Advancing Value-Based Healthcare (VBHC) for MedTech in the Asia-Pacific Region

APACMED VBHC POLICY POSITION PAPER

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FOREWORD

Anirudh Sen
Director, Market Access, Asia Pacific
APACMed

Healthcare systems across Asia-Pacific are confronting rising demand, shifting demographics, and increasing pressure to deliver better outcomes with finite resources. These challenges make the transition to value-based healthcare (VBHC) not just timely, but essential.

For several years, APACMed has actively championed this transition. Through continuous engagement with policymakers, HTA bodies, clinicians, patient groups, and global experts, we have fostered shared understanding, built regional capabilities, and shaped dialogue on how VBHC can support more sustainable and patient-centred care. This collective effort forms the foundation of the work presented in this policy position paper.

The analysis highlights both the progress made across APAC and the barriers that still limit widespread VBHC adoption. While readiness levels differ, the direction is clear: aligning incentives to outcomes, strengthening data systems, and embedding value-based principles into policy and procurement will be central to improving care quality and system resilience.

For the MedTech sector, VBHC offers a meaningful opportunity to partner with health systems in delivering measurable improvements in outcomes. It calls on us to generate stronger real-world evidence, support digital integration, and collaborate on designing care pathways that elevate patient value.

Advancing VBHC will require even closer collaboration across all stakeholders, but the momentum is strong and the vision is shared. I hope this paper supports the next stage of this journey and inspires continued partnership toward more equitable, high-value healthcare across the region.

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Associate Professor & Managing Director, Value Institute for Health and Care, Dell Medical School, University of Texas at Austin, United States

Prof Matthew Cripps, BA MA CPFA
Population Behaviour Change Specialist, NHS; Professor, Business School, University of Warwick, United Kingdom

Makoto Tamura, PhD
Director of Medical Technology Policy Research Institute (AMDD); CEO, Healthcare System Planning Institute; Research Professor, International University of Health and Welfare

Dr Shankar Prinja, MD, PhD
Professor of Health Economics, PGI Chandigarh; Former Executive Director, India's National Health Authority, India

Hans Bax, MBA
Senior Adviser, Value & Innovation-based Access, MedTech Europe, Belgium (EU MedTech Association)

CONTENTS

1

INTRODUCTION: VBHC FOR MEDTECH IN APAC

Macro trends and the importance of VBHC in the region

Across Asia-Pacific (APAC), structural forces such as economic expansion, rapid demographic transitions, and growing geopolitical uncertainties are reshaping the region's healthcare priorities and accelerating the need for more sustainable, outcome-focused care delivery models.

Globally, the VBHC market is gaining significant momentum, with its value projected to grow from USD 12 billion in 2025 to USD 38 billion by 2032, a compound annual growth rate of 17%.[1] Following North America, APAC is expected to be the second largest market, accounting for over 25% of the market share in 2025. This reflects the region's growing interest in adopting more sustainable healthcare models driven by both economic pressures and demographic changes.

Demographic changes, particularly driven by ageing populations, have been a critical catalyst for VBHC adoption in the region. By 2050, one in four people in APAC will be over 60 years old, with the population of older persons tripling between 2010 and 2050 (reaching close to 1.3 billion people).[2] This demographic change is coupled with a rise in chronic diseases and age-related health issues, necessitating a shift towards healthcare delivery models that focus on preventing costly hospitalisations and improving patient quality of life. Back in 2022, reports showed that APAC had a higher percentage of deaths due to non-communicable diseases (NCDs) than the global average, with NCDs representing more than 50% of all deaths in every APAC country.[3]

Geopolitical shifts also significantly influence the economics of healthcare delivery, as trade tensions and evolving tariff regimes can impact the flow and affordability of healthcare. Increased tariffs mean that pharmaceuticals and medical devices, which are generally exempt from customs duty, could be subject to tariffs upon import into major global markets.[4] Recent U.S. tariff measures in 2025 did not grant blanket exemptions for medical devices, reflecting a broader trend where governments increasingly prioritise industrial security, local production and supply-chain resilience over global efficiency.[5] For the APAC region, which is both a major manufacturing hub and a significant importer of health technologies, such dynamics risk escalating costs for providers, slowing technology diffusion, and potentially limiting patient access to essential MedTech innovations.[4,5]

Growth in GDP is reshaping how governments prioritise health system investments

Rising gross domestic product (GDP) across the APAC region is not only expanding fiscal capacity but is also reshaping how governments prioritise health system investments. Across the region, GDP growth has enabled countries to allocate more resources towards healthcare infrastructure, a critical enabler of faster VBHC adoption. Countries with stronger economic growth are better positioned to invest in the infrastructure required to support outcome-based care. This includes hospitals, primary care facilities, and digital health systems that enable the delivery, coordination, and monitoring of value-driven services.[6]

Healthcare infrastructure investments increasingly extend beyond physical assets to include digital capabilities. Countries are investing in interoperable data collection systems and health information platforms, which are essential for tracking outcomes and operationalising outcome-based agreements.[7] South Korea illustrates this well in practice. Through its Health Insurance Review and Assessment Service (HIRA), healthcare data is systematically collected and analysed to evaluate provider performance.[8] By linking reimbursement to quality metrics and patient outcomes, HIRA enables a data-driven approach to care improvement and establishes a foundation for scaling value-based models nationally.

