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## About this report

*Value-based healthcare in Europe: Laying the foundation* is an Economist Intelligence Unit (EIU) report, commissioned by Gilead Sciences. Value-based healthcare looks at health outcomes of treatment relative to cost. In this particular paper The EIU examines the way in which value is interpreted across the continent, the extent to which European countries are adopting cost-effectiveness as a key criterion for assessing it, and the efforts to develop new models for pricing innovation.

In December 2015 and January 2016 The EIU conducted six interviews with experts on value-based healthcare in Europe. The insights from these in-depth interviews appear throughout the report. The EIU would like to thank the following individuals (listed alphabetically) for sharing their insight and experience:

- Richard Bergström, executive director, European Federation of Pharmaceutical Industries and Associations (EFPIA), Brussels, Belgium
- Karl Claxton, senior research fellow, Centre for Health Economics, University of York, UK
- Patrick Jeurissen, Chief Strategy Group, Dutch Ministry of Health, and head, Programme for Fiscal Sustainability, Radboud University Medical Centre, Netherlands
- Bengt Jönsson, professor emeritus of health economics, Stockholm School of Economics (SSE), Sweden, and vice-chair, European Commission Expert Panel on Effective Ways of Investing in Health, Brussels, Belgium
- Finn Boerlum Kristensen, chairman, Executive Committee, European Network for Health Technology Assessment

(EUnetHTA), Copenhagen, Denmark

- Stefan Larsson, global leader, healthcare payers and providers sector, Boston Consulting Group, Stockholm, Sweden

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This report is part of a series of reports on value-based healthcare in Europe that includes the following papers:

- *An introduction to value-based healthcare in Europe* (<http://www.eiuperspectives.economist.com/healthcare/introduction-value-based-healthcare-europe>);
- *Value-based health assessment in Italy: A decentralised model* (<http://www.eiuperspectives.economist.com/healthcare/value-based-health-assessment-italy-decentralised-model>)
- *Value-based healthcare in Germany: From free price-setting to a regulated market* (<http://www.eiuperspectives.economist.com/healthcare/value-based-healthcare-germany-free-price-setting-regulated-market>);
- *Value-based healthcare in Spain: Regional experimentation in a shared governance setting* (<http://www.eiuperspectives.economist.com/healthcare/value-based-healthcare-spain-regional-experimentation-shared-governance-setting>);
- *Value-based healthcare in France: A slow adoption of cost-effectiveness criteria* (<http://www.eiuperspectives.economist.com/healthcare/value-based-healthcare-france-slow-adoption-of-cost-effectiveness-criteria>)

com/healthcare/value-based-healthcare-france-slow-adoption-cost-effectiveness-criteria);

- *Value-based healthcare in Portugal: Necessity is the mother of invention* (<http://www.eiuperspectives.economist.com/healthcare/value-based-healthcare-portugal-necessity-mother-invention>)

- *Value-based healthcare in the UK: A system of trial and error* (<http://www.eiuperspectives.economist.com/healthcare/value-based-healthcare-uk-system-trial-and-error>)

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## Executive summary

Since the global financial crisis of 2007–08 European governments have been seeking ways to get more out of their healthcare budgets. However, efforts to move towards a common framework for evaluating and implementing value-based healthcare across the continent have been a much more recent development.

This report by The Economist Intelligence Unit looks at the evolution of cost-effectiveness as a growing priority for evaluating health innovation and investigates how data on health outcomes are being used and shared. It examines how governments are grappling with adjusting pricing to reflect costs and benefits while ensuring that access to cutting-edge treatments is maintained for the most appropriate populations, including those who are most vulnerable.

The key findings include the following:

**Cost-effectiveness measures are slowly taking hold but remain controversial.** While the number of health systems that are actively adopting cost-effectiveness as part of the health technology assessment (HTA) process remains small, the focus on outcomes in relation to cost is being piloted in individual hospitals and clinical services across the continent. There is also a growing focus on the impact of spending on pharmaceuticals and technology on broader population-health agendas. Against this backdrop, policymakers are facing the challenge of convincing the public that cost-

effectiveness is not merely another term for cost-cutting. At the same time, they are looking to expand notions of cost-effectiveness from a more narrow focus on pharmaceuticals and technology to the broader components of care.

