

**Written Comments to the OECD Health Committee**

September 2026

Report on Health at a Glance: Europe 2026**Chapter 1: From infrastructure to impact: closing Europe's digital health implementation gap**

General Comments

- We welcome the *Health at a Glance: Europe 2026 - Chapter 1: From infrastructure to impact: closing Europe's digital health implementation gap*, and its aim on closing Europe's digital health implementation gap, including its attention to equitable access, trust, interoperability and digital literacy. We particularly welcome the inclusion of patient experiences and perspectives and the chapter's emphasis on ensuring that digital transformation delivers tangible benefits for citizens.
- While the chapter provides a comprehensive overview of large-scale digital health infrastructure initiatives, consideration could also be given to digital tools that directly support citizens and healthcare professionals in their day-to-day interactions with healthcare products and services. An example could be electronic Product Information (ePI). These offer practical examples of how digitalisation can improve access to health information at the point of use most needed. Future editions could consider how digital tools such as electronic Product Information (ePI) may support medicine adherence, informed health decisions, accessibility for people with disabilities, multilingual access and the provision of up-to-date information. These aspects could provide an additional patient-centred perspective on digital-health implementation. EMA, the Heads of Medicines Agencies and the European Commission have already established common principles for ePI in Europe, with the objective of improving access to authorized, accurate and up-to-date information on medicines.
- Beyond electronic Product Information, digital technologies are increasingly supporting self-care, prevention and chronic disease management through patient-facing applications, remote monitoring solutions and self-care medical devices. Digital tools can empower individuals to manage minor ailments, monitor health parameters, support adherence to treatment and engage more actively in maintaining their health. Future analyses could therefore consider how citizen-facing digital health services contribute to patient empowerment, health literacy and self-management alongside more traditional digital health infrastructure.
- Future editions could consider exploring the implementation and use of such tools across Europe, including citizens' preferences for accessing product information digitally, potential benefits for health literacy and informed decision-making, accessibility features such as multilingual content and assistive technologies, and their contribution to ensuring that information remains current and easily accessible. Additionally, analysis of national implementation approaches, user uptake and perceived benefits could provide another layer of valuable insights into how digital health tools are supporting citizens beyond the use of electronic health records and data-sharing infrastructures.
- *Business at OECD* welcomes the chapter's discussion of population ageing and the challenges associated with equitable digital uptake among older populations. As European

societies age, digital tools that support healthy ageing, self-management and independent living may become increasingly important. Self-care medical devices, such as blood pressure monitors, glucose monitoring systems and other self-monitoring technologies, can help older individuals play an active role in maintaining their health, supporting early intervention and facilitating more informed interactions with healthcare professionals. Future editions could explore the contribution of these tools to healthy ageing, chronic disease management and health-system sustainability.

- We also note the chapter's finding that digital health use is often lowest among groups with the greatest health needs. In addition to addressing connectivity and access barriers, future analyses could further consider the role of digital health literacy. Supporting citizens' ability to find, understand and use trustworthy health information remains essential to ensuring that digitalisation contributes to health equity. Digital health literacy can support informed decision-making, appropriate healthcare-seeking behaviour, treatment adherence and confidence in the use of digital health services.
- More broadly, we believe that examining digital tools that support medicine and product information could complement the chapter's existing focus on health data governance and digital infrastructure by illustrating how digital transformation delivers tangible benefits at the point of care. Electronic Product Information and other digital information tools can support digital literacy, facilitate informed decision-making, improve access to reliable and up-to-date health information, and contribute to interoperability by enabling the consistent exchange and availability of information across healthcare systems and Member States.
- While the report correctly identifies that smaller, local, or rural providers face acute cybersecurity and AI implementation constraints, it must explicitly ensure that public financial support (such as EU cybersecurity vouchers or digital upskilling funds) is accessible to all providers regardless of their public or private status, as all are strictly interconnected in the healthcare network (as per the EU cybersecurity plan for hospitals and healthcare providers).
- We also invite the OECD to highlight the importance of professionals in implementing and ensuring the success of digitalisation. This is one of the most important factors for the population's uptake of digitalised services, as becomes clear throughout the chapter.
- The chapter would benefit from an explicit definition of "digital health" at the outset. Although it refers to digital services, therapeutic applications and remote monitoring, the analysis is weighted towards electronic health records, health-data access and governance, cybersecurity, and AI. This may give digital health a narrower meaning than commonly used internationally e.g. by WHO. The scope should be clarified and expanded to include full eHealth journey including online/telehealth, online care, online medicine purchase, online refill opportunities, home delivery and care monitoring and support.
- The chapter should assess use of online care and medicine services beyond access to health data. Concretely, OECD should provide more systematic evidence on the actual use of online care and medicine services. While it reports EHR access, online appointment booking, health-information seeking, it does not consistently measure the use, frequency or impact of telemedicine/online consultations, online monitoring, e-pharmacy services, online medicine purchasing or home delivery. This is an important gap in assessing whether digital investment and/or capability translates into equitable and beneficial access to care and medicines.

Specific Comments

- **Page 2 - Paragraph 1:** our members welcome the emphasis on moving beyond infrastructure towards demonstrable outcomes. Consideration could also be given to

assessing whether digital tools contribute to prevention, health literacy, self-management and appropriate healthcare-seeking behaviour. Such outcomes may support improved population health, strengthen patient empowerment and help alleviate pressure on healthcare systems.

- **After:** "...whether they demonstrably improve care."
- **Insert:** "and whether they support prevention, patient empowerment, self-management and health literacy among citizens."
- **Page 6 - Paragraph 1:** *Business at OECD* agrees that digitalisation can contribute to workforce efficiency. Future analyses could also consider the contribution of digital self-care tools, remote-monitoring technologies and self-care medical devices in supporting prevention, chronic disease management and more efficient use of healthcare resources.
 - **After:** "...expand effective capacity without a proportionate increase in staffing."
 - **Insert:** "Digital tools may also support citizens in prevention, self-management and monitoring of health conditions, complementing healthcare services and helping to optimise resource utilisation."
- **Pages 8-14 - Foundational provider systems / ePrescriptions:** The chapter notes that ePrescription information is already one of Europe's most mature citizen-facing digital capabilities. We suggest considering how these established infrastructures could increasingly connect citizens not only to prescription and dispensing information, but also to authoritative information about the medicines they use. Electronic Product Information can make regulator-approved medicines information searchable, multilingual and easier to update, and could interact over time with digital health services such as ePrescriptions and electronic health records. This would provide a practical example of the chapter's broader shift from technical capability to patient value: digitalisation should not only show that a medicine has been prescribed or dispensed but can also help people understand how to use medicines safely and appropriately.

Interoperability and access to relevant health records: The chapter's discussion of electronic health records could also consider how appropriate access is shared across the care pathway. Alongside individuals having meaningful access to and control over their own health information, authorised community pharmacists could, where appropriate and subject to data-protection safeguards, access relevant medication and clinical information when supporting self-care. FIP's 2025 Statement of Policy on people-centred pharmaceutical care recommends interoperable electronic medical records with pharmacist access to medication and relevant health records, while its multinational needs assessment identified lack of access to patient medical records as a substantial barrier to community pharmacy teams providing self-care support. This may be particularly important for complex or higher-risk patients, where safe advice depends on understanding the wider medicines and clinical context. Better interoperability could also support the safe implementation of expanded non-prescription access where pharmacist assessment, counselling and referral form part of the care pathway.

- **Page 11 - Paragraph 2:** We welcome recognition of existing measurement gaps. Future monitoring could also assess the integration and use of connected self-care technologies, remote-monitoring tools and patient-facing digital applications that support self-management and prevention.
 - **After:** "How deeply digital tools are embedded in clinical work beyond these foundations is a different and largely unmeasured question."
 - **Insert:** "Similarly, little information is currently available on the uptake of connected self-management tools, remote monitoring technologies and other patient-facing

digital health solutions."

- **Pages 11-12:** We encourage OECD to expand the ePrescription discussion to reflections across patient journey for online healthcare. Concretely, the discussion of ePrescriptions on page 11 should distinguish their availability from access to a complete digitally enabled medicines pathway. Patients may be able to receive or view an electronic prescription without being able to order the prescribed medicine through a regulated online pharmacy, obtain remote health advice, or receive the medicine by home delivery.
 - Articles 172-174 of the revised Pharmaceutical Directive, replacing former Article 85c of Directive 2001/83/EC, retain Member States' discretion to prohibit online sales of prescription medicines and to establish national conditions where such sales are permitted. Consequently, ePrescription availability should not be treated as a proxy for patients' ability to obtain prescription medicines online or appropriate care online. National rules remain an important determinant of digital-care access and create differences between Member States.
 - [A recent European study reports](#)¹ substantial differences between Member States, with 19 countries continuing to prohibit or substantially restrict regulated online access to prescription medicines. In practical terms, this creates a two-tier digital healthcare landscape across Europe, in which some patients can access integrated online prescribing, dispensing and delivery services, while others remain dependent on in-person pharmacy models, widening inequities in access to digitally enabled medicines services.
- **Pages 14-16, Equity in digital health use:** We believe chapter should recognize the role of national regulation in creating unequal access to digital care and medicines across Member States. Equity in digital health should be considered not only in relation to age, education and digital skills, but also to national regulation and the availability of digitally enabled care pathways. Restrictions on online consultations, online medicine purchasing and home delivery may create additional barriers, particularly for rural communities, people with mobility limitations, chronic conditions or demanding work and caring responsibilities. Recent European evidence indicates substantial differences between Member States in access to regulated online prescription-medicine services. These regulatory differences can create a two-tier digital healthcare landscape and should be considered alongside individual-level determinants when assessing equitable access to digital care and medicines.

We support the chapter's emphasis on inclusive design and its finding that technical access alone does not guarantee meaningful use. Digital health literacy should be considered alongside digital access, including people's ability to find, understand and use reliable information to make informed health decisions. Medicines information provides a practical example. A 2023 consumer study commissioned by AESGP across six EU Member States found that 44% of respondents purchasing non-prescription medicines had accessed digital product information during the previous year, while also identifying age, education and digital literacy as important considerations for an inclusive transition. Electronic Product Information has the potential to improve accessibility through features such as search, adjustable text and multilingual information. However, evidence also shows that digitization alone is insufficient: a 2025 mixed-methods user study found that simply presenting conventional leaflet content electronically did not improve information retrieval or comprehension, reinforcing the need for patient-centered design, intuitive navigation, equitable access and real-world usability testing. We therefore suggest that digital medicines

¹ [Aligning-Patient-Demand-Digital-Infrastructure-and-Regulation.pdf](#)

information be considered within the chapter's wider discussion of health literacy, inclusive design and assisted access, while maintaining appropriate non-digital alternatives.

- **Page 14 - Paragraph 5:** *Business at OECD* welcomes the chapter's findings regarding inequalities in digital health use. Given that individuals with chronic conditions may have greater ongoing healthcare needs, future analyses could examine whether digital self-care tools and self-monitoring technologies help support disease management and patient engagement in populations experiencing a higher burden of disease.
 - **After:** "Along every dimension on which use falls, reported need is flat or rising."
 - **Insert:** "Further research could examine how digital self-management tools and remote-monitoring technologies may help support populations with higher health needs, particularly people living with chronic conditions and older adults."

We also invite to recognize the role of national regulation in creating unequal access to digital care and medicines across Member States. Equity in digital health should be considered not only in relation to age, education and digital skills, but also to national regulation and the availability of digitally enabled care pathways. Restrictions on online consultations, online medicine purchasing and home delivery may create additional barriers, particularly for rural communities, people with mobility limitations, chronic conditions or demanding work and caring responsibilities. Recent European evidence² indicates substantial differences between Member States in access to regulated online prescription-medicine services. These regulatory differences can create a two-tier digital healthcare landscape and should be considered alongside individual-level determinants when assessing equitable access to digital care and medicines.

- **Page 15, figure 1.6:** We note that the presentation of access to online medical records alongside the prevalence of chronic diseases, using the same visual markers, may create scope for misinterpretation. Readers could incorrectly infer a relationship between the two variables, such as concluding that chronic diseases are more prevalent in rural areas, where lower levels of digital access may also be observed. To avoid unintended conclusions, we encourage clarification of the chart design, underlying methodology, or any limitations regarding the interpretation of correlations between these indicators.
- **Page 16:** We believe it would be helpful if the methodology used to estimate the third calculation, could be explained in greater detail. We also note that analysis lacks people centricity and doesn't question why each of the age cohorts access EHR records at different rates. Data shared in Figure 1.6 indicates that in the 45-54 age range, 95% of those reporting a chronic condition access their health records (32,3% vs. 30,7%) and that in the 55-64 age range, the figure is 58% (44,8% vs. 26,2%). The rate among older adults is much lower at 35% (54,9 vs. 19,2%). Perhaps the reason that such a relatively low percentage of the younger cohorts currently access their EHRs is because they do not have chronic conditions that drive this use? This line of reasoning would lead one to conclude that as these cohorts do age and more within them develop chronic health conditions, the use of EHR and other digital health solutions will also increase.
- **Page 17 - Paragraph 2:** Future work on ageing could also explore the role of digital health technologies and self-care medical devices in supporting healthy ageing, maintaining independence and facilitating chronic disease management.
 - **After:** "Section 1.4 examines the available levers and the evidence behind them"
 - **Insert:** "Digital health technologies, including self-monitoring and remote-monitoring tools, may play an increasingly important role in supporting healthy

² [Aligning-Patient-Demand-Digital-Infrastructure-and-Regulation.pdf](#); [Copenhagen-Economics-Unlocking-the-benefits-of-online-access-to-prescription-medicines_2024.pdf](#)

ageing and enabling older people to remain active participants in managing their health."