Incorporation of VBHC in government policies

In recent years, governments across the APAC region have taken meaningful steps to embed VBHC into national policy, particularly in how public systems assess and fund medical devices. These efforts reflect a shared shift toward aligning health spending with improved outcomes, efficiency, and patient value.

In Singapore, the Ministry of Health's Implant Subsidy List (ISL) exemplifies this approach, where high-cost devices with demonstrated clinical and economic value are added to the list following a rigorous evidence review by the Agency for Care Effectiveness (ACE), the country's health technology assessment (HTA) body.[9]

South Korea has also adopted a structured pricing policy under its National Health Insurance (NHI) using a multi-criteria decision analysis framework to award premium reimbursement for devices that

demonstrate clear value. A selective benefit mechanism further allows for conditional reimbursement of high-impact technologies.

In Japan, cost-effectiveness evaluations are incorporated into reimbursement reviews. Although devices that initially receive innovation-linked premiums may undergo post-launch reassessment to confirm their real-world value, it is important to note that despite the theoretical possibility, HTA has never resulted in higher reimbursement prices since its formal introduction in 2019. In practice, all HTA-driven adjustments to date have led only to price reductions.[10–13]

In Australia, VBHC is supported by a national framework endorsed by federal and state governments. While implementation remains state-led, national-level bodies like the Medical Services Advisory Committee (MSAC) apply VBHC-aligned criteria in funding decisions, including the use of patient-reported outcome measures (PROMs).[14,15]

China has implemented nationwide Diagnosis-Related Group (DRG) payment reforms, transitioning hospitals from a fee-for-service to a case-based funding model. This incentivises the adoption of technologies that reduce complications, shorten stays, and improve health outcomes. National guidance links reimbursement levels to performance, reinforcing a value-oriented approach.[16]

India has been progressively aligning with VBHC principles through Ayushman Bharat, the national health insurance scheme. The use of bundled payments promotes more efficient care delivery, while the Health Technology Assessment in India (HTAIn) agency supports the evidence-based inclusion of medical devices, such as stents and implants, within health benefit packages.[17,18]

Across these diverse systems, VBHC adoption is primarily driven by three evolving policy mechanisms: HTA-based reimbursement tied to evidence of clinical and cost-effectiveness, value-based pricing models that reward innovations with superior health outcomes and bundled or DRG-based payments that link provider reimbursement to system efficiency and patient outcomes.

Common features across the implementation of these VBHC-enabling policies include a growing reliance on real-world evidence (RWE), stronger post-market outcome validation, and an increasing use of patient-centric measures in coverage decisions. Together, these reforms are reshaping how MedTech is evaluated and adopted, moving health systems toward more sustainable, outcome-focused care delivery.

Redefining the key principles of VBHC

At the core of the VBHC framework is the formula "value = outcomes/cost", requiring health systems to improve patient outcomes while using resources more efficiently. Achieving this balance depends on what outcomes are measured and how costs are defined. VBHC models typically assess outcomes such as reduced readmissions, improved functional status, and fewer complications,[19] but increasingly incorporate broader measures, including patient quality of life and daily functioning, to better capture the whole patient experience.[20] By emphasising prevention and early intervention, VBHC shifts care away from reactive, resource-intensive treatment toward more proactive and cost-effective models.

An effective VBHC model requires consideration of multiple cost dimensions. Immediate costs, such as hospital admissions, medications, and physician consultations, are often prioritised because they align with short-term budgeting priorities.[21] However, real value in a VBHC system stems from reducing long-term costs through better outcomes and fewer avoidable complications. VBHC frameworks may include non-medical and social costs, such as productivity loss, caregiver burden, and broader economic impacts on families and communities, to provide a more comprehensive and equitable view of value across the health system.

VBHC models also require a clear distinction between recurring costs and long-term investments, both of which are essential for building sustainable, outcomes-oriented health systems. Recurring costs refer to the routine expenditures necessary to deliver care, including diagnostics, treatment, and the ongoing maintenance of digital infrastructure. In contrast, long-term investments aim to transform health systems to enable value-based delivery at scale. These include deploying new technologies and infrastructure, redesigning care pathways, strengthening outcomes measurement and analytics, enhancing clinical training, and upgrading facility capabilities. Such investments create the foundation for sustained improvements in quality, efficiency, and patient outcomes.

The adoption of VBHC is shaped by differing pressures across stakeholders within the healthcare funding and delivery ecosystem. Payers prioritise cost containment and system sustainability, while providers often remain tied to volume-driven reimbursement. Patients, in turn, face uneven access to high-value technologies and limited awareness of VBHC concepts. These contradictory incentives create practical barriers that impede coordinated progress toward accelerating VBHC implementation.

VBHC priorities also vary by technology type, making it essential to tailor value-based strategies across different product portfolios. For mature, reimbursed, low-cost technologies, value is closely tied to the reimbursement and payment structure. These products are typically reimbursed on a per-procedure basis, creating incentives linked to volume. In contrast, innovative, high-cost (often self-paid) technologies require a different approach. Their value is driven by clinical novelty, therapeutic precision, and long-term impact, making pricing more explicitly value-based.

