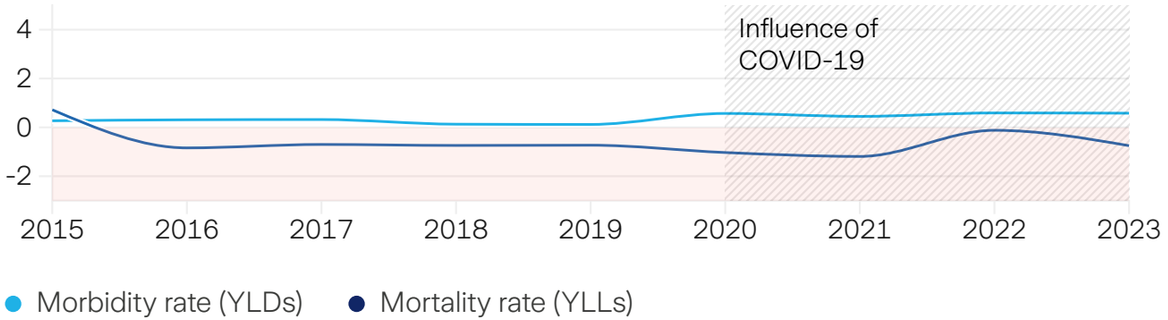
Switzerland

Switzerland ranks top 10, combining low–moderate burden with strong system performance. Exceptional Quality, though Capacity is constrained by efficiency.

Chronic disease burden

Rank: 10

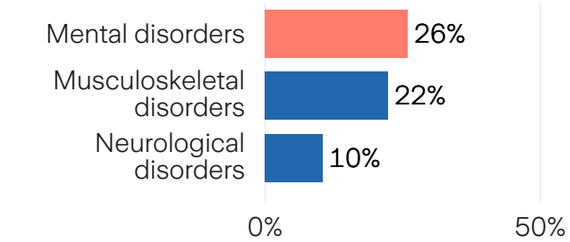
Average growth rates of morbidity and mortality, 2014-2023



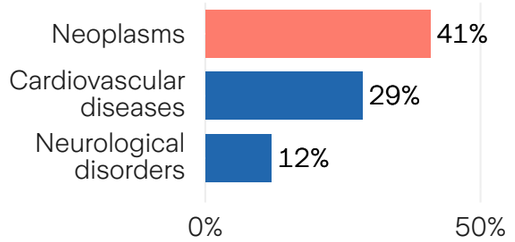
Disease burden by morbidity and mortality

Morbidity		Mortality	
Score:	46	Score:	83
Rank:	13	Rank:	9

By top condition



By top condition



Health system performance

Rank: 3

Performance by pillar, scores

Capacity:	48	Quality:	71	Readiness:	51
Resources:	63	Effectiveness:	71	Innovation:	64
Efficiency:	23	Equity:	70	Resilience:	38

Scores range from 0 to 100, with higher values indicating stronger performance.
Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

Turkey

Turkey ranks mid-table, combining low–moderate burden with uneven system performance. Strong efficiency offsets weak resources, while Quality remains limited.

