

**Written Comments to the OECD Health Committee**

September 2026

OECD Draft Report on Positioning workforce health and wellbeing at the core of corporate non-financial reporting

DELSA/HEA(2026)8

General Comments

Business at OECD welcomes the report's recognition that workforce health and wellbeing are increasingly important drivers of labour market participation, productivity and organisational resilience. This is a concept we have been actively promoting over the past three years, by framing population – and workforce – health as a key economic driver.

Business at OECD therefore supports OECD work that helps employers invest in healthier, more productive, and more age-inclusive workplaces, provided that reporting approaches are practical, privacy-preserving, globally interoperable, and proportionate to company size, sector, and legal context.

We also welcome the presentation of evidence showing how the impact of workforce ageing and the growing burden of chronic disease pose increasing financial risks for companies through lost productivity, while also creating opportunities for additional investments in disease prevention for their workforce. We are supportive of highlighting how a growing body of evidence shows that well designed interventions can improve workers health, productivity and boost companies' performance.

However, as part of the final report, we urge the OECD to better highlight the following key points explored within the draft report:

1. Recognize the methodological limits of linking workplace programmes to financial performance

Business at OECD supports the report's call to strengthen the evidence base on the relationship between workforce health, productivity, and corporate performance. At the same time, the final report should more clearly recognize that companies face real methodological challenges in isolating the effects of specific health and wellbeing programmes from confounding factors such as labour market conditions, job mix, baseline health status, benefit design, workplace culture, management practices, and broader economic trends.

The OECD paper notes that surveyed companies monitor programme effects through business outcomes and employee-reported measures, but also face difficulties establishing robust evaluation frameworks and isolating programme-specific effects. The report also

states that there is not yet robust evidence that non-financial reporting on workforce health directly drives investment flows, and that existing findings remain largely associative.

Business at OECD recommends that OECD avoid implying that every employer should be expected to demonstrate causal financial return for each workforce health intervention. Instead, OECD should support practical tools, independent expertise, common evaluation principles, and evidence-based guidance that help companies assess programmes proportionately. The goal should be to encourage learning and investment, not to create a compliance exercise that discourages companies from offering innovative or preventive health supports.

2. Support a voluntary and sector-specific approach that builds on existing frameworks

Business at OECD supports the OECD's proposal to identify a minimal set of comparable workforce health and wellbeing indicators, but recommends that this work proceed through a voluntary approach that builds on existing reporting standards and avoids creating duplicative or conflicting obligations. The paper itself shows that the non-financial reporting landscape already spans government-led disclosure regimes, international standard-setting initiatives, and voluntary or investor-led frameworks, including ESRS, ISSB/IFRS, GRI, OECD Guidelines for Multinational Enterprises, WDI, CCLA Mental Health Benchmark, ShareAction, and KENKO Investment for Health.

Business at OECD also notes that experience from sector-led initiatives has shown the value of developing common health and safety definitions, methodologies and indicators within industries and in consultation with relevant stakeholders. Workforce health risks, reporting practices and regulatory frameworks vary significantly across sectors and jurisdictions, which may limit the comparability of standardised cross-sector indicators. OECD should therefore consider a sector-sensitive approach when developing any future reporting framework.

While comparability across organizations is an important objective, indicator frameworks should recognize that workforce health and wellbeing outcomes are influenced by organizational structures, sector-specific circumstances, workforce composition, cultural factors and national policy environments. Companies should therefore be able to provide qualitative context alongside quantitative indicators to support fair interpretation of results and avoid comparisons that may effectively compare fundamentally different situations.

For companies, duplicative or inconsistent workforce health reporting rules could create substantial administrative burden while reducing comparability across markets. The OECD should avoid recommending a separate, stand-alone workforce health reporting regime that would add complexity without improving comparability or decision-usefulness.

