Zeumed
HEALTH ECONOMICS AND POLICY ADVISORY

Low Value Care:
Why Payment Design Matters

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Health Economics and Policy Advisory

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Introduction

Low Value Care as a Reimbursement and System Performance Issue

Healthcare coverage costs continue to rise across high-income health systems, consistently outpacing both inflation and household income growth and increasing the share of expenditure borne directly by individuals and households through insurance premiums and cost sharing.

These increases are commonly attributed to demographic change, the introduction of new technologies, and rising hospital costs. Less attention is paid to the contribution of services that deliver little or no clinical benefit. The OECD estimates that up to one fifth of healthcare expenditure makes limited contribution to patient outcomes. In Japan, more than one third of patients received at least one unnecessary service within a single year. In the United States, Medicare alone spends an estimated $3.6 billion annually on procedures that are not supported by clinical evidence. Much of this activity carries measurable risk of complications while also contributing to sustained expenditure growth.

The European Commission has recognised the importance of this issue directly. A current Horizon Europe funding call is dedicated specifically to identifying and addressing low value care across European health systems. Experience across multiple countries shows that durable reductions in unnecessary care depend on how reimbursement systems translate clinical evidence into coverage decisions, provider incentives, and contracting structures.

This paper examines the scale and characteristics of low value care, reviews the policy approaches that have been used to address it, and sets out a measurement-led framework for aligning reimbursement structures with clinical evidence.

02

Defining Low Value Care

Clinical Benefit Rather than Cost as the Primary Criterion

The term "low value care" is used in several different ways across the policy and clinical literature. In some frameworks it includes both the overuse of unnecessary services and the underuse of effective care, while in others it refers more narrowly to services that provide little or no clinical benefit. Recent work by the European Commission's Expert Group on Health Systems Performance Assessment defines low-value care from a health system perspective as encompassing overuse, misuse and underuse of healthcare services, including services that are ineffective, inappropriate, harmful or not cost-effective, as well as services that should be provided but are not.[1]

The definition of low value care is often interpreted primarily in economic terms, implying that the issue concerns services that deliver benefit at disproportionate cost. Evidence from large-scale reviews of low value care recommendations shows a different pattern. In most cases, the services identified provide little or no clinical benefit to patients and may expose them to avoidable risk. This distinction has direct implications for policy responses, because services lacking clinical benefit require different intervention approaches from those that are clinically effective but are inefficiently priced.

62%

of low value care recommendations cite absent or minimal clinical benefit as primary rationale

15%

explicitly reference economic value — low value care is primarily a clinical problem

Indeed most recommendations identifying low value care are based on absence of clinical benefit rather than cost. An analysis of 1,167 recommendations, the majority from the Choosing Wisely campaign, found

that lack of clinical benefit was the primary rationale in 62% of cases, while explicit reference to economic value appeared in only 15%.[2]

> *Where services deliver little or no clinical benefit, the relevant policy response concerns coverage conditions and reimbursement eligibility rather than price alone. If the problem is absent clinical benefit, which the evidence suggests it largely is, then the appropriate response is to stop funding the activity through de-implementation.*

This distinction matters for policy. It reframes the question from one of value for money to one of clinical appropriateness, and shifts the locus of intervention from pricing and negotiation to coverage decisions and reimbursement design.

KEY DEFINITIONS

Low value care: Care that delivers no or minimal clinical benefit to the patient, often carrying risk of harm, or are not cost-effective.

De-implementation: The deliberate reduction or cessation of a healthcare practice identified as low value, through changes to guidelines, coverage, or financial incentives.

Unwarranted variation: Differences in the rate of healthcare services across providers or regions that cannot be explained by differences in patient need or evidence — a primary signal of low value care.

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03

The Scale of the Problem

Financial Exposure and Opportunity Cost within Health Systems

Healthcare systems across the European Union collectively spend €1.72 trillion per year on health services.[1] Estimates from the OECD suggest that up to one fifth of that expenditure makes little or no contribution to improving patient health outcomes.[2] While this figure includes several categories of waste, including administrative inefficiencies and operational duplication, it indicates the scale of resources potentially absorbed by activity that does not improve outcomes.

