

The Analysis of the Healthcare System in Andorra from a Fiscal Perspective

Nick Carroll, Aidyn Bibolov

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Prepared by Nick Carroll, Aidyn Bibolov

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ABSTRACT: Andorra has a solid health system, delivering strong outcomes with lower public spending than the average in EU countries. However, health spending increased significantly between 2014 and 2025 and will remain a key source of pressure over the medium and long-term as the population continues to age. This paper reviews recent trends in government health spending in Andorra and identifies reforms that strengthen health financing and more tightly manage high-cost areas that could help reduce pressure on government expenditures, preventing the crowding out of other spending and/or the need for higher contributions.

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Author's E-Mail Address:	ABibolov@imf.org , NCarroll@imf.org

SELECTED ISSUES PAPERS

The Analysis of the Healthcare System in Andorra from a Fiscal Perspective

Principality of Andorra

Prepared by Nick Carroll, Aidyn Bibolov

Acronyms

CASS	Caixa Andorrana de Seguretat Social
COFOG	The Classification of the Functions of Government (COFOG) from the Government Finance Statistics
ECG	Excess Cost Growth
GFS	Government Finance Statistics
GHED	Global Health Expenditure Database
LTC	Long-Term Care
OECD	Organization for Economic Cooperation and Development
PPP	Purchasing Power Parity
SAAS	Servei Andorra D'Atencio Sanitaria
UNPP	United Nations World Population Prospects
WEO	IMF World Economic Outlook
WHO	World Health Organization

THE ANALYSIS OF THE HEALTHCARE SYSTEM IN ANDORRA FROM A FISCAL PERSPECTIVE¹

Andorra has a solid health system, delivering strong outcomes with lower public spending than average EU countries. However, health spending increased significantly between 2014 and 2025 and will remain a key source of pressure over the medium and long-term as the population continues to age. Reforms that strengthen health financing and more tightly manage high-cost areas could help reduce pressure on government expenditures, preventing crowding out of other spending and/or increasing contributions.

A. Introduction

1. Andorra has a healthcare system that delivers strong outcomes. The health system delivers strong health outcomes with lower public spending than the average in EU countries. Life expectancy is among the highest globally, and the system responded effectively to the pandemic, enabling a rapid reopening and recovery. However, public healthcare expenditure has risen significantly. Some of these increases reflect policy design and implementation, while others are structural, such as aging. This paper analyzes the patterns and drivers of *government* health spending and focuses primarily on policy aspects.²

2. Government health spending has been growing strongly in Andorra in recent years. Government health spending increased from 3.5 percent of GDP in 2003 to 6.0 percent in 2025. Without reform, spending is projected to continue to increase as a share of GDP over the medium-term, placing increasing strain on public finances.

3. Balancing the accommodation of health spending growth with tighter management of high-cost areas should be a central policy priority. Additional financing for health spending over and above population growth and inflation is likely to be needed over the long term, as the population ages. To limit increases in social contributions and household financing and preserve fiscal space for other spending priorities (such as housing and infrastructure), the government should aim to slow health spending growth to around the rate of population growth and inflation. There is scope to strengthen administrative controls including setting clearer medium-term targets, identifying concrete savings measures, implementing payment reforms to improve efficiency, and tightening eligibility and oversight of sickness benefits.

¹ Prepared by Nick Carroll (FAD) and Aidyn Bibolov (EUR). The authors would like to thank all our Andorran counterparts for their helpful inputs and comments.

² For an analysis of aging impact on healthcare sector, see Bibolov A., [Fiscal Implications of Aging in Andorra: Pension and Healthcare System Reforms](#), IMF Selected Issues Paper No. 2025/052.

B. Overview of the Andorran Health System

4. The Andorran public healthcare system provides broad coverage. The system delivers high-quality care to the population with extensive access, low household out-of-pocket spending, and low maternal and infant mortality.³ Andorra has several health institutions that finance, manage and deliver healthcare - the National Health service (Servei Andorrà d'Atenció Sanitària or SAAS thereafter), the Social Security Agency (Caixa Andorrana de Seguretat Social or CASS thereafter) and the Ministry of Health – which requires strong coordination across budgeting and financing, management, and policy functions.