**There is greater scope for crossborder co-operation in HTA, but this will require better sharing of data.** The European Network for Health Technology Assessment (EUnetHTA) and other organisations recognise that more co-operation in HTA is likely to be needed to help countries to make accurate decisions about cost-effectiveness. At the same time, this process is likely to involve better sharing of data and, potentially, a willingness to increase transparency about negotiating strategies.

**Industry and governments need to collaborate to develop new models for pricing innovation.** A growing number of European countries are already using a combination of payment-for-performance and risk-sharing agreements with pharmaceutical companies in an effort to maximise the value of their health-technology investments. Developing a sustainable reimbursement model could also ultimately provide benefits to both manufacturers and payers.

**Access remains a problem.** Access to both traditional healthcare and state-of-the-art medical treatment remains uneven both within countries and between them. Some policymakers are looking at ways of addressing this problem on a pan-European level.



# Introduction

Austerity budgets, stagnant economic growth, rising costs of cutting-edge medical treatments and growing demand from patients amid population ageing are just some of the factors that have led policymakers to look more soberly at how to manage healthcare budgets.

However, a focus on cost rather than outcomes has left many health and finance policymakers facing charges of concentrating on the bottom line at the expense of improving access to the innovative treatments that are most likely to improve the quality of care.

Only in the past few years have cost-effectiveness measures, previously adopted in a handful of countries—including the UK, Portugal and Sweden—begun to gain traction elsewhere in Europe.

In particular, countries are trying to find ways of balancing the desirability of increasing access to the most cutting-edge treatments for individual patients with the need to improve health for entire populations in their care.

“In a way, all healthcare systems are looking for value, but they are mainly approaching it in different ways,” says Bengt Jönsson, professor emeritus of health economics, Stockholm School of Economics, and vice-chair of the European Commission Expert Panel on Effective Ways of Investing in Health. “What is new now is that they are looking at value not just from the point of view of the individual patient, but from the point of view of the health system as a whole.”

At the same time, policymakers face a number of obstacles in implementing a value-based healthcare system that takes into account both cost and outcomes. Among these challenges are a lack of comprehensive data on outcomes; growing pressure for new pricing models, especially in the area of pharmaceuticals and medical devices; and safeguards to ensure that access to treatment is maintained for the most vulnerable populations.

## 1

## Chapter 1: The new language of cost-effectiveness

While a number of European countries have been measuring the cost and efficiency of healthcare delivery for some time, the focus on outcomes in the context of cost has only been evident over the past couple of years—and its roll-out remains spotty, according to Dr Stefan Larsson, a trained physician and global leader of the healthcare payers and providers sector at Boston Consulting Group in Stockholm.

Dr Larsson notes that close to half a dozen pilot projects are already under way. Santeon is a collaboration between six hospital groups in the Netherlands which measures patient outcomes for a number of disease areas, including prostate and lung cancer, using a set of metrics created by the International Consortium for Health Outcomes Measurement (ICHOM), as well as others agreed to by the group's physicians. Meanwhile, the Dutch Ministry of Health recently supported the establishment of the Dutch Institute for Clinical Auditing (DICA), a national platform for patient-reported outcomes registries. The DICA platform covers 18 areas, from breast and pancreatic cancer to paediatric surgery and Parkinson's disease, with another four under development.

Sweden and Denmark are looking at outcomes across a range of conditions based on patient registries for areas ranging from heart attack to shoulder arthroplasty, Dr Larsson says, while

the UK also has a number of registries—fewer, but similar in profile to those in Sweden and Denmark. Thoracic surgeons are unique in that their individual scores are published. Scotland, which also runs a series of registries, recently partnered with ICHOM to develop an international standard set for dementia.

"We've found that in organisations where clinicians and the leadership and management have measured outcomes, they have typically had an increase in quality," Dr Larsson observes. "If you are outcomes-focused, you often find that you have eliminated clinical procedures that don't lead to better outcomes."