Isolating the share attributable specifically to unnecessary clinical care is more difficult. Direct measurement requires detailed claims data and clinically validated indicators, which are available only in a limited number of systems. Where such measurement has been undertaken, usually at a specialty or individual payer level, the results consistently show that low value activity represents a measurable and persistent component of funded care.

€1.72 trillion

EU annual healthcare expenditure — up to one fifth estimated to deliver no benefit to patient health outcomes

What direct measurement shows

A 2025 study applying 47 measures to Medicare data in the United States identified approximately $3.6 billion in annual Medicare payments for low value services, alongside a further $800 million in out-of-pocket spending by beneficiaries.[3] Applying a broader set of indicators across all payers, the Lown Institute estimates that annual spending on low value care in the United States ranges from $100 billion to $700 billion.[4]

Comparable utilisation-based measurement in Japan found that more than one third of beneficiaries received at least one low value service within a single year across 52 indicators, corresponding to an estimated annual cost of approximately USD 1.7–2.6 billion.[5] Notably, more than 99% of those episodes involved low-cost services delivered at high volume, such as routine testing, repeat consultations and minor procedures. These findings illustrate that the financial impact of unnecessary care does not arise primarily from a small number of high-cost interventions, but from the cumulative effect of routine activity delivered at scale.

In Europe, direct measurement has been possible in systems with sufficiently detailed claims infrastructure. Analysis of data from Techniker Krankenkasse, covering approximately 11 million insured individuals in Germany, found that between 4% and 10.4% of evaluated ambulatory services across 24 indicators were classifiable as low value, corresponding to direct billing costs of €10–15.5 million within the insured population studied.[6] If similar proportions apply across the wider ambulatory sector, this would imply unnecessary activity at a national scale, measured between €5bn and €15bn of unnecessary care.

What the numbers mean in practice

Aggregate estimates can obscure what this activity represents in practice. Two widely studied examples illustrate both the persistence of low value care and the mechanisms through which it can be reduced when reimbursement rules change.

4 million

knee arthroscopy procedures annually

33%

reduction achieved by Norway in four years by embedding clinical thresholds in contracts

Knee arthroscopy for degenerative meniscal disease and osteoarthritis remains one of the most frequently cited examples. Approximately four million arthroscopies are performed annually,[8] yet the Choosing Wisely Guidelines have identified that the procedure offers no benefit over sham surgery or supervised physiotherapy for osteoarthritis and degenerative meniscal tears, the dominant indications in middle-aged

and older patients.[9] Despite this, utilisation increased substantially over two decades across health systems. In England, analysis of more than 1.76 million procedures between 1997 and 2017 found that rates of arthroscopic partial meniscectomy nearly tripled over the period, albeit with a slight decrease in later years, with persistent twofold variation between regions that cannot be explained by differences in clinical need.[10] In Spain, the standardised rate of arthroscopic meniscectomy increased 33% between 2003 and 2018, with the steepest rises in patients over 35 years of age, the group most likely to present with degenerative rather than traumatic pathology.[11]

These patterns demonstrate that the persistence of unnecessary surgical activity cannot be explained solely by uncertainty in the evidence base. In contrast, Norway reduced its national rate by 33% in four years by deliberately embedding clinical restrictions into reimbursement contracts.[12] This experience illustrates how utilisation responds when funding arrangements are aligned with clinical guidance.

Antibiotic prescribing for viral respiratory infections represents a second common example of unnecessary activity with negative consequences. The OECD estimates that up to half of all antibiotic prescriptions across member countries are unnecessary.[13] Surveillance data from the European Centre for Disease Control (ECDC) shows a fivefold variation in community antibiotic consumption across EU Member States, from under 10 defined daily doses per 1,000 people per day in the Netherlands to 28.5 in Greece, despite no corresponding variation in the burden of bacterial disease.[14] A 2023 analysis across multiple European countries found that the majority of antibiotic packages sold for respiratory infections in high-prescribing countries were prescribed for viral conditions, for which antibiotics confer no benefit.[15]

