OPINION ARTICLE

Value-based healthcare's blind spots: call for a dialogue

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Abstract

The value-based healthcare (VBHC) concept was first proposed as a solution to many of the ills of healthcare. Since then, we have seen the term “value” defined, used, confused, and interpreted in multiple ways. While we may disagree that competition based on value will solve healthcare’s complex challenges, value is a concept integral to the future of healthcare. Before VBHC becomes consigned to the long list of quality improvement trends and management fads that have passed through healthcare, we call for a dialogue around the term *value* and the implications of its different interpretations. The intention is not just to critique, but to facilitate ongoing efforts to substantially improve healthcare in ways that are relevant and sustainable for society at large.

Keywords

value-based healthcare, patient values, quality improvement, sustainability, co-creation, co-evaluation

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Introduction

In the face of expanding needs and demand for healthcare, coupled with rising costs, inequities, and undesirable variation^{1,2} in healthcare outcomes and care experience, there has been a surge of interest in the idea of value-based healthcare (VBHC) as a solution. Who could argue with adding value to patients and society through our efforts in healthcare? However, things are not that simple when we consider the many ways in which the term is being interpreted and used in practice around the globe.

In discussions about VBHC, it becomes clear that the word “value” is used in multiple, sometimes overlapping, or even contradictory ways. As pointed out in a recent report by the European Commission,³ many definitions exist, which causes confusion. This lack of consensus leads to misunderstanding between actors who share the same goal of improving care, where these misunderstandings can further entrench differences in perspectives. The aim of this article is to open a dialogue to reconsider VBHC, by clarifying some different lines of thought on the term *value* and implications of different uses, to facilitate efforts to improve health care systems. We will first consider the idea of *values* as a conviction or belief that individuals or social groups consider right, good, or desirable. Second, we will consider the term *value* in an economic sense of optimizing the use of finite resources. We will then illustrate how these two applications of the word value are often used interchangeably when the term VBHC appears. Unclear use of these two very different meanings makes it difficult to progress on how to define, operationalize and measure VBHC. Both meanings are important, but they point to very different concepts and assumptions.

Values (convictions that guide decisions)

Let's start with *values*, broadly and in plural, and then consider patient values in particular. Values are basic convictions among individuals or social groups; what they consider right, good, or desirable and what is most important in life.^{4,5} They are influenced by background and culture, but also by experiences and life events – including education or professional training. In daily life, values influence individuals' behaviors, and guide their evaluation of people, choices, and actions. Specific values such as integrity, balance, fairness, or autonomy are brought to the forefront when they are relevant to a particular context. A systematic review of studies⁶ where patients articulated what they mean by values, found that patients value their autonomy, consider themselves unique and a whole person, they want clinicians who exhibit professionalism, who listen and have empathy. In clinical interactions, people want to be empowered and to work in partnership. Patient preferences can be considered as expressions of those values.

When considering professional values, we can think of altruism, equality, capability, but also pleasure or intellectual stimulation. Most professionals eventually become a patient (or a patient's next of kin), and enough have shared those experiences in writing that has generated its own literature genre.⁷ Some patients also become healthcare practitioners. As Virchow's science of medicine has come into better balance with a return of the “art” and “humanity” of medicine as narratives of personal experience are integrated into curricula.

The same trend can be seen in efforts to design and measure quality and improvement.⁸ Patient flows should be mapped from patients' perspectives. Evaluations increasingly attempt to capture patient reported outcomes and experience measures (PROMs and PREMs), and patient-provider consultation frameworks, which create more space for patients to share the health and care experiences, and subsequently demonstrate a greater valuing of these outcomes and experiences by clinicians.⁹

This is especially the case when decisions need to be made. Shared decision making (SDM) needs to be focused on the awareness of possible differences in knowledge and experience of the patient in comparison with the healthcare professional versus the unfamiliarity of the professional with the individual patient's disease burden, lived experiences, experiences of care, values, and preferences.¹⁰ These items are part of the discussion during SDM integral to the co-production approach.¹¹ The combination of society's and individual patient's values, person-centered care and shared decision-making, leads to the view that healthcare is not a product, but a service, and a service is always co-produced.