3. Avoid creating unintended legal, reputational, or equity risks

Business at OECD recommends that the final report more explicitly address unintended consequences. Non-financial workforce health reporting can support transparency and investment, but only if designed carefully. Poorly structured reporting could unintentionally:

- encourage collection of sensitive employee health information beyond what is necessary or lawful;
- reduce employee trust and participation in voluntary programmes;
- penalize companies with older, higher-risk, or more transparent workforces;
- create reputational risk from non-comparable indicators;
- duplicate existing reporting obligations across jurisdictions;
- shift resources from actual workforce health programmes to reporting infrastructure; or
- create liability risks if indicators are misinterpreted by investors, regulators, employees, or the public.

The OECD paper already identifies several of these constraints, including regulatory and confidentiality standards, absence of standardised and comparable indicators, reputational risk, heterogeneous data quality, and limited employee trust. *Business at OECD* recommends that these concerns be reflected not only as barriers, but as design principles for any future OECD work reporting framework.

4. Prioritize privacy, confidentiality, employee trust, and lawful data use

Business at OECD strongly supports the paper's recognition that workforce health reporting must be bounded by data protection, privacy, employment, and confidentiality requirements. The report correctly notes that what employers may collect, process, share, or disclose is limited by legal standards designed to protect personal health information, and that employee willingness to share health data depends heavily on trust in data governance.

This point should be strengthened in the final report. Workforce health reporting should not encourage employers to collect or centralize identifiable clinical, diagnostic, claims, disability, genetic, behavioural, or mental health data. Reporting should be based on aggregated, de-identified, legally permitted, and purpose-limited indicators, with minimum aggregation thresholds, voluntary survey participation, transparent governance, and clear separation between health information and employment decisions. The OECD's own proposed safeguards—anonimisation or aggregation, proportionality, governance transparency, legal bases for processing, minimum aggregation thresholds, voluntary participation, and separation from employment decisions—should be elevated from implementation detail to a core policy principle.

5. Better highlight how workforce health analytics can be used as a management tool

Business at OECD supports the report's focus on mobilising investment in healthier, more productive and age-inclusive workplaces, but recommends that the OECD place equal emphasis on how employers can responsibly use privacy-protected, aggregated or de-identified workforce health analytics to improve employee wellbeing, strengthen prevention, address workforce ageing, support mental health and manage affordability pressures. The current paper focuses primarily on how workforce health and wellbeing can be embedded in corporate non-financial reporting and used by investors, while also recognizing that workforce health and wellbeing are increasingly important to labour

market performance and business sustainability. This management-use lens is essential because employers often generate the greatest workforce health value before any public disclosure occurs. Aggregated analytics can help employers identify emerging health risks, care gaps, generational differences, chronic disease trends, preventable emergency department use, mental health needs and opportunities to improve primary care engagement. Used responsibly, these insights can guide benefit design, prevention strategies, care navigation, workplace wellbeing initiatives and targeted communications while preserving employee privacy.

Industry example

In February 2026, UnitedHealthcare and Health Action Council published an analysis¹ of more than 225,000 Health Action Council members with health plans administered by UnitedHealthcare. The analysis found that Millennials and Gen Z employees are developing chronic conditions such as diabetes and obesity earlier in life; that their year-over-year claims growth from 2023 to 2025 was nearly double that of Baby Boomers; and that younger employees were using emergency rooms more frequently and engaging less often with primary care than other generations. UnitedHealthcare translated the findings into employer actions, including rethinking benefit strategies for younger workers, emphasizing preventive care and earlier screenings, improving access to primary care, and using early intervention and predictive analytics to identify rising risk before serious health events occur.

The same UnitedHealthcare/Health Action Council analysis shows why analytics should be treated as a workforce health improvement tool, not just a reporting input. It found that people who regularly see a primary care provider experience 27% lower claims for major health events, fewer emergency room visits and reduced hospital admissions; for people with chronic diseases such as diabetes and high blood pressure, regular primary care visits can reduce major health costs by about 20%. It also reported that Health Action Council member employers outperformed the PwC industry trend by more than 12% since 2021, resulting in \$292 million in paid-claims savings.

