care. First, this means abdicating of the notion of evidence-based medicine. If the user wants to take antibiotics, have a cesarean delivery, or undergo a computerized axial tomography (CAT) scan every time she has a migraine, this is what the service should offer him, because this is what she values. Second, this means abdicating of all equity concerns about resource allocation in healthcare, i.e. ‘like treatment of like individuals’. Indeed, the value-based concept implicitly defines needs according to willingness to pay, so that care is diverted towards those who better express this willingness (the better off) and against those who do not (the worse off).

It is therefore urgent to return to the scientifically robust notions of evidence-based medicine, the health of the population and equity in health so that the concept of value is not adulterated for purposes that are ill-suited to maximizing social well-being.

Conflicts of interest: None declared.

References

Julian Perelman
NOVA National School of Public Health, Public Health Research Centre, Universidade NOVA de Lisboa, Portugal

Correspondence: Julian Perelman, Escola Nacional de Saúde Pública, Avenida Padre Cruz, 1600-560 Lisboa, Portugal, Tel: +351 217512196, Fax: +351 217512128, e-mail: jperelman@ensp.unl.pt
doi:10.1093/eurpub/ckb026
Advance Access published on 20 June 2021

Value-based care: requiring conceptual checks and international balances

In his viewpoint, Perelman points to three potential risks associated with reorienting health systems towards value-based care: adverse effects of pay-for-performance schemes; the existence of monopolies in innovative pharmaceutical product markets; and the risk of providing inappropriate treatments if patients’ preferences should over-ride evidence-based recommendations. In this reflection, we would like to express the need for conceptual clarification regarding the term ‘value,’ and argue that international cooperation can help to mitigate some of these risks, while striving for value-based care.

Policy learning

Rather than being regarded as a blueprint for reorganizing health systems, the concept of value-based care is often used as a guiding principle.1–2 In policy learning, it is important to understand the local context into which innovations are being introduced and the local ‘twist’ that stakeholders give to innovations. For instance, Steinmann et al.3 show that in the Netherlands, shared decision-making is seen as an integral part of value-based care, in contrast to the original concept. At the same time, the issue of competition among providers is largely absent in the Dutch interpretation of value-based care, despite that fact competition forms the cornerstone of Porter and Teisberg’s thesis.4 International scientific fora, such as the European Public Health Association and others can serve as platforms for policy learning regarding value-based care. TO-REACH, e.g. is an initiative that aims at developing a framework for the identification, transferability and scaling up of organizational innovations in health and social care (https://eupha.org/to-reach). Essential for policy learning is a clear and shared understanding of the phenomenon of interest.

Conceptual checks

Unfortunately, the notion of value in health care, popularized by Michael Porter, has led to some conceptual confusion. While it is widely recognized that optimizing patient outcomes as efficiently as possible constitutes a proper aim in health care (summarized as value = outcomes/costs), its implications for various stakeholders appear to be ambiguous. Moreover, several academic texts casually refer to Porter’s perspective on value, without fully appreciating some crucial underlying assumptions.3

This often leads, for instance, to a direct association of Porter’s views with pay-for-performance schemes (P4P). This connection is mistaken: Porter explicitly argues that instead of P4P, healthcare systems should move to bundled payments (BP) for full cycles or episodes of care. The distinction is crucial: intrinsic to P4P is the presupposition that better care will always be more expensive, but this runs against the goal of value. BP, however, aim to reward efficiency while also holding providers accountable for achieved outcomes. In the value-based system envisioned by Porter, excellent providers are not directly rewarded with financial bonuses (P4P),
but indirectly, through an increased market share: ‘patients-for-
performance’.

Additionally, although the idea is indeed that value should be
‘defined around the customer’, this does not imply that the uncon-
strained demands of individual customers should therefore dictate
exactly what providers must offer. This would mistakenly confuse
the value-based goal to efficiently improve a patient’s health status,
with a radical consumer-based logic that is clearly ill-suited for
the health sector. In value-based care, treatments that do not lead to
improved outcomes should be deemed ineffective and not be pro-
vided. Thus, to use one of Perelman’s examples, prescribing anti-
biotics to a patient diagnosed with a virus infection just because he
or she wants to—not an uncommon phenomenon by the way—will
not improve outcomes, despite having costs, and is therefore not
value-based.