Furthermore, possible outcomes of different treatment options can also be part of this discussion. These outcomes consist of a complex combination of clinically reported outcomes (e.g. survival, organ function improvement, recurrence rate, complications, mobility, activities of daily living, etc., and of patient reported outcomes (PROs), e.g. functional status including physical as well as psychological wellbeing, quality of life, social aspects such as return to normal life etc. In a recent Dutch discourse analysis on VBHC¹² (see Box 1), even though four different discourses were recognized, the common grounds were related to SDM: outcome information should eventually be used within the consultation room, SDM was perceived as a core element in VBHC, value was redefined as the personal result of a good interaction between healthcare professionals and patients.¹²

Box 1. Value-based healthcare: a Dutch discourse analysis.

In 2020 Steinmann¹² conducted a discourse analysis on value-based healthcare (VBHC). He explored both the ambiguity and underlying assumptions that shape various interpretations. The analysis was based on document analysis and semi-structured interviews with key-stakeholders. Steinmann described four discourses: (1) a patient empowerment discourse (VBHC is a framework to strengthen the position of patients); (2) a governance discourse (VBHC is a toolkit to incentivize professionals); (3) a professionalism discourse (VBHC is a methodology for healthcare delivery); and (4) a critique discourse (VBHC is a dogma of manufacturability). Despite the different perceptions, the common ground was shared decision-making as the key-component across all discourses. These different discourses, based on deeply rooted presuppositions, shape the different ways in which VBHC is operationalized in practice.

Value (in an economic sense)

VBHC was preceded by a very rich quality improvement (QI) science and practice and has integrated a great deal of QI's learning models. For example, costs were a part of Juran's cost of quality¹³ and the clinical value compass.¹⁴ VBHC has brought this relationship to the fore as a focus for measurement. With measurement comes the possibility for comparison. This can be with oneself over time, i.e. a historical comparison, or with others. Comparison raises the question of the role competition can have in driving quality. Health outcomes can be assessed in relation to processes of care, what is done to achieve these outcomes, how resources and competencies are used, including costs. In VBHC, costs should cover the full cycle of care, not limited as often is the case now to a care provider organization or certain drugs or interventions. The result of this assessment, i.e. the relationship between the Health Outcomes achieved and the Costs required to attain them, is what we consider to be *Value*, value for patients and society, but this is not equivalent to *patient value* or what patients value. Porter and Teisberg state that 'value is outcomes achieved per dollar spent' and 'The goal is "what matters to patients" and "this unites the interests of all actors in the system"'.¹⁵

Yet, while VBHC as it was originally presented recognized the patient in the complexity of the healthcare system, the line of reasoning did not move much beyond that. Outcomes are clinically defined by medical condition, but neither the aspirations, priorities and preferences of the patient, nor societal goals, are explored. Instead, the focus moves to using the relationship to expose the competitive traits of care givers to drive improvement. The Value concept itself was not new and VBHC was preceded by a very rich QI science and practice and even to the point that one wonders what VBHC adds to the existing QI discipline.

Within VBHC, (Time-Driven) Activity-Based Costing is the recommended approach, but it has proven challenging to fully implement¹⁶ and often, in practice, supports more of the process improvement efforts we recognize as a staple in QI. VBHC assumes competition will lead to better quality, but this may turn out to be more tied to contextualized political ideologies rather than the medical culture of competition between physicians,¹⁵ certainly in Europe.

VBHC might be seen as the next in a long series of quality improvement trends, each introduced with a striking regularity as the end-all solution to health systems current ailments. Cataloguing this parade of health management concepts, Walshe illustrated (using the number of publications regarding each concept per year) how each is introduced, gains popularity for 3-5 years, before waning, soon to be replaced.¹⁷ The curious thing, he noted, was that each new concept tended to share much content with its predecessors. It might come with a new tool or approach, but is it enough to justify a whole new label and all the fanfare, or is it another example of *pseudo-innovation*? Part of the explanation is that certain stakeholders have a desire to market new ideas, to attract attention, acclaim, and, perhaps new business. So, is this also the case with the VBHC concept? A review of articles citing Porter's trendsetting article on VBHC seems to support this claim.¹⁸ For example, the idea that the value of healthcare is important can be traced to the early emergence of modern quality improvement theory in healthcare. Even the value equation – i.e. that health outcomes achieved per amount of resource expended – played a central role, but then it was packaged under the term, "The Clinical Value Compass", which was published alongside guidance on how to enhance value through continuous healthcare improvement.¹⁴

