WHO Policy brief

From value for money to value-based health services: a twenty-first century shift

World Health Organization

Contents

1. Background

The health sector represents a large and growing share of the global economy. In 2017, the world spent US$ 7.8 trillion on health, representing almost 10% of global gross domestic product (GDP) [1]. Across all income levels, between 2000 and 2017 health spending grew at an average of 6% faster than the GDP [2]. As a result, health is considered one of the drivers of economic growth with the expectation that, due to countries scaling up universal health coverage (UHC) programmes, 80 million additional jobs would be added within the sector [3] and an additional 2–4% GDP growth would be added to low- and middle-income countries [4].

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Despite economic growth and rising health expenditure, improvement in service coverage has slowed. According to the World Health Organization (WHO) monitoring report for UHC in 2019, service coverage growth peaked in 2006 and has been decreasing since, despite the increases in health expenditure [5]. As health care costs increase and populations age, health budgets are increasingly stretched across multiple competing needs. There is an urgent need to ensure that the increased expenditure is spent efficiently and effectively in order to ensure that service coverage can continue to increase.

Creating value for money through priority setting processes to support decision-making for health benefit packages and other policy decisions is one of the key processes through which efficiency in health spending has been pursued. Value for money is generally quantified by the application of an economic evaluation methodology, such as cost-effectiveness analysis. However, value for money in the decision-making process alone is not sufficient to ensure that the anticipated value is seen at the service delivery level.

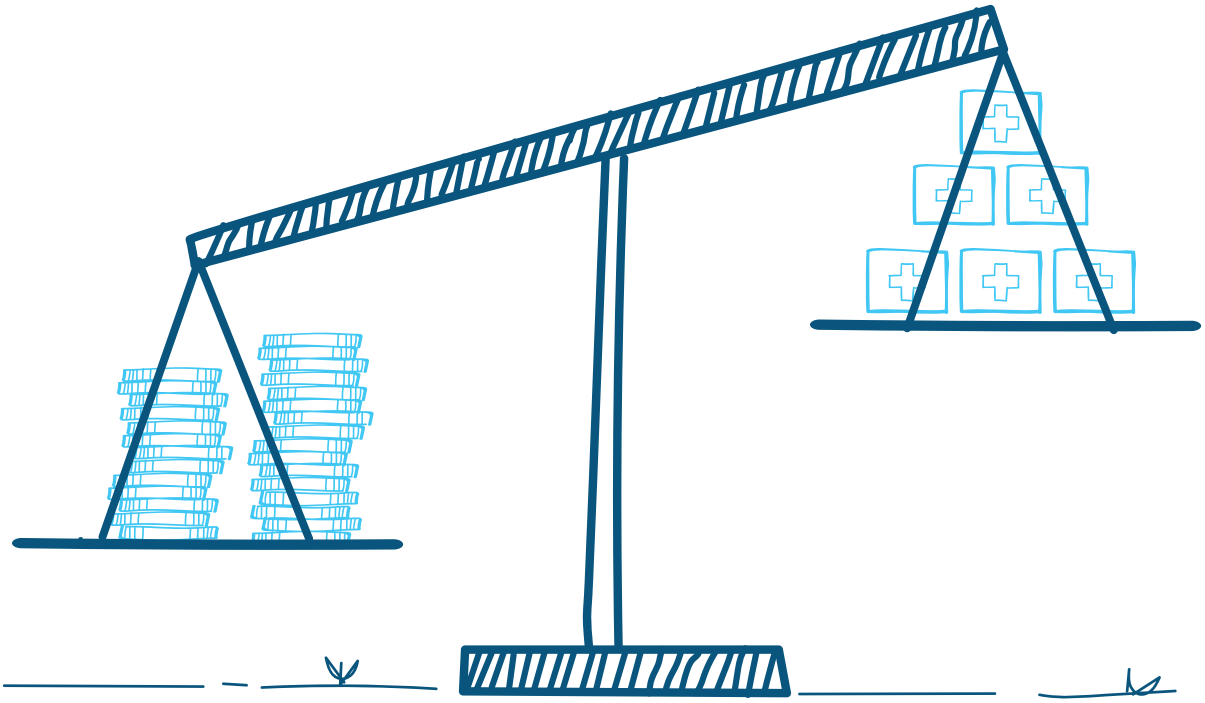
A broad and comprehensive definition of value-based health services (VBHS) requires a deeper understanding of what patients, families, health professionals, communities and societies as a whole value most in relation to health care. To genuinely understand value, there is a need to shift the focus away from "what is the matter with people" to "what matters to people", placing people at the centre of care. VBHS encompass a range of considerations beyond only considering value for money in selection processes, by making sure that this estimated value is passed on to patients and corresponds to their interpretation of value. This could include ensuring health improvement at the patient level, responsiveness of the health system to patient needs, financial protection, efficiency and equity [6].

