Expert Panel on Effective Ways of Investing in Health (EXPH)

Opinion on
Defining value in "value-based healthcare"

Expert Panel on Investing in Health

Provides independent non-binding advice on effective ways of investing in health. Established by Commission Decision 2012/C 198/06 following the Council conclusions of June 2011 'Towards modern, responsive and sustainable health systems'; renewed in 2017

The views in this presentation are those of the independent scientists who are members of the Expert Panel and do not necessarily reflect the opinion of the European Commission nor its services.

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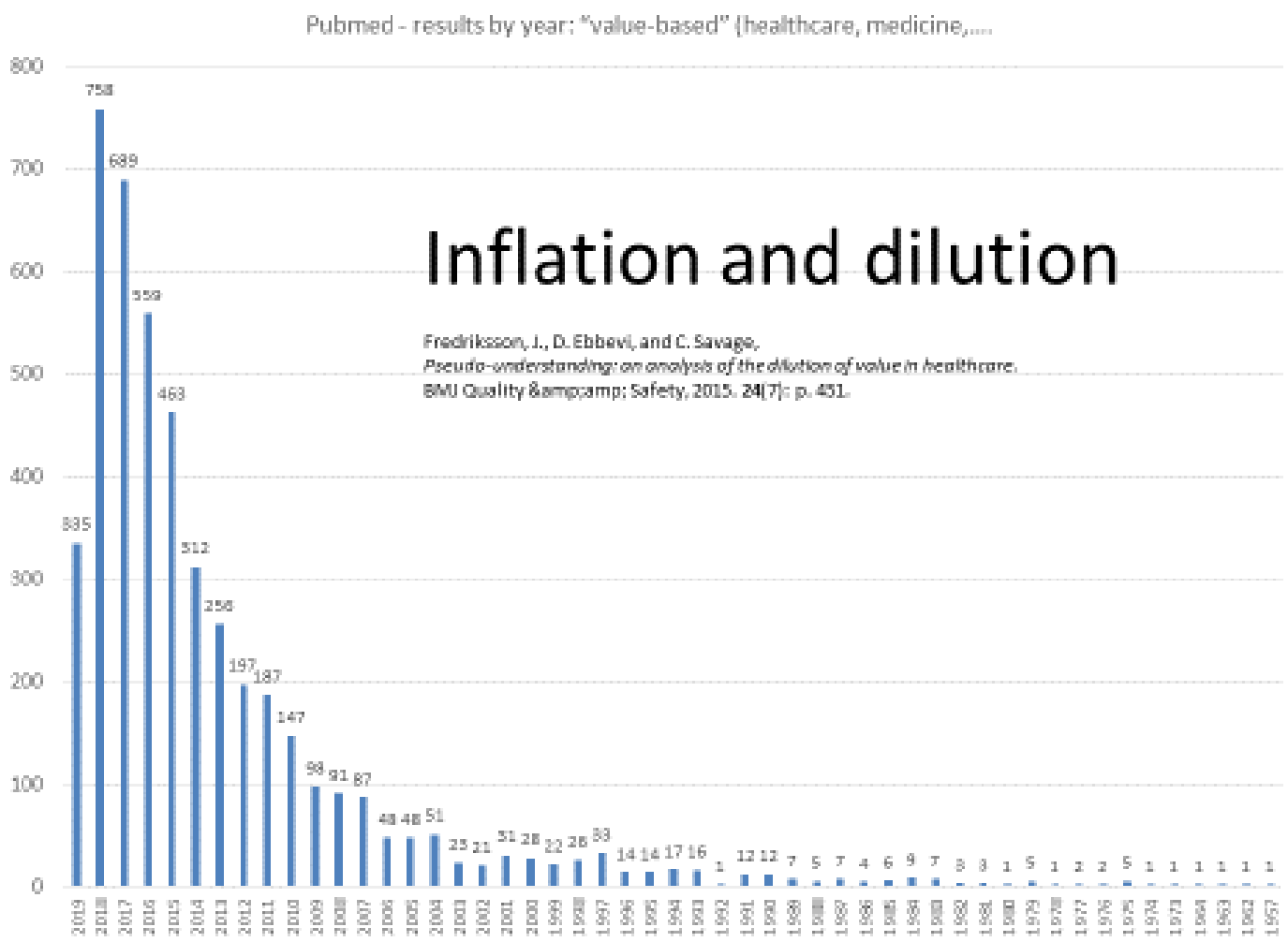
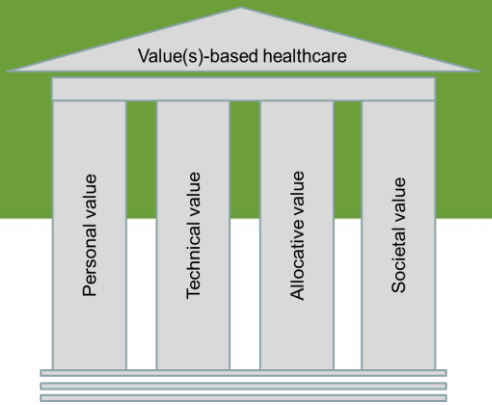


Mandate: TERMS OF REFERENCE

- How do you define value in “value-based healthcare”? What aspects of health systems could the different definitions cover?
- How can “value-based healthcare” inform decision making, contribute to health system transformation, and help health systems across the European Union become more effective, accessible and resilient?