OECD should therefore examine how employers can use health data responsibly to improve workforce outcomes while maintaining strong privacy protections. This would complement, rather than replace, the report's recommendations on comparable indicators and non-financial reporting.

6. Focus core indicators on governance, programme availability, access, and aggregate outcomes

Business at OECD recommends that the OECD distinguish among three categories of indicators:

- First, governance and risk-management indicators. These could describe whether companies have policies, governance structures, management accountability, employee engagement channels, and risk-assessment processes for workforce health and wellbeing.

¹ [New Report Reveals Americans Are Getting Sick More Often, Earlier in Life - UnitedHealth Group](#)

- Second, programme availability and access indicators. These could describe the availability, scope, and voluntary use of workforce health and wellbeing programmes, such as occupational health services, Employee Assistance Programmes, mental health support, flexible work arrangements where feasible, chronic disease prevention, physical activity, nutrition, smoking cessation, burnout prevention, and inclusive workplace initiatives.
- Third, aggregate outcome or functioning indicators. Where legally permitted and methodologically sound, companies may report aggregated information such as sickness absence, work-related injury or illness rates, presenteeism measures, or voluntary workforce survey results, provided individual confidentiality is protected and results are not used for employment decisions.

This approach is consistent with the OECD paper's proposed indicator categories: governance and risk-management arrangements, availability and effectiveness of workforce health programmes, and outcome-oriented information such as sickness absence and presenteeism. It also recognizes that companies already collect a wide range of workforce health-related information—such as EAP use, absenteeism, sick leave, employee-reported wellbeing, and health insurance claims or costs—but rarely disclose it publicly because disclosure raises privacy, comparability, methodological, and reputational challenges.

Business at OECD recommends that the final report caution against using workforce health reporting to compare companies on sensitive employee health status measures without adequate risk adjustment, context, privacy safeguards, and minimum sample sizes. Poorly designed comparisons could penalize companies with older workforces, higher-risk occupations, more transparent reporting cultures, or better employee participation in voluntary surveys.

7. Treat mental health as a priority while protecting sensitive information

The report notes that current reporting frameworks primarily capture safety indicators such as fatalities, accident rates, and days lost due to occupational injury or illness, while there are no systematic requirements to report on mental health, stress, physical inactivity, nutrition, tobacco use, or other behavioural risks.

At the same time, mental health data are particularly sensitive. Any workforce health reporting framework should therefore be voluntary (not requiring disclosure of mental health status, diagnosis, treatment, medication, claims, or disability information) and incorporated into a broader strategy prioritizing access to workplace support, and prevention strategies.

8. Encourage prevention, health workforce investment, and age-inclusive workplaces

Business at OECD supports the report's emphasis on prevention and age-inclusive workplaces. The paper notes that the share of workers aged 45-64 in OECD countries has risen from 29% to 39% over the past three decades, that around one-third of adults in OECD countries reported long-standing health problems in 2024, and that population ageing alone is expected to increase new NCD cases by 31% over the next 25 years.

The final report should encourage policies that make preventive investments more attractive and feasible for employers, including evidence-based guidance, incentives, voluntary certifications, public-private collaboration, and tools that help employers adapt work to an ageing workforce. OECD should also recognize that workforce health is linked to health workforce capacity itself.

