Value Based Competition in Health Care

A critical reflection from an ethical point of view

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Summary

Since the first decade of this century, it has become clear that health care expenditures have grown tremendously, while its performance is characterized by low, or at least variable quality, under- and overtreatment, too many preventable errors, and serious limits in (equal) access to health care. Michael Porter, a professor of business strategy at Harvard University in the United States, has claimed that there is only one escape from this worrysome situation: the introduction of value based competition in health care (VBCHC). Porter's VBCHC theory is based on two fundamental elements. First, competition will, as in any other economic sector, encourage health care providers to deliver high quality care for the lowest possible price. Second, competition should be based on value, which Porter defines as: 'outcomes relative to costs'.

In his work, Porter focuses on explaining how VBCHC should be applied. He pays little or no attention to the justification of his theory, let alone to the question whether VBCHC is an *ethically* defensible theory. Such an ethical reflection on VBCHC can also not be found in the literature yet. Therefore, this thesis investigates whether VBCHC can be ethically defended and what principles are relevant in the search for possible alternatives.

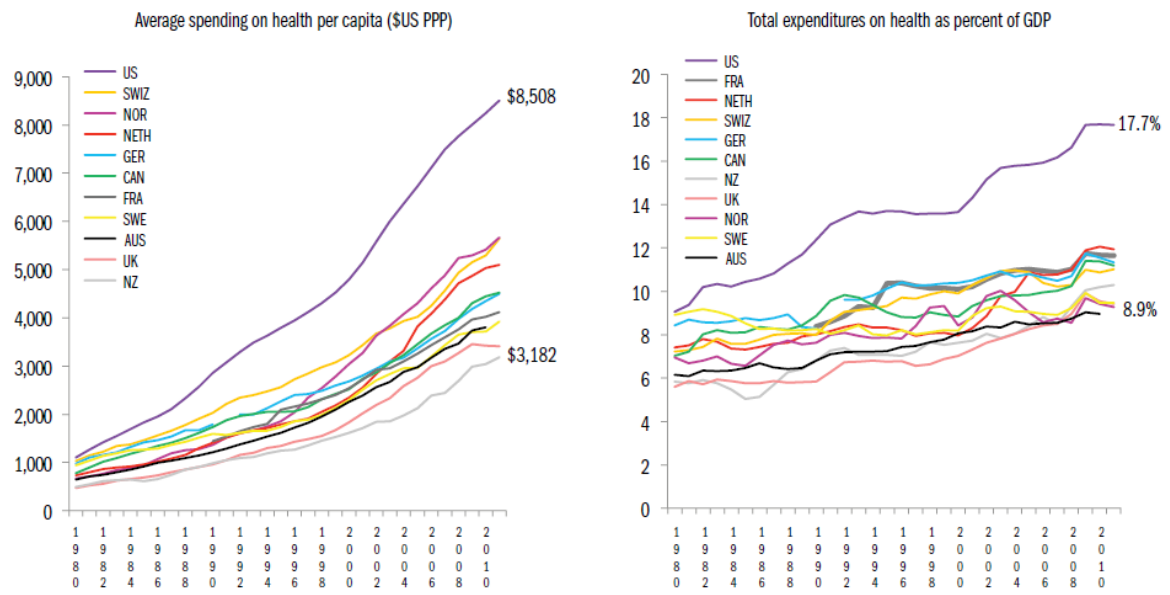
This thesis shows that 'competition' is only one possible mechanism in the distribution of public goods such as health care. Whereas Porter combines competition with choice and targets and performance management, there are good arguments to claim that health care would be better off with an intelligent focus on trust in the trustworthy and voice in combination with choice.

Regarding the element of 'value' in VBCHC, this thesis shows that Porter holds a rather reductionist conception of value. Instead of standardizing outcome measures for patients with the same medical condition, Value Based Medicine (VBM) offers an alternative approach that takes patients' personal values as a starting point. Besides, instead of valuing health care only instrumentally (in order to achieve better health), care ethics may help to acknowledge the intrinsic value of the caring relation. Combining these alternative approaches with the ethically defendible elements of Porter's VBCHC will not only affect the mechanisms for distributing health care (more trust and voice instead of a single focus on targets and performance management and choice), but also the way we measure and improve its quality (by trying to reach the deeper layers of the value of care).

1. Introduction

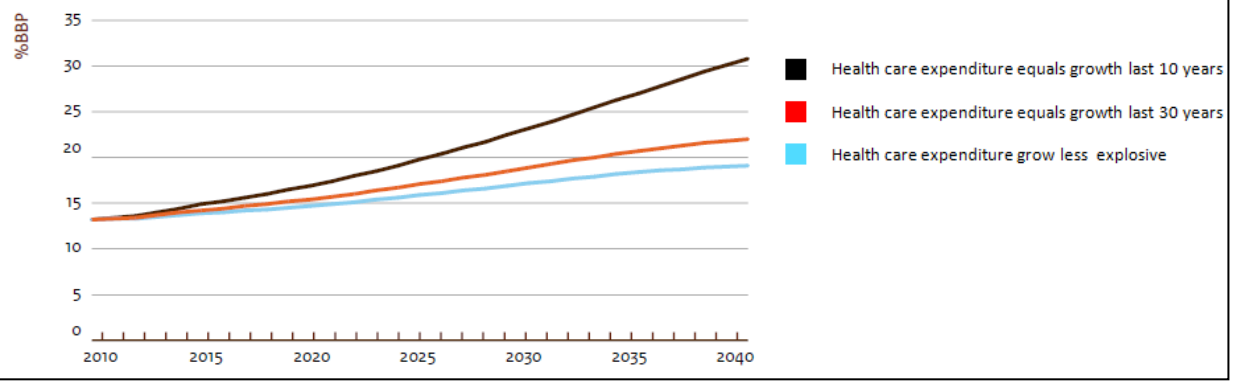
During the last three decades, expenditures on health and health care have grown rapidly worldwide (see fig. 1). Health spending accounted for 16,9% of GDP in the United States in 2012 - the highest share among OECD countries and more than 7,5 percentage points above the OECD average of 9,3%. The Netherlands was second highest in this ranking, spending 11,8% of their GDP on health in 2012 (OECD 2014).

Figure 1: International comparison on spending on health 1980-2011 (Davis, Stremikis et al. 2014, p.11)



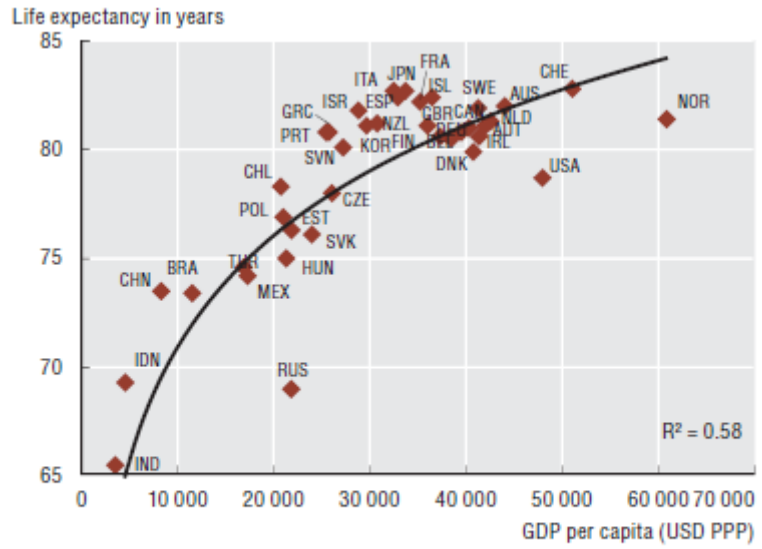
Forecasts in The Netherlands have predicted that this percentage could rise –dependent on the scenario– up to 30% of its GDP in 2040 (see fig. 2), creating a sense of urgency for cost-containment strategies.

Figure 2: predicted growth of health care expenditures (VWS 2012, p.7)



Figures like these become even more worrisome if we realize that increases in health care costs do not go hand in hand with better results. Recent OECD figures, combining the health care expenditures as a percentage of the GDP with life expectancy at birth, show that it are not always the countries that spent most, whose inhabitants have the best life expectancy (see fig. 3):

Figure 3: Life expectancy at birth and GDP per capita, 2011 or nearest year (OECD 2013 , p.25).



Source: OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en.
StatLink http://dx.doi.org/10.1787/888932916021

All in all, contrary to what one would intuitively expect, many Western countries with high health care expenditures, combine these with low, or at least variable quality (OECD 2013 , p.107-135, Davis, Stremikis et al. 2014, p.13-19), under- and overtreatment (OECD 2014), too many preventable errors[1] (Langelaan, Bruijne et al. 2013, p.88), and serious limitations in (equal) access to health care (Davis, Stremikis et al. 2014, p.20-24).

As is evident from the literature, there is a great variety of strategies applied by countries in order to bend cost-curves and to keep health care affordable, and accessible for the public (Mossialos, Wenzl et al. 2015). Apart from their variation in for example the distributive mechanisms through which health care is delivered (predominantly public or private), the role of copayments and deductibles etc., all strategies have one characteristic in common: they try to achieve lower health care *costs* while at the same time increasing health care *quality*. It was Michael Porter, a well known professor in business strategy at Harvard University, who in 2006 brought up the strategy of *value based competition in health care* (VBCHC) as the only reasonable strategy that is likely to get the

[1] Although in The Netherlands there has been a significant improvement in the prevalence of preventable harm over the last ten years. Of all patients that were admitted to a hospital in 2011/2012 1,6% (95% BI: 1,1% - 2,2%) experienced preventable harm. This is 30% less than in 2004 (2,3%; 95% BI: 1,9% - 2,7%) and 45% less than in 2008 (2,9%; 95% BI: 2,3% - 3,7%). The number of preventable deaths in hospitals decreased with 53%. Between April 2011 and March 2012, 970 died a preventable death (95% BI: 738 - 1.274). In 2004 this was a total number of 1.735 patients (95% BI: 1.482 – 2.032) and in 2008 1.960 patients (95% BI: 1.600 – 2.360).

health care sector out of its precarious situation (Porter and Teisberg 2006). Because I will further elaborate on VBCHC and its principles in chapter 2, only a short description of the concept will suffice here. What Porter claimed to be right objective of competition in health care, is to "*increase value for patients, which is the quality of patient outcomes relative to the dollars expended"* (Porter and Teisberg 2006, p. 98). Thus, health care adds value for patients if it results into better outcomes relative to the costs that were made. When measuring value, patient outcomes are multidimensional, and far more complex than whether the patient survives. Recovery time, quality of life, (e.g. independence, pain, range of movement), and emotional well-being during the process of care all matter. The relative importance of different outcomes will vary for different individuals (Porter and Teisberg 2006, p.99). Since its appearance in 2006 Porter's VBCHC theory has had great influence. Many Western countries have reformed their health care systems during the last decade, applying Porter's theory[2].

