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Transforming for value-based health care: Lessons from NHS Wales

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Executive summary

The sustainability of healthcare systems around the world are under threat - with the way we design and deliver care in need of reform.

The international movement of value-based health care (VBHC) presents a structured, whole of system approach to bring all parts of the system together to drive transformational reform that addresses the complex interplay of the issues undermining sustainability.

Both internationally and here in Australia, there are numerous definitions, theories, and approaches to achieving value in health care. However, all agree that VBHC is about achieving the best possible outcomes for people with the lowest use of resources, through providing a framework for evidence-based, person-centred decision making.

Recognising the great value of sharing and learning in driving the cultural change necessary to support VBHC implementation, the Australian Healthcare and Hospitals Association's (AHHA), Australian Centre for Value Based Health Care, held the VBHC Congress 2023. This was followed by a two-week roadshow exploring VBHC implementation in remote, rural and metropolitan locations across Australia.

International leader and early adopter of a whole of system VBHC approach, Dr Sally Lewis, National Clinical Director for Value Based Healthcare at the Welsh Value in Health Centre, NHS Wales, was invited to join both the Congress and roadshow to reflect on the experience of VBHC implementation across Wales.

More advanced in its implementation, the Welsh model of VBHC presents an iterative data-driven, evidence-based, outcomes focused approach to VBHC, built on the principles of equity, sustainability, and partnerships. This model resonated strongly with Australian audiences, highlighting an opportunity to harness leanings from Wales, to support VBHC operationalisation within the Australian policy context.

This Perspective Brief reflects on the conversations held throughout the Congress and roadshow, comparing the Welsh and Australian experience of exploring and implementing VBHC. Through considering the Welsh experience of VBHC within the policy context of Australia, a number of learnings emerged for Australia in the Welsh priority areas of:

- digital health,
- person-centred care,
- research impact and evaluation; and
- strategic partnerships.

Background

In late October 2023, Dr Sally Lewis, National Clinical Director for Value Based Healthcare at the Welsh Value in Health Centre, National Health Service (NHS) Wales, joined the Australian Healthcare and Hospitals Association's (AHHA) Australian Centre for Value-Based Health Care (VBHC) for the VBHC Congress 2023, as special guest and keynote speaker.

As an international leader and early adopter of a whole of system VBHC approach, Dr Lewis was invited to address the over 200 health system leaders gathered in Brisbane to reflect on the experience of VBHC implementation in Wales, a universal health system facing similar pressures as Australia, and to highlight learnings applicable to the Australian context.

Following the Congress, Dr Lewis joined AHHA CEO, Kylie Woolcock and Manager of the Australian Centre for VBHC, Emma Hoban, on a two-week roadshow across eastern Australia exploring VBHC implementation in remote, rural and metropolitan locations (Figure 1).

Throughout the roadshow, discussions centred on the sustainability challenges impacting health systems and the opportunities presented by VBHC as a framework to address the complex wicked problems undermining improvements in outcomes.

Further along in its journey towards VBHC, the Welsh model of VBHC implementation resonated with the various stakeholders across Australia. It presents a data-driven approach to shifting the culture of health care to focus on improving the outcomes that matter to people and communities at the levels of the individual (micro), the pathway (meso) and the population (macro) (Lewis, 2022).

The Congress and roadshow highlighted the growing interest and momentum in Australia that is propelling the VBHC agenda forward, though there is still much work to do.

This Perspective Brief reflects on the conversations held throughout the Congress and roadshow. It begins by outlining the problem, considers how we have tried to solve the problem and the journey to VBHC in both Australia and Wales, before identifying some of the critical components of the Welsh model of VBHC implementation and reflecting on what we can learn from the Welsh experience to embed a nationally-connected approach to VBHC within the context of Australia.

Figure 1: VBHC Roadshow locations

Transforming for value-based health care

The problem

The sustainability of healthcare systems around the world is under threat, with the way we deliver care facing similar pressures worldwide. Costs are rising at an unsustainable rate, we have increasingly depleted, demoralised and burnt out workforces, and in the developed world we are operating within outdated systems that were designed for a very different set of needs (episodic acute illness) than the ones our populations are currently experiencing (complex chronic conditions and multi-morbidity) (Lewis, 2022; Department of Health and Aged Care, 2019; Hurst et al., 2019).

Threats to the sustainability of health systems

- Escalating healthcare costs.
- Expensive technologies.
- Outdated information and digital systems.
- Changing community expectations of what the healthcare system is capable of / responsible for.
- Ageing populations and increasing comorbidities.
- Climate change.
- Workforce shortages, skill-mix imbalances, maldistribution and change management capacity.
- Focus on volume rather than value.

Globally, a persistent focus on the volume of healthcare activity, rather than the wellness outcomes being achieved, challenges investment decisions at all levels of the system, driving overdiagnosis, low value care and fragmentation of service provision (McCreanor, 2017; Bedlington et al., 2021; Cutler, 2022).

These challenges are felt most acutely by people who are already experiencing marginalisation, disadvantage and negative social determinants of health (Baker, Adams & Steel, 2021).

Significant inequities persist, both in terms of access to care and clinical outcomes (Lewis, 2022; Department of Treasury, 2023), with the impacts of climate change set to multiply these inequities and place an increasing burden on healthcare systems globally (IPCC, 2022).

The carbon footprint of health care is significant (4% of global CO2 emissions, equivalent to the fifth largest emitter if it were a country) (Karliner et al., 2019), contributing to the growing climate crisis and undermining the fundamental principle of medicine and health systems to 'do no harm' (Department of Health and Aged Care, 2023a).

New technologies and artificial intelligence have the capacity to improve outcomes and efficiencies, but also risk increasing low value care and further entrenching existing inequalities and systemic biases (O'Reilly-Jacob et al, 2021).

Fundamentally, it is increasingly becoming apparent that the outcomes that matter to people, communities and health systems are not improving at a rate that matches investment (Lewis, 2022; Bedlington et al., 2021).

The solution

Various movements have emerged around the world to try and tackle the challenges of health system sustainability (Lewis, 2022; Hurst et al., 2019). Examples include prudent health care in Wales (Bevan Commission, 2015; Welsh Government, 2019a), realistic medicine in Scotland (Realistic Medicine, 2023; Scottish Government, 2022), slow medicine in Italy (Bonaldi & Vernero, 2015), or the international initiative Choosing Wisely (The Commonwealth Fund, 2019).

Yet, these movements often solely target health professionals, or are focused on a specific element of the problem such as reducing unwarranted variation or embedding shared decision making between professionals and people receiving care (Lewis, 2022).

While these initiatives have raised awareness of important issues in some circles, they have not proved sufficient to address the complex interplay of factors undermining health system sustainability around the world.

An all-encompassing, whole of system shift is needed to truly tackle the wicked sustainability issues (financial, environmental, workforce) impacting health systems globally which is bigger than any one profession, clinical movement, state or nation can manage in isolation (Lewis, 2022).

The transformational change needed to deliver a sustainable health system requires structured consideration of the system as a whole – challenging the processes by which we manage, deliver and fund care.

Service providers, system stewards, consumers and stakeholders need to act collectively to transparently prioritise the investment of resources, directing them to where the greatest impact will be achieved, and shifting the system to drive better outcomes, not just more activity occurring in silos (AHHA, 2021).

VBHC presents a structured approach to bring all the various movements and stakeholders across the system together to drive transformational reform. Through reorienting all players, at all levels of the system, to focus on the collective goal of improving the outcomes that matter to people and communities, VBHC presents a whole of system approach to addressing the complex interplay of issues undermining sustainability.

International movements targeting health system sustainability challenges.

Prudent Healthcare, Wales (Bevan Commission, 2015; Welsh Government, 2019a) – is defined as 'healthcare which is conceived, managed and delivered in a cautious and wise way, characterised by forethought, vigilance and careful budgeting which achieves tangible benefits and quality outcomes for patients'. The principles of prudent healthcare are:

- Achieve health and wellbeing with the public, patients and professionals as equal partners through co-production.
- Care for those with the greatest health need first, making the most effective use of all skills and resources.
- Do only what is needed, no more, no less; and do no harm.
- Reduce inappropriate variation using evidence-based practices consistently and transparently.

