HealthPros

International Training Network for
Healthcare Performance Intelligence Professionals

POLICY SUMMARY REPORT ON BEST PRACTICES FOR LINKING FINANCIAL INCENTIVES TO HEALTH CARE PERFORMANCE AT INDIVIDUAL HEALTH CARE PROVIDER, INSTITUTIONAL AND REGIONAL LEVEL.

A business case for value-based health care systems based on performance intelligence

Healthcare Performance Intelligence Series No. 2.5 2022

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PREFACE

HealthPros is a H2020 Marie Sklodowska-Curie Innovative Training Network for Healthcare Performance Intelligence Professionals under grant agreement No 765141, running from January 2018–April 2022. Healthcare performance intelligence can be defined as a structured approach to acting on health policies, using knowledge and information generated through scientific methods and health data to systematically measure indicators of health system performance. The network set out with the aim to train a first generation of Healthcare Performance Intelligence Professionals (HealthPros Fellows) that can make effective use of available healthcare performance data in countries to improve integrated services delivery, patient engagement, equality in access to healthcare, health outcomes and reduce waste in healthcare.

Since 2018, HealthPros Fellows have completed innovative research and multidisciplinary training in Canada, Denmark, Germany, Hungary, Italy, the Netherlands and the United Kingdom. As part of their training, Fellows also completed secondments at partner organizations as an opportunity to obtain local guidance and conduct applied research.

Throughout the programme, HealthPros Fellows have worked to develop tools and implement methods to streamline healthcare performance measurement, develop and apply performance-based governance mechanisms and optimize the use of healthcare performance intelligence by different end-users. Topics explored through a healthcare performance intelligence lens in their work include: actionability of performance indicators; composite measures; integrated care; corporate governance tools; patient and citizen engagement; nudging; use of routine databases for performance improvement; and, long-term care. As the COVID-19 pandemic paralleled the HealthPros programme, many Fellows and the network at-large, sought opportunities to conduct a number of COVID-19-related studies at pace with the pandemic's changing context.

Outputs of the HealthPros programme have continuously been published as open access studies in international, peer-reviewed journals. Additionally, Fellows have actively contributed to webinars, conferences, the delivery of courses, policy dialogues, direct country support, and media engagements, among other types of dissemination to continuously share new findings throughout the programme.

This **Healthcare Performance Intelligence Series** represents the culmination of key research findings by the network into a collection of reports providing methodological, practical, and policy guidance. Reports in the series are tailored to different audiences, ranging from policy-makers, hospital

managers, clinicians, and the general public. The development of each report in the series has relied on close collaboration across the HealthPros network. The range of topics and resources making up this series includes the following:

- Practical experience with implementing disparity and composite measures in large-scale routine quality improvement work to support transferability to other HC systems (No. 1.2 2022)
- A practical guide towards actionable healthcare performance indicators: Selecting healthcare performance indicators that are fit for purpose and use for various stakeholders (No. 1.3 2022)
- Policy guidance on advancing the performance assessment of integrated healthcare systems (No. 1.4 2022)
- Policy guidance on the use of PREMs to improve health system performance (No. 2.2 2022)
- Policy summary report on the value of results-based tools in health care management-Lessons learned from COVID-19 dashboards (No. 2.3 2022)
- Business model for effectively involving patients in the financial decision-making of health insurance funds- A guide to health care insurers on fostering the engagement of citizens based on recent experiences in the Netherlands. (No. 2.4 2022)
- Policy summary report on best practices for linking financial incentives to health care performance at individual health care provider, institutional and regional level- A business case for value-based health care systems based on performance intelligence (current)
- Policy recommendations on the role of nudging for health care performance assessment agencies (No. 3.2 2022)

The full series of reports can be found online (https://www.healthpros-h2020.eu/). For questions related to the series or HealthPros network please contact Dionne Kringos, PhD (d.s.kringos@amsterdamumc.nl).