The direct cost of an unnecessary antibiotic prescription is modest, however the downstream consequences are not. Antimicrobial resistance, which is driven in human medicine primarily by antibiotic overuse, is estimated to generate approximately $66 billion annually in additional healthcare expenditure and productivity losses across OECD and EU/EEA countries.[16] Up to 40% of infections in some G20 countries are resistant to antibiotics[13] and the World Bank projects that without intervention, AMR could generate USD 1 trillion in additional global healthcare costs annually by 2050.[17]

Taken together, these estimates indicate that unnecessary clinical activity represents a measurable and persistent component of healthcare expenditure across multiple systems. Its financial impact arises less from isolated high-cost interventions than from the cumulative effect of routine services delivered at scale despite limited or absent clinical benefit. This pattern helps explain why low value care remains a structurally important component of overall health spending rather than a marginal inefficiency affecting only specific procedures or specialties.

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04

Who Pays

Transmission to Households, Employers and Public Budgets

Low value care is often discussed as a problem of health system efficiency. In practice, its financial effects are transmitted through the mechanisms used to fund healthcare coverage. Where unnecessary activity remains included within routine service delivery, the associated expenditure forms part of the baseline costs that determine insurance premiums, payroll contributions and public financing requirements. As a result, the burden of unnecessary care is not borne only by health systems as abstract entities, but by households and indeed employers.

Ultimately the burden of unnecessary care falls on individuals and households in two ways. First, through opportunity cost within the health system itself: a knee arthroscopy of marginal clinical value is a hip replacement not performed, a diagnostic endoscopy deferred, or a mental health referral delayed. Second, through its effect on the cost of maintaining coverage. Expenditure on services without clinical benefit forms part of the claims base used to determine insurance premiums and contribution rates across multiple health financing systems.

This transmission is most visible in insurance-based systems, where increases in routine claims expenditure translate directly into higher premiums or payroll contributions.

PREMIUM TRENDS ACROSS MAJOR MARKETS

Ireland	**€1,929 in 2026 — ~60% rise since 2019**	All three major insurers citing rising private hospital claims as primary driver
Switzerland	**+8.7% (2024), +6% (2025)**	Compulsory premiums have grown at roughly four times the rate of wages since 2000
Germany	**1.7% → 3.1% Zusatzbeitrag**	Variable statutory contribution near-doubled in under two years, 2024–2025

United States	**$25,572 family premium (2024)**	Second consecutive year of 7% growth; rising deductibles compound out-of-pocket exposure
Australia	**+4.41% from April 2026**	Above general inflation rate; industry body explicitly linking rises to low-value interventions in private system

Ireland

In Ireland, the average adult supplementary private health insurance premium reached €1,929 in 2026, an increase of around 60% from 2019. All three of the major insurers cited rising private hospital claims as the primary driver.[1] Because both households and employers finance supplementary private cover, increases of this scale affect the cost of maintaining access to private hospital treatment across the insured population. At the same time, the level of detail published on claims activity is low, limiting the ability of regulators, researchers and consumers to identify which categories of treatment are contributing most to premium growth.

Switzerland

In Switzerland, compulsory premiums have grown at roughly four times the rate of wages since 2000. The federal government has acknowledged that the costs of mandatory health insurance benefits could be reduced by up to 20% through the elimination of ineffective and unnecessary services.[2]

Germany

Premium rises have been particularly pronounced in Germany, where the variable statutory contribution rates essentially doubled in under two years, from a rate of 1.7% of gross salary in 2024, to 3.1% by late 2025. Because statutory health insurance contributions are financed through payroll deductions shared between employers and employees, increases of this scale affect both take-home pay and the cost of employment. Sustained increases in employer social insurance contributions are partially offset through slower wage growth over time, meaning that contribution increases are ultimately borne by households as well as firms.

United States

For the United States, the average employer-sponsored family health insurance premium reached $25,572 in 2024 — the second consecutive year of 7% growth.[3] Although employer-sponsored coverage remains the

dominant form of insurance for working-age households, rising premiums have been accompanied by sustained increases in deductibles and other forms of cost-sharing. As a result, insured households remain directly exposed to the cost of care through out-of-pocket payments. The United States continues to report some of the highest rates of healthcare-related financial hardship among high-income countries, with medical spending remaining a leading contributor to household debt and a persistent source of impoverishing expenditure despite widespread insurance coverage.

