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ORIGINAL ARTICLE

Value-based health care in translation: From global popularity to primary care for Dutch elderly patients

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Abstract

In this article we examine the fragmented interpretation and implementation of a remarkably popular concept, value-based health care (VBHC). By building on a case study of a project team working on the development of value-based primary care services for elderly patients, we shed new light on the way in which VBHC transitions from theory to practice. The concept of 'translation' is used to theoretically frame our analysis. Between June 2021 and May 2022, we gathered data through participant observation (50 h), semi-structured interviews ($n = 20$) and document analysis ($n = 16$). Our findings show how VBHC inspired new ways of working, and that, in line with previous studies, parts of the original concept have been neglected, while others have been modified. We identified three reasons for VBHC's locally varied applications: VBHC transforms to enable a growing support base, the originally radical idea is applied conservatively and the concept tends to get mixed up with other policy objectives. In all, VBHC appears to be successful in catalysing cross-disciplinary interaction aimed at improving value for patients.

KEYWORDS
actor-network theory, buzzword, case study, health care, implementation, patient needs, primary care, qualitative research, The Netherlands, translation, value, value-based health care

INTRODUCTION

Today, value-based health care (VBHC) is probably one of the most widely embraced concepts in relation to the governance and management of health care delivery (Bonde et al., 2018; Ramsdal & Bjørkquist, 2020). Such is today's popularity of VBHC that some scholars go as far as labelling it a 'global megatrend' (Kokko & Kork, 2020). Alongside this increasing popularity, however, grows an incoherent pattern of interpretation and implementation (Fredriksson et al., 2015; Steinmann et al., 2020; Van Staalduinen et al., 2022). Studies reporting on actual efforts to implement VBHC reveal a muddled, fragmented and scrambled picture (Bonde et al., 2018; Erichsen Andersson et al., 2015; Van Staalduinen et al., 2022). In most cases, VBHC is not adopted as an integrated strategy: only bits and pieces are being implemented and different versions of VBHC seem to pop up at various locations (Erichsen Andersson et al., 2015; Van Staalduinen et al., 2022). Hence, the original conception of VBHC (Porter & Teisberg, 2006) has garnered widespread recognition among scholars and practitioners across the globe (Vijverberg et al., 2022), but its practical applications have been characterised by locally varied adaptations, and often entail significant omissions of the original concept (Colldén & Hellström, 2018; Nilsson et al., 2017; Steinmann et al., 2021).

Within the growing body of literature on VBHC one can find several possible explanations for this incoherence. For example, it has been suggested that VBHC is a far-reaching reform strategy with a multitude of aspects concerning a wide variety of stakeholders, which inevitably complicates any implementation process (Steinmann et al., 2021). Alternatively, it has been argued that the concept itself is rather vague, which leaves VBHC open to interpretation (Colldén & Hellström, 2018; Ramsdal & Bjørkquist, 2020; Van Staalduinen et al., 2022). Relatedly, a literature review by Frederickson et al. (2015) found signs of VBHC becoming more of a diluted buzzword, rather than a widely implemented reform strategy.

It appears, therefore, that the term 'implementation'—indicative of the rather straightforward execution of a plan—does not properly represent how VBHC, popular as it may be, transitions from theory to practice (i.e. from idea to application). In recognition of the shortcomings of 'implementation', some scholars have started to use the concept of 'translation' to account for the locally varied ways in which VBHC is put into practice (Bonde et al., 2018; Colldén & Hellström, 2018). While we embrace the insights gained, we would like to further contribute, both empirically and theoretically, to the use of the concept of translation to trace how VBHC transitions from idea to application. Both of the abovementioned studies focus on hospital departments and how VBHC has inspired the development and use of certain performance indicators (Bonde et al., 2018; Colldén & Hellström, 2018). The current study concerns a primary care organisation, and (as far as we know) is the first to employ a translational approach to analyse the application of VBHC outside a hospital setting.

In this article, we develop insight into *how VBHC transitions from idea to application in primary care in The Netherlands.* We provide a qualitative case study of a project in which a Dutch primary care organisation worked on the development of value-based primary care services for elderly patients. We use the concept of translation, borrowing insights from actor-network theory

(ANT), as a theoretical lens for our analysis. Our main theoretical contribution, which will be discussed further below, consists of not only using the concept of translation to describe *how* the development of a particular localised version of VBHC takes place, but to also analyse *why* some parts of the original idea are adopted, while others are modified, and yet others ignored. Our analysis points to three ways in which VBHC transforms as it transitions from idea to application: VBHC undergoes modifications that explicitly enable it to gain support; it tends to blend with pre-existing policy objectives and transforms into an approach for their pursuit; and it transforms in ways that allow it to adhere to, rather than break with, formal organisational structures and traditional interprofessional arrangements. Additionally, our case study exemplifies how the application of VBHC can lead to increased cross-disciplinary interaction among (primary care) professionals.

The following sections start with a brief introduction of the idea of value-based primary care as it pertains to the original concept of VBHC. We then present our theoretical lens (i.e. a translational perspective), after which we describe our case and research methods. Next, we proceed into the findings. Finally, in the discussion, we reflect upon the findings of our case study, including its implications for our understanding of the popularity of VBHC and its locally varied transformations.

