



The Challenge of Translating Value in Performance Measures: A Response to Recent Commentaries

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We thank da Silva Etges,¹ Van Staalduin & Van der Nat,² and Sijm-Eeken et al³ for their thoughtful commentaries on our review of performance management in value-based healthcare (VBHC). The commentaries suggest that the field is moving toward greater strategic sophistication, conceptual clarification and measurement capability. Thereby, the studies also reveal a shared assumption: that the central challenge is one of implementation, integration and refinement. But what exactly is being integrated, refined and measured?

Our own review began from a seemingly straightforward observation. Given the strategic ambitions associated with VBHC, one would expect extensive attention to performance management systems in the academic literature. However, we found that this was not the case. The three commentaries offer different explanations for this observation. Van Staalduin and Van der Nat² suggest that practice may be more advanced than the literature indicates. These authors also rightly highlight the importance of greater conceptual clarity regarding VBHC. Sijm-Eeken et al³ show that some organizations, at least for part of their operations, already employ sophisticated dashboards and measurement systems, but that this is not yet reflected in the extant literature. Da Silva Etges¹ emphasizes that VBHC should be understood as a broader strategic transformation rather than a collection of isolated measurement practices. Collectively, the commentaries also suggest that the translation of VBHC ambitions into integrated performance management practices remains incomplete.

We agree with these observations and acknowledge that they may have impacted our findings. Practice inevitably advances beyond what is currently visible in the academic

literature; and VBHC can be viewed in many different ways, which we did not (all) distinguish in our paper. The three commentaries also reveal fragmentation across strategic ambitions, conceptual understandings of value, and operational measurement practices when it comes to implementing VBHC. We purport that such fragmentation may be symptomatic of a deeper issue: uncertainty regarding how value is defined, represented and acted upon. This raises the question: how do particular conceptualizations of value become translated into the performance architectures through which organizations are governed? This challenge becomes even more pronounced when value is expected to be created across care pathways and organizational boundaries, as envisioned in many conceptualizations of VBHC. The question then is not only how value is translated into measures within organizations, but also how shared understandings of value become coordinated across organizations. Here, leaders will play pivotal roles and will need to work to instill value into the organization's culture if it is to flourish within the organization and with its partners, as envisioned.

Consider the examples discussed by Sijm-Eeken et al.³ Among others, their commentary illustrates that healthcare organizations increasingly collect large quantities of outcome, process, and financial data. Organizations may collect information for specific patient populations, care pathways, or organizational units. However, it remains unclear how such information becomes connected to broader organizational priorities and decision-making processes. The presence of outcome, process, and financial measures does not in itself ensure that organizations can assess, prioritize, or govern value. The answers to these questions are not self-evident, as the existence of extensive measurement infrastructures should not be confused with the existence of integrated performance management. Organizations may possess dashboards, indicators and outcome measures without having developed shared understandings of how these measures should inform organizational priorities, professional judgement and accountability relationships. The existence of measurement therefore does not resolve the question of value; it relocates it.

One of the most striking features of the VBHC debate is that value is frequently treated as if it were an objective and ultimately measurable phenomenon. Consequently, the challenge researchers and managers see becomes one

of technical refinement: better data, better dashboards, better integration, and better governance. But even when organizations agree on outcome measures, disagreements often remain about what constitutes “good” care in particular situations. Such observations suggest that value is not merely discovered through measurement but emerges through interactions among patients, professionals, technologies, and institutions. Care is fundamentally relational – it emerges through interaction.⁴ Such interactions are often characterized by ambiguity, uncertainty and contextual judgement. What counts as valuable care is therefore not necessarily stable, self-evident or universally or easily agreed upon, which complicates its representation through performance measures.

If value is relational, contextual and negotiated, then the challenge facing VBHC cannot be reduced to identifying the right indicators, better integrative structures, or studying more of the examples that are “out there.” Before value can be measured, it must first be defined. Before it can be “managed,” it must be translated into categories, metrics and reporting formats. Howard et al⁵ propose a new comprehensive framework that considers multiple dimensions of performance, including specific metrics that could be useful in translating broad categorical domains into actionable metrics. However, these translations are not neutral. They privilege certain understandings of care while marginalizing others. For example, a dashboard emphasizing clinical outcomes may produce different priorities for the onlooker than one emphasizing patient experience, provider well-being, or population health.

Management control research suggests that performance measures do not merely represent organizational realities. They actively shape them.⁶⁻⁹ Hence, we would argue that an important task for healthcare researchers and managers is to critically examine the assumptions embedded within performance measurement systems, and have an eye for their consequences, which may well be unintended. While there is some healthcare literature that addresses the issue,¹⁰ we argue that a further step is required: understanding how the categories and measures embedded in performance measurement systems participate in defining what becomes recognized as valuable or “good” care. The challenge we see is one of integration *and* reflexivity.

For example, whose understanding of value becomes represented in a dashboard? Which aspects of care become visible through measurement and which remain invisible? What happens when professional judgement conflicts with standardized indicators or with patient preferences? How do performance measures influence relationships between patients and professionals? Under what conditions do measures support care, and under what conditions might they distort it?

Let it be clear that we do not argue against dashboards, indicators or governance arrangements; rather, we argue that these instruments deserve investigation as constitutive elements in the production of value itself. Until the relationship

between value and its measurement is more explicitly theorized, improvements in governance, dashboards and performance systems may address symptoms without fully addressing the underlying issue. We firmly believe the future of VBHC depends on a richer understanding of how value, care and performance become intertwined in practice. This is what we hope will mainly be picked up in future research.

Disclosure of artificial intelligence (AI) use

Not applicable.

Ethical issues

Not applicable.

Conflicts of interest

Authors declare that they have no conflicts of interest.

Authors' contributions

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