Strategic choices that align benefit package selection processes with value for money as core considerations and strategic purchasing policy instruments could drive high quality integrated people-centered health services (IPCHS). This shift from value for money alone to VBHS is fundamental to achieving the UHC objectives of quality health care, financial protection and equitable access to health services.

At present, many low- and middle-income countries face political, institutional and technical challenges to improving the way they make decisions about what to purchase, and how they purchase health services. New developments (e.g. new health technologies, new priorities, changes in provider behaviour or greater availability of data) continually emerge, requiring the adaptation of selected health benefit packages and purchasing arrangements.

This policy brief presents a framework for VBHS that links the policy instruments of value for money in health benefit package selection processes and strategic purchasing to enable IPCHS approaches. The latter reflects a high-performing service delivery function that is reflected in indicators of equity, access and quality, among others.

2. Ensuring value for money in health



Value can be generated at many different levels within the health system, both in terms of health benefits and non-health benefits [6]. The first stage in generating value is ensuring value in health policies, and specifically in measuring value for money when selecting policies to fund. In this context, value for money refers to using economic methods – commonly, cost-effectiveness analysis – to measure the health gain achieved for a given level of spending [7].

The concept of "value for money" is central to the development of health policy and the delivery of health care. A health care system that delivers value for money is defined as one that maximizes efficiency, enabling the population to attain the highest possible level of health given the level of expenditure.

The aim of WHO is to help countries achieve UHC by making evidence-informed decisions to use resources efficiently and effectively. Value for money, efficiency and impact are fundamental considerations for strategic investment in health at national and global levels. With funding availability no longer always considered the greatest barrier to achieving better health outcomes, making strategic choices at the country level becomes more important than ever. As a decision-making criterion within health, cost-effectiveness analysis helps countries and donors ensure that they get the best value for money possible from the resources being expended [8].

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3. Ensuring value through health benefit package selection processes

World Health Assembly resolution WHA64.9 (May 2011) on sustainable health financing structures and universal coverage called on Member States "to establish and strengthen institutional capacity in order to generate country-level evidence and effective, evidence-based policy decision-making on the design of universal health coverage systems" [9]. World Health Assembly resolution WHA67.23 (May 2014) called on WHO to develop global guidance on methods and processes for health technology assessment (HTA) in support of UHC, and to provide technical support to countries to implement HTA processes in decision-making [10].

These processes are encapsulated within the WHO 3D approach to priority setting, which could be applied generally in national health planning processes, within the benefit package selection space, or to an HTA mechanism [11]. The 3D approach identifies the three common steps in priority setting processes: data, dialogue and decision (Figure 1). It is important that the 3D approach is effectively linked to a country's legal framework and a strong institutional arrangement and governance mechanism to support the decision-making process. The 3Ds reflect a theoretical, ideal approach that countries follow to differing degrees and not always in a sequential form.

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Within the first stage, data analytics are undertaken in order to support the decision-making process. These data are the scientific evidence to support policy-makers and should be institutionally separated from the decision-makers themselves. These data generally consist of quantitative evidence such as burden of disease, cost-effectiveness, budget impact, resource needs, and qualitative criteria such as fairness, equity, acceptability and patient satisfaction. They also underpin many HTA processes that could inform benefit package selections.