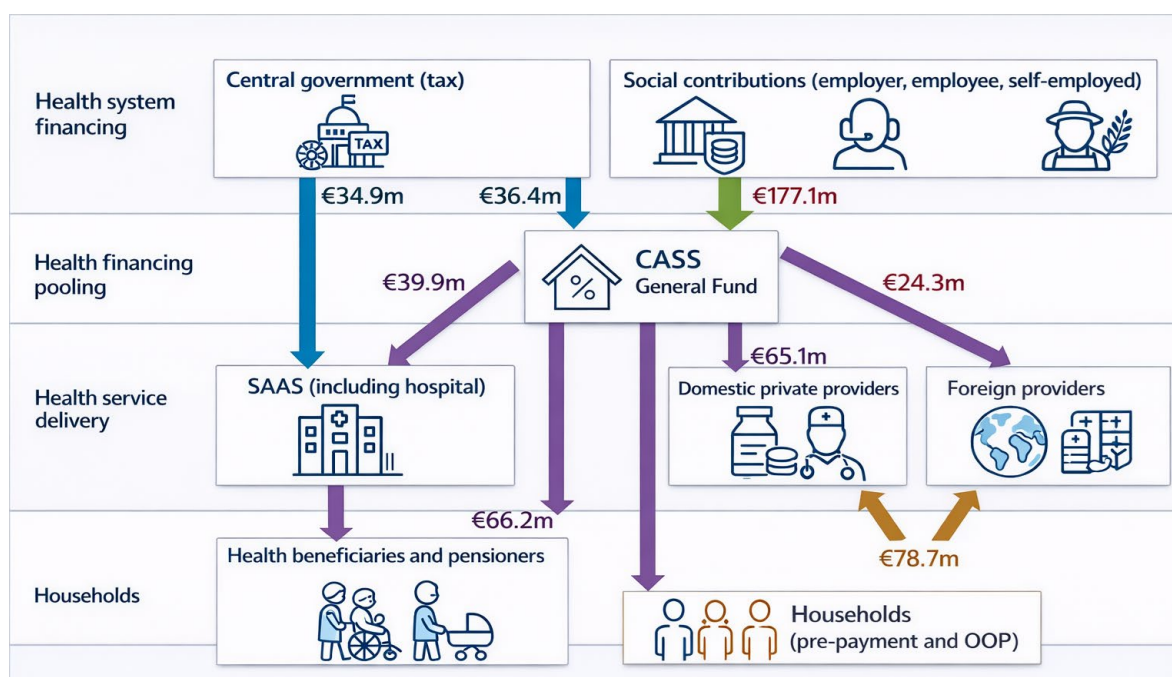
5. Total current health spending is 8.3 percent of GDP financed from taxation, social contributions and private financing. One quarter of health financing is from the central government budget, 18 percent from employee and self-employed contributions, 29 percent from employer contributions and 29 percent from voluntary health insurance and household out-of-pocket payments. Household out-of-pocket costs are low compared to European peers (Litvinova and Rechel, 2026)

6. There are four main health spending components in the central government budget (Figure 1). The main components of health spending in the central government budget are the: (1) transfer to the SAAS, particularly for the national hospital, (2) transfers to the CASS, including transfers to cover the health fund deficit, (3) transfers to the University of Andorra, (4) health spending directly by the Ministry of Health, including public health programs on primary and community care.

7. CASS finances a range of health-related services and payments. The General Fund of the CASS covers a wide scope of health services and goods. These include: (1) direct transfers to the national hospital for services, (2) payments to domestic providers for services, (3) payments to foreign providers, (4) health related benefits and pensions, (5) reimbursements for health-related goods. In general, covered treatments are subsidized at rates from 65 to 100 percent of total costs. Low-income households can receive government support to cover additional costs, while most of other residents opt for voluntary health insurance for this purpose.

8. The largest pool of health financing is managed by the CASS. It has two parts: the Pension Fund and the General Fund, (the latter includes health spending), which operate financially independently. Health spending from the CASS General Fund is financed by a 3 percent payroll contribution from employees and a 7 percent payroll contribution by employers (as well as self-employed and government contributions). CASS General Fund deficits are covered by the central government budget. In practice, tax financing to cover the deficit made up around one fifth of CASS health expenditure financing in 2024.

³ See Bibolov (2025) and Litvinova and Rechel (2026).

Figure 1. Financing Flows in the Andorra Health System, 2023

Sources and notes: Drawn from Central Government Budget, CASS Annual Financial Statements and the Global Health Expenditure Database. The figures are calculated by staff. The figures do not include the payments to the Ministry of Health (€4.2m) and the Andorra University (€1.5m), for simplicity, nor the financing flow from households to the SAAS.

9. Health services are delivered through the SAAS, which includes only hospital, private providers, and foreign providers. Health services are delivered through the Ministry of Health and the National Health Service, including spending relating to the national hospital, health system stewardship and capacity building. Financing is also provided to the Andorra University for training for nurses. Physicians, pharmacists and other health providers are a combination of public and private provision. Most providers are registered with CASS and so subject to a higher subsidy rate, while subsidies for non-registered CASS providers are subsidized at 20 percent of costs.⁴ Andorra benefits from agreements with its neighbors to provide specialized care that would otherwise be expensive to maintain in a microstate.⁵ Thus, a significant amount of health spending goes to the neighboring Spanish and French health systems including on high complexity and high-cost care (€24.3m directly from CASS in 2023).

10. Government health spending in Andorra is comparable to or below than in peer countries. Government health spending in Andorra, according to staff calculations based on budget

⁴ The government is exploring through the draft Health Sustainability Action Plan the degree to which this subsidy to unregistered private providers should continue.

