

A Value-based Steering Model for Healthcare

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Abstract

Background

When the commissioner of healthcare services is responsible for all health services of a certain population, the commissioner is incentivized to steer service producers towards better value (i.e. outcomes relative to costs). Value-based healthcare provides a setting for creating better value, but it is currently limited to some patient segments, not the whole population, and does not serve the purpose of steering multiple service providers with varying service portfolios and different degrees of specialization. This paper presents a tentative value-based steering model that aims to fill this gap in research and in practice.

Results

We constructed a value-based steering model which consists of three parts: (1) the principles of steering; (2) the steering process; and (3) Value Steering Canvas, a concrete tool for steering.

Conclusions

The commissioning body can start using value-based steering without changes in legislation or the present service system.

Background

Recently, outcomes have become more of a hot topic in healthcare, especially since Porter and Teisberg [1] introduced the concept of value, meaning patient-relevant outcomes in relation to the costs of delivering these outcomes. In health economics, the same concept has been known as cost-effectiveness [2]. What Porter adds to the discourse is an emphasis on the relevance of the outcomes to the patient [3] as opposed to general outcomes such as 5-year survival or percentage of reoperations. The rising trend of patient-centeredness [4] also contributes to this discourse. What this means from the point of view of outcomes measurement is essentially that outcomes must be measured on the patient level, not on the population level or producer level, and that outcomes measurement should include patient-relevant measures, which often means patient-reported outcome measures (PROMs). Value should be measured by the patient's medical condition, that is, the measurement of value should be tailored for each diagnosis. The International Consortium for Health Outcomes Measurement (ICHOM) aims to standardize health outcomes measurement by creating diagnosis-specific standard sets of measures, which usually include both PROMs and clinical measures, sometimes also clinician-reported outcome measures [5].

There are many potential use cases for the outcomes data. A patient may use provider-level outcomes data to choose the best provider for them [6]. A healthcare professional may use the data of their individual patient to monitor their development and to guide their care [7]. The manager of the healthcare

professional may use the data to benchmark and assess the performance of each healthcare professional, to motivate healthcare professionals to actively work for better patient outcomes, and for other such management-related uses [8]. A healthcare service provider organization may use the data to improve its performance [8, 9]. Finally, the commissioner of the services may use the data for steering the service providers.

The need to for steering stems from the division between the commissioner paying for the services and the provider producing the services, which exists on some level in every healthcare system, regardless of its financing structure. Healthcare systems are usually classified into three categories: the Beveridge model (national health service), the Bismark model (private insurance), and national health insurance [10]. In the Beveridge model, services are financed through taxes and provided by government-owned bodies. In the insurance models, the financing is either through a government-run insurance program that every citizen pays into, or through private insurance companies where participation is mandatory. In the insurance models, the provision of services is usually done by private hospitals and general practitioners contracted by the insurance companies. Regardless of the financing structure of the healthcare system, there is still a payer (or multiple payers), a commissioner of the services, responsible for the service provision for a certain population, whether it is a regional population base or a group of insurance holders. Thus, it is in the interests of the commissioner to maximize the cost-effectiveness of the services. Also, in every system there is a division between the commissioner paying for the services and the provider producing the services, at least on some level. Therefore, the commissioner can affect patient outcomes only through service providers. In order to do so, the commissioner must use policy instruments to steer the providers.

However, Porter's value-based healthcare (VBHC) provides only a part of the solution for an outcomes-based healthcare system. Torkki et al. (Torkki P, Leskelä RL, Mustonen P, Pikkujämsä S, Lillrank P. Value-based segmentation in public health system. Sent for review 2020) argue that when the population is segmented based on their service needs, VBHC (as implemented through ICHOM standard sets) is only applicable to a part of the population: the patients with a curable ailment, where the treatment is process-like and finite; and those with a single chronic condition. The rest are either multimorbid, making it difficult to base outcomes measurement on the medical condition, or their health needs are too minor to be measured through most PROMs. Thus, a large share of the population needs a different method of measuring outcomes. Furthermore, what is missing in the VBHC theory is a way to utilize patient-level outcomes to steer value in a healthcare system that consists of multiple service providers with varying service portfolios and different degrees of specialization.