To address uncertainty and demonstrate real-world benefits, outcome-based payment arrangements are increasingly being used. These contracts tie payment to real-world clinical effectiveness, such as improvements in survival, remission rates, or functional recovery, particularly in high-impact areas like gene therapies and breakthrough oncology treatments. In these cases, traditional pricing and reimbursement mechanisms are insufficient, necessitating more sophisticated outcome-based models to support access while ensuring value for money.

2

OUTSTANDING BARRIERS TO THE ADOPTION OF VBHC

HTA processes remain cost and budget-impact-driven

HTA is a multidisciplinary process that systematically evaluates health technologies to inform decisions on their adoption, coverage, and appropriate use, ensuring that healthcare resources are allocated efficiently and deliver the greatest overall value. In many APAC markets, HTA processes are still evolving and remain primarily driven by financial considerations, such as the cost and budget impact of new technologies, reflecting a narrow focus on cost containment. While there has been notable progress in introducing more comprehensive value assessment frameworks (VAFs), particularly in higher-income countries, these efforts are often still shaped by affordability thresholds and fiscal constraints. In middle-income countries, reimbursement decisions frequently prioritise lower-cost options, which can limit access to innovative technologies despite potential long-term benefits.[22]

Furthermore, the challenge is not only methodological but structural. HTA bodies in several markets face limited staffing, data access, and analytical capacity. These constraints reinforce conservative decision-making and may inadvertently favour lower-priced technologies at the expense of innovations that could reduce longer-term system costs or improve patient outcomes. The downstream result is that technologies with proven outcome benefits may face delayed or restricted access, perpetuating inefficiencies in care delivery and widening inequities between regions or patient segments with differing ability to pay.

VBHC is not sufficiently operationalised beyond HTA and reimbursement negotiation frameworks

While HTA contributes to assessing the clinical and sometimes the economic value of health technologies, its current scope in many countries may be too limited to fully support the broader aims of value-based care. According to the BRAVER Roadmap by the Office of Health Economics (OHE), most HTA frameworks in the APAC region limit assessment elements to direct healthcare costs and benefits, often overlooking societal domains such as productivity, informal care, and equity in care. Although there is growing recognition of the importance of incorporating broader innovative and societal value elements, their practical integration into HTA remains limited. For instance, only a few APAC countries, such as China and Thailand, allow the inclusion of a societal perspective in their economic evaluations in HTA.[23] True VBHC demands new ways of measuring broader benefits, rewarding value creation, and optimising resource use across the entire care continuum.

As implementation beyond HTA and reimbursement remains limited in various APAC countries, systems continue to reward activity volume rather than outcomes. Without clear downstream linkage to procurement, contracting, and provider incentives, HTA improvements alone cannot shift behaviour or funding flows toward prevention, long-term outcomes, or continuity of care.

Public procurement tends to be price-based

Prevailing public procurement practices represent another barrier to the adoption of VBHC. Most hospitals and health systems purchase medical products primarily based on upfront purchase costs. This is often driven by a focus on short-term cost savings, which may not adequately address the preferences of those delivering care and the needs of those receiving it. An estimated 70% of global MedTech sales are procured through a public procurement process, and 70% of the decisions in these cases are based on price.[24]

Several system realities reinforce this practice. Procurement teams are often mandated to prove fiscal stewardship, operate under strict annual budgeting cycles, and face audit scrutiny that disincentivises higher-priced tenders even when lifecycle value is superior. In decentralised purchasing environments, contracting officers may lack incentives to consider downstream outcomes, leading to lowest-price awards that overlook total system cost and patient benefit.

A good example of changing paradigms in this regard is where the European Parliament adopted a resolution that encourages contracting authorities, including hospitals and health systems, to move away from price-only procurement. Instead, the new public procurement directive, to be passed later this year, is expected to establish a more holistic perspective for procurement that factors in quality, innovation, and broader socioeconomic considerations in the purchasing of MedTech products.[25]

3

HEALTHCARE SYSTEM READINESS FOR VBHC ADOPTION

While healthcare delivery transformation has been accelerating across the APAC region, many healthcare systems continue to face structural barriers to adopting VBHC, including fragmented funding pathways, a lack of supporting infrastructure, and varying levels of data readiness. These gaps create challenges in scaling VBHC models and realising their full impact on patient outcomes and system sustainability.

Table 1 outlines the different dimensions assessed for determining VBHC readiness levels, including the maturity of VAFs, alignment of reimbursement pathways with population coverage pathways, payment innovation in procurement, infrastructure to support VBHC, and the level of stakeholder dialogue and collaboration. The detailed scorecard used for assessment across key dimensions is in the Appendix.

To facilitate cross-country learning, three archetypes were identified based on VBHC readiness levels. India, Singapore, South Korea, China, Australia, and Japan were selected to reflect the full spectrum of healthcare system maturities across the region.