⁵ See Bibolov (2025).

estimates, WEO data sources and WHO data, is comparable to the 6.1 percent average in advanced economies and 6.9 percent average in the EU in 2023 (Figure 2a). According to the Government Finance Statistics this spending is somewhat higher, potentially because it includes some privately financed but publicly managed health spending (for example, household out of pocket payments to SAAS).⁶

11. Efficiency of health spending in Andorra is high compared to peers in terms of life expectancy.

Andorra has one of the highest life expectancies in the world at 84 years and favorably compares to peer countries (Figure 2b). However, the OECD highlighted that across all health systems there are opportunities to further improve efficiency, even in the most efficient countries (OECD, 2017). Looking beyond life expectancy measures, Andorra's health system also performs well generally, although there are some issues in direct measures of amenable mortality and lifestyle factors associated with poor health. Andorra's ranking is slightly lower on the Healthcare Access and Quality (HAQ) Index generally, which assesses access to and quality of health care based on 32 causes of amenable mortality (GBD 2019 Healthcare Access and Quality Collaborators, 2022). The HAQ Index placed Andorra at 89.1 out of 100 in 2019, ranking ninth in Europe, lower than in the life expectancy ranking. In common with the trend of other countries, the older age group (65–74 years) scored substantially lower at 79.3. Litvinova and Rechel (2026) find that there is also a rising burden of disease associated with alcohol consumption, smoking and increasing levels of obesity.

12. The Andorran health system relies more on social insurance and private pre-paid financing than its peers.

One characteristic of the Andorran health system is that social contributions managed by the social insurance fund are more significant than in many other countries' systems (see Figure 2c). The advantage of this approach is that social contributions for health are managed at arm's length from the political process. However, it also means that it may be difficult to contain costs through political processes (and costs may therefore be higher) and may make population-level health initiatives more challenging (Wagstaff, 2009).

13. The number of doctors per capita is close to peers, but the number of nurses is lower.⁷

The composition of the health workforce should be based on clinical need. However, the relatively low number of nurses per capita in Andorra (Figure 2d) suggests that there may be scope to enhance resourcing of community and primary healthcare and/or consider task shifting towards nurses and community workers (see policy discussion below). This is consistent with the relatively high level of spending on hospitals through SAAS and CASS. The Andorran Government introduced a preferred route for accessing health services in 2020. Under this model, primary care doctors and nurses are the main entry point to the health system, offering patients lower co-payments compared to accessing specialist care directly (Litvinova and Rechel, 2026). This model, alongside Andorra's e-

⁶ Andorran administrative measures of government health spending also include some disability and sickness benefits spending administered by the CASS (which are defined as social protection spending under the Government Finance Statistics Manual), as they drive the General Fund deficit that is tax financed.

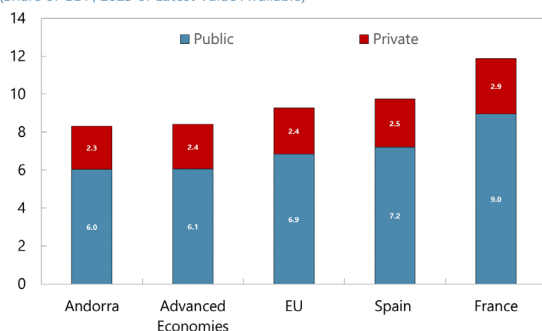
⁷ As many healthcare services are provided outside the country, per capita ratios of doctors and nurses likely understate effective access to medical professionals in Andorra.

health project supports better quality and more coordinated care, and improved efficiency over time.

Figure 2. Cross-Country Benchmarking of Andorra's Health Spending

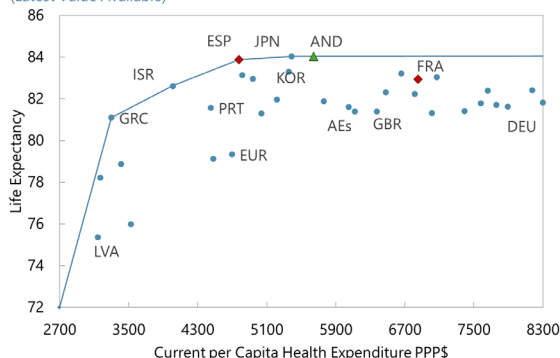
A. Government and Private Health Spending

(Share of GDP, 2023 or Latest Value Available)



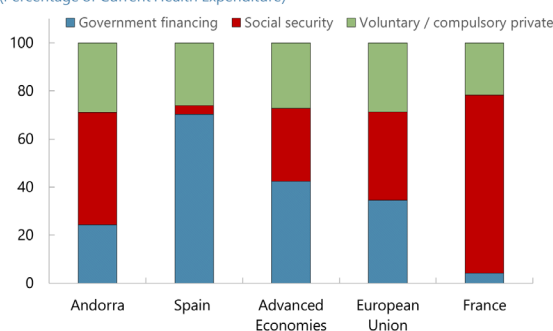
B. Current Health Spending per Capita and Life Expectancy

(Latest Value Available)



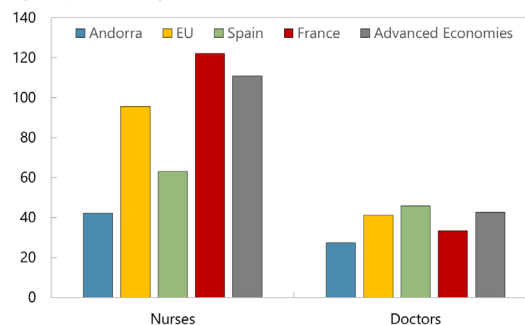
C. Health Financing Schemes

(Percentage of Current Health Expenditure)