Health systems are also increasingly looking at how improved management of the whole patient can lead to better outcomes. "The expensive patient and the expensive treatment are not always the same—co-morbidities are one of the things that make a patient expensive," says Patrick Jeurissen, Chief Strategy Group, Dutch Ministry of Health and head of the Programme for Fiscal Sustainability at Radboud University Medical Centre in the Netherlands. "If you look at fiscal sustainability, the top 1% or 5% of patients is where 50% of the money goes. If you have a good strategy, such as complex case management, you might be able to gain value at the same time as you reduce costs."



## Measuring cost-effectiveness thresholds

The UK's National Institute for Health and Care Excellence (NICE) is one of the few European agencies to have a defined threshold for measuring cost-effectiveness. Although NICE has been a model for other countries in the region, it has only recently been able to evaluate the other side of the cost-benefit analysis, according to Professor Karl Claxton, a senior research fellow at the Centre for Health Economics at the University of York.

"At the heart of what NICE has always done—which ought to be a part of what other European countries are doing—is to consider not only the benefits of what a new intervention might offer, but the additional things we will need to give up as a consequence of the cost they impose on the system," he says.

NICE research, commissioned in 2009 and published in a peer-reviewed piece in 2015, has finally provided some empirical evidence about the aforementioned opportunity costs of innovative treatments.<sup>1</sup> "Now we have some evidence about what the scale of those opportunity costs is," Professor Claxton adds.

Existing distortions in the system could mean that high-cost oncology drugs with modest benefits might end up displacing the development of new antibiotics, he observes.

Given the increasing attention paid to population health, Professor Claxton and others argue that payers need to look at what sort of measures of benefit they are using. These can range from health gained in a greater or lesser burden of disease, or impact on the economy, he notes. Societal benefits are also a key consideration, with objective measures of benefit that are likely to differ by disease area.

As European governments struggle with anaemic levels of economic growth, it is increasingly difficult to direct new resources into the system without displacing other investment, according to Professor Jönsson. "Today it is more about reallocation of resources," he explains. "Health expenditures in most countries have been stagnant or even going down, while at the same time the expectations about health improvements are still there." As a result, making a decision about which less beneficial treatments will be candidates for displacement to make room for new treatment opportunities remains a challenge.

The language of cost-effectiveness, although relatively new, has more recently been adopted explicitly as part of the health technology assessment (HTA) process in France,<sup>2</sup> and is already a key criterion in Portugal.<sup>3</sup> Other countries, such as Norway and Spain,<sup>4</sup> are also adopting the threshold approach to a greater or lesser extent.

## Inspiration from the US

"This language is fairly recent," says Richard Bergström, executive director of the European Federation of Pharmaceutical Industries and Associations (EFPIA) in Brussels. He notes that two pioneering US accountable care organisations, Kaiser Permanente and Geisinger Health System, have frequently provided a model for Europe, although these systems are not mainstream in the US. "I think, actually, the ideas are not new, but they have never been mainstreamed. There seems to be some sort of anxiety or ideological blockage by many healthcare systems experts in Europe about becoming too money-focused."

<sup>1</sup> Claxton, K, Sculpher, M *et al*, "Causes for Concern: Is NICE Failing to Uphold its Responsibilities to all NHS Patients?", *Health Economics*, 2015, Vol. 24, Issue 1, pp. 1-7.

<sup>2</sup> Economist Intelligence Unit, *Value-based healthcare in France: A slow adoption of cost-effectiveness criteria*, November 2015. Available at: <http://www.eiuperspectives.economist.com/sites/default/files/ValuebasedhealthcareFrance.pdf>

<sup>3</sup> Economist Intelligence Unit, *Value-based healthcare in Portugal: Necessity is the mother of invention*, December 2015. Available at: <http://www.eiuperspectives.economist.com/sites/default/files/ValuebasedhealthcarePortugal.pdf>

<sup>4</sup> Economist Intelligence Unit, *Value-based healthcare in Spain: Regional experimentation in a shared governance setting*, October 2015. Available at: <http://www.eiuperspectives.economist.com/sites/default/files/ValuebasedhealthcareSpain.pdf>



## 2

## Chapter 2: Using and sharing HTA

The experts interviewed for this paper acknowledge that the assessment of cost, budget impact and cost-effectiveness needs to be a key part of the HTA process, and they embrace the prospect of improved information-sharing through greater co-operation between HTA agencies. The challenges of doing so, however, remain significant, according to Finn Boerlum Kristensen, chairman of the executive committee of the European Network for Health Technology Assessment (EUnetHTA).