Summary: DEFINITION

The EXPH therefore proposes *to "value-based healthcare (VBHC)" as a* ***comprehensive concept*** *built on four value-pillars: appropriate care to achieve EACH patient's personal goals (personal* ***value****), achievement of best possible outcomes with available resources (****technical value****), equitable resource distribution across all patient groups (****allocative value****) and contribution of healthcare to social participation and connectedness (****societal value****).*

Principles to achieve Value

Awareness to health as essential investment in an equal and fair European society ("health is wealth") and to the centrality of European values of solidarity

Long-term strategy towards a reallocation of resources from low to high value care (as defined by EXPH): freeing resources for reinvestment

How did we get there: methodology

1. Analysis of current situation
2. Identification of initiatives to increase value
3. Appraisal of established instruments and methods
4. Identification of key values
5. Propositions for principles for implementation (& recommendations).

Analysis of current situation

OECD report on “Wasteful Spending in Health” (2017) presented alarming data on inappropriate care and wasted resources with estimations ranging from a conservative 10% up to 34% of expenditures

Unwarranted variation (in investment, activity, access and outcome),

Underuse of effective interventions (prevention, detection, treatment & inequity),

Overuse (overdiagnosis and –treatment, harms).

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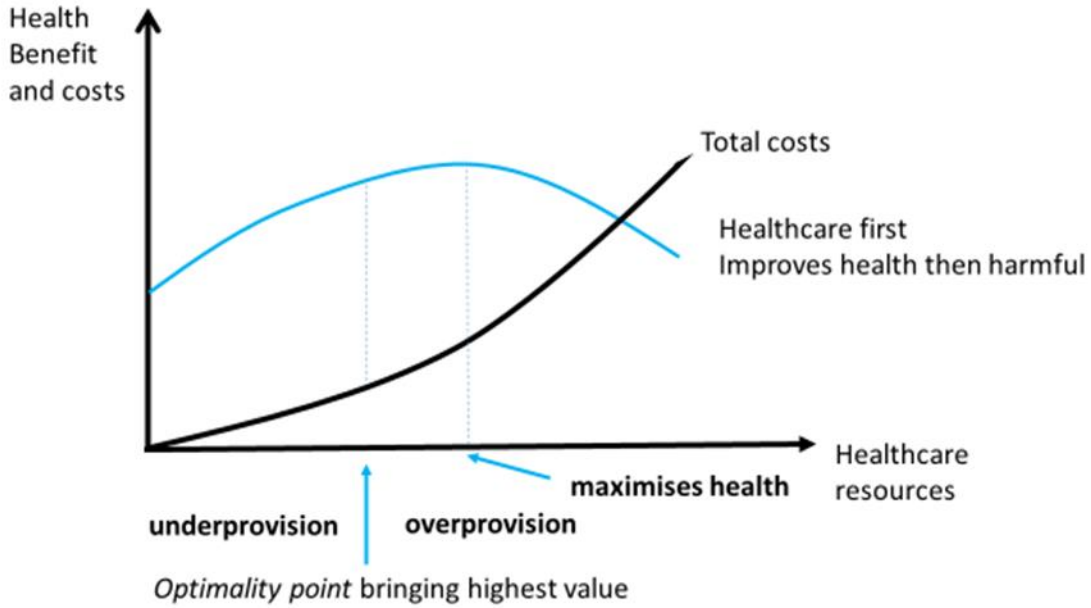
Enormous increase of volume and intensity of activities beyond the „point of optimality“: the health effects are marginal, sometimes even harmful, the costs are high.

