Value-based healthcare’s blind spots: call for a dialogue

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Abstract
The value-based healthcare (VBHC) concept was first proposed as a solution to many of the ills of healthcare. Since then, we have seen the term “value” defined, used, confused, and interpreted in multiple ways. While we may disagree that competition based on value will solve healthcare’s complex challenges, value is a concept integral to the future of healthcare. Before VBHC becomes consigned to the long list of quality improvement trends and management fads that have passed through healthcare, we call for a dialogue around the term value and the implications of its different interpretations. The intention is not just to critique, but to facilitate ongoing efforts to substantially improve healthcare in ways that are relevant and sustainable for society at large.

Keywords
value-based healthcare, patient values, quality improvement, sustainability, co-creation, co-evaluation
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**Introduction**

In the face of expanding needs and demand for healthcare, coupled with rising costs, inequities, and undesirable variation in healthcare outcomes and care experience, there has been a surge of interest in the idea of value-based healthcare (VBHC) as a solution. Who could argue with adding value to patients and society through our efforts in healthcare? However, things are not that simple when we consider the many ways in which the term is being interpreted and used in practice around the globe.

In discussions about VBHC, it becomes clear that the word “value” is used in multiple, sometimes overlapping, or even contradictory ways. As pointed out in a recent report by the European Commission, many definitions exist, which causes confusion. This lack of consensus leads to misunderstanding between actors who share the same goal of improving care, where these misunderstandings can further entrench differences in perspectives. The aim of this article is to open a dialogue to reconsider VBHC, by clarifying some different lines of thought on the term value and implications of different uses, to facilitate efforts to improve health care systems. We will first consider the idea of values as a conviction or belief that individuals or social groups consider right, good, or desirable. Second, we will consider the term value in an economic sense of optimizing the use of finite resources. We will then illustrate how these two applications of the word value are often used interchangeably when the term VBHC appears. Unclear use of these two very different meanings makes it difficult to progress on how to define, operationalize and measure VBHC. Both meanings are important, but they point to very different concepts and assumptions.

**Values (convictions that guide decisions)**

Let’s start with values, broadly and in plural, and then consider patient values in particular. Values are basic convictions among individuals or social groups; what they consider right, good, or desirable and what is most important in life. They are influenced by background and culture, but also by experiences and life events – including education or professional training. In daily life, values influence individuals’ behaviors, and guide their evaluation of people, choices, and actions. Specific values such as integrity, balance, fairness, or autonomy are brought to the forefront when they are relevant to a particular context. A systematic review of studies where patients articulated what they mean by values, found that patients value their autonomy, consider themselves unique and a whole person, they want clinicians who exhibit professionalism, who listen and have empathy. In clinical interactions, people want to be empowered and to work in partnership. Patient preferences can be considered as expressions of those values.

When considering professional values, we can think of altruism, equality, capability, but also pleasure or intellectual stimulation. Most professionals eventually become a patient (or a patient’s next of kin), and enough have shared those experiences in writing that has generated its own literature genre. Some patients also become healthcare practitioners. As Virchow’s science of medicine has come into better balance with a return of the “art” and “humanity” of medicine as narratives of personal experience are integrated into curricula.

The same trend can be seen in efforts to design and measure quality and improvement. Patient flows should be mapped from patients’ perspectives. Evaluations increasingly attempt to capture patient reported outcomes and experience measures (PROMs and PREMs), and patient-provider consultation frameworks, which create more space for patients to share the health and care experiences, and subsequently demonstrate a greater valuing of these outcomes and experiences by clinicians.

This is especially the case when decisions need to be made. Shared decision making (SDM) needs to be focused on the awareness of possible differences in knowledge and experience of the patient in comparison with the healthcare professional versus the unfamiliarity of the professional with the individual patient’s disease burden, lived experiences, experiences of care, values, and preferences. These items are part of the discussion during SDM integral to the co-production approach. The combination of society’s and individual patient’s values, person-centered care and shared decision-making, leads to the view that healthcare is not a product, but a service, and a service is always co-produced.