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1. Summary

The business case presented here is based on two role plays. In the first part, our HealthPros fellows in teams of 2 were asked to assume the viewpoint of one of the 6 specific key stakeholders of a health care system (citizens, patients, health care providers, health care managers, financiers, and the Government). Fellows had to prepare a series of key statements from the perspectives of the stakeholders on how they think a value-based health system can be realized through a better alignment of financial incentives based on performance information. In the second part, HealthPros Fellows were asked to form a Technical Advisory Group on value-based health care and to advise the Ministry of Health of a given country (Italy and Germany in this case) on how to design a value-based health care system, paying close attention to the financing mechanisms for the future.

2. Background

Health care spending across the world has become a concern to financiers, care providers, and many policymakers. In the past years, many health care systems in Europe have been targeted by several policies aimed at containing health expenditure without reducing the provision of health services to citizens.

Simultaneously, health care systems seek transitioning to care delivery designs that are more people-centered, aiming at providing high-quality care that is cost-effective, linking health care costs and outcomes in a meaningful manner, while improving value for its actors.

Nevertheless, making the shift to value-based health care is far from easy as it may require a rethink of the overall care system design, including how incentives are used across the system to spur quality care, better clinical outcomes and care experiences. The challenges are not to be underestimated, particularly in obtaining adequate performance intelligence from health data infrastructures that lack interoperability.

For the transition from value-based care to value-based health systems, it is important:

1) to understand the values of different actors with different interests: citizens, patients, providers, managers, financiers and government.
2) to identify financial incentives that help to improve performance of providers (health professionals), institutions (such as hospitals) and regions (integrated care delivery) considering the mix of public/private provision and financing.

The aim of the business case is to explore these issues in detail.

3. The business case

3.1. The aim of the business case

The aim of this business case is to find ways to transition to value-based health care systems by using performance intelligence as a basis for decision-making on financing and payment mechanisms. In the business case we are re-thinking the (financial) incentives for the various stakeholders to increase value for the health care system.

3.2. The structure of the business case

Part 1 – Identifying values for stakeholders

In the first part of the business case presented here is based on a role play, where our HealthPros fellows in teams of 2 were asked to assume the viewpoint of one specific key stakeholder of a health care system. In total, 6 stakeholders' perspectives were considered: citizens, patients, health care providers, health care managers, financiers, and the government.

The representatives of the actors were asked to prepare a series of key statements on how they think a value-based health system can be realized through a better alignment of financial incentives based on performance information. All these perspectives were presented in a plenary forum (HealthPros training week, March 2021), where key statements were discussed and synthesized.

Part 2 – Technical Advisory Group on value-based health care grounded in performance intelligence

In the second part of the business case, HealthPros Fellows were asked to imagine the government of a given country seeking experts to serve as members of a Technical Advisory Group on value-based health care grounded in performance intelligence. Given the context of a country, the experts were asked to report to the Ministry of Health on how to design a value-based health care system, paying close attention to the financing mechanisms for the future.

For the purpose of the business case, two countries were selected – Italy and Germany, representing each of the main financing models of the European health care systems, namely insurance based and tax-based.

3.3. Business Case Part 1 – Value statements of stakeholders

Stakeholders

Each of the following roles of stakeholders in the health care system should be taken into account when we consider a transition to a value-based health care system.

Stakeholders	Roles
Citizens	● are voters, who vote on the political system. ● contribute to the funding of the health care system by paying tax or social contributions. ● are the "insured", with decision for additional packages/premium/co-payments/personal risks. ● are employers. ● are family members of patient. ● are informal care deliverers. ● are also the consumers of health care services.
Patients	● are the consumers of health care. ● have personal values towards performance of providers/institutions (i.e. they wish to have access to the health services that could provide them the best possible outcomes that are valued by them). ● are often required to pay co-payments for health care services. ● are surrounded by various social support structures. ● can be the managers of their Personal Health Budgets.
Health care providers	● include all the professionals (nurses, physicians et al.) who are trained to provide health care services at different levels of care. ● follow professional standards and values with respect to performance. ● they can be self-employed or employees. ● they can be salaried, or their remuneration can be based on ○ Pro-capita payment ○ Fee for Service payment ○ Mixed models with Pay for Performance incentives.
Health care managers	● are responsible for managing and influencing how care providers such as hospitals are balancing demand, resources, and performance based on the care that is delivered. ● have managerial notions on value and performance of the services they coordinate. ● operate based on ○ Budget based financing models ○ DRG based financing models ○ Pay for Performance models ○ Bundled Payment.