Separating the ideas

We need both person-centered care through co-produced health care service with SDM (values/context-based decisions), and we need to optimize the use of finite resources for societal efficient co-production of user co-designed healthcare also grounded in societal values. We may disagree with the idea that competition based on value will solve healthcare's cost and quality conundrum. Either way, enhancing the value of healthcare by improving health and other outcomes while reducing the costs for achieving those outcomes remains a key concern for health systems everywhere.¹⁹ How to succeed is a core challenge for society and all stakeholders i.e. clinicians, managers, academics, health system leaders, politicians, citizens and ("third-party") payers. In recent years, patients and their family and friends have increasingly joined forces in the pursuit of better health and healthcare through different forms of co-production.²⁰

At the heart of these efforts lie the understanding of how health services contribute to better health, and how to improve these services' ability to do so, drawing on quality improvement theory as developed over most of the 20th century.^{13,21} Over the past four decades, this theory has been applied, evaluated, and refined specifically in health services.^{22,23} Key features include:

- a focus on meeting the needs of those individuals and populations for whom health services are intended
- understanding services in terms of processes and, often complex, systems with a shared aim (e.g. to alleviate the burden of illness; improve health and wellbeing)
- managing variation wisely (e.g. by distinguishing random variation from variation due to a distinct cause, and responding accordingly)
- addressing inequity in health (care)
- promoting learning, collaboration, and deliberate experimentation.

Closely linked to managing variation is the practice of measuring health services' performance, or quality.²⁴ Such measurement can come with different, sometimes even incompatible, motivations and purposes.²⁵ At its best, quality measurement can promote learning and improvement by highlighting particularly good performance, by bringing attention to areas in need of change, and by providing feedback as such change is introduced.²⁶ Of particular concern are the problems caused by attaching performance-based payment to quality metrics, since that inevitably brings a host of problems, including gaming, incomplete or even inaccurate reporting, and adverse selection of patients (to avoid "looking bad" or losing income).²⁷ This is precisely what VBHC in the competition-sense risks leading to. The problem is that the same measurement that can promote learning and improvement typically cannot also be used to determine financial reimbursement. This represents a huge challenge for proponents of VBHC.

Quality, like beauty, may lie in the eye of the beholder. Nevertheless, it can still be useful to articulate some common attributes of high-quality healthcare. In that vein, the US Institute of Medicine famously proposed that health services which successfully alleviate individuals' burden of illness or injury are: effective, patient-centered, efficient, safe, timely, and equitable.²⁸ One might argue that 'sustainability' is valuable to be added to this shortlist. Patient centered services then are: "services planned, delivered, managed, and continuously improved in active partnership with patients and their families to ensure integration of their health and health care goals, preferences, and values. It includes explicit and partnered determination of goals and care options, and it requires ongoing assessment of how care matches patient goals."²⁹ This patient centered view on healthcare combined with effective, efficient, and safe characteristics, in our opinion, gives a broader basis for a value-based concept. Including timely and equitable and also looking more precisely at long term effects of care brings the item of sustainability as a 7th item in the list of quality determinants. Increasing inequity, as dramatically shown in this recent COVID-19 period, is not easily "fixed", but should be addressed specifically by all stakeholders involved in healthcare.

Thus, it becomes really complicated since the assessment and valuation of the care or of some treatment is of course performed from the perspective of the patient but might be different if ethical and or societal perspectives are also taken into consideration. So, based on partnership encounters between a patient and his/her healthcare professionals, and in harmony with patient and professional values, using outcomes of other patients with similar conditions, a possible *value* is determined (outcomes vs costs) for the choices to be made. Again, a process of coproduction. During and after the treatment, together with the patient the real value is assessed by measuring clinician-reported outcomes and PROs, as well as process measures and costs, to if necessary, adapt or even change the treatment or the goals, as a form of coproduction leading logically also to co-evaluation.³⁰ Finally, considering outcomes that really matter to patients in light of the resources expended to achieve those outcomes might conflict with societal, ethical considerations. We should not close our eyes for this tension and should also be part of a dialogue we need to have about *value and values*. A dialogue about what really matters, inequity in this is a value conflict. A dialogue about the most meaningful impact on healthcare, about getting more health out of the health care system. This cannot be achieved through financial competition but invites to a dialogue about better ways to improve health and health care. VBHC certainly holds premise – provided we remember that there are two fundamental ideas nested in the phrase, one of which has been overlooked so far. We need just as much attention to 'values' (what matters when we are ill) as we give to economic value (maximum healthcare per unit of cost). More values are at stake, which presents us with complex dilemmas without clear and simple solutions. We call for a dialogue about how best to promote better health and health care in ways that are relevant and sustainable for our societies.