The EUnetHTA currently focuses on a core model for HTA, consisting of nine domains: definition of the health problem and current use of technology; description and technical characteristics of the technology; issues of safety; issues of clinical effectiveness; cost and economic evaluation; ethical aspects; organisational aspects; patient and social aspects; and legal aspects.<sup>5</sup>

“I think there is a pan-European process, but it is a network process, and it is a process where there is not one unique single standard operating procedure for doing this,” Dr Kristensen says. “It needs to be constantly reflecting and revolving around the country-specific and the general.”

In particular, he observes, health systems tend to have a narrow clinical focus when

they talk about value, one that concerns the value in terms of limited, traditional clinical outcomes of treating a given health problem. In traditional HTA this revolves around individual pharmaceutical products. But, he adds, with the most innovative drugs and technologies “very often the pharmaceutical can not be looked at alone. It is linked up to quite a bit of diagnostics and follow-up and combination therapy figuring into disease-specific programmes.”

As part of this development, there is likely to be a greater emphasis on looking at the impact of new technologies on smaller sub-populations of patients.<sup>6</sup> Given the way data are assessed in individual European countries, this can lead to starkly different decisions; for example, the oncology drug Avastin was approved for reimbursement in France, but not in the UK.<sup>7</sup>

Where countries are co-operating across borders, it is especially helpful to have a structure for sharing information, results and overviews. Within the nine-domain EUnetHTA model are 100 standard questions that can be used by those doing assessments, Dr Kristensen says.

Joint assessments under the aegis of EUnetHTA tend to look largely at safety, clinical effectiveness, drug characteristics and the epidemiology of the patient group, Dr Kristensen

<sup>5</sup> EUnetHTA, HTA Core Model for screening technologies, Version 1.0, December 2012. Available at: [http://www.eunetha.eu/sites/5026.fedimbo.belgium.be/files/HTACoreModelForScreeningTechnologies1%200Final\\_0.pdf](http://www.eunetha.eu/sites/5026.fedimbo.belgium.be/files/HTACoreModelForScreeningTechnologies1%200Final_0.pdf)

<sup>6</sup> PRMA Consulting, *PRMA Insights: Pricing and Reimbursement Success in NSCLC (2nd edition)*, 2012. Taken from a presentation by Deborah Saltman to an Imperial College seminar on Primary Care and Public Health, February 27th 2013, slide 16.

<sup>7</sup> *Ibid.*, slide 17.

explains. “The assessments coming out are increasingly used to inform national reporting and provide information to decision-makers using a joint work report and incorporating it into the process of compiling a national report.”

In a recent example of such joint action, the Dutch HTA institute ZIN and the Ludwig Boltzmann Institute for Health Technology Assessment (LBI-HTA) in Austria created a division of labour in which ZIN handled drug assessments and the LBI-HTA was responsible for evaluating devices.

Budget impact and cost-effectiveness are often looked at in greater detail as part of country-specific reports, Dr Kristensen adds.

## Improving access to data

Mr Bergström, who argued for greater sharing of data in a March 2015 letter to the EU Competitiveness Council, observes that Europe has an advantage over the US when it comes to mining data because just 30% of American medical records are electronic, compared with an average of two-thirds in Europe.<sup>8</sup>

“Because of the single-payer system in Europe, people are locked into the same provider for a long time, with digitised records and a decent history,” Mr Bergström says. “In Europe, you should in principle have everything—patient registries, and you may even have biobanks. But if you really want to make this sustainable and if you really want to aspire to have this population-based, then you have to have stand-alone registries, where everyone who deals with that patient, such as drug companies etc, is incentivised to record final results in integrated health records.”

Issues around privacy remain a key challenge to increasing data sharing, although Mr Bergström counters that these threats might be overridden by sending information directly to the cloud.

But while improving the sharing of data is one obvious target, creating meaningful data

measures—at a time when medical treatments are increasingly targeted at more specialised patient groups and their success may depend on complex clinical pathways—is likely to be more complicated. “The issue is how to weight data,” says Dr Jeurissen. “Many of these indicators are not really debated scientifically.”

