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Editorial

Extending Value-Based Healthcare Into Population Health

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1. Why Hospital-Centred Value Is No Longer Enough

Value-based healthcare has provided a vital corrective to volume-driven medicine. Its central contribution has been to insist that performance should not be judged by activity, throughput or institutional prestige alone, but by the outcomes achieved for patients relative to the resources used. Porter's influential formulation [1] defined value as "the health outcomes achieved per dollar spent", establishing a shared aim capable of aligning patients, providers, payers and policymakers around outcomes rather than raw activity. Hospitals have been among the most fertile settings for the operationalisation of value-based healthcare, and rightly so. Hospital care is often measurable, bounded, and episode-legible. Surgical pathways, admissions, specialist procedures, and defined interventions can be costed, audited, and compared with a degree of clarity that is harder to achieve in diffuse community settings. It is therefore unsurprising that value-based healthcare has matured around condition-focused outcome measurement, clinical registries, standardised care pathways and costing methods [2,3,4]. Organisations such as the International Consortium for Health Outcomes Measurement have further strengthened this movement by developing standard sets that seek to measure outcomes that matter to patients across specific conditions [5].

Yet, there is now a strategic constraint in how value-based healthcare is predominantly practised. Outcomes are often deliberately organised by medical condition. This has brought rigour, comparability and clinical relevance. However, across many developed health systems, the healthcare burden no longer has a natural shape that fits neatly within a single condition, specialty, or episode of care. Ageing populations, multimorbidity, mental-physical comorbidity, frailty, functional decline and social complexity increasingly determine risk, service use and lived outcomes. The World Health Organization (WHO) has highlighted multimorbidity as a growing challenge for health systems [6,7], including its association with poverty and earlier onset in disadvantaged populations.

The implication is straightforward but profound: optimising individual hospital or clinic episodes does not automatically culminate in meaningful value across a patient's life course. A hospital may reduce length of stay, improve theatre productivity and meet condition-specific outcomes, yet still fail to create durable value if the burden is displaced onto families, primary care, social care or the patient's future self. Relapse, functional decline, avoidable readmissions, and widening inequalities may all represent downstream costs of apparently efficient hospital care. The hospital can be excellent, while the patient's life-course trajectory remains suboptimal.

This critique is not new. It is already visible in the policy and academic literature on integrated, people-centred care, multimorbidity and population health. The WHO Framework on Integrated People-Centred Health Services [8] calls for a fundamental shift away from systems designed around diseases and institutions towards systems designed around people, coordinated across the continuum and responsive to needs across the life course. Similarly, the widely cited definition of population health [9] includes not only the health outcomes of a group of individuals, but also the distribution of those outcomes within the group. This distributional component matters. A system that improves average outcomes while leaving behind patients who are poorer, frailer, more socially isolated, or harder to serve cannot be said to have delivered value in a meaningful population sense.

Policy reforms in several countries are already moving in this direction. For example, Singapore's Healthier SG reform explicitly seeks to shift the system from reactive care to preventive care, mobilising family doctors, personalised health plans, screening, vaccination and community partners to support residents in staying healthy [10,11,12,13,14]. Australia's National Preventive Health Strategy similarly emphasises a systems-based approach to prevention, wider determinants of health, reduced inequities and improvedwellbeing across all stages of life [15]. Though these reforms may not necessarily identify themselves as value-based healthcare reforms, they converge on the central idea that these changes are aimed at maximising outcomes and value to the population and health system, while trying to control costs. The direction of travel is clear: health systems are asking institutions not

only to deliver excellent care within their walls, but to contribute to better health trajectories beyond them.

2. Important Reframes for Policymakers and Hospital Leaders

For policymakers and hospital leaders, this requires an important reframe. Condition-based outcomes remain essential, but they should be nested within person-level goals and population-level aims. Person-level goals include function, independence, symptom burden, wellbeing and the ability to live well with illness. Population-level aims include reducing preventable morbidity, narrowing inequalities, extending healthy life expectancy, and improving health span. This does not negate traditional value-based healthcare. It extends its logic to the realities that now define demand.

First, policymakers and hospital leaders must shift the outcome horizon from episodic endpoints to longitudinal life-course outcomes. Discharge should not be treated as the end point of hospital value, but as a waypoint in a trajectory that includes recovery, recurrence, rehabilitation, function and the patient's capacity to return to meaningful life. For some patients, the most important outcome of hospital care is not survival to discharge, nor even complication-free recovery, but whether they regain independence, avoid institutionalisation, maintain treatment adherence, or remain connected to primary and community care.

Second, cost perspectives need to move from per-case efficiency to risk-adjusted per-capita value. Reducing the cost of an admission is not necessarily saving if the total cost rises through fragmented follow-up, preventable readmission, poorly managed comorbidity, or unmet social need. A narrow institutional cost perspective can wrongly reward hospitals for shifting the burden elsewhere. A broader perspective asks whether the system has reduced avoidable utilisation and improved outcomes across the person's care journey. This is especially important for patients with multimorbidity, where high-cost use often reflects the interaction of clinical complexity, social vulnerability and fragmented care.