- **Pages 18-26 - From coverage to active use:** We suggest broadening the equity analysis to include national regulation and access to digitally enabled care and medicines, not only in terms of access to health data. The section could broaden the concept of "active use" beyond access to online health records. Active use should also capture whether patients are allowed to use digital services to obtain care and medicines, including online consultations, telemedicine, e-pharmacy, online medicine purchasing, and home delivery. This requires assessing not only awareness and provider offers, but also whether national regulation, interoperability and service design allow patients to complete the full digital pathway. When it comes to data interoperability reflections, the analysis should also assess whether countries have unified and interoperable systems, and whether public and private providers can exchange data and coordinate care effectively. Fragmented systems may limit practical access even where digital services are formally available.
- **Page 23 - Reimbursement as an evidence pathway for digital applications:** The section could address reimbursement of digitally delivered care, not only digital health products. Digital care is more likely to be adopted when services are reimbursed comparably to equivalent in-person care and integrated into routine clinical pathways. Differences in national reimbursement arrangements may therefore affect both the uptake and equity of access to digital care. In France, eligible teleconsultations are reimbursed at 70%, or 100% in certain cases such as long-term conditions, broadly in line with in-person consultations³.
- **Page 25 - The evaluation deficit:** The evaluation should include measure of patient benefits, wider health-system capacity benefits and economic effects. This should include patient outcomes and experience, continuity and scalability of chronic care, health-system capacity, workforce productivity, avoided travel and time costs, and overall value for money. The aim should be to assess not only whether digital services are used, but whether they improve access, care outcomes and system efficiency at scale. The finding in Chapter 1 that digital-health use is lowest among patients with the greatest chronic disease burden is particularly relevant to diabetes. Diabetes care increasingly involves continuous glucose monitoring, connected insulin delivery, and remote-management platforms. These technologies illustrate both the potential of digital health and the risk that unequal access may widen existing disparities.
- **Page 26 - Paragraph 1:** Future evaluation frameworks could also assess effects on prevention outcomes, patient empowerment, health literacy, self-management, healthcare utilisation and released healthcare capacity.
 - **After:** "...whether use improves care."
 - **Insert:** "Additional dimensions may include prevention outcomes, patient activation, health literacy, self-management and healthcare utilisation."
- **Pages 26-33: Institutional readiness: data governance, cybersecurity and public trust:** *Business at OECD* agrees with the overall stating that the successful implementation of digital health depends not only on having the appropriate legal frameworks in place, but also on their effective implementation through sound data governance, secure and resilient digital systems, and public trust in the institutions governing access to and use of health data. However, the legal safeguards established under the EHDS and GDPR should be fully upheld and effectively implemented at national level, and any simplification introduced through the Digital Omnibus should not weaken these protections. In particular, where health data or

³ [La téléconsultation | ameli.fr](#) | [Assuré](#)

inferred health data are processed, robust safeguards should ensure a clear legal basis, documented necessity and proportionality, and effective protection against re-use for profiling, advertising, commercial targeting or other unrelated commercial purposes.

The section addresses trust mainly in relation to health-data governance but not trust and patient safety in digitally delivered care and medicines services. The analysis could address patient-safety safeguards for online care/tele consultations, e-pharmacy and online medicine services, including pharmacist oversight, medicine authentication, pharmacovigilance, secure delivery and access to reliable health and medicines information. Examples include the EU Common Logo for legally operating online pharmacies. These factors are essential to public trust in digital care, alongside the secure processing of health data.

- **Page 31-35 - AI Section:** Future analyses could also consider how citizens increasingly use general-purpose AI tools to obtain health information, interpret symptoms and navigate care pathways. Such use may influence health literacy, healthcare-seeking behaviour and decisions regarding when, where and from whom individuals seek advice, with implications for patient safety, access to trustworthy information and interactions with healthcare professionals. As AI and digital health services become more widely used, workforce and patient readiness should be addressed together. Role-specific training for healthcare professionals, including pharmacists and primary care providers, should be accompanied by accessible patient information, assisted routes into digital services and continued access through non-digital channels. Adequate financial and logistical support will be needed to ensure healthcare professionals have the training, time and resources required to guide patients in the safe and informed use of AI-enabled services.
- **Page 43 -Last paragraph:** Consideration could also be given to recognising prevention, health literacy and self-management as important outcomes of digital transformation. Digital tools can support citizens in managing their health, making informed decisions and engaging appropriately with healthcare services, thereby contributing to health-system sustainability and resilience.
 - **After:** "...signposting them through providers, issuing timely notifications and offering assisted access."
 - **Insert:** "Digital services should also support prevention, health literacy and self-management, ensuring that digital transformation contributes not only to access but also to improved population health outcomes."
- **Page 45 - A measurement agenda for accountability:** As the OECD develops measures of citizen-facing digital health beyond technical availability, we suggest considering access to and use of authoritative digital medicines information among relevant patient-facing services. Measurement should go beyond whether information is technically available to assess awareness, actual use, usability and comprehension, including differences by age, education and health need. This would align with the chapter's proposed shift from measuring deployment towards measuring equitable use and benefit. Ongoing European ePI pilots also provide a useful evidence base for implementation: a 2026 overview by AESGP, EFPIA and Medicines for Europe identified ePI pilots across 31 European countries, including 14 countries with active pilots and seven in the planning phase.
- More generally, we also believe it would be helpful to consider including an explanatory box on the European Union's Artificial Intelligence Plan in Chapter 1, similar to the discussion of the OECD Strategic Public Health Planning for Antimicrobial Resistance (SPHeP-AMR) framework presented in Chapter 2. This could provide useful context and help readers better understand the broader policy environment shaping AI-related developments.

Chapter 2: Antimicrobial resistance in the EU: Key targets are off track for 2030, but not out of reach

General Comments

- *Business at OECD* welcomes the *Health at a Glance: Europe 2026 – Chapter 2: Antimicrobial resistance in the EU: Key targets are off track for 2030, but not out of reach*, and its focus on the importance of a One Health approach, antimicrobial stewardship, infection prevention and control, surveillance, and innovation in addressing antimicrobial resistance (AMR). We particularly welcome the recognition that most antibiotic consumption occurs in community care settings and agrees that achieving the EU's 2030 AMR targets will require coordinated action across the healthcare continuum. The importance of accelerating efforts is underscored by recent EMA and ECDC findings showing that the EU remains off track for four of its five 2030 AMR targets. Since 2019, overall antibiotic consumption has increased rather than declined, while the incidence of bloodstream infections caused by carbapenem-resistant *Klebsiella pneumoniae* and third-generation cephalosporin-resistant *Escherichia coli* has increased by more than 60% and 5%, respectively. At the same time, the share of WHO Access antibiotics remains below the EU target of 65%.²
- The report provides a helpful landscape overview of key trends and policy action across EU Member State and meaningfully connects different domains of the policy response, including the importance of appropriate use, and urgent need for pull incentive mechanisms to incentivize antibiotic R&D
- Against this background, we believe the report could more explicitly recognise the role of health literacy, public awareness and responsible self-care in reducing inappropriate antibiotic use. Persistent misconceptions regarding antibiotics remain common, with many Europeans still unaware that antibiotics are ineffective against viral infections and common illnesses such as colds and influenza. Empowering citizens to appropriately manage common self-limiting conditions, improving understanding of when antibiotics are and are not needed, and supporting responsible healthcare-seeking behaviour can complement stewardship efforts and contribute to reducing unnecessary antibiotic demand in community care.
- The continued need for action is illustrated by the experience of Ireland, where Access-group antibiotics accounted for 78% of antibiotic use in early 2025 and a national AMR action plan has strengthened awareness, surveillance, infection prevention and responsible prescribing. Nevertheless, Ireland remained the ninth highest antibiotic user in Europe in 2024 and still requires a 27% reduction in overall antibiotic consumption to meet its recommended 2030 target. Recent research has additionally highlighted the widespread presence of antimicrobial resistance genes across human, animal and environmental sectors, reinforcing the importance of coordinated One Health action. These findings demonstrate that, even where progress has been made in promoting appropriate antibiotic use and implementing stewardship measures, sustained efforts remain necessary to promote the responsible use of antibiotics while further strengthening antimicrobial surveillance, stewardship, infection prevention and control measures, as well as broader prevention strategies across a One Health framework.⁴
- We welcome the chapter's strong focus on stewardship, infection prevention and control, surveillance and innovation. To provide a more comprehensive perspective on the determinants of antibiotic consumption, future analyses could also consider the contribution of health literacy, patient expectations, healthcare-seeking behaviour and responsible self-

care. Antibiotic use is influenced not only by prescribing decisions but also by citizens' understanding of common infections, their expectations regarding treatment and their ability to manage self-limiting conditions appropriately. These broader behavioural and societal factors can complement stewardship efforts aimed at reducing unnecessary antibiotic use.

- We encourage to further acknowledge health literacy and responsible self-care as important components of comprehensive AMR strategies. Alongside stewardship, vaccination, diagnostics and infection prevention measures, self-care interventions can support the careful use of antibiotics, help address inappropriate demand, and contribute to the sustainability and resilience of healthcare systems across Europe.¹
- Improving health literacy should be recognized as a core component of comprehensive AMR strategies and as a behavioral determinant of antimicrobial use. According to the WHO, health literacy enables individuals to access, understand, evaluate and use health information and services appropriately. Higher levels of health literacy are associated with better preventive behaviors, more effective self-care, greater use of appropriate health services and improved ability to follow treatment recommendations. Conversely, low health literacy is associated with poorer understanding of health information, lower uptake of preventive measures, increased emergency-care utilization and higher healthcare costs. These factors are directly relevant to antimicrobial stewardship because they influence healthcare-seeking behavior, treatment adherence and the appropriate use of medicines.³
- Health literacy can help address inappropriate antibiotic demand by improving public understanding of the differences between viral and bacterial infections, supporting appropriate self-management of minor ailments, and strengthening informed decision-making when professional care is required. The evidence also suggests that improved health literacy contributes to better health outcomes across a broad range of conditions while reducing pressure on overstretched healthcare systems. OECD may therefore wish to highlight health literacy, alongside stewardship, diagnostics, infection prevention and vaccination, as a population-level intervention that supports responsible antimicrobial use and long-term AMR management.³
- Policymakers may also consider a broader approach encompassing organizational, professional and personal health literacy. This includes ensuring that health systems communicate clearly, healthcare professionals are equipped to support informed decision-making, and citizens have access to accurate, timely and culturally appropriate health information. Such an approach can strengthen community resilience against misinformation and support more appropriate use of healthcare resources and medicines.³
- *Business at OECD* recommends explicitly including the recent passage of the revised EU Pharma Legislation and the provisions related to Transferable Exclusivity Voucher (TEV) implementation as a crucial step forward within the EU pull incentive package, noting that robust implementation and M&E will be key. Further, we recommend explicitly recognizing the agreed provisions on the additionally proposed voluntary subscription model, and its importance in contributing to the EU part of the solution towards a healthy antibiotic R&D ecosystem, and availability of newly developed antibiotics in the EU.

Specific Comments

- **Page 2 - Paragraph 1:** To provide a more complete overview of the available policy tools, consideration could also be given to the contribution of citizen engagement, informed health decision-making and responsible antibiotic use in supporting AMR objectives, particularly in community settings.

- **After:** "vaccination, stewardship, surveillance"
- **Insert:** "health literacy, public awareness, appropriate self-care"
- **Paragraph 4 (Page 5):** We agree that improving community prescribing is central to achieving Europe's antibiotic consumption targets. Given that most antibiotic consumption occurs in community care settings, the chapter could also acknowledge the contribution of patient education, health literacy and responsible self-management of common self-limiting conditions in supporting appropriate antibiotic use and reducing unnecessary demand. Future analyses could further examine behavioural drivers of antibiotic demand, including patient expectations, health literacy and management of common self-limiting conditions.
 - **After:** "vaccination, stewardship, surveillance"
 - **Insert:** "health literacy, public awareness, appropriate self-care"
- **Page 9 - Paragraph 2:** We agree with the One Health framing and suggests that future analyses could also acknowledge the emerging concept of One Health Literacy. Effective implementation depends not only on policy and surveillance systems but also on citizens' understanding of the relationship between human, animal and environmental health.¹
 - **After:** "... verified evidence on implementation remain less developed."
 - **Insert:** "Public understanding of AMR and One Health principles may also support implementation by influencing behaviours related to antibiotic use, infection prevention and healthcare-seeking."
- **Box 2.1. An overview of EU 2030 targets):** We welcome the EU's 2030 AMR targets and recognizes the importance of measurable indicators to track progress. In addition to the current outcome indicators, consideration could be given to complementary measures relating to health literacy and public awareness, such as population understanding of appropriate antibiotic use and antimicrobial resistance. These factors can influence healthcare-seeking behaviour and antibiotic demand and may therefore help explain progress towards the existing antibiotic consumption and resistance targets.
- **Box 2.3. Europe's One Health approach to AMR:** *Business at OECD* values the recognition that addressing AMR requires coordinated action across human, animal and environmental health. In addition to surveillance, stewardship, infection prevention and research, the effectiveness of a One Health approach also depends on citizen engagement through health literacy and public awareness. Recent literature has highlighted the concept of One Health literacy, recognising that individuals require the knowledge and skills to understand the links between human, animal and environmental health and to make informed decisions that support public health outcomes. Strengthening awareness of antimicrobial resistance, infection prevention and the appropriate use of antibiotics can therefore complement policy, surveillance and stewardship measures by helping to address unnecessary demand for antibiotics in community settings, where most antibiotic consumption occurs. Reflection should be given to recognising health literacy and One Health literacy as important enablers of the successful implementation of the Europe's One Health AMR strategy.¹
- **Page 12 - Paragraph 2:** We consider it positive that the chapter highlights the concentration of antibiotic use within community care. As community settings account for the majority of antibiotic consumption, further analysis of the drivers of community antibiotic use, including healthcare-seeking behaviour, health literacy and community engagement, could provide valuable insights for policy development. Recent evidence showcases the importance of behavioural and community-level approaches in addressing AMR and suggests that exploring the role of responsible self-care in influencing antibiotic demand may provide additional insight for policy makers.² Given that approximately 92% of antibiotics are consumed in community settings, future analyses could further explore interventions that

address demand-side drivers of antibiotic use. These include public understanding of viral and bacterial infections, self-care practices, access to symptom-relief options and appropriate management of common self-limiting conditions.