Archetypes identified:

- **Foundational healthcare system:** Limited/no formal structures supporting VBHC for MedTech, with fragmented reimbursement, minimal data infrastructure for outcomes tracking, and largely ad-hoc stakeholder engagement.

- **Advancing healthcare system:** Emerging structures to support VBHC for MedTech, through piloting of VAFs, adoption of selective value-based procurement, early real-world data (RWD) infrastructure, and structured but limited stakeholder engagement in HTA, reimbursement and/or procurement.

- **Mature healthcare system:** Developed and institutionalised structures to support VBHC for MedTech, with integrated VAFs, aligned procurement and payment systems, robust data infrastructure and formal multi-stakeholder engagement across HTA, reimbursement and procurement.

***Table 1**. Categories of healthcare system readiness for VBHC adoption*

Category	Foundational	Advancing			Mature	
	India*	Singapore	South Korea	China	Australia	Japan
Maturity of VAFs	No formal or standardised VAF for MedTech	Ongoing development of VAF tailored to MedTech	Well-established, MedTech-specific VAF considered for reimbursement	Ongoing development of VAF tailored to MedTech	Well-established, MedTech-specific VAF considered for reimbursement	Ongoing development of VAF tailored to MedTech
Alignment of reimbursement pathways with population coverage pathways	Fragmented system with limited formal pathways for public reimbursement of MedTech or population-wide services	MedTech routinely included in covered benefit packages, based on transparent and multi-dimensional VAF	Emerging pilot frameworks with inclusion of MedTech in public reimbursement	Emerging pilot frameworks with inclusion of MedTech in public reimbursement	MedTech routinely included in covered benefit packages, based on transparent and multi-dimensional VAF	MedTech routinely included in covered benefit packages, based on transparent and multi-dimensional VAF
Payment innovation in procurement	Procurement is driven by lowest-price tendering or volume-based decisions with minimal consideration of value, safety, or innovation	Partial transition to value-based procurement	Partial transition to value-based procurement	Procurement is driven by lowest-price tendering or volume-based decisions with minimal consideration of value, safety, or innovation	Partial transition to value-based procurement	Procurement and payment systems are strategically aligned to reward value across the care continuum
Infrastructure to support VBHC	Data systems are sparse, fragmented, or siloed	Pilot projects for RWD and PROMs collection underway in selected regions or institutions	Data systems are sparse, fragmented, or siloed (with minimal infrastructure for tracking clinical outcomes, PROMs)	Pilot projects for RWD and PROMs collection underway in selected regions or institutions	Pilot projects for RWD and PROMs collection underway in selected regions or institutions	Pilot projects for RWD and PROMs collection underway in selected regions or institutions
Level of stakeholder dialogue and collaboration	Limited or informal consultation processes	Targeted stakeholder involvement in HTA reviews or procurement	Targeted stakeholder involvement in HTA reviews or procurement	Targeted stakeholder involvement in HTA reviews or procurement	Institutionalised multi-stakeholder dialogue platforms	Institutionalised multi-stakeholder dialogue platforms

** While India is currently classified within the "Foundational" archetype, experts acknowledged that more developed states in the country have made significant progress toward transitioning into the "Advancing" health system category.*

These archetypes were then used to develop pathways and define policy sequences to accelerate VBHC adoption, i.e. which foundational reforms (e.g. establishing a common understanding of VBHC among stakeholders) should come first, so recommendations are staged in a pragmatic order to support sustained regional progress toward VBHC.

It is important to note that the classification also reflects the extent to which mechanisms are limited to pilots versus routinely implemented and institutionalised across the assessed dimensions (including the presence of active multi-stakeholder support to drive VBHC progress in-country).

PATHWAYS TO INCREASING VBHC ADOPTION IN THE REGION

4

VBHC in APAC is advancing unevenly across markets, but the underlying drivers are shared - the need to align health outcomes with system sustainability and patient value. Moving from isolated initiatives to a cohesive regional movement requires comparable progress across six mutually reinforcing pathways.

Establishing a shared understanding of value

The first step toward VBHC adoption is a common definition of "value". Policymakers, payers, clinicians and manufacturers often interpret the term through different lenses, such as fiscal control, clinical performance or patient experience, which can fragment decision-making. Building consensus around value, which is the relationship between health outcomes that matter to patients and the total resources used to achieve them, creates alignment across stakeholders.

Embedding this shared understanding within national health strategies, HTA frameworks and procurement guidelines helps shift the focus from cost minimisation to optimising impact. It also encourages a more balanced view of value that considers allocative efficiency (how resources are distributed), technical efficiency (how care is delivered), and personal value (how care meets individual needs).

And as this shared understanding evolves, it is equally important to recognise that perspectives on value will continue to differ by context. A state procurement agency may assess value through budget impact and supply robustness, whereas a national purchaser may prioritise long-term outcomes and population-level benefit. Similarly, value metrics for capital equipment may differ from those for consumables or surgical devices. Context therefore nuances how value is interpreted and operationalised. Clearly articulating the contextual frame alongside the definition of value supports alignment across stakeholders and enables more coherent decision-making.