Financiers	• are grouped in two classic financing approaches through which financial resources are generated and distributed:
	  ○ Tax-based (national, regional, local)
	  ○ Insurance-based (social insurance, private insurance)
	• are involved in:
	  ○ Performance Based Contracting with providers/institutions
	  ○ Premium Based competition.
	• Decide on voluntary/mandatory elements of insurance packages.
	• focus on specific client groups versus population orientation.
	• are operating as population-based financing modalities or HMO structures.

Government	• represents the entity that sets the legislation wherein a health care system operates. In some systems the Government is also the Financier and/or a major employer.
	• can be national, regional, local.
	• is responsible for
	  ○ legislation;
	  ○ determining public/private balance and system design;
	  ○ valuing health, health care and health care costs;
	  ○ balancing value-based system design with potential government role as employer in health care or owner of health care services;
	  ○ aligning financial incentives to optimise value and reduce waste.

Guiding questions

Taking into consideration each role in the care system, the following issues should be explored:

- What is value to each stakeholder and how could it be measured?
- How could value be maximized, i.e., how could the health system become more responsive to each stakeholders' needs, expectations, and preferences?
- Which approaches and channels of communication are preferred to make information on each stakeholders' needs, expectations, and preferences available to other key stakeholders of the health care system?
- How can financing and reimbursement mechanisms be restructured to incentivise value creation from each stakeholders' perspective?
- Given the stakeholders' perspective, how to ensure that the care system ends-up purchasing and using the care that is needed, resulting in a value-based health care system?

Value statements

The representatives of the actors prepared the following key statements on how they think a value-based health system can be realized through a better alignment of financial incentives based on performance information.

Stakeholders	Value statements
Citizens	***Representation and responsiveness:*** ● I want my voice to be represented in local decision making for health service funding and management ● I want health care services which are appropriate to my needs, expectations and cultural background ***Money and finances:*** ● I don't myself or my family to suffer financial penalties for falling ill, or for supporting a family member with health needs ● I want my efforts to maintain my health to be recognised and encouraged, while acknowledging that many people are not able to do so ● I want my taxes to be used efficiently by the health services ***Choice and control:*** ● I want to be able to choose a provider which can provide the right care for me in the right timescale for my needs ● I don't want my healthcare expenditure to provide excessive profits for poor-quality care
Patients	"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me." - National Voices ***Values for patients and their measurement:*** ● Person-centred care, value is different for every patient ● Need for broader perspective on outcomes (not just medical) ● Weighted preferences that can be "tailor-made" through shared decision making (including what if I don't decide on treatment option). ***Methods to maximize value for patients:*** ● (inter)national strategy (clearly allocated mandate in health system) on implementation and use of PREMs and PROMs ● Professionalizing Real World Outcome data to evaluate long-term outcomes and costs ***Communication channels:*** ● Formalisation of patient representatives in health care organizations, financiers, and to include in decision making ● Social Media presence #HealthProsH2020 ***Financing and reimbursement mechanisms incentivising value creation:*** ● Value is based on broad patient outcome definition - no change in mortality is not the same as no change in outcome! ● Transparency in financing and reimbursement mechanisms