- **After:** "General practice, dentistry and other community settings generate the bulk of antibiotic consumption."
 - **Insert:** "Empirical prescribing, patient expectations, awareness and self-management behaviours are among the factors that may influence antibiotic demand in these settings."
- **Page 12 - Paragraph 2:** *Business at OECD* notes positively the discussion on community care. However, community-based AMR strategies could recognize that timely access to appropriate non-prescription topical treatments may help people manage well-defined minor conditions without unnecessary medical consultations. The role of community pharmacists in supporting correct product selection, appropriate use, referral and reinforcement of stewardship messages could also be made more explicit.
- **Pages 12-15:** *Business at OECD* notes that community pharmacists can contribute to AMR efforts through patient education, promotion of appropriate healthcare-seeking behaviour, support for symptom management and reinforcement of antimicrobial-stewardship messages. Future analyses could consider their role within community-based AMR strategies.
- **Page 23 - Paragraph 3:** Further examination of how awareness and risk-communication initiatives influence knowledge, behaviour and antibiotic use could provide useful evidence to support progress towards the 2030 AMR targets.
- **Page 25 - Paragraph 1:** The unique economics of the antibiotics market and the lack of suitable R&D incentives do not support a healthy R&D ecosystem. There are several examples of companies having successfully developed and launched a new antibiotic yet failing to achieve a return that would allow them to even keep the antibiotic available on the market. Suggest recognizing these factors more explicitly.:
 - **After:** "... This characteristic limits the sales volumes on which conventional returns depend and has contributed...."
 - **Insert:** " to several smaller company bankruptcies despite successful development and launch, to the weak and declining clinical pipeline, to researchers and venture capital leaving the field of AMR R&D."
- **Page 28 - Paragraph 3:** We stand behind the common objective of ensuring sustainable, appropriate access to new antibiotics globally. Recognizing the importance of improving global access, major push funders already require companies to develop access and stewardship plans, and the industry-led AMR Action Fund guides their portfolio companies in developing theirs. Further, large companies routinely carry out global access planning for products in their portfolios, with many such initiatives announced or in place.

However, to ensure long-term success, a collaborative approach between governments and industry will be essential. Given the broadly recognized challenges of the antibiotics market, well-thought-out sustainable access models that address these are needed. Even across the EU and many other most developed countries⁴, the availability of recently developed antibiotics is highly fragmented due to a lack of sustainable markets, which is even more pronounced at the global level. Addressing these shortcomings holistically will require differentiated approaches across different contexts. All countries that are able to do so

⁴ See e.g. <https://pubmed.ncbi.nlm.nih.gov/34251436/>

should implement decoupled models scaled to their capacity; for lower income settings, additional support and bespoke models may be necessary that also include a supportive implementation component with different partners.

The industry is committed to playing its part in improving global access to antibiotics. However, embedding such conditionalities within pull incentive contracts, or other reimbursement models, outside of the market they serve, would on the other hand i) place the onus on ensuring access in a variety of global contexts solely on the industry, ii) reduce individual incentive model predictability, iii) would be especially challenging for smaller developers, and iv) is unlikely to deliver the desired results.

We suggest rephrasing the below phrase:

- **From:** "... Pull incentives are also needed to reward the availability and therapeutic value of genuinely important products without making returns depend primarily on sales volumes. Their design should incorporate conditions supporting equitable access and stewardship...."
 - **To:** "... Pull incentives are also needed to reward the availability and therapeutic value of genuinely important products without making returns depend primarily on sales volumes. Their design should ensure equitable access...."
- **Page 29 - Paragraph 3:** *Business at OECD* appreciates the recognition that no single intervention will be sufficient to address AMR and that successful policy packages must tackle multiple drivers simultaneously. While stewardship, infection prevention and public-awareness campaigns remain essential, recent research suggests that many drivers of AMR are behavioural in nature and that effective responses should incorporate community engagement and behaviour-change approaches. Consideration could therefore be given to exploring the role of health literacy and responsible self-care in supporting more appropriate healthcare-seeking behaviour and reducing unnecessary antibiotic demand in community settings.²
- **Page 2 - Paragraph 1:** We support the chapter's scope and terminology. Nonetheless, the chapter could distinguish antibiotics from antimicrobial classes to avoid implying that all antimicrobials present an equivalent resistance risk. A short explanation of the differences among antibiotics, antivirals, antifungals and antiseptics would support more precise interpretation of the evidence and policy options.
 - **After:** "Relevant measures include infection prevention and control, vaccination, stewardship, surveillance, diagnostics and incentives for novel antimicrobials."
 - **Insert:** "Measures should be proportionate to the demonstrated resistance risk of the product and should take account of the microorganism targeted, whether exposure is systemic or local, treatment duration and evidence from clinical use and surveillance."

Supporting resources

1. Association of the European Self-Care Industry (AESGP). (2020). Antimicrobial resistance: The Self-Care Industry is part of the solution (AESGP Position Paper on AMR). AESGP. https://aesgp.eu/content/uploads/2019/11/AESGP_PP_AMR_2020-1.pdf
2. Cooke, E., & Rendi-Wagner, P. (2025). Rising antimicrobial resistance in Europe: EMA and ECDC outline urgent actions to achieve EU targets. *The Lancet Regional Health-Europe*, 59. <https://doi.org/10.1016/j.lanepe.2025.101539>
3. Impact, Economist. *Health drives wealth: the economic impact of health inclusivity. Findings from the third phase of the Health Inclusivity Index*; 2025.

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Chapter 3: Health status

General Comments

- While the analysis rightly focuses on health outcomes, we believe that future editions could further explore the factors that contribute to differences in these outcomes across populations. In particular, further thoughts could be given to how behavioural risk factors, preventive behaviours and broader determinants of health may influence variations in life expectancy, healthy life expectancy, chronic disease prevalence and self-rated health across Europe.
- *Business at OECD* also welcomes the inclusion of self-rated health indicators, which provide an important patient-centred perspective on population health. Future analyses could explore how factors such as health literacy, self-management capacity and access to reliable health information relate to self-reported health outcomes, particularly among older populations and people living with chronic conditions. Such factors may support prevention, informed decision-making, management of chronic conditions and healthy ageing and could therefore contribute to differences observed in self-rated health across populations.
- *Business at OECD* welcomes the chapter's attention to healthy life expectancy and population ageing. As European populations continue to age, maintaining functional capacity, independence and quality of life becomes increasingly important for preserving quality of life and enhance the sustainability of healthcare systems. Future analyses could further explore the contribution of prevention, health literacy, self-management and self-care interventions to healthy ageing and healthy life expectancy, including through metrics that capture individuals' capability to maintain health and the resulting benefits for long-term population health. Emphasizing mutual benefits of health and other sectors working together can make intersectoral action more appealing and bring other sectors on board. Health co-benefits can be achieved directly, through better health outcomes and greater health equity, and indirectly, through the broader effects that health systems and policies have on individuals, communities and other areas of society.¹
- We also identify that the explanation of cross-country differences lists smoking, obesity and alcohol but omits physical inactivity. The primary-prevention discussion then focuses almost entirely on smoking cessation.
- *Business at OECD* supports the report's call for more coordinated care and closer collaboration between patients and healthcare professionals, including general practitioners, pharmacists, nurses and other care providers, to effectively manage multiple chronic conditions. This is particularly important as population ageing increases the prevalence of multimorbidity and the pressure on healthcare systems.
- We believe it would be appropriate to reference the European Beating Cancer Plan in the section on cancer, as the Safe Hearts Plan is referenced in the section on cardiovascular diseases. Including both initiatives would help ensure a balanced presentation of relevant policy frameworks across disease areas.
- Traditionally, the section on routine vaccinations in the *OECD Health at a Glance* report has presented vaccination coverage data for measles, HPV and influenza. Given the report's particular focus on population ageing, and the strong evidence on the contribution of vaccination to healthy ageing and longer lives in good health, we would encourage the OECD to consider broadening the scope of vaccination programmes covered in this section. For adult immunisation, while influenza remains an important indicator, consideration could

also be given to acknowledging the broader range of vaccine-preventable diseases that disproportionately affect older adults and those with underlying health conditions, including for example, pneumococcal disease, respiratory syncytial virus (RSV) and herpes zoster. Such an approach may provide greater visibility to the contribution of preventive care across the continuum, through primary, secondary and tertiary prevention, including adult immunisation and screening, in supporting healthy ageing and population health outcomes

- In addition, in light of the forthcoming Council Recommendation on vaccination against respiratory infections to help prevent cardiovascular diseases, announced as part of the EU Safe Hearts Plan, it would be valuable to take stock of the comprehensiveness of National Immunisation Plans, including the extent to which they incorporate vaccination recommendations for adults and at-risk populations, such as people with cardiovascular disease.
- As populations age and multimorbidity becomes more prevalent, infectious diseases and chronic conditions increasingly intersect, with respiratory infections contributing to adverse outcomes among people living with underlying cardiovascular, respiratory and metabolic conditions. Greater visibility of these interactions could help provide a more holistic understanding of the health, societal and economic implications of ageing and multimorbidity in Europe.
 - This is particularly relevant in the discussion of respiratory health. While the chapter identifies respiratory diseases as a leading cause of mortality and highlights the growing prevalence of chronic conditions among older adults, greater attention could be given to the overlap between respiratory infections, chronic disease and ageing populations, including the role respiratory infections can play in exacerbating underlying conditions, contributing to complications, hospitalization and functional decline.
 - Similarly, the discussion of healthy life expectancy and disability presents an opportunity to acknowledge more explicitly the factors that can accelerate loss of function and worsen existing chronic conditions among older adults.
 - Such an approach may also help provide greater visibility to the contribution of preventive care, across the continuum from primary, secondary & tertiary prevention, including adult immunization and screening, in supporting healthy ageing and population health outcomes.
- We find that Diabetes does not currently appear as a named condition in Chapter 3's health-status analysis. We encourage OECD to include diabetes as a named priority condition in Chapter 3, with data on prevalence, mortality, and complications. We strongly encourage the OECD to acknowledge the links between obesity, diabetes, and cardiovascular risk in chapters 3 and 4.
- We also suggest reflecting two recent developments relevant to the chapter's measurement of health status: the 2026 World Health Assembly resolution on steatotic liver disease and the 2025 Lancet Diabetes & Endocrinology Commission distinction between clinical and pre-clinical obesity.

Specific Comments

- **Page 3:** The chapter correctly identifies chronic diseases as an important contributor to disease burden. Future editions could further explore factors supporting effective self-management of chronic conditions, including health literacy, patient empowerment, adherence and self-care interventions.

- The chapter notes that further gains in healthy life expectancy depend on prevention, equal access to care and better management of chronic disease. We suggest making the distinction between extending life and extending healthy life more explicit, including the compression-of-morbidity perspective, and clarifying what 'better management' entails and how it could be measured.
- **Page 4 - Paragraph 5:** *Business at OECD* welcomes recognition of health inequalities as an important determinant of life expectancy. Future analyses could also explore the contribution of preventive healthcare, self-care and health literacy in supporting healthier lives and reducing preventable mortality
 - **After:** "... further gains in life expectancy in these countries may also be achieved by reducing inequalities in life expectancy by gender and socioeconomic status, notably through effective and well-targeted public health interventions to reduce premature and preventable mortality (see indicator "Avoidable mortality" in chapter 6)."
 - **Insert:** "and strengthening prevention and healthy ageing initiatives throughout the life course"
- **Page 7:** Health literacy is identified as a resource shaping disability-free life expectancy, but unlike income and access to healthcare it is not measured. Comparable European data already exist through the HLS19 survey, including the HLS19-Q12 short form. We suggest either including a health-literacy indicator or, in the interim, noting explicitly that this determinant is not currently measured.
- **Page 8 - Paragraph 1:** We welcome the focus on healthy life expectancy as a complement to life expectancy. Maintaining health, functional capacity and independence throughout life requires attention not only to healthcare services but also to prevention, health literacy and self-management. Future analyses could examine the role of these factors in supporting healthy life years. Given the established links between health literacy and educational attainment, future analyses may wish to explore whether differences in health literacy contribute to observed inequalities in healthy life expectancy and chronic disease burden.
 - **After:** "...better management of chronic diseases when they occur..."
 - **Insert:** "including support for self-management, adherence and patient engagement."
- **Page 10: Main causes of mortality and cancer mortality:** Liver disease is not reported separately despite recent European and global evidence. The second EASL-Lancet Commission on Liver Health estimates around 284,000 annual deaths from cirrhosis and liver cancer in the WHO European Region and an associated EUR 55 billion annual reduction in regional GDP; it also reports that liver-cancer deaths have risen by more than half since 2000. In May 2026, WHA79.4 urged Member States to integrate steatotic liver disease into NCD strategies and monitoring frameworks. We suggest considering whether liver disease should be more visible in the chapter's mortality monitoring.
- **Page 12:** We believe it would be helpful for the graph on mortality from external causes to reflect the full range of causes captured within this category. While suicides and accidents are important components, consideration could also be given to highlighting deaths resulting from domestic violence and homicide. Including these causes would provide a more comprehensive representation of external-cause mortality and its distribution across population groups.
- **Page 13 - Paragraph 1:** Future analyses could further explore the relationship between health literacy, preventive behaviours and mortality outcomes across Europe. Health literacy

and patient engagement may influence awareness, management and treatment adherence regarding cardiovascular risk factors and could therefore contribute to observed differences in outcomes.

- **After:** "...reducing the burden of cardiovascular diseases by enhancing prevention, strengthening,"
- **Insert:** "including interventions supporting healthier lifestyles and self-management of cardiovascular risk factors,"

We would also like to highlight the forthcoming work from the United Nations University Centre for Policy Research, which is examining the financial and wellbeing returns from self-care in cardiovascular health as part of a wider assessment of self-care pathways to universal health coverage and development financing.

The draft report correctly states that primary prevention can reduce both incidence and mortality from cardiovascular disease. However, it would also be important to highlight the important role of secondary prevention. For example, enhancing secondary prevention in France, Germany, Italy, Spain, Denmark, Poland and the UK could prevent 67,170 fatal cardiovascular (CV) events (heart attack and stroke) per year. This equates to 671,700 avoided fatal CV events over the next ten years via improved management of hypertension, hyperlipidaemia and diabetes, or 1,2 million avoided deaths if scaled up to the whole EU.⁵

The chapter highlights primary-prevention conversations with clinicians but could recognize additional settings where prevention and self-care support are delivered, including community pharmacy. This would align with Indicator 8's emphasis on coordinated care and collaboration across healthcare professionals.