From VBHC to value-based primary care

VBHC was originally developed as 'framework for health care reform' (Porter & Teisberg, 2006, p. 326) aimed at optimising the organisation and governance of health care delivery (Porter, 2008, 2010; Porter & Lee, 2013; Porter & Teisberg, 2006). Key to this framework is the claim that improving value for patients should become the overarching goal for health care systems, with value defined as the health-related outcomes that matter to patients, divided by what it costs to achieve those outcomes. Regarding its implications, most of the original reform strategy focuses on organisations that provide specialty care such as hospitals (Porter, 2008, 2010; Porter & Teisberg, 2006). For specialty care providers, VBHC's originators advocate (re)structuring organisations around care cycles for medical conditions (e.g. breast cancer); and to reward those providers who demonstrate relatively high value (based on standardised measurements of outcomes and costs) with more patients (Porter & Teisberg, 2006). While the later developed framework for primary care (Porter et al., 2013) shares many of the features of the original value agenda (Porter & Lee, 2013; Porter & Teisberg, 2006), there is one crucial difference. For primary care providers, who inevitably address a wide variety of patient needs, it is not deemed feasible to restructure their organisations around specific medical conditions; instead, these providers are urged to focus on subgroups (i.e. 'customer segments') of patients with comparable primary care needs (Porter et al., 2013).

Rather than addressing all of their patients through a similar organisational approach, primary care providers are urged to divide their entire patient population into a relatively small number of subgroups that capture the main differences in care needs, and switch to 'value-based patient subgroup management' (ibid). The first step would be to distinguish subgroups of patients with similar primary care needs. While the framework does not profess a single best way to divide patients into subgroups, 'the focus should be on those groupings that translate into care team composition and service delivery needs' (ibid, p. 518). When subgroups are identified, the second step would be to compose specific care teams per subgroup, and design their delivery processes so as to optimise task allocation and coordination (ibid). Then, outcomes and costs should systematically be measured for each patient per subgroup. Accordingly, each team can focus on improving value for a particular segment of the patient population (ibid).

As mentioned, VBHC has become a remarkably popular idea, but its applications appear to be locally varied, and commonly entail modifications and omissions of the original concept. Rather than being consistently implemented, VBHC seems to transform as it transitions from theory to practice.

A TRANSLATIONAL PERSPECTIVE

To better capture the way in which ideas and theories transition into practices, scholars have turned to the concept of 'translation', which has been juxtaposed with the notions of 'implementation', 'transfer' and 'diffusion' (Colldén & Hellström, 2018; Cresswell et al., 2010; Latour, 1987, pp. 132–141; McMaster et al., 1997). Terms like implementation, transfer and diffusion, it is argued, suggest a relatively straightforward path from idea to practice. *Translation* on the other hand, stresses the messiness and friction that occurs when new relationships are brought into being; for instance, when a new idea or innovation is introduced within organisations (Cresswell et al., 2010; McMaster et al., 1997). More than implementation or diffusion, translation emphasises that the fate of any transition depends on the behaviour of the various actors involved; each may leave their imprint on the object or idea at hand (Latour, 1987; Røvik, 2016).

While there are different schools of thought on the exact meaning and utility of the term (Freeman, 2009; Røvik, 2016), it is generally agreed upon that translation inherently implies a relationship between two or more unsimilar things. And because of this, a process of translation always involves some degree of transformation (Callon, 1986; Freeman, 2009; Law, 2009; Røvik, 2016; Sismondo, 2004). It is particularly by emphasising and embracing transformations as unavoidable that the concept of translation has become a popular alternative to the notions of diffusion and implementation. Relatedly, the popularity of the concept runs parallel to the growing influence of ANT within sociology. Much scholarly work on translation is either inspired by or downright based on ANT, and this certainly applies to research on the health care sector (e.g. Bonde et al., 2018; Colldén & Hellström, 2018, 2022; Creswell et al., 2010; Røvik, 2016).

In essence, ANT conceives of translation as the process by which actor-networks are formed (Freeman, 2009). The inherently transformative character of this process refers to the changes that are required among actors so that a certain state of affairs can be reached and maintained: for a new network to stabilise or a new fact to be established, the interests and behaviour of various actors need to change and converge (Callon, 1986; Sismondo, 2004). Building on ANT, translation can be more specifically defined as *a process of (re)configuring the roles and converging the interests of a heterogeneous set of actors so that their behaviour, interaction, and evolution is 'regulated'* (Callon, 1986). Thus, in terms of ANT, a successful process of translation manages first to *enrol* various actors by aligning their interests towards a common purpose, and then to *tie and control* (i.e. regulate) their behaviour in a durable way (Callon, 1986; Latour, 1987, pp. 121–122).

However, it is important to note that in subsequent decades, this 'traditional' interpretation of ANT and translation has faced criticism for overemphasising convergence and stability, while downplaying the multiplicity and fluidity of meanings and practices (e.g. Berg & Timmermans, 2000; Law, 2009; Mol, 2002). More specifically, some scholars have challenged the notion that *successful* translation generates a stable and coherent network. From this perspective, translation also succeeds when relations are fluid and ephemeral (cf. Law, 2009; Mol, 2002). Key to this 'post-traditional' perspective is a recognition of the multiplicity of meaning: the same phenomenon (e.g. atherosclerosis or VBHC) can embody a variety of meanings and practices across settings (Mol, 2002).