Australia

In Australia the federal government approved an average private health insurance premium increase of 4.41% from 1 April 2026, which is above the 3.8% general inflation rate over the same period. Importantly, Private Healthcare Australia, an industry body, has argued that weaknesses in the regulation of medical devices and the Prescribed List are allowing low-value interventions to persist within the private system at significant expense to insured households.[4]

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05

What Has Been Done

Clinical Guidance, Measurement Initiatives and Policy Responses

Efforts to reduce low value care have generally followed three routes: identification of services that should not be routinely used, development of implementation strategies to support de-implementation, and changes to funding or coverage rules intended to alter provider behaviour. The experience across countries suggests that these approaches have not been equally effective. Identification and guidance have been important in establishing clinical legitimacy, but the strongest and most durable reductions have generally been observed where reimbursement or coverage conditions changed.

Clinical identification and professional guidance

The first major step in reducing low value care was to identify where it occurs. The Choosing Wisely campaign, launched in the United States in 2012 and now active across 25 countries, remains the most prominent international initiative in this area.[1] Clinical specialties identified tests, procedures and treatments that should not be routinely used and translated these into consensus recommendations grounded in specialty-led evidence review. This was an important development because it located the definition of low value care within clinical practice rather than payer-driven cost containment.

CHOOSING WISELY — GLOBAL REACH

500+	25+	2012
recommendations across clinical specialties	countries with active national programmes	year launched — now the global standard

PARTICIPATING SPECIALTIES INCLUDE

Cardiology	Oncology	Orthopaedics	Radiology
General Practice	Gastroenterology	Neurology	Paediatrics
Rheumatology	Urology	Pathology	Anaesthesiology

National programmes have extended this model. Spain's No Hacer programme, led by the Ministry of Health, produces specialty-specific "do not do" recommendations through scientific societies.[2] Catalunya's Essencial programme applies a similar approach at regional level through the Catalan Agency for Health Quality and Assessment.[3] Switzerland's Smarter Medicine initiative has adapted the same model within the Swiss system.[4] These programmes have played an important role in clarifying where care is not supported by evidence and in legitimising later efforts to restrict or redesign its use.

From identification to de-implementation

Identification alone does not reduce low value care unless it is followed by implementation. The Choosing Wisely De-Implementation Framework reflects this explicitly. It sets out a staged approach beginning with identification of potential areas of low-value care, followed by local priority setting, assessment of barriers to change, evaluation of implementation programmes, and subsequent spread of effective interventions.[5] The value of this framework is that it recognises low value care as an implementation problem rather than simply an evidence problem.

Review of funded services

A broader system-level example is Australia's Medicare Benefits Schedule Review. Between 2015 and 2020, the Review Taskforce examined all 5,700 items on the national benefits schedule and produced nearly 1,400 recommendations across more than 60 clinical committees.[6] Importantly, the final report did not treat low value care solely as a matter of identifying obsolete items. It also concluded that the structure of financing itself required attention, recommending a shift away from near-exclusive fee-for-service towards more blended payment models.[7] This is significant because it links the persistence of low value care to the architecture of provider payment rather than to information failure alone.

Guidance without strong incentive change

The limits of guidance-based approaches are evident in England's Evidence-Based Interventions programme. NHS England launched the programme in 2019, initially targeting 17 procedures, of which four were not to be routinely funded and thirteen were subject to specified clinical criteria. A second phase later expanded the list to 48 procedures.[8] Independent evaluations found that most targeted procedures were already declining before the programme began, and that the programme itself produced only modest additional reductions.[8] The strongest predictor of responsiveness was not the initiative alone but the degree of financial pressure facing local commissioners.[9] Separate analysis also found that reductions in

NHS-funded activity were partially offset by increases in privately funded volumes of the same procedures.[10]

The English experience is important because it shows that identifying low value services and issuing restrictions does not necessarily produce large behavioural change where incentive structures remain weak or where activity can shift into parallel financing channels.