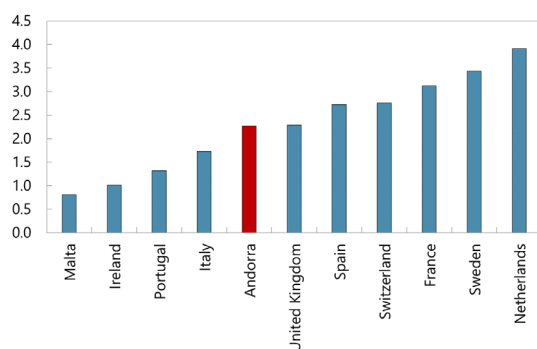
D. Number of Medical Professionals

(Per 10,000 residents)

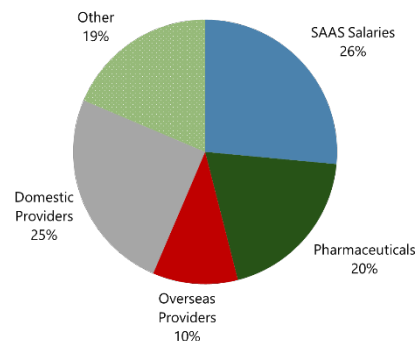


E. Government Spending on Social Protection Benefits

(Percentage of GDP, 2022; includes sickness/disability related benefits)



F. Annual Government Health Spending, 2025



Source: IMF staff estimates based on WHO, Authorities' data, IMF Government Financial Statistics (COFOG).

Notes: Panels A & F: data for Andorran Annual government health spending is for 2025 using budget numbers, otherwise WHO (GHED). Panel D provided by the authorities and the estimate of Andorran nurses and doctors does not include professionals not contracted to CASS. Panel E source IMF GFS (COFOG).

14. Pharmaceuticals and medical devices make up around one fifth of health spending.

CASS Financial Statements and SAAS data indicate that public spending on pharmaceuticals and medical products including hospital pharmacy and medical device reimbursement was around €46 million in 2023 (Figure 2f). However, this is likely to be a partial measure, depending on whether pharmaceuticals are also provided directly by other providers. Notably, Andorra sources pharmaceuticals and medical goods from France and Spain benefiting from their stronger bargaining power, as well as basing pharmaceutical selection on effectiveness assessments from these systems. OECD (2017) highlights generally that pharmaceuticals can be a source of savings, (through use of generics and biosimilars, and improved tendering, procurement and selection practices).

15. Spending on sickness and disability payments also contributes to administrative measures of health spending through the CASS General Fund. While not strictly health spending according to international definitions, spending by CASS on sickness and disability benefits is a key driver of the General Fund deficit, which in turn is tax-financed. Spending was €77 million in 2024 or nearly one quarter of total spending by the General Branch of CASS. Spending on sickness and disability benefits in Andorra is higher than in Portugal and Italy, but lower than in Spain and France (Figure 2e).

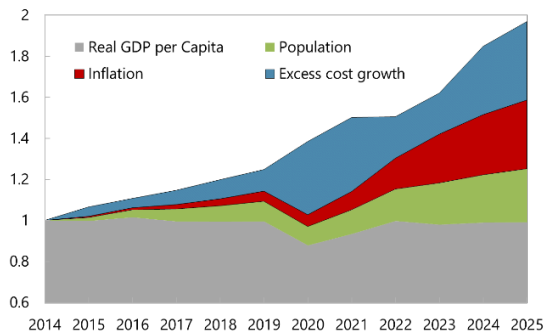
C. Government Health Spending: Trends and Outlook

16. Government health spending has been growing rapidly. Health spending grew faster than nominal GDP and population growth – a typical benchmark for expenditures – over the period 2014-25 (Figure 3a). Government health spending doubled in nominal terms from €119.8 million in 2014 to €236.0 million in 2025. This compares to no change in real GDP per capita and a 26 percent increase in population over the same period. Approximately half of the remaining increase in health spending can be attributed to inflation (34 percent of total increase) and another half to excess cost growth (38 percent). This growth has been driven by all major categories of spending, including a €37 million increase in payments to domestic providers, a €28 million increase in the wages and salaries of SAAS employees and a €23 million increase in spending on pharmaceuticals and medical devices, including through SAAS (Figure 3b).

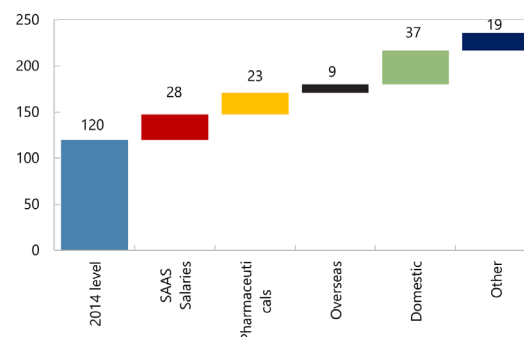
17. Rising spending on the SAAS wage bill reflects population growth, inflation, recruitment of health professionals as well as some real wage growth. SAAS salaries grew from €34.8 million in 2016 to €62.5 million in 2025 (Figure 3b). Population growth contributed €8.2 million to the increase in spending (i.e. increased employment to meet higher demand), inflation contributed €12.2 million, increase in the health sector employment to population ratio contributed €5.3 million, and a €2.0 million reflects an increase in real average wages. A collective bargaining agreement for 2026-30 will raise SAAS wages by €11.5 million over 2026-30 (discussed further below). To put it another way, if the SAAS wage bill grew at the population growth plus inflation then it would be spending €7 million less per year in 2025.