Inspired by this post-traditional view of ANT, the concept of translation is commonly utilised to account for the emergence of wide varieties of applications and local versions of ideas (such as VBHC) (Bonde et al., 2018; Colldén & Hellström, 2018, 2022; Røvik, 2016). Here, translation is understood more generally as the process of bringing things into relation with one another, thereby generating new meanings and practices. But this perspective has also faced criticism over the years. Some scholars have argued that this post-traditional application of translation essentially turns the concept into the key mechanism by which any kind of difference is produced (Chandler & Hwang, 2015, cited in Røvik, 2016). This may risk overstretching the concept, whereby 'translation is itself translated too far beyond its useful meaning' (Freeman, 2009, p. 439). Furthermore, by decoupling the success of translation from the stability and coherence of an actor-network, virtually any idea or innovation can be considered to have translated successfully, as long as one can describe a relationship across settings. When it comes to VBHC, or any other idea or (health care) innovation for that matter, studies applying this post-traditional conceptualisation thus risks contributing little more than to suggest that meanings and practices differ from one location to another, and that these differences are potentially boundless (Røvik, 2016).

Therefore, in recognition of these concerns, our current study relies more on the traditional view of translation: as the process by which networks of reliable interaction are formed (Freeman, 2009). Accordingly, translation is not synonymous with transformation or adaptation—if this were the case, we would not need it as an alternative concept. For the purpose of this study, superseding unavoidable transformation, successful translation also entails a state of stability and endurance (Callon, 1986; Latour, 1987). And since it is usually immensely difficult to converge interests and redirect behaviour, translation is not regarded as an automatic process, but as effortful and precarious, and as something that is more often endeavoured than successfully achieved (Callon, 1986; Freeman, 2009).

Some scholars have stated that applying a 'translation approach' to VBHC should specifically *not* entail comparing the original theory with whatever came into being at a certain time and location (Bonde et al., 2018). Although we agree with the claim that 'when translation is the ontological premise, then incongruence between vision and practical reality is inevitable' (ibid, p. 1115), we believe this inevitability does *not* necessarily imply that such incongruence is of no interest or utility. Especially if certain (international) patterns of incongruity were to emerge, studying them may very well provide insights into how VBHC travels from idea to application, and may offer avenues for explaining why certain parts of the original idea are adopted, while others are adapted, and yet others simply ignored (Latour, 1987, p. 140). Comparing original ideas with their practical applications, therefore, can be a suitable part of a translational approach.

By analysing our case study from a translational perspective, we not only describe *how* a particular local version of VBHC came into being, but by reflecting on our findings in light of existing literature on the application of VBHC, we also will provide an ANT-inspired discussion of *why* VBHC transformed in this particular way. Accordingly, we aim to contribute to understanding how VBHC transitions from theory to practice.

CASE AND METHODS

Case description

Between June 2021 and April 2022, the primary care organisation 'Blue Stone' embarked on a project in which new health care delivery services and ways of working would be developed

based on the principles of value-based primary care as outlined by Porter et al. (2013). For Dutch standards, Blue Stone is a relatively large primary care organisation, with multiple care centres that each have a multidisciplinary group of professionals providing care to patients. Before the start of the project, the organisation had already been preparing the launch of a new primary care centre, one specifically focusing on elderly patients. It is within this new elderly care centre, that the project deliverables would be put into practice. Blue Stone hired a consultancy agency, 'Red Tree', which had experience with projects regarding value-based primary care, to facilitate the project trajectory (e.g. they applied a phased planning, prepared and guided meetings, and made sure the scheduled advancements took place).

The core of the project trajectory consisted of 11 group meetings (totalling approximately 50 h) in which the project team members gradually developed 'mini business cases' for new primary care services that were presented in the final group session of the project. Next to three consultants, the project team consisted of 19 Blue Stone employees with various professional roles. Most of the project team members were directly involved in delivering primary care, including several general practitioners, nursing staff, physical therapists, a geriatrician and also two pharmacists. Others had various administrative or managerial roles, such as office managers, quality officers and board members. All in all, a multidisciplinary collection of Blue Stone employees from various care centres periodically came together to develop value-based primary care services for elderly patients. It should be noted that restrictions due to COVID-19 significantly delayed both the start and the duration of the project, and also caused the first two meetings to be held online.

Data collection

We build our case study on approximately 50 h of participant observation during the project meetings, in which the first author took descriptive field notes on site that would later be worked out in extended observation reports, which at times included a first level of interpretation (DeWalt & DeWalt, 2011, pp. 165–171). These observations not only gave us a front row seat to a local application of VBHC, but participation within the meetings also allowed us to gain some first-hand experience with actively moving from idea to application. Additionally, spread out over the course of the project, we conducted a series of semi-structured interviews ($n = 20$) with project team members. The interviews focused on respondents' interpretation of VBHC and their experiences and perceptions regarding the project. On average, interviews lasted 45 min: the majority were held online, six were held face-two-face and all were audio recorded and transcribed verbatim. Finally, we examined the various documents ($n = 16$) that were produced and sent out as part of the project. These documents consisted of preparatory reading material and summarised reports of each of the group meetings produced by the Red Tree. In addition to providing data on the project's proceedings, this documentation enabled us to see how this consultancy agency interpreted and presented the idea of VBHC for the purpose of this project. For most project team members, the documents and presentations by Red Tree constituted their first introduction to VBHC.

Data analysis

The extended observation reports, the interview transcripts, and the documents were all coded thematically with the application ATLAS.ti. We focused our analysis on how VBHC transitioned from idea to application within the project of our case study. Moreover, we examined our data through the lens of translation, and analysed if and how VBHC managed to converge the interest

(i.e. enrol actors) and redirect the behaviour (i.e. regulate interaction) of project team members in alignment with a common goal, while also attending to the modifications VBHC itself underwent within this process.