Realistic Medicine, Scotland (Realistic Medicine, 2023; Scottish Government, 2022) – provides the health care that people truly value. It is about putting people at the centre of their care and listening to what matters to them to ensure the right care is provided at the right time. It allows the delivery of care and treatment that people value as well as reducing inappropriate care. Realistic medicine is achieved through practicing the six pillars:

- Shared decision making.
- Personalised approach to care.
- Reduce harm and waste.
- Reduce unwarranted variation.
- Managing risk better.
- Become improvers and innovators.

Slow Medicine, Italy (Bonaldi & Vernero, 2015) – is inspired by the slow food movement and is focused on promoting processes of care based on appropriateness in the context of listening, dialogue and decision sharing with patients. It promotes balance and prioritises time with patients to counter the emphasis on speed and throughput in health care that can reduce quality. Three key principles underpin the slow medicine movement:

- Measured: to act with moderation, gradually and without waste.
- Respectful: a commitment to preserving the dignity and values of each person.
- Equitable: ensuring access to appropriate care for all.

Choosing Wisley, international (The Commonwealth Fund, 2019; Choosing Wisley Australia, n.d) – an international movement, originating in the US in 2012 and now in over 20 countries, to advance a national dialogue about how to avoid unnecessary medical tests, treatments and procedures. Choosing Wisely in Australia is governed by six core principles:

- Health profession-led.
- Clear emphasis on improving quality of care and on harm prevention.
- Multidisciplinary.
- Consumer-focused communication between health professionals and consumers.
- Evidence-based.

Value-Based Health Care (VBHC)

What is VBHC?

VBHC originated in the United States of America (USA) where its creators Professors Michael Porter and Elizabeth Teisberg (Porter & Teisberg, 2006) conceptualised value in health care as 'the measured improvement in a patient's health outcomes for the cost of achieving that improvement' reflected in terms of the value equation (figure 2) (Teisberg, Wallace & O'Hara, 2020; Porter & Teisberg, 2006).

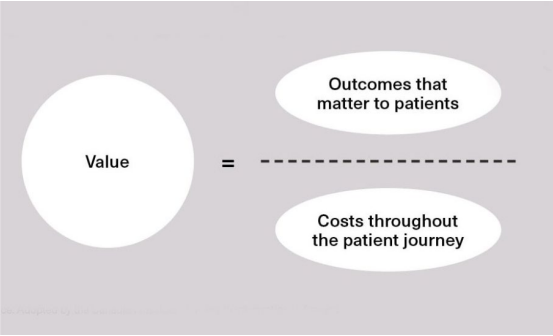

Figure 2: The value equation (Porter and Teisberg, 2006).

However, as the movement has grown and is increasingly being adopted in systems founded on the principles of universal health coverage, such as public value and equity, the need to consider community and population health and social, environmental, and cultural outcomes in the conceptualisation of VBHC has arisen (Verhoeven et al., 2020; Hoban, Woolcock & Haddock, 2021).

In the context of finite resources, it is not possible for everyone to get exactly what they want, when they want it. Value judgements must be made about where to prioritise resources to ensure equity, protect system sustainability and improve outcomes (Bedlington., 2021).

As such, understandings and definitions of VBHC in some contexts have evolved to reflect the idea of 'resource use' rather than 'costs' (Hurst et al., 2019), with implementation approaches focused on creating an enabling environment that supports decision making about the deployment of resources at the macro (population health), meso (pathways of care) and micro (person-centred care) levels of the system (Bedlington et al., 2021; Lewis, 2022).

As various jurisdictions around the world have pursued value in health, it has also increasingly become apparent that to successfully implement VBHC, our understanding and definitions of VBHC must be attuned to context and circumstance, reflecting local nuance and recognising social, cultural and organisational complexity (Papoutsi, Greenhalgh & Marjanovic, 2024). The Oxford Centre for Evidence Based Medicine recognises value 'as a relationship between resources, outcomes and context.' (Hurst et al., 2019) To embed value, we must focus on all aspects of this relationship.

Both internationally and here in Australia, there are numerous definitions, theories and approaches to achieving value in health care. However, all agree that VBHC is about achieving the best possible outcomes for people with the lowest use of resources, through providing a framework for evidence-based, person-centred healthcare decision making.

As highlighted in the Queensland Health Allied Health Framework for VBHC (Queensland Government, 2022), 'VBHC is a way of

thinking, not a strict process that must be followed'. It presents a mindset shift, a lens through which we can take a whole of system helicopter view and begin to tackle some of the entrenched wicked problems undermining the sustainability of health systems by pursuing the shared goal of improving the outcomes that matter to people and communities.

Conceptualisation of VBHC at different levels of the system

Macro

In the increasingly constrained fiscal environment where each dollar spent in the healthcare system must be justified and add value, the collection, aggregation and use of meaningful outcomes data at the population level is critical to informing investment decisions. Aggregation of data at the population level provides a view of whole of system performance, enabling comparisons across organisations and services to inform decision making (Bedlington et al., 2021). Outcomes data enables generation of real-world evidence to drive efficient, effective and equitable allocation of scarce resources (Lewis, 2022).

Meso

For value to be achieved there needs to be the optimum allocation of resources and optimised interventions across the whole pathway of care from prevention through to end of life. The meso level brings together individual data inputs at the level of a health condition, for example diabetes or heart failure, bringing together clinical, process, outcomes and cost data to inform decision making (Bedlington et al., 2021). Aggregating data at the meso level enables the identification of, and disinvestment in areas of low value care, and the reinvestment of saved resources in high value areas of the pathway to drive improvements (Lewis, 2022).

Micro

VBHC highlights the importance of shifting ingrained health system cultures to one that values and promotes the relationship between people and health professionals as that of an equal partnership in the delivery of care. The micro level is about creating the conditions, and collecting the data, that will enable the therapeutic relationship to thrive at the level of the consultation (Lewis, 2022). Goal setting is a key component of this, facilitating the development of individualised care plans built around what is important to the person receiving care (Bedlington et al., 2021). Measurement at the micro level must be simple and meaningful to both individuals and clinicians, providing the right information to enable patients and clinical teams to plot a treatment pathway that will deliver on the outcomes that matter. Clinicians must be supported to consider the goals and preferences of individuals alongside clinical guidelines, and then practice the gentlest form of medicine to achieve the desired outcome (Lewis, 2022).

VBHC in Wales

Wales is a country of 3.2 million people which has a universal health system overarchingly coordinated through NHS Wales (devolved from other NHS systems in the UK) (Institute for Government, 2020), and made up of 7 local integrated health boards (Figure 3), 3 NHS trusts, 14 NHS Wales Organisations and 64 general practice clusters (NHS Wales, n.d.-a).

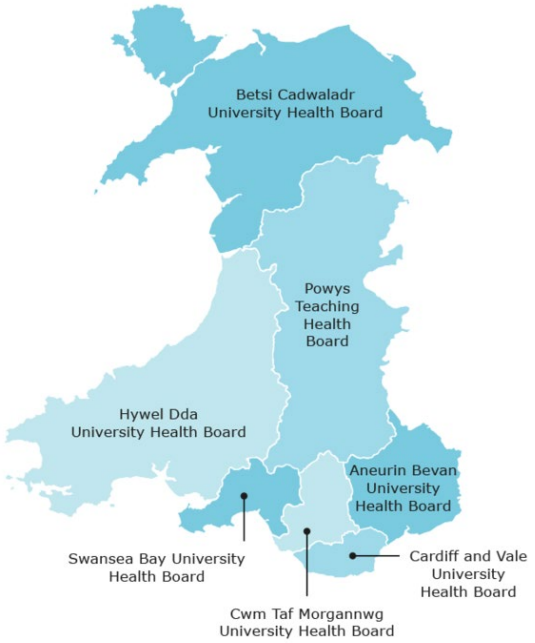

Figure 3. Welsh Integrated Health Boards (NHS Wales, n.d-a.).