Furthermore, in European healthcare systems, the range of treat-
ments that can be offered depends largely on the technologies that
have been granted access to the market, and which of these are being
reimbursed by payers. In this regard, international cooperation is of
particular interest.

**International balances**

Reimbursement decisions are ideally informed by health technology
assessment (HTA) in which the relative effectiveness of a healthcare
intervention is compared to an alternative. HTA requires specific
scientific expertise and is labour intensive. Hence, a division of la-
bour between healthcare systems is efficient. This is one of the
reasons why many European Union (EU) member states have been
cooperating in the European Network for Health Technology
Assessment (EUnetHTA) (https://eunethta.eu/) and why EU regu-
lations on HTA has been proposed.

In a full HTA, as in value-based care, the benefits of treatment are
weighed against the costs associated with treatment, measuring—as
Perelman points out—the incremental cost per quality-adjusted life
years. In measuring benefits, HTA and value-based care use similar
outcome measures, preferably focussing on outcomes that are rele-
vant for patients. How to define what matters to patients and how
to select or develop measures that are valid, reliable and fit-for-pur-
pose, requires a participative process guided by scientific expertise.
It would be inefficient if single providers and systems would have to
invest in producing that knowledge. For that reason, the
International Consortium for Health Outcome Measurement
(IChOM) (https://www.ichom.org/) has been established. IChOM
defines global standard sets of patient-relevant outcome measures.
In doing so, it builds on measures that have been developed by other
international organizations, such as the European Organization for
Research and Treatment of Cancer.

Apart from benefits, the focus in HTA and value-based care is also
on the costs of technologies. As Perelman argues, public financers
negotiate better prices with the pharmaceutical industry in case
drugs are not cost effective, but this model has proven to be insuf-
ficient to suppress price inflation. This brings us to another mech-
anism along which international cooperation can enhance value:
standing strong together. European countries cooperate in price
negotiations, for instance through the Beneluxa initiative (https://
beneluxa.org/collaboration). The Beneluxa initiative aims for sus-
tainable access to medicines through joint price negotiations for
specific products. In addition, it builds on exchanging expertise
(i.e. policy learning) and mutual recognition of HTAs (i.e. division
of labour).

Cooperation in the Beneluxa initiative has sparked yet another
example of international cooperation. In order to anticipate
effectively on price negotiations, authorities need early insight in
new pharmaceutical products and in new indications of existing
products that are coming to the market. This common need has
led to the establishment of the International Horizon Scanning
Initiative (IHSI) (https://ihsi-health.org/). Of the international ini-
tiatives that we presented in this comment, IHSI is the most recent
one in Europe and currently consists of eight participating coun-
tries. However, it is open for other EU Member States to join and
share valuable expertise and resources in an effort to enhance the
value of care for European taxpayers.

**Conclusion**

It is widely recognized that value for patients constitutes a proper
aim in health care. Yet, conceptual mix-ups complicate the academic
debate on value-based care. We hope to have contributed to some
clarification. Perelman ends his viewpoint by stressing the urgency
to stick to the scientifically robust notions of evidence-based medi-
cine, health of the populations and equity in health in order to
maximize social well-being. We agree that this is important.
However, we argue that—in view of a globalized market—
European public health systems can do that more efficiently and
effectively by working together in international initiatives, than on
their own. International cooperation enables public health systems
to divide labour, to join forces and to learn from each other.

**Conflicts of interest:** Diana Delnoij is chairman of the board of the
International Horizon Scanning Initiative.

**References**

value-based healthcare at a Swedish University Hospital—a longitudinal
interview study. *BMJ Health Serv Res* 2017;17:1.

analysis on value-based health care. *BMJ Health Serv Res* 2020;20:862.

3 Porter ME, Teisberg EO. *Redefining Health Care: Creating Value-Based Competition

4 Fredriksson JJ, Ebberg D, Savage C. Pseudo-understanding: an analysis of the di-

5 Boers M. Governance of European Cooperation Processes in Health Technology

6 Kalf RRJ, Vreman RA, Delnoij DM, et al. Bridging the gap: can International
Consortium of Health Outcomes Measurement standard sets align outcomes
accepted for regulatory and health technology assessment decision-making of on-