FINDINGS

In the following subsections, we shed light on how VBHC transitioned from idea to application within the project of our case study. When quoting respondents we refer to them with a preassigned number in parentheses; documents are referred to with the letter 'D' plus a number. Rather than chronologically detailing the project's proceedings, we start with a subsection on how project team members interpreted VBHC, and how this relates to a shared goal. Then follow two subsections in which we elaborate on (gradual) modifications of the original idea, one focussing on subgroup management, another one on costs. We end with a subsection concerning the impact of VBHC on the behaviour of project team members: it appears to increase interaction across professional disciplines, which is demonstrated by the project deliverables. This analysis of behavioural impact nicely completes our findings: it is related to project team members interpretation of VBHC, it is apparent from the project deliverables and it brings up an important point for our discussion: whether our case study indicates a successful process of translation.

Patient needs: A common goal

In each of the interviews, we asked respondents about their interpretation of VBHC ('What do you understand by VBHC?'). Perhaps not surprisingly, responses varied considerably. For instance, only a few project team members mentioned the importance of health outcomes and costs, and two replied not being able to answer the question at all (4; 18). Yet, a rather striking pattern emerged across responses from those who did. It became clear that for many project members, VBHC was above all about *patient needs*. More specifically, VBHC was understood to denote an approach to health care provision where the needs of patients should take centre stage when it comes to medical decisions. Several respondents felt that such an enhanced focus on patient needs would entail a break with the past.

> That is the traditional way of how I was trained: thinking for the patient. Whereas my idea of value-based health care is: looking together with the patient at what is important and what you want to achieve, and work on that, in accordance with how realistic and feasible the patient's goal is. And next to that, not only looking at my own frame, but also looking at other frameworks: how can we ensure that the patient reaches that point?
>
> (Coordinator allied health care, 19)

Furthermore, following the perception that VBHC concerns an enhanced focus on patient needs, several project members explicitly stated that VBHC implies alternative forms of organising and providing primary care:

> If you want to deliver VBHC, that means you really have to look: what are the needs of the patient? So, the ways of working really have to change, I think, to deliver VBHC.
>
> (Pharmacist, 8)

> You notice that, at this moment, the general practitioner (GP) care, yeah, tries to push every patient through the same mould. And by organising differently, around certain patient groups—subgroups, target groups—you can create more value.
>
> (Consultant, 6)

Thus, among our project members, the overarching interpretation of VBHC was one that emphasises the importance of taking *patient needs* into consideration, and respondents wanted to better address these needs, for which *alternative* ways of working were deemed necessary. The main objective of the project was exactly to develop such new types of services and new modes of organising primary care for elderly patients.

> So, the translation then is: can you make, for elderly [...] who are now more or less going through the same primary care landscape, [...] can you identify target groups, subgroups, and based on those target groups organise care differently so that you create more value? So, VBHC is about: different way of organising, different way of delivering care.
>
> (Consultant, 6)

Whereas some specifically referred to targeting groups of patients (i.e. patient populations) with new ways of working, others pushed the idea of accommodating patient needs a bit further, onto the level of the individual.

> By that [VBHC] I understand that it's care for patients and organising from the perspective of patients, and the needs that they have, and that the health care delivery fits to that. And what you see now is that in practice it is very supply-driven, and aimed at treating symptoms and reaching target values. And VBHC, in my opinion, is much more about: what does someone want with his life, what does that life look like, what is important to him, what care is needed to reach those individual goals?
>
> (Policy Officer, 2)

> Well, value in the sense that the care that you deliver is tailored, that it is tailored as much as possible for the patient.
>
> (Director, 1)

By relating VBHC to the idea that (primary) care provision should be customised according to the needs of individual patients, these project members are mirroring earlier accounts of what might be considered a Dutch version of VBHC, which has a strong focus on shared decision-making (Steinmann et al., 2020). But whether it concerns zooming in on the individual level or targeting groups of patients, the general aim was to better address patient needs—which really emerged as a shared goal throughout the project. And VBHC was primarily understood as a way to pursue that goal. In terms of translation, therefore, our case study indicates how VBHC successfully 'converged the interest' of the various actors involved in alignment with a common goal: to better attend to the primary care needs of patients.

The gradual fading of subgroups

At the outset of the project, the project team initially embraced the concept of value-based subgroup management, and the idea of identifying distinct patient subgroups based on similar primary care needs (Porter et al., 2013). Specifically, the choice was made to classify elderly patients into five subgroups according to their shared care needs and level of complexity:

1. Healthy elderly
2. Chronic condition management
3. Physical and mobility problems
4. Multidomain issues
5. Extremely fragile

Although these subgroup classifications influenced the project's trajectory, they did not lead to the profound organisational changes envisioned by the original theory of value-based primary care (i.e. subgroup management). Instead, the significance of the five subgroups—which once seemed to form the very basis of the project—dwindled as the project proceeded. Quite literally, the subgroups moved to the background within the project meetings: they were displayed on posters on the walls of the meeting room, but they never gained central prominence during discussions (except for the brief period described below).

Three distinct occurrences within the project highlight the diminishing importance of subgroup management. The first of these took place near the end of the first team meeting. Project team members were divided into small breakout groups of three to four individuals, each assigned randomly to one of the five subgroups. Over a 30-min span, each breakout group brainstormed and noted their perceptions of a specific patient subgroup and potential opportunities for enhancing their care. So, this session allocated just 30 min to envision the characteristics and needs of patients within each subgroup—conducted by a handful of project members. This brief episode exemplifies how, over the course of the project, limited time and effort were directed towards addressing the specific care needs of each subgroup. Instead, the majority of the project's resources were directed at developing new services.