This article aims to fill the latter gap in VBHC: to construct a steering model that is suitable for steering service providers from the point of a view of a commissioner wanting to implement VBHC on a system level. Such a model has not been introduced before, but it is important to understand the implication of implementing VBHC in the whole healthcare system and not only for a specific patient segment or a subset of producers. When the commissioner of healthcare services is responsible for all health services of a certain population, the commissioner is incentivized to steer service producers towards better value

in terms of outcomes relative to costs. Thus, the commissioner has a crucial role in making the services as cost-effective as possible.

The objective of this article is to answer the question: How can a commissioning body steer health services based on value in an environment where the commissioner is responsible for the health services of a population with varying health service needs? We build a model for value-based steering for healthcare services. We approach building the steering model by combining the principles of VBHC described above with policy instruments. Then, we move on to describing what steps need to be taken when implementing value-based steering. Finally, we provide a tool to assist in the planning and building of value-based steering.

The use of policy instruments in steering providers

Steering is management across organizational boundaries, where the governing body aims to transfer resources to desired actions, in this case public services. In the actual steering process, the governing body uses various policy instruments to pursue its goals [11, 12]. The basic elements of steering are (1) a steering subject, in this case, the commissioner, (2) steering instruments (policy instruments), (3) a policy goal set by the commissioner, and (4) the object of steering, in this case the service provider [11]. Thus, the essence of steering is usually seen as power and control [12].

Policy instruments can be classified in many ways, but they commonly include elements of regulating through legislation, economic means, and information [11–14]. Dialogue is often considered a part of information as a policy instrument, since these instruments are so closely connected in steering practices. Here, however, they are seen as two independent tools, as we want to emphasize the difference between the one-way flow of information and the two-way nature of dialogue.

When steering is seen as control, it is often assumed that the objects of steering are rational self-maximizers, calculating their best interests in deciding whether or not to comply with the demands of steering subjects. In this view, the steering subject emphasizes instruments that are based on coercion or financial incentives and disincentives [14].

The policy instrument that implies coercion is regulation: the object of steering, in this case the service provider, is obligated to do what the steering subject, the commissioning body, tells it to do. Regulatory instruments are used to define norms, acceptable behavior, or to limit activities [15]. When the commissioning body regulates the actions of service providers, it typically cannot resort to legislation as a means of regulation. Depending on the national service structure, the commissioner can either regulate the provider using a contract between the two parties, or it can set the conditions the providers have to meet to qualify as service providers funded by the commissioner.

The economic means refer to the use of remuneration or deprivation of material resources. They can be understood either narrowly (as incentives and disincentives) or widely (the allocation of resources in general) [12]. In VBHC, the economic means are generally connected to incentive schemes for service

providers, where service providers can basically decide whether the incentives or disincentives are big enough to be taken into account.

However, the object of steering has other motives aside from deciding whether or not to comply. Hence, regulation and economic means are useful but insufficient policy instruments. Weaver [16] lists various 'compliance problems' that affect the ability and willingness to act in accordance with steering. They include, among others, (1) information problems where the objects of steering lack information that would make compliance more likely, (2) attitude and objective problems where the steering objects are hostile or distrustful toward the steering subject, policy goal, or the means used, and (3) monitoring problems where steering object compliance may be difficult or costly to monitor.

To solve the information problem the commissioner must collect and share information about the desired outcomes. As a policy instrument, information thus refers to intellectual and moral appeals, where the relationship between the steering subject and object is persuasive, involving only the communication of claims and reasons instead of material resources or obligatory directives [12]. In healthcare, information has a particularly important role, as experts make independent decisions based on their best knowledge, and the availability of outcomes data extends this knowledge.

As there is always a gap between the intention and the aspired intervention [11], the most coercive means do not necessarily lead to the best results, at least not alone [12]. Dialogue builds trust between the parties, and helps to bridge the gap between the intention and the aspired intervention and solve all the compliance problems presented above. It also serves as a platform for co-production and co-creation, where the commissioner can gain knowledge about the provision of services that would otherwise have remained out of reach [14].

