HEALTH SYSTEMS AND POLICY ANALYSIS

POLICY BRIEF 37

Building on value-based health care

Towards a health system perspective

Peter C Smith
Anna Sagan
Luigi Siciliani
Dimitra Panteli
Martin McKee
Agnès Soucat
Josep Figueras

World Health Organization

European Observatory on Health Systems and Policies
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This policy brief is one of a new series to meet the needs of policy-makers and health system managers. The aim is to develop key messages to support evidence-informed policy-making and the editors will continue to strengthen the series by working with authors to improve the consideration given to policy options and implementation.

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Authors

Peter C Smith – Centre for Health Economics, University of York and Imperial College Business School

Anna Sagan – European Observatory on Health Systems and Policies, London School of Economics and Political Science and London School of Hygiene and Tropical Medicine

Luigi Siciliani – Department of Economics and Related Studies, University of York

Dimitra Panteli – European Observatory on Health Systems and Policies

Martin McKee – European Observatory on Health Systems and Policies and London School of Hygiene and Tropical Medicine

Agnès Soucat – Department of Health Systems, Governance, Financing, World Health Organization

Josep Figueras – European Observatory on Health Systems and Policies

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KEY MESSAGES

- Preoccupation with the value created by health systems has been longstanding, and will likely only intensify given the ongoing health systems strains and shocks such as the COVID-19 pandemic. But the focus so far has usually been limited to value as seen from the perspectives of certain actors in the health system and/or to certain dimensions of value.
- In this policy brief we call for a shared understanding of value that embraces the health system in its entirety, including preventive services and other public health functions. We then define value to be the contribution of the health system to societal wellbeing.
- Any meaningful formulation of the concept of wellbeing includes health, and by extension health systems, as an important contributor to our wellbeing.
- Health improvement, responsiveness, financial protection, efficiency and equity are widely accepted as health systems' core contributions to wellbeing. Health systems can also contribute to wellbeing indirectly through the spillover effects that its actions have on other sectors.
- Health systems are shaped by a wide array of actors, including national policy-makers, purchasers, providers, practitioners, citizens and patients. These different actors make important but discrete contributions to value, so in order to maximize it, their actions should be aligned. The aim should be to create a value-based health system.
- A range of policy levers can be used to enhance value, ranging from cross-sectoral policies to involving patients in decision-making. While such levers normally focus on one or two dimensions of value, it is important to ensure that they do not undermine other dimensions or the efforts of other actors.
- Effective governance of the whole health system is needed to ensure that stakeholder perspectives and policy levers are aligned to promote a common concept of health system value and, ultimately, of societal wellbeing. There are governance tools, such as the Transparency, Accountability, Participation, Integrity and Capacity (TAPIC) framework, that can help achieve this.
- Moving towards a value-based health system will often be a gradual process, focusing first of all on the areas where it might make the biggest difference.

Executive summary

Preoccupation with creating value in health systems has been longstanding, but the focus has usually been on certain stakeholder perspectives and/or certain dimensions of value

Health systems around the world have long sought to create as much value as possible out of their available resources. This preoccupation will likely only intensify, given the ongoing strains on health systems, such as population ageing, other underlying global trends, such as technological innovation, and the occurrence of shocks, such as the global financial crisis of 2007–2008 and the current COVID-19 pandemic, and their effects on the resources needed to deliver health care and on national budgets.

The development of concepts such as value-based health care or patient responsiveness are two examples among many of the efforts at creating value in the health system. Yet, these various initiatives have usually approached the notion of value from the viewpoints of a limited range of actors in the health system and/or have focused on certain dimensions of value. These limited perspectives inhibit progress towards maximizing the total value that could be achieved by the health system.

Understanding of value should be consistent amongst all actors and aligned with the overarching goal of maximizing societal wellbeing

In this policy brief we thus put forward a practical policy framework that seeks to reconcile the various contemporary approaches towards health system value. We define value to be **the contribution of the health system to societal wellbeing**. The distinctive contribution of this concept of value is that we focus on the value created by the health system as a whole, including health promotion and disease prevention functions. We are thus moving beyond value-based health care towards the concept of a value-based health system.

While there is no universally agreed definition of wellbeing, it is increasingly recognized that more tangible elements, such as health, education, employment and housing, and less tangible elements (such as social belonging) all contribute to our wellbeing. However, regardless of the precise formulation of the concept, health, and by extension health systems, are consistently included among those elements that make a substantial contribution to wellbeing.

Health improvement, responsiveness, financial protection, equity and efficiency are widely accepted as health systems' core contributions to societal wellbeing

There is a core cluster of objectives that has secured widespread acceptance amongst health policy-makers as reflecting many of their central priorities and therefore core elements of value: health improvement, responsiveness, financial protection, equity and efficiency. In particular, universal health coverage (UHC) is intended to make important contributions to wellbeing in a number of dimensions and is therefore likely in most countries to be central to the health system's concept of value.

Beyond these core objectives, health systems also contribute to societal wellbeing indirectly via the spillover effects that their actions have on other sectors, such as through the positive effects of good health on educational attainment or labour force participation.

The different dimensions of value can be ultimately translated into benefits and costs

Health systems generate value by creating health and non-health benefits that contribute to wellbeing. These benefits should be examined in relation to the costs they ultimately incur (e.g. in the form of taxation or direct payments), which detract from wellbeing. In this sense, the concept of health system value is closely aligned to the concept of health system efficiency.

Collectively, inefficiencies in the health sector can be thought of as waste, which some commentators have estimated to account for 20-40% of health spending. This waste destroys value, either by precluding spending on more valued health system activities, or by diverting expenditure unnecessarily to the health system and thus preventing the creation of wellbeing by other sectors. Indeed, empirical evidence shows that there are large variations in amenable mortality (which can be seen as a proxy for effective and timely health care) between countries with similar levels of spending and some of this variation can be ascribed to inefficiency and waste.

Different actors within the health system make partial contributions to value; to maximize value, these contributions should be aligned

Health systems are shaped by a wide array of actors, including national policy-makers, purchasers, providers, practitioners, citizens and patients. While each of the actors in the health system should contribute in some way to value, most of them, by the nature of their roles, can only make partial and specific contributions. For example, a prime goal for purchasers should be assuring allocative efficiency, while the central focus of citizens and patients should be on health improvement. National health policy-makers, by determining the shape of the health system, contribute to all dimensions of health system value. They can also contribute to health improvement achieved by policies that are outside health sector's core focus, by cooperating with other sectors. They make a key contribution to value by defining, through democratic processes, what value means in its specific national context and ensuring that it is transmitted to all actors in the system and taken into account in all policies.

A range of policy levers can be used to enhance value; while they normally focus on one or two dimensions of value, it is important to ensure that other dimensions are not undermined

Health systems can choose from several policy levers to promote various concepts of value, including:

1. working across sectors for health
2. fiscal and regulatory measures for health promotion and disease prevention
3. strengthening primary health care
4. funding health care for universal access
5. setting a health benefits package
6. strategic purchasing for health gain
7. paying for quality
8. integrated people-centred health services
9. evidence-based care
10. stepping up the introduction of eHealth and digital health
11. involving patients in their own care
12. involving citizens in decision-making.

These levers typically focus on a limited range of actors and only one or two dimensions of value. It is therefore important, when taking a holistic view, that they do not detract from attaining other dimensions, or inhibit other actors from doing so. For example, the prime focus of clinical guidelines is improving health. However, if guidelines do not incorporate the patient perspective, they might undermine responsiveness. If they do not consider the cost of care, they may have an inadvertently negative effect on efficiency. Most levers will affect and will be affected by several actors and will have an impact on other levers too. For example, the use of eHealth may provide ways of enhancing several levers such as involving citizens in decision-making, paying for performance, and integrating health services. It is thus important that a unified concept of value is taken into account when aligning policies.

Effective governance of the whole health system is needed to ensure that stakeholder perspectives and policy levers are aligned to promote a common concept of value, and that the levers work as intended

There should be appropriate instruments in place to promote, monitor and rectify any shortcomings in securing value, either by institutions or policies. Each accountability arrangement between the various actors in the system should be based on clarity about what aspects of value it is seeking to address, how that contribution is conceptualized and measured, and what mechanisms are in place to correct perceived shortfalls in the creation of value. Achieving this is not straightforward, but frameworks such as Transparency, Accountability, Participation, Integrity and Capacity (TAPIC) offer potential tools for designing and auditing the effectiveness of accountability relationships.

It may often be necessary to move towards value-based systems gradually, focusing first on the areas where it might make the biggest difference

It may not always be possible or desirable to seek immediately to apply a value-based approach throughout the health system. It may instead be necessary to move incrementally towards value-based services, focusing first on the areas where it might make the biggest difference, such as mental health. Yet it is important to formulate an explicit concept of health system value and translate it into a set of concrete goals that all actors can understand, and progressively move the system closer towards attaining them.

POLICY BRIEF

1. Introduction

Health systems of all types have for a long time been seeking to create as much value as possible out of their available resources. The urgency of this endeavour has been heightened in most countries by the ageing of the population, the growth in numbers of people with complex morbidities, advances in health technology, the increased expectations of citizens, and rapidly increasing expenditure on health services. It was also amplified by health systems shocks, such as the global financial crisis of 2007–2008, and will likely come under scrutiny again in the aftermath of the COVID-19 pandemic and its economic repercussions. The development of concepts such as value for money, value-based health care, cost-effectiveness, patient-reported outcomes, and patient responsiveness are examples of the preoccupation with creating value.

Yet, while reflecting similar concerns, these various concepts usually approach the notion of value from the different viewpoints of various actors in the system, such as regulators, purchasers, providers, practitioners and individual citizens. As an example, Box 1 summarizes the approach to value-based health care by Michael Porter and colleagues. Their approach has been developed with the US health system in mind and from a provider perspective within a competitive environment, rather than a health system perspective. Moreover, it focuses mainly on health care, and does not address the broader concerns of preventive health services at the population level and social solidarity that are a central concern of most health systems. A recent attempt to adopt the Porter approach in Sweden [1] has shown difficulties in implementing it in practice outside the US.

Box 1: Value-based health care according to Porter and Teisberg

Under the framework developed by Michael Porter and Elizabeth Teisberg [2], it has been suggested that competition among providers in the US should shift to value-based competition with providers seeking to achieve the best outcomes for patients at the lowest costs. Providers should no longer focus on discrete treatments but on the complete care cycles, as it is the health outcomes of entire care cycles and their total cost that make up the end value for the patients. This shift of focus, also referred to as the value agenda, is expected to improve the fragmented, largely supply-driven system.

Their proposed value agenda involves six components that are to be facilitated by insurers' initiatives, such as moving from fee-for-service (FFS) to performance-based payment:

1. organisation of care around medical conditions rather than around skills and facilities;
2. systematic measurement of outcomes and costs at the patient level;
3. moving towards bundled payments for care cycles (to replace FFS for separate services);
4. integration of care delivery systems by clearly defining the scope of the services, and integrating across locations, going beyond current multisite organisations that still suffer from duplications;
5. expanding geographic reach of providers, especially for specialised providers, and working in collaboration with less specialised "satellite" ones;
6. the final component, which supports the previous ones, is the construction of an information technology platform which supports integrated, multidisciplinary care across locations and services.