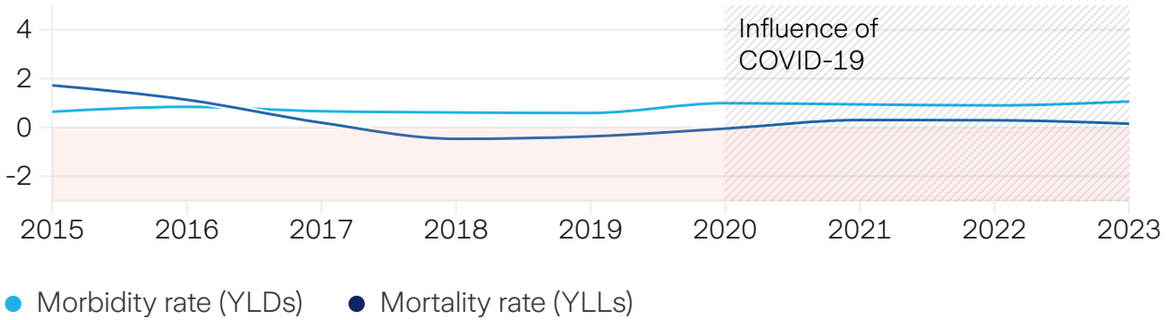
Chronic Care Index

Rank: 18

Chronic disease burden

Rank: 12

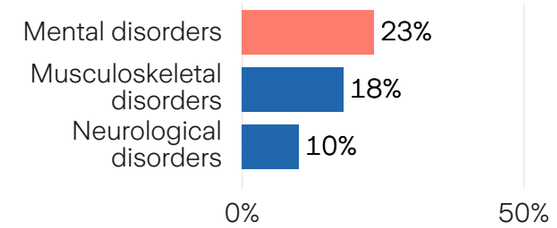
Average growth rates of morbidity and mortality, 2014-2023



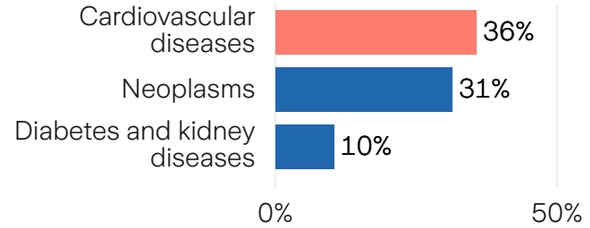
Disease burden by morbidity and mortality

Morbidity		Mortality	
Score:	68	Score:	75
Rank:	6	Rank:	13

By top condition



By top condition



Health system performance

Rank: 27

Performance by pillar, scores

Capacity:	**51**	**Quality:**	**47**	**Readiness:**	**39**
Resources:	26	Effectiveness:	41	Innovation:	24
Efficiency:	93	Equity:	57	Resilience:	54

Scores range from 0 to 100, with higher values indicating stronger performance.
Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

Chronic Care Index

Rank: 22

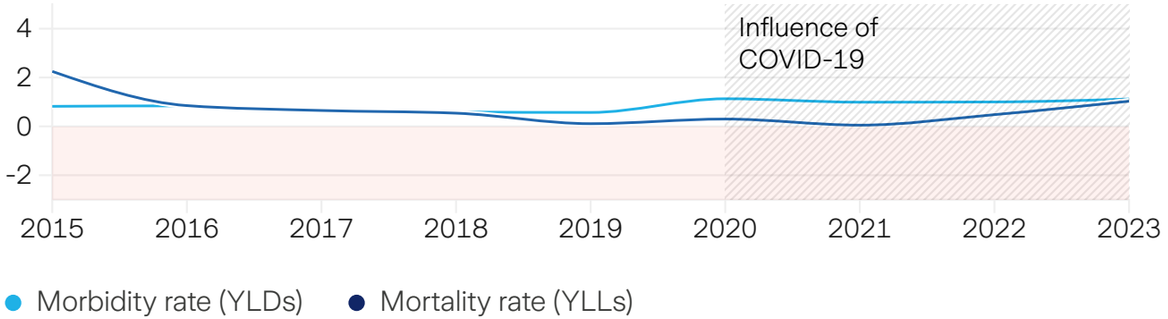
UK

The UK ranks mid-table, combining moderate burden with relatively strong system performance. Strong Readiness contrasts with weaker Quality and Capacity.

Chronic disease burden

Rank: 25

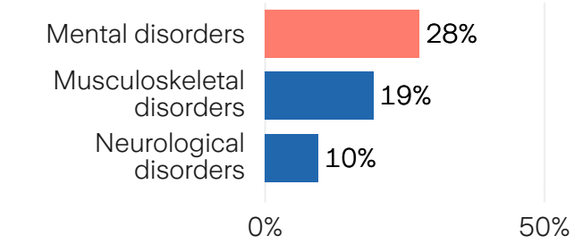
Average growth rates of morbidity and mortality, 2014-2023