Figure 2. Relation between healthcare resources and health



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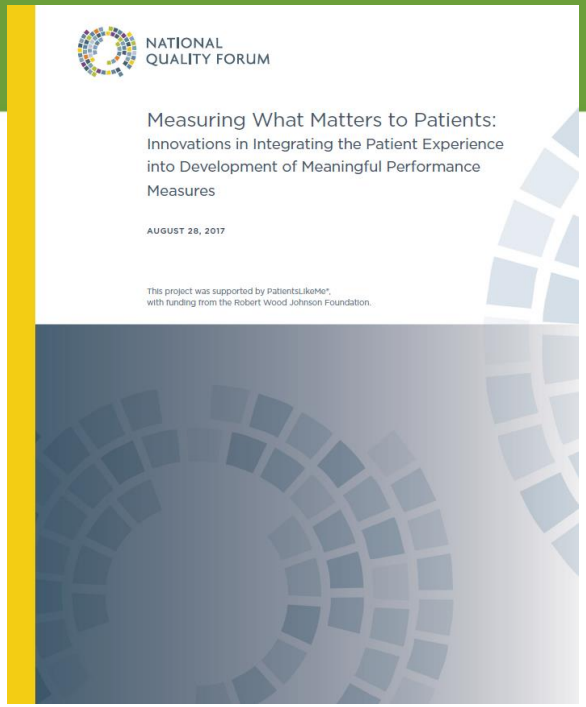
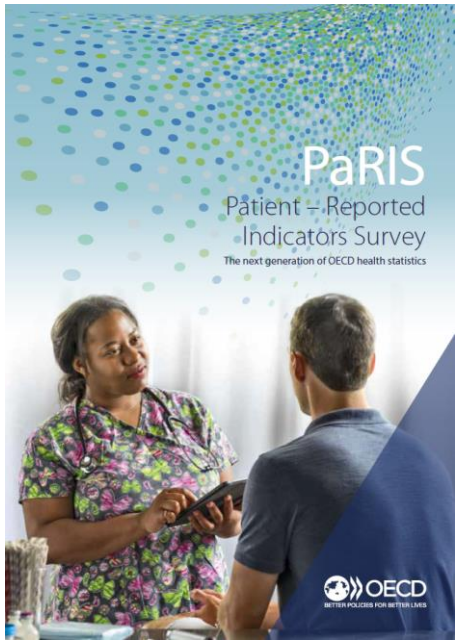
Identification of initiatives to increase value (and reduce waste)

Health

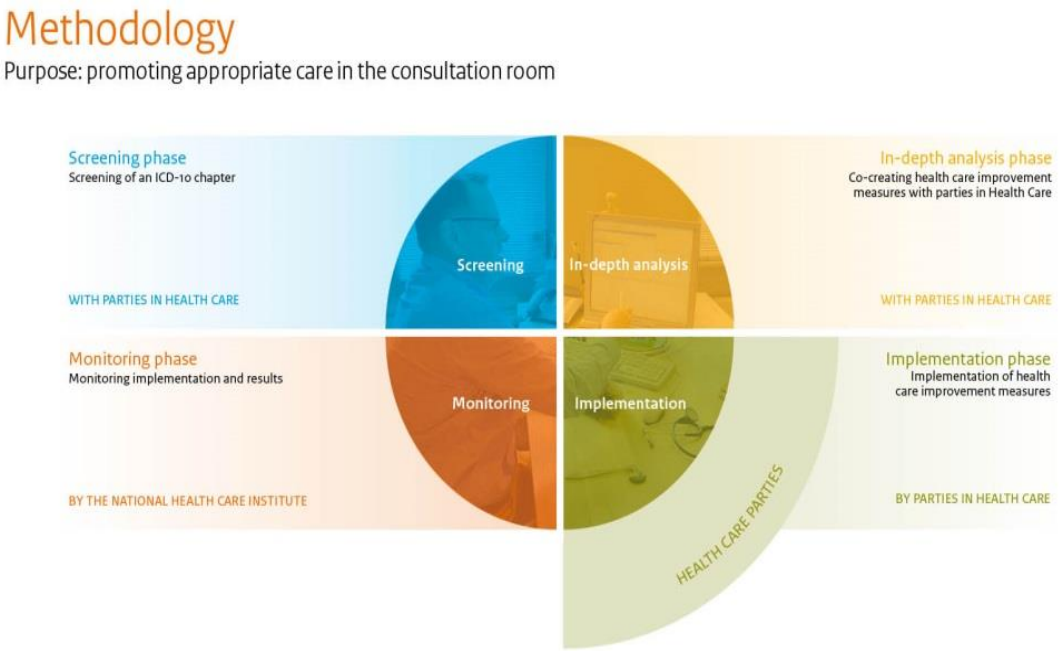
Patient-centred initiatives: „measuring what matters“ and Shared-decision-making



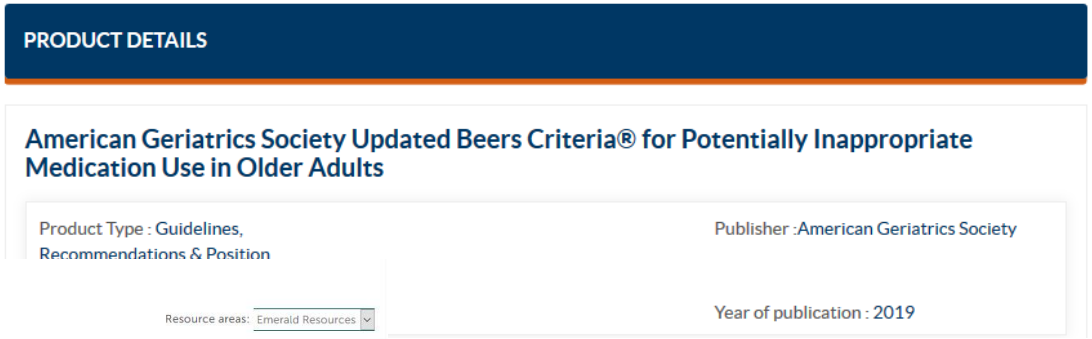


PRO →	PROM →	PRO-PM
patient-reported outcomes	*instrument, tool, single-item measure*	*PRO-based performance measure*
information on the patient, told by the patient, without interpretation	way to collect information told by the patient without interpretation	way to aggregate the information that has been shared and collected into a reliable, valid measure of performance
EXAMPLE: Patients with Clinical Depression		
Symptom: depression	Patient Health Questionnaire (PHQ-9©), a standardized tool to assess depression	Percentage of patients with diagnosis of major depression or dysthymia and initial PHQ-9 score >9 with a follow-up PHQ-9 score <5 at 6 months (NQF #0711)