Thus far, most discussion in the literature on Porter's ideas has focused on whether it is *technically* possible to introduce competition in health care (Rosenthal and Daniels 2006), to measure quality (Greenhalgh, Long et al. 2005) and costs (Kaplan and Porter 2011), and relate them to each other (Burke and Ryan 2014). They study the special characteristics of the health care market and define the specific conditions and prerequisites that should be met to overcome market failures (Arrow 1963). *Ethically* seen however this technical focus is of little importance. Moreover; it distracts from more fundamental discussions since, in my view, there are some crucial ethical aspects of VBCHC that deserve serious consideration. Interestingly enough, such an ethical and philosophical reflection on Porter's VBCHC cannot be found yet in literature. Current literature covers this area only indirectly, reflecting on the ethical challenges of Accountable Care Organizations (ACO's) in the USA (DeCamp, Farber et al. 2014), or ethical principles for health care commissioning in the UK (Medical Directorate 2013). Besides, there are of course philosophical and ethical reflections on the phenomena of 'competition' and 'value', which appear to be the two cornerstones of Porters VBCHC theory. Therefore, in this thesis I will 'jump into this gap of knowledge' by trying to come to an ethical reflection on VBCHC.

[2] The UK for example has officially embraced Porter's VBHC approach: http://www.rightcare.nhs.uk/index.php/programme/

In Germany, a tailormade version of Porter's book has been produced: Henke, K. D. (2012). "Redefining German Health Care - Moving to a Value-Based System." Jahrbucher Fur Nationalokonomie Und Statistik **232**(6): 717-721.

In The Netherlands in 2006, a new Health Care Insurance Act (ZVW) came into effect, its architecture being importantly based on the principles of VBCHC Engelsen, B. d., C. v. Beek and G. Blijham (2007). Marktwerking, concurrentie en zorgmarketing, Bohn Stafleu van Loghum.

Moreover, a European platform has been created in order to implement Porter's VBCHC theory all over Europe: http://www.vbhc.nl/

Al of the above leads to a clear research question and aim for this thesis. The main research question of this thesis is: *Is the theory of Value Based Competition in Health Care (VBCHC) ethically defendable and what principles are relevant in the possible quest for alternatives?* In order to answer this question, I will address several sub-questions:

1. *What are the core characteristics of VBCHC theory? - Chapter 2.*
2. *Is the phenomenon of 'competition' a morally defensible mechanism in health care, and if we would look for alternatives, what alternatives can be thought of? – Chapter 3.*
3. *How does VBCHC theory conceive of 'value', how does this relate to other philosophically relevant conceptions of 'value' in health care, and what other conceptions of 'value' in health care are morally relevant? – Chapter 4.*

In order to come to an answer to these questions, I will mainly focus on the two cornerstones of Porter's VBHC theory: the elements of "competition" and "value". I will only introduce them here shortly, and will elaborate on them in chapter 2, where VBCH is explained into more detail.

Porter conceives of *competition* as the phenomenon that a competitive market inevitably increases value for customers. It makes computer chips smaller and faster, it results into safer and more efficient cars, etc. The question that will be centre-stage in chapter 3 is however whether this can be translated this easily to health care. Here, I am especially interested in the underlying principles of competition; do these fit with the characteristics of health care, or would health care be better off with alternatives? In order to come to a better understanding of the phenomenon of competition in public services, I will first take a closer look at its principles and those of alternative mechanisms. Here, I will use a model by Julien le Grand (Le Grand 2007). Then, inspired by a threefold definition of 'the market' by Claassen, (Claassen 2006) I will look how both the demand-side (will needs be properly met?) and the supply-side (professional's ethics and intrinsic motivation) will be affected by the introduction of competition.

My second concern will be Porter's conception of *'value'* in VBCHC. This will be discussed in Chapter 4. Porter conceives of 'value' in VBCHC in a very specific way: outcomes per dollar expended. He chooses this (business) economical definition, which –philosophically seen- seems to stem from a utilitarian tradition. This choice is not self-evident however, especially not in health care, having a long tradition of charity, and stressing the intrinsic value of the caring relation (which measurability can be doubted at all), but I will come back to that in chapter 4. Besides, philosophically seen, the term 'value' – as studied in for example 'value theory'– is much broader. I think a philosophical reflection is needed on how we should conceive of 'value' in health care if its greatest aim is "adding value for patients".

2. Value Based Competition in Health Care (VBCHC)

This chapter starts with an analysis of the problems many Western health care systems have been dealing with during the last decade (2.1). Then, I will show how –according to Porter– VBCHC should redesign health care into value based competition (2.2).

2.1. Health Care as a "zero sum competition"

We saw that over the last decade, Western health care systems have shown unsustainable results: high costs, low –or at least variable– quality, under- and overtreatment, too many preventable errors in diagnosis and treatment, restrictions on choice, rationing of services, and limited access. It was Harvard professor Michael Porter who, in 2006, contrary to many doctors at that time, ascribed this problem not to the existence of competition in health care, but to the existence of *the wrong kind* of competition. This "*zero-sum-competition*", as Porter calls it, was (or in some countries still is) manifested in health care in a number of ways (Porter and Teisberg 2006, p. 35-45, Porter and Teisberg 2007, p.1104):

First, health care competition takes the form of cost shifting, rather than fundamental cost reduction. All single system participants (providers, hospitals, primary care) seek to lower their costs by shifting the burden to other parts of the system. This also continues outside the 'delivery chain', where costs are shifted from payer to patient, from health care insurer to hospital and vice versa, from hospital to physician, from health care insurer to enrollee, from insurer to government, from insured to uninsured, from central government to other governmental bodies, and so on. Even patients tend to play the cost-shifting game. They attempt to use political influence and the legal system to obtain expanded coverage and insurance schemes and greater contributions from government. Passing costs from one player to another, like a hot potato creates no added value. Instead, the gains for one participant come at the expense of others. All this cost shifting does nothing to improve health care at all. It distracts system participants from steps that would improve quality and the added administrative costs and inefficiencies created along the way actually do more harm than good (Porter and Teisberg 2006, p.35).

Second, the struggle to shift costs creates strong incentives for system participants to amass greater bargaining power, which they all use to create better results for themselves, instead of focusing on improving health results, raising efficiency, or improving the patient experience. For example, amongst hospitals, there has been a scramble to form the largest, most powerful full-line provider group. They sought to control a large share of capacity, and form large delivery networks able to offer a complete array of services to gain advantages in contracting. Physicians joined into

groups so they would not have to bargain as individual agents[3]. According to Porter, this arises two problems. First, economically seen, there is no rationale for these kind of economies of scale'. In practice, hospital mergers result in little or no consolidation and integration at the 'service line level'. Instead, duplicative services are often left in place, even when the facilities are close to each other. And even if measures are taken, prices still rise because –according to Porter– there is less regional competition (Porter and Teisberg 2006, p.37-40). This is phenomenon is empirically underpinned by recent analyses of 13 Dutch hospital mergers since 2011. The Dutch Health Care Authority (NZa) came to the conclusion that all mergers caused higher prices: varying from 1,3% to 28%. Eight out of 11 mergers would not have been approved by the Authority if current rules would have been applicable by then (Visser 2015).The second problem is that –according to Porter– economies of scale are only in in individual service lines (for specific diseases or patient groups) and not for the hospital as a whole.

Third, Porter observes a competition to capture patients and restrict choice. The struggle to accumulate bargaining power led health plans (for the Dutch situation we can read here: health care insurance companies) to merge and compete fiercely to sign up as many enrollees as possible. However, according to Porter, acquiring members has little impact on health care quality and costs. Competition for more members has taken place primarily through costly marketing campaigns[4]. In the USA as in The Netherlands, enrollees have the yearly opportunity to switch their health plans, respectively, insurer. However, according to Porter, this is not the right time and the right place for competition: "*The vast majority of families choose a health plan when members are healthy, without knowing which illness will need treating or which provider they will desire to use"* (Porter and Teisberg 2006, p. 41). This approach rather undermines value for patients, instead of adding it. Besides, once members are "locked in" health plans restrict free choice of providers to those who offer the lowest price, rather than those demonstrating the best results: *"Such restrictions would not be so important if all health care providers offered uniformly high quality and efficiency"* (Porter and Teisberg 2006, p.41). However, as we saw in the introduction, this is not the case.

Fourth, and maybe most important of all (Porter calls it 'The Root Cause'), competition in health care operates at the wrong level. It is both too broad and too narrow. It is too broad because much competition takes place at the level of hospitals, physicians, insurers, etc. Instead, it should occur at the level of particular medical conditions, such as the care for patients who suffer from Diabetes or cancer. It is too narrow because it often takes place at the level of discrete interventions

[3] In The Netherlands, so called "Regiomaatschappen" were created by medical specialists in hospitals (see: http://www.nvz-ziekenhuizen.nl/_library/10956/Factsheet%20regiomaatschappen,%20NVZ.pdf) and in primary care, so called "Zorggroepen" were created by primary care physicians (see: http://ineen.nl/leden/zorggroepen/).

[4] In the Netherlands, where the four largest insurance companies share 90% of the health care insurance market, each year, a total budget of 500 million euro's is spent for 'acquisition costs'. http://www.nrcq.nl/2014/11/28/geven-verzekeraars-echt-zoveel-uit-om-jou-te-lokken

or services, for example a surgical procedure. However, it should take place for addressing medical conditions over the full cycle of care, including monitoring and prevention, diagnosis, treatment, and the ongoing management of the condition after the intervention. One of the central dictums of Porter's theory is that *"value in health care* is *created or destroyed at the medical condition level, over the cycle of care, and not at the level of a hospital or physician practice"* (Porter and Teisberg 2006, p. 44).

2.2. Porter's solution: value based competition in health care (VBCHC)

Porter's solution to the problems described thus far is twofold: a) competition, b) based on value, or: *value based competition in health care (VBCHC)*[5]. Remarkably, Porter introduces the solution of 'competition' as a self evident 'fait accompli', almost without any further motivation for the "why" of competition. On the other hand, he spends 80% of the total volume of his book to explain "how" VBC should function: the core principles, and his definition of 'value'. Regarding the "why", only three arguments can be found in the first chapter of Porter's book.

Porter's first reason to suggest competition as the leading principle for health care is that competition can be seen in virtually every field of our Western societies: retailing, airlines, financial services, aerospace, and computer services (Porter and Teisberg 2006, p.33). Or, as he states elsewhere: electronic banking, stock brokerage, and plasma televisions (Porter and Teisberg 2007, p.1104). Such competition has transformed previously regulated fields, such as telecommunications, as well as sclerotic economies, such as those in eastern Europe, with extraordinary benefits.

"*When people buy new computers with far more capabilities, speed, and memory for the same or lower prices as their old ones, they are benefiting from productive competition. When automatic tellers and online services make banking possible at all hours, and when cars become safer, more comfortable, and defect free, value based competition is at work "* (Porter and Teisberg 2006, p.34).

His second argument is that competition, at least if it is value based, has some major advantages over other (distributive) mechanisms. Competition makes that the capable producers of goods and services grow and prosper, innovation is rewarded, efficiency increases, and customers have more choice and can afford more of an ever-improving product. Competition in health care can become a positive-sum game if it is value based. Then, all system participants will benefit:

[5] In the second part of his book, Porter explains how VBCHC should come to an expression at the macro level, the meso level and at the micro level. At the macro level, VBCHC should be used to set standards for coverage. At the meso level, it should improve health care insuranc and access through value based purchasing, at the micro level VBCHC should improve day-to-day health care delivery and medical decision making in the primary care process. However, due to the limited space in this thesis, I will not be able to elaborate on these levels. Ethcial considerations and examples may come from each of them.