These data are made available to inform deliberative dialogue process in which the tradeoffs inherent within the criteria are made explicit and discussed among an inclusive group of stakeholders. This process should ideally be as open and representative as possible, with a methodology designed to lend legitimacy to participants as well as the process so as to ensure a broad-based stakeholder acceptance of dialogue results. The stakeholder dialogue then makes a recommendation to the designated decision-maker, who in a consultative process makes a final choice about the priorities and funding allocations.

To support the data aspect of the 3D process, WHO has developed the UHC Compendium, a database with information on health interventions, intended as a global point of reference and primarily aimed to support benefit package design and service planning at the country level.

The overarching aim of the selection of a health benefit package, or an HTA mechanism, is to explicitly select health interventions that reflect country needs and values and can be provided within the available resource envelope. Within the context of UHC, this ensures that people can access the health services they need according to social preferences without being exposed to financial risk. However, this process is only as strong as its links and alignment with other policy instruments, such as the strategic purchasing mechanism.

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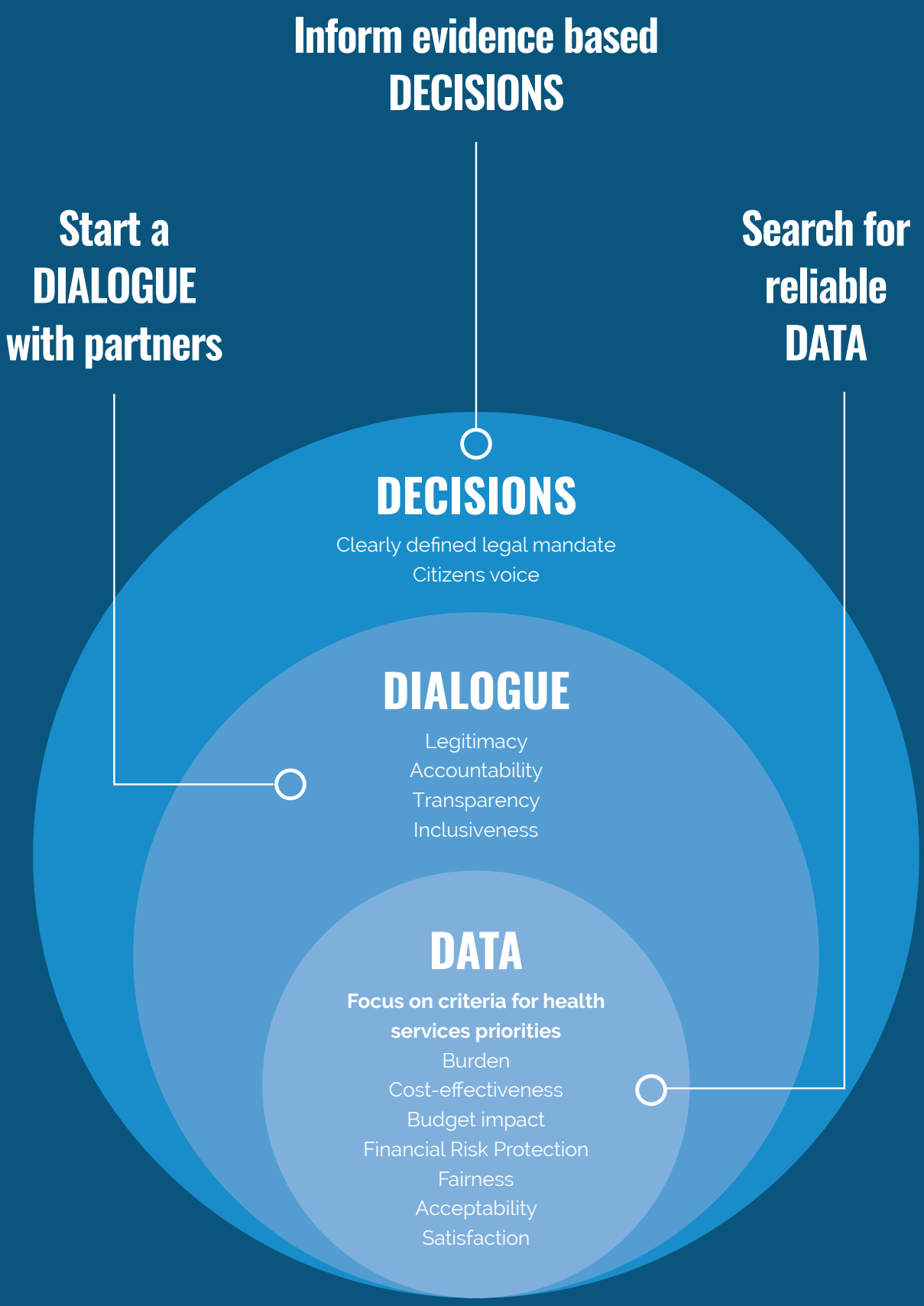
Figure 1: 3D approach: data, dialogue and decision