When these policy instruments are applied in practice, they are always intertwined and used together. The position and significance of different instruments varies, and generally, the role of information grows as the steering structures become more complex and the problems that need to be solved are complicated [14, 17].

Value-based healthcare and steering

When it comes to steering a VBHC system, the big question is how to combine steering with value [18, 19]. In earlier literature, *value-based steering* and *value-based management* held somewhat different meanings [20, 21]: *value* was defined as any common goal, depending on the industry or context. In our paper, value-based steering means steering toward the specific value of healthcare systems defined by Porter.

The literature on VBHC and steering has focused mostly on economic means of steering. Cattell et al. [22] design a theoretically preferred way of paying for value, focusing on the base payment. Roberts et al. [23] find that value-based payment may skew the system toward exacerbating healthcare disparities. Burns and Pauly [24] find that the adoption of value-based payment models has failed to reach its potential in improving outcomes. Chernew et al. [25, 26] and Choudhry et al. [27] focus on steering the patient by

means of value-based insurance, whereby the patient's co-payment is smaller for treatments where the cost-effectiveness is expected to be high. They postulate that such a setting does steer the patient toward higher use of cost-effective therapies, yet evidence of health outcomes is still lacking. The ways in which means of steering other than economic means could be coupled with outcomes data have not been extensively studied.

The core of VBHC is collecting outcomes data and using it in a way that maximizes health benefits. Since the entire system is based on outcomes data, information has a twofold role in steering. First, it is the way for the commissioner to communicate its claims and reasons for the providers to achieve its overall goals. Second, it is the most significant source of information behind the steering [28].

According to Porter's VBHC, outcomes and costs should be measured over patient episodes, making value a concept relevant on a patient or patient segment level [3]. The commissioner/payer aims to maximize value for all patient segments, which means that its goals are defined through the goals relevant for each patient segment. The challenge for the commissioner is that in order to achieve its goals, it needs to operate through the providers who provide the services for the patients and are in direct contact with them. However, in healthcare, the organization of service provision is largely based on specialization (general practitioners vs. tertiary care) and mode of operation (e.g. emergency care vs. elective care), which means that many producers participate in patient episodes, and each provider serves multiple patient segments. The solution suggested by Porter et al. [1] is to organize production around patient segments. However, there are several reasons why this may not be feasible. In many countries, populations are simply too small to accommodate such specialized units, except for some specific elective procedures such as joint replacement surgeries. Furthermore, Enthoven et al. [29] argue that such a structure exacerbates the problem of silos, whereby patients with multiple morbidities or diffuse symptoms are left out. It is therefore necessary to fit together the goals of the patient segments and the fragmented service provision.

How this fitting is to be done depends greatly on the context. If patients have extensive freedom of choice and money follows the patients (market-driven model), the commissioner needs to steer the patients, whereas in a hierarchical model the commissioning body needs to steer the producers. In practice the situation is often a combination of these two extremes: The commissioner has some control over producers, but the patient may be able to choose between (a limited selection of) producers. In this paper, we focus on the means of the commissioner to steer service providers.

The key question for the commissioning body to solve is the dilemma between the customer segment objectives (outcomes) and multiple producers participating in the production of services leading toward the outcomes—the same producers serving multiple customer segments. How can one steer the service system or network toward the customer segment targets when all the steering mechanisms target individual producers? How can one align the objectives of the producers with the objectives of the customer segments? The solution is simple when one producer is responsible for all the services for the customer segment. This is the case with many elective problems or procedures and minor acute

problems. However, with more complex problems, and often with chronic problems, the needs of the patients require the participation of different professionals often residing in different organizations.

Methods

We introduce a value-based steering model, which illustrates how the commissioner can steer value through the different policy instruments: regulation, economic means, information, and dialogue. It should be noted that while this paper focuses solely on value-based steering, in reality the commissioner may have other goals apart from value, such as equity, access, and safety, and thus value-based steering is applied simultaneously with other objectives of steering.