- **Page 16 - Paragraph 7:** *Business at OECD* welcomes recognition of prevention as a cornerstone of cancer control. Future analyses could further explore the contribution of health literacy to awareness of behavioural risk factors and participation in cancer prevention and screening activities.
 - **After:** Sustaining progress in reducing cancer mortality requires action across the full cancer control pathway, beginning with prevention through healthier lifestyles and environments.
 - **Insert:** "and improved health literacy"
- **Page 25 - Paragraph 1:** *Business at OECD* strongly welcomes the chapter's focus on chronic conditions and multimorbidity. Future editions could further explore the contribution of self-care and patient self-management in supporting people living with long-term conditions. Effective self-management can improve quality of life, treatment adherence and patient experience while supporting healthcare-system sustainability.
 - **In:** "Many chronic conditions are preventable through modifiable risk factors such as smoking, alcohol use, physical inactivity, malnutrition and obesity."
 - **Insert:** "Many chronic conditions are preventable through *disease prevention initiatives, promotion of healthier lifestyles and improved awareness of* modifiable risk factors such as smoking, alcohol use, physical inactivity, malnutrition and obesity."

The chapter rightly notes that chronic disease need not limit daily life when conditions are

⁵ Jennifer Gill, Aurelio Miracolo, Konstantina Politopoulou, Sahan Jayawardana, Alex Carter, Efstratios Apostolou and Panos Kanavos 2024. 'How can we Improve Secondary Prevention of Cardiovascular Disease?' London School of Economics and Political Science. DOI <https://doi.org/10.21953/lse.f81e9y7znju1>

well managed. We suggest reporting more about that management, including whether people feel confident managing their health, what support they receive and where it comes from. OECD PaRIS already measures confidence in managing one's own health and could provide a relevant patient-reported indicator.

The chapter names pharmacists among the professionals supporting people with multiple chronic conditions, yet pharmacist and community-pharmacy availability are absent from the publication's workforce indicators even though the OECD reports these measures in the global Health at a Glance. We suggest greater consistency across chapters and use of the term 'multimorbidity', in line with PaRIS and the scientific literature

Supporting resources

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4. Rubino F. et al. (2025). Definition and diagnostic criteria of clinical obesity. The Lancet Diabetes & Endocrinology 13(3):221-262. [Access here](#)
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6. M-POHL / WHO Action Network (2021). European Health Literacy Population Survey 2019-2021 (HLS19). [Access here](#)

Chapter 4: Risk Factors

General Comments

- *Business at OECD* particularly welcomes the life-course perspective adopted throughout the chapter and the analysis of trends across different population groups.
- While the chapter provides a strong overview of prevalence and trends, we believe that future editions could further strengthen the analysis by exploring, where possible, the factors associated with successful risk reduction and behaviour change. Consideration could be given to indicators relating health literacy, preventive behaviours and other factors that influence individuals' ability to adopt and maintain healthier lifestyles over their lifetime. Recent evidence has highlighted the role of health literacy and preventive behaviours in supporting risk reduction across the life course.³
- We believe that future analyses could also consider, where comparable data are available, additional indicators relating to smoking cessation behaviours, quit attempts, preventive health behaviours and health literacy. Such information could complement prevalence data and provide additional insight into the factors that influence the adoption and maintenance of healthier behaviours over time.³
- Additionally, the chapter contains substantial discussion of smoking prevalence, tobacco-control policies and e-cigarette use, including concerns about youth uptake and mixed evidence regarding smoking cessation outcomes. However, it does not currently acknowledge the role of licensed NRTs as evidence-based cessation aids or the importance of supporting progression towards being both tobacco-free and nicotine-free.
- With regard to nutrition, we welcome the chapter's focus on fruit and vegetable consumption among both children and adults. Future editions could consider including additional indicators on nutrient adequacy and micronutrient intake where comparable data are available. This information could complement dietary consumption data and contribute to a more comprehensive understanding of nutritional status across European populations. In this context, food supplements containing vitamins and minerals may play a complementary role in helping individuals meet specific nutritional needs, where appropriate, as part of a balanced diet and healthy lifestyle.¹
- Whilst this chapter gives physical activity a welcome prominence, the treatment could more fully reflect physical activity as an independent and multidimensional determinant of health. Combining them risks diminishing the importance of insufficient physical activity as an independent health risk and conflates three related but distinct concepts: physical inactivity, sedentary behaviour and screen exposure. Children can meet recommended activity levels while still spending substantial time sedentary. Screen use also raises concerns beyond physical inactivity, including sleep disruption, cyberbullying, exposure to harmful content and impacts on mental wellbeing.

Separate sections would allow the report to explain the distinct health pathways, measurement limitations and policy responses associated with each issue. This distinction is consistent with the OECD and WHO's Step Up! Report (2023), which states that insufficient physical activity, sedentary behaviour and low fitness are interrelated but independent risk factors.

- The need for greater clarity is reinforced by the report's own findings. Physical activity declines sharply during adolescence, with only 22% of 11-year-olds and 15% of 15-year-olds meeting the WHO recommendation of at least 60 minutes of moderate-to-vigorous physical

activity per day. This means that 85% of 15-year-olds are insufficiently active at a life stage when long-term health behaviours are being established. At the same time, 29% of children aged 6-9 across EU countries are overweight or obese, highlighting the close relationship between low activity levels, obesity and future chronic disease risk.

The report also documents high levels of sedentary behaviour and screen exposure, with 41% of children aged 6-9 spending at least two hours per day on screens during weekdays, rising to 78% on weekends, while adolescents aged 13-18 spend an average of 4.5 hours per day on screens during school days and 6.1 hours during weekends. These trends are further linked to socioeconomic inequalities and adverse mental wellbeing outcomes, with nearly one in three adolescents reporting feeling stressed, sad or socially excluded because of social media.

These findings support a stronger recognition of physical activity not only as an obesity-prevention measure, but also as a mental health, social participation and chronic disease prevention intervention. The report notes that insufficient physical activity accounted for 1.2 million disability-adjusted life years (DALYs) and approximately 64,000 deaths in the EU in 2023. Given this substantial health burden, greater emphasis could be placed on policies that increase physical activity throughout childhood and adolescence, including quality physical education, active schools, infrastructure that supports active travel, affordable access to sport and recreation, and community-based programmes that enable participation across all socioeconomic groups.

- The section notes WHO's recommendation that children and adolescents undertake at least 60 minutes of moderate-to-vigorous physical activity daily. We suggest also mentioning that WHO strongly recommends vigorous-intensity aerobic activities, as well as activities that strengthen muscle and bone, on at least three days per week. Likewise, while the paragraph notes WHO's recommendation that adults engage in at least 150 minutes of moderate-intensity physical activity per week, it omits the additional recommendation that adults undertake muscle-strengthening activities involving all major muscle groups on two or more days per week. While robust European compliance data for this aspect of the recommendation remain limited, evidence from the United States suggests substantially lower compliance with the combined aerobic and muscle-strengthening guidelines than with aerobic activity recommendations alone.
- *Business at OECD* notes that no data are presented on trends in alcohol-attributable health harms, despite these being indicators agreed by member states as part of the WHO NCD Monitoring Framework. We encourage the OECD to include all measures agreed by member states. Despite acknowledging that OECD modelling of health harms is based on "alcohol consumption exceeding one drink per day for women and 1.5 drinks per day for men", Chapter 4 largely refers to "alcohol consumption". As the harms modelled by OECD are derived from consumption above these thresholds, it should use the language of "harmful alcohol consumption" to accurately reflect the model outputs and be consistent across the chapters.
- We also believe obesity should not only be referred to as a risk factor, but as a chronic disease. The draft appropriately identifies obesity as a major contributor to non-communicable disease and reports that more than half of EU adults live with overweight or obesity, with prevalence increasing in nearly all EU countries since 2017. However, obesity is presented primarily as a behavioural risk factor and a target for population-level prevention thereby omitting recognition of obesity as a disease in its own right. Obesity is classified by the World Health Organization (WHO) as a chronic, relapsing disease arising from complex interactions between genetics, neurobiology, eating behaviours, access to healthy diet, market forces, and the broader environment.

A substantial proportion of body weight (estimated at 40-70%) is influenced by genetic factors⁶. Once obesity is established, physiological mechanisms act to defend body weight. These include increased hunger signalling and metabolic adaptations that favour energy storage, making sustained weight loss challenging⁷. As a result, for many individuals living with obesity, behavioural change alone is often insufficient due to these underlying biological factors⁸.

In this context, ensuring that obesity is accurately characterized as a complex chronic disease is important for scientific consistency and effective policymaking. Approaches that do not fully reflect this complexity may not be aligned with the positions of the WHO as well as numerous national and international medical associations. Greater alignment with the current scientific consensus would also help avoid unintended stigmatization of people living with obesity and support more coherent public health messaging.

Accurately reflecting the multifactorial nature of obesity is therefore important to support continued progress in addressing the global obesity challenge and to ensure that policies are grounded in the best available evidence. Consequently, the sections in chapter 4 (page 31 – 36) should be moved to chapter 3 addressing the burden of chronic diseases, which would also emphasize the interconnected nature of obesity and associated chronic diseases such as T2D and cardiovascular disease.

- Further, we believe that diabetes should be integrated in discussions on cardiovascular health more broadly, separating diabetes from the cardiovascular discussion produces an incomplete picture of cardiometabolic health. Obesity, insulin resistance, hypertension, dyslipidaemia, and type 2 diabetes are clinically interconnected and should be considered within a coherent framework. We encourage connecting the variation in avoidable admissions to treatment access and care quality.
 - The inclusion of diabetes in Chapter 6's avoidable hospital admissions data is welcome, but the condition's scale and policy relevance warrant more comprehensive treatment.
 - The International Diabetes Federation (IDF)⁹ estimates that approximately 66 million adults in Europe live with diabetes. Diabetes is a major contributor to cardiovascular disease and a leading cause of end-stage renal disease, non-traumatic lower-limb amputation, and new-onset blindness among working-age adults.
 - The draft's own data demonstrate the importance of this issue: diabetes-related avoidable admissions range from 31 per 100,000 population in Italy to 186 per 100,000 in Lithuania—a six-fold difference. Admissions also increased over the study period in Spain and Latvia.

Specific Comments

- For clarity, we suggest changing the sentence "The urgency of promoting active lifestyles is underscored by estimates of the overall health burden associated with sedentary behavior" to "The urgency of promoting active lifestyles is underscored by estimates of the health burden associated with insufficient physical activity."
- **Page 4 - Paragraph 6:** A more explicit distinction between products considered as risk

⁶ Keller M, Svensson SIA, Rohde-Zimmermann K, Kovacs P, Böttcher Y. Genetics and Epigenetics in Obesity: What Do We Know so Far? *Curr Obes Rep*. 2023 Dec;12(4):482-501. doi: 10.1007/s13679-023-00526-z

⁷ Spiegelman BM, Flier JS. Obesity and the Regulation of Energy Balance. *Cell*. 2001/02/23/ 2001;104(4):531-543. doi:[https://doi.org/10.1016/S0092-8674\(01\)00240-11](https://doi.org/10.1016/S0092-8674(01)00240-11)

⁸ WHO "Health service delivery framework for prevention and management of obesity", p. 1

⁹ Home | International Diabetes Federation, IDF (2023). IDF Diabetes Atlas, 11th Edition.

factors, products used in smoking cessation or smoking reduction efforts, and the different public health considerations associated with adolescent and adult use would help ensure a coherent and consistent presentation across the chapter.

- **Page 7 - Paragraph 5:** *Business at OECD* suggests that additional clarification may be useful regarding the reference to e-cigarettes as a smoking cessation aid. While approaches vary across countries, and some jurisdictions have incorporated e-cigarettes into smoking cessation strategies, different nicotine-containing products may have distinct regulatory statuses, intended uses and evidence bases. Clarifying these distinctions could help readers better understand the range of approaches used to support smoking cessation.
- Where smoking cessation is discussed, future analyses could more clearly distinguish between products specifically authorised and intended for smoking cessation, such as Nicotine Replacement Therapies (NRTs), and other nicotine-containing products, including those that may be used by consumers as part of smoking cessation efforts in certain jurisdictions. Such clarification would support consistent interpretation of the evidence across different product categories while reflecting the diversity of regulatory and policy approaches internationally.
- **Page 7 - Paragraph 4-5:** In addition to prevalence measures, future editions could consider including indicators related to smoking cessation, such as quit attempts, successful cessation rates and access to cessation support. These metrics could complement prevalence data and help assess progress towards long-term tobacco-control objectives.
- **Pages 4-8 - Tobacco smoking and electronic cigarette use among adults:** The chapter gives detailed coverage to fiscal and regulatory tobacco-control measures but little attention to cessation support for the individual. We suggest including cessation alongside these measures and considering whether availability and use of cessation aids should be measured. Cochrane evidence cited in our review indicates quit success of around 15% with nicotine replacement therapy versus around 8% without, and NRT is available without prescription in most European markets.
- **Pages 13-15:** Figure 4.7 notes “including data from the WHO Global Information System on Alcohol and Health (GISAH) for some countries (latest year available in these cases is 2022, not 2024” but does not specify which countries this applies to. The data used by the OECD are not comparable with data used by the WHO in its data reporting as it relies on reported consumption whereas the WHO adjusts for tourism and unrecorded consumption in its primary consumption indicator. Further, it seems to use tourism adjustments in some countries but not others. We encourage to use the same consumption data as the WHO and use up-to-date statistics released this year in the [Global Information System on Alcohol and Health](#).
 - The report acknowledges disparities in data sources across different countries: “Overall alcohol consumption is defined as annual sales of pure alcohol in litres per person aged 15 and over, with the exception of Denmark that measures consumption for those aged 18 and over. Consumption in Estonia, Italy, Latvia and Lithuania excludes tourist consumption. In Luxembourg, consumption is estimated as the average of France and Germany.”