Health care providers	• ***Need for a comprehensive and measurable definition for "Value“*** "Value is the health outcomes achieved per dollar of cost compared to peers“ → need for defining measurable health outcomes. • ***Create and ask for support for dealing with care fragmentation*** A more specialized system needs support (IT, Governance, Cooperation) to deliver care as a system. • ***Work with payers for incentive schemes alignment between business model and system objectives*** Understand the effects of payments schemes (including innovations like HS and P4P) over the business model and direction of the market. • ***Capital gains linked to value generation performance*** Business proficiency must be linked to value generation (DRGs, capitation or bundled payments control health grow and give room for care quality, but they don't support capital costs hence the business of health care delivery is still governed by quantity. • ***Process identification for accountability of results*** Identify where value comes from. Or doesn't come from. • ***Structure service delivery in cycles of care (not on series of interventions).*** Treatments as multi-specialty, multi-level interventions covering the whole spectrum of care. • ***Competition in value delivery*** Linked to point above, providers should compete in the delivery of the whole care cycle.
Health care managers	• ***Workforce/staffing:*** To optimize the use of a well-organized, high-performing, competent human resources across the organization. Optimizing staffing plans (number of health providers in each unit/facility); addressing absenteeism (monitoring staff presence); ensuring timely (re)certification of staff (CPD) • ***Services delivery:*** To safeguard the safety and quality of care that reduces wastes and optimizes patient outcomes. Reducing medical errors/safety incidents; reducing duplication of tests/repeat services; coordinating handovers within institution and transfers of patients to regular care providers across facilities; Avoiding inappropriate hospital admissions • ***Information:*** To ensure access to timely, complete and quality patient information and performance data to monitor structures, processes and outcomes. Measuring performance against standard (detecting errors); monitoring administrative performance (detecting instances of fraud); Measuring the completeness of EHRs • ***Pharma/tech:*** To choose low-cost, high-quality medicines and technologies. Using generics instead of more expensive brand drugs (monitoring the use of generics); selecting cost effective treatments.

	● ***Financing:*** To pay for goods and services that achieve the above. Using financing and incentive mechanisms that reinforce the intended staff, services, use of information and pharma/tech.
Financiers	● As financiers we have a responsibility to make sure that limited resources are used to maximize health. Example of approaches to do that include: ○ Considering cost effectiveness (but also ethical concerns and budget impact), ○ Reducing waste (especially overuse and unwarranted variations) ● As financiers we have a responsibility towards our customers. Examples of approaches to take this into account include: ○ performance based contracting that includes patient experiences ● As financiers we wish to incentivise value creation by sharing (financial) risks with other stakeholders. Example of approaches to do that include: ○ Risk-sharing contracts with (innovative) drug/device suppliers ○ Bundled payments for health services by patient group ○ Reimbursement for non-acute stay due to lack of available places in nursing homes ● Outcomes important to value creation are often measurable over the long-run. As financiers we would like to see these long-term outcomes being taken into account in performance based contracting schemes. ● Measurement systems and ICT infrastructure have their own costs. It is important to consider the allocation justice principle - maximize health with a given budget to the whole population (priorities).
Government	***Citizens:*** *We provide:* ○ Adequate funding and resources for health services which are accessible / available, of good quality, safe and equitable (Mostly non-out-of-pocket?) ○ Transparency… in monitoring and reporting on structures (including finance), processes and outcomes *We expect:* ○ Pay taxes / health insurance ○ Be proactive (protective) re: own health ○ Manage your expectations ***Patients*** *We provide:* ○ Accessible care, which is integrated, safe and of good quality ○ Having your voice hear, also through shared decision-making which results in outcomes which compare well internationally *We expect:* ○ Participate as partners in care and comply ***Health care providers*** *We provide:* ○ Professional autonomy ○ Education and continuing professional development

	○ Well resourced, safe and engaging working environment ○ Regulated workforce mix *We expect:* ○ Accountability ○ Professionalism ○ Standard of practice ○ Innovation ○ Involve citizens and patients ***Health care managers*** *We provide:* ○ Transparent and stable legal and financial environment ○ Continuing professional development *We expect:* ○ Accountability and transparency re: quality and safety ○ Innovation capacity ○ Timely, standardized and interoperable data pipeline ○ Involve citizens, patients and providers ***Financiers*** *We provide:* ○ Transparent and stable legal and financial environment *We expect:* ○ Accountability and transparency re: finance scheme implementation ○ Minimum set of services ○ Quality for money (value) ○ Timely, standardized and interoperable data pipeline ○ Involve citizens, patients and providers

3.4. Business Case Part 2 – Technical Advisory Group on value-based health care grounded in performance intelligence

In the second part of the case study, Members of the "Technical Advisory Group" were expected to present advice on the design of a value-based health care system to the Ministry of Health in Italy and in Germany.