Appropriateness and unwarranted variation (over- and underuse)



Payers' (and clinicians´) initiatives: Disinvestment, delisting, defunding: e.g. Polypharmacy,



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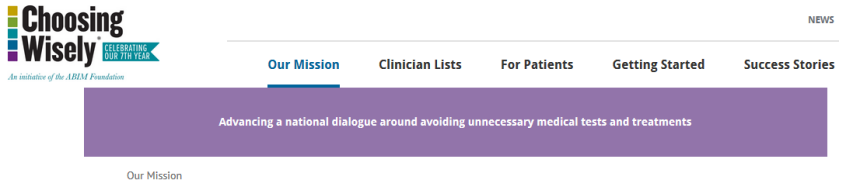
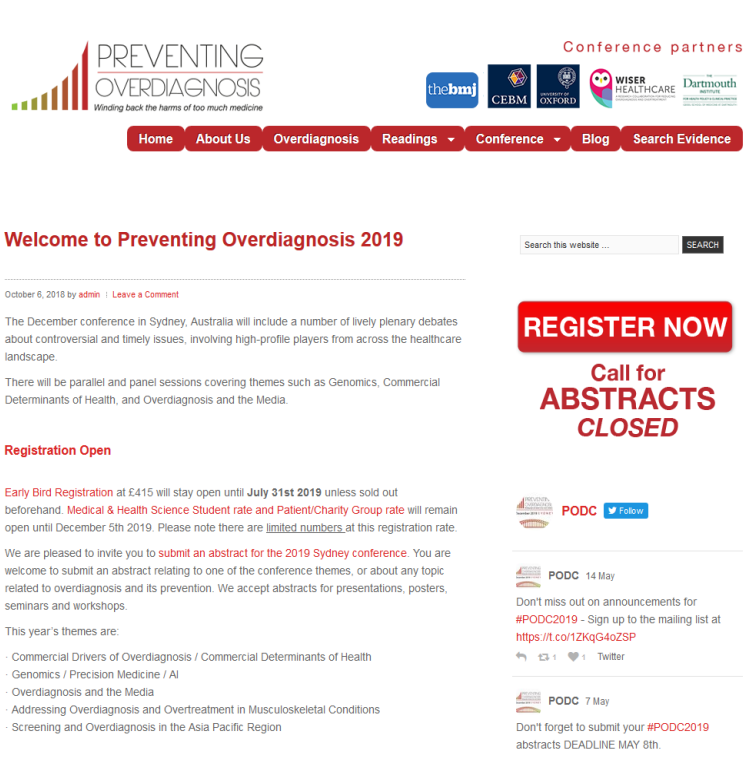
Clinicians' initiatives: Choosing wisely