Moreover, for data to be truly valuable, they must be consistent and transparent, Dr Larsson says. “The gathering of data is by orders of magnitude more valuable if you collect the same data,” he observes. “That’s the whole idea behind ICHOM: to create global standards defined by clinicians and patients.”

At the same time, he observes, in the case of data relating to healthcare providers some doctors may be unwilling to share results, feeling that their patient cohort is more challenging than that of other clinicians; this is why risk-adjustment measures must be finely honed.

“What I find is that clinicians who may once have been sceptical about those comparisons, once they start, they are incredibly motivated about what the data allow them to do and get much more focused in managing clinical quality,” Dr Larsson adds.

Those interviewed generally agree that consistent measurement of outcomes could allow scientists to collect data on increasingly large cohorts of patients around the world, providing a basis for valuable statistical analysis and aiding both population health and personalised medicine. ICHOM, which is already collaborating with doctor and patient groups globally, has established 13 standard measurement sets for cardiovascular, musculoskeletal and neurological conditions, among others. By 2017 the organisation aims to have published sets covering more than 50% of the global disease burden.<sup>9</sup>

## Transparency and confidentiality

Professor Jönsson notes that a conflict of interest is increasingly in evidence between HTA and

<sup>8</sup> eHealth Stakeholder Group, *Patient access to Electronic Health Records*, June 2013, p. 5.

<sup>9</sup> ICHOM, *Our Standard Sets*. Available at: <http://www.ichom.org/medical-conditions/>

reimbursement agencies, which are traditionally separate in most European countries.


“Traditionally, HTA has been about medical evidence from clinical trials and not about value. Reimbursement agencies look for effectiveness and cost-effectiveness in clinical practice. Information for assessing this is seldom available when a new treatment is introduced.”

This conflict can interfere with greater transparency, Dr Kristensen observes, noting that some national HTA agencies do not make their reports public because they are seen as internal information for reimbursement negotiators.

Moreover, issues of confidentiality can make it difficult to assess and share best practices. “On the one hand, the Dutch government is trying to increase measures of value to make things transparent,” says Dr Jeurissen. “Insurance

companies contract on value to a certain extent, and we can monitor that, but it is not all in the public domain.”

Mr Bergström notes, however, that the opaqueness of negotiations between national governments and industry can be beneficial for both sides, in part because of the reality that disease dynamics and the price an individual country is able to pay for the same medicine can differ significantly. “Some people in Europe are obsessed with transparency, but at the end of the day these confidential agreements are good for everyone,” he says. “You need to have a higher price in Germany than in Romania.”

The issues of crossborder co-operation, transparency and international reference pricing are among the top priorities of the Netherlands’ EU presidency in the first half of 2016, according to Dr Jeurissen. 

## 3

## Chapter 3: Risk sharing and new pricing models

European governments have started testing a number of ways of sharing both risks and rewards among payers, healthcare providers and pharmaceutical or medical-device manufacturers.

In the case of healthcare providers, individual countries and regions have experimented with a range of pay-for-performance (P4P) models. Examples include a contract between Stockholm's Karolinska Institute and imaging-equipment manufacturer Philips, under which Karolinska agrees to pay Philips an additional 10% of its total fee if it is able to help the hospital to achieve certain results among defined patient groups, according to Dr Larsson.

Similar P4P and risk-sharing agreements are being piloted with pharmaceutical companies as well, and those interviewed generally agree that the industry is recognising that the status quo in terms of payment models must by necessity evolve to recognise both scarce resources and the fact that new treatments cannot be isolated from their overall delivery systems.

EFPIA president and Novartis CEO Joseph Jimenez has acknowledged that pharmaceutical companies will need to become part of the solution in helping cash-strapped health systems, and that those that produce treatments which are ineffective or offer only incremental

improvements should not expect to be reimbursed for them.<sup>10</sup>

"I think risk sharing is very interesting, because the risk has moved from payers to providers, but also to the pharma and medtech industries," Dr Larsson says. "As long as the measurement of outcome is the same and the definition of the patient group is the same, that leads to an alignment of incentives that is quite powerful."

He cautions, however, that in the case of healthcare providers P4P systems can be overly aggressive, and if this happens, providers are likely to cherry-pick the least complicated—and therefore "safest"—patients to treat.