The second exemplary occurrence also took place early on, but reverberated throughout the project. In one of Red Tree's documents the phrase that originally read 'developing teams [...] for each subgroup' (Porter et al., 2013, p. 519), was translated into just 'teamwork'. This modification foreshadowed the diminishing importance attached to the subgroup management. It was indicative of a project in which the issue of the composition of teams per subgroup was bypassed entirely. Instead of forming specialised teams for each subgroup after patient classification, the project that Red Tree facilitated took a different direction, which was agreed upon the leadership of Blue Stone. Rather than focusing on subgroup management, the project primarily revolved around the development of new services. Initially, the plan was to develop one or more of these new services for each one of the five subgroups. However, as discussed later (see Project deliverables: New services with increased coordination across disciplines), most of the developed services and new ways of organising care were not significantly tied to a specific subgroup; they primarily concentrated on enhancing communication and coordination across disciplines.

The third occurrence took place during a meeting in later stages of the project. As usual, the people from Red Tree had sent out some preparatory reading material beforehand. One of these documents offered an 'imagination' of the new primacy care centre for elderly patients. This document was received very well among many of the group members, as it provided clarity

on their collective objectives, and how the different elements could all come together. Multiple project members explicitly welcomed this document for providing clarity. This prompted one participant (Coordinator Allied Health Care, 19), who had apparently also noticed the excitement about this document, to raise the question whether this imagination affected the group's perceptions of the newly developed services within the project. The short conversation that followed exemplifies and reaffirms our observation of a diminishing importance attached to the subgroups:

> 14 (General Practitioner): "In the [document], the division into subgroups seems important, but I think we let that go at some point, pretty quickly at the beginning."
> "Is that a bad thing?" 15 (Board Secretary) replied.
> 19 (Coordinator Allied Health Care) certainly doesn't think so: "only good, actually."
> (Observation report, 6)

Now, respondent 14 (General Practitioner) may have overstated things a bit by suggesting that the initial subgroup division was entirely let go. But the fact that even one of the project members (and possibly more) felt this way, plus the fact that others viewed this positively rather than as a problem, underscores the gradual fading of the subgroup management concept. Whereas it had initially laid the groundwork for the five subgroup categories for elderly patients, its significance gradually diminished as the project proceeded.

The disappearance of costs

A week or so before the first project meeting, Red Tree had sent out some preparatory reading material. This included a document that is referred to as a 'framework' and 'inspiration' regarding the application of the principles of value-based primary care specified for elderly patients. With regard to the notion of value, one thing that stands out in this document is the large emphasis that is placed on outcomes, while costs are mentioned only sporadically. Moreover, when costs are occasionally mentioned, they are portrayed as intrinsically connected to payment structures (*bekostiging*), rather than say, the idea of providers measuring costs and pursuing efficiency:

> In the current health care system, professionals are responsible for the (health) outcomes and health care insurers for the financing. Both parties and perspectives are important. Health care professionals and health care insurers are both responsible for value-based health care.
> (D1)

Accordingly, Red Tree has rhetorically framed the aspect of costs as something belonging solely to the sphere of payment structures. In effect, responsibility over costs, including the measuring and controlling thereof, was kept away from provider organisations and the work of care professionals, and placed in the hands of insurers. And at no point during the project did we observe any of the Blue Stone employees bringing it up either. Hence, when it comes to the responsibilities of providers, the objective of monitoring costs was bypassed.

The disappearance of costs was finalised on one of the slides that were presented during the first group meeting. It summarised the 'development framework VBHC primary care'. The

term costs (or efficiency for that matter) did not make it onto the slide. Instead, project members were presented a list of the five core elements of value-based primary care as outlined by Porter et al. (2013)—albeit with some slight modifications. Strikingly, with regard to the third point on the list ('measuring value' in the original text), Red Tree's version read '*benoem en meet uitkomsten*' (identify and measure outcomes).

Near the end of the project we interviewed the director of Red Tree, and, among other topics, asked him/her about the disappearance of costs that we were observing. We specifically asked to what extent framing the monitoring of costs as the responsibility of insurers had been a conscious 'rhetorical tactic' made by the consultancy agency.

> It is not that it has been avoided, but rather: what is feasible within a trajectory like this? [...] And from a change management point of view, and how do you get people on board? What drives them to get involved is better treatment outcomes and health outcomes for patients and their families. That is what binds us. That binds a health insurer; it inspires them. A health care professional, a hospital administrator, the patient—that inspires everybody. [...] A health insurer also knows; if quality and treatment outcomes are improved, costs will fall. That's why we haven't focused on that for now [cost]. But rather: how do you achieve better outcomes for that target group.
>
> (Consultant, 20)

So, the topic of monitoring costs was not avoided per se, it just did not have the immediate attraction that was deemed desirable in the eyes of Red Tree. By contrast, the goal to improve outcomes was considered a powerful notion that can 'get people on board'. At least within our case study, monitoring costs—unlike improving outcomes—did not manage to tie together a diverse set of actors in alignment with a common goal; and while being a major component of the original VBHC idea, *it got lost in translation in favour of that which binds*.