"When providers win by delivering superior care more efficiently, patients, employers, and health plans also win. When health plans help patients and referring physicians make better choices, assist in coordination, and reward excellent care, providers benefit. And competing on value goes beyond winning in a narrow sense. When providers and health plans compete to achieve the best medical patient outcomes, they pursue aims that led them to the profession in the first place" (Porter and Teisberg 2006, p. 97).

Third, Porter believes that unrestricted competition based on results is the only cure for the problems of medical errors, undertreatment, and overtreatment. Note here that Porter's conception of competition goes beyond that of what is elsewhere called 'managed competition' (Van de Ven and Schut 2009, Schut and van de Ven 2011), which is competition under certain restrictions. In his view, competition should be unrestricted, meaning that government should not influence the supply side of the health care market:

"*Some observers are now arguing for government limits on the supply of physicians to limit excessive care. However, simply limiting the number of physicians will not ensure that the services that physicians deliver will be higher value. Competition on results, not trying to control supply is the only effective way to crate accountability, motivate and inform process improvement, and drive up patient value"* (Porter and Teisberg 2006, p.102).

Contrary to his very limited, generic motivation for the "why" of competition in health care, much more details can be found on "how" Porter thinks competition in health care should be applied. He describes several principles of value-based competition; the first concerns the point of application of competition, the second is about the importance of transparency and information, and the third –I will most profoundly elaborate on this one– about the 'value' concept.

First, according to Porter, competition in health care should center on medical conditions over the full cycle of care, not just local, but at the regional or (inter)national level. He defines a medical condition (e.g. chronic kidney disease, diabetes, pregnancy) as a set of patient health circumstances that benefit from dedicated, coordinated care. The term *medical condition* encompasses diseases, illnesses, injuries, and natural circumstances such as pregnancy. A medical condition should be defined from the patient's perspective. It should encompass the set of illnesses or injuries that are best addressed with a dedicated and integrated care delivery process. Providers should organize themselves around medical conditions, not skills or discrete specialties or services. These integrated practice units should include all the services necessary to address a medical

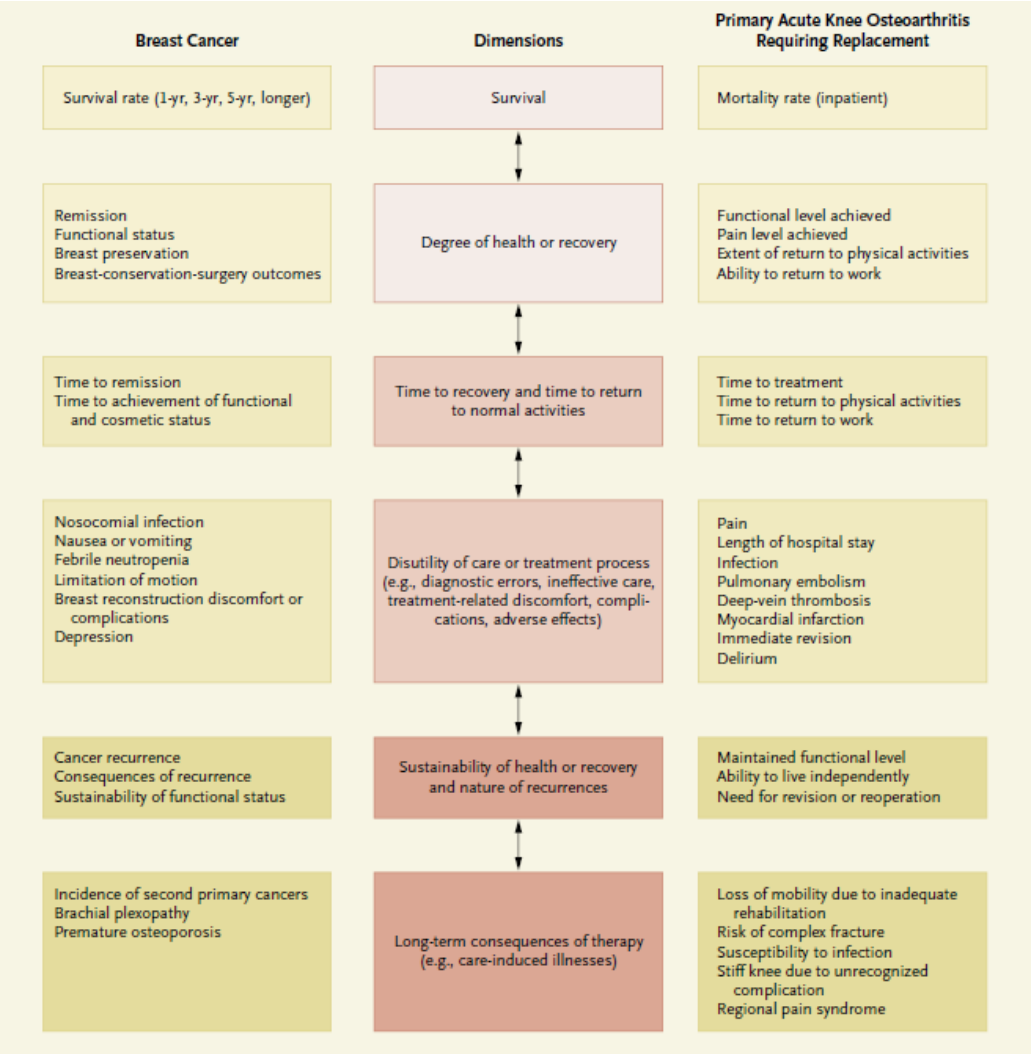
condition. Competition should take place over the full cycle of care; not just single interventions. For example, a low-cost surgery is no bargain if it results in avoidable complications or long-term reoccurrence of the condition (Porter and Teisberg 2006, p.105-106). Porter also states that at least a regional or (inter)national level is needed to find best practices, learn from each other and for patients to choose the best health care delivery chain for their medical conditions. This is the only way to overcome the 'local bias' in health care, that "*grows out of a time when medicine was more about comfort than cure (…), and matching patients to doctors was largely a matter of interpersonal chemistry"* (Porter and Teisberg 2006, p.120).

Second, Porter mentions the importance of the availability of information about health care results in order to support value-based competition. The decisions of referrers, purchasers, providers, patients, etc. could be an important driving force in the improvement of health care, as long as their decisions are based on objective knowledge of results of care over the full care cycle. Therefore, the gathering and dissemination of good data is important. Porter distinguishes (with increasing importance) four hierarchical levels of data that are needed: most basic are data about *patient attributes* (such as age, gender, social economic status, etc), then comes data about *methods* (processes of care), *experience* of providers in addressing medical conditions, and –most important– the *results* at the medical condition level. (Porter and Teisberg 2006, p.123).

Third, and most important of all, competition in health care should be based on results, or to be more specific: competition must be value-based. Porter conceives of value as *"the quality of patient outcomes relative to the dollars expended"* (Porter and Teisberg 2006, p. 98). These outcomes, Porter explains, are multidimensional, and far more complex than whether the patient survives. Recovery time, quality of life (e.g., independence, pain, range of movement), and emotional well-being during the process of care all matter. The relative importance of different outcomes vary for diseases, individuals, and patient groups. In 2010 Porter dedicated a complete article to the question: "What is value in health care?" (Porter 2010). Here, he defines value as an equation with (condition-specific and multidimensional) outcomes as a numerator and (total) costs (over the full cycle of care) as its denominator. Thus, Porter concludes: *"since value is defined as outcomes relatives to costs, it encompasses efficiency"* (Porter 2010, p.2477). Apart from the challenge of adequately measuring costs, Porter stresses the importance of accurately measuring patients outcomes. When determining the outcomes that should be measured, three important principles have to be followed: outcomes should encompass health statuses that are relevant for patients. Besides, outcomes should measure both short-term and longer-term health. Finally, outcome measurement should be adjusted for risk factors or initial conditions. (Porter 2010, p. 2479). According to Porter the outcomes for any medical condition can be hierarchally ordered in a scheme with three layers or tiers (see Figure 4). The top tier is the most important and the lower-tier

contains outcomes that are realized later, and depend on the success in the upper tiers. Each tier consists of two levels, of outcome dimensions. Each dimension is measured, using one or two indicators. There are of course diseases (think of metastatic cancers) where providers have a only a limited impact on survival or other outcomes in the first tier. Here they can show good outcomes by for example timely care, reduction of anxiety, etc. (Porter 2010, p. 2479-80).

Figure 4: Three tiers of outcome measures (Porter 2010, p.2480)



Tier 1 is the health status that is achieved or, for patients with some degenerative conditions, retained. The **first level**, survival, is of overriding importance to most patients and can be measured over various periods appropriate to the medical condition; for cancer, 1-year and 5-year survival are common metrics. Maximizing the duration of survival may not be the most important outcome, however, especially for older patients who may weight other outcomes more heavily. **The second level in Tier 1** is the degree of health or recovery achieved or retained at the peak or steady state, which normally includes dimensions such as freedom from disease and relevant aspects of functional status.

Tier 2 outcomes are related to the recovery process. **The first level** is the time required to achieve recovery and return to normal or best attainable function, which can be divided into the time needed to complete various phases of care. Cycle time is a critical outcome for patients — not a secondary process measure, as some believe. Delays in diagnosis or formulation of treatment plans can cause unnecessary anxiety. Reducing the cycle time (e.g., time to reperfusion after myocardial infarction) can improve functionality and reduce complications. **The second level in Tier 2** is the disutility of the care or treatment process in terms of discomfort, retreatment, short-term complications, and errors and their consequences.

Tier 3 is the sustainability of health. The **first level** is the recurrences of the original disease or longer-term complications. **The second level** captures new health problems created as a consequence of treatment. When recurrences or new illnesses occur, all outcomes must be remeasured.

3. Rethinking 'competition' in health care

As we saw, Porter introduces the mechanism of competition as a more or less self-evident solution to the problems in health care. It must be said that intuitively competition has great appeal. Competition delivers greater productivity in the rest of the economy hence, more welfare. Maximizing welfare is, at least in a utilitarian framework of economics, the first and ultimate merit of competition. Second, choice is generally highly valued by consumers. Not only in an instrumental way, (to achieve more welfare by freedom of choice), but also intrinsically. This intrinsic value of choice might either be justified from a libertarian viewpoint (free choice is a crucial element of individual freedom or liberty, and therefore, freedom is good in itself), or based in the (Kantian) principle of autonomy (freedom for all persons to form and realize their own 'picture of life') (Le Grand 2011, p.82-83). Extending competition to the health care sector seems a logical way of dealing with the problems that Porter strikingly addressed (Chapter 2). Competition between suppliers will encourage efficiency and raise quality, whereas increasing choice will meet consumer demands for a more personalized service and, in cases where there is cost sharing, make consumers more responsive to quality and price differences (Propper 2012).