Figure 3. Explaining the Growth in Government Health Expenditure, 2014-25**A. Government Health Spending Relative to GDP**

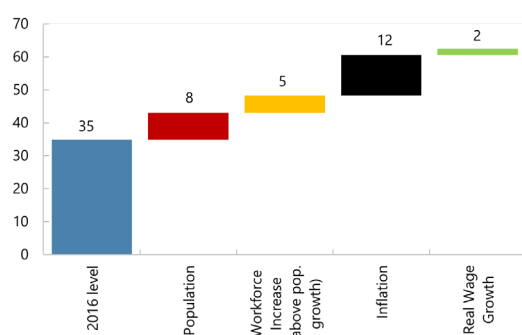
(Index 2014=1)

**B. Contributions to Government Health Spending Change**

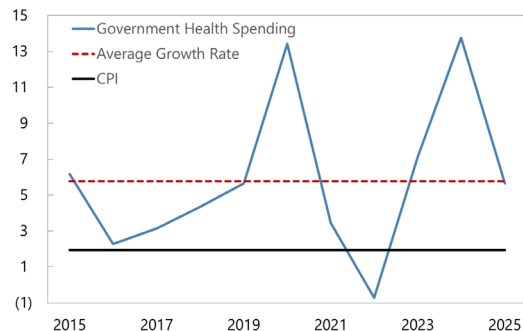
(In Million Euros, 2014-2025)

**C. Contributions to SAAS Salary Increase**

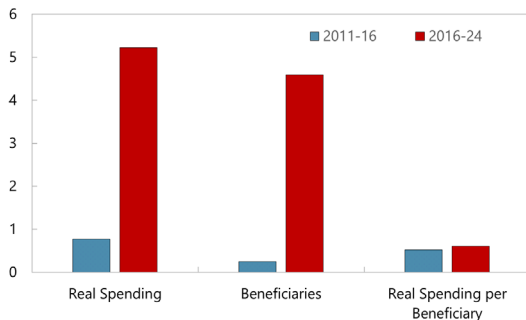
(In Million Euros, 2016-2025)

**D. Government Health Spending Growth**

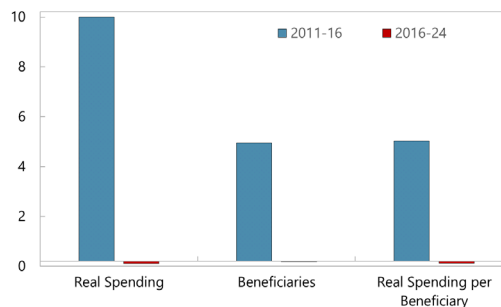
(Annual Percentage Growth)

**E. Growth in CASS Sickness Benefits**

(Annual Percentage Growth)

**F. Growth in CASS Pensions (General Branch)**

(Annual Percentage Growth)



Source: IMF staff calculations based on health spending data provided by the authorities.

18. Government health spending significantly increased in 2020 and 2024 (figure 3d). There was particularly strong growth in health spending in 2020 due to the COVID-19 pandemic (13.4 percent annual growth). Andorra successfully vaccinated its population and reopened the economy to visitors, supporting the economic rebound. In 2024, spending grew by 13.8 percent due in part to higher payments to domestic health providers from CASS. It is not clear what drove this increase, suggesting that this spending category warrants closer monitoring.

19. Spending on CASS sickness benefits has been growing at five percent per year and could become a significant source of pressure on the CASS deficit without reform. CASS provides benefits to people who are temporarily incapacitated (sickness benefits) or permanently disabled (disability-related pensions). A non-contributory solidarity benefit is paid where income falls below a minimum threshold. Strong recent growth in the number of sickness benefit recipients is a concern, as international experience shows that spending on sickness benefits can increase rapidly and persistently in the absence of reforms (Hemmings and Prinz, 2021). The number of sickness benefits recipients increased by more than 5 percent a year since 2016, leading to overall sickness benefit spending growing by a similar amount as spending per beneficiary grew close to inflation (Figure 3e). Between 2011-16 while there was strong growth in *real* disability pension spending driven by growth in both numbers as well as growth in the real benefits per beneficiary in 2011-16 (Figure 3f), a 2015 reform to the disability pension changed the pension point calculation which lowered the level of disability benefits and reduced incentives for take-up.

20. The increase in government health spending was financed both through increased central government spending as well as in social contributions to the CASS. Pressures on central government financing come through a larger transfer to the SAAS, while strong health spending growth was financed through an increase in CASS social contributions.

- Central government budget financing for health rose from €51.8 million in 2014 (2.1 percent of GDP) to €101.1 million in 2025 (2.6 percent of GDP), driven by a 28.5 million increase in the transfer to SAAS and a €17.5 million transfer to cover the CASS deficit.
- CASS General Fund spending increased from €137.1 million in 2014 to €244.7 million in 2025. This was mostly financed from an increase in social security contributions for the General Fund rising from 4.2 percent to 5.3 percent of GDP (an increase of €102.3 million over the 11 years).