An impetus for cross-disciplinary interaction

Our analysis revealed an image of VBHC working as a catalyst for interaction. The project of our case study in itself exemplifies how VBHC can bring together a multidisciplinary collection of professionals and foster communication among them concerning potential improvements in health care delivery. Interestingly, as the project deliverables (the six mini business cases) reveal, these improvements were primarily sought and pursued via increased cross-disciplinary coordination (see Project deliverables: New services with increased coordination across disciplines). In terms of translation, VBHC may not only have converged interests towards the shared goal of better addressing patient needs (see Patient needs: A common goal), it may have also redirected behaviour in alignment with that goal: by increasing communication and coordination across professional disciplines.

In several of the interviews, respondents expressed and reaffirmed this image of VBHC stimulating cross-disciplinary interaction. One respondent referred to 'bringing islands together' (General Practitioner, 14) and another (Business Operations Manager, 7) literally referred to 'de-pillarization' as the core of VBHC, particularly concerning the use and sharing of information and knowledge and the interaction between disciplines. S/he further emphasised this point when asked about his/her views on the main goal of the project:

> For me that is working across borders. What I just said: that you desegregate [*ontschotten*], de-pillarize between disciplines, and that you are equivalent. I think that *that* is the most important step, internally. Because everyone is very much thinking from their own existing role. And, well: period. I think that's the biggest obstacle. I think that I think if you were standing at a drawing board with different groups and [say] "how would you arrange the care for this patient?" Then something very different comes out than at a consult with the GP, or a doctor's assistant, or a practice nurse, or a nurse specialist.
>
> (Business Operations Manager, 7)

The quote above not only indicates a perceived potential for more cross-disciplinary collaboration as such, but expresses a belief that this would foster improvements for patients. In order to do realise this potential, however, obstacles would need to be overcome, and VBHC was seen as helpful tool in this regard. Another respondent further highlighted the image of VBHC as an impetus for cross-disciplinary interaction regarding the main goal of the project:

> Where you [...] actually have an integrated care path, in which all health care professionals come together and work efficiently, so that the quality of care, and particularly also how that should be in the vision of the elderly, that this can take place. [...] And in the end, I think that VBHC, the whole concept, can be a very nice tool for doing that. [...] I hope we can move towards that: that we can listen to the patient; that we can shape around it, in a permanent team.
>
> (General Practitioner, 5)

Apparently, within this *multidisciplinary* primary care organisation, there was a desire and aspiration for more profound *cross-disciplinary coordination*. And within our project, VBHC enabled Blue Stone to act on this aspiration. As the project deliverables reveal, it is primarily by enhancing cross-disciplinary coordination that project team members had been working towards better addressing patient needs.

Project deliverables: New services with increased coordination across disciplines

As mentioned, most of the time and energy within the project of our study was spent on developing new services. At the start, the plan was to develop two new services for each of the five patient groups, but as the importance of this subgroup division faded, the focus became placed on services for specific groups of patients. So, rather than having any one of the five original subgroups in mind (see The gradual fading of subgroups) some of the services came to target very specific groups (e.g. patients that need palliative oncology care), while others have target groups that cut across the original subgroup divisions (e.g. patients with osteoarthritis).

In general, however, the project deliverables (i.e. the six mini business cases) were designed to better address patient needs. And while each has its specifics, most of the new services contain a component that enhances cross-disciplinary interaction. Table 1 provides a summarised overview of the project deliverables: the six mini-business cases are listed in the first column; the second column describes their main objectives and how these will be pursued.

TABLE 1 A summarised overview of the project deliverables and the translation of VBHC.

Mini business case	Main objective and design of process
1. A program on movement and joy	What? Providing a social meeting place and group activities such as low-key physical exercise and yoga How? This space within the new care facility, aimed at meeting and moving, should enable easier communication between elderly and their primary care providers. To do so, workshops will be offered concerning both moving (e.g. dance) and mental well-being (e.g. mindfulness)
2. Optimising palliative oncology	What? Improving the care for this target group by enhancing coordination among various (primary) care practitioners How? Two ways to improve coordination. Firstly, by appointing a 'case manager oncology', a nurse tasked with facilitating communication and the coordination of care around the palliative patients, who will meet the case manager in periodically scheduled consultations. Secondly, ACPs which will be established and monitored for each patient in this target group
3. An online health test	What? Attract new patients and profile the primary care organisation as an expert centre for elderly patients How? A short online health-status test for elderly (free of charge). Participants are encouraged and invited to discuss test results and opportunities to improve their health
4. A care path osteoarthritis	What? Increasing the multidisciplinary collaboration between practitioners involved in osteoarthritis in order to improve outcomes and potentially lower costs How? GP refers each patient diagnosed with osteoarthritis to a physical therapist, who will discuss treatment options. If deemed viable, patients are offered a treatment program that includes patient education, physical therapy and at home exercise
5. Program for healthy ageing	What? Improve and sustain 'vitality' (i.e. good health) while ageing How? By offering multiple periodic activities year-round, aimed at increasing and sustaining both mental and physical health and well-being. The design and provision of the activities should bring together social and medical care workers, and enhance the communication and coordination between them
6. Geriatric primary care	What? Improving outcomes for a selection of patients who have multiple and relatively complex care needs How? By strengthening the role of the geriatrician in caring for these patients; more cross-disciplinary interaction, especially through enhanced and more structured interaction and coordination between the geriatrician and a practice nurse regarding the design, delivery and periodic evaluation of treatment plans

Abbreviations: ACPs, advanced care plans; GP, general practitioner; VBHC, value-based health care.