Local health boards have responsibility for planning and delivering NHS services in their area including dental, optical, pharmacy and mental health. NHS trusts look after public health, ambulance services, cancer and blood services (NHS Wales, 2020).

VBHC in Wales originated as an informal grassroots movement, as an implementation mechanism for the philosophy and policy of prudent health care, first launched in 2014 (Welsh Value in Health Centre, n.d.-b).

Transforming for value-based health care

In 2018 the Welsh Government launched *A Healthier Wales* (Welsh Government, 2018), a plan for the health and social care of the nation. It outlined the need for health services to change and become fit to meet the evolving needs of communities and deliver better health outcomes for all. 'One key component in this plan was to improve value for patients by giving a greater focus to the outcomes that matter to individuals and considering their relation to the costs of achieving those outcomes.' (Welsh Value in Health Centre, n.d.-a; Welsh Government, 2018). The release of this strategy created a hook for the VBHC movement to build momentum and secure executive buy-in within services, ensuring local strategic support and resourcing to enable VBHC projects to flourish (Lewis, 2024).

The position of National Clinical Lead for value-based healthcare was established in 2019, signalling formal government commitment to the movement (Welsh Government, 2019b). A small team and program of work developed from there, creating momentum and eventually securing support for the establishment of the Welsh Value in Health Centre in 2021 (Lewis 2024; Welsh Value in Health Centre, n.d.-b). This also enabled the foundation to be laid for the Intensive Learning Academy for Value-Based Health and Care, dedicated to formal VBHC education (Welsh Government, 2024).

The mission of the Welsh Value in Health Centre is 'to provide leadership, support, expertise and strategic direction across NHS Wales that drives better outcomes for patients in a way that is sustainable in the long term.' (Welsh Value in Health Centre, 2023a).

Key to the Welsh approach to VBHC is to identify opportunities to embed a value-based approach at every stage of the healthcare pathway, from prevention through to end of life (Welsh Value in Health Centre, 2023a). Partnerships across professions, conditions, sectors, departments (e.g. finance, digital, medical) and globally have been critical to enabling this.

VBHC in Wales has been conceptualised through the macro (population health), meso (pathways of care) and micro (person-centred care) approach with opportunities for optimisation identified and supported across all levels.

Figure 4: A whole pathway approach to delivering value in healthcare (Welsh Value in Health Centre 2023a)

Optimisation of Patient Reported Outcome Measures (PROMs) across the Welsh health system
(adapted from the Welsh Value in Health Centre., 2023b).

What are PROMs?

Patient Reported Outcome Measures, or PROMs, are questionnaires that provide a 'structured communication between a person receiving care and their clinical team, through delivering a standardised response about symptom burden and quality of life' (Welsh Value in Health Centre 2023b).

How PROMs can be used to drive value?

At the Macro level

- Looking at the data with a national focus.
- For population health.
  - To assess a population's needs and understand where those needs are met. To identify where resources need to be directed.
- For research.
  - PROMs data can support research in a variety of areas, for example in the uptake of technology, or when looking at treatment options.
- For evaluation.
  - PROMs can help us understand how a service is impacting patients. For example, is the new service working? Is it providing what patients want, and more importantly, is it helping to deliver the outcomes that patients want?
- For real world evidence.
  - To work towards real time data though the collection of a data set with real world evidence.
- For policy makers.
  - At the macro level, PROMs mean policy makers see the whole picture, providing the evidence for them to invest appropriately in communities to support them to live healthy lives, plan future services and help develop current services. PROMS also contribute towards the ability to compare performance across hospitals and health services to drive quality and improvements.

At the Meso level

- Service improvement and service planning.
  - By collecting at scale and in the correct way, we can see the opportunities to improve care and treatment at the service level. For example, identifying unwarranted variation in a treatment.
- Resource allocation.
  - Aggregated PROMs can highlight unmet need in terms of high symptom burden.

At the Micro level

- In direct care.
  - Provides a needs assessment.
  - Enables shared-decision making.
  - Gives structure to a consultation.
  - Allows patients to consider what matters to them the most.
  - Helps facilitate the discussion around difficult or sensitive issues.
  - Serves as a remote monitoring tool.
  - Helps manage patient expectations and is a two-way process, with the clinician and patient building a relationship around the patient's desired outcomes.

VBHC in Australia – a national approach

In line with the Welsh experience, VBHC in Australia also originated as a grassroots movement with health care leaders and professionals seeking solutions to address the growing sustainability issues undermining the system (Figure 5).

Throughout 2017, Australian health leaders came together to discuss how to transform health care into a fit for purpose, 21st century system that could meet the needs and expectations of Australians.
The result was the '*Healthy people, healthy systems'* blueprint for health reform, which mapped out a transformation agenda to reorient the system through focusing on outcomes and value (AHHA, 2021).

While states and territories were pursuing value, federal engagement with the concept became prominent in 2018 with the signing of the Heads of Agreement between the Commonwealth and the States and Territories on public hospitals funding and health reform (ratified in 2020), which demonstrated a commitment across all levels of government to the principles of VBHC and to 'paying for value and outcomes' (COAG, 2018).

In 2019, the Australian Centre for VBHC was established by the AHHA to bring stakeholders from across the health system together to drive collective action on VBHC to improve the health outcomes of Australians for the resources available, sustainably and equitably (Australian Centre for VBHC, 2019). Since its inception, the Australian Centre for VBHC has driven the value agenda though supporting educational and training opportunities, events and conferences, providing implementation support and advocating for enabling policies at the federal, state and territory level (Australian Centre for VBHC, 2019).

The AHHA recognises that a mix of top-down, bottom-up, centralised and decentralised approaches are needed to support the operationalisation and implementation of VBHC across Australia. As such, the Australian Centre for VBHC has adopted a connecting role, working in partnership with services to support networked problem solving and develop collective intelligence that is connected into, and can inform, the policy environment.