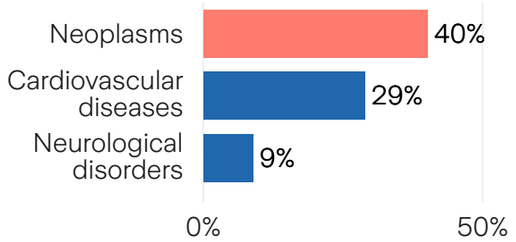
Disease burden by morbidity and mortality

Morbidity		Mortality	
Score:	12	Score:	60
Rank:	36	Rank:	22

By top condition



By top condition



Health system performance

Rank: 12

Performance by pillar, scores

Capacity:	49	Quality:	53	Readiness:	64
Resources:	52	Effectiveness:	51	Innovation:	69
Efficiency:	45	Equity:	55	Resilience:	60

Scores range from 0 to 100, with higher values indicating stronger performance.
Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

Chronic Care Index

Rank: 27

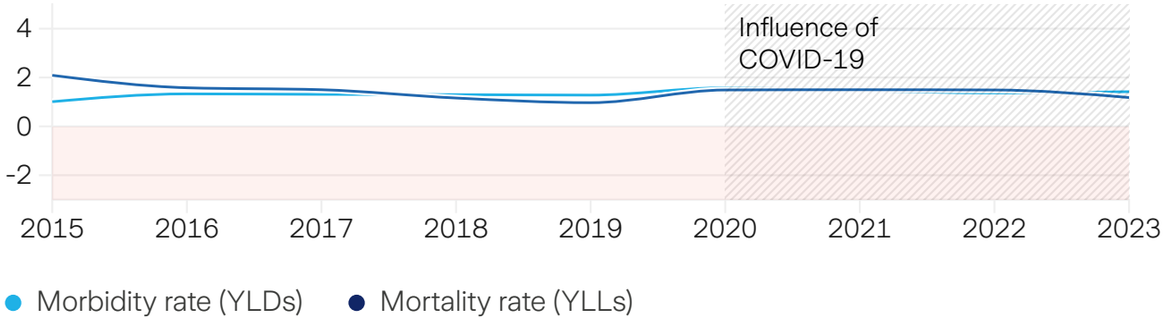
U.S.

The U.S. ranks lower-mid tier, combining higher burden with uneven system performance. Exceptional Readiness, driven by innovation and resilience, contrasts with weak Quality and Capacity.

Chronic disease burden

Rank: 31

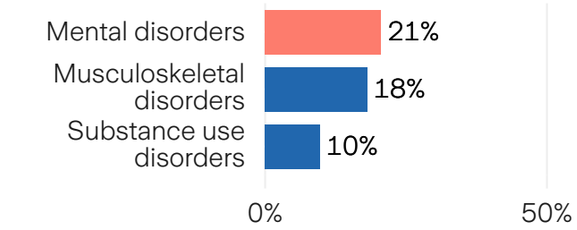
Average growth rates of morbidity and mortality, 2014-2023



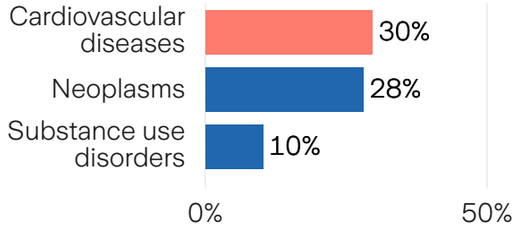
Disease burden by morbidity and mortality

Morbidity		Mortality	
Score:	0	Score:	50
Rank:	38	Rank:	28

By top condition



By top condition



Health system performance

Rank: 19

Performance by pillar, scores

Capacity:	45	Quality:	47	Readiness:	82
Resources:	49	Effectiveness:	52	Innovation:	88
Efficiency:	38	Equity:	38	Resilience:	76

Scores range from 0 to 100, with higher values indicating stronger performance.
Refer to Data and methodology for a full set of data sources, assumptions, and calculations.

Data and methodology

Data analysis for this report was undertaken by Mandala Partners, a specialist econometrics firm, in consultation with Zurich experts. This section should be read in conjunction with How to read the report. The following sections outline the primary assumptions, calculations, and data sources for the key inputs and metrics outlined in the report.