Specific Comments

- **Paragraph 1:** We found it very interesting to note that current corporate reporting frameworks capture workforce safety, rather than health and wellbeing and wish that Business at OECD can support further work to ensure this omission is addressed. We specifically welcome the inclusion of physical inactivity as a behavioural risk factor.
- **Paragraph 3:** Whilst focusing on how to deliver better reporting and data collection on workforce health and wellbeing should be considered an important priority connected to investment potential, the challenges with collecting this data that are presented in this report appear significant. This could continue to dissuade employers from the introduction of wellbeing interventions into the workplace. We welcome the consideration of simple reporting and data collection methods that would facilitate, and not create a barrier to, the significant opportunity of utilising workplace settings for delivering cost-effective health and wellbeing interventions including physical activity.
- **Paragraph 30:** Behavioral risk factors such as smoking, nutrition and physical activity are relevant determinants of health. However, these factors are influenced by a wide range of individual, social and societal circumstances that extend beyond the workplace. Reporting frameworks should take account of the limited influence employers may have on certain health behaviors and avoid creating unrealistic expectations regarding employer responsibility.
- **Paragraphs 40-42:** The report could distinguish broad wellbeing offerings from interventions responding to identified workforce needs. A needs assessment can identify conditions affecting functioning, attendance or safety-sensitive work and support targeted evaluation. In Italy, an initiative brought together occupational physicians, scientific and patient organisations, health and safety associations, a consumer association and the national workplace-safety authority to examine allergic rhinitis, alertness and safety. A survey of 60 companies representing an estimated 168,500 workers found that, while 78% reported employees in attention-critical roles, only 18% had formally incorporated these roles into workplace risk assessments. This type of baseline evidence and cross-sector engagement can support targeted, non-promotional interventions and reporting on awareness, confidence, functioning, absenteeism and presenteeism.
- **Paragraphs 74-76:**
 - First, the report should focus more on health literacy as a prerequisite for effective prevention and health promotion. Successful health interventions depend not only on workplace programs and reporting structures, but also

on individuals' ability to access, understand and use health information. Health literacy may therefore constitute an important complementary policy lever alongside workplace health promotion initiatives and workforce health reporting.

- Second, we would also welcome greater recognition of responsible self-care as part of workplace prevention. However, programme availability alone is unlikely to deliver results without workforce understanding, trust and participation. Health literacy, trusted information and appropriate support can help employees understand why initiatives matter, take preventive action, manage suitable everyday health needs and recognise when professional care is required. These capabilities may support employee buy-in, daily functioning, productivity and healthier workforce participation across the life course. The wider economic and environmental relevance of self-care may also merit acknowledgement. Global modelling estimates that self-care using registered non-prescription medicines generates 43.6 billion productive days and saves 2.2 billion physician hours annually. UK modelling further suggests that current over-the-counter self-care for allergic rhinitis may avoid 330-1,000 kt CO₂e annually - around 1-4% of NHS emissions - through fewer consultations and less patient travel. These findings illustrate potential contributions to productivity, health-system capacity and sustainability, without implying a direct return for every workplace programme.
- And third, also in the same paragraphs, the minimum indicator set could cover access and engagement, capability and outcomes. Access and engagement could assess whether employees understand the purpose of support and can obtain relevant prevention, information and self-care resources. Capability could assess whether they can apply trusted information, manage suitable health needs and recognise when professional care is required. Outcomes could include functioning, symptom impact, absenteeism and presenteeism. This would distinguish programme availability or uptake from genuine workforce buy-in and whether support enables informed action, while giving greater visibility to health literacy already identified in the report.
- **Paragraph 74:** The examples provided in paragraph 74 could be interpreted as encouraging the systematic collection of sensitive employee health data, such as smoking status or other behavioral risk factors. In many jurisdictions, including Germany, the collection and processing of such data are subject to strict legal limitations. Future reporting approaches should therefore focus on company measures, programs and governance arrangements rather than on the collection of individual health-related data.
- **Paragraphs 75-77:** Narrative disclosure on workforce ageing could consider prevention and health capability throughout working life, including employees living with NCDs or multimorbidity and those seeking to prevent or delay chronic conditions. This may include trusted information and appropriate self-care

resources. Reporting need not require individual diagnoses or medicine-use data: aggregated and voluntary measures can be accompanied by safeguards on confidentiality, data use and separation from employment decisions. Where employers enable such support, underlying health data could remain with occupational health services or independent providers, with only aggregated, non-attributable measures reported.