An alternative approach, which takes a more holistic view, was proposed by the European Commission Expert Panel on Effective Ways in Investing in Health (Box 2). This proposes four pillars of value created by the health system that focus on equity, person-centredness and social participation, as well as health itself.

Box 2: Value-based health care according to the European Commission Expert Panel on Effective Ways in Investing in Health

Within the context of solidarity-based European health care systems and the mounting concerns about ensuring financial sustainability of universal health care, the European Commission Expert Panel on Effective Ways in Investing in Health (EXPH) [3] proposed a comprehensive concept of value-based health care based on four pillars of value:

- achievement of best possible outcomes with available resources (technical value);
- equitable distribution of resources across all patient groups (allocative value);
- appropriate care to achieve each patient's personal goals (personal value);
- contribution of health care to social participation and connectedness (societal value).

Examples of value-based health care initiatives identified by the EXPH that can contribute to more effective, accessible and resilient health care systems include: reallocation of resources through disinvestment for reinvestment; addressing unwarranted variation, defined as variation in the utilization of health care services that cannot be explained; fighting corruption, fraud and misuse of public resources; increasing public value in biomedical and health research; regulatory policies aimed at improving access to high-value (but costly) medicines; incentives for fairer distribution; and more optimal use of resources.

To support implementation of value-based health care, the EXPH recommends focusing on increasing awareness that health is an essential investment in an equal and fair European society and developing a long-term strategy towards a gradual change of culture; supporting research on the appropriateness of care (e.g. measuring and monitoring patterns of clinical practice and unwarranted variation) and sharing of expertise and best practices; encouraging health professionals to assume responsibility and accountability for increasing value in health care; as well as supporting patients' initiatives for engagement in shared decision-making to implement empowering practices and goal-oriented person-centred care.

This policy brief seeks to contribute to the discussions about value by putting forward a practical policy framework that reconciles the various current approaches towards value-based policies in health systems. The distinctive contribution is that we focus on the value created by the health system as

a whole (including health promotion and disease prevention functions), thus moving beyond value-based health care towards value-based health systems. We define health system value to be the contribution of the health system to societal wellbeing. We argue that this concept of value cannot be enhanced solely by looking at the various actors of the health system in isolation and that instead the understanding of value should be consistent amongst all actors. The brief complements the WHO briefing paper "From Value for Money to Value Based Health Services: a 21st century shift" [4], which was also prepared to support G20 Member States in their work on value-based health care and which presents a framework on value-based health services that links together the policy instruments of value for money and strategic purchasing to promote integrated people-centred health services.

We start by outlining what we understand by the concept of health system value (in Section 2). Whenever possible, this understanding should be aligned with the overarching goal of society, which we argue is to maximize societal wellbeing, representing some aggregate measure of the life satisfaction of its citizens. Different actors within the health system make different contributions to value, and these are outlined in Section 3. However, we argue that their perspectives can and should all be aligned with a unifying concept of health system value. Health systems implement numerous policy levers to promote various aspects of value. In Section 4 we discuss some of these levers, and show how they can realistically only be expected to promote certain aspects of health system value. We give some examples of levers, assess how effective they are at enhancing value, and discuss how improvements can be effected. We then highlight the key role of governance in implementing a value-based approach within a health system (Section 5) and conclude by discussing some practical obstacles to its implementation (Section 6).

2. Clarifying the key concepts: what do we mean by societal wellbeing and health system value?

2.1. Societal wellbeing as the ultimate goal

There is an emerging consensus that the narrow metrics of prosperity traditionally used in economic debates, such as per capita GDP, have serious limitations [5]. The use of such metrics is in part responsible for a perception that health care is an unproductive drain on the economy. For example, GDP fails to acknowledge the value of health systems' role in promoting better health, and contributing to equity, social protection and social cohesion.

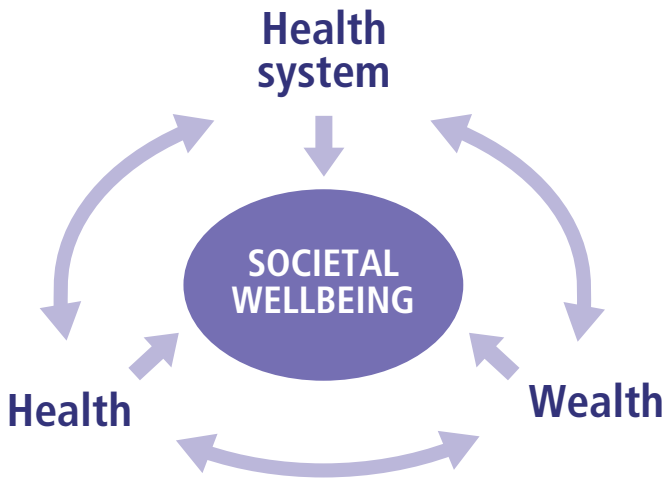
There is therefore a growing interest in considering more holistic approaches towards measuring progress, mostly centring on the broad concept of wellbeing. This is often used interchangeably with concepts such as happiness or social welfare, although some commentators have explored distinctions between them [6]. In practice, a common approach has been to assess an individual's wellbeing through survey questions about their life satisfaction using simple self-assessment questions such as "how satisfied are you with your life nowadays?". This question is in widespread use and forms the basis for many wellbeing measurement initiatives.

It is increasingly recognized that elements such as health, education and training, employment, housing, as well as less tangible elements (such as security, gender equality, social belonging and civic connections) that create a wider sense of engagement, all contribute to our wellbeing [7].

Several attempts have been made to make the broad concept of wellbeing operationally useful. The Better Life Initiative of the Organisation for Economic Cooperation and Development (OECD) captures data on topics such as housing, income, jobs, work-life balance and even life satisfaction itself, and allows analysts to create composite measures of wellbeing [8]. The World Bank Human Capital Index focuses on survival, health and educational attainment [9]. Examples from individual countries include the Gross National Happiness metrics used in Bhutan for the past 10 years, and the Living Standards Framework developed by New Zealand's Treasury to monitor societal wellbeing and inform their budgetary priorities. Within Europe, Finland prioritized the economy of wellbeing in its 2019 EU Presidency programme.

Regardless of the precise formulation that is adopted, health (and especially mental health) has always been found to make an important contribution to wellbeing, alongside concepts such as educational progress and economic prosperity [10]. Therefore the health system potentially has a major role to play in promoting wellbeing (Figure 1), as recognized in the 2008 Tallinn charter and reaffirmed on its 10th anniversary (also in Tallinn). The health system contribution acts both through its direct role in offering security and social protection, as well as indirectly, through the improved health it creates, which in turn influences factors such as labour productivity, educational attainment and savings. It also contributes through the improved wealth it creates more directly, for example by providing a large number of jobs [11, 12].

Figure 1: The triangular relationship between health systems, health, wealth and wellbeing



Source: Figueras and McKee [12].

2.2. How can health systems contribute to societal wellbeing?

In Section 1 we defined value to be **the contribution of the health system to collective or personal wellbeing**. The health system is expected to contribute to wellbeing in a number of respects, which are often expressed as a set of objectives for the health system. Generally speaking, there is a core cluster of objectives, developed from the *World Health Report 2000*, that has secured widespread acceptance amongst policy-makers as reflecting many of their central priorities: **health improvement**, **responsiveness**, **financial protection, efficiency** and **equity** [13]. We outline these objectives in more detail below. It is these strategic goals that should reflect the health system's concept of value (we thus also refer to them as the dimensions of value).

Figure 2 sets out a framework that captures the concept of health system value we propose. The health system is allocated funds that it is expected to convert into valued health-related outcomes, which in turn improve wellbeing. Note that we include inefficiency or waste as an intrinsic (negative) contribution to wellbeing. This is because any inefficiency in the health system detracts from wellbeing, as the wasted resources are not available for other activities (inside or outside the health system) that could in principle contribute positively to wellbeing. This is discussed further in Section 2.3.

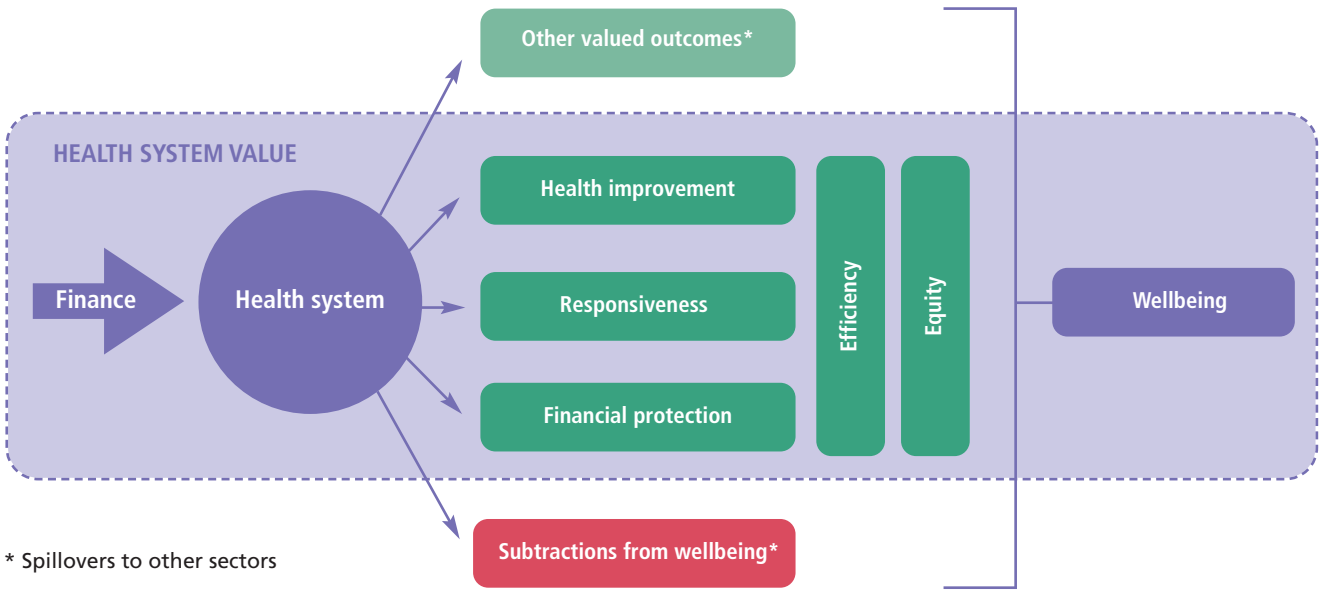
Each of the dimensions of value represented in Figure 2 is an explicit focus of most health systems, and contributes to broader wellbeing. They therefore serve as a useful basis for discussions on the value of the health system. For each dimension we briefly consider its potential contribution to wellbeing and the principal way in which the health system yields that contribution:

Health is a central element of wellbeing. It is valued both as an asset in its own right, and as an enabler for individuals to prosper and to achieve their potential [12]. Health improvement is clearly the major focus of all preventive, disease management and curative health services.

Responsiveness reflects the extent to which health services are aligned with the needs and preferences of individual patients and their caregivers. A responsive health system is therefore one that improves wellbeing by such alignment. Responsiveness is closely related to the concept of patient-centeredness, in the sense that satisfaction with services will often depend on responding to the variations in the needs and preferences of individual patients. Improved responsiveness is secured mainly through the design of health services and the actions of individual health service practitioners.