Data availability

No data is associated with this article.

References

1. Friel S, Marmot M, McMichael AJ, *et al.*: **Global health equity and climate stabilisation: a common agenda**. *Lancet*. 2008; **372**(9650): 1677–1683.
[PubMed Abstract](#) | [Publisher Full Text](#)
2. McGlynn EA, Asch SM, Adams J, *et al.*: **The quality of health care delivered to adults in the United States**. *N. Engl. J. Med.* 2003; **348**(26): 2635–2645.
[Publisher Full Text](#)
3. Defining Value in “Valuebased Healthcare”: *Report of the Expert Panel on effective ways of investing in Health (EXPH)*. European Union; 2019.
[Reference Source](#)
4. Heinrich N: *Des valeurs. Une approche sociologique*. Gallimard; 2017.
5. Value: Cambridge Dictionary.
[Reference Source](#)
6. Bastemeijer CM, Voogt L, van Ewijk JP, *et al.*: **What do patient values and preferences mean? A taxonomy based on a systematic review of qualitative papers**. *Patient Educ. Couns.* 2017; **100**(5): 871–881.
[PubMed Abstract](#) | [Publisher Full Text](#)
7. Ballatt J, Campling P, Maloney C: *Intelligent Kindness: Rehabilitating the Welfare State. 2nd edition: Using Kindness to Make Teams Work More Effectively*. RCPsych/Cambridge University Press; 2020.
8. Emanuel EJ: *Which Country Has the World's Best Health Care?*. Public Affairs; 2020.
9. van Egdom LSE, Oemrawsingh A, Verweij LM, *et al.*: **Implementing Patient-Reported Outcome Measures in Clinical Breast Cancer Care: A Systematic Review**. *Value Health*. 2019; **22**(10): 1197–1226.
[PubMed Abstract](#) | [Publisher Full Text](#)
10. Elwyn G: **Shared decision making: What is the work?**. *Patient Educ. Couns.* 2020; **104**: 1591–1595.
[Publisher Full Text](#)
11. Elwyn G, Nelson E, Hager A, *et al.*: **Coproduction: when users define quality**. *BMJ Qual. Saf.* 2020; **29**(9): 711–716.
[PubMed Abstract](#) | [Publisher Full Text](#)
12. Steinmann G, van de Bovenkamp H, de Bont A, *et al.*: **Redefining value: a discourse analysis on value-based health care**. *BMC Health Serv. Res.* 2020; **20**(1): 862.
[PubMed Abstract](#) | [Publisher Full Text](#)
13. Juran JM, Defeo JA: *Juran's Quality Handbook: The Complete Guide to Performance Excellence*. 6th ed. McGraw-Hill; 2010.
14. Nelson EC, Mohr JJ, Batalden PB, *et al.*: **Improving health care, Part 1: The clinical value compass**. *Jt. Comm. J. Qual. Improv.* 1996; **22**(4): 243–258.
[PubMed Abstract](#)
15. Porter ME, Teisberg EO: *Redefining Healthcare: Creating Value-Based Competition on Results*. Harvard Business Review Press; 2006.
16. Keel G, Savage C, Rafiq M, *et al.*: **Time-driven activity-based costing in health care: A systematic review of the literature**. *Health Policy*. 2017; **121**(7): 755–763.
[PubMed Abstract](#) | [Publisher Full Text](#)
