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Disease burden of obesity in Germany: prevalence, comorbidities, mortality, and healthcare costs

Abstract

Introduction: Over the past two decades, the prevalence of obesity in Germany has risen continuously. At the same time, obesity and its sequelae represent a growing challenge for healthcare systems and national economies, as both direct and indirect costs are increasing substantially due to the rising disease burden. The aim of this study was to determine the administrative prevalence of obesity, the frequency of obesity-associated comorbidities and sequelae, and the attributable treatment costs of obesity in Germany for the year 2024.

Methods: The study is based on claims data from the InGef research database, comprising approximately 10 million statutory health insurance insured persons for the year 2024. The administrative prevalence of obesity, the frequency of obesity-associated comorbidities and sequelae, and the 5-year mortality of insured persons with and without obesity were analysed. Obesity cases were defined as insured individuals with at least one confirmed ICD-10-GM diagnosis of E66.- in the study year. Treatment costs were estimated on the basis of morbidity-oriented risk structure compensation (Morbi-RSA) allocations. All results were extrapolated to the German population in 2024.

Results: In 2024, an estimated 9.3 million people in Germany had a diagnosed obesity (administrative prevalence: 11.8%; women: 12.6%, men: 10.9%). Individuals with obesity showed markedly elevated prevalences for nearly all conditions examined – most pronounced for diabetes mellitus (PR = 3.33), pulmonary heart disease (PR = 2.58), heart failure (PR = 2.56), and renal insufficiency (PR = 2.49). The relative 5-year mortality risk was particularly elevated in younger age groups (e.g., girls/women aged 5–19 years: RR = 2.55; men aged 30–39 years: RR = 2.29). Total treatment costs for obesity-associated conditions amounted to Euro 14.17 billion, of which Euro 8.80 billion (62.1%) were attributable to obesity. The largest share was driven by metabolic diseases (Euro 4.71 billion; attributable fraction: 82.2%).

Discussion: Obesity in Germany is associated with a substantial disease burden and considerable treatment costs. The findings underscore the need for effective prevention measures and evidence-based, guideline-compliant care. Early behavioural and structural prevention interventions could reduce the onset of sequelae and contribute to long-term relief of the healthcare system.

Keywords

obesity, administrative prevalence, treatment costs, comorbidity, mortality, statutory health insurance, Germany

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Obesity and its sequelae are among the most significant public health challenges worldwide. As obesity becomes more widespread, cardiometabolic diseases (e.g., type 2 diabetes mellitus, arterial hypertension, coronary heart disease and heart failure), certain cancers and musculoskeletal disorders are also increasing. Among adults in Germany, a higher body mass index (BMI) is one of the greatest risk factors in terms of disease burden and healthy life years lost to illness (Starker et al., 2025). Obesity is classified by BMI, which is calculated from body weight and height. According to the WHO classification (2026), adults with a BMI between 25 and 29.9 kg/m² are considered overweight and those with a BMI ≥ 30 kg/m² obese. A BMI ≥ 40 kg/m² indicates severe obesity. In children and adolescents, owing to physiological changes during growth, classification is based on age- and sex-specific reference percentiles (Kromeyer-Hauschild et al., 2001).

>> Over the past twenty years, the prevalence of obesity has risen steadily. Nearly 20% of adults in Germany were obese in 2023, compared with a prevalence of 12.2% in 2003 (Starker et al., 2025). Prevalence figures from population-representative surveys aim to capture the prevalence of obesity in the population regardless of whether obesity has been diagnosed in the individuals concerned. Administrative prevalence based on claims or routine data, by contrast, refers to diagnosed cases of obesity. It includes only cases documented or diagnosed by a physician with an obesity diagnosis (ICD-10 E66.0, E66.2, E66.8, E66.9). It thus reflects the morbidity actually visible within the healthcare system while also allowing a more precise economic analysis of healthcare utilization and the resulting direct costs.