Financial protection contributes to wellbeing through the *ex ante* reassurance it offers to citizens (before they get ill) that their health care needs will be addressed whatever their financial circumstances, and the knowledge that they will

Figure 2: Value from a health system perspective



Source: Authors' own compilation.

not suffer ruinous financial consequences *ex post* when seeking access to care (once they fall ill). It is therefore the insurance characteristics of the health system that in this respect make the major contribution to wellbeing, expressed most usually in the form of Universal Health Coverage (UHC) (see Box 3). With some additions, the contributions of UHC towards wellbeing are likely in most countries to form the basis for the health system's concept of value.

Box 3: Contributions of universal health coverage towards wellbeing

The governments of the world have committed to achieve universal health coverage (UHC) in the Sustainable Development Goals (SDGs). Most high-income countries, with the notable exception of the United States, have made considerable progress towards achieving this, and an increasing number of low- and middle-income countries are making headway too.

UHC is defined by the World Health Organization as "ensuring that all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship." [14]

The commitment to achieve UHC is easy to understand. Done well, UHC improves access to health services for many people who would otherwise be unable to use those services and can improve the use of services designed to prevent future ill health. UHC can reduce the incidence of serious impoverishment caused by health shocks. In addition, by making access to health services unrelated to ability to pay, UHC satisfies a widely held concept of fairness. Further, as well as promoting financial security, progress toward UHC can improve health outcomes for the population.

The funds needed to finance UHC are usually secured from taxation or mandatory social health insurance, with the intention that financial contributions should be related to an individual's ability to pay rather than medical circumstances. As noted, UHC is included within the SDGs, which include the imperative to "achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all", and which can only be achieved with some form of statutory collective financing arrangements.

Efficiency is a major concern of all health systems. Numerous policy initiatives have been used to enhance efficiency, but it remains a persistent problem. Efficiency improvements represent a key indirect contribution of the health system to wellbeing. By reducing waste (which makes little or no contribution to wellbeing), the health system releases resources that can then be used for enhanced health services, or valued activities in other sectors, thereby improving wellbeing. Many approaches to understanding value do not consider efficiency explicitly as a (valued) output, but instead examine dimensions of other valued outputs (such as the three mentioned above) in relation to the inputs consumed by the health system. For example, cost-effectiveness analysis uses the ratio of expenditure associated with a treatment to the health improvement it secures. Then the extent to which, using such a metric, achieved performance attains the ideal performance is an indicator of efficiency. We discuss the issue of efficiency more fully in Section 2.3 below.

In each of these dimensions their distribution across the population (equity) are also of interest. **Equity** is an elastic concept that can take a number of forms, such as reducing avoidable inequalities in health, and minimizing inequalities in access to health services. It is valued because, for either altruistic or pragmatic reasons, there is widespread abhorrence of the health inequalities that would arise in the absence of access to health services for the sick and the poor. This is one of the major reasons for the attractiveness of the policy of UHC, which in many countries effects a major redistribution of resources to more disadvantaged people in society. A well-designed system of UHC can also contribute to equity by ensuring the necessary financial resources are raised according to an individual's ability to pay rather than medical need.

Health systems can also produce outcomes that are valued by society but are not reflected in the core objectives of the health system. In effect, the actions of the health system spill over into the domain of other sectors, either through deliberate policy intention or accidentally. We define these outcomes as **spillovers**, represented as boxes outside the formal health system in Figure 2. For example, a programme directed at improving the health of schoolchildren may also lead to improved school attendance and associated improvements in cognitive development. Another example is contribution to macroeconomic stability through the jobs created in the health sector. Such consequences spill over from the health sector to another sector (they can also be more purposefully fostered within cross-sectoral policies; see Section 4.1) and undoubtedly contribute to wellbeing, and are therefore valued, but they are not usually considered to lie within the central remit of the health system. However, any full account of the health system's contribution to wellbeing should in principle acknowledge such spillovers. (Note that such contributions could also be negative: for example, the serious deleterious effects arising from excessive prescribing of opioids in some communities.)

2.3 Efficiency and health system value

Health systems generate value by creating health benefits and non-health benefits (such as responsiveness and financial protection). These benefits contribute to wellbeing but should be examined in relation to the costs incurred. Those costs ultimately fall on individuals in various forms (taxation, insurance premiums, or out-of-pocket expenses) that detract from wellbeing. For this reason, most concepts of value examine some ratio of valued outcomes (however defined) to the costs incurred. In this sense, the concept of health system value is closely aligned to the concept of health system efficiency, and many of the debates related to efficiency can be directly translated to debates about value [15].

Economists differentiate between allocative and technical efficiency. In essence, allocative inefficiency arises because the health system has allocated its resources to the wrong mix of services: for example, it may rely excessively on curative services, at the expense of preventive services. This results in some burden of illness that could have been avoided, leading to unnecessary ill-health and health care

expenditure, both of which detract from wellbeing and are a form of waste. In contrast, technical inefficiency arises when an entity (such as a hospital) produces fewer services than it could, given the inputs it has available. Thus, inefficiency can take the form either of the wrong outputs being produced, or of outputs being produced at greater than necessary cost. In either case, health system value is lost [15].

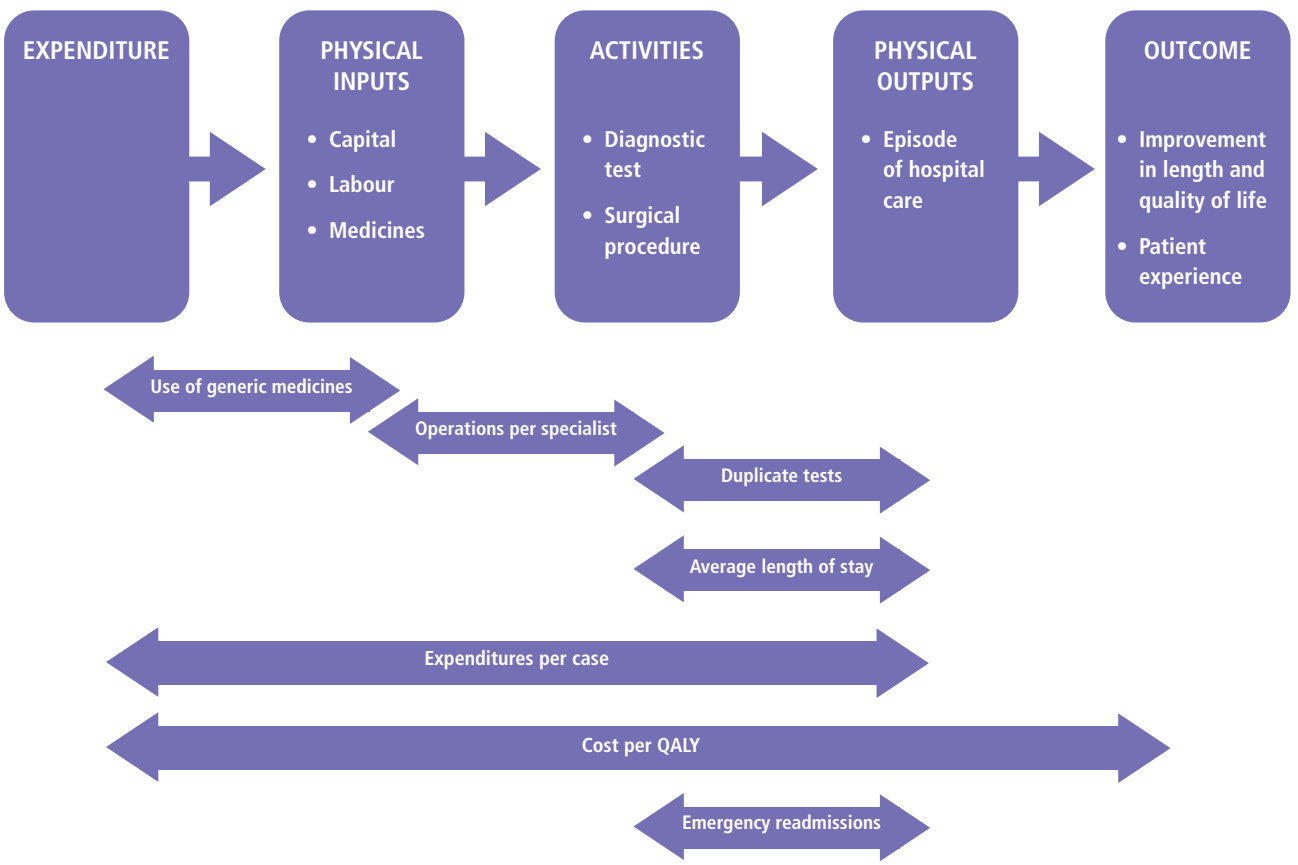
Techniques such as cost-effectiveness analysis [16] have sought to rank health services according to the benefits they create (relative to their costs), and therefore address allocative efficiency (see Section 4.5). They are particularly relevant in health systems with a fixed budgetary allocation, in which efforts are made to optimize the use of that spending. In such health systems, even though a treatment is expected to improve health, its provision may be inefficient if the funds used could be better spent on more cost-effective treatments (thereby creating more value).

Unnecessarily high production costs can arise from a multitude of sources, including unnecessary diagnostic tests, poor procurement practices, use of inefficient care pathways and excessive use of health system resources [14, 17]. Inefficiencies can arise at any stage of a health production process (Figure 3 illustrates where and how they can be commonly identified in hospital care).

It should be noted that it is quite possible to have highly technically efficient services operating within a health system that is allocatively inefficient, because it provides the wrong mix of services. For example, while primary care on its own and secondary care on its own may be organized efficiently, an incorrect balance between primary and secondary care may lead to allocative inefficiency, perhaps because some services that could be provided by primary care are being provided by secondary care at higher costs.

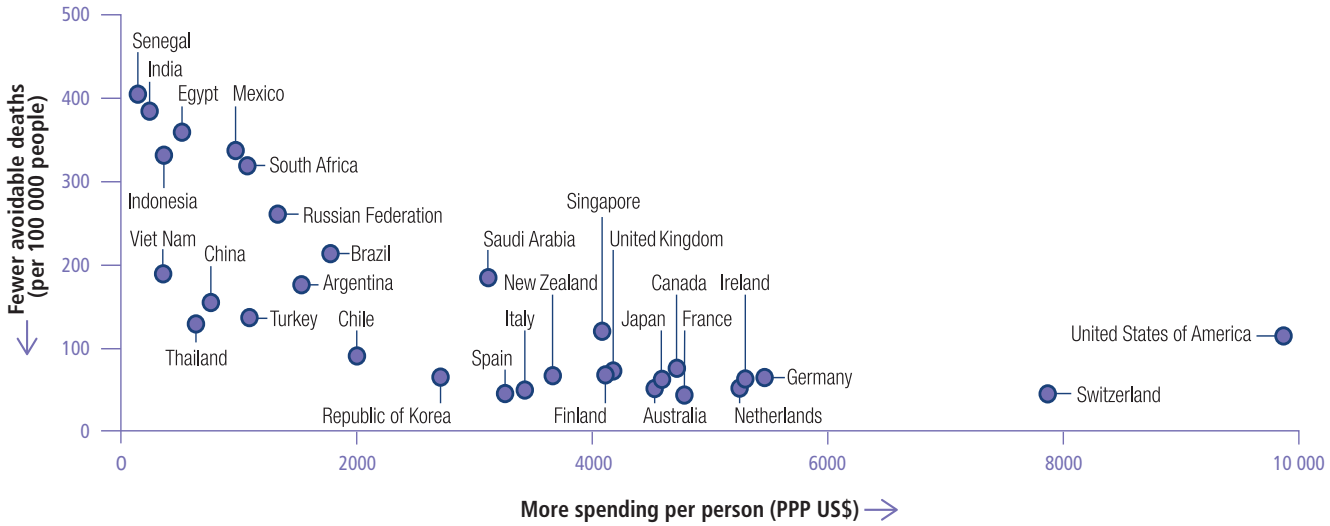
Collectively, inefficiencies in the health sector can be thought of as waste, which is estimated to account for 20–40% of health spending [14]. This waste reduces value, either by precluding spending on more valued health system activities, or by diverting expenditure unnecessarily to the health system, thereby preventing the creation of value by other sectors. The former effect can be illustrated by looking at per capita spending and amenable mortality rates, which accounts for deaths that could potentially be prevented with effective and timely care. Looking across G20 countries, countries that spend more are associated with lower amenable mortality rates (Figure 4). It is also noticeable that there are large variations in amenable mortality between countries with similar levels of spending. Some of this variation can be related to differences in higher risk factors (such as diet or smoking) but some can also be ascribed to inefficiency and waste. Yet, there is an important caveat: low per capita spending on health appears to put a limit on health outcomes regardless of efficiency levels.

