

#3
ISPOR

VALUE IS NOT ONE NUMBER

Outcomes per cost • Patient goals
Equity across populations • Social participation

BEFORE WE MEASURE VALUE
WE NEED TO DEFINE IT



A field guide to how health systems turn value into evidence and incentives.

INSIDE THIS FIELD GUIDE

- ISPOR
- EU • JCA
- CMS
- Medicinrådet
- Spain
- Denmark



THE SIGNAL

Value-based healthcare just entered ISPOR's top 3

01 Artificial Intelligence



02 Real-World Evidence



03 Value-Based Healthcare



WHAT ELSE MOVED IN THE SAME REPORT

#2

Real-World Evidence

continuous evidence, not one-off trials

#9

Value Measurement

pressure to define 'whole health'

New

Equity & Access

first appearance as a named trend

THE EVIDENCE

ISPOR's 2026–2027 Top 10 is built from a global survey of HEOR professionals across industry, academia and payers. VBHC was absent from the prior Top 10 entirely.

Source: ISPOR 2026–2027 Top 10 HEOR Trends

MY TAKE

I don't read this as a fad. I read it as the market finally admitting that a QALY alone was never going to carry the whole argument for access.



THE DEFINITION PROBLEM

Four lenses, one word



PERSONAL

Does care achieve what matters to the individual patient?

e.g. shared decision-making, goal-concordant care



TECHNICAL

Are the best possible outcomes achieved with available resources?

e.g. QALYs, clinical effectiveness



ALLOCATIVE

Are resources distributed fairly across populations and conditions?

e.g. severity weighting, disease burden



SOCIETAL

Does healthcare enable participation, wellbeing and social connectedness?

e.g. productivity, caregiver burden, equity

THE MEASUREMENT FRAMEWORK ALREADY CONTAINS A CHOICE ABOUT WHAT COUNTS

there is no neutral way to pick an outcome measure

THE EVIDENCE

Porter (NEJM, 2010) first framed value as outcomes achieved per dollar spent. The European Commission's Expert Panel (EXPH) extended this to four dimensions in 2019, rejecting any single-number definition.

Source: Porter, NEJM 2010 · European Commission EXPH, 2019

MY TAKE

In practice I've seen submissions win or lose on which of these four lenses the committee quietly favoured, long before anyone names it out loud.



THE EU MECHANISM

Europe is already harmonising the clinical half



Joint Clinical Assessment (JCA)

Jan 2025

oncology & ATMPs start

2026

high-risk devices join

2028

orphan drugs mandatory

2030

all other medicines

27

member states in scope

100

days: scope to dossier

WHAT CHANGES FOR A SUBMISSION

- Broader PICOs: more comparators and subpopulations than most national HTAs ask for, in one dossier
- The clinical assessment becomes shared — but pricing, reimbursement and implementation stay fully national
- A Member State HTA body (e.g. Denmark's Medicinrådet) can act as co-assessor on another country's product

THE EVIDENCE

As of 2026, 8 oncology/ATMP products are under JCA evaluation, with the first JCA report expected this year. Medical devices and orphan drugs follow in 2026 and 2028.

Source: EU HTA Coordination Group, 2026 Work Programme · Regulation (EU) 2021/2282

MY TAKE

JCA removes duplication on the clinical question. It does nothing for the economic or societal one — which is exactly where SROI-style, country-specific evidence has to pick up the thread.



REAL SYSTEMS

Same ambition, different infrastructure



Different infrastructures create different evidence questions

THE EVIDENCE Spain's model centres on registry-based real-world tracking at national scale. Denmark's model centres on regional pilots testing outcome measurement before scaling. Sources: Spanish Ministry of Health, 2nd VALTERMED Results Report, 2021 · Danish Regions / EuroHealth Observatory, 2015–2017 pilot	MY TAKE <i>Having worked inside the Spanish system, I'd say VALTERMED's strength is scale; the Danish pilots' strength is that five regions can disagree and learn from it before anyone commits nationally.</i>
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THE DANISH MODEL

A council without a published number, backed by a country full of data

MEDICINRÅDET

**No official
cost-per-QALY threshold**

Estimated implicit range: 458,000–970,000 DKK (≈€61,500–€130,000) per QALY

DANISH HEALTH DATA AUTHORITY

60 + 80

national health registries, plus 80 clinical quality registries (RKKP) — 350+ registries in total

WHAT THIS MEANS IN PRACTICE

2017

Medicinrådet founded, replacing two earlier councils (RADS, KRIS)

2021

QALY measure formally adopted for all new assessments

321 days

average time from EMA approval to first commercial use, post-QALY (2021)

~24 hrs

typical lag before EHR data reaches national registries

THE EVIDENCE

Denmark adopted QALYs in 2021 but has never published an explicit threshold; independent back-calculation puts it at roughly 458,000–970,000 DKK/QALY. Meanwhile its registry infrastructure is among the most complete in the world.

Sources: ISPOR Europe 2023 poster · Danish Health Data Authority · RKKP

MY TAKE

A country that won't name its threshold but will show you forty years of linked patient data is telling you where the real conversation happens: in the evidence, not the formula.



A PROFESSIONAL OBSERVATION

When clinical outcomes are not the whole story



Evidence can lose decision relevance when it describes the disease, but not the patient's life.