Much of the evidence available to date on the prevalence of obesity and the associated costs of illness is based on older data. Given the changes in obesity prevalence and medical care observed since then, there is a considerable need for up-to-date estimates. According to the AOK Research Institute (WIdO), the administrative prevalence in the German population was 10.5% in 2024 (Wissenschaftliches Institut der AOK, 2026). This is well below the obesity prevalence of around 20% reported in other studies (Starker et al., 2025). At the same time, obesity is increasingly becoming an economic challenge for healthcare systems and national economies. As the disease burden rises, both the direct costs of medical care and the indirect costs resulting from incapacity for work, early retirement and years of life lost are increasing.

According to health economic analyses by Effertz et al. (2016), the direct costs of treating obesity and obesity-associated comorbidities and sequelae in Germany amount to EUR 29.4 billion per year. In addition, there are indirect costs of around EUR 33.4 billion annually, for example due to loss of quality of life, productivity losses from sickness-related incapacity for work, or early retirement.

The aim of the present study was to determine the administrative prevalence of obesity in Germany as well as the disease burden associated with obesity and the related treatment costs. The focus

is not solely on the frequency and treatment costs of obesity itself; the treatment costs of sequelae and comorbidities that accompany obesity, or for which obesity is a risk factor, are also taken into account. Accordingly, the study determines the prevalence of selected sequelae and comorbidities of obesity and, in particular, shows to what extent they are attributable to obesity.

Methods

Data source

This study is based on anonymized claims data from the InGef research database (Institut für angewandte Gesundheitsforschung Berlin GmbH). At the time of analysis, the database contained individual-level, longitudinally linked data on approximately 10 million insured persons who were insured with one of 50 statutory health insurance (SHI) funds in Germany in 2024 and were aged between 5 and 89 years. In addition to sociodemographic information, the database contains information on outpatient services and diagnoses; hospital data including admission dates, primary and secondary diagnoses, and surgeries and procedures performed; data on drug prescriptions; information on medical aids and therapeutic remedies; and the costs incurred in these areas (Alibone et al., 2026). All data at patient and provider level are anonymized in accordance with German data protection regulations and federal law. Approval by an ethics committee was therefore not required.

Analytical method

To operationalize obesity, the administrative prevalence was determined on the basis of SHI routine data for 2024. Cases were defined as insured persons with at least one confirmed diagnosis in ICD-10-GM category E66.- (obesity) documented during the observation period. These included confirmed diagnoses from outpatient care by SHI-accredited physicians or outpatient hospital treatment, treatment diagnoses E66.- from outpatient hospital treatment, and primary or secondary diagnoses E66.- from discharge reports of inpatient hospital stays. The administrative prevalence of obesity is extrapolated to the population of Germany (Statistisches Bundesamt, 2026) and presented for 2024, stratified by age group and sex.

Furthermore, the administrative prevalence of obesity-associated diseases is shown for persons with and without obesity by age

Administrative prevalence of obesity-associated sequelae and comorbidities

Disease group	Persons without obesity	Persons with obesity	PR*
Malignant neoplasms of digestive organs	0,7%	0,8%	1,20
Malignant neoplasms of breast	2,4%	2,5%	1,04
Malignant neoplasms of genital organs	1,3%	1,5%	1,17
Malignant neoplasms of thyroid, parathyroid, paraganglia and other endocrine glands	0,1%	0,2%	1,63
Lymphomas and leukemias	0,6%	0,6%	1,12
Diabetes mellitus	6,8%	22,6%	3,33
Lipid metabolism disorders	5,3%	4,6%	0,87
Occlusion of extracranial cerebral arteries and transient ischemic attacks	0,2%	0,3%	1,42
Stroke and complications	1,0%	1,5%	1,45
Hypertension	14,7%	27,5%	1,86
Ischemic heart disease	4,0%	6,9%	1,73
Pulmonary heart disease and diseases of pulmonary circulation	0,3%	0,7%	2,58
Heart failure	2,9%	7,5%	2,56
Deep vein thrombosis	0,2%	0,5%	2,20
Thrombophlebitis, excl. deep veins	0,5%	0,9%	2,01
Gallstones with cholecystitis and other diseases of the gallbladder	0,6%	1,2%	1,99
Unspecified back pain and other pain conditions/disorders of the back/neck	11,3%	17,8%	1,58
Renal insufficiency	3,3%	8,2%	2,49
Nephrolithiasis / ureteral calculus / bladder stone	0,9%	1,5%	1,68
Osteoarthritis	7,0%	12,4%	1,77

