

Value-based healthcare – meeting the evolving needs of our population

Sally Lewis MRCGP, National Clinical Lead for Value-Based and Prudent Healthcare

NHS Wales, Crown Building, Cardiff CF10 3NQ, UK.

Swansea University School of Medicine, Swansea University, Singleton Park, Swansea SA2 8PP, UK.

Glan Rhyd Surgery, Riverside, Beaufort, Ebbw Vale NP23 5NT, UK.

Email: Sally.Lewis2@wales.nhs.uk

Value-based healthcare (VBHC) is a concept that is gaining in popularity around the globe. Perhaps this is in response to a growing sense of unease that all is not well in healthcare and we must take radical steps to redesign care around the changing needs of our populations if we are to improve outcomes with the precious resources that we have available. Its definition and purpose are widely debated.^{1,2}

Value is a tricky word. In this context, it should be viewed as an abstract concept to which a numerical value cannot be applied and therefore it has wider application than is used in health economics. It is a rule of thumb, to support good decision making at all levels of the system through an understanding of outcomes that are significant to patients. Have you improved my pain, my mobility, my continence, my ability to work or be a carer? Patients are asking for better information in order to then make better choices for themselves with their clinicians based on their likely outcomes and fully understanding the trade-offs, e.g. between length and quality of life. We can only do this if we longitudinally and consistently track patient-reported outcomes,³ which are essentially a structured communication tool between patient and clinician.

Those of us involved in providing health care too often look at the value we provide to our patients through the lens of the service in which we work, rather than the patient's perspective of the whole system working together to meet all of their needs. The greatest improvement in outcomes relative to cost may come from timely diagnosis and optimising early intervention, or in the context of palliative care, advance care planning sensitively carried out. In other words, doing simple things well. When we are considering how to deploy resources to benefit people, we frequently get this wrong and pour a lot of resource into things that cost a great deal but have uncertain gains for patients, often at the expense of high-value interventions.

Value for patients requires collaboration as it follows that no single organisation can do this alone and is therefore a helpful concept if we are to truly achieve integrated care for patients. Both over- and undertreatment are causes of low-value care so this is not about rationing or cost cutting alone, but about judicious deployment of resources.

For this last point we have to accept that healthcare resources are finite, particularly if we care about equity (I do). Even if we do not, no system in the world will be able to fund the projected

increase in costs easily. We have a duty to ensure that every dollar is effectively invested.

And so to industry. . . VBHC is not about driving the medical industrial complex. It is not about increasing market share or driving huge profits from marginal outcome improvements. It should be about a new relationship with industry which allows honest appraisal of new evidence from ongoing data capture post adoption of drugs and devices, so we have the courage to invest and disinvest according to the outcomes.

In the US, VBHC is often badged as driving up performance through competition and increasing one's 'customer' base.⁴ This encourages both fragmentation of care and too much of a focus on hospital care that does not make sense for the changing needs of the population. In a publicly funded system and with a desperate need to integrate care for patients to achieve the best possible outcome and experience, it is more about doing the right thing at the right time, with decisions better supported by data that comes directly from patient feedback.

Competing interests

None declared.

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