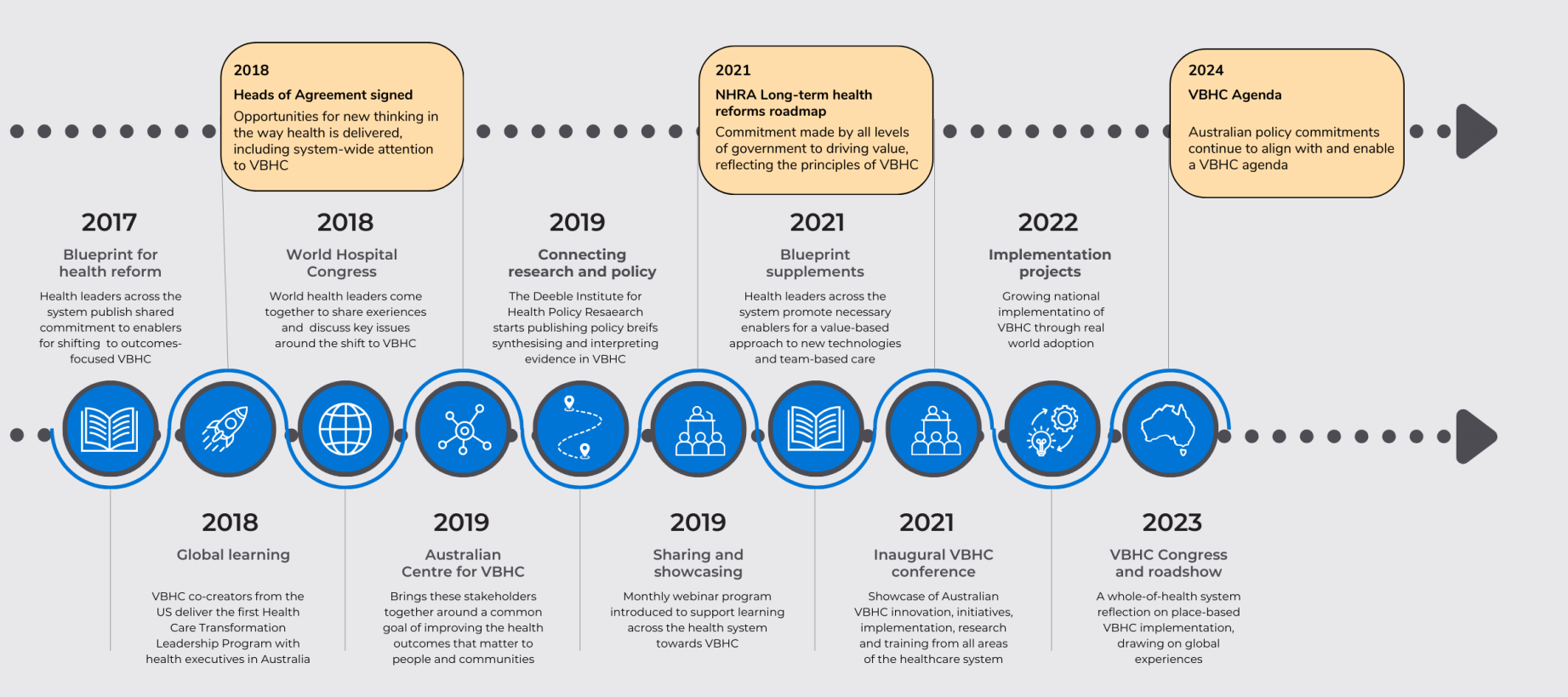

Figure 5. The role of AHHA and the Australian Centre for VBHC in supporting the operationalisation of VBHC across Australia.

In 2021, the National Health Reform Long-term Health Reforms roadmap (Australian Health Ministers, 2021) extended the commitment made by all levels of government to driving value, reflecting the principles of VBHC in its identified areas of reform, including:

- nationally cohesive Health Technology Assessment,
- paying for value and outcomes,
- joint planning and funding at a local level,
- empowering people through health literacy,
- prevention and wellbeing,
- enhanced health data; and
- interfaces between health, disability and aged care systems.

VBHC reform is also aligned with many other key national policy priorities in Australia.

Australian policy priorities that align with the VBHC agenda

- Measuring What Matters, Australia's national wellbeing framework putting 'people at the core of our thinking' (Department of Treasury, 2023).
- National Health Reform Agreement (NHRA) Mid-Term Review, recommendations align with the pursuit of VBHC (Huxtable, 2023).
- National Preventive Health Strategy 2021-2030, and its requirement for collective and comprehensive effort across sectors (Department of Health and Aged Care, 2021).
- Strengthening Medicare Taskforce Report, containing recommendations for a structured and outcomes-focused approach to increasing access to primary care, multidisciplinary team-based care, and supporting change management and cultural change (Strengthening Medicare Taskforce, 2022).
- National Healthcare Interoperability Plan, supporting the effective use of data that will be possible with interoperability (Australian Digital Health Agency, 2023).
- National Health and Climate Strategy, encouraging services to tackle unwarranted variation in providing appropriate care (Department of Health and Aged Care, 2023a).
- National Consumer Engagement Strategy for Health and Wellbeing, being developed to engage consumers in the design and development of health and wellbeing programs (Department of Health and Aged Care, 2023c).
- Health Technology Assessment Policy and Methods Review, with a need for value in real world adoption (Department of Health and Aged Care, 2023d).
- Digital Health Blueprint and Action Plan 2023-2033, which seek to advance efficient, flexible, value-based models of health care, providing better patient outcomes (Department of Health and Aged Care, 2023b).
- National Digital Health Strategy and Delivery Roadmap, placing people at the centre of a modern, connected and digitally enabled healthcare system (Australian Digital Health Agency, 2024b).
- Various workforce reviews and plans, with value only achieved through considering the workforce as a whole, not within professional silos (Department of Health and Aged Care, 2023e; Department of Health and Aged Care, 2023f; Department of Health, 2022).

Lessons from VBHC in Wales

The following compares the Welsh and Australian experience of exploring and implementing VBHC. Our reflections are based on discussions held at the VBHC Congress, and throughout the roadshow.

Listening to and learning from other systems as a source of ideas and evidence is a well-known form of policy development, known as policy transfer (Mossberger & Wolman, 2003).

However, no two health systems are the same and there are some critical differences between the Welsh and Australian health system, in particular the federated nature of the Australian system with divided responsibilities between state, territory and national government compared to a nationally governed system in Wales. Yet, there are also many similarities in the pressure and structural issues that both systems face; including for example, fragmentation between primary and secondary care, an ageing and shrinking workforce, a shift toward specialist rather than generalist care, and the rapid influx of AI and new technologies.

It is recognised that understanding the structures, context and cultural factors unique to each country is critical when considering how learnings from Wales can be applied in Australia.

We have aligned our discussion to the four initial focus areas identified by the Welsh Value in Health Centre (2023a):

- digital health,
- person-centred care,
- research impact and evaluation,
- strategic partnerships.

Conversation around these focus areas occurred frequently as we travelled around the country reflecting their importance as initial priorities and enablers when seeking to explore a coordinated approach to VBHC implementation.

We recognise that the Welsh model has now expanded its areas of focus to also include implementation across Wales; and communication, engagement and education.

Digital health

The Welsh approach

VBHC demands a digitally enabled and data-informed approach to decision making at all levels, whether that is to support shared decision making in consultations, for quality improvement in a service, for resource allocation or for research (Lewis, 2022).

In Wales, digital health has been recognised as of vital importance to VBHC in the following ways (Welsh Value in Health Centre, 2023a):

- To drive a coordinated approach to patient-facing technology, in support of new models of care and PROM collection.
- To build the data infrastructure and cultural shift towards outcomes focused decision making.

Digital health is recognised as a critical enabler of driving the cultural change necessary to embed VBHC as business as usual. Through collecting and acquiring outcomes and triangulating data as evidence, the Welsh Value in Health Centre has been able to gather and generate insights to drive learning and support value-based decision making at the macro, meso and micro levels (Welsh Value in Health Centre, 2023a).

Key areas of work that have been prioritised to build a consistent and coordinated digital health infrastructure to support VBHC include:

PROMs Standard Operating Model (PSOM) - It was recognised early that to effectively implement VBHC, timely and consistent PROMs would be critical to support the seamless aggregation, comparison and benchmarking of data. Time and resources have therefore been invested in the development of a PROMs Standard Operating Model (PSOM). This has enabled a common approach to the capture and use of patient reported outcomes across Wales, from software to support direct care through to the development of interoperability and data standards. This has allowed health boards to make more informed decisions about where resources should be directed (Welsh Value in Health Centre, 2023a).

Data standards – A critical component of this work has been the development of data standards for nationally approved PROM standard sets. In partnership with Health Boards and Trusts, pathway guides have been developed which set out minimum standards for collection points and provide supporting information across the different care and condition pathways (Welsh Value in Health Centre, 2023a).

Digital enablement – In partnership with industry and CEDAR (NHS Wales Centre for Health Care Innovation, Device Assessment and Research), work has been undertaken to develop and deliver digital care structures for nationally approved PROMs. These detailed documents specify what data should be collected, when this should occur and how it should be coded, ensuring a consistent approach to PROMs collection across Wales to inform analysis and decision making (Welsh Value in Health Centre, 2023a; NHS Wales n.d.-b).

PROMs Outcome Collection Framework – The framework supports decision making at the service level through providing a structured approach to PROMs service procurement

processes, ensuring Health Boards and Trusts have accesses to suppliers that meet PSOM specifications (Welsh Value in Health Centre, 2023a).

Data dashboards – In partnership with clinicians, the creation and sharing of national digital dashboards across NHS Wales has allowed more transparent access to health data. Work persists on these dashboards to enrich them with further data (e.g. PROMs) as it becomes available (Welsh Value in Health Centre, 2023a).