Table 1: Administrative prevalence of obesity-associated sequelae and comorbidities, standardized by age and sex to the German population in 2024. Source: Results of IGES's analysis of InGef claims data, standardized to the German population in 2024
Note: * PR = prevalence ratio.

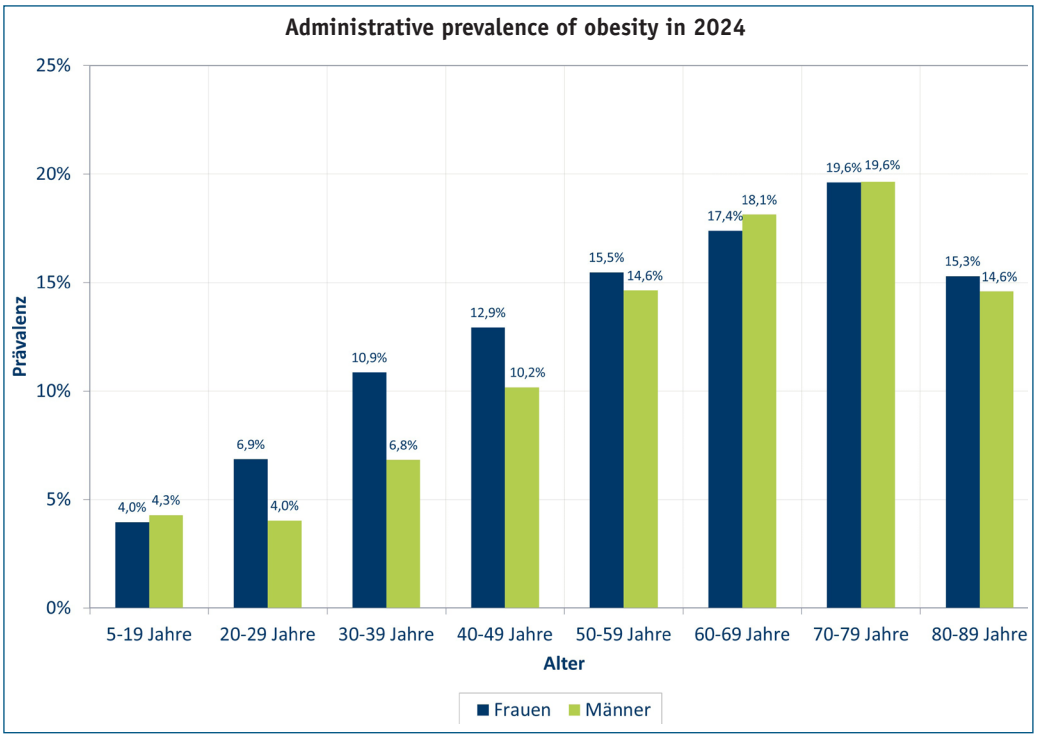


Fig. 1: Administrative prevalence of obesity in 2024. Source: own illustration.