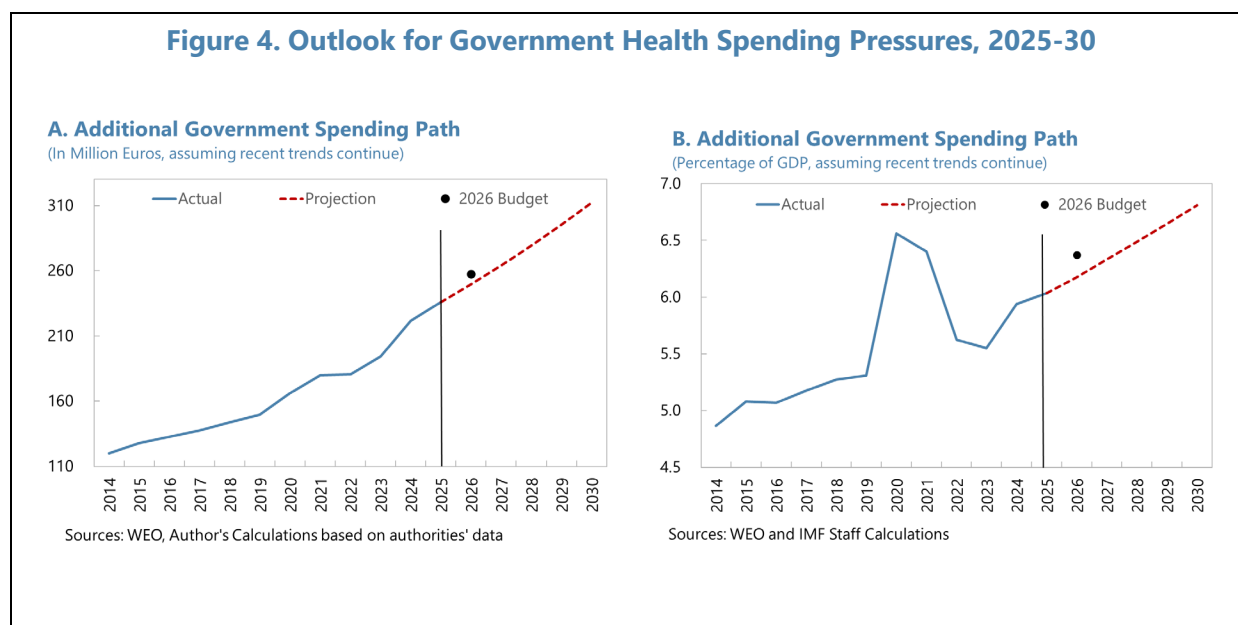
21. If recent trends continue then government health spending could rise from 6.0 percent of GDP in 2025 to 6.8 percent in 2030. To assess the spending pressures over the next five years, this paper uses a “what-if” scenario, assuming that average annual growth over 2014-25 continues through 2025-30.⁸ Under this assumption, health spending would rise from €236 million in 2025 to €312 million in 2030 (Figure 4a). Using the IMF WEO projections for nominal GDP, this results in

⁸ This scenario assumes that the trends that drove spending between 2014-25 will continue including: (1) the payroll will grow faster than GDP, (2) there is increasing access to high-cost treatments, (3) migration continues, (3) there is a similar rate of inflation and population growth, (4) aging continues. Figure 5 provide a more detailed assessment of the impact of increasing aging over the period 2025-50.

government health spending rising from 6.0 percent to 6.8 percent of GDP in 2030 (Figure 4b). These are illustrative spending pressures rather than forecasts, as policy choices can affect outcomes over the medium term.

22. The most immediate pressures on government health spending in the projection period will come from the expansion of the SAAS hospital and rising SAAS wages. In addition to regular inflation adjustments, the 2026–30 collective agreement will raise average remuneration for doctors by 25 percent and for nurses by 15 percent, increasing the annual SAAS salary bill by €11.5 million by 2030. These increases aim to restore competitiveness and retain and attract providers. The government is also considering a significant hospital expansion, reflecting strong population growth since the facility was built in 1993. This would reduce overcrowding and improve capacity at the hospital but will require significant capital expenditure and may also increase recurrent spending.