Figure 3: Example of value chain in hospital care



Source: Cylus, Papanicolas and Smith [18].
Note: QALY: quality-adjusted life year

Figure 4: Per capita spending on health versus amenable mortality in G20 and selected other countries, 2016



Source: Lessof et al [5].

3. How can various actors in the health system contribute to value?

Health systems are immensely complex social constructs, and in order to function they must create, finance and control certain organizations that are charged with creating the value sought by policy-makers. These organizations must in turn rely on countless personal interactions between health professionals and patients. Within any health system there is therefore an immense array of actors, including (but not limited to) policy-makers, purchasers, providers, practitioners and individual citizens, whose actions should in principle be oriented towards securing certain aspects of value for the health system.

In this section we consider how the various actors contribute to health system value. While each of the actors in the health system should contribute in some way to value, most of them make partial and specific contributions. The particular concepts of value of their contributions must therefore necessarily vary and we shall argue that a large amount of the confusion associated with the concept of value stems from a failure to recognize and reconcile the different perspectives of the various actors in the health system.

We make reference to the typical objectives held by these actors, and note that these might be distinct from the concept of value they are expected to produce for the health system. Therefore, appropriate governance arrangements must generally be put in place to ensure that they deliver value in line with intentions and to move towards a coherent vision of health system value. This is discussed in more detail in Section 5.

3.1. The role of national policy-makers

The ministry of health and its associated agencies are usually the guardians of the health system and its policies. They therefore have a legitimate role in defining what is meant by the value it creates. In principle, this value should reflect the contributions that the health system can make to national wellbeing, however that is defined. Policy-makers in the ministry should be therefore responsible for formulating a concept of value for the health system, transmitting that concept to all actors in the system, and ensuring that value is maximized, both by individual entities and in aggregate.

A first policy requirement is to identify a concept of health system value, the intended contribution of the health system to wellbeing. As discussed in Section 2, there is a considerable degree of consensus regarding the main dimensions of value. High-level goals do not differ substantially between health systems and will usually be formulated in the light of instruments such as national health plans, sustainable development goals (SDGs) and universal health coverage (UHC) (see Box 3 earlier).

Whatever concept of value is chosen, it should relate to the eventual outcomes secured by the health system, and not intermediate outcomes (such as the quality of care) or operational targets. In many respects the most problematic aspect of specifying value is the process by which its definition is reached. The ultimate arbiters of the contribution made by the health system to wellbeing should be citizens and patients (see Section 4.12), but the process of assessing and integrating their views into a statement of value may be far from straightforward.

Once value has been defined, policy-makers have a plethora of tasks to fulfil to ensure that all elements of the health system promote those aspects of value over which they have

control. These tasks may include determining the shape of health system, crystalizing objectives, monitoring performance, and ensuring that properly functioning governance arrangements are put in place to promote and assure the creation of all aspects of health system value (discussed more fully in Section 5). For example, policy-makers must assure financial protection of citizens by ensuring appropriate arrangements to finance the health system are put in place (see Section 4.4). These financial arrangements can also steer citizens towards behaviours that improve their health (see Section 4.2). Policy-makers should also monitor equity and mandate actions to promote equity.

As well as personal health services, national policy-makers need to assure the satisfactory provision of collective services such as disease surveillance and preparedness, which the WHO defines as "common goods for health". Because they take the form of public goods, such collective services may have to be directly purchased and mandated by national governments [19]. Detailed purchasing of most health services can however generally be left to purchasers. An important function of national policy-makers is then to transmit priorities and the concept of value to those purchasers.

Finally, national policy-makers are also charged with monitoring health effects of policies implemented in other sectors and ensuring that these are not detrimental to health and, ideally, lead to health improvements (see Section 4.2). The latter can be fostered through cross-sectoral initiatives (see Section 4.1).

3.2. The role of purchasers

The role of purchasers is to plan and purchase services for a defined population, taking into account national mandates, service and budget constraints and legitimate variations in local population preferences. They often take the form of insurers, local health authorities or local governments. In some health systems purchasers and providers are integrated into single entities, but this should not obscure the essential function of deciding which services should be provided. The concept of value adopted by purchasers should be shaped by the national concept of health system value, but will be constrained by the powers they have been granted. For example, some types of purchasers, such as local governments, may have discretion over the user fees that they charge, and will therefore have more control over the financial protection enjoyed by their population. Other types of purchasers such as local health authorities may have no such powers, but may nevertheless be able to influence financial protection through their decisions on coverage of services.

A prime consideration for purchasers is assuring allocative efficiency (the right balance of services), in order to maximize the value created from their available budgets (see Sections 4.5 and 4.6). Contracting also plays a central role amongst their functions, including purchasing and monitoring health services, assuring that they are technically efficient and offer services of adequate quality to all who are entitled (see Sections 4.6 and 4.7). Contracting by purchasers should aim to secure the highest possible value within their overall budget. The elements of value on which purchasers are best placed to focus are likely to be health improvement, service responsiveness, certain aspects of equity, and efficiency. However, the extent to which they can pursue these aspects of value will be constrained by the powers they have been granted, and the degree of autonomy they enjoy [20].

3.3. The role of provider organizations

The health system relies on a huge range of provider organizations, ranging from small primary care practices to complex tertiary hospitals. The objectives of these entities will vary depending on a range of factors, such as the scope of services they provide, their ownership status and the type of market in which they operate. However, some form of financial sustainability will be a central preoccupation of almost all provider organizations. The health system will in general rely on them to create value by delivering high quality and responsive services that generate health and non-health benefits, while keeping costs to a minimum (see Sections 4.3, 4.4, 4.10, 4.11). Purchasers will generally seek to put in place financial and non-financial incentives with those objectives in mind.

In pursuit of financial sustainability, providers will often be concerned with technical efficiency. Many larger provider organizations, such as hospitals, therefore seek to improve managerial and clinical processes that reduce unit costs and improve outcomes, using techniques such as internal audit and total quality management. Some may also seek to monitor the quality of care and patient satisfaction, using instruments such as monitoring adherence to clinical guidelines or patient-reported experience measures (PREMs). This may particularly be the case if purchasers have mandated such measures in order to benchmark provider performance, or provide comparative information for patients.

A major source of allocative inefficiency may arise from the inability of different provider organizations to coordinate the care of patients, and therefore create less than the potential value (see Section 4.8). For example, failures in the integration of various providers of care for patients with long term conditions may result in loss of value in the form of reduced health improvement, shortcomings in patient responsiveness, and waste. To some extent ensuring successful integration of care is a matter for strategic purchasers or national policy-makers. However, it will frequently also be an outcome for which the provider organizations themselves should be accountable, and any failures should be considered a negative contribution to value.

3.4. The role of practitioners

A vast range of clinical practitioners contribute to the functioning of the health system. Their objectives are likely to be complex, including the pursuit of income, career progression, minimizing effort, and an altruistic concern for patients. Their intended contribution to health system value

decisions in terms of the proportion of population covered (breadth of coverage), range and quality of services covered (scope of coverage) (see Section 4.6), and the proportion of total health costs to be met (depth of coverage) [14].

4.5. Setting a health benefits package

A health benefits package (HBP) is an explicit statement of the health services to which a citizen is entitled from a publicly funded health insurance fund [15, 38]. It seeks to promote several aspects of value, most especially equity, by ensuring that entitlement to the designated services is universal, or explicitly defined population groups. It is generally applied in systems in which the public funds available are limited to a fixed budget. Then the HBP can promote efficiency, by helping ensure the use of the budget maximizes some aspect of value (usually health improvement). Health technology assessment (especially cost-effectiveness analysis) offers a powerful tool for selecting the HBP, with tools such as the Tufts CEA Registry [39] and the WHO CHOICE initiative [40] covering an increasing range of services. The HBP can also be thought of a key element of strategic purchasing covered in more detail in the next section.

The HBP has ramifications throughout the health system, with important implications for purchasers (whose role is largely determined by the HBP), citizens (whose use of the public and private sector is shaped by the HBP) and service providers (whose activity and revenues depend on the HBP). There is growing interest in creating HBPs, particularly in low- and middle-income countries, with many exploratory exercises, and a few enduring examples such as Chile and Thailand. However, the bureaucratic processes involved in setting a benefits package are considerable, and it has proved challenging to initiate, implement and update HBPs. Furthermore, there are sometimes profound political difficulties associated with explicit exclusion of services. If properly designed, the HBP can nevertheless offer an important contribution by focusing the actions of purchasers, providers and citizens on the services that create most value and promoting the ideals of universal health coverage [41].

4.6. Strategic purchasing for health gain

Strategic purchasing refers to a combination of purchasers decisions that relate to what to buy (which services), from whom to buy (which providers) and how to buy (which payment model) [4, 42, 43]. Strategic and active purchasing can, in theory, increase value by purchasing those services that have been identified as cost-effective and of high priority, therefore improving efficiency, and/or those that are particularly relevant for population groups with high needs, therefore improving equity. It can also increase efficiency by steering the provision of care by carefully selecting appropriate providers, with outcomes of this steering including reduction of duplication or oversupply of services by shifting them across various levels (e.g. from secondary to primary care), a more appropriate distribution of facilities; or better coordination (see Section 4.8). However, it is important to create systems in which the transaction costs involved do not exceed any notional cost savings or shift costs to other sectors, for example by favouring contractors paying low wages to employees who must then be supported by the welfare system. Purchasing can also be used to enforce aspects such as minimum levels of quality (e.g. by making accreditation a mandatory requirement in the purchasing process). Again, it is important to avoid adverse consequences, such as the higher levels of hospital-acquired infection associated with contracting out cleaning services in the NHS in England [44].

Payment systems have to be optimally designed to ensure that the provider is adequately incentivized and compensated for the prioritized services. Payment systems have tended to focus on rewarding one dimension of performance (activity, treatment, episode of care), and increasingly referred to in very broad terms as pay-for-performance schemes. Limitations of single payment methods that reward one type of performance (FFS, activity-based payment, capitation) have been well recognized. To address this, purchasers increasingly rely on mixed or blended payments [43] that combine different payment methods (e.g. capitation with FFS or payment for quality (see Section 4.7) within primary care, and fixed budgets with DRG payments within secondary care) for the implementation of health priorities [4].