We would like to see whether policies designed to reduce total alcohol use per capita (APC) yield significant benefits in terms of reducing alcohol-related harm. To address harmful alcohol consumption, targeted rather than population-based measures are often most effective, and targeted indicators (such as prevalence of heavy episodic drinking) are more informative than APC. APC figures change for a wide variety of factors beyond whether population-based measures are in place or not. For example, there have been no significant

changes in taxes or alcohol-related restrictions in Switzerland, France or Denmark over the past 10 years, yet APC is decreasing.¹⁰

- **Page 19 - Paragraphs 1-3:** Future editions could consider complementing consumption indicators with information on nutrient adequacy and micronutrient intake, where comparable data become available. Such information could provide additional insight into nutritional status across different population groups and socioeconomic backgrounds.
 - **After:** "Fruit and vegetables are important components of a healthy diet"
 - **Insert:** "and contribute to achieving adequate intake of essential micronutrients."
- **Pages 22-24 - Nutrition among adults:** The chapter documents strong educational and income gradients in diet and notes that mobile and personalized information interventions can improve dietary habits. We suggest qualifying this finding by recognizing health literacy as an equity factor: information-based interventions may be less effective for groups with lower health literacy, who may also have the most to gain. The HLS19-Q12 offers a validated European measure that could be reported alongside existing education and income gradients.
- **Page 31:** The draft report uses wording such as "obese children" and we encourage OECD to instead use the wording "children living with obesity" or "people living with obesity" as people are not their disease, but they are living with it. This is also in accordance with the terminology applied by the World Obesity Federation (WOF)¹¹. Obesity is a complex, multifactorial chronic disease. Ensuring that the language reflects this complexity will help avoid unintended stigmatization and better support robust, inclusive and evidence-based policymaking.
- **Page 34:** We support the conclusion in the report that "Tackling obesity offers the greatest opportunity to reduce the burden of non-communicable diseases in the EU. This is driven primarily by its link to cardiovascular diseases and diabetes". Additionally, the report mentions that "Many EU countries have strengthened population-wide strategies to reduce obesity and improve diet, signalling a shift from individual behaviour change to multisectoral policies that promote healthier food choices and physical activity". However, the report completely omits initiatives, that support people already living with obesity:
 - For decades, initiatives to address obesity have focused exclusively on primary prevention, designed to stop the disease before it starts. However, as the obesity epidemic has increased in parallel with these measures, the WHO has acknowledged that it is time to recognize that multisectoral efforts to influence behaviours around healthy diet and exercise, while essential, have so far been insufficient to halt the rising prevalence of obesity¹².
 - The draft report describes obesity as a risk factor for a number of associated chronic diseases but fails to acknowledge the definition used by the WHO, which asserts that obesity is also a disease in itself, requiring prevention, management and treatment¹³. "The WHO Acceleration Plan to Stop Obesity" and "The WHO Health Systems

¹⁰ [Snowden, 2022](#) presents new evidence showing that there is no single distribution of alcohol consumption and that trends in per capita consumption and alcohol-related mortality often move in opposite directions. Economic interventions designed to reduce the prevalence of heavy drinking by reducing per capita alcohol consumption cannot therefore be assumed to be effective.

¹¹ [Obesity & Weight Stigma | World Obesity Federation](#)

¹² WHO [Health service delivery framework for prevention and management of obesity](#), p. 1

¹³ WHO [Health service delivery framework for prevention and management of obesity](#)

delivery framework for prevention and management of obesity” define obesity as “a chronic complex disease defined by excessive adiposity that can impair health. It is in most cases a multifactorial disease due to obesogenic environments, psychosocial factors and genetic variants.”

- According to scientific evidence, and recognition from the medical community, a holistic approach should also include access to treatment for those who need it, as governments will otherwise not be equipped to effectively tackle the public health challenge of obesity.

Business at OECD also appreciates the analysis of educational and socio-economic inequalities in obesity prevalence. Previous research has highlighted the cumulative effect of behavioural and socio-economic factors on obesity outcomes, demonstrating that dietary habits, physical activity, education and socio-economic circumstances are closely interlinked.¹ Further exploration of how these determinants interact and contribute to differences in obesity prevalence across population groups could also be given to the potential role of health literacy in supporting informed health choices and healthier lifestyle behaviours. Such analysis could provide additional insight into obesity inequalities and help inform more targeted prevention strategies.

- Towards the end of the chapter, the draft report focuses mainly on schools, active travel, national strategies, and a small number of public programs. It should acknowledge the broader infrastructure through which physical activity is delivered, including sport organizations, municipal services, workplaces, nonprofit and commercial fitness facilities, qualified exercise professionals, and primary-care referral or prescription programs.
 - Possible language: “Policies can also expand access to structured and supervised exercise through community, nonprofit and commercial fitness facilities, workplace programs, and referral partnerships between healthcare providers and qualified exercise professionals.”
- The draft report concludes that “Relative to maintaining current prevalence levels, reducing obesity would on average across EU countries over the period 2026-2050 lower annual premature mortality by 3.6%, expand the workforce by 495 000 FTEs and boost GDP by 0.6%”. While we agree with the report on the beyond health impact of obesity on productivity and workforce participation, the report fails to recognise the workforce gains from effective treatment of obesity. For example, the following evidence suggests that improving access to effective obesity treatments is not solely a healthcare expenditure consideration but may also represent a strategic investment in economic resilience, workforce participation, and long-term growth:
 - In a joint paper published by the Tony Blair Institute, Professor Andrew Scott modelled the impact of a 20% reduction in six long-term conditions, including obesity. The analysis found that such an intervention could reduce CVD and musculoskeletal disorders by 20%, leading to an estimated 0.3% increase in annual GDP, equivalent to £8.1 billion within five years¹⁴.
 - Similarly, a study presented at the 2025 European Congress on Obesity estimated that providing GLP-1 therapies to all eligible individuals in the UK could generate

¹⁴ Schindler Y., Scott A. and The Tony Blair Institute, The macroeconomic impact of chronic disease in the United Kingdom, The Journal of the Economics of Ageing, Volume 32, 2025. Available from: https://assets.ctfassets.net/75ila1cntaeh/258pfUDU2vyFt85o2LsHiz/90ad2b134463162fe4d95e8aedc06bc7/Tony_Blair_Institute__Prosperity_Through_Health__The_Macroeconomic_Case_for_Investing_in_Preventative_Health_Care_in_the_UK.pdf.

approximately £4.5 billion in economic benefit¹⁵. Based on data from 2,660 participants across three clinical trials, the study found that treatment was associated with increased productivity, including an average of five additional working days and twelve additional days of unpaid contributions such as volunteering or caregiving.

- Private-sector analyses point to comparable trends at larger scale. Goldman Sachs estimates that GLP-1 receptor agonists could increase US GDP by 0.4% to 1% over four years if 30-60 million individuals use these treatments and experience associated health improvements—potentially translating into up to \$1 trillion in additional economic output, driven by reduced absenteeism, lower disability rates, and improved workforce participation¹⁶.
- These macro-level findings are supported by real-world data. An analysis of approximately 50,000 individuals on a digital health platform found that those using GLP-1 therapies experienced 23% fewer sick days on average, alongside reported improvements in energy, focus, and overall work performance¹⁷.

Supporting resources

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8. OECD (2025). *Health at a Glance 2025 - Pharmacists and pharmacies*. [Access here](#)
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¹⁵ King R, Kettle J, Nørtoft E. Quantifying the Productivity Gains of Semaglutide Treatment in the UK for the Population Eligible for Reimbursement: A Modelling Study Using the Wider Societal Impacts Framework. Available on request.

¹⁶ <https://www.goldmansachs.com/insights/articles/obesity-drugs-are-among-breakthroughs-forecast-GDP>

¹⁷ McBride A. Enhancing workplace productivity through health solutions: Data-driven insights on the impact of GLP-1 medications on focus, productivity, and absenteeism. Presented at: World Obesity and Weight Management Congress; 2025; Florida, US.

Chapter 5: Health expenditure and financing

General Comments

- *Business at OECD* particularly welcomes the dedicated section on pharmaceutical expenditure, which provides valuable insights into spending levels, financing mechanisms and differences across Member States.
- While the chapter offers a detailed assessment of overall pharmaceutical expenditure, *Business at OECD* would welcome further analysis of expenditure on non-prescription medicines, which represent a significant component of retail pharmaceutical spending in several European countries. Future editions could also consider the contribution of prevention, self-care and self-management to health-system sustainability. Understanding not only expenditure but also potential cost avoidance, productivity gains, released healthcare capacity and broader system value may provide a more complete picture of healthcare efficiency and sustainability.
- *Business at OECD* welcomes the chapter's recognition of healthcare financing challenges and sustainability pressures. Future analyses could further explore the relationship between preventive investment, health outcomes and long-term expenditure trends. Prevention, health literacy and self-care interventions may support population health while reducing avoidable healthcare utilisation and associated costs.
- *Business at OECD* also notes the substantial variation across countries in the share of spending accounted for by non-prescription medicines and believes that further exploration of these differences may provide useful insights into patterns of medicine use, access pathways and healthcare expenditure across European health systems.
- *Business at OECD* suggests replacing the term “over-the-counter medicines” with “non-prescription medicines” throughout the chapter. The term non-prescription medicines more accurately reflects the range of regulatory frameworks, legal definitions and supply channels that exist while OTC is a common jargon word, that has frequently been misused, even in official international papers.
- Recognizing Cost-of-Living Realities for All Hospital Operators: this chapter mentions a robust per capita health spending growth in 2024 (approx. 5%) following pandemic stagnation but notes that high inflation has severely eroded these nominal increases. Public national payers must adjust their reimbursement tariffs and DRG rates to reflect actual inflation and rising labour costs, preventing the structural underfunding of private hospitals that provide public-contracted services within their National healthcare Systems.
- In this chapter, we note expenditure on immunisation is presented as part of overall spending on prevention. We understand that the OECD has been conducting an EU4Health-funded project aimed at providing a more granular analysis of preventive expenditure, including immunisation, and at developing a clearer understanding of the full costs of vaccination programmes, encompassing vaccine procurement as well as delivery and implementation costs. Against this background, it would be valuable to reflect the findings of this work in the *OECD Health at a Glance 2026* report. Greater granularity on immunisation expenditure would provide a more comprehensive picture of countries' investment in vaccination and prevention and facilitate more meaningful comparisons across health systems. In particular, disaggregating prevention expenditure by separating immunisation (both pediatric and adult) from health check-ups, where feasible, would provide policymakers with a clearer understanding of how resources are allocated within prevention budgets, enable more

accurate tracking of expenditure trends over time, and support monitoring of progress toward life-course immunisation objectives. This additional granularity could also strengthen the evidence base for assessing the contribution of immunization programmes to population health, healthy ageing, and health system resilience.

- Throughout the report, there is an opportunity to further strengthen the connections between ageing, multimorbidity, infectious disease risk, health system resilience and preventive care. Greater recognition of these relationships could help provide a more integrated picture of the health challenges facing ageing populations in Europe and support a broader understanding of the contribution of preventive care, including life-course immunization, to population health and health system sustainability.
- We also suggest making the economic value of prevention more explicit in the chapter's introductory framing. Financing and expenditure indicators are not only measures of cost; they also show whether health systems are investing in interventions that can prevent disease, reduce avoidable downstream utilisation and support long-term sustainability. This framing is increasingly important as demographic change, NCDs and health workforce constraints place pressure on European health systems. Within that context, we also suggest a more differentiated interpretation of out-of-pocket expenditure: spending arising from gaps in coverage for needed care raises important financial-protection concerns, whereas expenditure on appropriate self-care for suitable common ailments may enable people to meet health needs without drawing unnecessarily on more resource-intensive care.

Specific Comments

- **Page 4 - Paragraph 1:** *Business at OECD* welcomes the discussion of health expenditure growth and health-system sustainability. Future analyses could explore the extent to which prevention, self-management and health literacy interventions may contribute to improving health outcomes while reducing avoidable healthcare utilisation over time.
 - **After:** "depends on a wide range of demographic, social and economic factors"
 - **Insert:** "including the effectiveness of prevention and health promotion activities."
- **Page 10 - Paragraph 1-2:** *Business at OECD* welcomes the chapter's attention to out-of-pocket spending and financial protection. Future analyses could provide greater differentiation between prescription medicines and non-prescription medicines within household healthcare expenditure. Such distinctions may contribute to a more nuanced understanding of healthcare affordability and access.

The two are related but should not be treated as interchangeable measures. Financial protection depends not only on whether households contribute directly to healthcare, but also on the size, purpose and distribution of those payments and the protections available against unaffordable expenditure. Japan provides a useful illustration: its universal health insurance system combines patient co-insurance with age- and income-related contribution rates and a High-Cost Medical Expense Benefit System that places ceilings on household payments to protect against catastrophic expenditure. Recent peer-reviewed evidence from Japan also found that a 2022 increase in coinsurance from 10% to 20% for higher-income adults aged 75 and over produced modest reductions in outpatient expenditure, while demand remained highly price-inelastic; the authors conclude that income-based cost-sharing may contribute to financial sustainability with limited reduction in access. These findings do not imply that increased cost-sharing is desirable in all circumstances. Rather, they reinforce the importance of examining the design of financial protection rather than interpreting the aggregate out-of-pocket share alone.

This distinction is particularly important for non-prescription medicines. European economic analysis covering 30 countries estimates that self-medication for common ailments

generates substantial direct and indirect savings, illustrating why the composition and purpose of household health expenditure should be considered alongside the aggregate share. We therefore suggest an explicit cross-reference to the financial-hardship analysis in Chapter 7 and, where data permit, greater differentiation between spending arising from incomplete coverage of necessary care and spending associated with appropriate self-care.

Future analyses could distinguish expenditure associated with financial hardship or unmet healthcare needs from expenditure that reflects voluntary investment in prevention, self-care and health maintenance. Such differentiation may support a more nuanced assessment of affordability and financial protection. *Business at OECD* member AESGP research demonstrates that every euro spent in Europe by an individual on non-prescription medicines saves society € 6.70.