Furthermore, possible outcomes of different treatment options can also be part of this discussion. These outcomes consist of a complex combination of clinically reported outcomes (e.g. survival, organ function improvement, recurrence rate, complications, mobility, activities of daily living, etc., and of patient reported outcomes (PROs), e.g. functional status including physical as well as psychological wellbeing, quality of life, social aspects such as return to normal life etc. In a recent Dutch discourse analysis on VBHC (see Box 1), even though four different discourses were recognized, the common grounds were related to SDM: outcome information should eventually be used within the consultation room, SDM was perceived as a core element in VBHC, value was redefined as the personal result of a good interaction between healthcare professionals and patients.
Value (in an economic sense)

VBHC was preceded by a very rich quality improvement (QI) science and practice and has integrated a great deal of QI’s learning models. For example, costs were a part of Juran’s cost of quality11 and the clinical value compass.14 VBHC has brought this relationship to the fore as a focus for measurement. With measurement comes the possibility for comparison. This can be with oneself over time, i.e. a historical comparison, or with others. Comparison raises the question of the role competition can have in driving quality. Health outcomes can be assessed in relation to processes of care, what is done to achieve these outcomes, how resources and competencies are used, including costs. In VBHC, costs should cover the full cycle of care, not limited as often is the case now to a care provider organization or certain drugs or interventions. The result of this assessment, i.e. the relationship between the Health Outcomes achieved and the Costs required to attain them, is what we consider to be Value, value for patients and society, but this is not equivalent to patient value or what patients value. Porter and Teisberg state that ‘value is outcomes achieved per dollar spent’ and ‘The goal is “what matters to patients” and “this unites the interests of all actors in the system”’.15

Yet, while VBHC as it was originally presented recognized the patient in the complexity of the healthcare system, the line of reasoning did not move much beyond that. Outcomes are clinically defined by medical condition, but neither the aspirations, priorities and preferences of the patient, nor societal goals, are explored. Instead, the focus moves to using the relationship to expose the competitive traits of care givers to drive improvement. The Value concept itself was not new and VBHC was preceded by a very rich QI science and practice and even to the point that one wonders what VBHC adds to the existing QI discipline.

Within VBHC, (Time-Driven) Activity-Based Costing is the recommended approach, but it has proven challenging to fully implement16 and often, in practice, supports more of the process improvement efforts we recognize as a staple in QI. VBHC assumes competition will lead to better quality, but this may turn out to be more tied to contextualized political ideologies rather than the medical culture of competition between physicians,15 certainly in Europe.

VBHC might be seen as the next in a long series of quality improvement trends, each introduced with a striking regularity as the end-all solution to health systems current ailments. Cataloguing this parade of health management concepts, Walshe illustrated (using the number of publications regarding each concept per year) how each is introduced, gains popularity for 3-5 years, before waning, soon to be replaced.17 The curious thing, he noted, was that each new concept tended to share much content with its predecessors. It might come with a new tool or approach, but is it enough to justify a whole new label and all the fanfare, or is it another example of pseudo-innovation? Part of the explanation is that certain stakeholders have a desire to market new ideas, to attract attention, acclaim, and, perhaps new business. So, is this also the case with the VBHC concept? A review of articles citing Porter’s trendsetting article on VBHC seems to support this claim.18 For example, the idea that the value of healthcare is important can be traced to the early emergence of modern quality improvement theory in healthcare. Even the value equation – i.e. that health outcomes achieved per amount of resource expended – played a central role, but then it was packaged under the term, “The Clinical Value Compass”, which was published alongside guidance on how to enhance value through continuous healthcare improvement.14

Separating the ideas

We need both person-centered care through co-produced health care service with SDM (values/context-based decisions), and we need to optimize the use of finite resources for societal efficient co-production of user co-designed healthcare also grounded in societal values. We may disagree with the idea that competition based on value will solve healthcare’s cost and quality conundrum. Either way, enhancing the value of healthcare by improving health and other outcomes while reducing the costs for achieving those outcomes remains a key concern for health systems everywhere.19 How to succeed is a core challenge for society and all stakeholders i.e. clinicians, managers, academics, health system leaders, politicians, citizens and (“third-party”) payers. In recent years, patients and their family and friends have increasingly joined forces in the pursuit of better health and healthcare through different forms of co-production.20

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**Box 1. Value-based healthcare: a Dutch discourse analysis.**

