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An introduction to value-based healthcare in Europe

European governments, like those in other parts of the world, are feeling the strain on their health budgets caused by an ageing population, a rise in the prevalence of chronic conditions and the acceleration of medical innovations that have increased demand for state-of-the-art treatment. As a result, governments are looking to make their money stretch further.

Traditionally, efficiency in healthcare has been interpreted largely in terms of cost reductions. More recently, healthcare policymakers in developed economies have interpreted the notion of value according to the willingness of health systems or individual health providers to follow best clinical practice. Increasingly, however, practitioners are promoting a more holistic, patient-centred understanding of value—one championed by the academics Michael Porter and Elizabeth Olmsted Teisberg, who first coined the term "value-based healthcare"[1] (VBH) to describe outcomes of health treatment relative to cost.

"If you run a company and you don't know what your client benefit and satisfaction levels are, there is no way you can manage, but in healthcare we have done this over and over," says Dr Fred van Eenennaam, chairman of Value-Based Health Care Europe, a not-for-profit organisation.

A work in progress

The comprehensive introduction of VBH concepts on the continent has been complicated by the range of different health insurance and payment schemes, encompassing social insurance systems in countries such as Germany and France, and so-called "single payer" systems in the UK and Scandinavia.

In addition, different philosophies about healthcare delivery make it challenging to assess the value of treatment outcomes and to collect data, let alone develop any kind of standardised approach to VBH.

[1] Porter, M. E., "What is Value in Health Care?", *The New England Journal of Medicine,* 363:2477-2481, December 23rd 2010.

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Many European countries still have separate reimbursement systems for hospital services and primary care. Doctors in some systems are salaried, while in others they are self-employed. Meanwhile, a number of health authorities have introduced various forms of "bundling" of care, in which health providers are reimbursed for the comprehensive health needs of a patient population, for offering a particular "episodic" sequence of care or for treating patients with chronic conditions.

The UK and Germany have been at the forefront in introducing many aspects of VBH, including cost-benefit assessment of health technology and evidence-based protocols for individual diseases; smaller north European economies such as Sweden and the Netherlands have also been early adopters, with the latter benefitting from its position as a small country with a collegial community of healthcare providers.

By contrast, in other large European economies such as France, Italy and Spain, implementation of VBH has been more fragmented, with individual institutions often taking the initiative.

The search for more cost-effective payment systems

Most European efforts to measure healthcare value over the past decade or so have focused on what Porter and Teisberg define as processes, rather than outcomes. This is particularly true of efforts to make payment systems more efficient, although there is an increasing trend for governments and health policymakers to introduce performance goals for providers as part of the process of reforming reimbursement systems.

The transition from block payments to "episode-based" payments to one or more providers represents a move towards a more co-ordinated approach to treatment by rewarding a single pathway of care and making better use of more expensive services, such as hospitals.[2] Advocates of such payment systems say that they are especially efficient for the treatment of chronic conditions. The Netherlands introduced such a system in 2010 for the care of diabetes, chronic obstructive pulmonary disease (COPD) and for vascular risk management. German insurers have been able to negotiate integrated contracts with multiple health providers since 2000.

Less common in Europe are capitation payments, in which a provider or group of providers set amounts for each patient assigned to them, whether or not that person seeks care. One notable exception is the Alzira public-private partnership in Spain, which has been operating a capitation budget covering both hospital and primary care since 2003.[3]

In part due to these payment models, assessments of outcomes, where they exist in Europe, tend to focus on individual medical interventions—many of which are funded by pharmaceutical or medical technology companies—rather than on the full cycle of care provided.

Payment for performance, or P4P, is among the most popular approaches to improving the quality of healthcare, and has been introduced widely across Europe.[4] Although few quality incentive schemes have been introduced in hospitals, one notable example is the Commissioning for Quality and Innovation (CQUIN) tariff system, which was set up by the UK's Department of Health in 2009.

[2] Charlesworth, A., Davies, A. and Dixon, J., *Reforming payment for health care in Europe to achieve better value*, The Nuffield Trust, August 2012, p. 4.

[3] *Ibid*., p. 13

[4] *Ibid*.

The CQUIN system allows health commissioners to hold back 2.5% of the cost of hospital treatment contingent on outcomes; one-fifth of the outcome is assessed according to four national metrics, with locally defined ones making up the rest.

"The old system was payment by activity, and this was a method to introduce a quality element into it," says Adam Roberts, a senior economics fellow at the Health Foundation, a UK-based charity. He adds that other European countries have looked into replicating the system. At the same time, he points out, with the UK National Health Service under severe financial strain, it remains unclear how easy it will be to enforce the new system.

Meanwhile, European governments continue to grapple with how to fund and assess value for chronic—as opposed to acute—conditions. Countries such as the UK, Italy and Spain have focused on primary care based on nurse-led clinics and case management, while in countries such as Germany and France there has been an effort to introduce greater co-ordination between different health professionals and the introduction of disease management plans (DMPs) for certain conditions.[5]

State-of-the-art treatments for acute conditions present different challenges, largely because many come with a hefty price tag. One group of companies developing gene therapies to treat diseases such as haemophilia is trying to devise its own revolutionary payment model that incorporates elements of P4P. The model would allow a one-time curative dose of the drugs at a price that the manufacturers say represents a saving over longer-term treatment; in return, the payments would be amortised over a period of time, with payments "contingent on proof that the treatment is effective and safe."[6]

Identifying value in health outcomes

While payment reforms have introduced a level of value measure into European health systems, targeting the areas that have the greatest impact on patients—including survival rates and short-term quality of life—remains a key policymaking objective.[7] At the same time, the lack of sufficient levels of coordinated care and the scarcity of data to support pilot programmes make it harder to assess value in outcomes effectively.