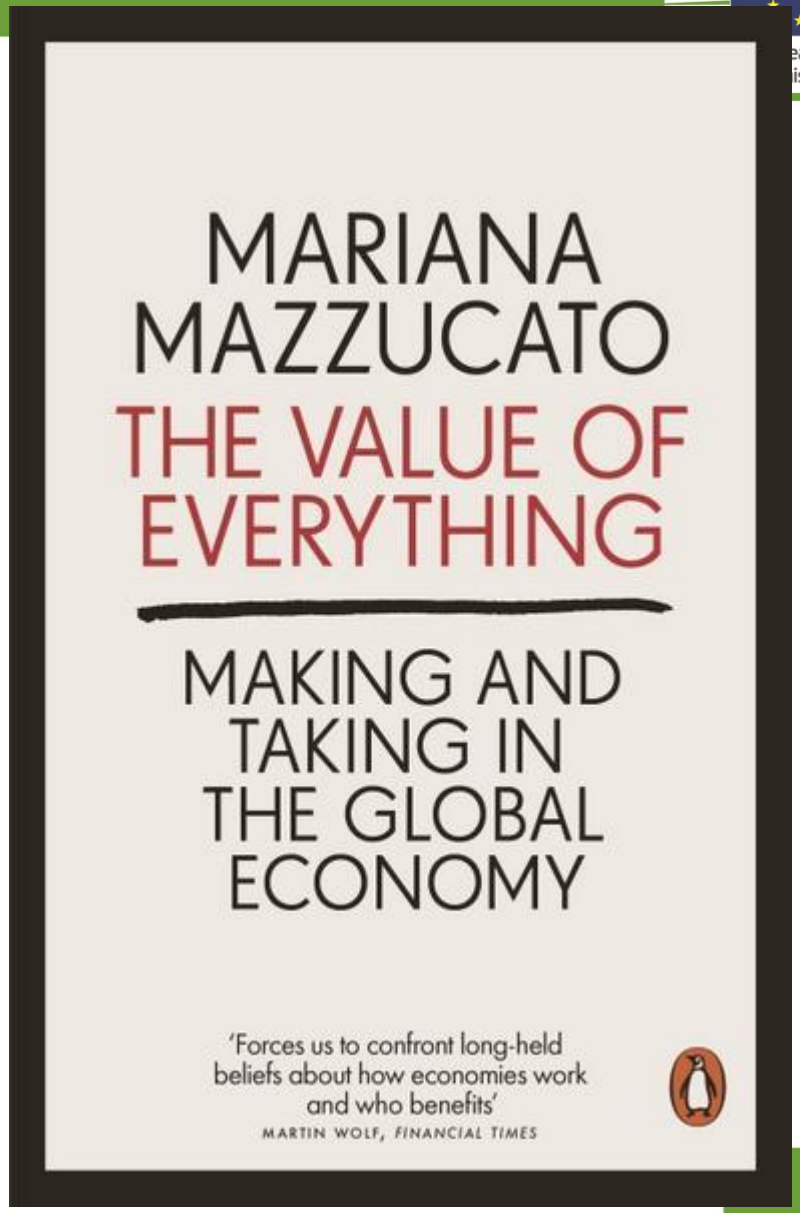


Health

Corruption, fraud and misuse

Categories	Definitions
Bribery in medical service delivery	A bribe is a financial or other advantage offered, given, solicited or accepted in exchange for privileges or treatments
Procurement corruption	Corruption of 'the complete process of acquiring goods, services and works from suppliers'
Improper marketing relations	'Improper marketing relations cover all interactions between the industry and healthcare providers and/or regulators that are not directly linked to the procurement process.'
Misuse of (high level) positions and networks	'Undue high-level interactions', such as 'trading in influence, revolving door corruption, regulatory state capture, conflict of interest, or favouritism and nepotism'
Undue reimbursement claims	Covers creative billing and reimbursement of unnecessary and non-delivered services
Fraud and embezzlement (of medicines, medical devices and services)	Fraud is the 'offence of intentionally deceiving someone in order to gain an unfair or illegal advantage' Embezzlement prevails 'When a person holding office … dishonestly and illegally appropriates, uses or traffics the funds and goods they have been entrusted with for personal enrichment or other activities'

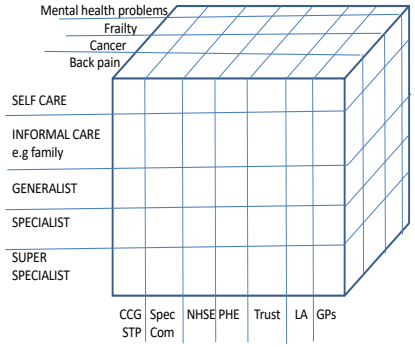
The main categories and definitions of corrupt activities according to the European Union (EU) typology (EHFCN)



R&D:
Public value of research

Public policies (incentives, programme budgeting against **inequity by disease**)

3D planning of resource allocation



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Innovative Payment methods for fair access

BeNeLuxA (http://www.beneluxa.org): Belgium, Netherlands, Luxembourg, Austria and Ireland. While recognizing that price and reimbursement decisions are retained at the country level, the group jointly negotiates prices of innovative drugs, aiming for a lower value (more affordable access to innovation). Cooperation extends to horizon scanning, health technology assessment (aiming for joint analysis) and information sharing. According to the information publicly available, joint negotiation in the context of the Beneluxa group of a price for a new product was done successfully by Belgium and the Netherlands.

FINOSE (https://www.tlv.se/in-english/international-collaboration/finose---a-nordic-cooperation.html): Finland, Norway and Sweden. The initiative from countries' authorities aims to harmonize and share health economic analyses of new products, providing a joint assessment by the three agencies. It started in March 2018 and it will run as a pilot project for two years.

Valletta: Croatia, Cyprus, Greece, Ireland, Italy, Malta, Portugal, Romania, Slovenia and Spain. The objectives of the initiative include joint clinical assessment and economic evaluation. Joint work already started (at late 2018) on several pharmaceutical products.

EUnetHTA (https://www.eunethta.eu/): Another initiative worth mentioning is the health technology assessment regulation proposal at the European Union level, building on the EUnetHTA experience of coordination of collaboration that will enforce the harmonization of methodologies, reporting and finally uptake of the collaborative assessments.

Fair And Affordable Pricing (FAAP): Hungary, Lithuania, Poland, Slovakia, Czech Republic (observer status) and Latvia (invited guest). The intiative also aims at cooperation across countries in pricing of new (pharmaceutical) products. As in other initiatives, cooperation in technical aspects is the first step. The pricing decisions are kept at the national level, with no joint negotiation (at least for the moment).