17. Walshe K: **Pseudoinnovation: the development and spread of healthcare quality improvement methodologies**. *Int. J. Qual. Health Care*. 2009; **21**(3): 153–159.
[PubMed Abstract](#) | [Publisher Full Text](#)
18. Fredriksson JJ, Ebbevi D, Savage C: **Pseudo-understanding: an analysis of the dilution of value in healthcare**. *BMJ Qual. Saf.* 2015; **24**(7): 451–457.
[PubMed Abstract](#) | [Publisher Full Text](#)
19. Teljeur C, Moran PS, Walshe S, *et al.*: **Economic evaluation of chronic disease self-management for people with diabetes: a systematic review**. *Diabet. Med.* 2017; **34**(8): 1040–1049.
[PubMed Abstract](#) | [Publisher Full Text](#)
20. Batalden M, Batalden P, Margolis P, *et al.*: **Coproduction of healthcare service**. *BMJ Qual. Saf.* 2016; **25**(7): 509–517.
[PubMed Abstract](#) | [Publisher Full Text](#)
21. Deming WE: *Out of the crisis*. MIT Press; 1986.
22. Batalden PB, Stoltz PK: **A framework for the continual improvement of health care: building and applying professional and improvement knowledge to test changes in daily work**. *Jt. Comm. J. Qual. Improv.* 1993; **19**(10): 424–447; discussion 48–52.
[PubMed Abstract](#) | [Publisher Full Text](#)
23. Berwick DM: **Continuous improvement as an ideal in health care**. *N. Engl. J. Med.* 1989; **320**(1): 53–56.
[PubMed Abstract](#) | [Publisher Full Text](#)
24. Perla RJ, Provost LP, Murray SK: **The run chart: a simple analytical tool for learning from variation in healthcare processes**. *BMJ Qual. Saf.* 2011; **20**(1): 46–51.
[PubMed Abstract](#) | [Publisher Full Text](#)
25. Solberg LI, Mosser G, McDonald S: **The three faces of performance measurement: improvement, accountability, and research**. *Jt. Comm. J. Qual. Improv.* 1997; **23**(3): 135–147.
[PubMed Abstract](#)
26. Thor J, Peterson A, Lindahl B: **The role of quality registries in health care improvement**. Jacobsson Ekman GLB, Nordin A, editors. *National quality registries in Swedish health care*. Stockholm: Karolinska Institutet University Press; 2016; pp. 53–67.
27. Bevan G, Hood C: **Have targets improved performance in the English NHS?**. *BMJ*. 2006; **332**(7538): 419–422.
[PubMed Abstract](#) | [Publisher Full Text](#)
28. Institute of Medicine Committee on Quality of Health Care in A: 2001.
[Reference Source](#)
29. Frampton S, Guastello S, Hoy L, *et al.*: **Harnessing Evidence and Experience to Change Culture: A Guiding Framework for Patient and Family Engaged Care**. 2017.
[Reference Source](#)
30. Lachman P, Batalden P, Vanhaecht K: **A multidimensional quality model: an opportunity for patients, their kin, healthcare providers and professionals to coproduce health**. *F1000Res.* 2021; **9**: 1140.
[PubMed Abstract](#) | [Publisher Full Text](#)

