

Value-based healthcare just entered ISPOR's top 3. But whose value are we measuring?

When ISPOR published its 2026–2027 Top 10 HEOR Trends report, value-based healthcare (VBHC) entered the list for the first time, debuting at #3, behind AI and real-world evidence. ISPOR describes VBHC as a healthcare delivery model in which providers are paid based on patient health outcomes, and positions HEOR as essential to putting that model into practice. <https://www.ispor.org/heor-resources/about-heor/top-10-heor-trends>

The ranking itself is global. It comes from a survey of ISPOR members around the world, across industry, academia and other stakeholders, not a regional vote. But having spent several years working on market access in Spain, what strikes me is how differently "value-based" is actually being built out, not just between continents, but between neighbouring European countries.

In Europe, the starting point is a definition. Back in 2019, the European Commission's Expert Panel on Effective Ways of Investing in Health proposed that value in healthcare should be understood through four pillars: personal value (care that fits the patient's own goals), technical value (the best outcomes achievable with the resources available), allocative value (how fairly resources are distributed across patient groups), and societal value (what healthcare contributes to a connected, participating society). <https://www.alzheimer-europe.org/news/european-commission-expert-panel-publishes-document-defining-value-based-health-care>

That four-pillar framework is now showing up in how individual countries contract for medicines and devices. Across Europe, outcomes-based agreements and managed entry agreements tie part of the payment to whether a treatment actually delivers the outcome it promised, rather than paying for it upfront in full. Spain and Denmark are a useful contrast here. Spain has built broad, systematised outcomes tracking through its VALTERMED registry, while Denmark integrates outcomes-based elements into its own alternative agreements, prioritising what is practically feasible within its system. <https://www.ispor.org/heor-resources/presentations-database/presentation-cti/ispor-europe-2026/poster-session-2-5/comparing-the-implementation-of-outcomes-based-agreements-in-spain-and-denmark-implications-for-managing-uncertainty-in-european-markets>

I recognise that contrast from the inside. For several years, roughly 60% of my time at Coloplast was spent on Spain, working on a strategy to reopen a reimbursement system that had been closed to new MedTech categories since 2007. That work led to real traction: the problem began being taken seriously at both regional and national level, after more than a decade of being closed to the conversation at all. Spain's system does not move on clinical evidence alone; it moves on being able to show, over time, that an outcome is real and sustained. That was also where I saw Spain's genuine interest in a more holistic way of assessing the patient. We pushed to have Social Return on Investment (SROI) thinking included as part of submissions, capturing what a condition cost the patient beyond the one healthcare box it sat in: their mental health, relationships, isolation and economic situation. It was a big process, and a real fight to get a broader patient perspective treated as a standard part of the evidence, not an optional extra. Denmark asks a related but distinct question:

not only whether an outcome holds up, but whether the agreement around it is one the system can actually run. Same ambition, two different architectures, two different evidence burdens.

The US is telling a different, more structural version of the same story. Rather than agreements layered on top of a single system, CMS is rebuilding the payment models themselves. The Transforming Episode Accountability Model (TEAM), a mandatory five-year bundled payment programme, began on 1 January 2026, tying a single payment to an entire episode of surgical care instead of paying each provider separately. The Cell and Gene Therapy (CGT) Model lets state Medicaid programmes pay for high-cost therapies through outcomes-based agreements. And the new Long-term Enhanced ACO Design (LEAD) model extends accountable care arrangements over a longer time horizon, so providers are incentivised to invest in sustained outcomes rather than short-term participation. <https://www.cms.gov/newsroom/fact-sheets/2026-medicare-accountable-care-organization-initiatives-participation-highlights> · <https://www.nortonrosefulbright.com/en/knowledge/publications/cedea1fd/cmmi-resets-value-based-care-landscape>

ISPOR itself seems to recognise this gap between ambition and method. In July 2026, an ISPOR Special Task Force published the "IMPACT" framework, a set of six key considerations for bringing HEOR's methodological rigour, incentive design, outcomes evaluation and costing from the perspectives of providers, payers and patients, into how VBHC initiatives are actually designed and evaluated. The task force found that two-thirds of published VBHC studies used some health economics methods, usually simple cost analysis, while full economic evaluation remained rare. In other words, the ambition has been outrunning the method. <https://www.ispor.org/heor-resources/news-top/news/view/2026/07/13/new-isor-report-introduces--impact--framework-to-guide-value-based-healthcare-implementation>

Seen side by side, Europe is largely negotiating value into existing systems, one agreement, one product, one national HTA body at a time. The US is trying to engineer value into the payment system itself, one mandatory model at a time. Both are real, both are accelerating, and both now sit inside the same ISPOR trend.

For HEOR, that is the uncomfortable part of VBHC's rise. "Value-based" is not one evidence requirement we can standardise and reuse. In Europe, it increasingly means being able to track and report the real-world outcome an agreement was built around, as I learned first-hand with Spain. In the US, it increasingly means generating evidence that holds up inside a specific payment model, a bundle, an ACO benchmark, a state Medicaid contract, each with its own definition of what counts as success.

Which brings me back to the thread running through this whole series. AI can help us produce more evidence. JCA can help us share more of it across borders. But value-based healthcare is a reminder that evidence still has to answer to a specific payment system before it can be called valuable at all. The question is not whether we can measure value. It is which value, for whom, and inside which system we are being asked to measure it.

#HEOR #MarketAccess #ValueBasedHealthcare #HTA #HealthEconomics #AI #US #Europe