Strengthening outcome measurement and data systems

Outcome measurement and data infrastructure are core to VBHC operationalisation. Without reliable and comparable data, health systems cannot evaluate the effectiveness of technologies or reward improvements in patient outcomes. Developing interoperable health information platforms, common standards for PROMs, and secure data-sharing governance will be critical to scale.

Countries can begin with smaller, more manageable disease-specific registries and progressively build toward larger national datasets. Digital health investments should be prioritised to enable RWE generation for MedTech, especially where long-term clinical and economic benefits need to be demonstrated. Systems that link payment to measurable results, for example, premiums for demonstrated cost savings or superior outcomes, illustrate how data can directly support value recognition.

Embedding VBHC principles into payment and procurement

Traditional fee-for-service structures reward volume rather than outcomes. Introducing payment models that tie reimbursement to performance is key to aligning incentives. Hybrid arrangements, such as bundled or case-based payments combined with outcome-linked components, can strike a balance between financial predictability and encouraging innovation.

Procurement mechanisms should evolve from price-based bidding to strategic purchasing that considers total value over the product lifecycle. Evaluating technologies based on their ability to improve outcomes, reduce downstream costs, and enhance system efficiency enables governments to reward genuine innovation while maintaining budget discipline. Outcome-based agreements and risk-sharing contracts can be introduced gradually through pilots before being scaled nationwide.

Creating supportive policy and regulatory environments

National policy frameworks are the backbone of sustained VBHC implementation. Embedding value-based principles within HTA, pricing and reimbursement guidelines ensures consistency and clarity for industry and payers. Policymakers should consider expanding assessment criteria to capture societal and productivity benefits in addition to direct medical costs.

Recognising economic premiums for cost-saving technologies or enabling co-payment schemes that improve access to innovative treatments, can accelerate adoption without compromising equity.

A shift from price-based decision-making to a VBHC-oriented policy approach is inherently incremental. Clear, staged milestones are needed to guide this transition, with stakeholders jointly defining progress indicators that reflect both policy evolution and real-world impact. Establishing these markers enables transparent tracking, supports accountability, and builds momentum for sustained reform.

Empowering healthcare providers and patients

Clinicians and patients are at the centre of the VBHC transformation. Frontline engagement ensures that care pathways and measurement systems reflect real-world practice and patient needs. Empowering providers to co-design and lead improvement initiatives encourages ownership and sustains behaviour change beyond policy directives.

Patient involvement in treatment decisions and outcome evaluation should be institutionalised through shared decision-making tools, transparent information platforms, and feedback mechanisms. Health literacy initiatives and neutral sources of treatment information help patients understand their options, contributing to more informed care choices.

Fostering multi-stakeholder collaboration and capacity building

Adopting VBHC at scale requires a culture of collaboration and continuous learning. Governments, industry associations, academia and providers should jointly support forums for exchanging knowledge on value assessment, health data analytics, procurement reform and outcome measurement. Regional platforms such as APACMed can convene stakeholders to share best practices and develop common methodologies for evaluating MedTech innovations.

Public-private partnerships and knowledge-exchange networks help disseminate successful models across markets and develop the skills necessary to integrate VBHC principles into everyday practice. Education and capacity building are long-term investments that enable sustained change in how value is understood, measured and rewarded.

VISION FOR VBHC FOR MEDTECH IN APAC

5

APACMed envisions a foreseeable future where medical technologies are assessed, adopted, and reimbursed based on the value they deliver to patients and health systems. Advancing VBHC for MedTech requires coordinated policy reform, stronger data and evaluation frameworks, and deeper partnerships across stakeholders.

Global and regional case studies demonstrate how VBHC approaches can be more effectively operationalised across varying healthcare systems. The following examples illustrate how countries around the world, at various stages of system maturity, have integrated VBHC in ways that reflect their local contexts. Although all these countries are still refining and scaling their approaches, their experiences thus far offer valuable insights for other regions seeking to expedite the advancement of VBHC.

International VBHC example: The Netherlands

The Netherlands, like other high-income countries, has seen a rising incidence of type 1 diabetes (T1D), placing increasing pressure on health systems and families, particularly where glycaemic control is suboptimal, and complications drive avoidable hospitalisations and long-term costs. Diabeter, a centre for T1D care and research, was founded in 2006 by paediatric diabetologists in response to this growing burden, with the explicit aim of improving outcomes for people with diabetes. This includes fewer complications, fewer hospitalisations, and better quality of life, while containing total system costs.[26]

Key factors	VBHC implementation details
Recognising the need for VBHC	Clinicians at Diabeter recognised that traditional, fragmented diabetes care (e.g. short consultations, limited data integration, and a focus on episodic visits rather than continuous management) was not delivering the best possible outcomes for children and young adults with T1D.
VBHC implementation through the full care cycle	To shift from volume to value, Diabeter concluded that diabetes care needed to be reorganised around the patient's condition over the full care cycle, supported by continuous data collection and a team dedicated to long-term outcomes rather than fee-for-service activity. The centre operationalises value through various areas:[27] 1. Condition-focused, integrated clinic model based on the diabetes "care cycle". 2. Intensive use of digital health and IT systems to allow for streamlined tracking of glucose data and patient coaching. 3. Personalised technology-enabled care pathways. 4. Partnership with a MedTech company to scale Diabeter's clinic model beyond T1D to broader diabetes populations.
Outcomes achieved	Evidence from Diabeter and independent analyses indicates meaningful improvements in health outcomes and efficiency. This includes improved glycaemic control in patients, reduced acute events and hospitalisations (a low admission rate of ~3%) and lower total cost of care compared to other providers. Diabeter has even been highlighted in European VBHC discussions and awarded the VBHC Prize as a leading chronic disease model that systematically measures outcomes and integrates them into care improvement.[28]

Diabeter offers a concrete example of how a condition-focused, digitally enabled, outcome-measured clinic model can operationalise VBHC in chronic disease, as well as how MedTech can move from a transactional device provider to a strategic partner in delivering measurable value.