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Adding values in different ways

In their paper, Hazelzet *et al.* call for a discussion of 'value' in relation to the concept of value-based healthcare (VBHC). While this notion has originally been introduced to advance an economic understanding of healthcare, the authors point out that other meanings of value—which they refer to as 'values'—have also been put forward, including societal and professional ones, in which they built on the discourse analysis of Steinmann *et al.* on how VBHC has been conceptualised in the Netherlands (Steinmann *et al.* 2020¹). Moreover, they show how VBHC is in actuality a continuation of earlier conceptualisations of quality improvement—adding another fad to the already densely populated business-like approaches to quality of care (Arndt and Bigelow, 1998). Interestingly, they also add a 7th dimension to the notion of quality—adding to the 6 earlier defined by the IOM—namely sustainability, thus bringing a temporal dimension to quality discourse.

As the authors argue, nobody can argue with the notion that healthcare should add value. The trouble starts when we want to give substance to the notion of value. In the words of political philosopher Michael Walzer, value is a 'thin concept', that is, like freedom or democracy, a concept that we can all adhere to (Michael Walzer, 2019. *Thick and thin: Moral argument at home and abroad* : University of Notre Dame Pres.). Once we start discussing what we mean with the concept of value (or, for that matter, freedom or democracy)—that is, trying to make it 'thick'—disagreement arises. Not only do substantiations of value differ between people or institutional actors, they also change over time. For this reason, in fields such as valuation studies (Helgesson and Muniesa 2013²) and care ethics (Tronto, 2013. *Caring democracy: markets, equality, and justice*. New York and London: New York University Pres.), values are seen as relational. Values, that is, are not 'out there', to be established once and for all, but are emergent properties of social interactions. In this sense, they are indeed, as Hazelzet *et al.* argue, 'co-produced'.

Healthcare, moreover, is full of contradicting values. This is already true for the 6 values defined

by the IOM. Efficiency, for example, often clashes with patient-centeredness. But so does safety. In a study on community housing services for people with intellectual disabilities and severe mental illness, we for example showed how patient preferences were often at odds with safety (Heerings *et al.* 2021³). Respecting the autonomy of the patient (another value) in such situations often clashes with notions of hygiene, lifestyle choices, but also becoming under influence of criminals. Whilst an economic 'solution' to this would probably be looking for the optimum of the two (or more) conflicting values—seeking to fix them in time—care ethicists would be more interested in the pragmatic, situated, temporal and collective settlements of such value conflicts, focussing on the ways in which actors 'tinker' with values.

The relational perspective on values also has consequences for the role of numbers and measurements in healthcare. The economic version of values, as expressed in VBHC, gives them a huge role. Numbers should give as objective as possible representations of states of quality of care, of patient preferences and of costs. Of course, this then brings many discussions about how such measurements should be performed, what the 'right' indicators are, how 'costs' can be bounded, etc. And it brings huge investments in actual measurements to deliver all this data necessary for the machinery of VBHC to function—and thus its own market. From a relation perspective numbers do not have a representational function but a performative one. That is, they are agents of change. Measurement guides our understanding of an issue or event and when institutionalized often comes to stand for those issues or events. But measurements and data are also used in a situated manner. E.g. patients might use the PRE/OM scores to focus attention on specific issues; doctors might use scores for getting the 'right' medication for their patients; regulators use measurements for steering organizations in specific direction (Wallenburg, Essén, and Bal, 2021⁴). Such a relation understanding moreover shows how quantitative and qualitative data can be used alongside, as they are both directed at getting an understanding of the situation and thus serve as reflective tools to enable actors to learn. Strengthening these reflexive capacities then becomes more important than 'getting the numbers right'.

One of the interesting aspects of VBHC is that it has put renewed emphasis on integrated care (not that this wasn't already done by others of course—there is a whole field of integrated care research), including a reframing of quality and costs as emerging properties of a network rather than characteristics of a single organization. Most (economic) research still takes place at the organizational level though, arguing for example that concentration leads to better and more efficient care, without looking at what happens in the whole system, including the places that are now deprived of specific specialty services. Reframing towards governing healthcare (costs and quality) at a population or regional level then becomes necessary as this allows to take into account the effects of changes in one place on others. It also allows for a better planning of services, instead of letting 'the market' (which does not exist in healthcare as it is highly regulated) fix it. Again, relational perspectives here come into play in the sense that they put an emphasis on equity and justice when it comes to governing healthcare and thus adding values such as plurality and solidarity to the value-conundrum (Tronto 2013. *Caring democracy: markets, equality, and justice*. New York and London: New York University Press.). Such a reframing towards population or regional levels also shows the complexities involved as interventions in one area might have (unintended) effects on others; effects moreover that are often unpredictable. This then also leads to the necessity of other types of research to evaluate interventions (Greenhalgh *et al.* 2017⁵).

Amongst many other things, COVID-19 has shown us that as societies we are prepared to invest in our health almost without limits. Though healthcare might have boundaries, it is unclear where

they are. In my country, the Netherlands, boundaries of care are more and more seen not as a cost issue but as an issue of workforce. There simply are not enough people to accommodate the increasing demand for care. This means we have to rethink our approach to governing healthcare, including questions such as what quality can be attained, where healthcare should be placed, what role patients and informal carers have in healthcare and how different professional groups and care providers can collaborate; we also have to rethink the relation between health care and other public services such as housing, education, work. And we have to rethink healthcare in relation to global developments such as climate change and migration (Wagenaar and Prainsack, 2021. *The pandemic within. policy making for a better world*. Bristol: Policy Pres.). VBHC is not particularly well suited for such challenges. We should be thinking about adding values in different ways.