Except for the online test (3), which is aimed at attracting new patients, all of the care concepts are based on the identification of specific patient needs; two includes a program for physical movement or exercise in group setting; and four explicitly emphasises enhanced forms of coordination between caregivers (either within or across organisational boundaries). Thus, within this

project, VBHC got translated into an approach for better addressing patient needs by increasing interaction and coordination across primary care disciplines.

DISCUSSION

In this study, we analyse how VBHC transitions from theory to practice by building on the ANT-inspired concept of translation—referring to a process of converging interests and redirecting behaviour in alignment with a common goal (Callon, 1986). While we are not the first to apply a translational perspective to study VBHC (Bonde et al., 2018; Colldén & Hellström, 2018), this is the first of such studies that focusses on a primary care organisation rather than hospitals. Moreover, and unlike these earlier studies, we not only use the concept to describe how a certain local transformation of VBHC took shape, but also build on our findings to explain why VBHC transforms the way it does.

In contrast to the notion of 'implementation' and its close cousin 'diffusion', which both suggest a process of something consistently being *rolled out*, translation stresses the need to *enrol* (Callon, 1986; Latour, 1987). From this perspective, the growth and endurance of any product or idea across time and space will depend on its ability to enrol 'allies'. The project of our case study exemplifies VBHC's ability to bring together (i.e. enrol) a diverse set of actors and converge their interests towards a common goal. This ability has been documented before, and probably plays a major role in VBHC's global popularity (Bonde et al., 2018; Svallfors et al., 2022; Van Elk et al., 2021).

Within a process of translation, however, successful enrolment will inevitably entail transformations to the original idea: allies will leave their imprints; they will adapt it for their own purposes (Latour, 1987). In our case, the original goal of patient value was translated into the objective of better addressing patient needs, and VBHC was interpreted as an approach to do so. More specifically, VBHC became an impetus for more cross-disciplinary interaction. As shown by several of the project's deliverables (see Table 1), it was particularly through enhanced cross-disciplinary coordination that the common goal of better addressing patient needs was pursued. Furthermore, our findings show parallels with earlier studies that documented projects in which parts of the original idea of VBHC were gradually omitted (i.e. got lost in translation) (Colldén & Hellström, 2018; Nilsson et al., 2017). Within the project of our case study, the original idea to measure costs was quickly left behind in favour of an emphasis on outcomes. Additionally, the importance attached to the idea of value-based subgroup management—a crucial component of the original views on value-based primary care (Porter et al., 2013)—faded away as the project proceeded.

But while translation indeed emphasises unavoidable transformation, it also emphasises a (subsequent) state of stability and endurance (Callon, 1986; Latour, 1987). In terms of ANT, or what we refer to as the 'traditional' view on translation in our theoretical section, a successful process of translation consists not only of enrolling actors by converging interests towards a common goal, but also of the durable redirection and controlling of behaviour in alliance with that goal (Latour, 1987). Thus, the most successful processes of translation manage to redirect and control the behaviour of enroled allies as if they were parts of a machine (Latour, 1987, p. 129). Regarding VBHC, our analysis indicates there may be early signs of some predictability in the behaviour of enroled actors; we would consider it premature, however, to speak of a successful process of translation. As will unfold below, these potential signs of a stable pattern point

towards three underlying explanations for the locally varied and seemingly incoherent ways in which VBHC transforms as it transitions from theory to practice.

For instance, regarding the disappearance of costs in favour of an emphasis on outcomes, it is worthy to note that similar observations have been made in earlier studies on VBHC (Erichsen Andersson et al., 2015; Nilsson et al., 2017; Steinmann et al., 2021, 2022). In terms of translation, it appears that on several occasions the topic of (measuring) costs is omitted in favour of an emphasis on outcomes and its perceived ability to enrol a variety of allies. Medical professionals in particular seem to be more interested in the outcomes than the costs of their work processes (Nilsson et al., 2017). As one of our respondents explained, outcomes rather than costs is what 'drives them to get involved'. It is not unlikely, and perhaps even somewhat obvious from a translational perspective, that VBHC transforms (i.e. undergoes modifications) in ways that serve its ability to enrol.

With regard to the fading importance attached to subgroup management, we believe the underlying reason lies in the profoundness of the organisational change that this would entail for most (Dutch) primary care providers. Earlier work on the adoption of VBHC principles in Dutch hospitals revealed that, here too, rather than making radical structural changes, these organisations overlay their existing structures with new forms of (informal) cross-disciplinary coordination (Steinmann et al., 2022). Thus far, at least in The Netherlands, VBHC's transition from theory to practice does *not* bring about the radical organisational restructuring professed by its originators. In terms of translation—even among enroled allies—VBHC has not (yet) been able to redirect and control organisational behaviour to such an extent. And this conservative approach may well become a stable pattern: radical changes in health care organisations are often constrained by dominant medical professionals who tend to prefer the status quo over facing the risks that may accompany profound structural change (Currie et al., 2012). Therefore, we posit that VBHC will often transition from theory to practice in ways that keep traditional organisational structures and formal inter-professional arrangements intact. However, as reaffirmed by our case study, this does leave room for VBHC to become an impetus for the types of cross-disciplinary coordination that overlay rather than break with traditional arrangements (Steinmann et al., 2022). Nevertheless, it is simply too early to tell whether this will eventually constitute an enduring pattern of behaviour that, as part of a successful process of translation, is tied together in alliance with a VBHC-inspired goal.

