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## Viewpoints

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### Value-based care: a good idea, many caveats

#### A good idea

The advantages of reorienting the health system toward value-based care are known.<sup>1</sup> First, the focus on ‘service production’ decreases, contrary to hospital financing in several countries, where the payment per service prevails.<sup>2</sup> Unnecessary acts are diminished that do not create value because benefits do not justify their costs. Second, as the focus is on health outcomes, prevention and health promotion are favored. Third, as the focus is not on the provision of services by a particular professional or institution, integration of care is promoted. However, there are major risks that must be taken into account, notably the way(s) in which the idea is conceived, implemented and can be used.

#### *Implementation (1): the questionable payment for value*

The main practical consequence of value-based care has been the worldwide implementation of value-based payment to health care providers, also known as payment for performance (P4P).<sup>3</sup> This payment model directs financial rewards to those who achieve better results in terms of health, quality of care or satisfaction. Yet, recent reviews point to small effects limited to the short term.<sup>4</sup>

To understand the possible causes of the disappointing results, one can invoke the insufficiency of incentives, or the way they are attributed. Also, the adverse effects of P4P are pointed out, including professionals focusing too much on the indicator values while neglecting other activities.<sup>5</sup> Others have however criticized P4P more fundamentally, pointing out the danger of P4P replacing the professionals’ intrinsic motivation by the search for profit.<sup>6</sup> As a consequence, P4P becomes indispensable to motivate health workers because it has undermined the natural reward of providing good care.

#### *Implementation (2): exorbitant prices based on value*

In many countries of The Organisation for Economic Co-operation and Development (OECD), the price of new medicines has been based on value for many years (i.e. value-based price in action), through the need, for reimbursement and price definition, to demonstrate that medicines are ‘cost-effective’.<sup>7</sup> In fact, like value, cost-effectiveness means that gains related to therapy justify an additional cost, assessed for each new therapy, by measuring the incremental cost per quality-adjusted life years. The notion of value encourages the public financier to negotiate better prices with the pharmaceutical industry in case drugs are not cost-effective. Yet, this model has proven to be insufficient to suppress price inflation,<sup>8</sup> endangering the sustainability of health systems.

The economic inefficiency of this system has been clearly described.<sup>9</sup> The value-based price means that prices are set according to our ability to pay, that is, the greater the expected gain, the higher the price that we are expected to pay—and that we *will* pay. This notion rests on a fundamental principle of economics—that consumers define their preferences by the price they are willing to pay. To give a simple example, an antibiotic that saves the life of a newborn child who goes on to live for 80 years, yields a gain of

80 years of life; if a year of life is valued at 30 000 euros, it means that the value-based price of the antibiotic is  $80 \times 30\,000 = 2.4$  million euros. This is the value-based price that the company that markets the antibiotic could claim.

Why is the antibiotic not sold for 2 million euros in practice? In a competitive market, the price based on value is driven down by the mechanism of competition. In the realm of healthcare, especially when it comes to innovation, we are faced with situations of monopoly exercised by large pharmaceutical companies that distribute products to patients in situations of great need. It is this monopoly, in conjunction with the inelastic need for many therapies, that fuels the emergence of prohibitive prices based on value—far higher than what prices would be in a functional market. Alternatives to prohibitive prices based on value have been pointed out, that is, prices based on development and roll-out costs, presented in a transparent way, together with public and collaborative R&D financing models.<sup>10</sup>

#### *Implementation (3): value as the consumer’s choice*

This notion of value is originally defined by Michael Porter as the ratio of ‘health outcomes per dollar spent’,<sup>1</sup> with a very cautious definition of health outcomes. On the one hand, it rejects the notion of user satisfaction as a central element, due to the risk of excessive focus on aspects such as the friendliness of the professionals. On the other hand, it highlights the patient subjectivity regarding health outcomes, referring to the measurement of quality of life.

However, the very notion of subjective value questions this cautious view. From an economic perspective, the value corresponds to what the customer/user is willing to pay. On the business side, the rhetoric of ‘value creation’ means, in practice, the ability to produce a service that can be sold at a price higher than its cost, generating profit. Ideally, based on an inexpensive product (e.g. a portion of ground beef), we can produce a product presented in a way that generates the appearance of greater value (a gourmet hamburger) and for which the consumer can be expected to pay an elevated price. ‘Value is created’.

Michael Porter’s own text, mentioning that ‘the value must be defined by the consumer, not by the provider’,<sup>1</sup> does not put an end to this commercial reading. If we assume that the consumer/user must be at the center of the concept of value, then it is their preferences and their subsequent valuation that must dictate what is valuable. The providers are now focused on creating value, in the strict sense that Porter initially gives (quality-adjusted life expectancy), or in the original economic sense of producing a service for which the customer can be expected to pay more.

This value perspective assumes that the health sector is a market like others, with informed consumers exercising their freedom of choice according to their preferences. Yet, we have long known that the idea of the rational consumer in health is hardly credible; although increasingly informed, the specific lack of competence in the use of information makes users particularly vulnerable to any manner of quackery (consider the current pandemic).

This deviation can be seen as positive if we include among preferences elements such as humanity in care, but also as negative if it opens the door to a purely commercial view of the provision of

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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*Julian Perelman*

NOVA National School of Public Health, Public Health Research Centre, Universidade NOVA de Lisbon, Portugal

**Correspondence:** Julian Perelman, Escola Nacional de Saúde Pública, Avenida Padre Cruz, 1600-560 Lisbon, Portugal, Tel: +351 217512196, Fax: +351 217512128, e-mail: jperelman@ensp.unl.pt

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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.<sup>1–2</sup> 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.*<sup>2</sup> 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.<sup>3</sup> 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.<sup>4</sup>

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),