In developing the model, we utilized the principles outlined in the literature above. We also studied case examples of outcomes-based steering, chosen primarily from Finland, and secondarily from other countries. The Finnish case examples are public-private partnerships or from the private sector. For the international cases, we referred to Papanicolas et al. [30] for a nation-level comparison of outcomes in relation to costs. We identified Japan, the UK, and Singapore as countries where outcomes (life expectancy) were good relative to costs. However, it was difficult to find steering mechanisms connected to the outcomes in a further evaluation of the systems of these countries. The case examples studied are presented in Table 1.

Table 1
The case examples examined in the study

Case example	Economic steering	Utilization of other means of steering
“Tesoma” primary healthcare, dental care, and social services outsourcing—Tampere, Finland	1,6% of compensation tied to outcome metrics	Outcome measurement is obligated in the outsourcing agreement. Information and dialogue are utilized by sharing and discussing the outcomes data regularly
Korpilahti and Tikkakoski (and Säynätsalo) primary health care outsourcing—Jyväskylä, Finland	1% (and 3,5%) of compensation tied to outcome metrics	Outcome measurement is obligated in the outsourcing agreement. Information and dialogue are utilized by sharing and discussing the outcomes data regularly
“Kotitori” elderly care outsourcing with integrator—Tampere, Finland	2% of compensation tied to outcome metrics	Outcome measurement is obligated in the outsourcing agreement. Information and dialogue are utilized by sharing and discussing the outcomes data regularly
Pohjola Hospital and Pohjola Insurance—Finland	-	Pohjola Insurance, as the owner of Pohjola Hospital, obligates the measuring of outcomes
Santeon hospitals—the Netherlands	5% of compensation tied to outcome metrics	Outcome measurement is obligated in the agreement. Information and dialogue are utilized by sharing and discussing the outcomes data regularly

Based on the literature and the case examples, we created an initial model for value-based steering. The model was further developed together with focus group workshops with two commissioning bodies (two Finnish regional healthcare authorities). This work was regularly validated by a steering group that consisted of public officers from different Finnish ministries (Ministry of Social Affairs and Health, Ministry of Finance, Ministry of Economic Affairs and Employment).

Results

The case examples in particular are very consistent in highlighting what works in terms of policy instruments: the economic means that are emphasized as the main policy instrument in the VBHC literature are utilized in each one, but their steering capacity is very limited—financial incentives only cover 1–5% of the remuneration. The case examples also do not rely on regulation. Instead, they are all based on continuously utilized information—the regular tracking and evaluating of outcomes and systematic dialogue about the data and the outcomes to ensure the continuity of the steering process, and, in the end, the cost-effectiveness of the services.

Based on the case analysis we identified three essential parts: (1) the principles of value-based steering; (2) the steering process; and (3) the Value Steering Canvas.

Figure 1 illustrates the principles of steering. Based on the cases, outcomes and cost data collected from customers and patients are the engine of the entire steering system, and all the policy instruments are connected to the data. The commissioner obliges the service providers to collect the data, which is then pooled. The commissioner utilizes the data to inform the service providers and professionals about the outcomes of the services, and to allocate resources. The commissioning body can create reimbursement models for service providers based on their outcomes or use it to reframe the budget, which can mean either rewarding for performance or supporting services where outcomes are below target. Dialogue builds trust and mutual understanding, modifies and strengthens steering, and fills the inevitable gaps in the data.

The principles of steering, in essence, answer the question of how outcomes data can be utilized in defining the vision and objectives and coupled with steering mechanisms.

Figure 2 illustrates the process of steering. It describes how the steering model is built and maintained. First, the commissioner defines concrete large-scale objectives. Then the population is segmented (based on their service needs) and objectives are defined for each segment and for each type of service provider.

Based on the case analysis, the main difficulties in creating a value-based service system is aligning the objectives of patient segments with the objectives of service providers. The system is based on customer segmentation, but the steering is directed at the service providers. A service provider may have various patient segments with varying objectives. As an example, a health center may be responsible for non-severe acute patients and chronic patients.