4. Ensuring value through strategic purchasing

Purchasing is a core health financing sub-function that refers to the allocation of pooled funds to public and private health care providers for the health services they deliver. There is a growing consensus that purchasing of health services must be more active or strategic if countries are to make progress towards UHC and achieve value in health service provision. Strategic purchasing means aligning funding and incentives with legal entitlements to health services and must, therefore, be guided by detailed information on the performance of providers and the health needs of the population served [12]. As such, strategic purchasing aims to maximize health system objectives through an active, evidence-based process. Thus, a VBHS approach will have to define what is meant with performance of providers and take measures to understand people's health needs and preferences.

Revenue raising and effective pooling of funds for health are important, but strategic purchasing is vital for countries to be able to progress towards UHC. Strategic purchasing transforms budgets into effective coverage, with the aim of realizing gains in efficiency and managing expenditure growth. This frees up resources and, as such, is an important revenue source for expanding service or cost coverage. It also seeks to improve quality by giving signals to health providers. Strategic purchasing can also improve financial protection through reduced out-of-pocket expenditure, make the distribution of resources more equitable, and enhance the transparency and accountability of providers and purchasers [13].

Strategic purchasing involves several interrelated areas, namely:

1) further specifying benefits (what to buy) by building upon the health benefit selection process (as outlined above);

2) determining from which providers to purchase (from whom to buy); and

3) applying a context-appropriate mix of payment methods and related payment rates combined with effective contracting arrangements (how to pay).

These three areas need to be aligned and addressed jointly, as outlined in Figure 2. A related core element of strategic purchasing is information management to provide the basis for strategic purchasing decisions, i.e. detailed and up-to-date information are needed for a purchaser to be able to allocate funds according to population needs and provider performance, to design payment methods as well as to monitor provider behaviour. Likewise, effective governance arrangements are critical to support these purchasing decisions and to align the various purchasing areas.

The purchasing setup is very complex in most countries and often highly fragmented, with multiple purchasing agencies buying different benefit packages for different population groups from different providers and levels and using multiple payment methods. As a result, the challenge for providers is that they are often faced with multiple payment methods and funding flows that could easily create an incoherent set of incentives triggering provider behaviour that is not conducive to value-based health care, such as resource-shifting (implying patient cream-skimming on the one hand, leading to patient discrimination on the other hand), cost-shifting and/or service-shifting [15]. There is growing evidence and increased consensus that purposive alignment of payment methods, such as balancing the undesirable incentives of a single payment method and harmonizing the range of incentives, is the optimal approach to improving the payment system. The aim is to set incentives for integrated and coordinated care across the system of good quality [16].