group and sex for 2024. The ratio of disease prevalence in persons with obesity to that in persons without obesity is presented as the prevalence ratio (PR). The PR indicates by what factor the prevalence of a sequela or comorbidity is increased (PR > 1) or decreased (PR < 1) in persons with obesity compared with persons without obesity. A total of 20 selected diseases were considered as obesity-associated; these are used by the Federal Office for Social Security (BAS) as a higher-level classification tier for the inclusion and exclusion of ICD-coded diagnoses in the risk structure compensation (RSA) classification model (Annex 1 to the determination pursuant to Section 8 (4) RSAV; Bundesamt für Soziale Sicherung, 2025). These comprised metabolic diseases (diabetes mellitus, lipid metabolism disorders), cardiovascular diseases (hypertension, ischemic heart disease, heart failure, pulmonary heart disease and diseases of the pulmonary circulation, stroke and complications, occlusion of extracranial cerebral arteries and transient ischemic attacks, deep vein thrombosis, and thrombophlebitis), diseases of the kidney and urinary tract (renal insufficiency, nephrolithiasis), musculoskeletal diseases (osteoarthritis, back pain and other disorders of the back or neck), gastrointestinal diseases (gallstones with cholecystitis and other diseases of the gallbladder), and selected malignant neoplasms (malignant neoplasms of the digestive organs, breast, genital organs, thyroid, parathyroid and other endocrine glands, as well as lymphomas and leukemias). The diseases were selected on the basis of the Global Burden of Disease (GBD) Study and comprised those for which a high body mass index is described as a relevant risk factor and which account for the largest share of the obesity-associated disease burden (Zhou et al., 2024).

To depict mortality, age- and sex-specific 5-year probabilities of death were determined for persons with and without obesity. The relative 5-year risk of death (relative risk) was calculated as a measure of the association between obesity and mortality. The relative risk (RR) indicates by what factor the risk of dying within five years is increased (RR > 1) or decreased (RR < 1) in persons with obesity compared with persons without obesity. The results are presented by age group and sex.

To determine obesity-associated treatment costs, the disease-related allocations of the morbidity-based risk structure compensation scheme (Morbi-RSA) were used as proxies for healthcare costs. The RSA allocations are based on regression models of the BAS and reflect the average prospective healthcare expenditure associated with specific morbidity groups (BAS, 2025). To determine treatment costs, the diagnoses of the obesity-associated diseases considered (see above) documented in the routine data were assigned to the diagnosis groups (DxG) and hierarchical morbidity groups (HMG) used in the Morbi-RSA. The DxGs were validated in accordance with the provisions of the RSA procedure. Subsequently, for insured persons with and without obesity, and by age and sex, we analyzed how frequently HMGs of the obesity-associated sequelae and comorbidities occurred and which HMG-related RSA payments they triggered. By linking HMG frequencies to the respective average RSA payments, the treatment costs attributable to obesity for 2024 could be determined.

All analyses were stratified by sex and 5-year age groups (5–9 years, 10–14 years, 15–19 years, 20–24 years, 25–29 years, 30–34 years, 35–39 years, 40–44 years, 45–49 years, 50–54 years, 55–59 years, 60–64 years, 65–69 years, 70–74 years, 75–79 years, 80–84 years, 85–89 years).

Results

Prevalence of obesity and obesity-associated sequelae and comorbidities

In 2024, an estimated 9.3 million people in Germany had diagnosed obesity, corresponding to an administrative prevalence of 11.8%. 12.6% of women (extrapolated: 5.0 million women) and 10.9% of men (4.3 million men) had an obesity diagnosis. Figure 1 shows the administrative prevalence of obesity in the German population by age group and sex.

Higher prevalences of administratively recorded obesity are observed in middle and older age. The lowest prevalences are found among 5- to 19-year-olds (girls/women: 4.0%; boys/men: 4.3%).

The highest prevalence is found among 70- to 79-year-olds, at 19.6% for both women and men. In the 80- to 89-year age group, prevalences decline again to 15.3% in women and 14.6% in men.

In the age groups between 20 and 59 years, women consistently show higher prevalences than men. The differences are particularly pronounced among 20- to 29-year-olds (6.9% vs. 4.0%) and 30- to 39-year-olds (10.9% vs. 6.8%). From age 60 onward, the prevalences of the two sexes converge. In the 60- to 69-year age group, prevalence among men (18.1%) is slightly higher than among women (17.4%), while no differences between women and men are discernible in the 70- to 79-year age group. In the oldest age group examined (80–89 years), prevalence declines to 15.3% in women and 14.6% in men.