One way in which European governments have sought to bridge this gap is through the creation of health technology assessment (HTA) agencies. The UK's National Institute for Health and Clinical Excellence (NICE) is one of the best-known examples; the agency's remit includes deciding whether new treatments are cost-effective.

In Germany, the analogous agency is the Institute for Quality and Efficiency in Healthcare (IQWIG). France, Italy and Spain also have bodies fulfilling a similar function, as do Sweden and the Netherlands.

Yet, the measures that European HTA bodies use and the approaches they take vary significantly. The UK's NICE uses quality-adjusted life years (QALYs) to assess the cost-effectiveness of treatments, but is the only one to do so in a strict way. Dr van Eenennaam argues that while QALYs make sense on a

[5] Nolte, E., Knai, C. and McKee, M., *Managing Chronic Conditions: Experience in eight countries*, European Observatory on Health Systems and Policies, 2008.

[6] "INSIGHT – Paying for gene therapy: are annuities the next big thing?", Reuters, February 19th 2015. Available at: http://www.reuters.com/article/2015/02/19/usa-healthcare-payments-idUSL1N0VR01120150219

[7] Fleurance, RL et al, *The Rise of Value Based Health Care: A Report of the ISPOR Health Policy Special Interest Group, Value Based Health Care Working Group*, International Society for Pharmcoeconomics and Outcomes Research, Draft Manuscript, January 30th 2012.

"macro" level, they are a weaker measure of treatment benefits because of the difficulties of defining the worth of a human life to individual patients.

NICE is broadly viewed as the HTA agency that uses the most stringent process for assessing medicines—a process that leads to high rates of rejection, especially with orphan drugs and medicines for certain cancers. While NICE's approach has the advantage of being more structured and transparent, it focuses on just one metric—price—which is determined largely by the cost proposed by the drug manufacturer, without evaluating standard of care.

By contrast, France's system balances the usefulness of a drug against a standard of care in order to measure the benefit. This approach creates a relevant comparison to a known standard of care and allows price negotiation to proceed according to the level of innovation; however, it has the disadvantage of being both less transparent and more time-consuming.

Other countries try to find a middle ground. Germany uses value dossiers, which assess treatments as a summary of clinical, economic and patient-relevant therapeutic value.[8] Yet, in attempting to keep the best of both worlds, Germany's system is more opaque with regard to the discounts offered and results in a discrepancy between net and list prices. The fact that some countries use their neighbours' pricing models as reference points for their own further complicates the picture.

European countries have found it difficult to reach a consensus on the implementation of value-based pricing (VBP). While France rewards the degree of innovation in medicines, Germany moved from a free pricing market to a highly regulated one in 2011. In the UK, NICE amended earlier plans to introduce a VBP programme in 2014; the agency still leaves pharmaceutical suppliers free to set prices for treatments.

HTA agencies have a degree of leeway when evaluating individual interventions, and they are sometimes willing to step in and fund measures that the pharma or medtech industry will not fund because they relate to wider care pathways or involve products that are no longer under patent.

This level of differentiation has a direct impact on patient access to treatment by creating so-called "postcode lotteries" for certain treatments, with all the consequent political ramifications.[9] There are efforts to create a more coordinated approach to the use of HTA across the continent. The European EUnetHTA project, set up in 2005, aims to create a network for sharing information between national HTA agencies, ministries of health and others, to support member states in their policymaking, create economies of scale and raise the profile of HTA.

The use of healthcare delivery value chain models that measure outcomes—such as symptoms, complications, sustainability of recovery or treatment-related discomfort—is in its infancy in Europe, but pilot results are encouraging. In Germany's Martini Klinik, doctors have agreed on the patient-relevant medical outcomes of its prostate cancer treatment programmes and have identified a number of measures to help them produce meaningful data. Similar work is going on at the Schön Klinik in Germany, which has developed a method of evaluating patient value for knee-replacement operations, known as Time-Driven Activity-Based Costing.

[8] von der Schulenburg, J. M. Graf, *Value-Based Pricing: How do Approaches Vary by Health Care Context?"*, Center for Health Economics. Available at: http://www.ispor.org/congresses/Spain1111/presentations/IP2_SchulenbergMatthias.pdf

[9] Weale, A. and Clarke, S., *High Quality, Comprehensive and Without Barriers to Access? The Future of Health Care in Europe*, a thought-piece for the Future of Healthcare in Europe conference, May 13th 2011, University College London.

Conclusion

The effort to assess more accurately the value of healthcare investment has extensive implications for patient access, reimbursement of healthcare providers and health outcomes. Yet, the adoption of VBH assumptions in Europe has been piecemeal so far, with large variations in the extent to which European health systems measure patient outcomes, the ways in which they define value and the metrics that they use to do so. Equally, despite the demand for better access to healthcare innovations, the impact of public opinion on health policy varies across the continent.

Efforts to extend the use of VBH models in Europe have fallen short because of a lack of consensus so far about what performance indicators should be used, who to reward and how to quantify the value of incentives to motivate further efficiency. The absence of data on activity, cost and outcomes is particularly lacking in the area of ambulatory and primary-care-based interventions. A more extensive and standardised approach to VBH will require stronger evidence to support treatment and better co-ordination of care.

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