Nordic Pharmaceuticals Forum (NLF): Norway, Iceland and Denmark, Sweden (observer). The initiative started as an informal space for cooperation among the Nordic countries, concerned initially with security of supply. The Nordic Pharmaceuticals Forum (NLF – Nordisk Legemiddel Forum) started in 2015 http://www.amgros.dk/en/areas/nordic-collaboration). It has the goal of analysing the possibilities of joint tendering procedures for pharmaceuticals, as the concern on security of supply is related to older drugs, at the end of their life cycle. It is driven by Amgros, the pharmaceutical procurement office for the five regional health authorities in Denmark.

On **joint health technology assessments**, the **BeNeLuxA** initiative is already active, while the **FINOSE** and **NLF** initiatives are progressing in that direction.

On **joint price negotiations**, the **BeNeLuxA** initiative has concluded successfully one case, while the **NLF, Valletta** and **Visegrad** initiatives are still progressing towards it. The last two groups also announced the intention of moving to joint procurement (implying common prices for the group of countries involved).

The Baltic partnership is already active in **joint procurement** but collaboration did not extend to more areas, explored by other initiatives.

On **horizon scanning** (a forecast to highlight important pharmaceutical innovations before they reach the market), the BeNeluxA, NLS, Valletta and Visegrad initiatives have

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VALUE(S): WHOSE VALUES ?

Health

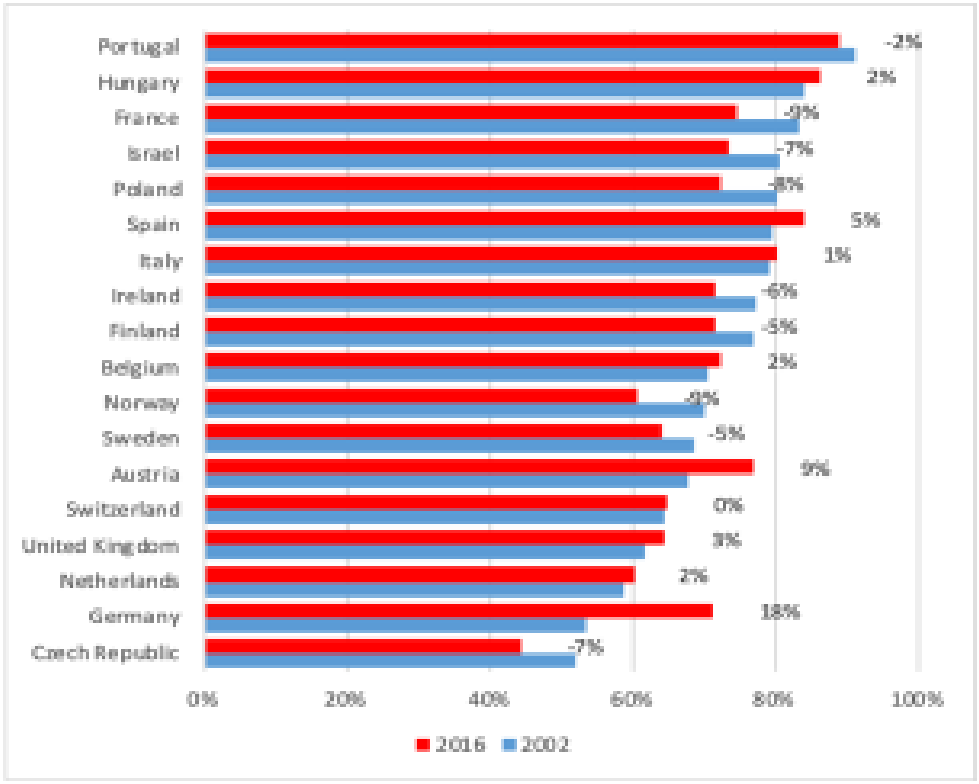
Identification of key values in Europe: Solidarity

The concept of solidarity is enshrined in the **EU Treaties**, including the values and objectives of the Union, which include **solidarity "between generations"** and **"among Member States"**,

while Chapter IV of the **Charter of Fundamental Rights** is entitled **Solidarity** and covers rights at work, family life, welfare provision and **health**.

European Pillar of Social Rights states that "Everyone has the right to timely access to affordable, preventive and curative healthcare of good quality", **universal healthcare** is one of the policy priorities of the European Union to build a more inclusive and fairer European Union and to ensure social cohesion within the EU.

Change in percentage in "agreement to redistribution of income" in rounds 1 (2002) and 8 (2016) of European Social Survey (https://www.europeansocialsurvey.org/)



Operationalisation of & guiding principles for solidarity in healthcare

1. Access and equity (social justice, fairness)
2. Quality and performance (responsive, appropriate & safe care)
3. (Value), Efficiency and productivity (optimization and distribution of resources).