MENTAL HEALTH
Psychological burden can shape outcomes and adherence.
OECD PaRIS tracks mental wellbeing alongside physical outcomes across 19 countries



RELATIONSHIPS
Isolation changes what recovery itself means.
caregiver strain rarely appears as a line item in a submission



ECONOMIC REALITY
Work and household circumstances shape whether treatment succeeds.
return-to-work is measured in under half of HTA dossiers reviewed

THE EVIDENCE

OECD's PaRIS survey (2024) is the first to systematically compare patient-reported outcomes and experience across primary care systems in 19 countries, covering physical, mental and social dimensions.

Context: OECD PaRIS, 2024 · professional observation from market access work in Spain

MY TAKE

The challenge was never only 'can we measure it.' It was 'will the decision-maker consider it relevant' — and that's a cultural question as much as a methodological one.



THE US MECHANISM

When value becomes a payment design



SURGICAL CATEGORIES: LEJR • HIP/FEMUR FRACTURE • SPINAL FUSION • CABG • MAJOR BOWEL

the same outcome data now determines reimbursement, not only evidence

THE EVIDENCE

TEAM is a 5-year mandatory model (2026–2030) covering ~740 hospitals, assessed on a Composite Quality Score across readmissions, safety and patient-reported outcomes for each 30-day episode.

Source: CMS, Transforming Episode Accountability Model (TEAM), final rule

MY TAKE

This is the clearest example I've seen of a health system turning HEOR's own output — outcome data — directly into the payment mechanism, not just a reference for it.



THE STRATEGIC DISTINCTION

We do not just measure value, we define the decision

01 **WHAT** counts as an outcome
a QALY? a return to work? a caregiver's sleep?

02 **WHO** decides whose outcomes matter
the patient, the payer, or the population average?

03 **WHEN** is success measured
at 30 days, at one year, or across a lifetime?

04 **WHERE** must the outcome hold
in a trial population, or in everyday practice?



PATIENT



PROVIDER



PAYER



POPULATION

THE EVIDENCE

Porter's 2010 framework and the EU HTA Regulation both assume a single clinical answer can serve multiple decisions. In practice, JCA, national HTA and payment models each ask a materially different version of the same question.

Evidence base: Porter, 2010 · Regulation (EU) 2021/2282 · CMS TEAM

MY TAKE

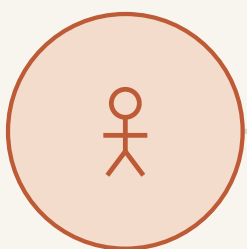
Most friction I've seen in a submission isn't bad data. It's a perfectly good answer to a question the decision-maker in the room wasn't actually asking.



THE CENTRAL HEOR SHIFT

Evidence must travel

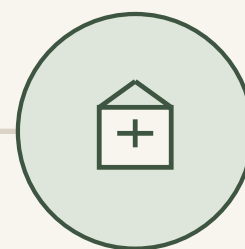
A model is not decision-ready until it can move through the system, across borders and over time.



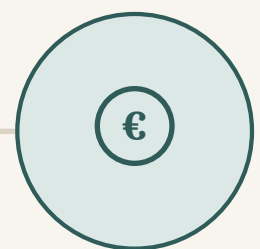
01
Define
OUTCOMES



02
Align
DECISION



03
Track
PRACTICE



04
Adapt
MARKETS

THE EVIDENCE BEHIND THE SHIFT

109

EMPIRICAL STUDIES REVIEWED

24

INTERNATIONAL EXPERTS INTERVIEWED

~66%

USED HEOR METHODS, MOSTLY COST ANALYSIS

THE EVIDENCE

ISPOR's Special Task Force on HEOR in VBHC implementation (2026) found comprehensive economic evaluations were rare, despite most studies using at least basic cost analysis. Its IMPACT framework is meant to close that gap.

Source: ISPOR Special Task Force on HEOR Methods in VBHC Implementation, 2026

MY TAKE

More evidence is not the goal. Evidence that survives contact with a different country, a different payer, or a different year is the actual, much harder target.



THE SYNTHESIS

The hard part is not measuring value
It is deciding which value the decision needs

VALUE FOR WHOM Patient · provider · payer · population	MEASURED HOW Clinical · economic · patient-reported · societal
OVER WHAT TIMEFRAME Episode · year · lifetime	USED BY WHOM HTA · payer · hospital · clinician
LINKED TO WHICH DECISION Access · payment · pathway · implementation	 The metric is never neutral
THE EVIDENCE Across ISPOR, the EU HTA Regulation, CMS and Medicinrådet, every mechanism in this carousel answers a different combination of these five questions — none answers all five at once. Synthesis based on sources cited throughout this carousel	MY TAKE <i>Evidence becomes valuable only when it can change a decision. If the decision cannot use it, the evidence has not finished its journey.</i>

CONCLUSION • ABOUT THE AUTHOR

The question is not whether we can measure value

It is which value the decision needs.

A metric can quantify an outcome. It cannot decide whose outcome matters, which trade-off is acceptable, or whether the evidence can travel into implementation. That judgement is the strategic work — and it is where HEOR earns its place at the table, not after the analysis, but before it.

THE FINAL TEST

Does the evidence help the system make a better decision?

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