This line of reasoning (which –as we saw– is also Porter's line of reasoning) however, derives from a purely economic approach, which is actually of limited significance from an ethical point of view. In the context of this thesis I am therefore much more interested in the question: *can 'competition' as a mechanism be ethically justifiably introduced in health care?* In order to answer this question, I will first show that 'competition' is only one model for the delivery of public services. I will use Julien le Grands work about the politics of the provision of public services to show the altnernatives (Le Grand 2007). Then, I will take a closer look at some disadvantages Porter's conception of competition has. At the same time, I will also look at some advantages the alternatives may have, as offered by Le Grand. I will do so by first looking at the impact of competition on the 'demand side' (does the mechanism of competition guarantee that patients' true needs are met in a better way?), and second on the supply side of the market (how does the mechanism of competition influence professional ethics and the providers' intrinsic motivation?)[6].

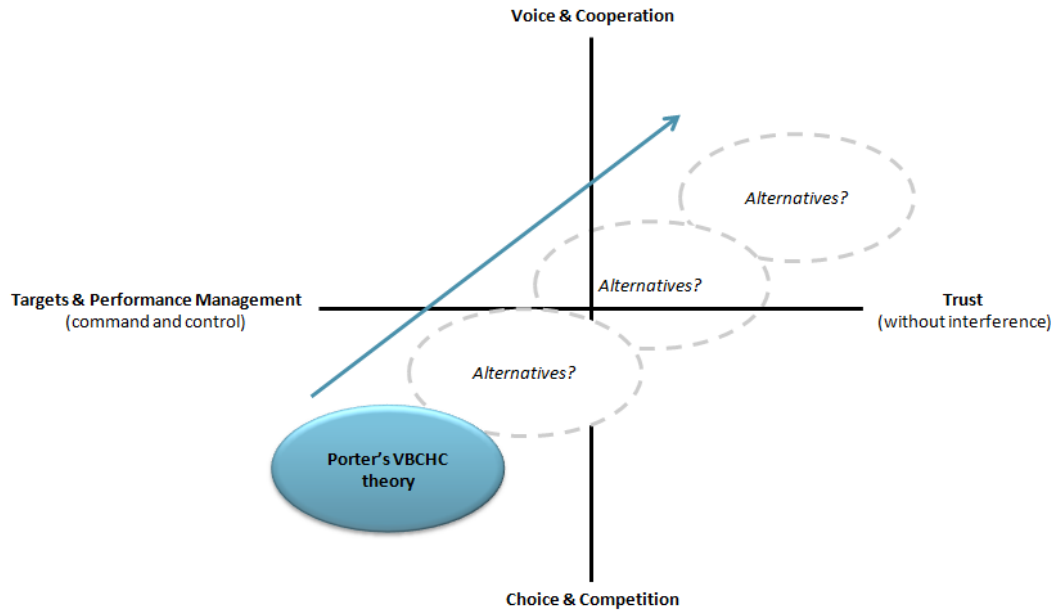
3.1. Four basic models for the delivery of public services

Le Grand (2007) distinguishes four basic models for the delivery of public services, such as health care: the *trust-model*, and (the opposite of trust) the *targets and performance management model*

[6] I base approach partly on Le Grand (2007), who also discusses both providers' and users' attitudes toward competition; and partly on an accepted definition of "market": "*the market is the economic mechanism that fulfills the demand of consumers by exchanging private goods and services with providers who are in mutual competition and who are profit-driven*". Claassen (2006, p.7) discerns three elements in this definition: consumers' *demands*, the character of the *supply* and the *exchange of goods and services* (the latter, I will discuss in the next paragraph). Claassen, R. (2006). Markt en Zorg. Filosofische grensverkenningen. Rijswijk, Leeuwendaal.

on the one hand, and the *voice model* versus the *choice and competition model* at the other hand. Le Grand presents these models as four different ways of delivering public services. In my view they also represent different views on dealing with the question "what drives good results of these public services and what helps improvement when results are bad?" The voice model and the choice and competition model deal with the question: "what should providers do (compete or cooperate) and what should patients do if they experience bad results?" Thus, the focus here is on the relation between providers and their clients or patients. The other two (trust model and targets and performance management model) deal with the question "what is the preferable relation between health authorities and management with professionals?" In my view, the models can be put on the extremities of two axes, leading to a system of coordinates in which I would put Porter's theory in the third quadrant (figure 5). The reason for this position is that VBCHC is characterised by the combination of choice and competition (we saw this in chapter 2 and in the introduction of the current chapter) on the one hand, and that competition is based on results that are continuously measured (using performance indicators), compared, publicly disclosed and steered on (Porter and Teisberg 2006, p. 101-104) on the other hand:

Figure 5: Voice, Cooperation and Trust versus Choice, Competition and Targets- and Performance Management. Derived from Le Grand (2007).



What relation between authorities and management towards professionals should be preferred? In the *trust model*, professionals (doctors, nurses and others) are simply trusted to know what is best for their users, and to deliver high-quality services without interference from government or any other source. Proponents of this model believe in the prevalence and the desirability of 'knightly' motivations, or what may be termed, more loosely, the public service ethos. This is the belief that

those who work in the public sector are 'knights' or something close to perfect altruists: to have as their principal concern the welfare of those whom they are supposed to be serving, and not to be motivated to any significant extent by their own personal concerns, as their linguistic counterparts, the 'knaves' would be. In such a world, professionals can be trusted to get on with the job. They do not have to be told what to do, or incentivised in other ways to provide a good service (Le Grand 2007, p. 209). However, opponents of the trust model believe (and I think they rightly do so) that on occasion, even knightly professionals can get it wrong. That some knights may even in reality be knaves[7], and that users might not always be satisfied with the service that they get.

Hence, Le Grand suggests a second model: the *targets and performance management* model. This is the opposite of trust; a version of command and control where central management sets targets for providers, rewards them if they succeed in meeting those targets and penalizes them if they fail (Le Grand 2007, p. 208). Proponents of the trust model do not like the distortions that targets create; and they dislike the authoritarianism implicit in performance management. This is not only because it demoralizes the knights, but they believe that the provision of incentives could even be counterproductive: treating knightly public servants like knaves might turn them into knaves (Le Grand 2007, p. 209). I will elaborate on these arguments in the next section.

What drives good results of public services and what helps improvement when results are bad? In the *voice model* users express their dissatisfaction (or satisfaction) directly to providers through complaints to higher managers or elected representatives. Those who prefer this model, mainly do so because they believe in the fundamental knightliness of public-service providers: all that doctors, nurses and teachers have to do is to be told that something is not quite right and they will willingly correct that. Others however claim that the voice model can seriously violate fundamental social democratic principles of social justice or equity (Hirschman 1970, Le Grand 2011). Besides, they claim, voice has always to be coupled with other models. Voice without choice, for example, or without command and control, is relatively powerless, for voice on its own can (depending on the democratic state of a society) always be ignored.

In the *choice and competition model*, users choose between services offered by competing providers. Proponents prefer this model mainly because they have different believes about the motivation of those who work in the public sector: they do not believe them to be perfect knights, but rather knaves; egoists, primarily focused on their own interests. They believe in the ethos of the market, that is reigned by the 'invisible hand' (Smith 1909).

[7] There is a whole body of literature about the question why (even good) people sometimes do bad things (see for example, Kaptein, M. 2011. *Waarom goede mensen soms de verkeerde dingen doen. 52 bespiegelingen over ethiek op het werk*. Amsterdam/Antwerpen, Uitg. Business Contact). I will not elaborate on this in this thesis.

What we learn from Le Grand's models is that Porter's VBCHC theory, which is a combination of the choice and competition model with the targets and performance management model, is only one possible combination of models, for the provision and distribution of public goods. In the next section I will look at some of the possible disadvantages of Porter's combination, and see what advantages the alternative (voice and trust) may bring. I will first look at the 'demand-side' of the market, and then at the 'supply side'.

3.1. How competition affects the demand side

How does Porter's conception of competition affect the demand side of the market? Given the limited space in this thesis I will have to limit myself to mentioning only two considerations on the demand side. Given my choice for using Le Grand's models, I will first look at the opposite of 'choice', which is 'voice'. The other consideration is about the phenomenon of supplier induced demand[8].

Porter extensively describes the implications of VBCHC for 'consumers', both as subscribers and as patients: *"In value-based competition, patients and their families, freed from health plan restrictions and empowered with better information, would accept more responsibility for their health care choices (…)"* (Porter and Teisberg 2006, p.295). According to Porter, patients have to gather relevant information and actively seek advice, in order to make better, and more informed choices. They have to choose excellent providers, not the closest one, or the past provider of unrelated care: *"These choices have to based on excellent results, not on convenience or amenities. The closest provider is not necessarily the best provider"* (Porter and Teisberg 2006, p. 301). This is an important characteristic of VBCHC: 'vote with your feet'. The question is however whether this is the favorable way of creating a high-quality, sustainable health care system. I therefore take a look at the alterative: the voice (and cooperation) model that Le Grand puts opposite to the choice and competition model.

In Le Grand's *voice model* users express their dissatisfaction (or satisfaction) directly to providers, for example by writing letters, having conversations or via patient councils within institutions. Compared with exit or choice, voice has the advantage of offering information about why people are not satisfied (van de Bovenkamp, Vollaard et al. 2013). Some have claimed that the voice model does not deliver equity because not everyone has the same possibilities and capabilities to raise their voice, especially if there is the opportunity of going privately: "*If better-off patients do not like the prospect of being transferred to their local hospital, then they have the articulateness and*

[8] Of course, other considerations on the 'demand-side' can be made, but I had to leave them out of this thesis, due to limited space. I think for example about Norman Daniels' claim that the introduction of competition in health care is not simply neutral with regard to equity in the financing, and in the access to services and regarding social solidarity in health care. He claims that -on the contrary- it is likely to have substantial and inequitable distributional effects. Rosenthal, M. and N. Daniels (2006). "Beyond competition: the normative implications of consumer-driven health plans." J Health Polit Policy Law **31**(3): 671-685.

confidence to persuade the GP to send them to another hospital which they perceive as of higher quality"(Le Grand 2007, p.209, Le Grand 2011, p.85). Collective voice and choice may provide a partial solution to this problem of inequality (van de Bovenkamp, Vollaard et al. 2013, p.62). Besides, in my view the problem of 'going private' is more an objection to 'exit' than to 'voice'. I would therefore agree with those who claim that voice is not only a solution for possible inequity, but that voice also (and this is a second, probably even more important element) is associated more with awareness and responsibility for maintaining shared public goods: *"while exit alone may undermine general solidarity, particularly when middle classes would escape the public system, voice would be a necessary corrective, calling on people as citizens to defend the public good"* (Morone 2000, van de Bovenkamp, Vollaard et al. 2013, p.61)