- **Paragraphs 71-72 and 78:** We would welcome a distinction between the wider economic, societal and environmental value of prevention and self-care and the financial return of a particular programme. Company-level results will depend on workforce needs, intervention design, uptake, timeframe and other factors. Guidance could encourage reporting of the target population, intervention, baseline, outcomes and methodological limitations. Functioning, absenteeism, presenteeism and health capability may offer a more credible assessment than generic return-on-investment claims. Where relevant, environmental assessment could consider avoided consultations and patient travel, with clearly defined analytical boundaries.

Country Example: Germany

- Workplace health promotion and occupational safety and health are strictly separated in the German occupational safety and health system (OSH). OSH is a mandatory employer obligation, whereas workplace health promotion is voluntary. Well-being, i.e. ensuring and promoting well-being, is not part of occupational safety and health, since occupational safety and health in Germany is intended solely to ensure the protection and preservation of health. The promotion of well-being goes beyond merely preserving health and should therefore be attributed to voluntary health promotion.
- Germany is also seeing a positive trend in the implementation of the mandatory risk assessment, particularly among micro, small and medium-sized enterprises. More companies are carrying out systematic risk assessments; the share of companies with 1-9 employees in which a risk assessment has been conducted increased by around 50% between 2015 and 2023/24 (Joint German Occupational Safety and Health Strategy / Federal Institute for Occupational Safety and Health, 2025).
- This also applies to the implementation of risk assessments for mental workload, which are now carried out by a good 80% of micro, small and medium-sized enterprises (up to 250 employees) (Joint German Occupational Safety and Health Strategy employee survey 2026, in press).
- While the report correctly highlights the importance of prevention and workforce health, greater attention should be paid to health literacy as a prerequisite for effective prevention and health promotion. Health literacy enables individuals to access, understand, assess and use health information and is therefore an important determinant of health outcomes (WHO, 2025). In Germany, recent evidence shows that 75.8% of adults have low health literacy (TUM, 2025). Similar challenges can be observed among younger age groups: only 16% of students in grades 5-10 demonstrate high health literacy, while 84% display only moderate or low levels of health literacy (DAK-Gesundheit/IFT-Nord, 2025). Strengthening health literacy

should therefore be considered a central societal objective involving educational institutions, health systems, social insurance institutions and other stakeholders. It should not be understood as a responsibility to be shifted primarily to employers.

- We reject new mandatory reporting obligations for companies, particularly those intended to collect health and well-being indicators. Studies confirm the enormous burden that bureaucracy places on companies. In a survey by the ifo Institute, more than 70% of experts assessed bureaucratic burdens in Germany as critical, while bureaucratic obstacles at global level were cited as a negative factor by “only” 40% (ifo Institute, 2024b). The German economy already loses €146 billion each year due to bureaucratic requirements (ifo Institute, 2024a).
- This is compounded by a substantial decline in trust in the state’s ability to solve problems (National Regulatory Control Council, 2025).
- Four out of ten companies believe that excessive control undermines companies’ autonomy and responsibility (Bonn Institute for SME Research, 2024). This is particularly common among small and medium-sized enterprises with fewer than 250 employees. 80% of companies feel rather controlled. Companies particularly burdened by bureaucracy would like to see greater trust placed in them (ibid.).
- The OECD should focus on strengthening competitiveness and fostering economic growth. New reporting obligations, however, would create additional costs and bureaucracy and would be counterproductive to these objectives. According to a recent report by *Business at OECD (The Risks of Divergence Between Global ESG Reporting Standards*, July 2025), the financial costs of ESG reporting are substantial and rising rapidly. More than half (57%) of survey participants spend over US\$1 million annually on sustainability reporting, with a significant share investing even higher amounts. In addition, 83% expect these costs to continue rising over the next year under the current framework conditions. Complying with multiple reporting standards often leads to duplication of work (e.g. preparing separate reports or data streams for different standards) and requires specialized resources. Almost half of the companies surveyed already spend more than 25% of their total sustainability budget on compliance with reporting obligations.
- The call for new reporting obligations also runs counter to efforts at European level to reduce bureaucracy. The Omnibus I Directive raised the scope of application of the Corporate Sustainability Reporting Directive (CSRD) from 250 to 1,000 employees. Around 80% of companies therefore fall outside the original direct scope of the CSRD. In practice, this means that only the largest companies (with more than 1,000 employees and meeting certain financial thresholds) are subject to the reporting obligations. As a result of these measures, the European Commission expects annual cost savings for companies of around €4.4 billion – resulting from the narrowing of the CSRD’s scope and the simplification of the standards – as well as one-off savings of around €1.6 billion due to the elimination of initial investments required for compliance.