APAC VBHC example: India

India's health system has historically been operated under volume-driven reimbursement practices, where providers are paid based on the quantity of services delivered rather than the quality or outcomes achieved. However, the country continues to face a high burden of disease, including rising NCDs, persistent infectious diseases, and climate-linked illnesses, alongside high out-of-pocket expenditure (nearly 50% of total health spending) and quality concerns, where thousands of deaths annually are attributable to poor care quality. These systemic challenges highlighted the need for a shift toward value and patient-centred outcomes within India's largest public insurance scheme, Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-JAY).[29]

Key factors	VBHC implementation details
Recognising the need for VBHC	The National Health Authority (NHA) explicitly recognised that PM-JAY's existing incentive model had loopholes, including a lack of direct measurement of outcomes or patient experience and weak linkage to financial protection or readmissions. NHA thus concluded that a new value-based incentive model was necessary to align provider behaviour with PM-JAY's objectives of improving health outcomes, patient experience, and financial protection.
VBHC implementation through the full care cycle	The NHA developed the country's first national VBHC framework for PM-JAY in India through a 2022 policy document, "Volume-Based to Value-Based Care". The reform follows a structured, multi-step plan: 1. Establishing the conceptual foundation for value-based care to align with the international value agenda (e.g.systematic outcome measurement, integrated care pathways). 2. Introducing a redesigned incentive model to tie incentives with measurable results (e.g. patient satisfaction, reduced readmissions, out-of-pocket [OOP] expenditure). 3. Development of data, IT and analytical infrastructure to operationalise value-based payments. 4. Piloting of the new value-based incentive system. 5. Nationwide rollout of the VBHC model, supported by a multi-tier governance structure and extensive capacity building.
Outcomes achieved	While still in phased implementation, reforms are expected to benefit various stakeholders. This includes reduced OOP expenditure, protection from catastrophic spending, reduction in avoidable readmissions for the health system, increased alignment of incentives towards outcomes rather than accreditation for providers, and better continuity of care and long-term health outcomes tracking.

This VBHC roadmap for PM-JAY in India is expected to deliver improved outcomes, greater financial protection, and more transparent provider performance. For MedTech, the shift brings heightened emphasis on RWE, measurable value, digital integration, and lifecycle performance, which creates both opportunities and responsibilities as India deepens its transition from volume to value.

Both case studies shed some light on the value that MedTech companies can bring in advancing VBHC by shifting from product-centric to outcomes-oriented partnerships. In this regard, several priority areas for stakeholder collaboration emerge:

1. Co-design high-value care pathways

Work with policymakers and providers to develop condition-focused care pathways (as seen in the Netherlands case study) that integrate diagnostics, devices, and digital tools. This helps address pathway gaps, such as delayed diagnosis, variability in care, and inadequate follow-up, while aligning technology adoption with measurable outcomes.

2. Strengthen outcome measurement through PROMs and RWD collection

Support the development of PROM tools, registries and analytics platforms, and collect local RWD to subsequently demonstrate the full clinical and economic value of adopted medical technologies.

3. Enable digital and data interoperability

Contribute interoperable digital solutions, including remote monitoring and device-integrated data flows, that can connect with national digital health platforms or hospital electronic health record (EHR) systems.

4. Build provider capabilities for VBHC delivery

Support training on outcomes measurement, care-pathway redesign, digital tools, and VBHC contracting. This can involve collaborations with global initiatives, such as the ICHOM Certified Value-Based Health Care Professional Program, to enhance VBHC capabilities among providers and facilitate knowledge sharing among MedTech industry experts across the APAC region.

5. MedTech readiness as a value-based seller and innovator of medical products

Similar to procurement systems, MedTech organisations have historically operated within price-driven markets. Transitioning toward value-based competition requires rethinking product design, evidence generation and commercial models. This involves demonstrating contributions to outcomes and system efficiency, as well as societal and environmental value where relevant. By adapting business models, strengthening evidence strategies and aligning innovation to provider and patient needs, MedTech companies can position themselves as partners in value creation rather than prod-

uct suppliers. Over time, this shift incentivises innovation that delivers meaningful improvements in care pathways and population health.

To conclude, as APAC health systems face rising demand, fiscal pressure, and growing expectations for patient-centred care, advancing VBHC has become a strategic necessity. This position paper outlines the regional trends driving VBHC adoption, the remaining structural barriers to progress in implementation, and the differing levels of system readiness across countries for its adoption. The case studies from the Netherlands and India illustrate how value-based models have been operationalised in varying contexts.