> *Identification and guidance, without structural incentive change, moved the dial only at the margins.*

Coverage restriction and reimbursement change

The clearest reductions have been observed where low value care was addressed through direct changes to coverage or reimbursement conditions.

In Switzerland, a 2025 study using claims data from SWICA examined two sequential interventions relating to vitamin D testing. First, Smarter Medicine issued a recommendation against routine testing in low-risk patients. Second, a federal coverage restriction that made the test an out-of-pocket expense for low-risk individuals.[11] The use of guidelines alone produced a modest but significant reduction of approximately 6% in tests per physician over twelve months. The coverage restriction, by contrast, produced a 58% reduction within six months. Estimated savings from the restriction alone were CHF 1.58 million over six months for SWICA's insured population, implying national annual savings of approximately CHF 33 million if extrapolated by market share.[11]

Norway provides a second example. In 2012, South-Eastern Norway Regional Health Authority began disseminating evidence against routine knee arthroscopy for degenerative disease. In 2015, it went further and altered the contractual terms applying to publicly reimbursed providers, whether they were public or private facilities. The new contracts required that no more than 20% of knee arthroscopy patients be over 50 years of age and that physiotherapy must have been attempted for at least three months before referral.[12] Three other regional health authorities introduced no equivalent measures. Procedure rates fell by 48% in South-Eastern Norway, compared with 13% elsewhere. In private hospitals specifically, rates fell by 30% in the intervention region while increasing by 63% in the others.[12]

What the evidence suggests

Taken together, these experiences suggest that the problem is not primarily the absence of clinical guidance. In many areas, guidance already exists and has existed for some time. The more important question is whether that guidance is translated into implementation mechanisms strong enough to alter routine delivery. Professional consensus is necessary because it establishes legitimacy. On its own,

however, it has generally not been sufficient. The strongest evidence of effect comes from interventions that changed benefit design, reimbursement eligibility, or contractual conditions for funded care.

Intervention type	Example	Observed effect
Professional guidance	Choosing Wisely / No Hacer	Necessary for clinical legitimacy; limited behavioural effect on its own
Implementation framework	Choosing Wisely De-Implementation Framework	Supports structured de-implementation; effect depends on local incentives
Schedule review	Australia MBS Review (2015–2020)	Identifies obsolete items and structural payment issues; implementation ongoing
Restriction without strong incentives	NHS Evidence-Based Interventions programme	Modest additional effect (~0.10 percentage points); activity partially shifted to private funding
Coverage / reimbursement change	Switzerland vitamin D; Norway knee arthroscopy	Largest observed reductions: –58% and –33% respectively, sustained over time