Regarding the latter, it was Elisabeth Anderson who claimed that there are goods or services where competition or other forms of marketisation will have negative, or even degrading effects (Anderson 1990). These goods or services have intrinsic values, that are called '*shared values'.* Shared values differ from values of markets and competition in that their being good consists in the fact that they are understood to be held in common – that everyone in the group both acknowledges the thing to be good and participates in its benefits. Shared values' value for oneself is dependent on other people also enjoying them. Such values cannot be realized in private acts of use, but rather reside in a shared public understanding of the meanings of the goods. "*For example, certain sites of historical events may be valued as parts of a national heritage or the layout of a neighborhood valued as the locus of a particular community"* (Anderson 1990, p.181). Common enjoyment of the good also encompasses a common responsibility for the improvement of the good, if some members of the group experience problems or dissatisfaction in the use of the good. This sharply contrasts with values of competition and of the market. Dissatisfaction within a market relation is expressed primarily by "exit", not "voice". That is, one simply drops out of the market relationship rather than sticking with it and trying to reform it from within (Anderson 1990, p.183-4). As we saw VBCHC puts all its effort in the paradigm of "choice" and "exit", instead of voice. Based on equity arguments and on the intrinsic value of shared goods, which I believe, are also applicable to large parts of our health care system[9], I would plea for at least adding the mechanism of voice to the model of choice and exit

[9] I do not only *believe* this, it is also a *observable,* and also described trend that (groups within) society nowadays becomes more responsible again for organizing, maintaining and improving caring activities. This phenomenon is part of a developmental cycle that already started in the 4th century, when the clergy in the monasteries took over health care functions from civil society. It was not until the 16th century that this was partially changed again and that local communities and government became (also) responsible in the field of care for the poor and the ill. Later the role of the communities was handed over again, but now to privately and collectively financed institutions (the period of the Dutch 'verzorgingsstaat'). Patients now became anonymous 'users' or 'clients'. Nowadays, this is rapidly changing again under the influence of the 'societization' of especially supportive caring activities (In the Netherlands, for example, for most of these activities, people and their networks become responsible again themselves, due to the Societal Support Law –WMO–). This results into a renewed closer linkage and perceived responsibility between society, neighborhoods, etc. and the caring

in VBCHC. A combination of exit and voice opportunities is necessary to reach the goals of quality improvement and democratic empowerment of citizens (Hirschman 1970, van de Bovenkamp, Vollaard et al. 2013).

3.2. How competition affects the supply side

In terms of Le Grand (2007), VBCHC uses the 'targets and performance management model in order to realize health care that adds value for patients. A lot can be said about this from a management point of view (Weggeman and Hoedemakers 2014), but given the focus of this thesis, I only discuss one *ethical* consideration here[10], which is about the tension between performance management and trust, and the way this may influence professionals, their professionalism and their intrinsic motivation.

We have to acknowledge that, during the last decade, health care is subject to *"greater standardization, measurement, auditing and bureaucracy, tighter organizational control over work, and an emphasis on the entrepreneurial identities of both professionals and their organizations"* (Brandsen, Dekker et al. 2010, p.83-98). Looking at how Porter's VBCH prescribes the measurement of results, experience, methods and patient attributes, using performance indicators, registries, and so on, we must come to the conclusion that VBCHC further contributes to this development. All of these changes have affected the work of professionals. This is reflected in the literature, in two ways (Tonkens, Broer et al. 2013, p.2).

First, scholars debate whether –as a consequence of increasing control– professional values are indeed on the decline (Freidson 2001, Evetts 2011). It was already in the mid eighties that some referred to the 'proletarianization of physicians' (McKinlay and Arches 1985). Since then, numerous empirical studies have found that professional values are influenced by this increase in control. Some have stressed the risk that performance management comes into fundamental conflict with the idea of professional autonomy and personalization of care (Smith 2015). There has been provided evidence on declining professional autonomy and dominance (Harrison and Ahmad 2000), while others have shown conflicts between the professional logic and the logics of the market and bureaucracy (Mol 2008). It is Edmund Pellegrino who has extensively analyzed the moral consequences of what he calls 'a paradigm shift from a professional to a market ethic' (Pellegrino 1999, p.246). According to Pellegrino the consequences of competition and marketisation are ethically unsustainable and deleterious of to patients, physicians and society. He identifies that the actual decision making at the bedside is negatively affected and that the relation between doctor and

facilities that they (mutually) organise. Boer, T. A. and A. S. Groenewoud (2012). Vroegchristelijke denkers en hedendaagse morele zorgdilemma's. Den Haag, ZonMw , p.26

[10] Again: more than only one ethical consideration can be made regarding the center-stage position of the targets and performance management in Porter's VBCHC theory. I think for example of the role of financial incentives (pay for performance), that has been extensively discussed by, for example, Anderson (1990) and Sandel (1998, 2013).

patient is under pressure of becoming a commercial relation, causing conflicts of interest and challenges to the personal integrity of doctors. They feel incentivized to see patients as profit- or loss centers, and to see the doctor-patient relationship as subordinate to results. Physicians do not see patients as "theirs" anymore; where they used to feel a continuing responsibility for a given patient's welfare. As a matter of fact, Pellegrino claims that professional ethics are replaced with business ethics, with emphasis on worth creation. Though he does not doubt the validity of business ethics, he does challenge the idea that it would be appropriate for health and medical care:

"When humans are at their most vulnerable and exploitable, they need much more secure protection than a business ethics can afford. Buying an automobile, for example, is a tricky business, to be sure. Much faith must be placed in the manufacturer and the salesperson (a slender reed, indeed). One hopes for an ethical dealer. But the vulnerability of the auto purchaser pales to insignificance when compared to entering an emergency room with a pain in the chest or a fractured skull" (Pellegrino 1999, p.254).

A second line of inquiry into the effects of competition on professional ethics and behavior, has studied how professionalism adapts to organizational change. These show mixed or hybrid forms of professionalism, describing the way professionals adept, negotiate, co-optate or resist the introduction of competition and market-elements in their day-to-day work. (Noordegraaf 2007, Numerato, Salvatore et al. 2012). In a recent study different strategies were identified of how professionals cope with the introduction of market elements into health care. Two of them are not very surprising: the 'entrepreneurial way', that embraces commodification as part of the job; and the 'activist way', that tries to fight the influence of the market. The other three 'ways of professionalism' however, were not foreseen: 'bureaucratic professionalism', that focuses on procedures; 'pretending' (saying yes and doing no) in order to protect autonomy; and 'performing', doing the best they can to convince patients and others of good performance (Tonkens, Broer et al. 2013, p.17). Besides, several tensions were found. First of all, the introduction of the market into health care is meant to guarantee quality of care. However, research shows examples of professionals who underperform as a direct consequence of financial pressure. Also, examples of misdiagnosis, fraud, and 'gaming the numbers' were found. This has of course negative consequences for transparency. All in all, the introduction of the market into health care increases leads to differences in professional attitudes and increases the risk of mismatch between patients' needs and professionals' supply (Tonkens, Broer et al. 2013, p.18).

So far, I have focused on how the introduction of the target and performance management model in health care has affected professionalism and the relation between professionals and patients. Opposite to the target and performance model, Le Grand (2007) places the trust model. This immediately raises the question whether the trust model would form a better alternative for health care. I believe this is however not the right question. Of course we have to deal with the problems caused by the targets and performance management model, but jumping immediately to the opposite may not be a wise thing to do. Baroness Onora O'Neill, a philosopher who has reflected a lot on the principle of trust, warns for what she calls unintelligent conceptions of both trust and accountability:

"Trust has been widely criticised and rejected on the assumption that it is intrinsically immature, if not blind: a form of deference that could make sense only on the simplistic assumption that others have goodwill towards us. It is not, I think, surprising that if we start with an intrinsically unintelligent conception of trust we can find good reasons to reject it. Unfortunately, the most widely recommended successor to this unintelligent conception of trust has been an equally unintelligent conception of accountability, (…)" (O'Neill 2004, p.271).

It must be admitted that O'Neill, as well, criticizes the target and performance management model. What she criticizes is that it is a deliberately unintelligent form of accountability. Rather than relying directly on reports based on knowledgeable inspection of what is actually done, the audit culture looks at simplified, derivative information, such as numerical performance indicators that can be compiled in standardized protocols (often literally by ticking boxes) and aggregated into league tables, thus ostensibly avoiding reliance on experts or professionals. Supposedly, this simplified information is objective, yet the indicators used are often not a particularly accurate representation of the complex performances they (supposedly) indirectly measure or represent (O'Neill 2004, p.270). What, according to O'Neill, should be the question of our concern, is how we can support well-judged trust that enables people to gain enough evidence – never, and necessarily never, total evidence – to judge whether to place or refuse trust (O'Neill 2004, p.271). According to O'Neill, our aim should not be to have more trust instead of accountability, but real intelligent accountability should help us to better, and in a more differentiated way 'trust the trustworthy' (O'Neill 2013). Trustworthy are those who have shown to be competent, honest and reliable. For the target and performance management model, this means two things. First, it should not be *the* dominant paradigm, as it is in VBCHC, but it may be used in order to support trust in the trustworthy. Second,

for judging the competence, honesty[11] and reliability of health care providers objective, independent judgment by means of performance indicators cannot be not the only way of determining trustworthiness. We will also have to include professional expertise:

"If we want serious and intelligent accountability, we cannot turn our backs on professionalism and expertise and settle for simplified 'box-ticking'. Equally, we cannot settle for cosy, unmonitored professionalism in which conflicts of interest persist unchallenged and professional solidarities swamp the needs of public service and patient care. We need do neither: we can support and maintain robust ways of monitoring standards, investigating failure, disciplining the slipshod and removing the incompetent" (O'Neill 2004, p.272).

What we have learned thus far, is that the target and performance management element in VBCHC may negatively influence professionals, their professionalism and their intrinsic motivation, especially when accountability and performance management starts replacing trust. This does not mean however, that targets and performance management can never be morally justifiably applied in health care. Intelligent and responsible use of targets and performance management would be ethically defendible if it helps to identify and trust the trustworthy in a better way. Therefore, in terms of the model based on Le Grand (figure 5), I would say that we need intelligent elements of both targets and performance management and trust, However, the focus should shift to trust, or better stated: 'trust in the trustworthy'. Targets and performance management in VBCHC should be used more instrumentally to identify these trustworthy, instead of a default paradigm. Now that we have discussed the ethical considerations regarding 'competition' in VBCHC, including possible altnerative mechanisms, the question is how Porter conceives of 'value' in VBCHC, and whether this conception is morally defensible in health care. I will reflect on this in Chapter 4.

[11] It is especially the 'honesty' of (medical) professionals that is hard to measure. Where results have more to do with the utilitarianism and technical skills with deontology, 'honesty' is a virtue. This is exactly why many professionals experience feedback based on indicators as unjust mistrust, or even as undermined integrity. Recently, the Journal of the Ductch Society of Medicine published the story of Chantal van der Zandt, a general practitioner who felt accused of fraud, and distrusted by the local insurance company, who charged her for conspicuous claiming behavior (Medisch Contact, 2015, 12 februari 2015, p. 288-290).