Moving forward, coordinated action across policymakers, payers, providers, and industry will be essential. By aligning incentives, strengthening outcome measurement, investing in digital infrastructure, and building outcome-oriented partnerships, APAC countries can accelerate a more even transition to sustainable, high-value healthcare systems where medical technologies are assessed and rewarded based on the value they deliver.

APPENDIX

***Table 1**. Criteria for categorisation of healthcare system readiness for VBHC adoption*

CATEGORY	CRITERIA	FOUNDATIONAL	ADVANCING	MATURE
Maturity of VAFs	Maturity of VAF for MedTech	No formal or standardised VAFs specifically for MedTech • Limited consideration of broader factors (e.g., patient outcomes, innovation)	Ongoing development or adaptation of VAFs tailored to MedTech • Frameworks consider multiple value dimensions (clinical benefit, safety, innovation, cost), but application is selective	Well-established, MedTech-specific VAFs considered for reimbursement • Frameworks consider clinical, economic, patient-centred, and societal value
Alignment of reimbursement pathways with population coverage pathways	Integration of reimbursement and population coverage pathways across health and social care systems	Fragmented system with limited or unclear formal pathways for public reimbursement of MedTech or population-wide services. Health and social care budgets are siloed, with no structured coordination or reinvestment pathways between sectors. Funding and decision-making responsibilities are dispersed across entities, with minimal linkage to outcomes or cross-sector benefits.	Emerging pilot frameworks or early-stage inclusion of MedTech in public reimbursement often limited to specific technologies or diseases. Some inter-ministerial arrangements exist to co-fund services or to reinvest social care savings into selected healthcare services (e.g., elderly care, chronic disease management).	MedTech routinely included in covered benefit packages, based on transparent and multi-dimensional VAFs. Coverage and reimbursement decisions are tied to value, including clinical, economic, and patient-centred outcomes. Fully integrated population-based funding pathways between health and social care, with mechanisms to reinvest savings from one sector into another. Coordinated governance structures ensure funding flows reflect system-wide goals, including prevention, long-term care, and outcome optimisation.

Table 1. Criteria for categorisation of healthcare system readiness for VBHC adoption

CATEGORY	CRITERIA	FOUNDATIONAL	ADVANCING	MATURE
Payment innovation in procurement	Integration of value-based procurement and payment innovation to support outcome-oriented care delivery	Procurement is driven by lowest-price tendering or volume-based decisions with minimal consideration of value, safety, or innovation. Procurement criteria often focus on basic product characteristics (e.g., classification, price, origin), and are siloed from provider payment structures. Payments are predominantly fee-for-service, disconnected from quality or patient outcomes.	Partial transition to value-based procurement: • Tenders incorporate some lifecycle cost or clinical value elements, though inconsistently • Emerging pilot models for outcome-linked or bundled payment contracts, typically limited to selected care episodes or device types Some alignment between procurement and payment: • E.g., joint pilots using risk-sharing agreements, lifecycle-based pricing, or outcome-based tenders	Procurement and payment systems are strategically aligned to reward value across the care continuum: • Procurement includes comprehensive service packages, lifecycle cost assessments, and quality metrics • Payments are blended and linked to performance, combining fee-for-service, capitation, bundled payments, and outcome-based models Systems include multi-stakeholder engagement (clinicians, payers, suppliers, patients) to ensure transparency, value assessment, and shared accountability. Provider and supplier incentives are harmonised, tied to clinical outcomes, patient-reported measures, and overall system effectiveness.
Infrastructure to support VBHC	Availability of the data and infrastructure required to facilitate outcomes-based contracting	Data systems are sparse, fragmented, or siloed (with minimal infrastructure for tracking clinical outcomes, PROMs)	Pilot projects for RWD and PROMs collection underway in selected regions or institutions	PROMs and comprehensive RWD are routinely integrated into evaluations, procurement, and reimbursement (supported by robust national health data infrastructure, interoperable EHRs, and registries)
Level of stakeholder dialogue and collaboration	Presence of mechanisms available for consultation/ stakeholder input in procurement/ reimbursement	Limited or informal consultation processes • Stakeholder engagement is mainly reactive or project-specific	Targeted stakeholder involvement in HTA reviews or procurement • Structured but still limited or selective engagement	Institutionalised multi-stakeholder dialogue platforms (e.g., advisory councils, committees) • Formal, transparent, and ongoing engagement of providers, patients, industry, and payers

REFERENCES

1. Ltd CMIP. Global Value-Based Healthcare Market Forecast, 2025-2032. Coherent Market Insights. March 4, 2025. Accessed June 27, 2025. https://www.coherentmarketinsights.com/industry-reports/global-value-based-healthcare-market

2. Asian Development Bank. Adapting to Aging Asia and the Pacific. January 11, 2022. Accessed June 27, 2025. https://www.adb.org/what-we-do/topics/social-development/aging-asia

3. NCDs in Asia and the Pacific: recent findings and key challenges - Devpolicy Blog from the Development Policy Centre. Accessed June 27, 2025. https://devpolicy.org/ncds-in-asia-and-the-pacific-recent-findings-and-key-challenges-20221116/