Overall, the results point to marked differences in obesity prevalence between age groups, with higher prevalences observed in the older age groups. In addition, there are sex differences that are particularly pronounced in young and middle adulthood.

Table 1 shows the prevalences of selected obesity-associated sequelae and comorbidities in persons with and without obesity by age and sex in 2024. For most of the diseases examined, markedly higher prevalences are observed in persons with obesity than in persons without obesity. The differences are particularly pronounced for diabetes mellitus, which occurs more than three times as often in persons with obesity as in persons without obesity (22.6% vs. 6.8%; prevalence ratio [PR] = 3.33). Persons with obesity also have a more than twofold risk of developing pulmonary heart disease and diseases of the pulmonary circulation (PR = 2.58), heart failure (PR = 2.56), renal insufficiency (PR = 2.49), deep vein thrombosis (PR = 2.20), and thrombophlebitis (PR = 2.01).

Other cardiometabolic and musculoskeletal diseases are also more common in persons with obesity than in persons without obesity. Persons with obesity are more frequently affected by hypertension (27.5% vs. 14.7%; PR = 1.86), ischemic heart disease (6.9% vs. 4.0%; PR = 1.73), osteoarthritis (12.4% vs. 7.0%; PR = 1.77), and chronic back pain and other disorders of the back or neck (17.8% vs. 11.3%; PR = 1.58) than persons without obesity. In addition, diseases of the gallbladder are almost twice as common in persons with obesity (PR = 1.99).

For various malignant diseases, by contrast, only small differences are observed between persons with and without obesity, with prevalence ratios between 1.04 and 1.20. One exception is malignant neoplasms of the thyroid, parathyroid and other endocrine glands, for which persons with obesity show a 1.63-fold higher prevalence than persons without obesity. Only lipid metabolism disorders show a lower prevalence in persons with obesity than in persons without obesity (4.6% vs. 5.3%; PR = 0.87). Although this epidemiologically implausible finding cannot be conclusively explained within the scope of the study, anecdotal evidence from outpatient medical practice suggests that there is no reason to code a lipid metabolism disorder in obese patients, whereas in non-obese patients it is required to justify treatment.

Overall, the results indicate a considerable additional disease burden among people with obesity. This is particularly evident for metabolic, cardiovascular, renal and musculoskeletal diseases, for which prevalence is in some cases more than twice as high as in persons without obesity.

Mortality

Figure 2 shows the relative 5-year risk of death of persons with obesity compared with persons without obesity, extrapolated to the German population in 2024 and differentiated by age group and sex. Across all age groups, obesity is associated with increased mortality. The highest relative risks of death among persons with obesity are observed in the younger age groups. Girls and women aged 5 to 19 years with obesity have a 2.55-fold higher 5-year risk of death than those without obesity. Among boys and men with obesity aged 5 to 19 years, the relative risk of death is 1.78. In the 30- to 39-year age group, men with obesity have more than twice the risk of death of men in the same age group without obesity (relative risk [RR] = 2.29).

With increasing age, the relative risk of death of persons with obesity compared with persons without obesity gradually declines. While both women and men with obesity in the age groups 5 to 19 years and 30 to 49 years have up to twice the risk of death, the