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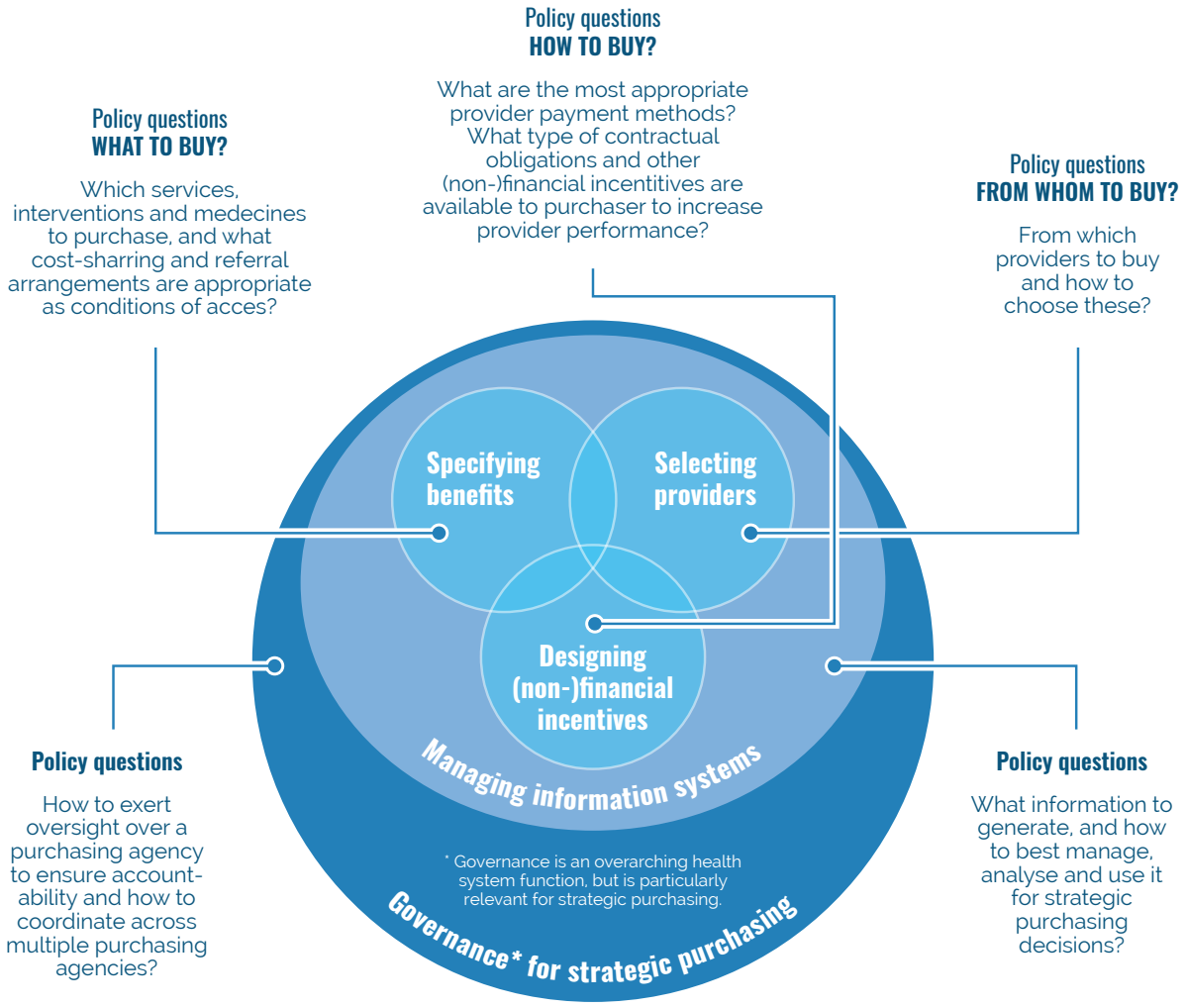
Figure 2: Core areas of strategic purchasing and policy questions



Source: Mathauer et al. 2019 [14].

Blended payment methods are one way to do this. Blending means two or more payment methods are combined purposively. One specific example is to blend bundled payment could also provide incentives for integration of care.