In addition, a single service provider may take care of only part of the care or service pathway. Thus, service pathways will require integration and coordination. In practice this means that the role of the service provider in the care pathway has to be taken into account when defining the outcomes objectives. In addition, the network of service providers is developed through interaction between the commissioner and the service providers, that is, using information and dialogue as policy instruments. Finally, the content and the process of steering, as well as the objectives, are evaluated and renewed based on the outcomes data.

The process of steering answers the question of how individual-level outcomes ($n = 1$) and service providers caring for many different patient segments can be coupled.

Figure 3 illustrates the third part of the steering model, the Value Steering Canvas (VSC), which can be used as a tool when designing and implementing a value-based steering model. We modelled the VSC loosely on the Business Model Canvas, originally introduced in 2005 by Osterwalder [31]. The VSC is a tool for the commissioner to design the details of the value-based steering of both the provider and the patients, and to help align the goals of the patient segments with the incentives of the providers.

The VSC combines the most relevant attributes of the service provider and the customers/patients. It takes into account the goals of the service provider as well as the needs of the patient segments. It includes 9 elements or boxes. The titles of the boxes as well as the descriptions of their intended content are described next. It should be noted that the detailed content of the boxes in Fig. 3 is only meant as an example and is not based on research.

At the top of the VSC, the provider is named. The left-hand side of the figure represents the service provider.

Services

describe the services produced by the service provider for the commissioner. Only services potentially aimed at the same patient segments should be listed here. If the provider is large, there may be many more services produced, but unless the patient segments overlap, these should be ignored (or rather, they are the building blocks of another VSC). When the commissioner and the object of steering are different organizations, there is usually a contract between them that regulates the service production. As a rule of thumb, there should be one VSC per contract. For example, the services listed here could be outsourced primary healthcare outpatient services. While the provider may also produce home care, unless this is part of the same contract or otherwise tightly coupled to the provision of primary healthcare services, this should be ignored.

Role & relationships

describes the role of this particular service provider within the network of service providers serving the same patients, and its relationships to these other providers. For example, other service providers in the care path of the same patients should be mentioned here. In our example of primary care, this box could include secondary care providers to whom this provider refers patients.

Goals

describes the ultimate goals of the service provider. These depend on whether the provider is for-profit or non-profit, and whether it is part of the same organization as the commissioner (internal) or not (external). These attributes affect the intrinsic incentives of the provider.

The right-hand side of the figure represents the patients.

Patient segments

describe the patient segments served. Again, only the relevant ones should be included. In our example, the provider serves only adult patients, which should be mentioned in this box. The patients should be segmented in a meaningful way, preferably (as outcomes are relevant here) based on their service needs in a way that is meaningful in terms of their expected outcomes.

Objectives

describe the relevant objectives for the patient segments. The objectives should be thought of in terms of outcomes—they should conceivably lead to better outcomes. For example, for the chronically ill, good control of the disease is usually a meaningful objective, as it is in many cases statistically linked to fewer adverse outcomes. For example, good HbA1C control in diabetes mellitus is linked with fewer vascular and renal complications. It should be noted that the objectives are usually different for each patient segment.

Needs

describe the high-level needs of the patient segments, that is, what they need in order to reach the objectives. Again, these are usually different for each segment. For example, for diabetes patients to reach good control, they need continuity of care, which could mean their own personal nurse (and/or physician) and a written care plan.

Relevant outcomes

are a synthesis of the opposing sides: they are the overlap between what the patients need and what the service provider does. The outcomes are at the heart of the steering model: they are what is measured, and they are what the incentives aim at.

Outcomes-based steering of the provider

includes the outcome metrics and the steering instruments through which the commissioner steers the service provider. This includes all the steering instruments, such as economic instruments (bonus/sanction model), information (measuring outcomes and sharing the information), dialogue (forums for discussing the outcomes), and regulation (contracts and other norms).