In addition, *Business at OECD* recommends that OECD consider adding the following elements to the final report:

- **Privacy-first reporting principle:** Workforce health reporting and analytics should rely on aggregated, de-identified, legally permitted, purpose-limited information

and should not expand employer access to individual clinical, diagnostic, claims, disability, behavioural or mental health data.

- **Minimum aggregation and suppression standards:** OECD should recommend minimum cell-size thresholds, suppression rules and governance safeguards to prevent re-identification, especially for small worksites, rare conditions, disability information, mental health, demographic subgroups or highly sensitive health categories.
- **Management-use before public disclosure:** OECD should recognize that many of the most important workforce health benefits come from internal use of responsible analytics to improve prevention, access, primary care engagement, mental health supports, benefit design and care navigation. Public reporting should not be the sole or primary measure of success.
- **Clear separation from employment decisions:** Workforce health information used for analytics or reporting should be separated from hiring, promotion, compensation, performance management, discipline and termination decisions.
- **Process, access and outcome indicators:** OECD should distinguish among governance indicators, programme availability indicators, access indicators and aggregate outcome indicators. Process and access indicators may often be more suitable for external reporting than sensitive health-status outcomes.
- **Voluntary, phased pilots:** OECD should pilot a small set of workforce health analytics and reporting principles with companies, investors, employee representatives, privacy experts, occupational health professionals and health-sector organizations before recommending broader adoption.
- **Interoperability with existing standards:** Any indicator set should map to existing frameworks such as ESRS, ISSB/IFRS, GRI, OECD Guidelines for Multinational Enterprises and relevant national frameworks to reduce duplication and improve comparability.
- **Sector and workforce-context adjustment:** OECD should recognize that workforce health risks vary by sector, occupation, geography, workforce age, socioeconomic context, worksite size, job type and remote, hybrid or on-site work arrangements.
- **Evaluation support rather than punitive comparison:** OECD should provide methods and tools to help companies evaluate programme effectiveness, while avoiding simplistic rankings that could penalize companies with older, higher-risk or more transparent workforces.

Business at OECD appreciates the opportunity to comment on this important work. Companies have a direct interest in supporting healthier, more productive, resilient, and age-inclusive workforces. The OECD can add significant value by helping policymakers,

standard setters, companies, investors, and workers converge around practical and privacy-preserving approaches to workforce health reporting. The final report should encourage investment in workforce health while ensuring that any reporting framework remains proportionate, voluntary or phased where appropriate, legally compliant, trusted by employees, and focused on actionable improvements rather than disclosure for its own sake.

Supporting Resources

1. Global Self-Care Federation. The Global Social and Economic Value of Self-Care: Self-Care at the Forefront of Prevention. Geneva: GSCF, 2026. [Access here.](#)
2. World Health Organization. Health literacy. WHO fact sheet, 2025. [Access here.](#)
3. World Health Organization. WHO guideline on self-care interventions for health and well-being, 2022 revision. Geneva: WHO, 2022. [Access here.](#)
4. Pascual P, Caudwell A, De Man S, et al. Exploring the Impact of Delivering Allergy Medication as Self-Care on Healthcare Greenhouse Gas Emissions in the United Kingdom. Adv Ther. 2026. [Access here.](#)
5. Consumers' Forum, et al. Allergie respiratorie e attenzione: strategie per ridurre i rischi invisibili. Italy, 2026. [Access here.](#)
6. New Report Reveals Americans Are Getting Sick More Often, Earlier in Life - UnitedHealth Group. [Access here.](#)