Transforming towards value-based, sustainable, and people-centred health systems in Europe

Our vision, mission, and principles

European Alliance for Value in Health

1. European health systems are under pressure, patient outcomes differ significantly, and limited resources are spent inefficiently

We are in a pivotal moment for European health systems, when the COVID-19 pandemic has put health systems under severe stress and added to the already existing pressures stemming from ageing populations and chronic diseases. Health systems are complex, often fragmented and heavy with legacy. To a great extent they are still operating on a logic from an older era, built around treating acute illness and disease, and have therefore been struggling to meet the needs coming from today's demographic, societal and technological developments.

Despite the best intentions, patient outcomes can differ significantly depending on in which hospital or clinic the patient was treated, and also across countries despite similar levels of healthcare expenditure. Significant parts of healthcare budgets are spent inefficiently, having little or no impact on patient health, and efficient solutions that could improve health systems are many times not implemented as they do not fit into the current model.

As a result, patients' lives and their quality of life may suffer, and limited health and social care resources are spent on managing unnecessary complications and low-value care.

2. A movement to value, outcomes and people-centred health systems has started, but implementation is scattered, hampering real transformation

During recent years, an important movement has been developing in Europe and globally to replace the old logic with a new one, centred around the outcomes that ultimately matter for people and patients and how these can be achieved with the best resource utilization for the system and society as a whole by innovating the delivery of care. Value-based healthcare, outcomes-based healthcare and people-centred health systems are all concepts that with some variation build on this theme.

However, although a lot of progress has been made in different healthcare settings across Europe, implementation in most cases remain scattered and piece-meal, and there is still a lack of common understanding between health system actors on which principles should underpin the transformation to a value-based system.

3. The European Alliance for Value in Health has a clear mission to facilitate European health systems transformation

The European Alliance for Value in Health (the Alliance) is a group of associations representing stakeholders active in the broader European health systems. They want to CONNECT different stakeholders to CREATE conditions and INSPIRE others.

The VISION of the Alliance for Value in Health is a Europe, where health systems are value-based, sustainable, and people-centred.

Our MISSION is to partner to facilitate health system transformation, by disseminating knowledge and best practices, and engaging with policy makers and stakeholders – at European, national, and regional levels.

4. Value-based, sustainable, and people-centred health systems are built around six key principles

The Alliance believe value-based, sustainable, and people-centred health systems are built around six key principles.

1. Outcomes that matter to people and patients, as well as benefits valued by health systems and societies, are at the centre of decision-making

The ultimate goal of every health system is to have a population in good health, and to improve longevity and quality of life. Therefore, all parts of the health system need to focus on the outcomes that matter to people and patients, and this can only be done if patients or their representatives are involved in all levels of decision making in health systems. Patient-relevant outcomes are both about clinical outcomes as well as patient-reported outcomes relating for example to quality-of-life and functional status. The measurement of these relevant outcomes can be quantitative and qualitative in nature and should be defined and agreed upon in collaboration with patient representatives. Outcome data can be more effectively compared across providers and health systems by standardizing the way in which they are defined, measured, and collected (for example by disease, condition or patient group).

On an individual patient level, outcomes measurement can be used prospectively, whereas for healthcare providers and the health system as a whole, outcomes will often be used more retrospectively:

- At the individual patient level, outcomes can be used for shared decision making, to determine the best treatment or intervention and to follow and discuss progress of the disease;

- At the healthcare provider level, outcomes can be used to compare and benchmark providers, to identify best practices and for internal improvement of quality of care;
- At the health system level, outcomes can be used to assess the effectiveness of intervention, care models and pathways in a real-world setting, improve treatment guidelines and to inform value-based payment models.

Beyond health outcomes for people and patients, decision-making on investments and resource allocation should also be informed by the broader benefits valued by health care providers, the health systems and societies. For example benefits for healthcare professionals, savings achieved on the overall cost of care, information to guide decision making and benefits due to having people in good health being socially and economically active.

2. Interventions and services addressing prevention, social care and healthcare are organised in an integrated way around people and patients

The increasing incidence of chronic diseases and ageing populations have significant impacts on sustainability and efficiency of health systems in Europe. Failure to provide patients with carefully coordinated and holistic care can allow small problems to escalate into medical emergencies which can then result in unnecessary hospitalizations, increased mortality, lower quality of life for patients and higher health system costs. Care fragmentation also frustrates service users and their families, who find it difficult to navigate the numerous providers and as such are disempowered from taking a greater role in managing their own care.

At its heart, integrated care ensures people who use health and social care services are able to get the right care and support whatever their needs, at the right time and in the right setting at any point in their care journey, and has a focus on community-based, preventative care, and promotion of healthy living.

Integrated care combines horizontal and vertical integration. Horizontal integration connects the social and health domain, while vertical integration connects different care levels. Both are important for meeting patients' needs, ensuring patients' safety and the co-operation and communication between sectors.

Prevention (primary and secondary) and health promotion are the corner stones of the measures and should be evaluated on both outcomes and cost off-sets.

3. Resources are allocated towards high value care and prevention, with outcomes and costs of care measured holistically

A cohesive approach to financing, and rigorous assessment and comparison of the value of different healthcare models requires holistic measurement of: outcomes for people and patients, the costs for health systems and societies, and must take into account all relevant parts of the patient's journey.