Personal, institutional, societal values and goals

Health is considered to be an *intrinsic* value: a **precondition** for pursuing a "good life", for obtaining other (vital) goals what people wish to pursue in life. Since **universal healthcare** intends to provide health to the population (patient populations as much as the whole population) the **"equitable" achievement of health** for all is the aim as precondition for social cohesive European societies.

Appraisal of established instruments and methods 1/2

Whose Values	Values and goals	Means to achieve the goals
Patients	Benefit/ outcome, adverse events + complications, achievement of individual patient´s goals	Added benefit assessment shared-decision-making (SDM)
Clinicians	Benefit + harm, Progress in goal achievement of many patients	Relative Effectiveness Assessment (REA) Clinical guidelines
Provider/ institution	Net benefit + costs/budget impact	Budget Impact Assessment Cost-effectiveness Analyses (CEA) Utilities Risk-sharing/managed-entry agreements
Payers + planning	Population health within given budget Net benefit + opportunity costs + quality + equity	Priority setting Program Budgeting

Appraisal of established instruments and methods 2/2

Whose Values	Values and goals	Means to achieve the goals
Industry	Market share and sales	Marketing "Value based" pricing strategies
Health Policy	Net benefit + opportunity costs + equity + appropriateness (balance innovation and net benefit)	Need Assessment Aggregated (weighted) utilities Technology Foresight & Horizon Scanning Program Budgeting,
Policy/ Government	Social impact (cohesion), impact on generations	Health Impact Assessment (HIA) Societal Impact

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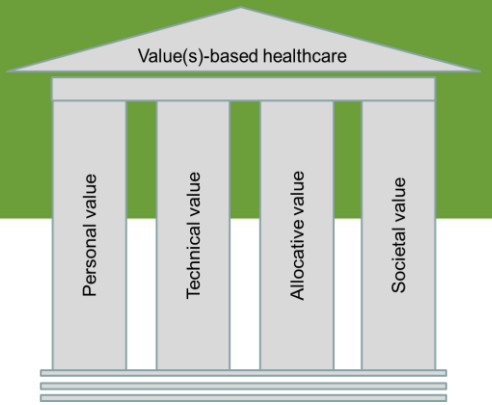
Value vs. Values

Generic definitions (Oxford Dictionary): Values vs. Value	**Values**: Beliefs and attitudes a person holds that lead to the judgement of what is important (in one´s life). **Value**: the importance and worth or usefulness of something to a person.
Narrow (price-based) utilisation of "Value"	**Value** defined as the health outcomes achieved per dollar spent
Value-based healthcare	**Value** = Quality (outcomes + patient experience) / Cost (direct + indirect costs of the intervention)
Value-based pricing:	**Process** whereby pricing and reimbursement of a service (e.g. drug, medical device) are regulated according to its therapeutic value
Comprehensive (normative) utilisation of "Value" *Value-based healthcare*:	**Allocative Value**: ensuring that all available resources are taken into account and distributed in an equitable fashion. This concept is also referred to by economists as "allocative efficiency". **Technical Value**: ensuring that the allocated resources are used optimally (no waste). **Personal Value**: ensuring that each individual patient´s values are used as a basis for decision-making in a way that will optimise the benefits for them. **Societal Value**: ensuring that the intervention in healthcare contributes to connectedness, social cohesion, solidarity, mutual respect, openness to diversity.



ValueS-based healthcare

The EXPH therefore proposes *to "value-based healthcare (VBHC)" as a* ***comprehensive concept*** *built on four value-pillars:*

1. *appropriate care to achieve EACH patient´s personal goals (**personal value**),*
2. *achievement of best possible outcomes with available resources (**technical value**),*
3. *equitable resource distribution across all patient groups (**allocative value**) and*
4. *contribution of healthcare to social participation and connectedness (**societal value**).*

valueS-based healthcare for decision making (financial sustainability of UHC)

Health

Recommendation 1

(to ensure societal value): Creating greater **awareness of health as an essential investment** in an equal and fair European society ("health is wealth"), of the centrality of as a European value, and of the commitment, in the Sustainable Development Goals, to achieving universal health coverage (UHC).

This process will provide **clear narratives** setting out how the financial sustainability of existing progress towards **UHC is endangered** by

- Overdiagnosis leading to overtreatment
- Inequity by disease and "voiceless" patient groups
- Unwarranted variation in healthcare interventions
- Unreasonable prices of treatments
- Waste arising from inefficiencies, fraud and corruption

Recommendation 2 (1/2)

(to ensure all four pillars of values: personal, technical, allocative and societal value): Develop a **long-term strategy** for a step-by step value(s)-based approach towards change of culture.

By 2030, this should have created a movement …

- Develop a **consistent language** to capture the drive towards sustainability of universal health coverage,
- Train **"change agents" (leaders)**, who assess the risks and opportunities that exist and contextualize the change process in the EU member states,
- Define a **series of goals** that support the long-term objective of change, moving forward in small steps (work plans), for example using analyses of regional variation of, say, the 20 most frequent Diagnostic Related Disease Groups (DRGs),

Recommendation 2 (2/2)

(to ensure all four pillars of values: personal, technical, allocative and societal value): Develop a **long-term strategy** for a step-by step value(s)-based approach towards change of culture.