Significant learning has informed this work with it recognised that the collection, pulling and storing of data is just the beginning. Work is now underway to use the data collected to drive insights, ensuring the right information is in the hands of the right person at the right time to drive value-based decision making (Welsh Value in Health Centre, 2023a).

Reflections on Australia

Australia lags behind Wales in investing in, and progressing, a consistent approach to digital health and data collection, particularly when it comes to data sharing and interoperability. It is recognised that digital health and data are key components of achieving high-quality, high-value, safe and equitable care (Australian Digital Health Agency, 2018). However, bringing together information from different sources in a way that is easy to understand and act on has been a challenge (Hardie et al., 2022).

As in Wales, a substantial volume of data is collected across the Australian health system. The work of the Australian Institute of Health and Welfare (AIHW) (AIHW, 2023a) and the Australian Commission on Safety and Quality in Healthcare (ACSQHC) (ACSQHC, 2023a), as well as state-based agencies, continues to provide important population level insights and ongoing improvements in our understanding of variation.

However, while Australia's data linkage capability has grown substantially over the past 50 years (Smith, & Flack., 2021), for example through efforts led by NSW Health to facilitate system wide data linkage (NSW Government, 2024), in most cases, healthcare data remains steadfastly siloed.

Additionally, there are still many challenges to the implementation of a holistic and consistent data and digital health infrastructure that facilitates real-time access to information (Zurynski, et al., 2020; Hardie., et al., 2022). This is due to challenges in stakeholder and community support, complex legal and ethical environments, difficulties of cross-jurisdictional collaborations, and a lack of continuous financial investment (Smith, & Flack., 2021).

Vested interests, workforce shortages and entrenched business models are also seen to limit progress and innovation (Productivity commission., 2022), with competition for funding, resources and patients as a source of income, disincentivising engagement with collaborative digital enablement and data sharing processes.

A critical example of this is My Health Record, which in principle, provided an opportunity to centralise sharing of information between clinicians but has so far been ineffective in building collaborative capacity due to low submission rates by health providers contributing to the perception of patchy and out of date content (Burton, 2022: McMillan, 2020).

There is an increasing recognition within the health community of the importance of embedding digital systems that support outcomes data collection. Yet the lack of a clear, consistent and resourced approach, supported by interoperable digital infrastructure and information, means that many healthcare providers are going it alone (Appendix 1: Castle, 2022), limiting the significant efficiencies and learnings that come with the sharing, spread and scale of initiatives (Papoutsi, Greenhalgh & Marjanovic, 2024).

Funding models that are tied to activity rather than outcomes are also inhibiting the ability of the system to shift to a digitally enabled, outcome driven approach (NSW Legislative Council., 2022). For example, in a roadshow anecdote, we heard about a state and federal government, pooled funding diabetes initiative in which funding was tied to the process of assessment rather than the outcome. People within the community were receiving a diabetes assessment, but the incentives within the system did not drive access to the supports they needed – as identified in the assessment. While the funding was being spent, it was not driving real change in the outcomes that mattered to those people, nor was it generating savings to the system through supporting prevention and early intervention.

This example highlights the need within the Australian context, for a stronger focus on collecting and understanding outcomes data, and using this to drive real impact.

Australia could adopt a similar approach to Wales by investing in and supporting the collection of PROMs and other outcome measures, and in the development of interoperable digital systems to support and generate insights that inform decision making at the macro, meso and micro levels (Welsh Value in Health Centre, 2023a).

While the ACSQHC have undertaken work to curate a validated lists of PROMs to support uptake in the Australian context (ACSQHC 2023b), the list is narrow in scope and there is limited awareness of its existence within the sector. It does, however, highlight an important signal that the government and institutions that govern our health system are recognising the importance of a more outcomes driven approach to data collection in Australia.

We are continuing to see a strengthened commitment from the Commonwealth to a more interoperable health system. This has been shown through the release of the National Healthcare Interoperability Plan 2023-2023 (Australian Digital Health Agency, 2023), National Digital Health Strategy 2023-2028 and delivery roadmap (Australian Digital Health Agency, 2024b) and the Digital Health Blueprint and Action Plan 2023-2033 (Department of Health and Aged Care, 2023b).

The Digital Health Blueprint articulates a vision for 'trusted, timely and accessible use of digital and data [that] underpins a personalised and connected health and wellbeing experience for all Australians' with a key outcome to 'advance efficient, flexible, value-based models of health care, providing better patient outcomes' (Department of Health and Aged Care, 2023b).

The National Health Reform Agreement (NHRA) Mid-Term Review also identifies digital health as a priority (Huxtable, 2023). The Mid-Term Review recommends that a future Agreement should 'encourage appropriate

data collection, curation and analysis of health data assets to make the health system more efficient and enhance equity and patient outcomes' (Huxtable, 2023). While the Commonwealth has not indicated intent to adopt all the recommendations of the review, the prioritisation of digital health highlights an additional policy level signal for the digital health reform that is needed.

While announcements such as these show intention, it is unclear if they will result in tangible and meaningful action. COVID-19 taught us that rapid digital enablement is possible and that our communities will adapt and respond (Dyda et al., 2021).

We can no longer hide behind the excuse of digital literacy as the people that move through our health system are increasingly being trained by other industries to use and expect digitally enabled, interoperable systems. For example, digital banking systems connect and secure our private financial information, airlines rapidly share our data across national and international jurisdictions, and online shopping platforms collect and store our preferences once, and then generate tailored recommendations to meet them.

Data from the Digital Health Blueprint highlights that 69% of consumers and 85% of health professionals agree or strongly agree that they are comfortable trying new technologies (Department of Health and Aged Care, 2023b). So, while equity and ensuring access through literacy must always be at the forefront of our minds when designing and implementing digital solutions, we are increasingly seeing a community that is comfortable and expects digital health infrastructure and interoperable data systems.

It is time we rise to meet these expectations.

Lessons for Australia

- Consistent and coordinated digital health infrastructure and an enhanced digitally interoperable system are critical enablers of VBHC implementation and should be a priority of policy reform to support the shift to a value-based health system.
- Digital systems must move beyond collecting, pulling and storing data to support the triangulation of data as evidence to generate real-time insights. Data and insights must then be presented, to the right person, at the right time and in an appropriate format to drive learning and support decision making at all levels of the system (macro, meso and micro).
- A stronger system wide focus on collecting and understanding outcomes data is required; and using this data to drive real impact. Workforce capability building will be a critical component of this.
- A more coordinated and consistent approach to PROMs collection is needed to support system and population level benefits such as benchmarking for quality improvement, and to generate population level insights.

Person-centred care

The Welsh approach

The Welsh model recognises that:

> *'We are all unique individuals, and each person is an 'expert in their own life' with different goals, preferences and aspirations for their care. Active involvement in our own care improves our outcomes whether that is through health behaviours or confident management of our chronic conditions.*
>
> *To do this we need to be able to access the information we need and be supported to make the choices about treatments that will achieve our health goals, whatever they may be and at every stage of life. We need to be able to navigate the healthcare system to access the help that we need at the right time' (Value in Health Centre., n.d.-a).*

Supported self-management is a key objective of person-centred care within Wales, with a focus on striving to ensure the creation of an environment that supports this objective. This is achieved through developing and 'providing patients and health professionals with materials and tools to set goals and preferences, improve health literacy and support shared decision making' (Welsh Value in Health Centre, 2023a).

Through prioritising and focusing on person-centred care, the Welsh Value in Health Centre strives to effect cultural change, moving away from the paternalistic approach to care which has traditionally underpinned health systems, to focus on people as partners in their own care (Welsh Value in Health Centre, 2023a).

Reflections on Australia

Person-centred care is not a new concept in Australia. The ACSQHC recognises person-centred care as 'care that respects and responds to the preferences, needs and values of patients and consumers' (ACSQHC 2023c). It is a foundation to the delivery of safe and high-quality healthcare that it is embedded throughout all safety and quality standards developed by the ACSQHC.