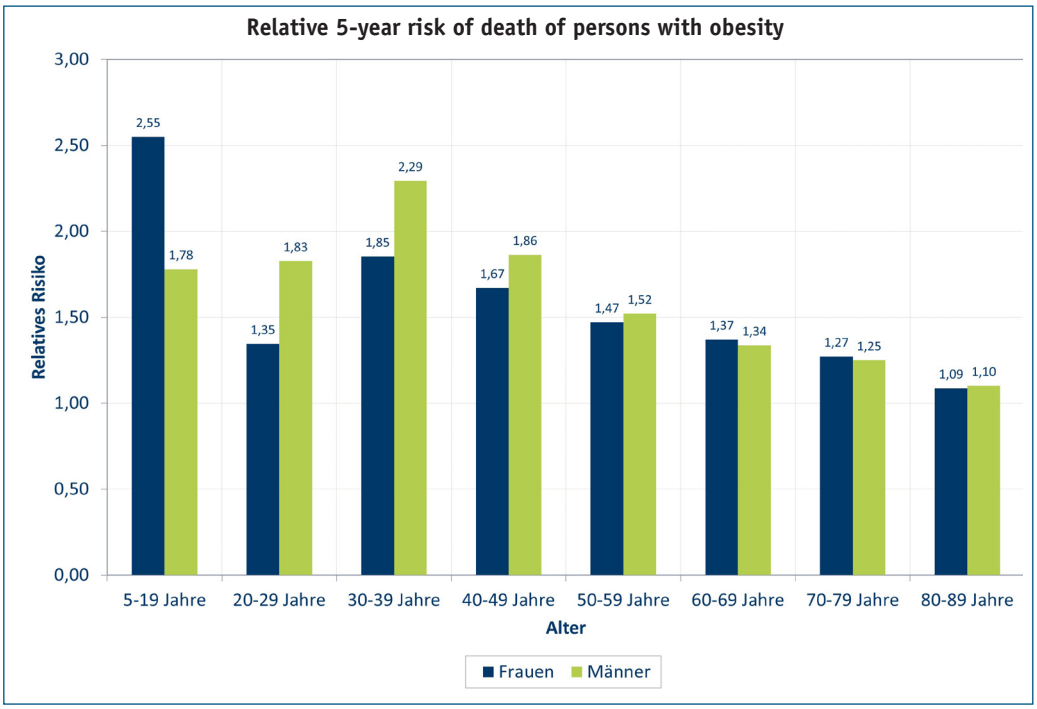


Fig. 2: Relative 5-year risk of death of persons with obesity. Source: own illustration.

risk gradually declines from age 50 onward. Among 20- to 29-year-olds, men with obesity have twice the risk of death, while among women the risk with obesity is increased 1.35-fold. Among 80- to 89-year-olds, the risk in persons with obesity is only slightly higher than in persons without obesity (women: RR = 1.09; men: RR = 1.10). In the age groups between 20 and 59 years, men with obesity show higher relative risks of death than women with obesity, whereas women with obesity show higher relative risks in the youngest age group (5–19 years) and between ages 60 and 79.

Overall, the results suggest that obesity is associated with markedly increased relative mortality, particularly in younger and middle age groups, while the relative risk in persons with obesity compared with persons without obesity gradually decreases in older age. This could partly be due to a selection effect whereby persons with obesity and an increased mortality risk die disproportionately often at younger ages.

Treatment costs

Table 2 shows the treatment costs of obesity-associated sequelae and comorbidities in persons with obesity, extrapolated to the German population in 2024. In total, the treatment costs of obesity-associated diseases amount to EUR 14.17 billion for 2024. Of this, EUR 8.80 billion can be attributed to obesity, corresponding to an attributable fraction of 62.1%.

The highest treatment costs are accounted for by metabolic diseases, totaling EUR 5.73 billion, of which EUR 4.71 billion (82.2%) are attributable to obesity. Diseases of the kidney and urinary tract also incurred high costs (EUR 2.98 billion), of which EUR 1.79 billion, or 60% of treatment costs, are attributable to obesity. For heart diseases, total costs amount to EUR 2.70 billion, of which EUR 1.39 billion (51.4%) are attributable to obesity.

Musculoskeletal diseases also generate high treatment costs. Of total costs of EUR 767 million, EUR 483 million (63%) are attributable to obesity. For vascular and circulatory diseases, the attributable fraction is 53.2% (EUR 157 million out of a total of EUR 295 million). For cerebrovascular diseases, EUR 124 million, or just under 29% of treatment costs, are due to obesity.