For each indicator, the strongest-performing country received a score of 100, and the weakest-performing country a score of 0. Health system performance was rescaled to a range of 0–100 to enable direct comparison with Chronic disease burden to construct a composite score (Chronic Care Index).

Chronic disease burden

The Global Burden of Disease (GBD) study was selected as the sole data source for the morbidity and mortality pillars. It is the largest and most comprehensive effort to quantify health loss across places and over time. The dataset covers 204 countries starting in 1990 with detailed breakdown at the condition level, enabling selection of specific diseases for analysis. Figures are based on the GBD's latest meta-analysis of country studies, from structured clinical interviews to administrative data sources, published in 2025 using data to 2023.

The impact of chronic conditions is measured in years of healthy life lost using Disability Adjusted Life Years (DALYs). One DALY represents the loss of the equivalent of one year of full health.

This includes mortality (Years of Life Lost, YLLs):

- **Terminal:** What is the mortality rate associated with chronic conditions?
- **Life lost:** How many years of life are lost to premature mortality from chronic conditions?

And morbidity (Years Living with Disability, YLDs):

- **Persistent:** How long do patients of chronic conditions live with the disease?
- **Severe:** To what extent do chronic conditions diminish quality of life through disability?

The GBD presumes a consistent distribution of severity within conditions across countries, as well as life expectancy. Differences in DALYs and YLDs between countries therefore reflect variation in condition mix and age profile.

We selected more than 200 conditions that are classified as chronic based on Zurich expertise and international literature. Based on the GBD hierarchy, this includes:

Communicable, maternal, neonatal, and nutritional diseases

A.1 HIV/AIDS and sexually transmitted infections
- HIV/AIDS - Drug-susceptible Tuberculosis
- HIV/AIDS - Multidrug-resistant Tuberculosis without extensive drug resistance
- HIV/AIDS - Extensively drug-resistant Tuberculosis
- HIV/AIDS resulting in other diseases
- Genital herpes

A.2 Respiratory infections and tuberculosis
- Latent tuberculosis infection
- Drug-susceptible tuberculosis
- Multidrug-resistant tuberculosis without extensive drug resistance
- Extensively drug-resistant tuberculosis

A.4 Neglected tropical diseases and malaria
- Chagas disease
- Cutaneous and mucocutaneous leishmaniasis
- African trypanosomiasis
- Schistosomiasis
- Cysticercosis
- Cystic echinococcosis
- Lymphatic filariasis
- Onchocerciasis
- Leprosy

A.5 Other infectious diseases
- Tetanus

A.7 Nutritional deficiencies
- Protein-energy malnutrition
- Iodine deficiency
- Vitamin A deficiency
- Dietary iron deficiency
- Other nutritional deficiencies

Non-communicable diseases

B.1 Neoplasms
- Lip and oral cavity cancer
- Nasopharynx cancer
- Other pharynx cancer
- Esophageal cancer
- Stomach cancer
- Colon and rectum cancer
- Liver cancer due to hepatitis B
- Liver cancer due to hepatitis C
- Liver cancer due to alcohol use
- Liver cancer due to NASH
- Hepatoblastoma
- Liver cancer due to other causes
- Gallbladder and biliary tract cancer
- Pancreatic cancer
- Larynx cancer
- Tracheal, bronchus, and lung cancer
- Malignant skin melanoma
- Non-melanoma skin cancer (squamous-cell carcinoma)
- Non-melanoma skin cancer (basal-cell carcinoma)
- Soft tissue and other extraosseous sarcomas
- Malignant neoplasm of bone and articular cartilage

- Breast cancer
- Cervical cancer
- Uterine cancer
- Ovarian cancer
- Prostate cancer
- Testicular cancer
- Kidney cancer
- Bladder cancer
- Brain and central nervous system cancer
- Eye cancer
- Neuroblastoma and other peripheral nervous cell tumors
- Thyroid cancer
- Mesothelioma
- Hodgkin lymphoma
- Non-Hodgkin lymphoma
- Multiple myeloma
- Acute lymphoid leukemia
- Chronic lymphoid leukemia
- Acute myeloid leukemia
- Chronic myeloid leukemia
- Other leukemia
- Other malignant neoplasms
- Myelodysplastic, myeloproliferative, and other hematopoietic neoplasms
- Benign and in situ intestinal neoplasms
- Benign and in situ cervical and uterine neoplasms
- Other benign and in situ neoplasms