To support its implementation the ACSQHC has established a person-centred care network, an online community in which people can share stories and resources to learn and improve the delivery of person-centred care in Australia (ACSQHC 2023d). However, while the importance of person and community centred care is overwhelmingly recognised within Australia, its application is fragmented.

Top-down prescriptive approaches to health care are stifling innovation and preventing communities from developing the solutions that meet their own needs (Productivity Commission 2021). For example, in extremely remote communities, the prescriptive nature of assessment and service delivery tied to the different funding and accountability structures such as NDIS, aged care, primary care or hospital services, means that people are turned away from services and/or delayed access to care.

A fly-in-fly-out clinician funded to deliver NDIS assessments or treatment in a remote community may be prohibited from also delivering an aged care assessment or service that is within their clinical scope on the same day. In many instances the same clinician must

return to the remote community on a different day, travelling a great distance at significant cost to the system, to perform the aged care service. This inhibits access, undermines the delivery of person-centred care, and highlights huge inequities in access for very remote communities where life expectancy is already significantly lower than the Australian average of 83 years (AIHW 2023b), only 53 for First Nations Australians and 65 for non-indigenous Australians (Western Queensland PHN 2016). When faced with these real-world examples, it is clear the top-down approaches are not appropriate for all communities.

We need to create the conditions to support the self determination of communities to drive their own health and wellbeing (Australian Human Rights Commission, n.d.), particularly within our First Nations and rural and remote communities. Recognising people as experts in their own lives and local context, listening to them and elevating them to the position of leaders and partners in health care will be critical to improving outcomes.

To drive value in our health system we need to create and embed structures and processes that allow communities to come together and use data to collectively understand their needs and to collaboratively drive the solutions to the wicked problems that impact their lives.

Accountability can be ensured if we pivot our reporting and funding structures to focus on the outcomes that matter, as determined by people and communities, and reflect how people experience care, rather than solely focusing on inputs and outputs (AHHA 2021). This shift aligns with the growing movement towards a wellbeing economy and the creation of the Measuring What Matters framework by the Australian Treasury designed to 'track progress towards a more healthy, secure, sustainable, cohesive and prosperous Australia' (Department of Treasury 2023).

Lessons for Australia

- Supported self-management should be recognised as an active intervention that is resourced, not a passive deflection of responsibility for care to an individual.
- Understanding and responding to local context is important in how we design, fund and deliver VBHC initiatives.
- To drive value in our health system, we need to create and embed structures and processes that support self-determination within communities, allowing people to come together and use data to collectively understand their needs, and to collaboratively drive the solutions to the wicked problems that impact their lives.
- To ensure accountability we need to pivot our reporting and funding structures to focus on the outcomes that matter as determined by people and communities, rather than solely focusing on inputs and outputs.

Research, impact and evaluation

The Welsh approach

In Wales it is recognised that VBHC requires a large cultural and transformational change for the health community. All parts of the system need to evolve, from policy through to clinical encounters, to embed principles of VBHC (Welsh Value in Health Centre, n.d.-a).

Evidence and engagement are needed to effect cultural change, with the Welsh model focusing on supporting the creation of a learning health and care system that fosters innovation through sharing and learning from evidence and experience. The Welsh Value in Health Centre strives to achieve this though conducting research, publishing evidence, providing support for innovative projects, and conducting evaluations to support scaling for value (Welsh Value in Health Centre, n.d.-a; Welsh Value in Health Centre, 2023a). Examples of how this has been pursued include:

Research – The PROVISION (PROMs VISualisatION) study is a program of research designed to understand if and how patients would like to see PROMs data reported to them. It is about ensuring PROMs data is presented in a way that is easy to understand and meaningful to patients. This research will inform the development and implementation of a patient-friendly visualisation model of PROMs data (Welsh Value in Health Centre, 2023a).

Impact – A £20 million fund was allocated to the Welsh Value in Health Centre by the Welsh government to drive value. £15 million of this was provided to the Health Boards to drive local priorities with £5 million used to fund value-based innovation though a grant process. 64 grant applications were received, with 12 projects selected, several of which demonstrated a national approach to driving value in a particular clinical area or pathway. Despite the relatively small amounts of funding provided, this initiative has signalled government commitment to VBHC implementation fostering courage and confidence within the sector to think outside the box and attempt bigger and better things (Welsh Value in Health Centre, 2023a).

Evaluation – A critical element of ensuring impact of the funding allocated for value, was a strong evaluation process embedded from conception. To be selected, all applications had to demonstrate a robust evaluation framework, aligned to the principles of VBHC (Welsh Value in Health Centre, 2023a).

Learning and sharing – A PROMs collaborative was established to 'support and troubleshoot a coordinated approach to implementation of software, data standards and other technical issues, data visualisation and robust analysis' (Welsh Value in Health Centre, 2023a).

Reflections on Australia

The Australian Productivity Commission's 5-year Productivity Inquiry Interim report (Productivity Commission, 2022) identified that in the health sector, where government funding and regulation have a heavy influence, it is not simply scientific breakthroughs that will drive innovative, high-quality and sustainable health care. More significantly, it will be the diffusion of ideas and embedding of adaptive business models that will allow innovation to flourish.

In Australia, innovation and cultural change must occur across a complex mix of health professionals and service providers; who deliver services in various ways in numerous settings, and who are funded, operated, managed and regulated from all levels of government and non-government settings (AIHW, 2022).

Across the system there are many examples of innovation and excellence (Appendix 1), yet VBHC leaders continue to report feeling their ability to effect change is challenged by stakeholders, models of care or policies with inconsistent incentives or motivations.

Further, evaluations of the implementation of different models of care are not undertaken in a manner that supports adoption, diffusion, and spread (Huxtable, 2023). It has been suggested that network models of innovation and diffusion are needed, that draw from complexity science and connect evidence from various specialties, sectors and individuals in a more organised way to facilitate shared learning and the rapid dissemination of new ideas (Braithwaite, Glasziou, & Westbrook, 2020; Hardie et al., 2022).

Learning health systems have been identified globally as 'the next stage in quality improvement' and 'what is required to find a sustainable way out of the current crisis,' for health systems (Hardie et al., 2022). They are defined as 'a systematic approach to iterative, data-driven improvement', where a learning community is 'formed around a common ambition of improving services and outcomes' (Hardie et al., 2022).

The Welsh model presents an example of a learning health system. Through its prioritisation of learning from data and sharing ideas and experience it has been able to drive real VBHC service and system level impact (Welsh Value in Health Centre, 2023a).

In Australia, the National Digital Health Blueprint 2023-2033 highlights a commitment to ensuring that 'data and information are shared and reused securely to deliver a sustainable learning health system' as one of its four key outcomes to support the future wellbeing of services to 2033 (Department of Health and Aged Care, 2023).

The NHRA Mid-Term Review (Huxtable, 2023) also called for the establishment of a National Innovation and Funding Agency to administer an Innovation Fund that would support the implementation of successful innovation and reform at scale through an Innovation Funding Pathway, that maps the transition from seed funding to operation at scale, subject to evaluation milestones being met.

The Welsh model has highlighted the value of such an approach in driving impact when structured to facilitate grassroots innovation, not top-down prescriptive approaches. Through its VBHC grant program, the support provided to health boards to deliver VBHC and other initiatives, the Welsh Value in Health Centre provides the link between policy and practice, building momentum through creating and sharing the evidence to support initiatives to scale and propel whole of system cultural change (Welsh Value in Health Centre, 2023a).

With Health Ministers across all levels of government in Australia signalling a commitment to VBHC reform (Australian Health Ministers, 2021), there is an opportunity to align a national health innovation funding approach with the creation of a value-based learning health system.

If pursued through a coordinated, networked model focused on harnessing and connecting existing expertise and infrastructure to effectively align data, evidence, policy and practice, a VBHC learning health system presents a nimble and cost-effective way to support the operationalisation, spread and scale of innovation (Hardie et al., 2022; (Papoutsi., Greenhalgh, & Marjanovic, 2024).