4. Rethinking 'value' in health care

As we saw in chapter 2, Porter conceives of 'value' in his VBCHC concept, as *"the quality of patient outcomes relative to the dollars expended"* (Porter and Teisberg 2006, p.98). He defines 'outcome' as the health status achieved or retained (achieved recovery or survival) through a good recovery process (timely and without complications), and with sustainable, long term results (no recurrence and minimal loss of functionalities) (Porter 2010, p. 2479-80). Besides, he concludes: *"since value is defined as outcomes relative to costs, it encompasses efficiency"* (Porter 2010, p2477). Philosophically seen however, this economic focus is only one of the ways one may conceive of 'value', and –especially in health care– it might not be the most obvious one to choose. In this chapter I will first look at what philosophy, and more specific 'value theory' teaches us about the possible (other) conceptions of value (4.1), raising some concerns regarding VBCHC. Then I will take a closer look at Value Based Medicine (VBM), which is another, but different value-driven approach in health care (4.2). Probably VBM offers a solution for the concerns regarding VBCH. Third, because both VBCHC and VBM still conceive of health care as an instrumental activity (in order to achieve better health), we will also look how care ethics' intrinsic value conception might add to this (4.3).

4.1. Value Theory

How is the concept of value studied in philosophy and into what conceptions of value does this result? This is the field of 'value theory'. The term value theory is used in three or more different ways in philosophy. The broadest conception of value in , 'value theory' is a concept used to cover all parts of moral philosophy, social and political philosophy, aesthetics, feminist philosophy and the philosophy of religion . Thus, it encompasses all areas of philosophy that have some 'evaluative' aspect (Schroeder 2012, p.1). In this sense, 'value' is not self-evidently 'moral value', but could refer to economic value as well. In its narrowest sense, 'value theory' is used for a relatively narrow area of normative ethical theory, particularly of concern to consequentialists. In this narrow sense, 'value theory' is roughly synonymous with 'axiology'. *"Axiology can be thought of as primarily concerned with classifying what things are good, and how good they are*" (Schroeder 2012, p1). In a third sense, value theory designates the area of moral philosophy that is concerned with theoretical questions about value and goodness of all varieties – the theory of value. Then, value theory encompasses axiology, but also includes many other questions about the nature of value and its relation to other moral categories (such as deontology, or virtues besides consequences) (Schroeder 2012, p.1). Traditional axiology seeks to investigate what things are good, how good they are, and how their goodness is related to one another. In other words: *"what stuffs are good: what is of value?"* (Schroeder 2012, p.12).

One of the central questions philosophers in the field of axiology have always been interested in is whether there is more than one fundamental value or not. This is also known as the monism / pluralism debate (Schroeder 2012, p.14). Monists answer "no", and pluralists answer "yes" to this question. Consequentialists will always have a monistic point of view because they have to weigh several outcomes of possible actions and decide which option adds most happiness for the most. It is known, for example, that as important as he held the value of knowledge to be, John Stuart Mill was committed to holding that its value is instrumental, not intrinsic (see next paragraph for this distinction). Mill thought that knowledge is only of value if it contributes to the ultimate value: happiness (Schroeder 2012, p.14). At first sight, Porter seems to be a pluralist, in the sense that different outcomes seem to be equally valuable at the same time: *"For any condition or population, multiple outcomes collectively define success. The complexity of medicine means that competing outcomes (e.g., nearterm safety versus long-term functionality) must often be weighed against each other"* (Porter 2010, p.2479). However, I think we have good reasons to claim that Porter holds a monistic viewpoint. First, he reduces the concept of 'value' to 'efficiency', and defines the ultimate value through the equation 'outcomes divided by costs' (Porter 2010, p.2477). Second, in the 'weighing' of competing outcomes, there are certain outcomes that are more important than others, or even of ultimate importance: *"Outcomes should (…) cover both near-term and longer-term health, addressing a period long enough to encompass the ultimate results of care"* (Porter 2010, p. 2479). Thus, Porter suggests that there are certain 'ultimate results of care', that should be measured in order to identify the value that health care added. The third reason why I think Porter can be called a 'monist', is that he distinguishes several 'tiers' of outcomes, that are hierarchically ordered, and *"in which the top tier is generally the most important and lower-tier outcomes involve a progression of results contingent on success at the higher tiers"* (Porter 2010, 2479).

Why is it so important to understand whether Porter's VBCHC theory holds a monistic or pluralistic viewpoint toward value? It is important because if value can only be added if certain specified 'ultimate outcomes' are achieved, then these outcomes are the same for all patients with a certain medical condition, and medical decision making becomes a highly standardized 'job'. And it really seems that Porter favors such an approach when he says: "*Results also must be the ultimate basis on which drugs, medical devices, other technologies, and services are selected"* (Porter and Teisberg 2006, p.102). The danger of such an approach may be that Evidence Based decision making on results becomes the dominant paradigm and that patients' personal (possibly deviant) values are neglected. This would at first sight result into 'value based health care', but in individual cases no true value may be added at all. In the next section (4.2) I will discuss how a pluralistic approach such as VBM might overcome this problem.

A second question philosophers in the field of axiology study, is: are things only of *instrumental value* (because they help you to attain 'higher' goals) or are there also things that are of *intrinsic value*? Why is this question also important in the evaluation of Porter's VBCHC theory? It is important because if health care is only, or primarily of instrumental value (to achieve better health), it makes perfectly sense to focus only, or especially on the outcomes, as Porter does. If on the other hand the caring activity has value in itself, then focusing only on outcomes related to costs, may be a too reductionist conception of value. Though Porter does not explicitly mention whether he thinks health care is only of instrumental value or also of intrinsic value, we have reasons to believe he only values health care in an instrumental way. This is shown best by the sections in his book where he explains why competition should be based on results and on results only: *"The real proof of success is better patient results (…). Results, it must be stressed, mean actual health value for patients"* (Porter and Teisberg 2006, p.102). Thus, according to Porter, health care is only of value if it results into better health outcomes, relative to costs. At first sight, such an instrumental approach makes perfectly sense. However, it does not take into account that there may also be intrinsic values in the activity of caring or the receiving of care that do not come to an expression in measurable (clinical) outcomes. Moreover, trying to reduce these values to measurable indicators, may have a degrading effect on the caring activity itself. I will come back to this in 4.3. when I discuss the intrinsic value of the giving relation and we will also see how care ethics might be of additional value for VBCHC.

4.2. Value Based Medicine (VBM) and its pluralistic conception of value

We saw that one of the problems of VBCHC is that it conceives of value in a monistic way. Of course, Porter admits that outcomes may differ for patients with different medical conditions, but within such a medical condition, the relevant outcomes are highly standardized. Medical decisions at the micro level (treatment decisions), meso level (value based purchasing) and macro level (deciding on coverage schemes) are then made on the basis of previously defined values that are assumed to be the same for each and every person with that medical condition. I would however prefer a conception of value that is highly sensitive of patients' very personal values. Let me present a case that shows this problem remarkably well:

"Diane Abbot, a 64-year old artist and art historian, was referred by her GP (family doctor) to a psychiatrist, Dr Kirk. She had a history of occasional but increasingly disruptive episodes of hypomania. One of her academic colleagues had been successfully treated for a similar condition with lithium. Combined with Dr Kirk's individual expertise, and Diane Abbot's understanding of her colleagues' experience, the resources of EBM allowed everyone concerned to be satisfied that her eventual decision to start on lithium was securely evidence-based. Values only implicitly played a role,

and the decision was mainly based on respectively clinical effectiveness, cost, and potential adverse side-effects. Yet, after a few weeks, that decision, turned out to have been wrong. That is, as judged by her values as an artist. She explained that although she had had no 'real' problem with the lithium, and that although her mood had indeed been more stable, she could no longer "see colours". No, she did not mean colour blind! But colours had lost their emotional intensity, which, for her as an artist, was a disaster. Had her need to be able to 'really see' colours been more apparent at the time, then the evidence of lithium's 'emotional blunting' effects would probably have been discussed at that stage. Diane Abbot might still have decided to start on lithium but with her eyes open to the possibility of this side effect and with her GP, also aware that this was a concern (Fulford 2008, p.2-3).

In terms of VBCHC, Porter would initially have measured good outcomes (her mood had been more stable thanks to the lithium), relative to the costs (this treatment has proven to be cost-effective in several studies (Soares-Weiser, Bravo Vergel et al. 2007)). But this would leave Diane's loss of capacities as an artist unnoticed. One may protest that a VBCHC approach would also have measured the adverse effects that –after a few weeks- appeared to exist. However, besides this is a contestable claim (it is not a clinical adverse outcome, but more a functional, long term effect, which is only in the lower tiers of Porter's value-measures-model), it is also obvious that these adverse outcomes could have been prevented if –from the beginning– Dr. Kirk would have given proper attention to Dianes values in life.

A normative value theory in health care, that does take into account patients' personal and individual values in life is "Value Based Medicine" (VBM). This theory, that was developed early 2000 by Bill Fulford, a professor of philosophy and mental health at the university of Warwick, is *"the theory and practice of effective healthcare decision-making for situations in which legitimately different (and hence potentially conflicting) value perspectives are in play"* (Fulford 2008, p.1). An important similarity between VBCHC and VBM is that they both strive for good outcomes (Fulford 2008, p.6). In this sense, also VBM perceives health care purely instrumentally, and not as a possible value in itself (I will come back to this in the next section). However, there are some important differences between VBCHC and VBM.

The first difference is that besides good *outcomes*, VBM also emphasizes the importance of good *processes* in the form of improved clinical practice skills (Fulford 2008, p.6). Whereas the VBHC, leaning on evidence based results, describe the rules and regulation; "*what should be done*", forms VBM a framework for practice; a set of skills, supporting the "*how it should be done*" (Fulford 2008, p.6). Where VBCHC is rather outcome-focused, with consensus-based rules and (professional) guidelines supporting the attainment of these desired clinical outcomes, VBM shifts the emphasis to the individual. Of course, also in VBM there is an essential place for a standardized professional

framework of practice. However, VBM is aware of the fact that with scientific and societal developments, *diversity* rather than shared values will increasingly be the norm in health care decision making. VBM in contrast to VBCHC, instead of relying primarily, or even solely on rules and regulation to prescribe outcomes, wants to be tailor made to enable effective decision making through a balance of legitimately different value principles (Fulford 2008, p. 6).

Second, where VBCHC responses to the growing complexity of decision making in healthcare by focusing on clinically proven evidence (Evidence Based Medicine (EBM)), VBM is the values-counterpart of EBM. According to VBM, health care decisions, either on the macro, meso or the micro-level should not only be based on *facts* (as in Porter's equation of clinical outcomes relative to costs), but also on patient's *values.* All decisions stand on these two feet (Fulford 2008, p.2).

Third, this value driven approach is also reflected in what I call their respective "first calls" for information. VBCHC is much more evidence based, and its first call for information is information about the (expected) clinical results relative to the costs. Decisions in VBCHC are based as much as possible on fact-based information, which is as free as possible from the particular subjective perspective of this or that individual or group. VBM's first call is, in contrast, the perspective of the particular patient concerned in a given situation (Fulford 2008, p.5).

A fourth important difference between VBCHC and VBM is that the former incentivizes professionals to strive for good outcomes relative to costs by focusing on evidence based, standardized guidelines. VBM however, links the evidence based scientific knowledge to the individual values (needs, wishes, desires and expectations) that patients have (Petrova, Dale et al. 2006, p. 703-704). These 'additional' values may be of all sorts and kinds: *personal existential values* (related to one's views about what is important in life and the kind of person one has to be); *social/cultural/ethnic/group values* (securing the structure and functioning of different societies, cultures or groups within them); *disciplinary/scientific/theoretical values* (value-laden assumptions of different disciplines, theories, models and professions), etc. (Petrova, Dale et al. 2006, p.708).