B.2 Cardiovascular diseases

- Rheumatic heart disease
- Ischemic heart disease
- Ischemic stroke
- Intracerebral hemorrhage
- Subarachnoid hemorrhage
- Hypertensive heart disease
- Non-rheumatic calcific aortic valve disease
- Non-rheumatic degenerative mitral valve disease
- Other non-rheumatic valve diseases
- Alcoholic cardiomyopathy
- Other cardiomyopathy
- Pulmonary Arterial Hypertension
- Atrial fibrillation and flutter
- Aortic aneurysm
- Lower extremity peripheral arterial disease
- Other cardiovascular and circulatory diseases

B.3 Chronic respiratory diseases

- Chronic obstructive pulmonary disease
- Silicosis
- Absestosis
- Coal workers pneumoconiosis
- Other pneumoconiosis
- Asthma
- Interstitial lung disease and pulmonary sarcoidosis
- Other chronic respiratory diseases

B.4 Digestive diseases
- Cirrhosis and other chronic liver diseases
- Peptic ulcer disease
- Gastroesophageal reflux disease
- Inguinal, femoral, and abdominal hernia
- Inflammatory bowel disease
- Gallbladder and biliary diseases

B.5 Neurological disorders
- Alzheimer's disease and other dementias
- Parkinson's disease
- Idiopathic epilepsy
- Multiple sclerosis
- Motor neuron disease
- Headache disorders
- Other neurological disorders

B.6 Mental disorders
- Schizophrenia
- Major depressive disorder
- Dysthymia
- Bipolar disorder
- Anxiety disorders
- Anorexia nervosa
- Bulimia nervosa
- Autism spectrum disorders
- Attention-deficit/hyperactivity disorder
- Conduct disorder
- Idiopathic developmental intellectual disability

B.7 Substance use disorders
- Alcohol use disorders
- Opioid use disorders
- Cocaine use disorders
- Amphetamine use disorders
- Cannabis use disorders
- Other drug use disorders

B.8 Diabetes and kidney diseases
- Diabetes mellitus type 1
- Diabetes mellitus type 2
- Chronic kidney disease due to diabetes mellitus type 1
- Chronic kidney disease due to diabetes mellitus type 2
- Chronic kidney disease due to hypertension
- Chronic kidney disease due to glomerulonephritis
- Chronic kidney disease due to other and unspecified causes

B.9 Skin and subcutaneous diseases
- Atopic dermatitis
- Contact dermatitis
- Seborrhoeic dermatitis
- Psoriasis
- Fungal skin diseases
- Acne vulgaris
- Alopecia areata
- Urticaria
- Decubitus ulcer

B.10 Sense organ diseases

- Glaucoma
- Cataract
- Age-related macular degeneration
- Refraction disorders
- Near vision loss
- Other vision loss
- Age-related and other hearing loss
- Other sense organ diseases

B.11 Musculoskeletal disorders

- Rheumatoid arthritis
- Osteoarthritis hip
- Osteoarthritis knee
- Osteoarthritis hand
- Osteoarthritis other
- Low back pain
- Neck pain
- Gout

B.12 Other non-communicable diseases

- Neural tube defects
- Congenital heart anomalies
- Orofacial clefts
- Down syndrome
- Turner syndrome
- Klinefelter syndrome
- Other chromosomal abnormalities
- Congenital musculoskeletal and limb anomalies
- Urogenital congenital anomalies
- Digestive congenital anomalies
- Other congenital birth defects
- Benign prostatic hyperplasia
- Male infertility
- Uterine fibroids
- Polycystic ovarian syndrome
- Female infertility
- Endometriosis
- Genital prolapse
- Premenstrual syndrome
- Thalassemias
- Thalassemias trait
- Sickle cell disorders
- Sickle cell trait
- G6PD deficiency
- G6PD trait
- Other hemoglobinopathies and hemolytic anemias
- Thyroid diseases
- Other endocrine, metabolic, blood, and immune disorders
- Caries of deciduous teeth
- Caries of permanent teeth
- Periodontal diseases
- Edentulism
- Other oral disorders

Individuals may experience more than one condition (comorbidity).

