Executive summary

Health care systems in OECD countries are better than ever at promoting improved health and longevity, yet they involve major budgetary commitments that countries struggle to keep in check. Pressure is ever-mounting to provide greater and more equitable access to quality care and new treatments to ageing populations.

A significant share of health spending in OECD countries is at best ineffective and at worst, wasteful. One in ten patients is adversely affected during treatment by preventable errors, and more than 10% of hospital expenditure is allocated to correcting such harm. Many more patients receive unnecessary or low-value care. A sizable proportion of emergency hospital admissions could have been equally well addressed or better treated in a primary care setting or even managed by patients themselves, with appropriate education. Large cross-country variations in antibiotic prescriptions reveal excessive consumption, leading to wasted financial resources and contributing to the development of antimicrobial resistance. The potential for generic medicines remains underexploited. Finally, a number of administrative processes add no value, and money is lost to fraud and corruption. Overall, existing estimates suggest that one-fifth of health spending could be channelled towards better use.

This report takes a systematic approach to: i) identifying ineffective and wasteful activities within health care systems; ii) analysing their causes and the actors involved; and iii) providing a catalogue of suitable countermeasures. Acknowledging the existence of ineffective spending and waste might not be easy for health workers, managers and even the politicians responsible for health care systems. But this report highlights the positive corollary to this difficult admission: opportunities exist to release resources within the system to deliver better value care. Cutting ineffective spending and waste could produce significant savings – for policy makers struggling to cope with ever-growing health care expenditure, the opportunity to move towards a more value-based health care system is one that must be pursued decisively.

This report pragmatically deems as "wasteful": i) services and processes that are either harmful or do not deliver benefits; and ii) costs that could be avoided by substituting cheaper alternatives with identical or better benefits. Linking actors – patients, clinicians, managers and regulators – to key drivers of waste – errors and suboptimal decisions, poor organisation and co-ordination, incentives misaligned with health care system goals, and intentional deception – helps to identify three main categories of wasteful spending:

- Wasteful clinical care covers avoidable instances when patients do not receive the right care. This includes duplicate services, preventable clinical adverse events – for instance, wrong-site surgery and many infections acquired during treatment – and low-value care – for instance, medically unnecessary caesarean sections or imaging.

- Operational waste occurs when care could be provided using fewer resources within the system while maintaining the benefits. Examples include situations where pharmaceuticals or medical devices are discarded unused or where lower prices could be obtained for the inputs purchased (for instance, by using generic drugs instead of originators). In other instances, costly inputs are used instead of less expensive ones, with no additional benefit to the patient. In practical terms, this is often the case when patients seek care in emergency departments, end up in the hospital due to preventable exacerbation of chronic disease symptoms that could have been treated at the primary care level, or cannot be released from a hospital in the absence of adequate follow-on care.
- Governance-related waste pertains to resources that do not directly contribute to patient care. This category comprises unneeded administrative procedures, as well as fraud, abuse and corruption, all of which divert resources from the pursuit of health care systems' goals.

All OECD countries are already seeking to tackle waste. At least 10 countries produce atlases to identify variations in health care activities that may not be medically justified, and 19 countries use Health Technology Assessment (HTA) to help determine the value of some new treatment options. Nearly half of OECD countries are actively striving to promote greater prescription of generic drugs. At least 14 countries have strengthened access to primary and community care services to divert inappropriate visits from emergency departments. To date, though, only a few have set up comprehensive and transparent adverse event reporting systems, which encourage learning and foster prevention of future problems, or systematic approaches to detecting fraud and abuse. Overall, significant opportunities still remain for more systematic efforts.

Better information is key. Generating and publishing indicators (such as those on unnecessary or low-value care, overprescription of antibiotics, and delayed hospital discharges) is required to bring the scale of the problem to the attention of a wider public. Today, no country can report on the unnecessary use of magnetic resonance imaging for low back pain and only five can link antibiotic prescription to diagnostics. Data on delayed discharges are available for only three countries. Such data are needed to inform policies to target waste through regulations, incentives, and organisational and behavioural changes.

Sustainable change can be achieved if patients and clinicians are persuaded that the better option is the least wasteful one. Approaches such as the *Choosing Wisely*® campaign illustrate what is possible. This clinician-led initiative aims to reduce low-value care by encouraging patient-provider conversations about whether specific services truly add value. It is now active in at least a third of OECD countries. Changing habits is often a necessary and key way to tackle waste – whether to improve adherence to clinical guidelines, increasing the safety of care, or to convince patients not to rush to the emergency department or request antibiotics at the first sign of a cold.

Incentives also matter. Policy makers should create an environment that rewards provision of the right services rather than their quantity – for example, by moving towards payment systems that promote value for patients across the stages of care delivery. As many as a third of OECD countries already seek to reward different types of providers for results achieved rather than for the number of interventions. To reduce the incidence of unnecessary health care services and wasteful failures in co-ordination, a handful of payers, most notably in the United States but also in Sweden, Portugal and the Netherlands, have moved towards bundled or population-based payments, with some promising results.

In addition, direct interventions to prompt organisational changes and co-ordination among providers are required to reduce wasteful spending. Good practice examples include the development of explicit discharge planning – seen in at least five countries – or the joint procurement of hospital pharmaceuticals. Many revolve around ICT-enabled sharing of information among different stakeholders – although efforts to develop a more complete picture of the full care pathways can be impeded by inadequate health data governance frameworks. Finally, regulation can have a role to mandate or expand desired practices – such as the use of HTA in coverage decisions, or accreditation to impose safety standards – or to ban undesired ones – for instance, self-referrals or inappropriate marketing.

Strategies to reduce waste can be summed up as: i) stop doing things that do not bring value; and ii) swap when equivalent but less pricy alternatives of equal value exist. While these solutions may not always require profound remodelling of health care systems, they do involve investment and behavioural changes. Substantial room exists to release resources by tackling health care system waste across the OECD.