- **Page 13 - Paragraph 1:** We welcome the inclusion of spending on medical goods and pharmaceuticals within the broader discussion of healthcare expenditure. Future analyses could also consider the relationship between expenditure on self-care interventions, healthcare utilisation and health outcomes, helping to assess value alongside expenditure.
 - **After:** "...directed towards medical goods (mostly pharmaceuticals),"
 - **Insert:** "including products supporting self-management and prevention,"
- **Page 16 - Paragraph 5:** Evidence on the wider returns from preventive self-care suggests that its value extends beyond direct preventive expenditure. The Global Self-Care Federation estimates that current self-care practices generate approximately USD 144 billion in annual health-system savings globally, save 2.2 billion hours of physician time, generate 43.6 billion additional productive days and add 24 million quality-adjusted life years. It further estimates that the economic and societal benefits of self-care could increase by up to 50% by 2040 with supportive policy environments. This suggests that assessing prevention solely through its share of current health expenditure may understate its wider value, including avoided healthcare utilisation, released workforce capacity, productivity gains and improvements in quality of life.
- **Page 17 - Paragraph 1:** We note that discussions of primary healthcare expenditure frequently focus on physicians and nursing services. Future editions could also consider the contribution of community pharmacists to prevention, vaccination, medicines optimisation, management of minor ailments and support for self-care. Including pharmacy within broader discussions of primary healthcare investment may provide a more complete picture of healthcare delivery across Member States.
- **Page 16 - Paragraph 6:** *Business at OECD* welcomes the analysis of prevention spending and the observation that preventive expenditure remains relatively limited in many countries. Future analyses could further examine the return on investment associated with preventive interventions, including health promotion, health literacy and self-care initiatives, and their contribution to population health and healthcare-system sustainability.
 - **After:** "additional spending on preventive care is still needed"
 - **Insert:** "to improve population health outcomes and support long-term sustainability of health systems and"
- **Pages 16-12: Primary healthcare, prevention and health expenditure by provider:** The chapter acknowledges that primary healthcare is a complex concept and that there is no definitive consensus on which services or providers should be included. Its current proxy is based largely on basic care services delivered by ambulatory healthcare providers. At the same time, the System of Health Accounts places pharmacies within a "retailers" provider category. We recognise that this may be required for accounting consistency, but the

terminology risks obscuring the professional healthcare role of community pharmacies. We suggest using “community pharmacies” consistently in the narrative and clarifying that “retailer” is an accounting classification, not a description of their healthcare function. The OECD’s own Health at a Glance 2025 recognises community pharmacists’ contribution to vaccination, medicine adherence, chronic disease management and medication review. Without this clarification, preventive and primary-care activity delivered through community pharmacy may be under-recognised or mischaracterised in expenditure measures. This would also provide useful context for the chapter’s observation that prevention expenditure appears to be underestimated in a number of EU countries.

- **Page 22 - Pharmaceutical expenditure:** The chapter uses two different descriptions for the same category. The narrative refers to “over-the-counter medicines” as medicines that do not require a physician’s prescription and are generally paid for out of pocket, while the definition and comparability section refers to “self-medication (often referred to as over-the-counter products)”. We suggest using consistent terminology and defining the category primarily through its regulatory status. For example, the chapter could refer to non-prescription medicines – medicinal products classified by the competent authority as not requiring medical prescription – and describe financing separately. This would avoid characterizing the category primarily by who pays for it and would better distinguish the role of medicine within the care pathway from its financing arrangement
- **Page 22 - Paragraph 3:** *Business at OECD* values the inclusion of expenditure on non-prescription medicines within the analysis, as these products constitute an important component of pharmaceutical use in several European countries.

We nevertheless suggest replacing the term “over-the-counter (OTC) medicines” with “non-prescription medicines”. The term *non-prescription medicines* more accurately reflects the range of regulatory frameworks, legal definitions and supply channels that exist across Europe. The term OTC, although part of industry jargon, it lacks a consistent legal or regulatory definition and does not refer to the legal status of a medicine. The term OTC can be misleading and has already been misinterpreted in official papers as the unlawful supply of prescription medicines without a prescription.

Self-care through self-selection and administration represents only one component of the broader concept of self-care, which also encompasses health promotion and disease prevention, health literacy, self-monitoring and self-management, and appropriate interaction with healthcare professionals.

- **Financing incentives for prevention and self-care:** We suggest that the chapter also recognise that financing policy can influence how care is allocated between formal healthcare services and appropriate self-care. International experience demonstrates that financial policy can be designed not simply around reimbursement, but also around prevention and appropriate use of healthcare resources. Japan’s Self-Medication Tax System provides one relevant example. Under the scheme, eligible individuals who undertake specified health-promotion or disease-prevention activities can claim an income-tax deduction for qualifying non-prescription medicine expenditure above an annual threshold. The approach is notable because it explicitly places eligible self-care expenditure within a broader policy framework for prevention and responsible healthcare utilisation.

Japan’s FY2026 tax reform further strengthens the long-term basis of the scheme for switch OTC medicines. We cite the Japanese model not as evidence that an equivalent tax instrument should be introduced in Europe, but as an example of how financing systems can recognise appropriate self-care as part of a prevention strategy rather than viewing all household expenditure on medicines solely as residual out-of-pocket spending.

Supporting resources

1. OECD/Eurostat/WHO. A System of Health Accounts 2011: Revised Edition. [Access here](#)
2. World Health Organization. Financial protection and universal health coverage. [Access here](#)
3. European Parliament and Council. Directive 2001/83/EC, Articles 70-72 – classification of prescription and non-prescription medicinal products. [Access here](#)
4. OECD. Health at a Glance 2025 – Pharmacists and pharmacies. [Access here](#)
5. May, U., Bauer, C. et al. (2023). Self-Medication in Europe: Economic and Social Impact on Individuals and Society. *Gesundheitsökonomie & Qualitätsmanagement*, 28(06), 298-310. [Access here](#)
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9. Japan National Tax Agency. No.1129 – Self-Medication Tax Deduction. [Access here](#)
10. Japan Ministry of Finance. FY2026 Tax Reform – Self-Medication Tax System. [Access here](#)
11. Global Self-Care Federation (2026). The Global Social and Economic Value of Self-Care: Self-Care at the Forefront of Prevention. [Access here](#)

Chapter 6: Effectiveness: Quality of care and patient experience

General Comments

- *Business at OECD* welcomes the *Health at a Glance: Europe 2026 – Chapter 6: Effectiveness: Quality of care and patient experience*, and values its comprehensive assessment of healthcare quality, patient safety and patient-centred outcomes across Europe. *Business at OECD* particularly welcomes the chapter's broad perspective on health system effectiveness, encompassing avoidable mortality, vaccination, patient experience, prescribing practices, cancer outcomes, avoidable hospital admissions and integrated care. The chapter highlights the important contribution of prevention, primary care and care coordination to improving health outcomes and reducing avoidable disease burden.
- We appreciate the chapter's emphasis on patient experience and person-centred care. As healthcare systems increasingly respond to the challenges of population ageing and a growing prevalence of chronic conditions, the active involvement of individuals in their own care becomes increasingly important. Health literacy, patient empowerment and self-care can support prevention, informed health decision-making, treatment adherence, early intervention, and the day-to-day management of chronic conditions, and may therefore contribute to improved health outcomes, better patient experiences of care and healthcare-system sustainability.
- *Business at OECD* also supports the chapter's attention to prescribing practices, polypharmacy and care integration. Given the growing complexity of healthcare needs across Europe, future editions could further explore factors that support appropriate medicine use, continuity of care and effective long-term disease management. Consideration could also be given to the role of patient engagement, health literacy and self-management support in helping individuals navigate healthcare pathways and contribute to the effectiveness of healthcare interventions.

The chapter's discussion of medication safety, multimorbidity and polypharmacy provides a particularly strong opportunity to recognise community pharmacists earlier in the analysis. Pharmacist-led medication review and reconciliation can help identify medicine-related problems, support adherence and patient understanding, and improve continuity of care. The OECD's own *Health at a Glance 2025* notes the expanding contribution of community pharmacists to medication review, chronic disease management and other healthcare services. These established medicines-management competencies are also relevant when health systems consider expanding non-prescription access to suitable medicines, where safe implementation depends on appropriate assessment, counselling and referral.

- In the context of avoidable mortality, the discussion attributes cross-country differences in preventable cardiovascular mortality to smoking and alcohol consumption only. Suggest including insufficient physical activity and obesity among the preventable risk factors.
- In the context of effectiveness & quality, we find analysis highlights the importance of effective prevention and chronic disease management in reducing avoidable hospital admissions for COPD, congestive heart failure and diabetes. Given the close relationship between infectious diseases and exacerbations of many chronic conditions, greater visibility of the factors that contribute to disease destabilization and acute deterioration could further strengthen the discussion around avoidable admissions and chronic disease management.
- In the context of health system effectiveness (chapter 6) and expenditure on pharmaceuticals (chapter 5), we would like to highlight new research that explores the link between the

introduction of innovative medicines in three major drug classes in European countries, and reduced hospitalization and mortality related to the corresponding diseases. The report shows that between 2014 and 2022 use of new medicines is associated with a reduction of 1.83 million years of life lost before age 85 and the reduction of 20.9 million hospital days across 29 European countries, equivalent to freeing up more than 57,000 hospital beds for a full year. In total, pharmaceutical innovation generated € 66.18 billion in socioeconomic benefit across the 29 European countries, including € 38.10 billion in paid work productivity, € 18.96 billion in unpaid work productivity, and € 9.11 billion in direct hospitalization cost savings, corresponding to an average return on investment (ROI) of 5.67.¹⁸

Specific Comments

- The sections on COPD, heart failure, diabetes, stroke and post-discharge care focus heavily on medication, monitoring and prescribing. They should also acknowledge access to cardiac and pulmonary rehabilitation, physical activity support, and structured exercise. In the integrated-care section, “recommended prescribing practices” could become “recommended prescribing practices, rehabilitation, physical activity support and other elements of secondary prevention.”
- **Page 4 - Paragraph 1:** *Business at OECD* supports the emphasis on preventable mortality. Future analyses could also recognise health literacy and self-care as complementary components of prevention strategies, helping individuals adopt healthier behaviours and reduce exposure to preventable risk factors.
 - **After:** “effective primary prevention or other public health measures (i.e. measures taken before the onset of disease or injury to reduce its occurrence)”
 - **Insert:** “such as health literacy interventions and behaviour-change approaches”
- **Page 7 - Paragraphs 1-4:** We welcome the chapter's strong focus on vaccination. Future analyses could explore the relationship between health literacy, vaccine confidence and vaccination uptake, given the important role that citizen understanding and trust play in achieving high immunisation coverage. Community pharmacists can contribute by providing trusted information, supporting appropriate self-care and medicine use, and helping people recognize when referral to another healthcare professional is needed.
- **Page 10 - Paragraphs 2-4:** We welcome the chapter's analysis of person-centred care and care co-ordination. Future editions could further examine the relationship between patient activation, health literacy and positive patient experiences. Patients who are equipped with the knowledge and confidence to manage their health may be better able to navigate healthcare systems and participate in shared decision-making.
- **Page 13 - Safe prescribing in primary care:** We support the emphasis on regular medication reviews, medication reconciliation and appropriate deprescribing, particularly as multimorbidity and polypharmacy increase with population ageing. The chapter could more explicitly recognise pharmacists’ medicines expertise in these activities. Pharmacist-led medication review can support identification of medicine-related problems, treatment optimisation, adherence and patient understanding, alongside referral or collaboration with prescribers where changes to therapy are required. FIP’s medication review framework specifically addresses clinical appropriateness alongside health literacy, self-monitoring, adherence and follow-up. These capabilities also provide a relevant foundation where suitable medicines are reclassified for non-prescription use, as pharmacists may need to

¹⁸ WIFOR institute 2026. How innovation drives health and growth in Europe: Assessing the Return on Investment of innovative medicines. <https://www.wifor.com/en/download/how-innovation-drives-health-and-growth-in-europe-assessing-the-return-on-investment-of-innovative-medicines/?wpdmdl=364001&refresh=6a9f425eb9b731788822110>

assess risk, counsel patients and identify when referral is required.

- **Page 13 - Paragraph 6:** *Business at OECD* welcomes the attention given to medication safety and polypharmacy. As the number of people living with multiple chronic conditions continues to increase, supporting patients in understanding and managing their medicines becomes increasingly important. Future analyses could further explore the contribution of medication literacy, patient education and shared decision-making to safer medicine use.
 - **After:** "Interventions to improve medication safety include regular medication reviews,"
 - **Insert:** "patient education and support for medicine self-management,"
- **Page 19 - Paragraph 1:** We welcome the focus on screening participation. Future analyses could further examine how health literacy and awareness influence participation in cancer screening programmes and early diagnosis.
 - **After:** "self-sampling and digital solutions to improve accessibility and participation"
 - **Insert:** "and strengthen awareness of screening opportunities"
- **Pages 25-29 - Avoidable hospital admissions and integrated care:** We welcome the recognition that effective chronic disease management depends substantially on patients' ability to manage their conditions, supported by education, monitoring and appropriate medicine use. This discussion could be broadened to recognize community pharmacy within integrated chronic-care and transitional-care pathways. Recent FIP work on community pharmacy-led NCD management emphasizes that pharmacy services are most effective when embedded in recognized care pathways and supported by interprofessional collaboration. Integrating accessible healthcare professionals into these pathways can reinforce health literacy, medication continuity and appropriate self-management between clinical consultations and following discharge from hospital.
- **Page 25 - Paragraph 1:** *Business at OECD* welcomes the recognition that effective disease management, regular monitoring, patient education and appropriate use of medicines are important factors in reducing avoidable hospital admissions for chronic conditions. Consideration could also be given to the role of self-care and patient self-management as complementary elements of chronic disease management. Self-care interventions can support symptom monitoring, treatment adherence, informed health decision-making and appropriate healthcare-seeking behaviour helping people maintain better control of chronic conditions and help reduce avoidable hospitalisations.¹
 - **After:** "Effective disease management, regular monitoring, patient education"
 - **Insert:** ", support for self-management,"
- **Page 28-30 (Integrated care section):** In the context of integrated care, future analyses could consider a broader understanding of integrated care that includes community pharmacists, carers and individuals themselves as active participants in care coordination.