The question is of course, why VBCHC would need this extra 'value-dimension' of VBM and what happens if it is missing. First, we have already seen in the example of Mrs. Abbot that important patient-specific values may be out of sight, resulting in sub-optimal (though in terms of VBCHC still high-value) health care. However, most of the time, these deviating, personals values remain unnoticed. And, it must be admitted, in many cases this does not affect the outcome at all because there is universal agreement about the underlying basic principles (for example in acute care, there will be agreement on the value that human life is precious and that all efforts should now be taken to protect life).

However –and this would be my second argument in a plea for adding VBM's conception of value to that of VBCHC– there are many situations that are less clear cut, where often agreement lacks on how to deal with (the relative importance of) conflicting values. When in The Netherlands in 2005, following the VBCHC principles, a set of performance indicators was developed for nursing homes and homes for the elderly, the percentage of patients with pressure ulcers was one of the important indicators. Health care providers started to change their protocols, and bedridden patients had to be turned several times a day. After a while, however, there were some sad stories about terminally ill patients who were constantly turned during their last days of life, causing a lot of distress and discomfort for both patients and their spouses. This would not have happened if care would not only have been approached evidence based, but also value based. VBM would have resulted in the identification of values such as 'a dignified dying process' or 'respect for the dying person' versus values such as 'protection from preventable complications (such as pressure ulcers). This would have given patients, spouses and professionals the possibility to weigh conflicting values.

Third, in modern health care, due to the fast technological developments, this often assumed universal agreement about values is rapidly diminishing. Scientific advances have increased the range of available options, with different options accommodating different values ('science driven principle'). Society is nowadays more diverse and open to different forms of dealing with the values they think that are of importance, and health care has come to reflect this. Besides, the focus of professionals has also changed. There has been a change in paradigms: from from treatment to prevention, and from institutions to the community, from uniform institutions towards a variety in lifestyle and practices. Such changes decrease the number of shared values that can be assumed to form the basis of medical decision making (Petrova, Dale et al. 2006, p.704). Take for example new (personalized) cancer medication; their value can of course be measured by looking at their (adverse) outcomes relative to costs, but besides that, it requires a good understanding of the values that are at stake at the end of someone's life. Then it becomes clear that therapy, its effects and side-effects are only one thing, but –for example– children, spouses, the preferred place of death, unfulfilled dreams, etc. form other important elements of someone's goals to attain in life.

Based on the previous paragraphs, I would say that VBM's conception of value, and how it deals with personal values in day-to-day medical decision making, forms an important addition to the somewhat too reductionistic value conception of VBCHC. However, both VBM and VBCHC, in their quests for 'good outcomes', still take an instrumental perspective on value. In the next section I will therefore search for alternative conceptions of value in health care that also takes into account the possible intrinsic value of the caring activity.

4.3. Gift Values and Care Ethics

According to the market, functioning from an economic paradigm, the value of a thing is defined by its usefulness relative to its costs. Porter's conception of value in health care, which is the equation of (clinical) outcomes divided by costs, is also in line with this. However, there are also goods (and – certain elements of– health care may examples of these), whose value cannot fully be realized by merely *using* them. Moreover, there are certain values that are realized only if the exchange of particular goods is responsive to personal characteristics. Especially in 'transactions' where personal relationships are important, some ideals may be realized only if the provision of a good is responsive to the needs of others or reflects shared principles and not just individual matters of taste (Anderson 1990, p.184). Anderson calls these ideals 'gift values'. *Gift values* differ from commodity values[12] in that their worth is at least partially constituted by the nonmarket motives for which they are given. They are valued as tokens of love, admiration, respect, honor, and so forth, and consequently lose their value when they are provided for merely self-interested reasons. What is important about these goods as gift values is the fact that they express the giver's acknowledgment and affirmation of a certain relationship to the beneficiary, or of some characteristic she has, which is valued for its own sake (Anderson 1990, p.201).

In health care, these gift values are very important, not only within the intimate, personal relationship of patients and their spouses, but also within the relationship between professionals and patient. This as been thoroughly argumented by philosophers as Mol (Mol 2008), Van Heijst, who studied the phenomenon of 'Professional Loving Care' (PLC) (Lindemann, Verkerk et al. 2009, p.199-217), or Pellegrino, who also stresses the importance of the personal relationship in medical care (as a contrast with commodities):

"The medical relationship, in contrast, is intensely personal. Confidence and trust are crucial as is a continuing relationship, at least in general medicine if not in the subspecialties. (…) the universality, unpredictability, inevitability, and intimate nature of the assault of illness on our humanity, the impediments it generates to human flourishing, and the intimate and personal nature of healing give health care a special place among the helping professions" (Pellegrino 1999, p.249).

Though Porter at first sight seems to endorse the viewpoint that health care is anything but a commodity (Porter and Teisberg 2006, p.46), his conception of value shows differently. He commodifies health care by means of the equation 'outcomes divided by costs', which should enable purchasers, patients and referrers to compare, select and choose the care that shows best results on

[12] *"Something is a commodity, if its production, distribution, and enjoyment is properly governed by the (…) norms of the market, and if its value can be fully realized through use"* (Anderson, 1990, p.184)

this equation. However, in my view –and this is supported by Anderson's conception of 'gift goods'– certain important elements of care are not properly valued in this way. Let me give an example to show this.

Imagine two neighbor women, both having a full-time job, but also both having a terminally ill mother. These severely ill women are in a desperate need for 24/7h palliative care. Neighbor woman "A" calls the local home care organization and succeeds in arranging a professional caregiver who takes care of her mother during the last days or weeks of life. Neighbor woman "B" decides to give up her job in order to be with her mother and to take care of her during the last period of her life. If we would use Michael Porter's definition of value, and also his 'three tiers of outcome measures', we would probably measure no difference between the value that is added in situation "A" versus situation "B". We may suppose we would measure equal pain levels, functional satuses, and satisfaction with care. Maybe the professional caregiver would even succeed in better outcomes. Apart from the fact that Porter would probably not include the societal (opportunity) costst of daughter "B" losing her economic productivity and as a result of that, her income, we all feel something else is missing here. We would look for a way to express our appreciation or respect for the fact that daughter "B" puts everything aside in order to be with her mother and to take care of her. To express the special character of "caring situation B". And this is exactly the element of 'value' that VBCHC does not measure. In "gift values" it is the *relationship* between, and the *identity* of caregivers and receivers, that are relevant. But also the *altruistic character* of care, and the importance of the '*caring transactions*' themselves. This sharply contradicts with the way competitive markets function. Here, relations are impersonal ones, identities of participants in the market are unimportant, and one is free, within the limits of the law, to pursue one's personal advantage unrestrained by any considerations for the advantage of others, and the transaction is unimportant in itself (Anderson 1990, p.182, Kaveny 1999, p. 211).

But could we not try to measure for example the value of the caring relationship and how it is experienced by both caregiver and care receiver? And could we not just add this to the value conception of VBCHC, giving it a more intrinsic dimension? I think there is a fundamental problem with that, because even the attempt of measuring the intrinsic value of the giving relationship could already have a *degrading or corrupting effect* on the care that is given (Sandel 1998,p.35-38 and 94-96). Values that are embodied in a personal relationship may be undermined if they are drawn into a market or competition based mechanism, such as VBCHC:

"F*or a certain dimension of value to be realized in a good, or for the good to serve as the vehicle for the realization of our ideals, the production, distribution, and enjoyment of this good must take place within the context of certain social relations. To (…) subject its conditions of valuation to market*

forces and market norms, is to remove it from these social relations or to undermine their integrity. When the good in question is an ideal, the argument is that the social relations that most adequately embody the ideal are undermined when people adopt market norms to regulate their interactions in these relationships" (Anderson 1990, p.202).

But not only the good may be undervalued, there is also a change in the way we appreciate each other. The example about the two neighbor-daughters perfectly shows this. The 'targets-and-performance-management approach' in VBCHC is not sensitive for the special character of the caring relation between daughter and mother. However a forced attempt to value this anyway, for example by giving her a discount on her insurance premium or tax, would undermine the *fraternal relations* among people in the community, whereas a purely volunteer system enhances such relations. Financial rewards rather than appealing to a sense of civic duty or fraternity promotes the social expectation that people may feel entitled to some merely personal advantage for voluntarily doing good things. This attitude makes it seem as if small acts contributing to the health of one's neighbors should be seen merely as inconveniences requiring compensation instead of as enhancing the spirit of the entire community: "*the significance of my volunteer gift*[13] *is trivialized when other donations are paid for. If gifts become also a commodity, then all I have given to the recipient is the cash equivalent of the donation, not the gift of life itself"* (Singer 1973, p.315-316).

But is it not impossible for certain (highly specialized and expensive) forms of care to be (only) delivered in informal care settings? And can health care professionals not have 'mixed motives' by caring with love and earn money with that at the same time? I would say they surely can. And I would say that the concept of 'gift values' is not limited to the informal caring domain. As we saw in the previous paragraphs, love and personal relationships are also present in professional care settings, giving health care a special position amongst other professions (Pellegrino 1999, Lindemann, Verkerk et al. 2009). However, I would not recommend to solve the reductionist view of VBCHC on value, by trying to incorporate the value of the caring relation into a target and performance management system. What then should we do? After all, using this too narrow conception of value embodies the danger of turning the caring relationship unimportant and unvalued. And this danger is real: we saw in Chapter two that in Porter's VBCHC the relationship is (at the best) subordinate to the results of a treatment. According to Porter, a focus on (the value of) relations stem from *"(…) a time when medicine was more about comfort than cure (…) and matching patients to doctors was largely a matter of interpersonal chemistry"* (Porter and Teisberg 2006, p.120). We also saw in the previous section that VBM –though it gives a more pluralistic approach

[13] Singer refers to blood donations. I replaced the word 'blood' for its generic equivalent here: 'donation' or 'gift'.

also has a very instrumental view on health care. I therefore suggest we now take a look on the field of care ethics, because care ethics has a long tradition (not only in health care) of putting the caring relationship centre stage.

It is especially the field of *care ethics* that does pay attention to the intrinsic value of the caring relation. Care ethics has its roots in the fields of psychology and feminism, which took a flight in the early seventies of the previous century. It was a reaction to the individualistic view on humanity, in which justice is as central value. Care ethics, on the other hand, has as its central idea idea that humans are interconnected in relational networks in which they care for each other, feel responsible for each other and use communication to come to practical solutions for (moral) problems (Leget 2013, p.13). It was Joan Tronto, who – in her book Moral Boundaries – formulated a definition of 'care' that is currently dominant and widespread (Tronto 1993). She defines care as a way of acting and responding towards others, as an attitude or disposition and as an activity or practice: *"First, care implies a reaching out to something other than the self. Second, care implicitly suggests that it will lead to some type of action"* (Tronto 1993, p.102). It is "*Not just a cerebral, concern, or a character trait, but the concern of living, active humans engaged in the processes of everyday living"* (ibid. p. 104). Care ethics claim that the power of their approach lies in the fact that it opens a new perspective on reality; a perspective that makes us sensitive for people who are pressed out of sight and who might get the worst of it (Leget 2013, p.14). The practical aspect of care is evident in four stages of caring (Vorstenbosch 2012, p.44) (Tronto 1993, p.106-108): *caring about* (recognizing that care is necessary), *taking care of* (assuming some responsibility for the identified need and a response, consisting of both the physician's delivery of technical care and an empathic or emotional engagement), *care giving* (the direct action or actual physical work that is involved in the caring response), *and care-receiving* (the object of care will respond to the care it receives).