In 2020 Steinmann12 conducted a discourse analysis on value-based healthcare (VBHC). He explored both the ambiguity and underlying assumptions that shape various interpretations. The analysis was based on document analysis and semi-structured interviews with key-stakeholders. Steinmann described four discourses: (1) a patient empowerment discourse (VBHC is a framework to strengthen the position of patients); (2) a governance discourse (VBHC is a toolkit to incentivize professionals); (3) a professionalism discourse (VBHC is a methodology for healthcare delivery); and (4) a critique discourse (VBHC is a dogma of manufacturability). Despite the different perceptions, the common ground was shared decision-making as the key-component across all discourses. These different discourses, based on deeply rooted presuppositions, shape the different ways in which VBHC is operationalized in practice.
At the heart of these efforts lie the understanding of how health services contribute to better health, and how to improve these services’ ability to do so, drawing on quality improvement theory as developed over most of the 20th century.13,21 Over the past four decades, this theory has been applied, evaluated, and refined specifically in health services.22,23 Key features include:

- a focus on meeting the needs of those individuals and populations for whom health services are intended
- understanding services in terms of processes and, often complex, systems with a shared aim (e.g. to alleviate the burden of illness; improve health and wellbeing)
- managing variation wisely (e.g. by distinguishing random variation from variation due to a distinct cause, and responding accordingly)
- addressing inequity in health (care)
- promoting learning, collaboration, and deliberate experimentation.

Closely linked to managing variation is the practice of measuring health services’ performance, or quality.24 Such measurement can come with different, sometimes even incompatible, motivations and purposes.25 At its best, quality measurement can promote learning and improvement by highlighting particularly good performance, by bringing attention to areas in need of change, and by providing feedback as such change is introduced.26 Of particular concern are the problems caused by attaching performance-based payment to quality metrics, since that inevitably brings a host of problems, including gaming, incomplete or even inaccurate reporting, and adverse selection of patients (to avoid “looking bad” or losing income).27 This is precisely what VBHC in the competition-sense risks leading to. The problem is that the same measurement that can promote learning and improvement typically cannot also be used to determine financial reimbursement. This represents a huge challenge for proponents of VBHC.

Quality, like beauty, may lie in the eye of the beholder. Nevertheless, it can still be useful to articulate some common attributes of high-quality healthcare. In that vein, the US Institute of Medicine famously proposed that health services which successfully alleviate individuals’ burden of illness or injury are: effective, patient-centered, efficient, safe, timely, and equitable.28 One might argue that ‘sustainability’ is valuable to be added to this shortlist. Patient centered services then are: ‘services planned, delivered, managed, and continuously improved in active partnership with patients and their families to ensure integration of their health and health care goals, preferences, and values. It includes explicit and partnered determination of goals and care options, and it requires ongoing assessment of how care matches patient goals.’29 This patient centered view on healthcare combined with effective, efficient, and safe characteristics, in our opinion, gives a broader basis for a value-based concept. Including timely and equitable and also looking more precisely at long term effects of care brings the item of sustainability as a 7th item in the list of quality determinants. Increasing inequity, as dramatically shown in this recent COVID-19 period, is not easily “fixed”, but should be addressed specifically by all stakeholders involved in healthcare.

Thus, it becomes really complicated since the assessment and valuation of the care or of some treatment is of course performed from the perspective of the patient but might be different if ethical and or societal perspectives are also taken into consideration. So, based on partnership encounters between a patient and his/her healthcare professionals, and in harmony with patient and professional values, using outcomes of other patients with similar conditions, a possible value is determined (outcomes vs costs) for the choices to be made. Again, a process of coproduction. During and after the treatment, together with the patient the real value is assessed by measuring clinician-reported outcomes and PROs, as well as process measures and costs, to if necessary, adapt or even change the treatment or the goals, as a form of coproduction leading logically also to co-evaluation.30 Finally, considering outcomes that really matter to patients in light of the resources expended to achieve those outcomes might conflict with societal, ethical considerations. We should not close our eyes for this tension and should also be part of a dialogue we need to have about value and values. A dialogue about what really matters, inequity in this is a value conflict. A dialogue about the most meaningful impact on healthcare, about getting more health out of the health care system. This cannot be achieved through financial competition but invites to a dialogue about better ways to improve health and health care. VBHC certainly holds premise – provided we remember that there are two fundamental ideas nested in the phrase, one of which has been overlooked so far. We need just as much attention to ‘values’ (what matters when we are ill) as we give to economic value (maximum healthcare per unit of cost). More values are at stake, which presents us with complex dilemmas without clear and simple solutions. We call for a dialogue about how best to promote better health and health care in ways that are relevant and sustainable for our societies.
Data availability
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References


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