Supporting resources

1. Global Self-Care Federation. (2026). *The global social and economic value of self-care 2.0: Self-care at the forefront of prevention*. Global Self-Care Federation. <https://www.selfcarefederation.org/sites/default/files/media/documents/2026-08/EcoSoc%202.0%20-%20Scientific%20Report.pdf>
2. OECD (2025). Health at a Glance 2025 - Pharmacists and pharmacies. [Access here](#)
3. International Pharmaceutical Federation (FIP) (2024). FIP knowledge and skills reference guide for pharmacists supporting self-care. [Access here](#)

4. International Pharmaceutical Federation (FIP) (2025). Advancing health literacy through pharmacist-led public health initiatives: Global insights from a survey and interviews. [Access here](#)
5. International Pharmaceutical Federation (FIP) (2022). Medication review and medicines use review: A toolkit for pharmacists. [Access here](#)
6. International Pharmaceutical Federation (FIP) (2026). Enabling the implementation of community pharmacy-led toolkits for NCD management: Report from a FIP insight board. [Access here](#)

Chapter 7: Accessibility: Affordability, availability and use of services

General Comments

- The chapter provides valuable insights into the current barriers that can limit access to healthcare services despite the widespread coverage arrangements across European health systems.
- *Business at OECD* particularly welcomes the chapter's focus on inequalities in access to care and the disproportionate burden of unmet healthcare needs experienced by socio-economical differences. The findings demonstrate that affordability, waiting times and workforce shortages continue to affect access to healthcare services and contribute to health inequalities across Europe.
- While the chapter provides a robust overview of healthcare accessibility and unmet healthcare needs, in addition to financial, workforce and geographic barriers, future analyses could explore factors that influence healthcare-seeking behaviour and access to care, including health literacy, patient empowerment and self-care. These factors may support individuals in navigating healthcare systems, accessing the most appropriate level of care and making informed health decisions, thereby complementing measures aimed at improving healthcare accessibility.
- We welcome the chapter's analysis of financial hardship and out-of-pocket expenditure and notes that pharmaceuticals and other medical goods represent the largest component of household out-of-pocket spending on health across the European Union. Future editions could consider providing additional analysis of prescription and non-prescription medicines within out-of-pocket spending and affordability assessments. Such analysis may contribute to a more comprehensive understanding of healthcare accessibility and financial protection across Member States.
- Accessibility is influenced not only by the availability of healthcare professionals and services, but also by individuals' ability to understand when, where and how to seek care. Future analyses could further explore how health literacy and self-management capabilities contribute to improving access, particularly for people living with chronic conditions and vulnerable populations. We would welcome recognition that effective access is also shaped by whether suitable health needs can be met through appropriately regulated self-care without first requiring a formal medical consultation. For appropriate common ailments, non-prescription medicines and community pharmacy can provide a timely and accessible route to care, while maintaining clear pathways to medical assessment when needed.

This is particularly relevant in the context of persistent GP shortages, waiting times and "medical deserts" identified in the chapter. Evidence-based reclassification of suitable medicines from prescription to non-prescription status can be one policy mechanism to widen appropriate access and make better use of constrained clinical capacity. Any such approach should remain evidence-based, include appropriate safeguards and referral pathways, and complement rather than substitute for universal health coverage and adequate financial protection.

- We recognize that waiting lists for elective surgeries (e.g., cataracts, hip/knee replacements) remain a profound problem in several countries. Several examples prove that expanding surgical capacity and removing restrictive provider budget ceilings can quickly reduce backlogs. The role of private hospitals representing the fastest, most effective mechanism to expand capacity could be recognized.

- **Accessibility and provider neutrality:** We encourage the report to adopt a more provider-neutral approach when assessing healthcare accessibility. While the chapter focuses on public coverage, private insurance and out-of-pocket expenditure, it gives less attention to the role of private providers in delivering publicly financed healthcare. Public financing does not necessarily imply public provision, and analyses would benefit from clearly distinguishing between financing, coverage and provider ownership.
- **Role of private providers in universal health systems:** In many European health systems, publicly financed care is delivered through a mix of public, private not-for-profit and private for-profit providers. Assessments of accessibility should therefore consider the full capacity available to patients and the extent to which different providers contribute to the delivery of publicly funded care.
- **Data limitations:** We welcome the report's acknowledgement that private-sector activity is not consistently captured in all datasets. However, this limitation should be more explicitly recognised, as cross-country comparisons may be distorted where a substantial share of healthcare activity is excluded. Future work by the OECD could support more comprehensive, ownership-neutral data collection covering public, private not-for-profit and private for-profit providers.

Specific Comments

- **Pages 4 & 19:** The chapter identifies waiting times, distance and shortages of healthcare professionals as important barriers to access. Alongside measures to improve the supply and distribution of doctors, the discussion could recognize appropriate self-care as a complementary access pathway for suitable common ailments. Peer-reviewed modelling across 30 European countries estimates that almost 1.2 billion cases are already managed through self-medication each year, with EUR 26.31 billion in direct cost savings and EUR 10.41 billion in indirect savings; the same analysis estimates that 10-25% of current GP visits for such conditions could potentially be substituted by responsible self-care. These estimates are model-based and should be interpreted accordingly, but they illustrate the potential contribution of non-prescription access to reducing avoidable demand, waiting and travel burdens while preserving clinical capacity for more complex needs.
- **Page 4 - Paragraph 2:** We welcome the analysis of unmet healthcare needs and the emphasis placed on financial, geographic and waiting-time barriers. Given the significant inequalities observed between income groups, consideration could be given to further exploring factors that may influence healthcare-seeking behaviour and access to care, including health literacy, patient awareness of available healthcare pathways and services, and the role of self-care. Appropriate self-care can support individuals in managing certain health needs, making informed decisions about when and where to seek care, and accessing the most appropriate level of support. This may be particularly relevant given evidence suggesting that up to 20% of GP consultations relate to minor self-limiting conditions that may be suitable for self-care and that approximately 1.2 billion cases of minor ailments are already self-managed annually in Europe.¹ Further analysis of these factors may provide additional insight into unmet healthcare needs and healthcare utilisation across different population groups.
 - **After:** "Accessibility to healthcare can be limited for a number of reasons, including cost, distance to the closest health facility and waiting times"
 - **Insert:** "including difficulties in navigating healthcare pathways and accessing relevant information."
- **Page 10 - Paragraph 5:** *Business at OECD* values the inclusion of pharmaceutical coverage within the assessment of healthcare coverage. Given the substantial variation across

countries in the proportion of pharmaceutical expenditure covered by public schemes, future editions could consider providing additional analysis of differences in pharmaceutical reimbursement arrangements and their impact on affordability and access to medicines.

The chapter appropriately assesses coverage through the range of services included in benefit packages and the proportion of costs financed by public or compulsory schemes. For medicines, however, financial coverage is only one dimension of access. Regulatory classification also determines whether a person must first obtain a prescription before accessing a medicine. We therefore suggest acknowledging evidence-based Rx-to-OTC reclassification as a potential access policy mechanism for suitable medicines. A 2025 systematic review of the triptan switch experience in Germany found overall positive effects on access, quality of care, health-related quality of life and socioeconomic outcomes, while also identifying risks for higher-risk groups. This reinforces the importance of robust evidence, clear eligibility criteria, appropriate information and referral safeguards when considering switch.

The chapter could also acknowledge that access pathways for the same active ingredient can differ substantially between European countries because prescription status is generally determined nationally. The AESGP OTC Ingredients Directory currently compares the legal status of 269 active pharmaceutical ingredients across 30 European markets and documents significant variation in whether established ingredients are available without prescription. These differences mean that patients with comparable health needs may face materially different access pathways depending on their country of residence. This could be recognized as an additional dimension when interpreting cross-country differences in access to pharmaceuticals.

- **Page 13 - Paragraph 3:** We support the analysis of out-of-pocket expenditure and catastrophic health spending. The finding that pharmaceuticals and other medical goods account for 42% of household out-of-pocket expenditure on health across the EU highlights their importance within household healthcare spending. Further analysis of expenditure patterns for prescription and non-prescription medicines across Member States may provide useful additional insight into affordability challenges and financial protection.
- **Page 16 - Paragraphs 3-5:** We welcome the discussion of doctor shortages and growing pressures on primary care. Future analyses could explore how prevention, health literacy and self-care contribute to alleviating pressure on healthcare systems and supporting more efficient use of healthcare resources.

We note that community pharmacies represent one of the most geographically distributed healthcare infrastructures in Europe and are frequently the first point of contact for health advice, self-care support and medicine-related services. Future analyses could consider including indicators relating to access to community pharmacies alongside existing measures of healthcare workforce and service accessibility.

- **Page 25 - Paragraph 1:** *Business at OECD* welcomes the recognition of oral health as an important component of overall health and the discussion of inequalities in access to dental care. Given the chapter's findings regarding unmet dental care needs and cost-related barriers, consideration could be given to further examining preventive approaches and factors that support better oral health outcomes.
- **Pages 38 and 41:** The report admits that data for several countries (including the UK, Netherlands, and Sweden) systematically exclude private or privately-funded hospital activities. However, Eurostat and the OECD actively cooperate with national private federations to integrate these volumes. Excluding private hospital data severely underreports actual European healthcare capacity and distorts cross-country efficiency

metrics.

- **Page 43 - Paragraph 1-2:** We appreciate the analysis of waiting times for elective procedures and the comparison of developments before and after the COVID-19 pandemic. Future editions could consider further exploring the relationship between waiting times, patient-reported experiences and approaches that support individuals in managing their health while awaiting treatment, including patient education, self-management support and appropriate self-care interventions where relevant.²

Suggested additional box with specific information and data from Switzerland

- Evidence from Switzerland illustrates the potential relevance of health literacy for healthcare accessibility. The Swiss Health Literacy Survey 2019-2021 found that 49% of the population reported frequent difficulties in dealing with health information and services, while 74% showed limited health literacy in navigating the healthcare system. These findings suggest that accessibility depends not only on the availability and affordability of healthcare services, but also on people's ability to identify, understand and navigate appropriate healthcare pathways.^{1,2}

Supporting resources:

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2. Erni, P., von Overbeck, J., Reich, O., & Ruggli, M. (2016). netCare, a new collaborative primary health care service based in Swiss community pharmacies. *Research in Social and Administrative Pharmacy*, 12(4), 622-626. DOI:10.1016/j.sapharm.2015.08.010.
3. May, U., Bauer, C., Schneider-Ziebe, A., & Giulini-Limbach, C. (2023). *Self-Medication in Europe: Economic and social impact on individuals and society*. *Gesundheitsökonomie & Qualitätsmanagement*, 28(06), 298-310. <https://doi.org/10.1055/a-2089-5142>
4. Witter, S., Thomas, S., Topp, S. M., Barasa, E., Chopra, M., Cobos, D., Blanchet, K., Teddy, G., Atun, R., & Ager, A. (2023). *Health system resilience: a critical review and reconceptualisation*. *The Lancet Global Health*, 11(9), e1454-e1458. [https://doi.org/10.1016/S2214-109X\(23\)00279-6](https://doi.org/10.1016/S2214-109X(23)00279-6)
5. May, U., Bauer, C., Schneider-Ziebe, A. and Giulini-Limbach, C. (2023). *Self-Medication in Europe: Economic and Social Impact on Individuals and Society*. *Gesundheitsökonomie & Qualitätsmanagement*, 28(6), 298-310. [Access here](#)
6. Global Self-Care Federation (2026). *The Global Social and Economic Value of Self-Care: Self-Care at the Forefront of Prevention*. [Access here](#)
7. Association of the European Self-Care Industry (AESGP) (2023). *Self-Care in Europe: Economic and Social Impact on Individuals and Society*. [Access here](#)
8. Imanuel, C.A., Atwan, Z. and Tabche, C. (2025). The public health impact of the Rx-to-OTC switch of triptan in Germany: Systematic review and framework analysis. *Journal of the American Pharmacists Association*, 65(6), 102489. [Access here](#)
9. Millier, A., Cohen, J. and Toumi, M. (2013). Economic Impact of a Triptan Rx-to-OTC Switch in Six EU Countries. *PLOS ONE*, 8(12), e84088. [Access here](#)

10. AESGP (2024). OTC Ingredients Directory - comparative legal status of non-prescription medicines across European markets. [Access here](#)
11. Global Self-Care Federation (2025). Advancing Self-Care: The Critical Role of Rx-to-OTC Switches in Empowering Health and Expanding Access. [Access here](#)
12. Uliana, T. et al. (2026). Analyzing Prescription Drug to Over-the-Counter Drug Switch Rejections: Understanding Regulatory Concerns, A Global Overview. Clinical Therapeutics, 48(2), 148-158. [Access here](#)

Chapter 8: Resilience: crisis preparedness, response capacity and fiscal sustainability

General Comments

- *Business at OECD* welcomes the *Health at a Glance: Europe 2026 – Chapter 8: Resilience: crisis preparedness, response capacity and fiscal sustainability*, and its focus on strengthening the capacity of health systems to anticipate, respond to and recover from crises. The inclusion of climate and environmental change as a factor shaping crisis preparedness is particularly welcome. The experience of COVID-19 and the subsequent development of the European Health Union have highlighted the importance of prevention, preparedness, continuity of care and the ability of health systems to maintain essential services during periods of disruption.⁴ We also welcome the chapter's treatment of resilience as a distinct dimension of health system performance and supports its definition of resilience as "the ability to prepare for, absorb, recover from and adapt to shocks".
- Against this background, we encourage the OECD to consider self-care as an additional dimension of health system resilience. Investing in health today, including in prevention, health literacy and self-care, supported by robust governance and strategic collaboration, represents one of the most fiscally prudent strategies for achieving resilient economies and sustainable health systems.⁷ Alongside measures such as intensive care capacity, teleconsultations, workforce capacity and preparedness, self-care can strengthen resilience by supporting individuals to take a more active role in managing their health, improving health literacy, enabling appropriate early intervention and helping maintain access to care when health systems are under pressure. It can also contribute to the continuity and sustainability of essential health services by reducing avoidable demand and allowing healthcare professionals to focus on patients with more complex and urgent needs.¹⁰
- Self-care may become increasingly important in the context of population ageing, workforce shortages and rising healthcare expenditure, all of which are identified in this chapter as key challenges for European health systems. By empowering individuals to manage minor ailments and appropriate aspects of long-term conditions, self-care can support more efficient use of limited healthcare resources while contributing to better health outcomes. Recent literature has also emphasised the role of self-care interventions as strategic investments that can strengthen health system resilience, responsiveness and sustainability.⁹
- Additionally, self-care already represents a significant component of healthcare delivery in Europe. Estimates suggest that between 70% and 80% of healthcare needs are managed outside hospitals, while approximately 1.2 billion cases of minor ailments are self-managed annually. In addition, up to 20% of GP consultations relate to minor, self-limiting conditions that may be suitable for self-care. Current estimates indicate that self-care generates approximately €36.7 billion in annual savings across Europe, including more than €26 billion in reduced healthcare costs and over €10 billion in avoided productivity losses. Analyses further suggest that wider uptake of appropriate self-care interventions could generate an additional €17.6 billion in annual savings and release healthcare capacity equivalent to approximately 58,000 general practitioners. These figures illustrate the existing and potential contribution of self-care to health-system capacity, sustainability and resilience.^{1,5}
- More broadly, the OECD could consider how its measurement framework could better capture the contribution of prevention, self-care and health literacy to maintaining health and supporting longer healthy lives. Current indicators largely measure existing ill health, healthcare utilisation and system capacity. Complementary metrics focused on preventive behaviours, individual capability, health outcomes and healthy ageing would provide greater

insight into how health systems support long-term individual and population health.