The economic instruments often revolve around a bonus/sanction model, where economic incentives are coupled with outcome measures. This is the case for Santeon hospitals, which receive 95–105% of their base tariff from the payer based on the outcomes reached.

Coercive policy instruments are often thought to be the strongest ones, but regulation has its limitations. Each contractual obligation needs a potential sanction for failure to comply, otherwise it is meaningless. Therefore, it is essentially a bonus/sanction model without the bonus [13]. Even so, things that can and should be regulated from the point of view of value-based steering include measuring the outcomes and sharing the data: only comprehensive data can fuel the steering engine, ensuring that the policy instruments relying on the outcomes data operate on reliable information.

Healthcare professionals, almost without exception, have high moral standards and an obligation to their patients, which is a strong motivator. Therefore, information steering in the form of sharing data is a particularly efficient policy instrument in the context of healthcare. A simple thing such as measuring disease control and reporting it per professional is usually enough to make the professionals benchmark against each other, striving to learn from their more successful counterparts. Any manager reporting such results to their employees should handle it with great discretion, so as to avoid ranking the professionals or blaming the ones with poorer outcomes. Case mix should be taken into consideration, and wherever possible, the set of measures should be all-encompassing so that everyone excels at something.

Outcomes-based steering of the patients

describes the means of steering patients, and the responsibilities (service provider or commissioner). Both commissioner and service provider play a role in steering patients toward better outcomes. Typical things to consider here are lifestyle choices, such as nutrition and exercise, which are paramount for achieving good outcomes, yet both the commissioner and the service provider have at best a limited possibility of influencing them.

We suggest that the VSC be used by the commissioner for creating a value-based steering model for a service provider. The VSC can be used as a blueprint for negotiations between commissioner and service

provider, thus creating a win-win situation.

Discussion

This article aims to construct a steering model that is suitable for VBHC. It answers the question: How can a commissioning body steer value-based health services in an environment where the commissioner is responsible for all health services of a certain population with various needs? Earlier studies focused more on reimbursement based on value [19] and paid less attention to other steering mechanisms. Steering such a complex system requires changes in all steering mechanisms and multiple levels of steering, from basic principles of steering to specific tools to steer a single service provider. In this article we described the main principles, the process, and a tool for value-based steering.

The key requirement for value-based steering is patient-level information of outcomes and costs—all value-based steering mechanisms are based on this information. In Finland as well as internationally, the missing piece is the outcomes data. PROMs in particular are still rarely collected. Governments could take an active role in setting goals for PROM collection. Another challenging issue is the co-creation of value: Patients also contribute to value creation outside the healthcare system. The requirement for extensive knowledge linking health outcomes to the full cycle of treatment and its costs significantly challenges the adoption of the value-based steering system [19].

Patients should be segmented based on their needs. The original value-based approach [1] needs to be widened from specific health problems to also taking into account prevention and multimorbidity when building a steering system for the whole population. On a system level, the data must enable a comparison of outcomes and costs between different patient segments, in addition to measuring relevant outcomes for each patient segment. Value-based steering objectives should be aligned with public health objectives.

The commissioning body can start using value-based steering without changes in legislation or in the present service system. The model could first be implemented in one or a few customer segments, and then gradually—as the data and the knowhow accrue—it could be applied to a larger population. Similarly, the steering mechanisms can be developed incrementally, starting with information and dialogue, and only later developing rules and incentives based on the experiences of utilizing value-based information.

The study is based on Finland, where the system is tax-funded. However, the steering model can be used in any setting where there is a commissioning body and service providers.

We constructed a conceptual model for value-based steering of a commissioner. Further studies are required to test the model.

Conclusions

In this article we described the main principles, the process, and a tool for value-based steering. Previous studies have largely focused on economic means of steering while neglecting other means of steering. Ours is the first study to present a value-based steering model for healthcare, including all means of steering.

Abbreviations

PROM = Patient-reported outcome measure

ICHOM = International Consortium for Health Outcomes Management

VBHC = Value-based healthcare

Declarations

Ethics approval and consent to participate

Not applicable

Consent for publication

Not applicable

Availability of data and materials

Data sharing is not applicable to this article as no datasets were generated or analysed during the current study.