4.7. Paying for quality

A prominent type of pay for performance (P4P) refers to financial schemes that are designed to incentivise the quality aspect of primary and secondary care providers. Although these schemes can be thought as being part of strategic purchasing, we discuss them here in more detail to reflect the appeal of designing payment methods directly related to quality measures, which was precluded in the past under more traditional payment methods (e.g. FFS or activity-based payment). We therefore label these P4P schemes as "paying for quality". The feature is that the effort exerted by the provider to improve quality is commonly assessed with metrics focusing on health outcomes (e.g. mortality, emergency readmissions, and patient reported outcome measures (PROMs)) or on metrics focusing on processes (e.g. following certain protocols and guidelines for stroke or hip fracture patients) [45]. Pay for quality has the potential to add value by improving patient health at moderate expense for the purchasers. To achieve financial sustainability, these schemes can be designed as a mixed payment system with additional revenues from the scheme being accompanied by reductions in revenues from other payment components (e.g. within secondary care, introduction of pay for performance would involve a reduction in the basic DRG tariff). Reviews find that these types of P4P schemes generally lead to positive but modest changes in the quality metrics (the performance) they are meant to incentivize, and that they are more effective in ambulatory and primary care (e.g. the Quality and Outcome Framework in the UK) than in secondary and specialized care [46]. Where P4P has no effects, this may be due to small size of incentives involved (often less than 10% of revenues).

Policies in this area call for a greater involvement of providers in the design of P4P schemes, in particular clinicians, and larger incentives within a mixed payment system. Attention should be paid to a robust scheme design to avoid gaming and cream skimming. It is also important to

is usually to provide health improvement for service users, and be responsive to their needs, subject to any restrictions on treatments applied by policy-makers, purchasers or provider organizations. This will be the case whether they work in a large provider organization or as a lone practitioner. To assure that their members provide high quality care, many professions require participation in continuous professional development (CPD), and an important role for senior practitioners is to train their less experienced colleagues. Leadership of the professions therefore becomes a key requirement at all career stages, but especially with seniority.

The value contributed by practitioners is closely aligned with, but not identical to, those of provider organizations. The main concern will be with the extent to which they secure health improvement and treat service users responsively. Some elements of efficiency may also be important when considering the value created by practitioners; for example, the unnecessary use of diagnostic services or prescribing branded medicines can in many circumstances be considered health system waste. Adherence to best practice guidelines and the reduction of unwarranted variation may be an important mechanism for promoting the value created by practitioners (see Section 4.9).

3.5. The role of citizens and patients

Citizens and patients should be included in any discussion of health system value (see Section 4.12). They should be central to informing the definition of what is meant by the value created by the health system. Furthermore, their preferences vary, and so only individuals can say whether the service received is sufficiently person-centred. In countries in which user fees are significant, patients will have a keen interest in whether the services represent value for (their own) money. And as financial contributors to the health system as a whole, through tax payments or insurance premiums, people have an interest in the overall value of the health system.

Citizens and patients can also play a crucial role in maximizing the value created by the health system, either collectively or individually. For example, reducing risky behaviour plays a major part in preventing or delaying onset of disease and ameliorating its consequences once established. Once a treatment is initiated, its effectiveness may be enhanced substantially if the patient adheres to the recommended regimen. Therefore, behaviour can make a major contribution to health system value by minimizing the impact of illness and maximizing the effectiveness of treatment. Improved health literacy and responding to carefully designed "nudges" can also contribute to value, for example resulting in more appropriate use of health system resources, thereby improving allocative efficiency and reducing waste.

4. Key policy levers for enhancing value: what do we know?

In this section we look at a range of policy levers used for enhancing value and examine how they attain this goal according to the definition of value proposed in this brief. In presenting these levers, we are not necessarily recommending they should be adopted in all health systems. Indeed, in some cases the evidence of effectiveness has so far been disappointing. However, we suggest that the selected policies are promising initiatives that seek to promote certain aspects of health system value. With careful attention to previous experience, and the relevance to their own system, these levers should be considered by health policy-makers interested in promoting value.

The selection of policy levers covered in this section is not intended to be comprehensive. Rather, it seeks to cover a broad range of health system actors and functions, and different dimensions of value. The focus is on contributions that can be subsumed within the core functions of the health system, but including some cross-sectoral mechanisms. While this brief is by necessity selective in its coverage, it is nevertheless likely that all health policy levers could be interrogated using the framework adopted in this section.

For each lever, we first identify its primary objectives, then discuss how it is expected to enhance value, and to what extent this is achieved. We outline the main challenges encountered, and the key actors involved (how they affect and are affected by the lever). We then briefly discuss how its effectiveness can be improved from a health system value perspective.

Table 1 provides selected examples of policy levers that are used to enhance value, including those covered in this section.

We shall see that usually the levers directly address only one or two aspects of health system value. But value can often be further enhanced by paying close attention to the other aspects too, ensuring, at the minimum, that they are not negatively affected. We shall also see that all the levers are closely connected, not only because they affect or are affected by the same actors and relate to the same aspects of value, but because they influence the effectiveness of other levers too. They should thus not be considered in isolation from each other.

We order the examples broadly in line with Table 1, starting with levers that relate mostly to a specific actor (national policy-makers, purchasers etc.) and for a given actor the health system objective. Therefore, we start from the examples in the first row (left to right) in Table 1, followed by the second row (left to right) etc., with the caveat that in practice each example can involve multiple actors and objectives, as also made clear by Table 1.

Table 1: Examples of policy levers to enhance health system value

	Health improvement	Responsiveness	Financial protection	Efficiency (min. waste)	Equity
National policymakers	HiAP initiatives; fiscal and regulatory measures for health promotion and disease prevention; behavioural interventions (nudging); strengthening PHC; promoting the use of evidence (e.g. via clinical guidelines); collection of digital data	Strengthening PHC	Funding sources; exemptions from user charges	Promoting the use of tools such as CEA, HTA, WHO CHOICE	Resource allocation; funding sources
Purchasers	Resource allocation (e.g. selection of health benefits package); strategic purchasing/payment mechanisms (e.g. to incentivize provision of health promotion and disease prevention)	Strategic purchasing (through e.g. better coordination, incentivising quality through P4P); personal budgets for patients and caregivers; integrating care services	Monitoring use of private sector	Strategic purchasing; payment mechanisms	Strategic purchasing; assuring access to services; local resource allocation
Provider organizations	Training; promoting adherence to clinical guidelines	Workforce development; adapting skill mix; supporting patient involvement; use of eHealth		Management processes; internal accounting; use of eHealth	
Practitioners	CPD; adherence to clinical guidelines	Training; use of eHealth		Adherence to economic guidelines; minimizing waste; use of eHealth	
Citizens and patients	Healthy living/avoiding risky behaviours; compliance with treatment regimens; involvement in decision-making (bodies) related to health; participation in treatment decisions	Exercising choice of provider; making preferences clear (e.g. via PREMs); use of eHealth	Assuring usefulness of purchased services	Exercising choice of provider; using resources appropriately; use of eHealth	Ensuring knowledge and exercise of entitlements

Notes: The darker shading indicates a greater contribution to the given dimension of value, while the lightest shading suggest smaller contribution. CEA = cost–effectiveness analysis; CHOICE = CHOosing Interventions that are Cost-Effective (a WHO initiative developed in 1998 with the objective of providing policy-makers with evidence for deciding on interventions and programmes which maximize health for the available resources); CPD = continuous professional development; HiAP = Health in All Policies; HTA = health technology assessment; PREMs = patient-reported experience measures; PHC = primary health care.

Source: Authors' own compilation.

4.1. Working across sectors for health: Health in All Policies

Health in All Policies (HiAP) is about tackling the commercial and social determinants of health by including health considerations in the policies of all other sectors [21, 22]. These can add value because transport, energy, education and all other sectors have impacts on health like road injuries and fatalities, air pollution and health literacy, just to name a few. HiAP is vital for health systems because it can improve population health and therefore reduce the burden of disease on health systems as well as on society. The key actors in HiAP are the ministries of health taking the initiative to reach out to other sectors, and in particular to other ministries and the centre of government, in order to raise awareness for health, inform on effective and suitable interventions and propose collaborations. There is a long list of intersectoral governance structures facilitating this intersectoral dialogue and collaboration including committees at cabinet, parliamentary and departmental level; joint and delegated budgets; state health conferences, citizens' hearings and collaborations with industry [23] and civil society [24].

The Sustainable Development Goals (SDGs) adopted by the United Nations (UN), the European Commission [25] and the UN Member States, are an opportunity and argument for HiAP. The SDGs define goals, targets and indicators not only

for health but for all other sectors which are usually covered by national and regional governments. Working with other sectors, however, has often proven cumbersome, marred by indifference, scepticism, missing political mandates or sheer resistance. All too often, health sector initiatives to promote HiAP have been badly received as imposing or irrelevant to the policy goals of other sectors. An alternative strategy is to focus on the so-called co-benefits that recognize spillovers across sectors. Co-benefits are substantial specific benefits to the other sectors that can be gained by investing in health-related actions [26]. Arguing for co-benefits is a way to enable HiAP in both senses: by enhancing other sectors' contribution to health and the contribution of health systems to other sectors.

4.2. Fiscal and regulatory measures for health promotion and disease prevention

There is a substantial evidence base suggesting that many health promotion and disease prevention interventions, delivered within the health system (see Section 4.3) and in partnership with other sectors, can be highly cost-effective or even cost-saving. The most effective interventions against health-damaging substances, such as tobacco or alcohol, address price, availability, and marketing, while educational interventions are mostly of limited effectiveness or even counterproductive. As would be expected, the manufacturers of these products promote policies that do the opposite [27]. Nudging (the reframing of individual choices over health promoting actions based on behavioural psychology) can complement these measures but the main focus should always be on regulatory and fiscal measures [28], especially as these measures may have more impact on some population groups than others [29].

Despite its cost effectiveness, the level of investment in health promotion and disease prevention activities remains stubbornly low in many countries [27]. Ministries of health and ministries of finance can play pivotal roles in increasing investment within and outside the health system (see Section 4.1). Barriers to investing are many and include the reluctance to invest in actions which may not generate positive benefits for many years and the difficulty of actors being able to appropriate such benefits due to promotion being just one of many factors affecting health. The removal of such barriers will be pivotal in improving health promotion and value.

4.3. Strengthening primary health care

Primary care can be defined as "the first level of professional care […], where people present their health problems and where the majority of the population's curative and preventive health needs are satisfied" [30]. This definition highlights three key dimensions of primary care: being the first point of contact with the health system; being able to respond to the majority of population health needs; and being a provider of both curative and preventive health services (see Section 4.2). Indeed, screening and immunization, or interventions to support healthy lifestyles, are public health functions that are commonly provided in primary care [31]. Some of these preventive actions, such as brief physician advice interventions to protect the mental health of people with physical health problems and screening programmes for hazardous drinking, have been found to be highly cost-effective or cost-saving [32].