"Transparency of outcomes themselves will drive a lot of change on its own," Dr Larsson says. "To put on top of that a large financial incentive may skew the results. There should be an upside for good results—say, the best providers get 5% extra pay—but that goes straight to the bottom line. That's attractive enough for them to fight for but not to corrupt the model."

As part of the drive to assess value in new treatments, some national agencies are also mandating a stricter comparison with active comparator agents in the case of pharmaceuticals—something that France's new

<sup>10</sup> "Novartis chief backs shake-up in drug pricing", *Financial Times*, June 7th 2015. Available at: <http://www.ft.com/cms/s/0/fff835be-0cf2-11e5-a83a-00144feabdc0.html#axzz3yXFBbpVK>

regulator, the National Agency for the Safety of Medicines and Healthcare Products (Agence nationale de sécurité du médicament et des produits de santé—ANSM), was due to start requiring from 2016. These guidelines reflect a higher threshold for determining additional clinical benefits in many countries.<sup>11</sup>

Others are submitting medicines to regular re-evaluation after they have been approved for market access—a process that is now taking place in Portugal and Germany, among other countries.

In Germany, in particular, legislative changes introduced in 2011 require companies to submit a cost-benefit study to the country's reimbursement body, the G-BA, after market launch. The G-BA assesses the drug's benefits over recognised therapeutic comparators, taking into account patient-related benefits based on discussions with the country's health technology agency, IQWiG. Within six months it is required to give drugs a final rating, ranging from "less benefit than the comparator" to "extensive benefit". According to a study by consulting firm McKinsey, just 51% of the 124 assessments completed since January 2011 received a positive rating, and ultimately 13 products were withdrawn from the market.<sup>12</sup> At the same time, the new legislation has reportedly cut the prices the country pays for the top 25 top-selling innovative drugs launched since the law's inception by an average of 23%.<sup>13</sup>

### Differentiated pricing

Some innovative treatments, such as those in the field of oncology, involve a combination of different drugs, meaning that the true "value" may differ between one application and another. This suggests that an individual drug should be priced differently depending on how it is used and whether it is used in combination with other drugs or not, according to Mr Bergström. "We need to employ a new pricing model," he says. "If the pharmaceutical industry fully embraces the idea of a system focusing on value, it should strive to be paid for results."

In the end, he adds, the move to outcomes-focused healthcare and more integrated care will make the pricing system more nuanced by necessity, because outcomes will generally no longer be defined by a single intervention.

"It's an increasingly complicated market and quite complicated to change traditional pricing models," agrees Professor Jönsson. "But I am pretty sure we will see continuous change in payment mechanisms, because when both the buyer and the seller understand that the traditional model doesn't work, they reject it. We have to find some way where doing business is win-win."

Some smaller countries, such as Belgium and the Netherlands, have even started to talk about negotiating together, Dr Kristensen notes. "The clearer the processes are—not necessarily the content of the specific negotiations but the processes—the better we can link to this with HTA work."

Few analysts expect there to be a Europe-wide agreement on price any time soon, but Mr Bergström predicts that countries might pursue other forms of collaboration that would enable them to be "good purchasers".

Ultimately, says Professor Claxton, a sustainable rebate scheme will be one in which the rebate represents the discrepancy between the price charged and how much the country can afford to pay for the benefit. "With a national rebate scheme, the manufacturers aren't forced to reduce their prices," he says. "Those producing modest benefits at very high prices would pay the lion's share of the rebate, rather than reflecting market share."

Such a system, he adds, would also help to further level the playing field between wealthier countries and lower- to middle-income ones by allowing for different effective prices in different healthcare systems.

<sup>11</sup> PRMA Consulting, *PRMA Insights*, slides 6/7.