Comparatively low treatment costs were determined for gastrointestinal diseases (EUR 9 million), diseases and injuries of the spine (EUR 68 million), and diseases of the eye (EUR 2 million). The highest attributable fraction is found for metabolic diseases (82%), followed by musculoskeletal diseases (63%) and diseases of the kidney and urinary tract (60%). By contrast, neoplasms (10%) and diseases of the eye (16%) show the lowest shares of costs attributable to obesity.

Overall, the results make clear that a considerable share of the treatment costs of obesity-associated sequelae and comorbidities is attributable to obesity. The disease burden is particularly pronounced for metabolic and cardiovascular diseases and diseases of the kidney and urinary tract, which also account for the majority of obesity-related treatment costs. A large share of the treatment costs for musculoskeletal diseases is likewise attributable to obesity.

Discussion

The steady rise in obesity prevalence over the past twenty years shows that previous prevention measures are insufficient and of limited effectiveness. In Germany, obesity is associated with a considerable disease burden and costs of illness. In 2024, the administrative prevalence of obesity was 11.8%. Since obesity is not necessarily accompanied by medical treatment or the corresponding medical documentation, this calculation should be regarded as conservative. By comparison, current population studies show an obesity prevalence of around 20%.

With regard to obesity prevalence, the analyses show higher prevalences of obesity in both men and women from middle age into old age. In young and middle adulthood in particular, women are also proportionally more often affected by obesity than men. Furthermore, persons with obesity show a markedly higher prevalence of numerous sequelae and comorbidities, in particular diabetes mellitus, cardiovascular diseases, renal insufficiency, and musculoskeletal diseases. At the same time, an increased relative 5-year risk of death is seen in persons with obesity across almost all age groups. The analyses show that of the annual treatment costs of EUR 14.2 billion for the sequelae and comorbidities examined, around EUR 8.8 billion (62.1%) are attributable to obesity. The analysis is based on a conservative calculation, so the actual obesity-associated treatment costs are likely to be higher. Metabolic diseases account for the largest share of obesity-related costs, followed by diseases of the kidney and urinary tract and heart diseases.

The study findings underline that obesity is a major risk factor in terms of disease burden and, owing to its many sequelae and comorbidities, a key determinant of morbidity, mortality and healthcare utilization. In particular, the high share of obesity-attributable treatment costs for metabolic and cardiometabolic diseases underscores the need for effective prevention and evidence-based, guideline-compliant care for obesity. Early behavioral and structural prevention measures could not only reduce the occurrence of sequelae but also help to ease the burden on the healthcare system in the long term. In addition, legislative measures to promote healthy nutrition should also be considered at the political level; among other things, the results can be seen as a health economic argument for introducing a tiered tax on sugar-sweetened soft drinks, as proposed by the FinanzKommission Gesundheit (Health Finance Commission, 2026). <<

Treatment costs of obesity-associated sequelae and comorbidities in persons with obesity			
Disease group	Treatment costs		Attributable fraction
	Total in EUR million	Of which obesity-related, in EUR million	
Neoplasms	1.183	118	10,0%
Metabolic diseases	5.728	4.711	82,2%
Gastrointestinal diseases	9	4	46,1%
Musculoskeletal diseases	767	483	63,0%
Diseases/injuries of the spine	68	24	35,2%
Heart diseases	2.698	1.387	51,4%
Cerebrovascular diseases	433	124	28,6%
Vascular and circulatory diseases	295	157	53,2%
Diseases of the kidney and urinary tract	2.983	1.790	60,0%
Diseases of the eye	2	0	15,9%
Total	**14.165**	**8.798**	**62,1%**

Table 2: Treatment costs of obesity-associated sequelae and comorbidities in persons with obesity, extrapolated to the German population in 2024. Source: Results of IGES's analysis of InGef claims data, extrapolated to the German population in 2024. Note: Attributable fraction = share of treatment costs attributable to obesity.

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Note

An appendix on the disease burden in people with obesity is available on the MVF online portal: https://t1p.de/cb6n2

Citation

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