While in too many countries primary care is still undervalued and lacks investment and prestige, primary health care has been recognised to be at the core to achieving universal health coverage and the health-related Sustainable Development Goals. The 2018 Astana Declaration, reaffirming the values and principles of the 1978 Declaration of Alma-Ata, emphasized that strengthening primary health care is the most inclusive, effective and efficient approach to enhance people's physical and mental health, as well as social wellbeing [33]. Key dimensions of strong primary care are accessibility, comprehensiveness, continuity of care, and coordination of care. This means that strong primary care provides accessible, comprehensive care, in an ambulatory setting, to patients in their own context on a continuous basis, and coordinates the care processes of patients across the health system [34]. For many conditions it is the most appropriate and cheapest form of care that can place the patient at the centre of health services and coordinate the input of other health professionals (Section 4.8). This increasingly involves team work whereby primary care physicians work in partnership with nurse practitioners and newly emerging professions. Overall, strong primary care improves the capacity of a country to achieve a responsive, high-quality and cost-effective health system that improves population health [34].

4.4. Funding health care for universal access

The goals of universal coverage are most likely to be met when health care costs are largely financed through pre-payment with risk pooling, so that individuals do not encounter financial barriers to access or experience financial hardship [35]. Such funding mechanisms include direct (e.g. income tax) or indirect (e.g. value added tax (VAT)) taxation revenue, social health insurance or mandatory private insurance. Policies based on direct taxation achieve better health outcomes than those relying on regressive indirect sources, such as sales or flat rate taxes. By pooling risks, unlike user charges or voluntary private health insurance, these arrangements allow access to health services to be based on need (rather than ability to pay) and ensure financial protection against catastrophic health spending that disrupt households' living standards or can push them into poverty. There is by now sufficient evidence showing that expansion of coverage improves access and financial protection, and increasing evidence that it has a positive impact on health outcomes [36, 37]. Universal access to health services can also enhance health system value by generating health gains that more than offset the increase in health spending, therefore enhancing efficiency, but also improving the health of the most vulnerable and poorer groups, addressing equity. In some cases, the most vulnerable groups might also be those with highest ability to benefit so that equity and efficiency are aligned.

Policy-makers, particularly in those countries where politicians have given a low priority to health or are unwilling to raise funds through taxation or other sources, continue to face stark trade-offs in balancing coverage

decisions in terms of the proportion of population covered (breadth of coverage), range and quality of services covered (scope of coverage) (see Section 4.6), and the proportion of total health costs to be met (depth of coverage) [14].

4.5. Setting a health benefits package

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Payment systems have to be optimally designed to ensure that the provider is adequately incentivized and compensated for the prioritized services. Payment systems have tended to focus on rewarding one dimension of performance (activity, treatment, episode of care), and increasingly referred to in very broad terms as pay-for-performance schemes. Limitations of single payment methods that reward one type of performance (FFS, activity-based payment, capitation) have been well recognized. To address this, purchasers increasingly rely on mixed or blended payments [43] that combine different payment methods (e.g. capitation with FFS or payment for quality (see Section 4.7) within primary care, and fixed budgets with DRG payments within secondary care) for the implementation of health priorities [4].

4.7. Paying for quality

A prominent type of pay for performance (P4P) refers to financial schemes that are designed to incentivise the quality aspect of primary and secondary care providers. Although these schemes can be thought as being part of strategic purchasing, we discuss them here in more detail to reflect the appeal of designing payment methods directly related to quality measures, which was precluded in the past under more traditional payment methods (e.g. FFS or activity-based payment). We therefore label these P4P schemes as "paying for quality". The feature is that the effort exerted by the provider to improve quality is commonly assessed with metrics focusing on health outcomes (e.g. mortality, emergency readmissions, and patient reported outcome measures (PROMs)) or on metrics focusing on processes (e.g. following certain protocols and guidelines for stroke or hip fracture patients) [45]. Pay for quality has the potential to add value by improving patient health at moderate expense for the purchasers. To achieve financial sustainability, these schemes can be designed as a mixed payment system with additional revenues from the scheme being accompanied by reductions in revenues from other payment components (e.g. within secondary care, introduction of pay for performance would involve a reduction in the basic DRG tariff). Reviews find that these types of P4P schemes generally lead to positive but modest changes in the quality metrics (the performance) they are meant to incentivize, and that they are more effective in ambulatory and primary care (e.g. the Quality and Outcome Framework in the UK) than in secondary and specialized care [46]. Where P4P has no effects, this may be due to small size of incentives involved (often less than 10% of revenues).

Policies in this area call for a greater involvement of providers in the design of P4P schemes, in particular clinicians, and larger incentives within a mixed payment system. Attention should be paid to a robust scheme design to avoid gaming and cream skimming. It is also important to

ensure that P4P works in favour of the more disadvantaged and costly patients, therefore improving equity and not only efficiency.

4.8. Integrated people-centred health services

Integrated care refers to a structured effort to provide coordinated, proactive, person-centred, multidisciplinary care by two or more communicating and collaborating care providers [47]. It may require coordination across different sectors within and beyond the health care sector to address fragmentation of services and improve patient experience [48]). The primary health care level is often at the centre or part of the integration. An example here may be a primary care practice which employs a pharmacist and community carers, specialised nurses and even specialist doctors (see Section 4.3). Care integration can improve value by improving patient experience by reducing fragmentation of services, and thus enabling improved care coordination and continuity [4, 49]. The key financial tool to support care integration are bundled payments, i.e. using a single payment to fund a pre-defined set of services by multiple providers for a specific group of patients [48].

There is a range of approaches, such as organizational models (e.g. centring provision of care around primary care or introduction of care pathways, use of eHealth (see Section 4.10), and supporting greater patient involvement, that have been effective in enhancing integration and have resulted in increased cost effectiveness and value (albeit not always leading to cost containment) [50]. It remains uncertain which integrated care models are the most successful. Future policies will need to be refined to ensure that integrated care delivers the patient-centred continuum of care that it has promised.

4.9. Evidence-based care

A major lever for improving value is the commitment to basing decisions about care on best available evidence. Evidence-based practice encompasses an integrated approach based on three pillars: scientific evidence, clinical expertise and patient values [51]. Evidence-based care has the potential to improve health outcomes but also quality and safety of care, as well as reduce unwarranted practice variation and waste. To the extent that it considers, as it should, patient preferences and values, it can also boost responsiveness of care. A 2017 report by the OECD estimated that about one fifth of health spending goes to ineffective and wasteful care, and considerable variation can be observed across and within countries [17]. A number of tools are used to enhance the use of evidence in decisions about patient care. Clinical guidelines draw on the same methods as HTA, which informs coverage decisions (see Section 4.5), for the identification and appraisal of evidence; while they have different intended primary users, they can inform and complement each other. Evidence on the effect of clinical guidelines on health outcomes shows mixed results, but a clear link with implementation modalities [52]. The extent to which they further the goal of efficiency has not been sufficiently investigated; but if guidelines do not consider the cost of care, they may inadvertently impede its attainment [53].

The development of clinical guidelines can be established by policy-makers centrally or regionally to ensure evidence-based care, or be based primarily on initiatives led by health professional organizations. Guidelines typically contain recommendations and are rarely binding for practitioners, but deviating decisions might need to be justified [52]. Patient participation in guidelines development has increased in recent years to ensure that recommendations reflect patient values and enable shared decision-making. Guidelines-based quality indicators can be used to monitor health system performance and inform payment mechanisms (see Section 4.7) [52], highlighting the importance of the lever for policy-makers and payers alike. For evidence-based care to function as intended there is a need for good quality research to be available for priority areas, which presupposes an appropriate prioritization and funding mechanism; for health professional education to include the tenets of evidence-based practice; for clear mechanisms for the development and implementation of clinical guidelines (and HTA) to be in place, with involvement of all relevant stakeholders, including patients, and with transparent accountability structures and evaluation mechanisms. Advances in information technology can support evidence-based practice by simplifying evidence synthesis, endorsing adherence (e.g. decision support software) and improving the accessibility of evidence at the bedside.

4.10. Stepping up the introduction of eHealth and digital health

The use of information and communication technology for health (eHealth) has the potential not only to improve the efficiency of care, but to enable fundamental changes in how health systems achieve all their objectives [54]. This lever thus has the potential to provide cross-cutting enhancements to other levers as well, in particular paying for quality (Section 4.7), integrating health services (Section 4.8) and involving citizens in decision-making (Section 4.12). Implementing eHealth technologies has proved difficult and time-consuming in practice. Technologies need to be able to link to each other in terms of both technical capacity and governance, which remains challenging; and precisely the potential of eHealth to enable fundamental health care change means that introducing eHealth technologies involves also rethinking structures and processes and engaging with relevant actors. Implementation remains patchy, with greater efforts needed to realise the potential efficiency gains from eHealth. Equity is also an important consideration in eHealth, ensuring that patients who cannot or do not wish to use eHealth tools are still cared for effectively.

The value of eHealth is being taken further by combining it with the generation, use and re-use of data for health and care (digital health) [55]. This has the potential to add value through generating innovations in improving health, improving responsiveness and the efficiency of care (Section 4.11), and to provide an improved evidence base for value-added care (Section 4.9). However, it also raises new concerns, in particular around the secondary use of data. The central challenge is how to maintain public trust in the

secondary use of highly sensitive data, which relates both to how the data is being used, and by whom [56] This in turn illustrates a specific challenge for this lever, which is how best to work with the private sector actors such as technology companies who are central to eHealth and digital health but whose private interests must be balanced with the wider societal value to which they are contributing.

4.11. Involving patients in their own care

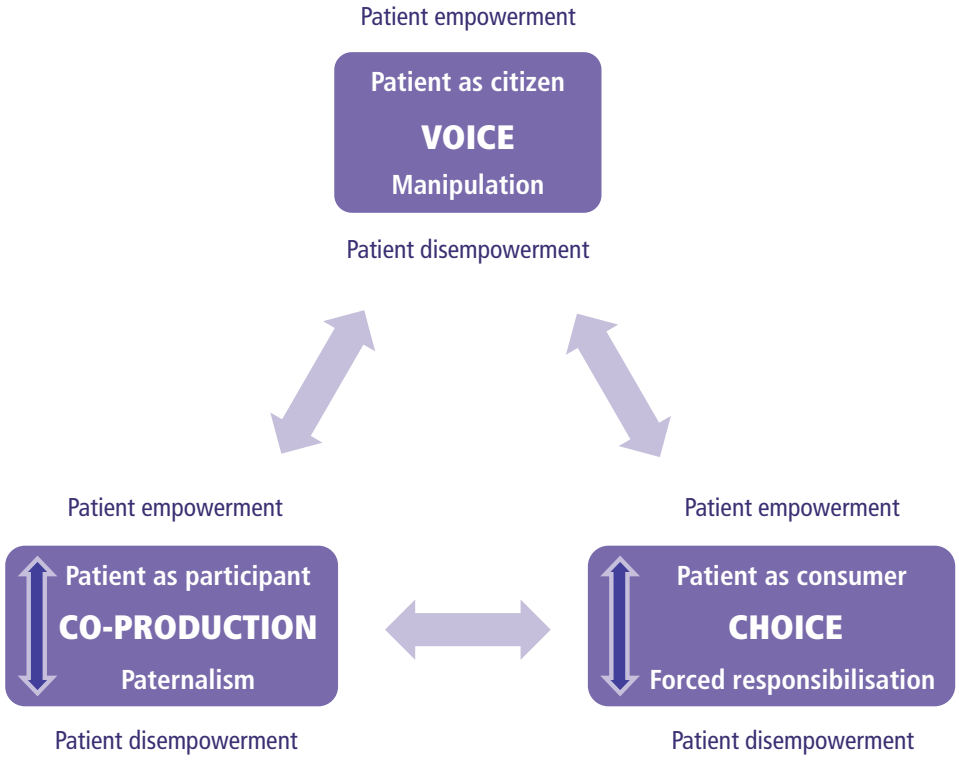
A person-focused approach has been advocated on political, ethical and instrumental grounds and is believed to benefit patients, health professionals and the health system more broadly [57]. Person-centred care means ensuring that patients' preferences and values are considered, that their interactions with practitioners are empathetic and informative, and that health care service delivery responds to people's physical, emotional, social and cultural needs [58]. This is important because people's health care experiences can influence the effectiveness of their treatment. For example, in shared decision-making between patients and practitioners factors such as trust, reassurance and comfort have been found to influence intermediate outcomes including adherence [59] and self-care skills, which in turn influence health outcomes [60]. Furthermore, many countries have formally recognized shared decision-making in policy and regulatory frameworks as part of a move towards more person-centred care, typically in the context of legislation on patients' rights to informed consent and information. There has also been progress in the understanding of how people view the quality of services, with recent moves to the collection of patient-reported experiences and outcomes measures (PREMs and PROMs), with the latter being used for clinical research and to facilitate shared decision-making between practitioners and patients to improve clinical practice [58] (see Section 4.9). Public reporting systems have the objective of supporting service user choice. Public reporting is useful to facilitate performance assessment and benchmarking between services or organizations and to help practitioners reflect on their own or their organisation's performance; however, public reporting may result in providers focusing on improving those indicators that are reported on, such as waiting times [61].