- Invest in research and development of **methodologies, in appropriateness and implementation research** (H2020 and later framework programmes),
- Pilot need-based public R&D for **true innovative technologies** and consider as innovations **social interventions** as much as technology-based interventions,
- Orientate **digital interventions** in ways that genuinely support high value care
- Monitor the **effects of large scale implementation** by use of existing data sources (e.g. quality registries in Finland, Sweden etc.) and existing methodologies (e.g. indicators and
- Create mechanisms to further guide the direction of change.

Recommendation 3

(to ensure all four pillars of values: personal, technical, allocative and societal value): Support Research & Development on/of **methodologies on appropriateness** and unwarranted variation.

Examples of actions are

- Creating **fora for exchange** on measuring and monitoring patterns of clinical practice, regional variation, appropriateness research (specifically in multi-morbidities) and inequity by disease as a basis for a potential to reallocate resources,
- Stimulating **data analyses** and the use of quality registries for identification of regional variation and outcomes.

Recommendation 4 (1/2)

(to ensure allocative and societal value): Support the **creation of Learning Communities** to bring together the best expertise, experiences and practices and to learn from each other by measuring, benchmarking and implementing actions across the EU. Member States should take the lead in identifying and pinpointing the most important tasks, the EC should create a supportive and facilitating environment for the establishment of those Learning Communities.

This can be done by

- Identifying, **sharing and celebrating** examples of good practice,
- **Rewarding** (co-funding, awareness and publicity, …) countries taking **systematic** approaches to developing and disseminating good practice
- Stimulating exchange on **managerial techniques** (financial incentives, regulatory mechanisms and managerial instruments) for **shifting resources from low to high value care** and on measuring the effects, including positive incentives (e.g. cash) and negative ones (restriction on certain interventions).

Recommendation 4 (2/2)

(to ensure allocative and societal value): Support the **creation of Learning Communities** to bring together the best expertise, experiences and practices and to learn from each other by measuring, benchmarking and implementing actions across the EU. Member States should take the lead in identifying and pinpointing the most important tasks, the EC should create a supportive and facilitating environment for the establishment of those Learning Communities.

- Creating a learning community on the **piloting of programme budgeting** within and **across diseases** and accordingly for the **shifting of resources from budgets** where there is overuse to disease groups where there is evidence of underuse and inequity, finally
- Exchanging on strategies for **changing attitudes** and rethinking value in our medical culture.

Recommendation 5

(to ensure allocative and societal value): Encourage **health professionals to take responsibility and feel accountable** for increasing value in health care, which may require freeing resources from low-value care to reinvest in high-value care. Health professionals hold a key role in advocating a change of culture.

Examples of action are

- Stimulating a reflection process on the **accountability for resources** as a core **aspect of professionalism** by medical, nursing, and other societies
- Developing **training in stewardship**, emphasising the importance of health professionals becoming accountable for the health of the population, including equitable distribution of resources for those with different diseases,
- **Steering clinician leadership** to ensure acceptance of responsibility for **allocative efficiency** and for the social (i.e. not only the individual patient but wider society) impact of their decisions, encompassing positive and negative freedom in clinical decision-making,
- Strengthen **professional integrity**.

Recommendation 6 (1/2)

(to ensure personal value): Support **patients´ initiatives for engagement** in shared decision-making (SDM), recognising the importance of patients´ goals, values and preferences, informed by high quality information.

Action points include

- Co-creating models of care with the patient community (including families and informal carers) , and adopting a framework for **meaningful patient and public involvement** in health systems and services design (in evidence requirements, M&E, policy discussions and decision-making), leading to value-based healthcare in its wider sense.
- Developing, together with patients' organisations, authorities in Member States, and other stakeholders, a comprehensive strategy to implement **empowering practices** and goal-oriented person-centred care.
- Ensuring appropriate involvement of patients and their communities in the creation and implementation of **patient-defined outcome measures** and experience measures (PROMs and PREMs).

Recommendation 6 (2/2)

(to ensure personal value): Support **patients´ initiatives for engagement** in shared decision-making (SDM), recognising the importance of patients´ goals, values and preferences, informed by high quality information.

- Exploring alternative ways of **encouraging research** and innovation that meets patients and societies' needs and goals, while ensuring solidarity and equity, including partnerships that fully involve patients.
- Involving patients in the training and continuous professional development of all stakeholders involved in value-based health care, **resource allocation and disinvestment**
- Promoting effective patient and **public dialogue about societal goals** and priorities.

EXPH Opinion

A **reallocation of resources** - the freeing of resources and accordingly the reinvestment - from low to high value care is perceived by the EXPH as the **utmost necessity for sustainable and resilient European healthcare systems**.

Hearing

Questions?

Comments?

Additions?

Health