

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.

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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 override 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.*² 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.³ 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.⁴

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 unconstrained 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 provided. Thus, to use one of Perelman’s examples, prescribing antibiotics 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 treatments 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 labour 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://eunetha.eu/>) and why EU regulation on HTA has been proposed.⁵

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,⁶ preferably focussing on outcomes that are relevant for patients. How to define what matters to patients and how to select or develop measures that are valid, reliable and fit-for-purpose, 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 financiers negotiate better prices with the pharmaceutical industry in case drugs are not cost effective, but this model has proven to be insufficient to suppress price inflation. This brings us to another mechanism 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 sustainable 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 initiatives that we presented in this comment, IHSI is the most recent one in Europe and currently consists of eight participating countries. 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 medicine, 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.

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