Decision-makers across Europe have recognized the need for implementing strategies to support self-care and self-management [62], mainly for chronic diseases and often in the context of disease management programmes. These arrangements will be linked to the patient's primary care provider (Section 4.3), eHealth platforms where available (Section 4.10), and be part of wider moves towards integrated care (Section 4.8). Supporting the active participation of patients in their care is seen as a priority to optimally respond to patient needs and improve health outcomes.

4.12. Involving citizens in decision making

Citizens can occupy three core roles in the health care setting, beyond their established role in the democratic process in which they elect those who make decisions. These include consumerist (choice), deliberative (voice) and participatory (co-production) (see Figure 5) [57]. Choice relates to the notion of the patient or service user as a

Figure 5: Three core roles of citizens in the health system



Source: Nolte et al [57].

consumer within the health system. The concept of voice represents the individual patient or service user as a citizen who is actively involved in decision-making (bodies) related to health. For example, community or citizens' juries and other forms of deliberative democracy can support policy decisions on disputed policy issues, such as public coverage of PSA testing [63] (see sections 4.5 and 4.6). Co-production can be seen to be located at the interface between voice and choice and describes how patients or service users engage, individually or collectively, in the delivery of their own treatments and care in partnership with providers [57]. These distinctions present different roles that individuals can take, at times simultaneously, as a patient, decision-maker, taxpayer and active citizen [64].

The role of public participation has been identified as both a means to improve service provision and utilization, and to achieve greater equity in health care. There has been renewed interest in public participation internationally, while in European settings participation in the context of health service design and delivery is variable in terms of who is engaged, for what, how and why [57]. Therefore, participation programmes need to be realistic and take account of the ability of marginalized people in particular to participate [65]. Factors which have been found to increase the value added by community participation include: appropriate financing of the initiative, logistics and systems of communication, and partnerships with relevant organizations [66]. Involving people in the health care policy process can be seen to be a value in its own right. Moving forward, it will be important for all actors involved in the development of involving citizens in decision-making on health services and systems to agree on a set of common objectives and how to achieve them. A caveat is necessary. In divided societies it is important to include strong protection for disadvantaged minorities as a majoritarian approach can easily entrench discrimination.

5. The central role of governance in aligning the levers

In the preceding sections we have noted that the institutions of the health system, and their missions, should be aligned with a common concept of value, and that policy levers should be designed to promote that concept.

To achieve this, there should be in place appropriate instruments to promote, monitor and rectify any shortcomings in securing value, either by institutions or policies. In brief, assurance of value requires effective **governance** of the whole health system [20].

Box 4: TAPIC: the five domains of governance

Transparency means that institutions inform the public and other actors of both upcoming decisions and decisions that have been made, and of the process by and grounds on which decisions are being made.

Accountability means that an actor must give an account of its actions, with consequences if the action and explanation are inadequate.

Participation means that affected parties have an opportunity to provide input to relevant deliberations without fear of retribution.

Integrity means that the processes of representation, decision-making, employment and enforcement should be clearly specified. Individuals and organizations should have a clear allocation of roles and responsibilities.

Policy capacity refers to the ability to develop policy that is aligned with resources in pursuit of goals.

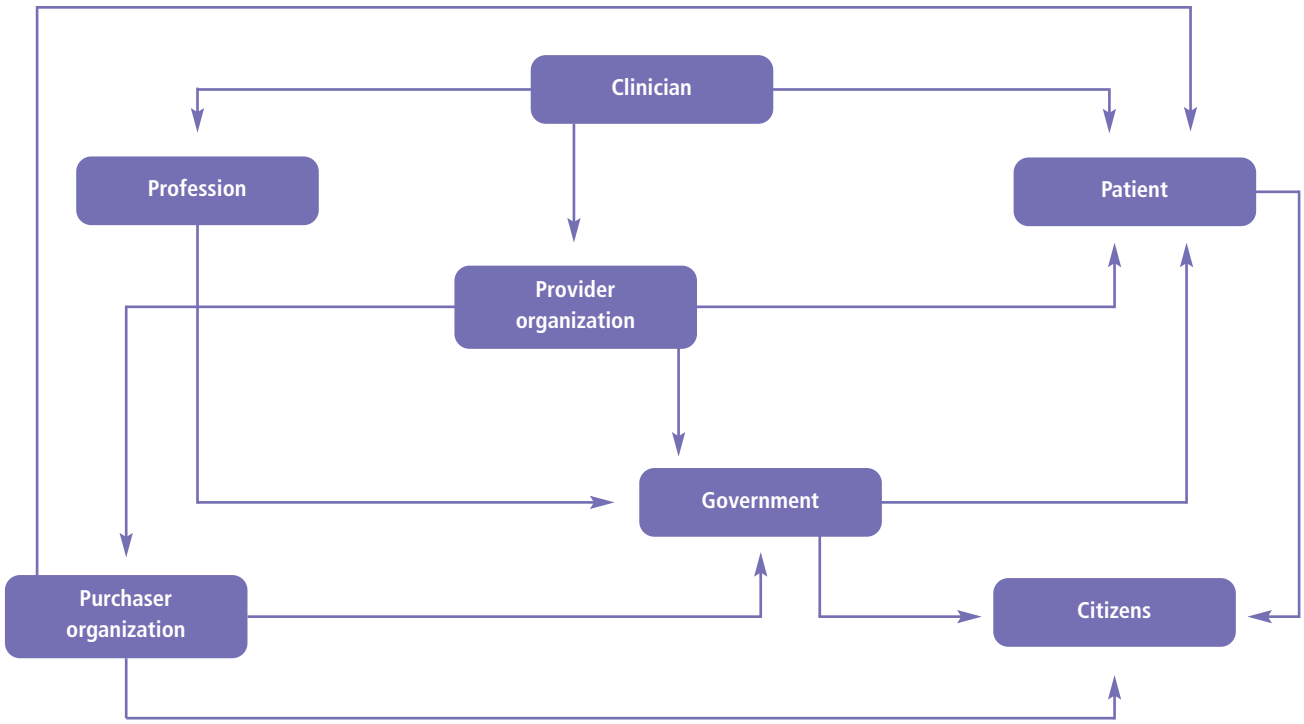
Source: Greer, Wismar and Figueras [67].

Governance is a multifaceted concept that is comprehensively described elsewhere [68]. Greer and colleagues [67] present a five-dimensional framework for designing and assessing governance and arrangements (see Box 4). Here, following Section 2, we focus on the accountability relationships that exist between actors within the health system, and how their governance can be designed to promote value. Figure 6 illustrates some of the many relationships (arrows) that can be found within a health system, each of which can be conceptualized as a principal–agent relationship. Each agent (the blunt end of the arrow) is expected to deliver some aspect of value to the associated principal (at the arrow head). Note that most actors can be both a principal in some of their relationships and an agent in others.

Numerous approaches have been taken to improving the performance and accountability of actors within the health system. Some of these are documented in Section 4. From the perspective adopted in this brief, the important consideration should be that these initiatives promote the chosen concept of value. That is, each accountability arrangement should have clarity about what aspects of value it is seeking to address, how that contribution is conceptualized and measured, and what mechanisms are in place to correct shortfalls in the creation of value that have been identified. This requirement matches the TAPIC concept of integrity: the clear allocation of roles and responsibilities. Only by having a clear idea of who is creating what aspect of value will it be feasible to create the integrated health system capable of promoting value effectively.

The TAPIC perspective suggests that transparency to the public and all relevant actors should be a principle underlying all governance arrangements. Central to any form of governance should therefore be the metrics chosen to monitor the creation of value within each of the principal-agent relationships. This often requires the specification of performance measures, aligned with the relevant concept of value, for every actor within the health system. This does not necessarily mean that performance indicators should directly measure the outcomes associated with value. For example, it would clearly be infeasible to measure directly the long-term health improvement associated with a vaccination programme. Instead, performance metrics will often capture

Figure 6: A map of some important accountability relationships in the health system



Source: Smith, Mossialos and Papanicolas [69].

processes that are known to be associated with long term outcomes (and value), such as, in this case, vaccination coverage rates.

The practical limitations associated with performance measurement initiatives have been well documented, and in practice it is likely that even effective schemes will be incomplete and imperfect in their ability to capture value. Indeed one of the fundamental reasons why Swedish experiments with value-based health care have foundered is that the information demands have been found to be excessive [1]. Policy-makers should therefore be realistic about the limitations to securing good governance, and should ensure that adequate capacity is put in place to make the chosen governance arrangements effective.

Our map of accountability relationships demonstrates the importance of participation of all relevant actors in the governance of a value-based health system. Careful attention should be given to the intrinsic objectives of agents in order to determine whether or not to introduce explicit financial or non-financial incentives. To that end, for example, there have been numerous experiments with methods of paying provider organizations, especially when they operate in some sort of market. The intention is usually to promote some aspects of value, such as health outcomes or efficiency. Such initiatives recognize that the organizations may have additional objectives that are not aligned with health system value, such as enhancing their own financial performance or avoiding excessive effort.

Perhaps the least well-developed aspects of health system governance are the mechanisms to secure improvement when an agent fails to provide expected levels of value. Smith and colleagues suggest four broad approaches: central directive, markets, democratic processes and professional development [70]. Each of these has strengths and limitations, and most health systems rely on a mixture for most parts of their system. There is a clear need for more research to inform the design of accountability relationships. In this respect, TAPIC offers a potential tool for auditing the effectiveness of accountability relationships, and the chosen concept of value should offer an overarching criterion for assessing that effectiveness.