Figure 4. Outlook for Government Health Spending Pressures, 2025–30



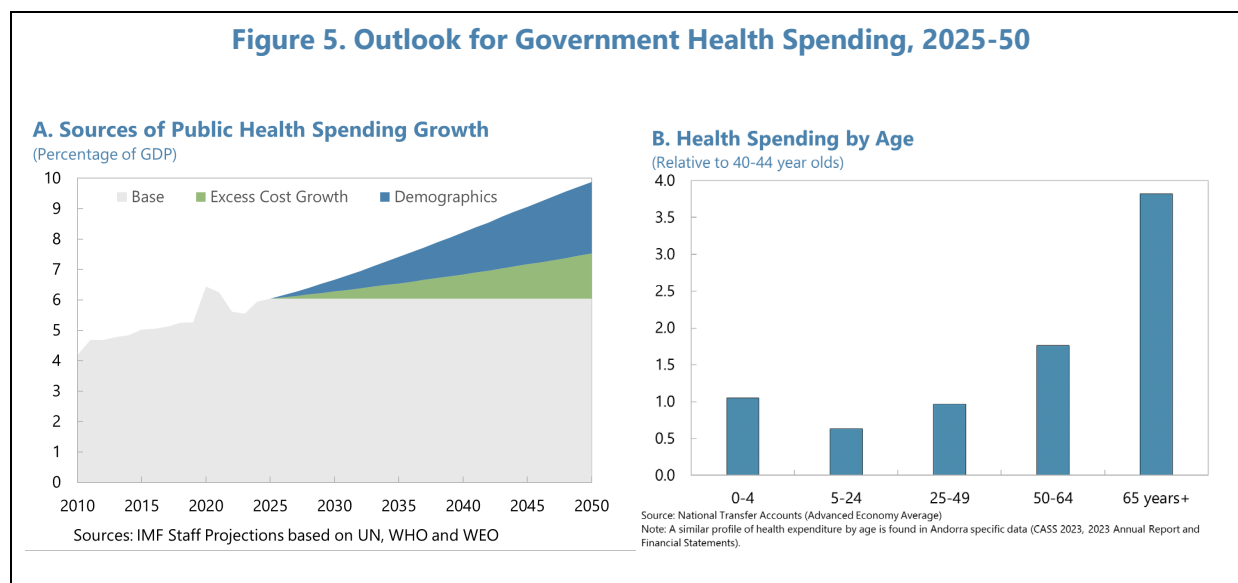
23. Population aging will add to health spending pressures beyond 2030. The share of the population aged over 65 years is expected to rise from 15 percent of the population in 2025 to 25 percent by 2035. This metric is particularly relevant, as health spending increases significantly for this group. On average, population over 65 years have health costs around 3.8 times the population average (Figure 5b).

24. Longer-term spending projections suggest that health spending could rise to 7.4 percent of GDP by 2035. The methodology used for the projections of government health spending is the same as that used in the IMF Fiscal Monitor. This approach uses age-health spending profiles and UN projections of population composition to estimate a demographic

component with the residual being excess cost growth. This is a different methodology from the medium-term spending pressures above as it uses a longer-term series on government health spending and estimates a separate demographic effect.⁹ Using this method, government health spending is projected to rise from 6.0 percent in 2025 to 7.4 percent in 2035 (Figure 5a). This is driven by:

- *Aging* – a 0.9 percentage point increase between 2025 and 2035, and a further 1 percentage point by 2045.¹⁰
- *Excess cost growth* – a 0.5 percentage point increase over 2025-35 and an additional 0.6 percentage points over 2035-45.

Figure 5. Outlook for Government Health Spending, 2025-50



25. The health system will need to adapt to an increasing elderly population. An aging population will put increasing pressure on services that the elderly tend to use more, such as geriatric care, dementia and support for daily tasks. However, it is important that alongside these trends that respond to increasing demand, that health systems take a proactive approach to promoting healthy aging. IMF (2025) shows that there has been a trend towards healthy aging over time and this can support improved economic outcomes. With its focus on aging well and preventative, primary and community care in its recent reforms, Andorra has started the process of transforming its health system to respond to the needs of an aging population (see Bibolov, 2025).

⁹ As health spending growth was lower in 2000-14, this lowers the excess cost growth estimate, while the effect of faster aging increases health spending projections.

¹⁰ This is very similar to the estimated impact of aging on government health spending of 2.0 – 2.2 percentage points of GDP in Bibolov, 2025.

D. Policy implications

26. Government health spending will face continued pressure from aging and other cost drivers. Using a “what-if” scenario, this paper estimates that government health spending could rise from 6.0 percent of GDP in 2025 to 6.8 percent in 2030. Some of these changes will be driven by structural increases in demand for health care. While spending increases from population aging will need to be accommodated, the government retains policy options to address other spending increases.

27. Rising health spending will require the government to decide how to accommodate these pressures through higher revenue, lower spending elsewhere, or higher deficits. There is a strategic choice regarding how much of the 0.8 percent of GDP health spending growth to accommodate, given that it is partly driven by aging, and therefore how much social contributions and tax financing should increase. If the additional government health spending were to be entirely financed by social contributions, this would imply contributions rising from 10 percent of payroll in 2025 to 11.5 percent in 2030. There may be scope to carefully increase private household financing in some areas (for example, by reducing the subsidy to health providers not registered with CASS). If government health spending were prioritized over other government spending, this would imply €32 million less in spending in other areas (in 2025 GDP-equivalent terms).

28. Setting clear medium-term expectations for health spending can support fiscal sustainability. Government health spending in Andorra is budgeted using a bottom-up assessment of the health sector’s needs. However, this spending must be aligned with underlying cost drivers and available sustainable financing. There are a range of general public financial management practices that can support the management of health spending (see Box 1). A top-down anchor—such as aligning spending growth with GDP—could help discipline expenditure, with additional needs met through efficiency gains.