Guiding questions

The following are some of the guiding questions to the members of the Technical Advisory Group:

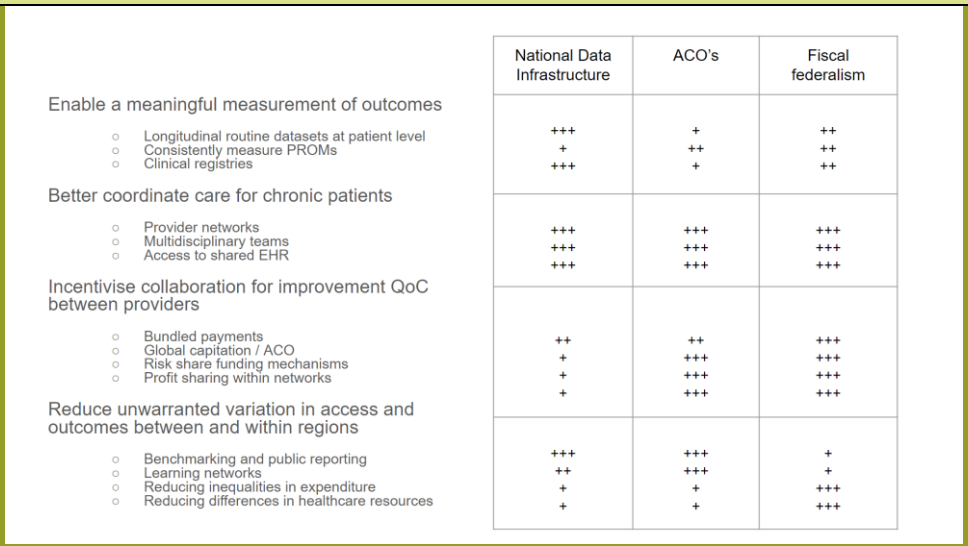
- How to measure, assess, and monitor value in a people-centered health care system?
- Which could be the design of an incentives structure, in particular of the reimbursement mechanisms, that could help with strengthening value across the system?

- Which types of performance intelligence are needed and how could these be used at different levels of the health care system to strengthen value-based care?
- How could performance intelligence that informs on value creation be linked to financing models at a three-tier level: individual health care provider, institutional, and regional?

Value-based Health Care Systems – the case of Italy

Italy 	• Decentralised, regionally based national healthcare system, Servizio Sanitario Nazionale (SSN) • The regions are responsible for allocating and managing the resources and providing and promoting health care services • Secondary care data available at regional level • Prescribing data available on national level • Some regions have patient reported outcome measure programmes • Administrative registries
Identified challenges 	• The main challenges for the Italian healthcare system relate to ***coordination of care*** for the growing (and aging) population with chronic conditions and reducing disparities in healthcare. • Payment system in Italy mostly ***volume based*** (+capped) for secondary care, and capitation for primary care. • The number of ***avoidable hospital admissions*** is high • There are significant ***regional variations in performance*** (and availability of healthcare workers): "The proportion of patients in the south choosing to be treated in another region is almost twice as high as in the north." (OECD, The Country Health Profile Series: Italy, 2019) • Regional differences in ***performance information availability***. • Variations in ***resources spent*** for the same services.
Policy ambitions	• Enable meaningful measurement of outcomes • Provide better coordinated care for chronic patients • Incentivise collaboration between providers for better QoC • Reduce unwarranted variation in access and outcomes between and within regions
Possible responses	**Enable a meaningful measurement of outcomes** ○ Longitudinal routine datasets at patient level ○ Consistently measure PROMs ○ Clinical registries **Provide better coordinate care for chronic patients** ○ Provider networks ○ Multidisciplinary teams ○ Access to shared EHR **Incentivise collaboration between providers for better QoC**