No health policies can succeed without effective governance arrangements being put in place. The precise form that these take will depend on the type of health system, and the agency relationship under scrutiny. However, there is no question that they require explicit consideration and careful design. Health systems should therefore ensure there is adequate capacity both to create and to operate the governance arrangements necessary to assure the creation of value in all parts of the health system.

6. Conclusions

Value-based health care has become a clarion call that has attracted widespread attention from policy-makers in recent years. However, the various approaches advocated to date have addressed specific aspects of health services in specific types of health systems, and have failed to secure the general transformation of performance hoped for by their advocates. We have argued that it is the diversity of perspectives of existing schemes, and the associated confusion, that has inhibited broader success. In this brief we have therefore proposed a practical framework that seeks to reconcile the various approaches towards value-based policies. The distinctive contribution is that we have focused on the value created by the health system as a whole (not just health care), and we therefore designate our approach as promoting a value-based health system.

In Section 2 we define health system value to be the contribution of the health system to societal wellbeing. Alongside education, employment, housing, and less tangible dimensions (such as social belonging), health, and by extension health systems, have a major role to play in promoting wellbeing. This perspective underlines the need to formulate an explicit concept of health system value that can be translated into a set of concrete goals and transmitted coherently to all the relevant actors within the health system. We have adopted a widely accepted framework of five broad dimensions of value, embracing health improvement, health care responsiveness, financial protection, efficiency and equity. Such dimensions can in turn be mapped onto a society's aggregate wellbeing. There is no reason why an individual country should necessarily adhere to these dimensions, so long as it formulates a definition using a process that reflects the views of its citizens and patients, and then applies it consistently across the health system.

We argue in Section 3 that this concept of value cannot be enhanced solely by looking at the various actors of the health system in isolation. Instead, the brief shows how an overarching view of health system value and ultimately societal wellbeing can be used to align the different perspectives adopted by all the various actors within the health system. It recognizes that most of those actors contribute only partially to the value created by the health system. But with careful attention to their objectives, and the appropriate design of policy levers, it should be possible to create a health system that makes an effective and important contribution to population wellbeing. Our brief therefore extends current perspectives on value by offering a unifying and more holistic approach towards the development of health policy.

In Section 4 we briefly discuss some widely used policy levers, and assess how they contribute to the creation of health system value. These include:

1. working across sectors for health
2. fiscal and regulatory measures for health promotion and disease prevention
3. strengthening primary health care
4. funding health care for universal acces
5. setting a health benefits package
6. strategic purchasing for health gain
7. paying for quality
8. integrated people-centred health services
9. evidence-based care
10. stepping up the introduction of eHealth and digital health
11. involving patients in their own care
12. involving citizens in decision-making.

In almost all cases, the levers are designed with just one or two dimensions of value in mind, and target a limited range of actors. However, it is important that policy-makers keep in mind their impact on all aspects of value (whether positive or negative) and monitor whether the lever is having beneficial or deleterious consequences for the creation of value by other actors in the health system.

In Section 5 we underline that good governance is essential to the success of any value-based approach. We suggest that the TAPIC domains of transparency, accountability, participation, integrity and capacity are useful criteria against which to assess the design and performance of governance arrangements. However, we acknowledge that, whatever its theoretical merits, there are enormous practical barriers to applying the value-based concept across the entire health system. For example, the immense complexity of health needs and the associated services seriously affects the ability to develop meaningful metrics for many aspects of value [61]. It may therefore be necessary to adopt a gradual pathway towards a value-based system, focusing first of all on the areas where it might make the biggest difference. Such priority-setting is likely to involve scrutiny of a country's burden of disease, the instruments available for tackling that burden, the feasibility and effectiveness of adopting the sorts of policy levers described in Section 4, and the availability and effectiveness of governance arrangements.

In conclusion, we underline the importance of adopting a value-based approach to all actions of the health system, both preventive and curative. The health system concept of value should lead to an alignment of objectives of purchasers, providers, practitioners and citizens and patients. This is not to say that all objectives or instruments for creating value should be the same; they will be determined by the mission and constraints of the entity under scrutiny. And the approach can be implemented in stages as experience unfolds. However, it is difficult to see how the contribution of a health system to national wellbeing can be optimized without adopting a system-wide value-based approach.

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How do Policy Briefs bring the evidence together?

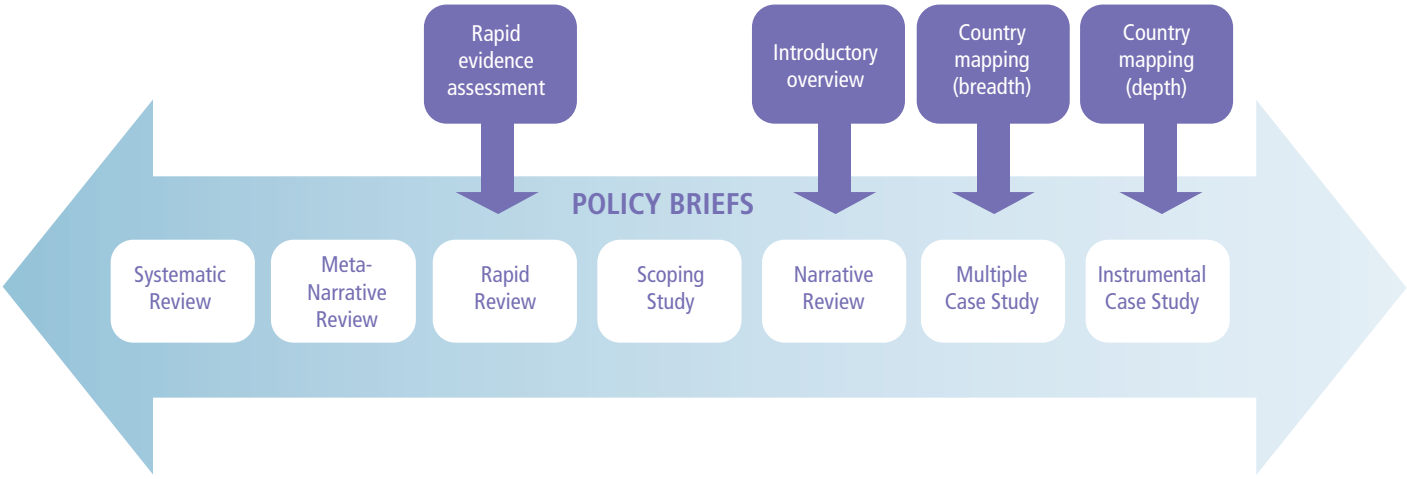
There is no one single way of collecting evidence to inform policy-making. Different approaches are appropriate for different policy issues, so the Observatory briefs draw on a mix of methodologies (see Figure A) and explain transparently the different methods used and how these have been combined. This allows users to understand the nature and limits of the evidence.

There are two main 'categories' of briefs that can be distinguished by method and further 'sub-sets' of briefs that can be mapped along a spectrum:

- A rapid evidence assessment: This is a targeted review of the available literature and requires authors to define key terms, set out explicit search strategies and be clear about what is excluded.
- Comparative country mapping: These use a case study approach and combine document reviews and consultation with appropriate technical and country experts. These fall into two groups depending on whether they prioritize depth or breadth.
- Introductory overview: These briefs have a different objective to the rapid evidence assessments but use a similar methodological approach. Literature is targeted and reviewed with the aim of explaining a subject to 'beginners'.

Most briefs, however, will draw upon a mix of methods and it is for this reason that a 'methods' box is included in the introduction to each brief, signalling transparently that methods are explicit, robust and replicable and showing how they are appropriate to the policy question.

Figure A: The policy brief spectrum



Source: Erica Richardson

Joint Policy Briefs

1. How can European health systems support investment in and the implementation of population health strategies?
   David McDaid, Michael Drummond, Marc Suhrcke
2. How can the impact of health technology assessments be enhanced?
   Corinna Sorenson, Michael Drummond, Finn Børlum Kristensen, Reinhard Busse
3. Where are the patients in decision-making about their own care?
   Angela Coulter, Suzanne Parsons, Janet Askham
4. How can the settings used to provide care to older people be balanced?
   Peter C. Coyte, Nick Goodwin, Audrey Laporte
5. When do vertical (stand-alone) programmes have a place in health systems?
   Rifat A. Atun, Sara Bennett, Antonio Duran
6. How can chronic disease management programmes operate across care settings and providers?
   Debbie Singh
7. How can the migration of health service professionals be managed so as to reduce any negative effects on supply?
   James Buchan
8. How can optimal skill mix be effectively implemented and why?
   Ivy Lynn Bourgeault, Ellen Kuhlmann, Elena Neiterman, Sirpa Wrede
9. Do lifelong learning and revalidation ensure that physicians are fit to practise?
   Sherry Merkur, Philipa Mladovsky, Elias Mossialos, Martin McKee
10. How can health systems respond to population ageing?
    Bernd Rechel, Yvonne Doyle, Emily Grundy, Martin McKee
11. How can European states design efficient, equitable and sustainable funding systems for long-term care for older people?
    José-Luis Fernández, Julien Forder, Birgit Trukeschitz, Martina Rokosová, David McDaid
12. How can gender equity be addressed through health systems?
    Sarah Payne
13. How can telehealth help in the provision of integrated care?
    Karl A. Stroetmann, Lutz Kubitschke, Simon Robinson, Veli Stroetmann, Kevin Cullen, David McDaid
14. How to create conditions for adapting physicians' skills to new needs and lifelong learning
    Tanya Horsley, Jeremy Grimshaw, Craig Campbell
15. How to create an attractive and supportive working environment for health professionals
    Christiane Wiskow, Tit Albreht, Carlo de Pietro
16. How can knowledge brokering be better supported across European health systems?
    John N. Lavis, Govin Permanand, Cristina Catallo, BRIDGE Study Team
17. How can knowledge brokering be advanced in a country's health system?
    John. N Lavis, Govin Permanand, Cristina Catallo, BRIDGE Study Team
18. How can countries address the efficiency and equity implications of health professional mobility in Europe? Adapting policies in the context of the WHO Code and EU freedom of movement
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    David McDaid
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    Marieke Kroezen, James Buchan, Gilles Dussault, Irene Glinos, Matthias Wismar
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    Jaime Espín, Joan Rovira, Antoinette Calleja, Natasha Azzopardi-Muscat , Erica Richardson, Willy Palm, Dimitra Panteli
22. How to strengthen patient-centredness in caring for people with multimorbidity in Europe?
    Iris van der Heide, Sanne P Snoeijs, Wienke GW Boerma, François GW Schellevis, Mieke P Rijken. On behalf of the ICARE4EU consortium
23. How to improve care for people with multimorbidity in Europe?
    Mieke Rijken, Verena Struckmann, Iris van der Heide, Anneli Hujala, Francesco Barbabella, Ewout van Ginneken, François Schellevis. On behalf of the ICARE4EU consortium
24. How to strengthen financing mechanisms to promote care for people with multimorbidity in Europe?
    Verena Struckmann, Wilm Quentin, Reinhard Busse, Ewout van Ginneken. On behalf of the ICARE4EU consortium
25. How can eHealth improve care for people with multimorbidity in Europe?
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26. How to support integration to promote care for people with multimorbidity in Europe?
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World Health Organization
Regional Office for Europe
UN City, Marmorvej 51,
DK-2100 Copenhagen Ø,
Denmark
Tel.: +45 39 17 17 17
Fax: +45 39 17 18 18
E-mail: postmaster@euro.who.int
web site: www.euro.who.int

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