29. There is room to find efficiency savings in hospitals, sickness and disability benefits, and pharmaceutical products. There is a need to monitor high-cost treatments closely and consider ways to rationalize and improve efficiency over time (e.g. cancer treatment and dialysis):

- *Integrate and implement the draft Health Sustainability Action Plan into the budget* – the government has developed a draft Health Sustainability Action Plan that includes reviewing provider payments and moving away from fee-for-service payment models, updating health nomenclature and tariff and treatment codes, revising referral codes for overseas treatments and other actions. These actions should be prioritized and integrated with the budget process.
- *Addressing hospitalization expenditures (€110 million+)* – there are a range of opportunities to enhance hospital spending efficiency, these include (1) promoting treatment outside hospitals, (2) improving the management of chronic conditions, (3) optimizing workforce roles, (4) managing wage and employment growth expectations, and (5) reducing waste (OECD, 2017).

- *Pharmaceuticals and medical products (€46 million)* – generally, pharmaceuticals and medical devices spending in Andorra is well managed with reliance on analysis and procurement from the large French and Spanish health systems. There is an opportunity to improve the quality of information around cost and effectiveness of high-cost treatments (including considering affordability) when making decisions to add treatments to the publicly covered treatments schedule. Current initiatives to reduce waste and improve the use of generics are important as well as a greater monitoring of hospital pharmaceuticals and medical devices use may be beneficial.
- *Sickness and disability payments (€66.2 million)* - *Stricter and earlier work capacity assessments and encouragement to return to work have been associated with savings in other cases (Box 2).* For instance, in Sweden changes in the sickness benefit level and focus on work participation impacted sickness benefits numbers.

Box 1. Budgetary Practices for Health in OECD Countries

Robust budget formulation mechanisms set a clear total budget allocation for public spending on health, which provides predictability of funds as well as cost control. A total budget or target for public health expenditures is set in most OECD countries to help control expenditure growth. Total budgets for health are typically derived from baseline estimates of the cost of maintaining existing services and coverage, with the cost of funding new health initiatives estimated separately.

- Efficiency dividends can be based on top down-constraints or bottom-up policy changes within this framework. Spending reviews may support the identification of savings and efficiencies.
- Multi-year budgeting can improve certainty for sectoral planning but may reduce flexibility for the Ministry of Finance to manage spending to a fiscally sustainable level.

Many OECD countries use corrective mechanisms to enforce spending objectives and improve budget compliance. Despite budget control measures, overspending occurs in most countries' health systems, creating deficits which are often covered by governments. In most cases, corrective mechanisms include systems to detect overspending and identify actions. An Alert Committee can steer compliance with the budget. This can be done throughout the year and alerting the government, Parliament, and the health insurance funds in the event the evolution of health expenditures risks exceeding the ceiling (by more than 0.5 percent in France)

Countries also use complementary spending controls and incentive mechanisms at different stages of budget implementation to help keep health expenditure within overall spending limits. Complementary spending controls and incentives include Health Technology Assessments, price regulation, volume controls and incentive mechanisms.

Source: OECD, 2024, *Fiscal Sustainability of health systems*, OECD.

30. Implementation of reforms will determine their durability and success. The approach to addressing rising health spending will rely on increasing financing, reducing spending elsewhere and finding productivity improvements in the health sector. There is a need to engage with key stakeholders and design reforms that support system sustainability over time. Large swings in health spending between years (“feast and famine” cycles) make it difficult for the sector to plan and make it challenging to maintain health spending discipline over time. Likewise, numerous uncoordinated or poorly sequenced health reforms can lead to reform fatigue and loss of trust in the health system. Andorra has experience in implementing successful reforms. Timely action to address rising public health costs can enhance sustainability while preserving quality.

Box 2. Reforming Sickness and Disability Benefits

Sickness and disability benefit rates administered through CASS are as high as many other countries.

While disability and sickness benefit spending is comparable in Andorra to that in OECD peer countries, like in many other countries it is a significant spending item. While there are significant political and implementation challenges, there are lessons from other countries on how to better manage this spending area.

Swedish reforms highlight that the levels of benefits and the focus on workforce participation influence spending. Sweden’s and Switzerland’s mandatory payout is initially set at 80 percent of previous salary, and in the Netherlands, it is 70 percent of previous salary for two years. Sweden’s reform experience is that the level and structure of sickness benefits influences benefit take-up with even small reductions (or increases) in the payment rate having an impact on outcomes. It also appears that Sweden’s stronger focus on work participation is effective.

The Dutch reform experience demonstrates that employer incentives (matched by corresponding worker incentives) matter. In the Netherlands, when premiums to sickness and disability insurance became experience rated, i.e. dependent on the employer’s sickness and disability record, new benefit claims fell drastically.

The Swiss reform experience underlines that early identification of problems and early intervention is critical to reducing disability benefit claims. The Swiss experience demonstrates that shifting the assessment decision from general practitioners to a public medical authority is feasible and effective. The Netherlands and Switzerland also feature third-party medical assessments.

Sources: Hemmings, P and C Prinz, 2020, *Sickness and disability systems: comparing outcomes and policies in Norway with those in Sweden, the Netherlands and Switzerland*, OECD Economics Department Working Paper no.1601.

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