References

1. Steinmann G, van de Bovenkamp H, de Bont A, Delnoij D: Redefining value: a discourse analysis on value-based health care. *BMC Health Serv Res*. 2020; **20** (1): 862 [PubMed Abstract](#) | [Publisher Full Text](#)
2. Helgesson C, Muniesa F: For What It's Worth: An Introduction to Valuation Studies. *Valuation Studies*. 2013; **1** (1): 1-10 [Publisher Full Text](#)
3. Heerings M, van de Bovenkamp H, Cardol M, Bal R: Tinkering as Collective Practice: A Qualitative Study on Handling Ethical Tensions in Supporting People with Intellectual or Psychiatric Disabilities. *Ethics and Social Welfare*. 2022; **16** (1): 36-53 [Publisher Full Text](#)
4. Wallenburg I, Essén A, Bal R: Caring For Numbers: Performing Healthcare Practices through Performance Metrics in Sweden and the Netherlands. 153-172 [Publisher Full Text](#)
5. Greenhalgh T, Wherton J, Papoutsi C, Lynch J, et al.: Beyond Adoption: A New Framework for Theorizing and Evaluating Nonadoption, Abandonment, and Challenges to the Scale-Up, Spread, and Sustainability of Health and Care Technologies. *Journal of Medical Internet Research*. 2017; **19** (11). [Publisher Full Text](#)

Is the topic of the opinion article discussed accurately in the context of the current literature?

Yes

Are all factual statements correct and adequately supported by citations?

Yes

Are arguments sufficiently supported by evidence from the published literature?

Partly

Are the conclusions drawn balanced and justified on the basis of the presented arguments?

Yes

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I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard.

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Thank you for inviting me to this dialogue about value-based healthcare.

The article *Value-based healthcare's blind spots: call for a dialogue* problematizes the blurry use of the term 'value'. It describes consequences for the understanding and use of the concept of Value Based Health Care (VBHC) and it presents some critical points.

The authors propose two main definitions of value. First, they discuss values as principles and standards of behavior with examples from patients and professionals. In the same section, they link the term value to patient reported outcome and experience measures, shared decision making, quality improvement as well as coproduction. The authors cite a discourse analysis on VBHC¹ that found diverging discourses on VBHC that, however, were bound together on the grounds of shared decision making as a criterion of (good) VBHC.

Second, the authors review value in the economic sense. That is '[...] outcomes achieved per dollar spent' as Porter and Teisberg² have put it. The authors highlight foundations for VBHC in industrial quality improvement, for example Juran³ or the clinical value compass⁴. Then they outline the VBHC's use of measurement, comparison and competition among providers. This is followed by a general criticism that VBHC does not consider preferences of patients or societal goals. They further question its assumption that competition improves the quality of health care. The authors also doubt the novelty of VBHC compared to earlier approaches to improving health care. Rather they consider it old wine in new bottles or a pseudo innovation.

The third section *Separating the ideas* opens perspectives for addressing major problems of health care such as cost, unwarranted variation, inequity, and quality. The authors discuss measurement of quality and problems of financial rewards linked to performance on quality metrics in the context of VBHC. Then they describe attributes of high-quality health care. These are the six dimensions of the IOM report from 2001⁵ and they propose adding sustainability as a seventh dimension. The final paragraph describes the complexity of assessing and valuing health care as well as the need to include patient and societal perspectives in evaluating and improving health care in sustainable ways. The authors end with a call for dialogue about how to do all this.

Comments:

I very much welcome the invitation to this dialogue and I want to applaud the authors for trying to advance the understanding of what constitutes value in health care (and in society) today. This dialogue is important given the number, the urgency and the complexity of the challenges and the multitude of vested interests of different actors and of possible solutions. Going back to the

building blocks of understanding, words, seems a good way to start.

Dialogue from Greek διάλογος (*dialogos*) means conversation. Its roots are διά (*dia*: through) and λόγος (*logos*: speech, reason)⁶. I will start the conversation by a study of words of the term 'value' and then ask some questions and make some propositions that hopefully will contribute to further improve the invitation.