With VBHC being translated into an approach for better addressing patient needs by increasing cross-disciplinary coordination, our case study displays a process in which VBHC latches onto and re-emerges as a revived version of two previously dominant principles within Dutch primary care policy: multidisciplinary collaboration and patient-centred care (Felder et al., 2018). This tendency to blend with pre-existing policy objectives may well be crucial in understanding both VBHC's global popularity, and also *why* it transforms the way it does at various times and places. While previous studies pointed more generally towards VBHC's inherent ambiguity in explaining its popularity (Colldén & Hellström, 2018; Ramsdal & Bjørkquist, 2020), our analysis indicates a more specific capability to latch onto and blend with other (previously) influential policy objectives. Accordingly, VBHC can (re)emerge as part of an agenda for patient empowerment and shared-decision-making in one setting (Steinmann et al., 2020), part of a 'knowledge-driven management system' in another (Falkenström & Svallfors, 2022) and elsewhere gets mixed up with Berwick's (et al., 2008) Triple Aim (Lewanczuk et al., 2020). So, in several locally varied cases, part of how VBHC transitions from theory to practice is by linking up with (previously) influential objectives. Now and again, VBHC will undergo modifications, additions, and omis-

sions as it blends with these policy objectives and transforms into a suitable approach for their pursuit.

Here, our findings demonstrate an overlap with prior work in medical sociology, particularly regarding the prevailing coexistence of competing ideals—clinical effectiveness, economic efficiency, and patient involvement—which are entrenched in the reform agendas of many contemporary health care systems, and which put pressures on medical professionals to manage the tensions between them (Moreira, 2013, cited in Moleman, 2021). Indeed, our case study revolved around a project in which medical professionals were introduced to a novel reform framework (VBHC), where the overarching goal of patient value combines the ideals of effectiveness (outcomes) and efficiency (costs). And the fact that project members explicitly blended patient-centeredness into their conception of VBHC reflects the prominence of patient involvement in the Dutch health care system (Moleman, 2021; Steinmann et al., 2020). Within the project of our case study, the complexity resulting from these competing ideals was compounded by a project trajectory that focused on the development of new services by care providers, who were essentially tasked with assuming the role of service innovators. And all of this unfolds within the context of the Dutch health care system, in which primary care providers, especially GPs, have been assigned a critical gatekeeping role, aimed at ensuring appropriate rather than supply-driven access to specialist care and diagnostic tests (Rotar et al., 2018). Without question, Dutch primary care providers are tied to multiple competing interests and ideals. As they navigate their way through these tensions, the application of new reform frameworks such as VBHC will often not entail radical changes that neatly align with the original objectives, but translate into relatively minor adjustments to health care systems that are already characterised by a highly intricate status quo (Moreira, 2013, cited in Moleman, 2021).

So, as exemplified by the current study, it is clear that the transition of VBHC across settings implies that the concept will concede at least some of its original components: its spread hinges on various local concessions (cf. Latour, 1987). It should also be clear, however, that these concessions will be neither random nor neutral. Rather, they will result from the demands put forth by new potential allies, and the diverging interests of existing networks. In this regard, a translational perspective highlights the parasitic potential that is embedded in the spread of ideas within and across health care systems. Existing alliances may very well expropriate a new and seemingly popular idea, mould it such that it serves their own purposes, and exploit it to redirect behaviour accordingly. With regard to VBHC, we have already described how the concept is taken up by various existing policy agendas, and other scholars have warned against the concept's parasitic exploitation, particularly through the promotion of a 'deceptively simple' understanding of value for patients (Triantafillou, 2020), whose popular appeal can be wielded to mask the pursuit of vested interests (Svallfors et al., 2022).

CONCLUSION

While the concept of translation as developed within ANT indeed emphasises unavoidable transformation, it also stresses a (subsequent) state of stability and endurance (Callon, 1986; Latour, 1987). It is the *combination* that gives the metaphor its sway: a stabilised relationship between unsimilar things (like translations between languages). Our translational account of VBHC's global popularity confirms its ability to 'enrol allies', which inevitably entails changes to the original concept. Our analysis suggests three underlying reasons that could help explain the seemingly incoherent ways in which this popular concept transforms as it moves from (original)

idea to (local) application. First and foremost, VBHC undergoes transformations because this enables the enrolment of a growing support base (e.g. by emphasising outcome measurement at the expense of costs). Second, the original idea professes radical changes, too radical perhaps; its applications tend to remain conservative (e.g. by overlaying rather than overthrowing traditional structures). Third, in locally varied ways, VBHC has the tendency to get mixed up with previously dominant health policy objectives and to transform into an approach for their pursuit (e.g. patient centeredness; multidisciplinary collaboration). While these types of transformations could be early signs of the emergence of a stable and enduring pattern, they could, by contrast, also be part of an increasingly incoherent array of estranged actors and initiatives, which may at some point have been related to the label 'VBHC', but without ever forming an alliance of reliable interaction. Therefore, based on this study, we consider it premature to speak of 'successful translation', and we strongly encourage future research that further traces VBHC's journey across the globe.

AUTHOR CONTRIBUTIONS

Gijs Steinmann: study design; data collection; data analysis and interpretation; drafting and completing manuscript. **Hester van de Bovenkamp:** study design; assisted in data analysis and interpretation; assisted in drafting and completing the manuscript. **Antoinette de Bont:** study design; assisted in data analysis and interpretation; assisted in drafting and completing the manuscript. **Diana Delnoij:** study design; assisted in data analysis and interpretation; assisted in drafting and completing the manuscript. All authors read and approved the final manuscript.

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DATA AVAILABILITY STATEMENT

Data that support the findings of this study are available upon reasonable request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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