In addition, it would ensure innovation at all levels of the system is pursued through a value lens, with a focus on achieving the outcomes that matter to people and communities through the equitable allocation of resources, affirming the sustainability of our planet and the overall health system.

Lessons for Australia

- A coordinated approach to research, evidence and evaluation is needed that involves all parts of the system, from policy through to clinical encounters, to drive the cultural change necessary to support VBHC implementation and deliver real world impacts.
- A VBHC learning health system, pursued through harnessing and connecting existing expertise and infrastructure, presents the opportunity to align national policy commitments with data, evidence and the real-world experience of implementation, to support the operationalisation, spread and scale of innovation.
- Pursuing innovation through a value lens will support the creation of a sustainable (financial, environmental, social) health system, focused on improving the outcomes that matter to people and communities through the equitable allocation of resources.

Strategic partnerships

The Welsh approach

Value-based system redesign requires a cultural shift and change in mindset to the same extent that it involves the technical implementation of outcomes measurement or optimisation of investment. However, change only happens when people are engaged and connected (Lewis, 2024; Welsh Value in Health Centre 2023a; Queensland Health, 2022).

In Wales, it is recognised that VBHC is a bottom-up activity that needs top-down support. Deep collaboration between clinicians, financial managers, operational managers and informaticians is required to drive success in all the elements of system redesign. It is also critical to drive forward in parallel the necessary policy changes at the regional and national level to ensure that barriers to progress are removed. In short, every part of the system needs to be pulling in the same direction (Lewis, 2024).

In Wales, partnerships and collaboration have been critical to driving a system wide approach to VBHC reform and developing the underlying evidence base to influence cultural change (Welsh Value in Health Centre, 2023a).

Intrinsic to this approach has been recognition that health systems are complex, with valuable expertise distributed across the various sectors, regions, services, organisations and professions. No one area of the system has been able to drive VBHC alone and it is only through working together in Wales that they have been able to achieve sustainable change.

One mechanism that has allowed Wales to achieve this has been the adoption of a distributed leadership approach within the Welsh Value in Health Centre (Welsh Value in Health Centre n.d.-a). A conscious decision was made to have key members of the team based in the offices of partner entities, for example Digital Health and Care Wales. This has allowed the existing expertise and established infrastructure of these organisations to be harnessed and fostered momentum for transformational value-based change though regular connection and engagement. This approach reflects the key principles of the Welsh definition of VBHC ensuring the 'equitable, sustainable and transparent use of available resources' (Hurst et al., 2019), and signals a top-down commitment to a culture of partnering, learning, sharing and growth.

Key strategic partners of the Welsh Value in Health Centre have included:

Digital Health and Care Wales (NHS Wales n.d.-c) – A dedicated VBHC team has been established within Digital Health and Care Wales. Under the direction of the Welsh Value in Health Centre, the team has supported Health Boards and Trusts with mechanisms to implement value-based approaches within their own organisations. Work has focused on (Welsh Value in Health Centre, 2023a):

- the creation of data tools to bring clinical audit data to life and products to support value-based decision making.
- development of an ecosystem for patient facing technology.

CEDAR (NHS Wales n.d.-b) – As the Welsh Value in Health Centre Research group, CEDAR has supported the VBHC agenda in Wales though:

- providing analytical and evaluation capacity,
- advising on PROMs selection, use, licences and administration; and
- supporting the production of outputs and reports for presentations and publications.

Their role has required close collaboration with a broad range of stakeholders including consumers, clinicians, government, services and health boards to support both local and national projects (Welsh Value in Health Centre, 2023a).

Finance Delivery Unit (NHS Wales 2021) – Recognising alignment with their own principles and objectives, the finance delivery unit has become involved in value-based projects across all aspects of the Welsh health system (Welsh Value in Health Centre, 2023a).

Health Boards and Trusts (NHS Wales, 2020) – Since 2018 the Welsh Value in Health Centre has been working collaboratively with Health Boards and Trusts to promote a whole of system approach to embedding VBHC and optimising available resources. All Health Boards and Trusts now have value-based teams, and a National Leads of Value Planning and Delivery Group has been established, creating a platform for sharing and driving a whole of system approach to VBHC implementation (Welsh Value in Health Centre, 2023a).

Value-Based Health and Care Academy at Swansea University (Swansea university, n.d.)– The Welsh Value in Health Centre team works closely with the Value-Based Health and Care Academy contributing content and helping to develop VBHC educational offerings that build the health sector capacity within Wales to deliver VBHC (Welsh Value in Health Centre, 2023a).

Reflections on Australia

As with the Welsh experience, a whole of system shift in mindset is required in Australia to drive the collective action necessary to embed VBHC in practice.

While there is a growing commitment to the pursuit of VBHC in Australia, much of the activity to support this shift is occurring in silos. Entrenched cultural beliefs around professional and jurisdictional boundaries are hampering people's ability to adopt the necessary helicopter view and look beyond their traditional spheres of influence to identify opportunities for optimisation and innovation across the full pathway of care, from prevention through to end of life (Lewis, 2022).

In the words of Dr Sally Lewis, it 'is time we challenged ourselves on the status quo.' In Australia this will require lifting our heads to look beyond the entrenched silos of our health system to connect, share and collaborate in pursuit of the shared goal of improved outcomes.

Examples of this type of collaboration are emerging with meetings and roundtables held to bring various elements of the sector together, such as primary care, hospitals, universities and specialist services, to discuss how to drive VBHC within their communities (AHHA, 2023). However, these partnerships are in their infancy.

Attention and resourcing are needed to support the further development of trusted and meaningful partnerships across the

system. Partnerships must be prioritised with consumers, across primary care and the acute sector, across professional boundaries, across departments within our organisations (finance, digital, innovation), across jurisdictions (federal, state, territory, local government) and across sectors, working with those outside of health who have a strong influence on health outcomes, for example justice, disability, education, social services, employment and environment (AHHA, 2023).

We are beginning to see a shift in the policy landscape in support of this approach with a growing recognition of the need for connection and strategic partnerships across traditional boundaries being highlighted in rhetoric and government policy initiatives.

In 2022, the Independent Health and Aged Care Pricing Authority (IHACPA) had its remit expanded beyond hospital funding, to not only explore aged care funding but to also work with 'Commonwealth and state and territory governments to explore and trial innovative new approaches to funding that improve health outcomes' including looking beyond the four walls of the hospital (IHACPA, 2022).

This has been further supported by the NHRA Mid-Term Review, which recommends that the scope of public hospitals within the NHRA be reviewed with the view to broadening the understanding of a public hospital service 'to address current disparities between States and Territories and to incorporate those services that are provided beyond the hospital door' (Huxtable, 2023).

The National Health Reform Agreement 2020-2025 (Australian Health Ministers 2021) also highlights 'joint planning and funding at the local level' as one of its four strategic priorities for reform between 2020 and 2025 creating the space for primary health networks and local health networks to partner and pursue joint priorities.

In addition, there is a growing recognition of the need to engage beyond the health sector to drive solutions. In a 2023 speech to the Whitlam Institute, the Federal Minister for Health and Aged Care highlighted his commitment to the principles of equity, proactive health protection, community involvement, and to investing in 'care that looks beyond the medical to the social determinants of health' (Butler, 2023).

The wellbeing agenda and the Measuring What Matters framework driven by the Department of Treasury also demonstrates a commitment to better understanding and measuring the interplay between the various sections of the Australian economy in the pursuit of improving overall wellbeing (Department of Treasury 2023).

It is clear we have significant expertise and experiences within our system pursuing VBHC. At the policy level many of our leading institutions are exploring elements of VBHC. For example, ACSQHC is pursuing work in areas of unwarranted variation and person-centred care (ACSQHC 2023d). The AIHW has extensive population level data and analysis expertise (AIHW 2023a). The Digital Health Agency is seeking to create a connected, accessible, progressive and secure healthcare system (ADHA 2024a) and IHACPA is pursuing innovative funding models that drive value and improvements in outcomes (IHACPA, 2022).