In the context of Porter's VBCHC theory, where health care quality is constantly measured, compared, and related to costs, care ethics is often viewed as an object of suspicion. It is even considered that care ethics is 'nothing new', superfluous, extremely vague and even dangerous (Verkerk, 2001, p. 289). Those who expand on the outcomes of medicine (survival, reduction of illness), often reduce care to a virtue, expressed by words as compassion, comfort, empathy, sympathy, kindness, tenderness, listening, support, and being there. Care is, however, more than just a virtue or a 'good professional's' characteristic. Virginia Held warns against seeing the virtue of compassion and caring as similar: *"(…) the caring promoted by the ethics of care is quite far from compassion. This misses the heart of what goes on in practices of caring and misses what is of most value in them, which is that they care caring relations"* (Held 2006, p.34, 35). In seeing care simply as a virtue, *"we miss a central feature of care, namely its evaluations of and recommendations*

concerning relations between persons" (ibid, p. 52). The value of the caring relation cannot only be simply measured by asking the patient for his satisfaction or experienced outcomes, as is currently often done in health care (Delnoij, Rademakers et al. 2010). Especially because this caring relation is not a one-direction activity from professional toward patient. Value is created both by care giving and by care-receiving. This care relation is a-symmetric and both sides have valuable knowledge and experiences that serves mutual understanding (Leget 2013, p. 15). So, our first conclusion regarding care ethics in relation to VBCHC is that care ethics could help VBCHC to focus on the intrinsic value of the caring relation and not only on the (clinical) outcomes.

Here, I think, Porter would raise the question why we cannot perceive of the caring relation as 'just one of the elements that form the input', whereas we should be focused on the outcomes. An important answer to this question was already given in the pargraphs above that showed that the value of 'gift relations' cannot be reduced to the use of it, or the results it delivers. On the other hand, the caring relation *does have* some benefits, that VBCHC however is not aware of, and thus will not properly value. According to Tronto (1993) care is aimed at maintaining, continuing, or repairing the world. Much of the technical side of medicine has a concrete reparative function in terms of correcting damage or imbalance. This is what VBCHC *can* measure and disclose. However, the *reparative function* of care may also be understood in a more general sense, for instance in terms of boosting the patient's courage to live. In other words: the experience of being cared for, in terms of someone seeing and recognizing the patient's need may contribute to strengthening the patient's life courage. A physician's ability to grasp the patient's agony and frailty rather than abandon it. Thus perceiving the patient's appeal for help and expressing this in terms of a caring act, may strengthen a patient's courage to encounter and live through suffering (Olthuis, Kohlen et al. 2014, p. 124-125).

Another concern of the ethic of care is the harm caused by relationships that lack care. This is not harm caused deliberately by some kind of destructive activity or by an unexpected negative event (what Porter calls 'disutility of care', and which may be measured by the registration of adverse effects and complications); rather, it is harm caused by the *absence of care,* i.e. active beneficent participation in the relationship. How we meet the other and how we take care of the other in a relationship becomes ethically significant, because by not caring, we may hurt the other (ibid, p. 122). As a consequence, an ethic of care is more concerned about the dangers of abandonment than about the dangers of interference (Verkerk 2001). On the other hand, *'co-suffering'* has proven to be helpful, especially in situations where professionals deal with patients who suffer from life threatening diseases (Olthuis, Kohlen et al. 2014, p. 122-123).

I assume that at this point Porter would ask again: "But then, tell me how to measure the caring relation and take it into account in my 'value equation'?" Here we encounter another difference between Porter's VBCHC theory and care ethics: the role of metrics, performance

indicators, and quantitative data. Where VBCHC uses the paradigm of "erklären" (seeks law-governed explanation of cause and effect), care ethics is more about "verstehen" (the interpretative understanding of the meaning of things). In behavioral sciences, verstehen and erklären are two ways to make scientifically respectable sense of a phenomenon. The scientist who engages in erklären tries to make explanatory sense of the phenomenon by finding the laws that govern it, whereas the scientist who engages in verstehen, tries to make empathetic sense of the phenomenon by looking for the perspective from which the phenomenon appears to be meaningful and appropriate (Pavitt, Steinmueller et al. 2000, p.16165-16170). Also "verstehen" distinguishes several 'layers' of a phenomenon that must be unraveled before one truly understands it it:

"The first layer is the 'objective', 'clean', and 'factual' or 'outsider'-perspective. Here, "meaning" has to with events that occur during a certain period of time and that form a logical cohesion. There are other layers, that can only be revealed and understood if studied in a qualitative way. The second layer of 'meaning' is about how a certain event is experienced. It can be seen as the 'inside-perspective'. Here 'meaning' has to do with the degree to which someone is touched in his feelings. Like someone can say: "this means so much to me". The former layer of 'meaning' can be understood even better when we add a third dimension: seeing an experience within the context of the broader story of someone's life. This has to do with a person's 'biography'. The fourth layer is the existential 'meaning'. Other authors call this the level of 'spirituality' or 'the meaning of life' (Leget 2013, p.7-8).

The difference between the paradigms of verstehen and erklären, and the multilayered character of erklären, have important consequences, not at least for the methods that can be applied in order to get a 'grip' on value (Leget 2013, p.7-8). In order to really understand the specific context, care ethics needs conceptual, ethical and qualitative empirical research. Qualitative research is needed to come to a scientific and valid interpretation and description of reality. Conceptual ethical reflection is needed to discover the implicit normativity of the empirical qualitative research. VBCHC on the other hand, uses quantitative data on outcomes, that can be related to costs and mutually compared. In terms of "verstehen" such an approach only enables you to understand the 'first layer'.

We have seen that in the caring and giving relation, there are certain values that VBCHC is not aware of and sensitive for, whereas care ethics is. Trying to measure these intrinsic values and relating them to costs can both have degrading effects and is also impossible because of the difference in paradigms between VBCHC and care ethics. I therefore suggest that both VBCHC's value conception, and its methods (indicators, clinical registries, administrative data, etc.), should be supplemented and enriched by other methods, such as interviews, observations, and shadowing in order to get a taste of the other 'layers' of value in health care.

5. Conclusion

In this thesis I studied the question: "*Is the theory of Value Based Competition in Health Care (VBCHC) ethically defendable and what principles are relevant in the possible quest for alternatives?"* I answered this question by looking at the moral defensibility of two core concepts of VBCHC: 'competition' in health care, and Porter's conception of 'value'. Regarding the first, I have shown that competition is only possible mechanism for for the distribution of health care. The element of 'choice', not only undermines solidarity, but also has a potential risk that shared values (values that are based in collective use of and responsibility for facilities) are carved out. I therefore claim that health care needs at least a combination of choice with the instrument of 'voice'. But also the other element of competition: 'targets and performance management' have some morally questionable elements. It potentially not only conflicts with professionalism and professionals' intrinsic motivation, but also negatively influences the patient-doctor relationship. I therefore suggest that targets and performance management should no longer function as the fundamental dictum of VBCHC, but that intelligent accountability should support the identification of the trustworthy, so that 'trust in the trustworthy' can become the dominant paradigm in health care.

Regarding the second element: Porter's conception of 'value', this thesis shows that Porter holds a rather reductionist conception of value. The problem with this is twofold. First, it over-standardizes outcomes for groups of patients with the same medical condition and neglects the fact that patients' personal values in life may differ. Value Based Medicine (VBM) could be an alternative approach of additional value to VBCHC, because it does take patients' personal values as a starting point. Second, VBCHC values health care only in a very instrumental way and forgets the intrinsic value of the caring relation. Here, I have shown how care ethics may help to acknowledge intrinsic 'gift values' that are present in caring relations.

These two findings will have important impact: both on day-to-day health care delivery, and also on the way we try to measure, value and improve health care quality. Regarding health care delivery, if we believe that adding real value for patients requires awareness for their personal values, then health care professionals should be focused more and more on identifying these values and involving them into medical decision making. Second, quality measurement should seek for ways to involve professionals again. This would help to re-establish the paradigm of trust, but (using also elements of targets and performance management) in a more intelligent and differentiated way, namely: trust in the trustworthy. We will also need different research methods which will be of complementary value to the completely quantitavely oriented performance indicators, clinical registries, patient reported outcomes, etc. In order to understand ("verstehen") the intrinsic value of the caring relation in health care, we need qualitative research such as observations, sight-visits in

health care institutions, interviews, etc. Besides, we should not step into the pitfall of trying to quantify or even commodify these values, because this may have corroding effects. We will have to find other ways to incorporate these intrinsic values into our judgments about value in health care. Last but not least, our focus should be less on equipping patients to become experienced health care consumers, using the instruments of 'choice' and 'exit'. In a sustainable health care system common enjoyment of health care also encompasses a common responsibility for the improvement of it. I think we should therefore invest in infrastructures that help (future) patients fulfilling that task.

Of course, this thesis has its limitations. Most importantly, there are many related topics that I could not address here, because of the limited space. I would recommend these to be subject of future consideration and research regarding the ethics of VBCHC. I mention some of these subjects, without the ambition of being exhaustive. Porter focuses, for example, fully focuses on patients' medical condition. This has great impact on the way he structures health care (cycles), how he claims health care should be measured rewarded, etc. A patient is however more than his or her medical condition. Moreover, there are new conceptions of health, that focus more on the possibilities and capabilities patients have, instead of their deseases (Huber, Knottnerus et al. 2011). I would recommend that the philosophical relation between Porters medical condition-focus and these new conceptions of health will be subject of further research, and also its implications for VBCHC.

A second subject for further research would be the phenomenon of supplier induced demand and (its philosophical and sociological counterpart) medicalisation. In my view, Porter takes the current demand for health care almost completely for granted. He focuses on how we should organize, measure and improve our health care supplies to meet patients' current demands in the most valuable way. It is however known that the phenomenon of medicalisation has great impact, both via supplier induced demand and both via society itself (Illich 1995, Conrad 2005, Sadler, Jotterand et al. 2009). Therefore the question rises: is it the right 'demand' VBCHC tries to meet or could even more value be added if VBCHC would also have as its aim to discern true needs from induced demand? In future philosophical research and ethical reflection on VBCHC I would suggest this question should be addressed.

Third, some elements of health care are difficult to measure in terms of (clinical) outcomes. These also happen to be the parts of health care where the caring relation is of even more importance than elsewhere. Think for example of care for the disabled, the elderly or mental health care. One of the possible dangers of VBCHC could be that the more easy-to-measure parts of health care (such as elective surgery) get more attention, are more rewarded and probably higher valued than other health care sectors. I would suggest to involve also this phenomenon in an ethical reflection in the future.

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