Health system performance

Grounded in an international literature review of health system frameworks,[24] potential data sources were assessed against three criteria:

1. **Relevance:** Characterizes national health system performance quantitatively, at the indicator level

2. **Repeatability:** Contains longitudinal data, with guaranteed future collection

3. **Scale:** Covers at least 20 high- and middle-income countries

Data approaches

The full list of indicators and applied weighting is outlined below. The following assumptions, calculations and limitations apply:

- Imputation: If country data was only available for a subset of six years, missing values were imputed using data from the nearest available year. If country data was missing across all years, the value was imputed using a Ridge regression based on observable independent variables (GDP per capita, Healthcare expenditure as a share of GDP). For indicators 4b.2–4b.4, the Gini coefficient was used as a sole regressor, with income inequality being a more suitable predictor of health system inequity.

- Normalization: Each performance metric presents a unique range and is measured using different units. Normalization was therefore required prior to aggregation. A min-max normalization was applied to preserve the relative distribution of raw data. Where material outliers were present, the normalization range was trimmed using the IQR method.

- Weighting: Literature-based weights were assigned to the three pillars of health system performance to maintain conceptual coherence. Health system outcomes were treated as equally important as health system output, with the Capacity and Quality pillars weighted identically (42.5% each). Reflecting the long-term nature of chronic disease, future capacity of the health system (i.e., Readiness) was weighted 15%. Principal component analysis (PCA) was run within each of the three pillars to mitigate the risk of double counting among highly correlated indicators.

- Unless otherwise indicated (blue text in the table), higher values translate to a higher score and ranking on the index.

Data sources

Indicators 3a.1-3a.9, 3b.1-3b.3, 4a.1–4a.4, 4b.1-4b.4, and 5b.1-5b.3 are sourced from OECD Health Statistics.[25]

Indicators 4a.5-4a.9 are sourced from the Patient-Reported Indicator Surveys (PaRIS) carried out by the OECD.[26] Respondents included people aged 45 years and over who received primary care within the 6 months preceding the survey, 80% of which live with chronic conditions. Data collection took place in 2023 – 2024. We thank all patients and primary care professionals who participated in the OECD Patient-Reported Indicator Surveys (PaRIS), without whom this report would not have been possible. We also thank the national teams and health authorities across participating countries in data collection and validation.

Indicators 5a.1-5a.2 are sourced from the OECD Data Explorer.[27]

24. Kruk et al. High-quality health systems in the Sustainable Development Goals era: time for a revolution (2018); OECD. Health Care Quality Indicators Project: Conceptual Framework Paper (2006); WHO. Health system performance assessment: A framework for policy analysis (2022).

25. OECD. Health Statistics 2025 (2025).

26. OECD. Patient-Reported Indicator Surveys (PaRIS) Public Use Files (2024).

27. OECD. OECD Data Explorer (accessed January 2026).

3: Capacity (42.5%)

3a Resources: Is the health system adequately resourced, in terms of personnel, capital, and funding?	26.56%
3a.1 Personnel: Availability of physicians (# per 1,000 inhabitants)	2.98%
3a.2 Personnel: Availability of nurses (# per 1,000 inhabitants)	2.73%
3a.3 Personnel: Availability of long-term care workers (# per 100 inhabitants aged 65+)	3.32%
3a.4 Personnel: Availability of pharmacists (# per 1,000 inhabitants)	3.08%
3a.5 Capital: Availability of medical technology[28] (# per 1,000,000 inhabitants)	2.80%
3a.6 Capital: Availability of hospital beds (# per 1,000 inhabitants)	2.61%
3a.7 Capital: Availability of long-term care beds (# per 1,000 inhabitants aged 65+)	3.27%
3a.8 Funding: Total health expenditure as a share of GDP (%)	3.26%
3a.9 Funding: Total long-term care expenditure as a share of GDP (%)	2.51%
3b Efficiency: How productive is the country's health system?	15.94%
3b.1 Hospital efficiency: Average length of stay in hospital (days)	5.67%
3b.2 Consultation efficiency: Average in-person consultations per doctor (# per year)	4.75%
3b.3 Pharmaceutical market efficiency: Share of generics in pharmaceutical market (%)	5.51%

