

**Written Comments to the OECD Health Committee**

June 2026

Issues Paper on Tackling Wasteful Spending on Health - Plans for New Analyses

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General Comments

Business at OECD members welcome the Issues Paper on tackling wasteful spending on health. As health and social protection budgets are under pressure from an ageing population, including as regards burden from chronic disease and multimorbidity and a worsening old-age dependency ratio, and many OECD countries struggle with limited economic growth, it is as important as ever that health and social care budgets are spent efficiently, providing the best value for money for patient and population health, the broader society and the economy.

The financial sustainability of health and social protection systems is under pressure. The aging population worsens the old-age dependency ratio, putting strain on the pension and social security systems. Increasing reliance on the economically active labor force makes their health and productivity ever more critical from the economic perspective. Increasing burden of chronic diseases, multimorbidity, which is becoming younger year-to-year, and persistent waste in the system puts heavy pressure on the health and social sector budgets. Many OECD countries struggle with slow economic growth, and debt-constrained fiscal space. In this context it is as important as ever that health and social care budget decisions are guided by strong discipline of allocative and technical efficiency so the fiscal and economic stewards get the best value out of their investment in patient and population health, and with that maximize broader societal welfare.

We note that the plan is to retain the framework for identifying wasteful spending from the 2017 report, focusing on inappropriate and/or overuse of products and services. We would propose that while the OECD should retain the established framework's focus on inappropriate or overused products and services, it should also define and treat waste dynamically: recognising underuse, delayed prevention, avoidable care fragmentation, low-value but costly administrative processes and avoidable medication non-adherence.

These dynamic forms of waste can worsen outcomes and raise downstream costs. A dynamic view of waste will ensure that health budgets are not taken as static/given but are structured around the future value maximizing opportunities emerging from value-based models of care and technological innovations, which are currently encountering entry barriers from the same sectoral budgets they can save in the future. A broader definition would help identify opportunities to improve both affordability and patient outcomes while supporting value-based models of care and innovation rather than being a narrow review of expenditure at the point of authorisation.

In this regard, we would like to highlight the report from the EU expert group on Health Systems Performance Assessment on low-value care.

In this report, the expert group introduces “underuse of care” as a new category of wasteful, low-value care, which considers waste across the patient pathway. It includes the following points:

- (i) First, the services that are necessary and considered cost-effective but are not provided to patients fitting a particular clinical description (e.g. indicated cancer screening).
- (ii) Second, services that are necessary and save costs across a patient’s lifetime (e.g. immunisations or early detection and treatment of chronic diseases but are not provided despite clear or long-term population and patient benefit).

Business at OECD would recommend adopting this more comprehensive definition of wasteful and low-value care, in order to capture the considerable waste that occurs when not giving the appropriate intervention in time results in larger costs further down the line (e.g. due to complications or more severe disease). This would ensure that the true value of secondary and tertiary prevention through medicines and vaccines in avoiding wasteful spending is recognised within this work stream.

The objective should be better affordability, safety and patient outcomes without discouraging needed care. Digital tools can improve collaboration across the health care system by integrating workflows between pharmacists, prescribers and providers to ensure patients receive timely, coordinated care. We recommend the OECD consider administrative-level improvements and digital innovations (e.g., simplification, pharmacy pricing transparency etc.) that can reduce costly friction, barriers to access or complexity

across a health system as well as improve medication adherence. These interventions have long-term cost-reduction effects across health systems and across a patient's lifetime care journey. As an example of administrative simplification is prior authorisation reform: In the US, health insurer UnitedHealthcare is eliminating prior authorization requirements¹ for 30% of healthcare services that previously required insurer approval by end-2026, expanding exemptions and standardizing electronic submissions. This tackles waste by removing low-value approval steps, reducing administrative friction and making submissions and approvals simpler and faster while retaining clinical review safeguards. Now, prior authorization is required for only 2% of medical services and 92% of submitted authorizations are approved in less than 24 hours on average.

A related source of waste is the delivery of care in higher-cost settings than clinically necessary, in particular where those settings do not have surplus capacity. Ensuring the distribution of activity across care settings makes the best use of health system resources should be considered in the same framework: for example, enabling community pharmacists to manage common minor conditions to avoid overuse of emergency departments or general practice, as in established programmes in England, Scotland and much of Canada.

We also urge caution when it comes to assessing innovative products and services within this framework. The claim (point 21) that many new cancer medicines have unclear therapeutic value is based on ratings from HTA agencies which is often due to available evidence at the time of market authorisation in relation to strict evidence requirements set by the agency, and doesn't necessarily reflect the true value of these medicines in real world clinical practice. Still, all innovation should not be presumed valuable before comparative effectiveness, affordability and patient-relevant outcomes are demonstrated. Rather than assessing value at authorization, the OECD should propose evaluating emerging products and services through post-market evidence, real-world patient outcomes, affordability and total cost of care.

Finally, while unwarranted variation in clinical practice is an important source of waste and low-value care, *Business at OECD* would welcome a development where this is measured based on actual patient outcomes, rather than procedural indicators. A further development

¹ <https://www.unitedhealthgroup.com/newsroom/2026/2026-05-05-uhc-cuts-prior-authorization-requirements-by-30-percent.html>

of the PaRIS initiative could for example help identify where best-in-class clinical care is being provided based on patient-relevant outcomes metrics.