The Charter of Fundamental Rights of the European Union and the European Pillar of Social Rights states that "Everyone has the right to timely access to affordable, preventive and curative healthcare of good quality" (Article 35). Furthermore, the core principles of European solidarity can be seen as indicators for achieving the goal of a fair distribution of healthcare resources to those in need: financed health systems, access and equity, quality and performance, and efficiency.

Around a fifth of healthcare spending is wasted on inappropriate or ineffective care, preventable errors and administrative inefficiencies according to the OECD. In current health systems it is very difficult to correlate the level of investments against the value of the healthcare provided

There is a need for reallocation of resources away from low value care towards high value care. However, the acceptability of reallocation will require a culture that prioritizes what matters to patients, shaping the care around their preferences and goals. Furthermore, budget silos and fragmented systems for health financing create barriers to efficient resource allocation, as long-term benefits and cost savings are often realised in a different budget silo than where an investment needs to be made. Health systems should therefore strive towards more integrated and flexible budget frameworks for health and social care, which also would be an important enabler of integrated care.

4. Continuous learning, education and healthcare improvement is based on evidence, and supported by data and insights

Continuous improvement is a systematic, sustainable approach to enhancing the quality of care and outcomes for patients, while controlling the cost. In order to facilitate a continuous learning environment, health systems should reward outcomes and implement collaborative care models that promote optimal outcomes.

A strong focus on transparency is also fundamental, making the performance of care delivery visible in terms of clinical and patient reported outcomes. Patients can make more informed choices when performance information is clearly and transparently communicated. Healthcare providers can then use these outcomes for internal and external benchmarks and provide an infrastructure to share best practices to further improve the total care delivery. Rewarding the resulting improved outcomes further promotes continuous learning.

A supporting IT and digital health infrastructure is important to support the data collection needed for learning health systems, with an emphasis on routinely collected data from clinical practice. Electronic Health Records are the fundament, for both medical and patient-related information. They should be comprehensive and routinely shared with patients.

New sources of (health) information, like advanced in-vitro-testing, artificial intelligence and big data, should be leveraged as much as possible to generate relevant insights.

Leadership and management in health systems should develop approaches that fully embrace the concept of continuous learning and strengthen its application in day-to-day settings. This should be nurtured from the tertiary education system through to the workforce, so that all managers have a mindset where the use of data and insights to further improve health outcomes is a normal practice.

5. Innovative ways of care delivery are fostered

In order to facilitate the implementation of innovations in our health systems a collaborative approach is required amongst the various stakeholders, with structure incentives accordingly driven by a value-based health care thinking.

Disruptive and transformative innovation in care delivery across all aspects of healthcare will help overcome the myriad of challenges and limitations that remain in our health systems. Common problems that result in avoidable costs in our systems include: misdiagnosis, medical errors, uninformed or outdated clinical practices, treatment and healthcare delivery complications, avoidable exacerbations, lack of person-centredness and organisations that are ill-adapted to address multiple-morbidities and chronic care, including through lack of care coordination. The adoption of innovative solutions, including new technologies and services, that could transform and innovate care delivery are not taken up fast enough by the health systems.

The implementation of innovation is complex and often requires changes or investments at different levels of the health system and can only be made with profound changes in attitudes and approaches. To achieve this health systems must reward better performance, have funding systems that perform optimally and incentivises long-term investments, and there should be robust rationale behind the selection of innovations that are funded. Innovation adoption depends upon change, which in of itself generates new challenges. Co-design of innovations with healthcare users – patients – is key and requires including patients and their organisations as full partners in healthcare improvement efforts.

Quality improvement systems may struggle to keep up with the pace of innovation, and so the evaluation of innovations must not be too narrowly focused in order for the system-wide and societal effects of new practices or technologies to be understood. A value-based, co-creation approach to innovation and investment decisions would create the right conditions for fast uptake of innovative solutions that bring true value to patients, health systems and societies.

6. Financing models and payments reward value and outcomes

In today's health systems, most products and services are still reimbursed based on the volumes provided rather than the outcomes achieved, including: fee-for-service models, Diagnose Related Group (DRG) payments, and most contracts for procuring medical goods. Relatively easy to implement, and therefore often chosen, volume-based payment models can sometimes create incentives which are misaligned with the ultimate goals of the health system – to improve health outcomes for people and patients and offer safe, high quality and affordable care. Further examples include incentives for over-provision of services which are not medically justified, or diversion of resources to healthcare interventions which are less optimal in the long term both in terms of outcomes and overall costs.

To facilitate better outcomes for people and patients while keeping systems sustainable, health systems should strive to remove payment models that create misaligned incentives, and implement models that link reimbursement to the overall outcomes and value achieved, be it on an individual patient, on a population level or a system level. Examples include population-based capitation models which can incentivise prevention and coordination of care for patients with chronic diseases, bundled payments, value-based procurement, and different types of outcomes- or value-based agreements. These payment models often require: alignment across stakeholders on which outcomes to measure and how to assign risks and rewards, bearing in mind that outcomes should reflect what matters to patients, better data to monitor and assess the outcomes achieved, and risk-adjustment of the results. This can require some initial investments and implementing new ways of working, but resulting in long-term gains for patients, health systems and all stakeholders.

More information

In case you want more information and/or want to keep track of our activities on the European Alliance for Value in Health, please reach out and connect to us:

Website: www.valueinhealth.eu

Email: info@valueinhealth.eu

Twitter: @ValueInHealthEU (https://twitter.com/ValueinHealthEU)

LinkedIn: http://www.linkedin.com/company/value-in-health-eu