Third, care delivery models must expand from hospital multidisciplinary teams to broader care ecosystems. The multidisciplinary team remains central, but it is no longer sufficient if its boundaries end at the hospital door. Future value will depend on structured relationships with primary care, rehabilitation, community nursing, mental health services, social care, voluntary organisations, local government and digital health platforms. Cross-sector collaboration should therefore be seen as a core hospital function, not corporate social responsibility or an optional extra.

Fourth, workforce redesign must accompany this shift. The answer cannot be to add population health tasks to an already saturated workforce. Hospitals need redesigned roles, boundaries, training pathways and digital workflows. Clinicians require the capability to practise across transitions of care, interpret longitudinal outcomes, work with community partners and understand risk at the level of both individuals and populations. Administrative and operational teams need similar redesign, with responsibilities for navigation, care coordination, data integration and equity monitoring built into job architecture rather than appended as unfunded expectations.

These reframes are easy to state but difficult to implement in practice. Moving from episodic value to longitudinal and population-level value requires more than rhetorical alignment; it requires new governance arrangements, shared accountability across institutions, interoperable data systems, redesigned incentives and sustained clinical engagement. No single hospital, payer, policymaker or community organisation can achieve this alone. The next phase of value-based healthcare will therefore need to be developed collaboratively, through implementation research, comparative learning across health systems, pragmatic evaluation and honest attention to what works, for whom, and under what conditions. For hospital leaders and policymakers, the task is not simply to endorse a broader vision of value, but to build the organisational capabilities and evidence base needed to deliver it.

3. Implications for the Future

Extending value-based healthcare into population health also requires a broader approach to measurement. Traditional value-based healthcare measurement, including condition-based standard sets, remains highly important. It gives clinical teams meaningful outcomes around which to organise improvement and should not be discarded. However, it is no longer sufficient on its own. Hospitals will increasingly need to supplement condition-specific metrics with measures that capture cross-condition burden, patient-reported outcomes, longitudinal recovery after discharge, functional status, continuity of care and equity-stratified outcomes.

This distributional lens is essential. Without equity stratification, average improvement may conceal widening disparities. A service may appear to deliver high value because it performs well for lower-risk, well-supported patients, while systematically underperforming for those with greater clinical complexity, social vulnerability or care coordination needs. This would represent a perverse form of value: high for the easy to serve, but limited for the population as a whole.

None of this implies that hospitals should be responsible for everything that determines health. They cannot be, and attempts to make them accountable for every social, behavioural, or environmental determinant would be unrealistic and counterproductive. Rather, the argument is that hospitals must reinterpret their role within contemporary health systems. The relevant question is no longer only whether a hospital delivers efficient, high-quality episodes of care as an isolated component of the system. It is also

whether the hospital measurably contributes to prevention, continuity, equity, and system-wide value.

For hospital leaders, the practical challenge is therefore to preserve the discipline of value-based healthcare while widening its field of vision. The next stage is not to abandon condition-based improvement, but to connect it to the patient's wider trajectory and to the distribution of outcomes across the population. Hospitals will remain indispensable centres of specialist expertise, acute care and innovation. Their future relevance, however, will increasingly depend on how well that expertise is integrated into broader systems that keep people well, restore function, reduce avoidable disease and narrow inequities.

The imperative is therefore not a new slogan but a broader accountability. Value-based healthcare began by asking hospitals to look beyond volume. Its next task is to help hospitals look beyond the episode.

Key Points

• Value-based healthcare has provided an important corrective to volume-driven healthcare by focusing attention on outcomes achieved relative to resources used, but its implementation has largely matured around condition-specific, hospital-centred, and episode-based models of care.

• Ageing populations, multimorbidity, frailty, functional decline, mental-physical comorbidity, and social complexity increasingly challenge value-based healthcare models that focus primarily on individual conditions, specialist pathways, or discrete care episodes.

• Extending value-based healthcare into population health requires hospitals and health systems to shift from episodic endpoints towards longitudinal life-course outcomes, including recovery, function, independence, continuity of care, and prevention of avoidable deterioration.

• Measurement approaches should preserve the discipline of condition-specific outcome measurement while incorporating cross-condition burden, patient-reported outcomes, functional status, longitudinal recovery, continuity of care, and equity-stratified outcomes.

• Hospitals should not be made responsible for every determinant of health, but they should reinterpret their role within broader care ecosystems by contributing more deliberately to prevention, care continuity, equity, and system-wide value.

• Delivering this broader form of value will require new governance arrangements, shared accountability across institutions, interoperable data systems, redesigned incentives, workforce redesign, and sustained collaboration across hospital, primary care, community, and social care sectors.

Availability of Data and Materials

Not applicable.

Author Contributions

HYT conceptualised the article, reviewed the relevant literature, drafted the manuscript, critically revised the manuscript for important intellectual content, and approved the final version for submission. HYT has participated sufficiently in the work and agreed to be accountable for all aspects of the work.

Ethics Approval and Consent to Participate

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Conflicts of Interest

The author declares no conflicts of interest.

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