	○ Bundled payments ○ Global capitation / ACO ○ Risk share funding mechanisms ○ Profit sharing within networks **Reduce unwarranted variation in access and outcomes between and within regions** ○ Benchmarking and public reporting ○ Learning networks **Promote more efficient spending for services at the regional level** ○ Use of "standard costs"
	National data infrastructure as a basis for performance measurement
	• A new value generator in town → Data • Establish a fundamental health data infrastructure grid and health data use legislation • Mandate national institution(s) to: ○ Set technical standards for interoperability between the fundamental health data infrastructure and (software) providers ○ Standardize reporting in the health system (aligned with European initiatives and international coding systems) • Adjust legislation ○ Mandatory interoperability with national data infrastructure and technical standards ○ Legislation on health data ownership and secondary health data usage • Possible applications ○ Integrated routine datasets on a regional level - enable data linkage between regions ○ Data linkage between clinical registries, civil registration system and covariates (e.g., socioeconomic status) via personal identifier ○ Develop national based registries for key conditions ○ Performance dashboards for policy decision making ○ Basis for EU health data
	Creating a reimbursement model for accountable care networks
	• Establish global capitation budgets for local accountable care networks, covering the full cost of care for patients across primary, community and secondary care. • These budgets should be held by groups of providers, working collaboratively together. • Contracts may formally be held by a lead provider, all forming a single organisation, or a risk-share contract. The appropriate lead may vary between areas. • Patient populations will vary according to the most appropriate local provider configurations and their catchment areas but must be a minimum size to allow budgetary risk to be managed. • Alongside the baseline per capita payments, a proportion of network reimbursement will be based on achieving: ○ patient outcomes (as measured by clinical measures, administrative measures, and PROMs) and ○ patient experience (general PREMs, care transitions) • The data to inform these adjustments will be based on the national data infrastructure. • Agree best practice bundled payment tariffs for within-ACN specialties to encourage within-ACN efforts to coordinate for specific conditions.
	Fiscal federalism - recalculating equalization funds
	• Continue transfer of resources from wealthier regions to regions where there's a revenue-spending gap • Replace weighted capitation-based transfers, causing significant inefficiencies, with reallocation funds computed based on a system of standard costs, identical for all regions

	• Standard costs of production should be set at the level of the average service costs in the best performing regions on health-care expenditure targets • This would incentivise poorer regions to spend resources more efficiently and become less dependent
How do the interventions impact on the objectives?	
How do these interventions increase value at each level?[1]	***Personal:*** Including a range of outcome measures in payment models encourages providers to focus on the outcomes that matter most to patients. Moving away from payment for volumes encourages a focus on only activity which increases value. ***Technical:*** Global capitated payment models encourage providers to operate more efficiently within their yearly sum, to retain savings. ***Allocative:*** Recalculating equalization funds in fiscal federalism supports more equitable resource distribution between regions. ***Societal:*** Linking of the civil data to health data can give insights to GPs to contact at risk groups who have no support from the system. Unallocated money from ACO budgets (unearned P4P) will be spent on local social projects.

[1] Expert Panel on effective ways of investing in health (EXPH) (2019) Defining value in "value-based healthcare". Available: https://ec.europa.eu/health/sites/health/files/expert_panel/docs/024_defining-value-vbhc_en.pdf

Germany 	• Statutory health insurance financed by statutory health insurance funds which,
	  ○ public-law corporations
	  ○ financially and organisationally independent
	  ○ have the right to self-government by elected representatives of the insured and of the employers
	• The National Association of Statutory Health Insurance Funds is to create binding collective regulations on, for instance, care provided by physicians and in-patient care.
	• The Federal Joint Committee decides on the specific benefits to be included in the statutory health insurance catalogue.

