PROCURE4HEALTH

VALUE-BASED PROCUREMENT IN HEALTHCARE: TURNING THEORY INTO ACTION

Online webinar: 23rd April 2024

Questions & Answers

Nº	Question	Reply
1	Why wouldn't you involve patients every time? After all they are the people who know what outcomes are of value to them.	Patients or patient representatives can be involved in several ways. They can contribute to the design of the agreement and the subsequent governance of it. They can help identify the outcomes to be used within the OBA. However, the current lack of universal capture of PROMs means that it is not always possible to include these in the measures that drive the OBA, although the use of a PROM by the health provider could form part of the agreement.
2	Will you be providing a copy of the PPT after? Sorry if I missed this being answered.	Yes, sure. You will receive a follow-up email after the webinar with the recording and presentations. They will be also available in the Procure4Health website: https://procure4health.eu/repository/
3	Would you consider some technology groups/categories not fitting to VBP at all? Many Thanks!	In principle all services/products or medicines should create value and so could be subject to an OBA. However, it is necessary for the outcomes to be measurable within a meaningful timeframe and for the resources to do so to be proportionate to the value of the contract.
4	Given the complexity of OBA through tenders, do we see more traction for VBP approaches with large regional health systems or procurement platforms than individual hospitals or hospital networks?	I do see a larger traction of the application of VBP by larger hospital networks and regional healthcare systems. However, they tend to apply the VBP approach in a pilot hospital, and when successful, expand to other healthcare facilities, e.g. NHS Supply Chain, UniHA and the Danish regions. A reason may be the staff capacity.
5	Hello, the sound quality of Karsten is not great. Difficult to hear sometimes.	Apologies for that… Anyhow, you will have the opportunity to catch a webinar replay afterwards.
6	UNIHA - As LOS and SSI are multifactorial how could you ensure that the results were due solely to the intervention?	We did measure the hypothermia rate and use a health economic model validated by NICE to estimate on SSI, cardiac event, and LOS. Link between hypothermia rate and SSI has been

		demonstrated through multiple RCTs. This type of project is always endorsed by the medical community, especially learned societies, which validate what we call "the scientific norm" procurement relies on for measuring performance.
7	How do you segment the therapy areas to prioritise for this VBP approach?	It is important to focus on areas with problems of greatest need and where there is good clinical engagement for a Value-Based approach. Starting small to build trust and then being more ambitious. Also consider things that could be scaled across other hospitals /regions if successful.
8	What role do ethical and sustainable aspects play in the value assessment in the procurement process and how can they be effectively considered?	There is increasing interest in environmental sustainability in procurement: we would consider this part of societal value. In the UK there is now a 10% component for supplier sustainability/ GHG reductions in all public sector tenders. It is also important to work with suppliers to be clear which patients should have the intervention/device/medicine and which should not. The best way to be sustainable is not to use products on patients who will not benefit. Low value = wasted carbon too. Sustainability is already part of the VBP Framework (3rd layer of the model).
9	Do you have examples of innovation projects that impact mostly the healthcare professionals in institutions (ex: to recover time for the nurses and the doctors)? How easy or difficult to adapt your framework when the outcome is indirect for the patient but more direct on the institution's organisation? Do you recommend involving PREMs/PROMs when having indirect benefits for the patient or is it already enough to demonstrate tremendous value for the institution (ex: time for professionals, cybersecurity, "positive" digitisation, better communication, improved work-life balance, etc.)?	Any framework can be adapted for clinical reported experience measures or improved efficiency / system benefits as long as those outcomes can be defined and measured reliably. For example, a better surgical instrument may make the surgery easier, thus saving surgical time, reduced surgical fatigue and with fewer complications. Those benefits may indirectly benefit the patient be hard to directly attribute to the instrument. However, it is important not to lose sight of the fundamental principle of VBHC, which is better outcomes (that matter to the patient) at the same or lower cost.
10	In the context of an OBA, do you think it make sense to take into account the creation of measurable value for the safety and productivity of healthcare professionals, over and above the results for patients?	There is no reason why increased technical value (improved efficiency) cannot be included in an OBA if it can be measured and of course this will have value for patients too (through shorter operations, shorter waiting lists, shorter length of stay etc.). Part of the 2nd layer in the VBP Framework model.

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11	Question about the example that Karsten explained: We (7 hospitals) have just started delving into VBP and patient outcomes/indicators through dashboards for knee and hip implants. We now include several suppliers because they score differently on different aspects. Do you choose 1 supplier or several? If 1, how do you weigh the different indicators against each other?	I would choose 1 supplier per hospital. You are welcome to send me further questions on kk@rsyd.dk
12	What if improvements in PROMS are not necessarily to be expected, e.g. in the case of people with (complex multiple) chronic conditions: I guess in that case it is rather difficult to clearly relate a better value to a specific (part of) a solution/service offered by a supplier? Any concrete/ practical ideas for how to design procurement agreements for these cases?	The early focus on VBHC was on "episodic care" where a PROM might be measured before and at a defined time after a surgical procedure (for example). Most healthcare costs are in long term care for chronic conditions and so opportunities to increase value for these patients are important. There will always be potential confounding variables. Has the persons QoL improved because of their diabetes care or their mental health management? It is important to clearly map interventions and treatments on a timeline with PROM capture which can help to identify attribution and to select outcome measures that are relatively specific to the condition. Capturing good baseline data and aggregating change in outcomes in a cohort rather than individual can help reduce the impact of other factors. Ultimately this is the reality of outcomes in the real world and the risk of confounding factors that cannot be managed in the OBA need to be shared.

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