The authors distinguish 'value' and 'values.' These words share a root in the Latin 'valere' meaning 'be strong, be of value, be worth' and interestingly for health care also 'be well'. Further back, the Proto-Indo-European root *wal- means 'be strong'. A market-oriented dimension of value appears around 1300 with "price equal to the intrinsic worth of a thing". In the late 14th century value denotes the "degree to which something is useful or estimable." The meaning of value as 'social principle' (or values) appears in the early 20th century. Further technical meanings were added later, for example, value as the relative duration of a musical note, a numerical quantity that is assigned or is determined by calculation or measurement, or the relative lightness or darkness of a color⁷.

The study of words reveals a positive connotation (strong, well) at the root of value/values. Further it illustrates how different understandings emerged. One is the importance of something positive in the absolute, qualitative and immaterial sense, for example, empathy as a health professional value. The other is the quantifiable, countable amount of something in a relative sense, for example, the outcome of a surgical intervention in relation to its cost.

Modern users of the words value and values might feel more attracted to one meaning of the word than to the other. The abovementioned professional value of empathy might appeal to clinicians. The balanced view on outcomes over cost might appeal to payors. Quality improvers might find themselves between these two in wanting to make care more patient centered while respecting the dogma of "what you cannot measure, you cannot improve" and the value of efficiency.

This is only a beginning. To take this reflection further, one could ask questions such as:

- What does the two-sidedness of values/value mean for clinical care?
- What does it mean for quality improvement?
- What does it mean for health care governance?
- What does it mean for VBHC?
- What does it mean for coproduction of healthcare service?

A dialogue about the meaning of values and value and about their relationship could address questions such as:

- What does value mean for patients? For professionals?
- Which values do they share? Which should they talk about?

Apparent consequences of the values-value distinction for quality improvement, for health system reform and coproduction could be reviewed (and mentioned in the introduction to the current

editorial).

General comments on the manuscript:

From reading the title (and the abstract), I expected an editorial about the blind spots of VBHC. Yet, the article is structured as an analysis of the meanings of the words 'values' and 'value.' It is somewhat difficult to get an overview over the critique of VBHC (the blind spots). A clearer presentation of the purpose of the editorial and a revision of its structure might make it easier for the reader to participate in the proposed dialogue. For example, the article might begin with a presentation of the problem and its causes (lack of agreement on the meaning of words) followed by a presentation of the possible meanings of values and value. The third part might be a presentation of the implications of the confusion of words for VBHC, for quality improvement, for coproduction and for measurement etc. The final part might then present the invitation to a dialogue and propositions on how to make it happen.

References

1. Steinmann G, van de Bovenkamp H, de Bont A, Delnoij D: Redefining value: a discourse analysis on value-based health care. *BMC Health Serv Res.* 2020; **20** (1): 862 [PubMed Abstract](#) | [Publisher Full Text](#)
2. Porter ME, Teisberg EO: Redefining Health Care: Creating Value-Based Competition on Results. *Boston: Harvard Business School Press.* 2006.
3. Juran JM, De Feo JA: Juran's Quality Handbook: The Complete Guide to Performance Excellence, Sixth Edition. *US: McGraw-Hill Professional.* 2010.
4. Nelson E, Mohr J, Batalden P, Plume S: Improving Health Care, Part 1: The Clinical Value Compass. *The Joint Commission Journal on Quality Improvement.* 1996; **22** (4): 243-258 [Publisher Full Text](#)
5. Institute of Medicine US Committee on Quality of Health Care in America: Crossing the Quality Chasm: A New Health System for the 21st Century. 2001. [PubMed Abstract](#)
6. Wikipedia. [Reference Source](#)
7. Online Etymology Dictionary. [Reference Source](#)

Is the topic of the opinion article discussed accurately in the context of the current literature?

Yes

Are all factual statements correct and adequately supported by citations?

Partly

Are arguments sufficiently supported by evidence from the published literature?

Partly

Are the conclusions drawn balanced and justified on the basis of the presented arguments?

Partly

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: Quality improvement, patient safety, coproduction, health services research

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard, however I have significant reservations, as outlined above.

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