Identified challenges 	• Lack of gatekeeping function of primary care (GPs); compromised role of PC • Limited prevention (high levels of lifestyle risk factors) • Overuse of hospitals and doctor consultations • Limited data sharing among insurers • Lack of patient-reported measures at regional or national level
Policy ambitions	• Shift from fee-for service payments to a network and capitation/bundle care to discourage unnecessary services • Support a shared risk and fair distribution of savings model • Involvement of community panel in the setting of a care priority agenda for their community

Possible responses	**Formation of networks of providers (cycles of care)**
	Create networks of providers based on the cycles of care:
	• the network of GPs, specialists and allied health providers provide the services that they see fit, as long as they respect the care standards for chronic conditions.
	• patients will choose to be treated by a network (sign a consent) or be treated as a separate provider
	• competition between Cycle of care networks
	Financing
	Outpatient services:
	• payment of outpatient services based on a capitation principle + bundled payments (network of GPs, specialists and allied health care providers).
	• inclusion of a pay for performance element based on outcomes.
	  ○ These outcomes to include performance measures, including patient centered measures such as PREMS and PROMS.
	  ○ Also, outcomes that generates savings for insurance funds in secondary care (avoided hospitalizations) taking into account long term care consequences of good ambulatory care and prevention.
	High healthcare uses:
	• Capitation + bundled payments for high healthcare uses.
	Financed through SHI
	• Bundled payments include direct care costs, rehab, monitoring and case management…
	• Capitation for other (“healthier”) patients adjusted by age and sex
	Financed through Community Council funds:
	• P4P bonus that considers performance, PREMS and PROMS

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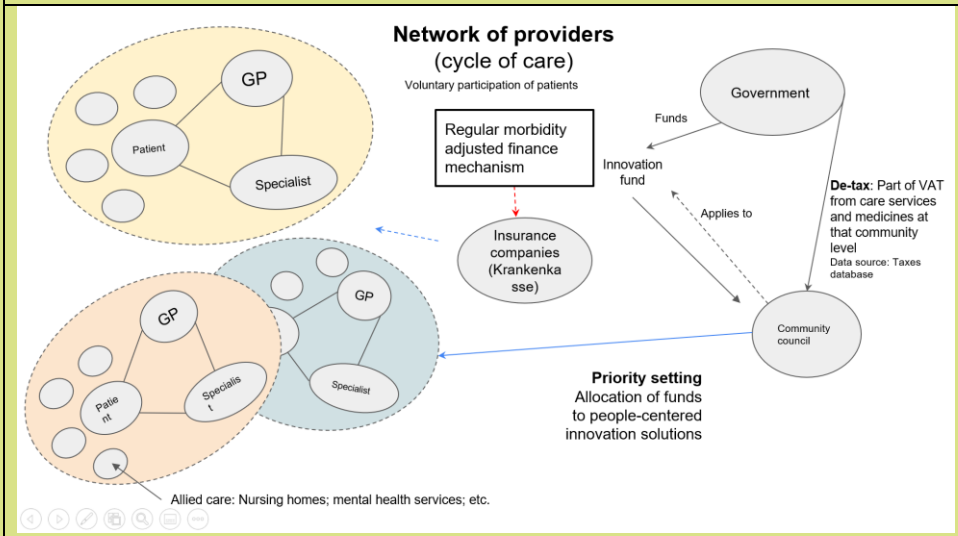
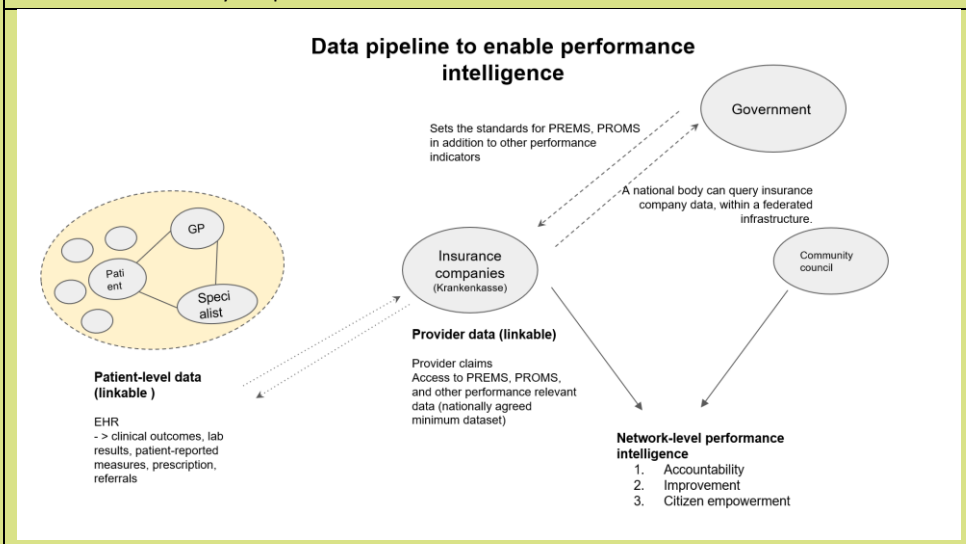
- Prevention bonus (consider the incentive for prevention is included in the capitation)