Competing interests

The authors declare that they have no competing interests

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Authors' contributions

LP managed the project and was responsible for putting together the manuscript. All authors took part in the workshops where the model was developed. All authors contributed to writing the manuscript. All

authors read and approved the final manuscript.

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Figures

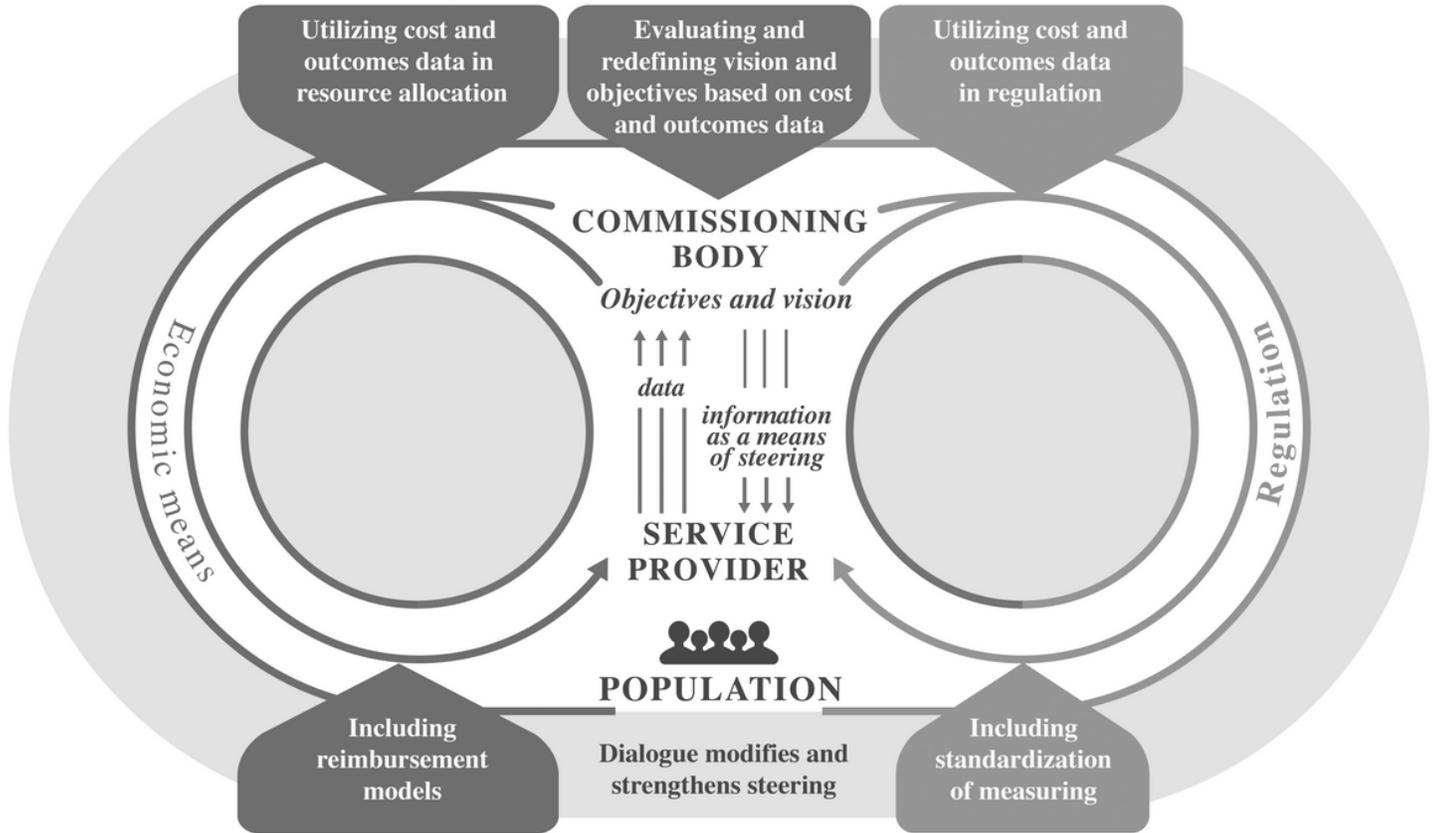


Figure 1

The principles of steering

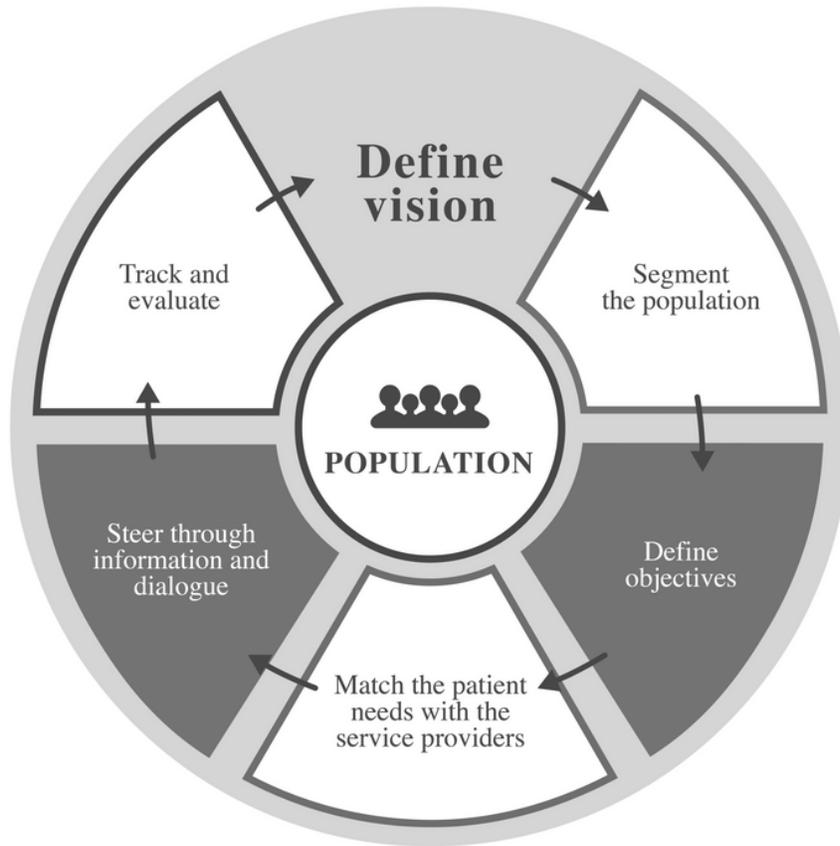


Figure 2

The process of steering

Service provider The Piggy & the Fly Healthcare Inc.				
Services Primary care services (doctors and nurses)	Role & relationships <ul style="list-style-type: none"> Refers patients to secondary care (public) Refers patients to physical therapy (private) 	Relevant Outcomes <ol style="list-style-type: none"> Disease control, quality of life Short throughput time (from first contact to healthy) 	Needs <ol style="list-style-type: none"> Continuity of care (personal nurse + care plan) Quick access to service at a convenient time 	Patient segments adult patients: <ol style="list-style-type: none"> continuous service needs (chronic) occasional service needs (healthy)
	Goals <ul style="list-style-type: none"> For-profit Paid per capita 		Objectives <ol style="list-style-type: none"> Disease control Quick service and return to health 	
Outcomes-based steering of provider <u>Economic:</u> +5 % of total reimbursement based on: <ol style="list-style-type: none"> Percentage of patients in disease control (based on lab results; HbA1c, LDL etc.) Patient satisfaction with access to care (SMS questionnaire) <u>Regulation:</u> The aforementioned metrics must be collected monthly <u>Information:</u> The aforementioned metrics must be published online monthly <u>Dialogue:</u> Semiannual meetings to discuss results			Outcomes-based steering of patients <u>Information & dialogue:</u> Discuss results at every contact (personal results relative to peer group results)	

Figure 3

The Value Steering Canvas