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06

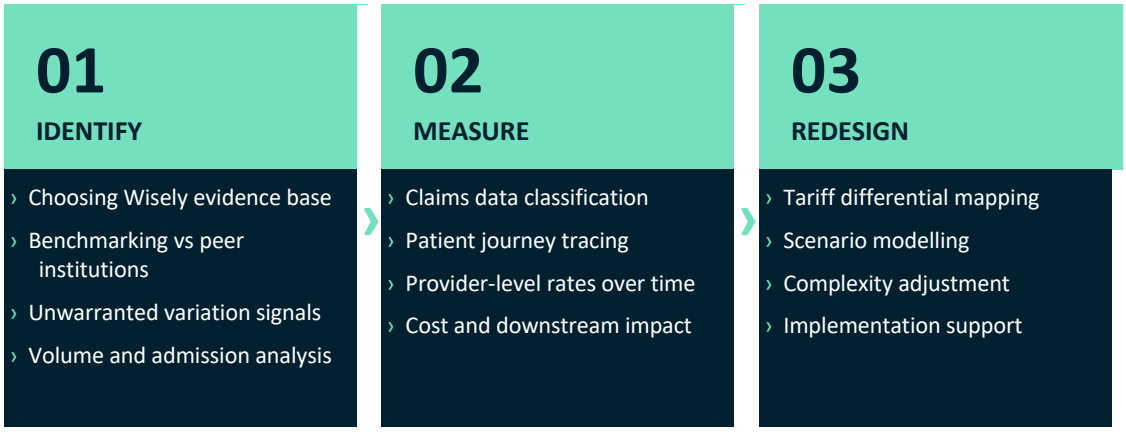
How We Approach This

Claims Analysis, Tariff Design and Implementation Pathways

Reducing unnecessary and low value care requires translating clinical evidence into reimbursement decisions in systems where financial incentives may point in the opposite direction. In some countries, specialty-led initiatives such as Choosing Wisely have already identified areas of care that are unlikely to benefit patients. In others, the starting point may instead be variation analysis, utilisation review, or examination of high-volume services within existing benefit schedules. The practical task in both cases is the same: identifying where unnecessary activity persists within funded delivery pathways and adjusting payment structures in ways that change behaviour without disrupting access to appropriate care.

The Choosing Wisely evidence base provides a useful entry point where it exists. Because these recommendations are produced by clinical societies about their own specialties, they provide a level of professional consensus that makes them difficult to dispute. Beginning from established clinical agreement avoids reopening debates about appropriateness and allows analytical effort to focus instead on measurement, variation and incentive structure. Where equivalent guidance has not yet been developed, the same role can be played by benchmarking, utilisation analysis and structured clinical review.

In practice, implementation follows three linked stages: identifying where low value care occurs at scale, measuring its clinical and financial impact within a specific system, and redesigning reimbursement structures so that funded activity reflects the clinical evidence base more closely.



Where Choosing Wisely recommendations exist, they provide a useful starting point because they are produced by clinical societies about their own specialties and therefore carry a degree of professional legitimacy that is difficult to dispute. They do not, however, show where unnecessary activity is occurring at scale within a given system, or where it is financially material. That requires claims analysis, benchmarking and review of treatment patterns over time.

CLAIMS DATA ANALYSIS

Claims data, cross-referenced against primary and secondary ICD diagnostic codes and prior claims history, allows individual episodes of care to be classified. Rates of inappropriate care can then be examined over time and across providers, identifying persistent variation that cannot be explained by differences in clinical need.

PATIENT JOURNEY ANALYSIS

Claims data also allows the patient journey to be traced beyond the initial episode. A procedure that carries a higher tariff than its conservative alternative may still represent good value if it reduces downstream complications, repeat presentations, or total treatment burden. Where the longitudinal record shows that outcome, it is not a candidate for de-implementation. Where it does not, the case for intervention is stronger.

BENCHMARKING

Not all low value care appears in Choosing Wisely. Descriptive analysis of procedure volumes, admission rates and length of stay — compared against regional benchmarks, peer institutions, and trends over time — identifies the indicators with the largest variation or the greatest financial exposure. These become the priorities for episode-level claims review and reimbursement analysis.

TARIFF DIFFERENTIAL ANALYSIS

Tariff differentials — the gap between what a reimbursement schedule pays for a procedure and what it pays for the conservative management of the same clinical presentation — identify where financial incentives point in the wrong direction. Where that differential is large, treatment patterns are often sensitive to them, with reimbursement levels influencing the balance between operative and conservative management. Research on Medicare physician payments shows that supply of elective procedures is elastic to reimbursement: higher payments shift the treatment mix toward more intensive options with no

measurable improvement in patient outcomes.[1] Mapping these differentials across fee schedules identifies where relatively small adjustments to reimbursement are most likely to change treatment mix.

SCENARIO MODELLING

Scenario modelling translates the findings from claims analysis, tariff comparison and patient journey review into recommendations that can be stress-tested before implementation. The key question is not only whether a reimbursement adjustment is warranted, but how large it needs to be to change behaviour and alter treatment patterns, and what happens at different magnitudes. Small adjustments may have little effect; larger adjustments may produce unintended consequences including financial risks to providers from sudden shocks in reimbursement.

Quantifying provider-level revenue exposure if volumes shift also identifies where changes in reimbursement may lead to withdrawal from a clinical area altogether, with consequences for access to necessary care. For this reason, implementation typically requires advance notice and a transition pathway for providers whose activity is most affected.