With the growing momentum and appetite for VBHC, and the top-down shift to create a more supportive policy landscape, a window of

opportunity currently exists in Australia to harness the existing expertise and, in the image of the Welsh Value in Health Centre model, resource a coordinated and distributed VBHC leadership approach. Such an approach must recognise the importance of context, and support evidence-based sharing and learning to operationalise innovation. This presents a nimble and flexible alternative to the creation of additional top-down bureaucratic structures, ensuring alignment with the principles of VBHC by driving transformational cultural change through the optimal use of scarce resources.

Lessons for Australia

- A strong focus on enabling and resourcing meaningful strategic partnerships will be necessary to support the whole of system cultural change required to drive collective action to embed VBHC in practice.
- Significant expertise and experience in VBHC exist within the Australian health system; with many services, stewards and institutions already contributing to the pursuit of value and outcomes within their spheres of influence. However, coordination of this activity through a distributed leadership model will be required to support the operationalisation of VBHC in Australia.
- The Welsh Value in Health Centre (NHS Wales) has been identified as providing an exemplar framework for operationalising VBHC in Australia; and could be mirrored through the Australian Centre for VBHC.

Conclusion

Health systems around the world are facing increasing issues of sustainability, undermining their ability to improve the health and wellbeing of the people they serve. Real and transformational change is needed to drive improvement in the outcomes that matter to people and communities.

VBHC presents a whole of system structured approach to drive transformative change, enabling us to centre everything we do, in all corners of our system, around the shared goal of improving the outcomes that matter to people and communities through the most efficient and effective use of resources. It provides a framework to support evidence-based, person-centred healthcare decision making at the macro (population health), meso (pathways of care) and micro (person-centred care) levels of the system (Bedlington et al., 2021; Lewis, 2022).

The 2023 VBHC Congress and roadshow has identified a growing appetite for change across the Australian health system, emphasising that current ways of doing things are no longer sustainable.

The Welsh model of VBHC presents an iterative, data driven, evidence-based, outcomes focused approach to VBHC, built on the principles of equity, sustainability, and partnerships. This model has resonated strongly with Australian audiences, highlighting an opportunity to harness their learnings within the Australian policy context.

Through exploring the focus areas of digital health, person-centred care, research, impact and evaluation, and strategic partnerships, we can see some of the basic foundations for VBHC reform already in place in Australia. An increasingly enabling policy environment further supports the path to VBHC implementation with the Commonwealth government and many of the institutions that govern our system shifting to examine outcomes and value within their spheres of influence.

Yet the coordinating mechanism that brings the various expertise from across the system to connect with grassroots operationalisation of VBHC, and the ability to support the sharing, learning and the scaling of innovation, is lacking.

To build an equitable and sustainable health system that improves the outcomes that matter to Australians, the Government must capitalise on the growing momentum towards VBHC implementation by harnessing the existing expertise and infrastructure within our system. The Welsh Value in Health Centre (NHS Wales) has been identified as providing an exemplar framework for operationalising VBHC in Australia; and could be mirrored through the Australian Centre for VBHC.

In the words of Dr Sally Lewis (2023 VBHC Congress):

> *'If not this, then what?*
> *If not now, then when?*
> *If not us, then who?'*

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Appendix 1: Case studies

The following case studies reflect examples of how VBHC is currently being explored and implemented within the Australian health system. While each has been explored though the lens of a level of the health system, it is recognised that, in reality, there is considerable interaction across the various levels required in the operationalisation of VBHC.

MACRO: Healthy Outback Communities (Western Queensland PHN 2023)

Problem: Inequitable health outcomes at a population level.

Desired outcome: Healthier communities and effective chronic disease management, improving quality of life, increasing life expectancy, and reducing acute health care need and use.

Value-based health care solution: The Healthy Outback Communities (HOC) initiative in the very remote Western Queensland shires of Boulia, Diamantina and Barcoo is a new, collaborative model of health and social care that shifts health service focus to measuring outcomes, rather than a focus on the volume of health services.

The model presents a community-led, place-based initiative driven though collaborative, cross-sector effort that places health and wellbeing in the hands of local residents and communities. Residents and families are supported to take control of their own health and wellbeing journey by 'linking up' to local support.

MESO: Breast Cancer Bundle of Care (Zissiadis et al., 2023)

Problem: Patients diagnosed with cancer report the need for more "joined up" holistic care and the financial impact of care, as two obstacles to improved quality of life.

Desired outcome: To develop a bundle of care and test whether it can improve patient experience, create financial transparency and certainty, improve patient outcomes and form a model that can be scaled to other geographies/ cancers.

Value-based health care solution: The breast cancer bundle aims to deliver a "joined up", holistic 12-month package of care for people newly diagnosed with breast cancer undertaking treatment in the private health system, providing upfront transparency in fees.

Optimisation of the care pathway is enabled through the engagement of a non-clinical navigator who provides personalised support to help people coordinate their care, access the services they require to improve treatment outcomes and support self-management. The partnership approach of the model enables patients to move through the system more efficiently with various services (pathology, surgery, oncology, radiology, physiotherapy, dietetics and clinical psychology) collectively working together and sharing information to help maximise the best possible outcomes for the patient.

MESO: West Australian Eating Disorder Specialist Services (WAEDSS) Collaborative Model (Miller, 2023)

Problem: Siloing of clinical governance and decision making across state, commonwealth and privately funded providers within the eating disorder care pathway contributing to duplication, fragmentation, access blocks and undermining patient outcomes and experience.

Desired outcome: Equitable access to a person-centred, evidence-based, integrated continuum of care that optimises outcomes and experiences for people experiencing eating disorders.

Value based health care solution: The WAEDSS collaborative model is designed to ensure sustainability of state-based funding to integrate and optimise efficiency of the contributions of all components of eating disorder service delivery as a 'joined up' experience across the system, regardless of funding source or setting of care and without overwhelming any one service with unmet demand.

State funding will enable the establishment of three hubs delivering a range of step-up, step-down services integrating with existing hospital and community services across the Australian state of Western Australia.

Dedicated roles to optimise and improve patient experience at vulnerable transition points between WA Country Health Service and Child and Adolescent Health Services to the area-based components are included along the pathway, as well as peer workers with a lived experience who are integral to bringing an understanding of value-based outcomes to care planning. Partnerships with primary care and Medicare funded psychology and dietetic services providing early identification, and interventions are supported via funded state-wide clinical liaison and education functions to build capacity across the health workforce beyond the WAEDSS services themselves and sustain flow across the system.

Looking ahead: A state-wide purpose-built database, data scientist role, and Clinical Advisory Group will ultimately enable a learning health systems approach to inform individual patient-care decisions (mico), area-based service quality improvement (meso) and population-level planning for future investment (maco) within a recovery-oriented framework consistent with the National Eating Disorders Strategy.

MICRO: Psychology Outcomes Clinic (Castle 2022)

Problem: Time consuming measurement approach not delivering value to clinicians or psychology clients.

Desired outcome: An understanding of, and improvement in, the outcomes that mattered to clients attending a private psychology practice in regional Australia.

Value-based health care solution: Integration of distress outcome measures into treatment. Clients attending a psychology session complete a short (one minute) distress PROM at the beginning of each session. The results, including a graph of their distress over the course of the treatment, are then used to inform discussions within the immediate session.

A decrease in a client's distress is celebrated, with discussions focusing on what has been working so that more of this can be embedded within treatment. If a client's distress has not changed or has increased, time is spent discussing what is not working and what needs to happen for distress to come down. The collaborative process ensures that the clients voice outlines the treatment approach elevating the relationship between clinician and patient to that of an equal partnership in the delivery of care.

It also allows clinicians to monitor and improve the effectiveness of the treatment they deliver through the identification of data trends and comparisons with international benchmarks.

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AHHA acknowledges the Aboriginal and Torres Strait Islander peoples as Australia's First Nation Peoples and the Traditional Custodians of this land. We respect their continued connection to land and sea, country, kin, and community. AHHA also pays our respect to their Elders past, present, and emerging as the custodians of knowledge and lore.