<sup>12</sup> Sieler, S, Rudolph, T et al, "AMNOG Revisited: How has German health reform impacted pharma pricing and market access, and what can the industry learn from the experience?" McKinsey, May 2015. Available at: [https://www.mckinsey.de/sites/mck\\_files/files/2015\\_ext\\_pharmatimes\\_amnog\\_revisited.pdf](https://www.mckinsey.de/sites/mck_files/files/2015_ext_pharmatimes_amnog_revisited.pdf)

<sup>13</sup> "German drug law has cut top sellers' prices by 23%, say health funds", *Pharma Times*, September 25th 2014. Available at: <http://www.pharmatimes.com/article/14-09-25/German-drug-law-has-cut-top-sellers-prices-by-23-say-health-funds.aspx>

Figuring out what is the most reasonable price in different healthcare systems ensures that low- and middle-income countries participate in the market and allows them to influence research priorities in the industry, providing a further benefit, he points out.

“To some extent, donated funds are now being used to pay for failures on the demand side of the market,” Professor Claxton observes. The advantage of a more differentiated system, by contrast, is that there is “something in it for everyone. Manufacturers and healthcare systems will benefit from it, and global bodies will see it as a way of getting a much bigger bang for their donated funds.”

### Patient access issues

Given the heavy impact of austerity budgets on health systems across Europe—and in Greece and Portugal in particular—the issue of equitable access has become a key concern for policymakers.

EU law—including Article 35 of the EU Charter of Fundamental Rights (which has been binding since 2009) and the common values and principles for EU health systems agreed by the Council of Health Ministers in 2006—commits member states to ensuring that health systems are both effective enough to improve health and cost-effective given limited resources for healthcare.<sup>14</sup>

A consultation report by the European Commission Expert Panel on Effective Ways of

Investing in Health found that member states made significant progress in improving access to healthcare between 2005 and 2009, with the number of people reporting unmet need due to cost, travel distance or waiting times falling from 24m (5% of the population) to 15m (3%); however, since 2009 this progress has reversed, with the number of people reporting unmet need for healthcare rising to 18m (3.6% of the population) in 2013.<sup>15</sup>

Pan-European programmes are looking to address this problem. For example, the Innovative Medicines Initiative (IMI) is an EU public-private partnership aiming to foster research collaboration between universities, industry, patient organisations and regulators in order to boost patient access to innovative treatments. The IMI has been in place since 2008 and has dedicated funding of €3.3bn (US\$3.6bn) for 2014–24. Projects have focused on areas such as antimicrobial resistance, cardiovascular disease, diabetes, neuro-degenerative diseases, psychiatric disorders, respiratory diseases, immune-mediated diseases, ageing-associated conditions, cancer, rare diseases and vaccine development. Many of its projects are focused on personalised or targeted medicines.<sup>16</sup>

These include a €215m project to scale up the manufacturing of vaccines and rapid diagnostic tests for Ebola, as well as a €21.4m programme to identify sub-types of diabetes and determine the most appropriate treatments for individual sub-groups of patients.

<sup>14</sup> Expert Panel on Effective Ways of Investing in Health, *Access to health services in the European Union*, public consultation opinion, September 25th 2015, p. 11. Available at: [http://ec.europa.eu/health/expert\\_panel/opinions/docs/010\\_access\\_healthcare\\_en.pdf](http://ec.europa.eu/health/expert_panel/opinions/docs/010_access_healthcare_en.pdf)

<sup>15</sup> *Ibid.*, p. 4.

<sup>16</sup> The Innovative Medicines Initiative. Available at: <http://www.imi.europa.eu/>



## Conclusion

It may be a recent innovation, but a value-based approach to healthcare delivery characterised by an emphasis on cost-effectiveness and a focus on patient outcomes looks likely to become the dominant trend in European countries.

It is a movement driven by a perfect storm of forces, including austerity budgets, medical innovations that offer tantalising opportunities for extending and improving the quality of life, and increasingly demanding populations. However, patient access to both traditional healthcare and state-of-the-art medical treatment remains uneven both within countries and between them.

To get the full benefit out of value measurements, healthcare systems will need to better define what they consider to be value in outcomes,

refine their assessment of technology and care pathways that can deliver it, and expand access to supporting evidence.

As this report has shown, there is scope for stronger crossborder co-operation to help countries to make more accurate decisions about cost-effectiveness. However, this requires better sharing of data. Collaboration is also important for industry and governments in order to agree on new models for pricing innovation, including P4P and risk-sharing agreements.

Finally, health systems need to determine how to incorporate the concept of whole-patient management, as well as broader population health measures, into their overall evaluation of outcomes and value.



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