Innovation bonus (for particular interventions (IT), innovation is structurally incentivized in the bundled)



Use of performance intelligence

- Use of Patient Reported Outcomes (PROMS): (e.g. in Public Private Partnerships)
- Need for standards setting & harmonization (interoperability of data structure, vendor selection, etc) and regulations around data protection – governments' role:
- Need to add the citizen's voice, ensuring that the reporting is understandable, accessible, relevant - Community councils' role
- Benefits of performance intelligence:
  - Provides accountability to the public
  - Stimulates quality improvement
  - Empowers users
- Other benefits of integrated data pipeline:
  - Operational efficiency within the network
  - Improved clinical decision making (re: treatment decisions) enabled by easier comparability of outcomes data between different treatment among similar patient profiles -> reduce administrative and financial costs of lesser treatments
  - Improved self-management, improved adherence and remote monitoring -> reduction of unnecessary hospitalizations



How do these interventions increase value at each level?[2]	**Citizens**: • Community council brings representation of the public to decision making at the local level (detax); performance-based choice **Patients**: • More coordinated care; Access to a network of different providers • Access to personal health information in networked way • Experience measures collected/used in decision-making **Health care providers/management – outpatient level:** • Better care of the patients = less demand for regular/repeat care; incentives to provide more coordinated care in handling of more complex patients; shared performance incentives **Health care providers/management – inpatient level:** • Avoiding unnecessary hospitalizations; shared performance incentives **Financiers (insurers):** • Less costly hospital care **Government (policy):** • A value-based health care system driven by prevention, staying healthy; greatest return for investment

4. Concluding remarks

In the Business Case HealthPros Fellows explored how to transition to value-based health care systems by using performance intelligence as a basis for decision-making on financing and payment mechanisms. First, they identified the values of different actors with different interests (citizens, patients, providers, managers, financiers, and government). Second, they investigated the role of financial incentives to improve performance of providers (health professionals), institutions (such as hospitals) and regions (integrated care delivery) to maximize value for stakeholders.

Key elements identified in the business case for building a value-based health care systems are the following:

Financial mechanism should:

- build on performance intelligence, including patient reported experience and outcome measures (PREMS and PROMS) to increase value in the system by providing people-cantered care.

[2] Expert Panel on effective ways of investing in health (EXPH) (2019) Defining value in "value-based healthcare". Available: https://ec.europa.eu/health/sites/health/files/expert_panel/docs/024_defining-value-vbhc_en.pdf

- enhance the role of integrated health care provision to increase value for patients and strengthen financial responsibilities of providers.
- consider cost-effectiveness of health care technologies (services and medical products) in financing to increase value by decreasing waste and by improving outcomes relevant from the population's perspective.
- Also, the case study pointed out the need for citizen involvement in financial decision making of insurance funds or of the public payer.

5. Reading materials on value-based health care systems used in the business case

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