- It could be explored whether, and how, the contribution of self-care could be reflected in future analyses of health-system resilience, preparedness and prevention where comparable data are available. With this broader measurement framework, potential indicators could include healthcare utilisation patterns, such as GP consultations, emergency department visits and hospital admissions, the number of potentially avoidable consultations, healthcare capacity released, health outcomes, and associated costs or cost-effectiveness. Such analysis could help assess the contribution of self-care to prevention, demand management and the continuity of care during periods of increased pressure on health systems. Importantly, measures of healthcare utilisation should be considered alongside health outcomes to ensure that reductions in healthcare use reflect appropriate self-care rather than unmet healthcare needs.¹⁰
- The report gives limited attention to pharmacists and community pharmacies despite their important contribution to healthcare accessibility, continuity of care and health-system resilience. As one of the most widely accessible healthcare infrastructures, community pharmacies often serve as citizens' first point of contact with the health system. Pharmacists support prevention, health promotion, health literacy, self-care, the safe use of medicines, and the management of minor ailments and chronic conditions. Given growing workforce shortages, population ageing and increasing pressures on healthcare access, future analyses could more explicitly recognise pharmacists and community pharmacies as an integral part of primary healthcare and health-system resilience.¹⁹
- The chapter outlines alarming demographic replacement pressures, with one-third of doctors and one-fourth of nurses approaching retirement. The private hospital sector calls for multi-stakeholder strategies to make nursing attractive again, focusing on improving workplace culture, flexible scheduling, and supporting advanced practice nurse roles. Government initiatives to increase medical/nursing graduates must ensure clinical training placements are equally allocated across both public and accredited private hospitals to optimize training capacity.
- We also find a potential area for further consideration to be the strong routine immunisation programmes across the life course warrant greater visibility within the resilience framework. On a day-to-day basis, they provide routine protection, reduce preventable illness and help limit pressure on health services. They also provide essential systems, infrastructure and delivery capacity that can support countries in responding at speed and scale during outbreaks and other health emergencies.
 - Beyond protecting individuals from vaccine-preventable diseases, adult immunization can contribute to reducing severe illness, hospitalizations and pressure on health system capacity, particularly among older adults and individuals living with chronic conditions. As Europe faces growing demographic pressures, workforce constraints and rising healthcare and long-term care expenditure, greater recognition of the contribution of prevention, including life-course immunization, could help strengthen the link between routine service delivery, preparedness, population health, healthy ageing and the long-term sustainability of health systems.
- We observe that the indicators built on this definition focus exclusively on the system's

¹⁹Examples include: during COVID-19, supporting vaccination programmes, testing, the preparation of disinfectants and continuity of treatment when other services were curtailed; in response to avian influenza (H5N1), supporting the controlled dispensing of antivirals and access to personal protective equipment; supporting people displaced by the war in Ukraine, including by facilitating access to medicines, advice and vaccination; during major power outages in Spain and Portugal, continuing to provide guidance and helping maintain access to medicines where possible; more generally, helping maintain continuity of treatment during emergencies and relieving pressure on other parts of the health system;

capacity to absorb demand and provide no insight into the factors that determine how much demand arises in the first place. The capacity of a population to manage appropriate health needs without recourse to clinical services is a determinant of how much of that buffer is consumed, and it is absent from the framework. Peer-reviewed European analysis covering thirty countries estimates that between 10% and 25% of current general practitioner consultations could be substituted by self-care. Whatever the precise figure, a variable of that magnitude directly bears on the demand a health system must absorb in a crisis, and the publication currently has no way of observing it. We suggest the publication consider whether its resilience framework should include a demand-side dimension alongside the four supply-side dimensions it currently contains

Specific Comments

- **Page 3 - Paragraph 1:** We welcome the chapter's emphasis on preparedness capacities and operational readiness. Future analyses could also explore community resilience and population preparedness, including health literacy and individuals' capacity to manage health needs during public-health emergencies.
 - **After:** "This chapter presents indicators related to health system resilience - the ability to prepare for, absorb, recover from and adapt to shocks."
 - **Insert:** "including the capacity of individuals and communities to respond appropriately to health threats."

Future analyses could also consider the role of trusted health information, health literacy and public preparedness in supporting resilience to climate-related health risks and other population-level health threats. Resilience depends not only on institutional preparedness but also on individuals' capacity to understand risks, navigate services and take appropriate preventive action.

- **Pages 4-5 - Crisis preparedness and confidence in institutional readiness:** The chapter reports 'Surveillance (87) and laboratory capacity (80) were the strongest areas', while "scores were lower, and varied more widely between Member States, for human resources (65), risk communication (66), and the legal and financing arrangements underpinning IHR implementation (67)".

Risk communication is the capacity of a system to convey health information that the population can receive, understand and act on under pressure. Its effectiveness therefore depends on the population's capability as much as on the institution's messaging, and that capability is unequally distributed. Chapter 3 of this publication identifies health literacy as one of the resources whose unequal distribution shapes disability-free life expectancy, and Chapter 1 documents people turning to unregulated conversational artificial intelligence for health information outside service hours, concentrated "in the evening and at night, when conventional services are least accessible".

We suggest the chapter develop its risk communication finding rather than reporting it once, and that the publication consider measuring the population-side capability on which risk communication depends. A validated health literacy instrument, for example the HLS19-Q12 short form, would allow that to be reported alongside the institutional score.

- **Page 10 - Paragraph 1:** We welcome the discussion of teleconsultations as part of healthcare-system resilience. Future analyses could further explore how telehealth supports prevention, self-management, follow-up care and management of chronic conditions, particularly among ageing populations and people living in remote areas.
 - **After:** "Remote consultations can improve access and continuity of care,"

- **Insert:** "and support ongoing self-management and monitoring of health conditions."
- **Pages 13-18 - Medical and nursing graduates. Indicator 5, Age profile and training origin of doctors:** The chapter presents two main responses to shortages of skilled staff: expanding education and training, and international recruitment. Community pharmacy is notably missing from this workforce resilience discussion. This is a significant omission given the OECD's own Health at a Glance 2025 recognition of community pharmacists as accessible healthcare professionals providing services including medication review, adherence support, vaccination and chronic disease management.

A third response to workforce pressure is therefore to make better use of the skills already available across the health workforce. Chapter 7 already recognises that redistribution of appropriate tasks can improve access and reduce waiting times. We suggest that the resilience chapter apply the same logic more broadly by including community pharmacists explicitly within its discussion of skill mix, task shifting and scope of practice, alongside doctors and nurses.

This matters for resilience because some health needs can be managed safely through community pharmacy or responsible self-care without a clinical consultation. Making use of these pathways can preserve deployable clinical capacity for more complex needs and can be implemented more quickly than workforce expansion that depends on multi-year training or international recruitment.

- **Page 19 - Paragraphs 1-3:** We welcome the chapter's focus on digital health infrastructure. Future analyses could further consider citizen-facing digital health tools, including digital health information resources, **electronic Product Information** (ePI) and digital support for self-management, as complementary components of resilient health systems.
- **Page 19 - Paragraph 4:** We propose the following insertions:
 - **After:** "...notably the Recovery and Resilience Facility (RRF).."
 - **Insert:** "and lately, the New Economic Governance Framework."
 - **After:** "...With RRF-funded investments due to be completed by 2026.."
 - **Insert:** "With the National and Regional Partnership Plans set to shape investment priorities under the next EU budget 2028 - 2034, they could play an important role in supporting continued investment in health infrastructure and strengthening the resilience and capacity of health systems across Europe."
- **Page 22 - Paragraphs 1-4:** *Business at OECD* welcomes the chapter's analysis of long-term expenditure pressures associated with ageing populations. Future analyses could further examine the contribution of prevention, health literacy, self-management and self-care interventions in supporting healthy ageing, maintaining functional capacity and potentially reducing avoidable healthcare utilisation.

The United Nations University Centre for Policy Research notes that existing estimates point to as much as USD 119 billion in potential savings from self-care and is examining how governments can integrate self-care into universal health coverage and development-financing strategies. This also raises a broader financing question: how health systems can shift from predominantly financing treatment after illness occurs towards financing and incentivising prevention, early action and appropriate self-care, while maintaining equity and financial protection.

We also propose the following insertions:

- **After:** The end of paragraph 1
- **Insert:** "At the same time, greater investment in prevention can deliver substantial returns by reducing the burden of preventable disease and associated healthcare costs, with public health interventions, in particular adult vaccination programmes offering particularly strong potential for return on investment."²⁰
- "These projections provide a useful indication of the potential budgetary...": We propose to amend the last sentence in this paragraph to as follows
- **Insert:** "A healthy-ageing assumption embedded in the baseline scenario highlights the importance for longer life expectancy to translate into additional years in good health through effective investment in prevention and public health to contain healthcare and expenditure growth, while also supporting a healthier and more productive workforce and boosting labour productivity - an increasingly important driver of EU economic growth in the context of demographic change."²¹

Proposed additional box with specific information and data from Switzerland

- **"Self-care as a Building Block of Resilient Primary Care: Evidence from Switzerland**

Readily accessible, high-quality non-prescription medicines can strengthen the resilience of primary care by enabling people to manage minor, self-limiting conditions that are suitable for self-treatment, thereby preserving physician resources for patients who genuinely require medical care. A recent health economic analysis by Bauer et al. (2026) quantifies this capacity-relieving effect for Switzerland. The model estimates that each case in which a physician consultation is substituted by use of non-prescription medicines frees up approximately 15 minutes of physician time. Without the current level of self-care, general practitioners would, according to the model, have to work almost three additional hours per day. Alternatively, if working hours remained unchanged, nearly one-third more full-time physicians would be required. In addition, the model estimates that self-medication avoids almost CHF 1.3 billion in healthcare costs and nearly CHF 350 million in productivity losses in Switzerland each year.²

This capacity-relieving effect is particularly relevant in view of increasing workforce pressures in primary care. The fifth Swiss Workforce Study indicates a substantial future replacement need: 22% of currently practicing general practitioners will need to be replaced by 2030 and 40% by 2035. At the same time, the amount of time devoted to direct patient care has declined by around six hours per week since 2005, while the administrative burden has increased. More than three-quarters of the surveyed general practitioners already perceive a shortage in their region.⁶

Swiss research also shows that shortages in primary care capacity affect healthcare provision. Bischof and Kaiser (2021) show that, following the closure of their general practitioner's practice, patients make persistently less use of general practitioner services while increasing their use of specialist and hospital outpatient services. GP visits declined by 12%, while specialist visits increased by 11% and hospital outpatient visits by 6%. The effects of practice

²⁰ Masters, R., Anwar, E., Collins, B., Cookson, R., & Capewell, S. (2017). "Return on investment of public health interventions: a systematic review". *Journal of Epidemiology and Community Health*. Office of Health Economics (2024). "Socio-Economic Value of Adult Immunization programs."

²¹ B. Goranova, S. Calvo Ramos (2026), The Impact of Ageing on the Fiscal Sustainability of EU Health Care Systems Projections and Policy Responses.

closures on access to primary care are particularly pronounced in regions where physician density is already low.³

A complementary analysis by Schärer (2026) shows that, in such regions, the remaining general practitioners partially increase their activity following practice closures but are unable to fully compensate for the lost capacity.^{8,10}

These findings illustrate two complementary dimensions of resilient primary care. On the one hand, sufficient workforce capacity is required to absorb additional pressures and the loss of individual healthcare providers. On the other hand, resilience can be strengthened through the targeted use of available resources. Readily accessible, high-quality self-medication can help preserve scarce physician capacity for health problems requiring medical expertise. It therefore complements measures to secure the future primary care workforce and ensure sufficient healthcare capacity. Health literacy, access to appropriate non-prescription medicines, and competent advice and triage by pharmacists and other qualified healthcare professionals are important prerequisites. In Switzerland, drugstores ("Drogerien") also perform such a role as qualified dispensing points for non-prescription medicines."

Supporting resources

1. Association of the European Self-Care Industry (AESGP). (2021). The economic and societal value of self-care in Europe. AESGP.
[AESGP-Summary-Report-Self-Care-in-Europe-Economic-and-Social-Impact-on-Individuals-and-Society.pdf](#)
2. Bauer, C., May, U., Schlosser, J., & Schneider-Ziebe, A. (2026). Der wirtschaftliche und soziale Wert gesundheitlicher Eigenverantwortung durch Selbstmedikation in der Schweiz. Eine gesundheitsökonomische Analyse des Status quo und künftiger Potentiale. [*The Economic and Social Value of Individual Responsibility for Health through Self-Medication in Switzerland. A Health Economic Analysis of the Status Quo and Future Potential.*] Unpublished manuscript; publication in preparation.
3. Bischof, T., & Kaiser, B. (2021). Who cares when you close down? The effects of primary care practice closures on patients. *Health Economics*, 30(9), 2004–2025. <https://doi.org/10.1002/hec.4287>
4. Gallina, S. (2023). Preparing Europe for future health threats and crises: the European Health Union. *Eurosurveillance*, 28(5), 2300066. <https://doi.org/10.2807/1560-7917.ES.2023.28.5.2300066>
5. mfe Haus- und Kinderärzte Schweiz. (2025). *Neue Workforce-Studie 2025 zeigt: Ohne Hausärztinnen und Hausärzte droht eine Versorgungslücke im ganzen Land.* [Official Media Information.](#)
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 11. Global Self-Care Federation (2026). Strengthening Pandemic Prevention and Preparedness Through Self-Care and Access to Non-Prescription Products. Position paper, August 2026. [Access here](#)
 12. OECD (2025). Health at a Glance 2025 - Pharmacists and pharmacies. [Access here](#)
 13. M-POHL, WHO Action Network on Measuring Population and Organizational Health Literacy (2021). International Report of the European Health Literacy Population Survey 2019-2021 (HLS19). [Access here](#)