28. The availability of six medical technologies are included as separate indicators with respective weightings. The six technologies are: Computed Tomography scanners (CT units), Magnetic Resonance Imaging units (MRI units), Positron Emission Tomography scanner units (PET units), Gamma cameras, mammography machines, and radiation therapy equipment.

4: Quality (42.5%)

4a Effectiveness: Does the health system support chronic care patients' preferences and needs?	26.56%
4a.1 Quality: Avoidable hospital admissions (# per 100,000 inhabitants)	10.63%
4a.2 Quality: Mortality following acute myocardial infarction (# per 100 admissions)	1.77%
4a.3 Quality: Mortality following ischaemic stroke (# per 100 admissions)	1.77%
4a.4 Quality: Congestive heart failure patients with adverse outcomes following discharge (# per 100 admissions)	1.77%
4a.5 Self-management: Patients reporting confidence to manage own health (% of total chronic care patients)	1.28%
4a.6 Integrated care: Patients reporting experience of care co-ordination (% of total chronic care patients)	2.60%

4a.7 Person-centeredness: Patients reporting experience of person-centered care (% of total chronic care patients)	2.60%
4a.8 Quality: Patients reporting experience of quality primary care (% of total chronic care patients)	2.07%
4a.9 Trust: Patients reporting trust in the health system (% of total chronic care patients)	2.07%
4b Equity: Can all people access the health system regardless of income and geography?	**15.94%**
4b.1 Income: Healthcare price levels (indexed)	*3.79%*
4b.2 Income: Share of lowest income quintile reporting unmet needs for medical care (%)	4.10%
4b.3 Geography: Physician density in remote areas (# per 1,000 inhabitants)	4.16%
4b.4 General: Share of population reporting unmet needs for medical care (%)	3.89%

5: Readiness (15.0%)[29]

5a Innovation: Does the health system invest in new technology to improve future service delivery?	**7.5%**
5a.1 R&D: Medical technology patent applications (#)	3.75%
5a.2 R&D: Medical and health sciences R&D expenditure as a share of GDP (%)	3.75%
5b Resilience: Can the health system withstand and recover from potential shocks to demand?	**7.5%**
5b.1 Funding: Estimated expenditure on prevention, preparedness, response, per capita ($)	2.59%
5b.2 Capital: Gross fixed capital formation in the health sector as a share of GDP (%)	2.64%
5b.3 Capital: Availability of intensive care beds (# per 100,000 inhabitants)	*2.27%*

29. Indicators 5a.1–5a.2 are sourced from OECD Data Explorer. Indicators 5b.1–5a.3 are sourced from OECD Health Statistics.

Risk factor analysis

Countries were grouped using hierarchical clustering, based on similarity of their attributes across all dimensions. This method was deemed suitable because it does not require pre-specifying the number of clusters, is less sensitive to outlier countries with extreme risk factor profiles and allows flexible identification of natural groupings at multiple levels of similarity.

Standardized risk-attributable burden values per cluster were then calculated based on: attributable burden to $risk_i$ for $cluster_j$; Average attributable burden to $risk_i$ for all OECDD countries; and the standard deviation of all clusters' attributable burden to $risk_i$.

Positive values indicate that a cluster carries a higher attributable burden for that risk than the OECD average; negative values indicate the reverse. Negative values reflect below-average burden relative to other OECD countries, not low absolute burden. All OECD countries share elevated burden from high fasting plasma glucose, high systolic blood pressure, and high BMI, a convergence that reflects the shared characteristics of OECD membership.

The greater the absolute value, the larger the deviation from the OECD average. For example, a value of "2" represents 2 standard deviations above the mean, placing that group above approximately 97% of all countries.

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