HIGH VALUE CARE AND COMPLEXITY ADJUSTMENT

De-implementation and reduction of low value care addresses only one side of the incentive problem. The other is ensuring that high value care, including complex interventions for patients with significant clinical need, is adequately rewarded. Current reimbursement schedules, including DRG-based systems, do not always achieve this. Procedures that vary substantially in surgical complexity are often grouped under the same payment category and paid at the same rate, meaning that providers taking on harder surgical cases may be systematically undercompensated.

Value-based healthcare payment models were intended in part to address this by linking reimbursement more closely to outcomes rather than activity. However, many outcome-linked payment approaches rely on functional forms that assume relatively smooth or linear relationships between intervention and outcome improvement after risk adjustment. In practice, outcome gains are not linear across patients with different levels of clinical severity. Patients with the greatest need often require disproportionate clinical effort for smaller observable outcome changes, which standard adjustment approaches do not fully capture.

Where reimbursement is tied to average outcome response rather than to the marginal clinical effort required to treat higher-complexity patients, providers treating more severe case-mix are systematically exposed to financial risk. Addressing this requires careful specification of complexity adjustment within the payment model itself. Without explicit attention to functional form and the limits of risk adjustment, a reimbursement schedule that removes incentives for unnecessary activity risks may just replace one distortion with another.

THE FULL METHODOLOGY

Identify: Choosing Wisely evidence base, benchmarking, and variation analysis to establish which services are low value and at what scale.

Measure: Claims data analysis and patient journey review to quantify the problem in a specific system, provider, or payer context.

Redesign: Tariff differential mapping, scenario modelling, and high-value care adjustment to build reimbursement changes that reduce unnecessary care without creating new distortions.

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07

Conclusion

Reducing Low Value Care through Reimbursement Alignment

Low value care persists despite a substantial clinical evidence base identifying services that provide little or no patient benefit. In most systems, the issue is no longer one of evidence generation but of implementation: locating where unnecessary activity occurs within funded pathways and adjusting reimbursement structures so that they reflect the clinical evidence more closely.

The scale of the problem is increasingly visible not only in aggregate expenditure but in its effects on households. Rising insurance premiums, increasing payroll contributions and pressure on waiting lists all reflect the continued financing of activity that does not improve patient outcomes. These effects are often treated separately in policy discussions, but they arise from the same underlying misalignment between evidence and reimbursement.

Addressing this misalignment requires detailed analysis rather than programme-level commitments. Claims classification, benchmarking against peer institutions, patient-journey tracing and tariff differential mapping make it possible to identify where unnecessary activity persists and where reimbursement structures are contributing to it. Scenario modelling then allows adjustments to be introduced in a controlled way, taking account of provider revenue exposure and the need to maintain access to complex care.

For this reason, reducing low value care is best understood not as a single intervention but as a structured process of aligning utilisation patterns, reimbursement schedules and clinical evidence. Where these elements are addressed together, the conditions that allow unnecessary care to persist can be changed without introducing new distortions elsewhere in the system.

Zeumed
HEALTH ECONOMICS AND POLICY ADVISORY

About Zeumed

Zeumed is an independent health economics and policy advisory working with governments, insurers and provider systems on the design of sustainable payment structures and coverage policies. Its work focuses on the practical application of clinical evidence within reimbursement systems, including tariff redesign, claims-based utilisation analysis, value-based payment structures and capacity planning.

In the area of low value care, Zeumed supports payers and health systems to translate clinical recommendations into measurable changes in funded activity. This includes identifying unwarranted variation using claims data, analysing treatment pathways and downstream utilisation, mapping tariff differentials between operative and conservative management, and modelling the provider-level effects of reimbursement adjustments before implementation.

The objective of this work is not simply to reduce activity, but to improve the alignment between clinical evidence, treatment patterns and payment structures while maintaining access to complex care.

Zeumed operates across Europe and the Middle East and works directly with national payers, ministries of health, insurers and hospital systems on reimbursement reform, financing strategy and the economic evaluation of system change.

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