4. International: The impact of tariffs on the life sciences industry. Accessed June 27, 2025. https://insightplus.bakermckenzie.com/bm/healthcare-life-scences/international-the-impact-of-tariffs-on-the-life-sciences-industry

5. Zhang J, Zhou Z. The impact of US tariff hikes on health care. Accessed December 5, 2025. https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(25)00779-2/fulltext

6. Health expenditure in relation to GDP. OECD. November 7, 2023. Accessed June 30, 2025. https://www.oecd.org/en/publications/health-at-a-glance-2023_7a7afb35-en/full-report/health-expenditure-in-relation-to-gdp_e3566919.html

7. Cross-border health data flows in Asia-Pacific: breaking the ties that bind digital transformation. Piers Ford. Accessed June 30, 2025. https://piersford.co.uk/project/cross-border-health-data-flows-in-asia-pacific-breaking-the-ties-that-bind-digital-transformation/

8. Value-based healthcare in Korea: A pioneer in Asia. Economist Impact - Perspectives. Accessed June 30, 2025. https://impact.economist.com/perspectives/health/value-based-healthcare-korea-pioneer-asia

9. Transcatheter mitral valve leaflet repair (TMVLR) for patients with mitral regurgitation. Agency for Care Effectiveness. 2023. Accessed June 30, 2025. https://www.ace-hta.gov.sg/healthcare-professionals/ace-technology-guidances/medical-technology-guidance/transcatheter-mitral-valve-leaflet-repair-(tmvlr)-for-patients-with-mitral-regurgitation/

10. 10. Fukuda T, Shiroiwa T. Cost effectiveness evaluation of health care technologies in Japan: J Natl Inst Public Health. 2021;70(1):22-27. doi:10.20683/jniph.70.1_22

11. 11. Hasegawa M, Komoto S, Shiroiwa T, Fukuda T. Formal Implementation of Cost-Effectiveness Evaluations in Japan: A Unique Health Technology Assessment System. Value Health. 2020;23(1):43-51. doi:10.1016/j.jval.2019.10.005

12. 12. HIRA. Health Insurance Review Assessment Service (HIRA). Published online 2013. https://repository.hira.or.kr/bitstream/2019.oak/2098/2/Health%20Insurance%20Review%20&%20Assessment%20Service.pdf

13. 13. Lee SS, Salole E. Medical Device Reimbursement Coverage and Pricing Rules in Korea: Current Practice and Issues with Access to Innovation. Value Health. 2014;17(4):476-481. doi:10.1016/j.jval.2014.03.1719

14. 14. Australian Healthcare and Hospitals Association Limited. About Value Based Healthcare - AHHA. November 11, 2023. Accessed June 30, 2025. https://ahha.asn.au/about-value-based-healthcare/

15. 15. Medical Services Advisory Committee. Guidelines for preparing assessments for the Medical Services Advisory Committee. Published online 2021. https://www.msac.gov.au/resources/guidelines-preparing-assessments-msac

16. 16. Yu L, Lang J. Diagnosis-related Groups (DRG) pricing and payment policy in China: where are we? Hepatobiliary Surg Nutr. 2020;9(6):771-773. doi:10.21037/hbsn-2020-8

17. 17. Prinja S, Rajsekhar K, Gauba VK. Health technology assessment in India: Reflection & future roadmap. Indian J Med Res. 2020;152(5):444-447. doi:10.4103/ijmr.IJMR_115_19

18. 18. National Health Authority, India. About Pradhan Mantri Jan Arogya Yojana (PM-JAY). Accessed June 30, 2025. https://nha.gov.in/PM-JAY

19. 19. Khalil H, Ameen M, Davies C, Liu C. Implementing value-based healthcare: a scoping review of key elements, outcomes, and challenges for sustainable healthcare systems. Front Public Health. 2025;13:1514098. doi:10.3389/fpubh.2025.1514098

20. 20. PROMoting quality of care through patient reported outcome measures (PROMs). OECD. June 29, 2025. Accessed June 30, 2025. https://www.oecd.org/en/publications/promoting-quality-of-care-through-patient-reported-outcome-measures-proms_c17bb968-en.html

21. 21. Leusder M, Porte P, Ahaus K, Elten H van. Cost measurement in value-based healthcare: a systematic review. Published online December 1, 2022. doi:10.1136/bmjopen-2022-066568

22. Teh K. Health Technology Assessment (HTA) for Medical Devices in Asia Pacific Webinar Summary Report. APACMed. April 10, 2024. Accessed June 29, 2025. https://apacmed.org/health-technology-assessment-hta-for-medical-devices-in-asia-pacific-webinar-summary-report/

23. The BRAVER Roadmap to Broader Assessment of the Value of Health Interventions in the Asia-Pacific Region - OHE. April 14, 2025. Accessed June 30, 2025. https://www.ohe.org/publications/the-braver-roadmap-to-broader-assessment-of-the-value-of-health-interventions-in-the-asia-pacific-region/

24. Procurement: The Unexpected Driver of Value-Based Health Care. BCG Global. January 8, 2021. Accessed June 30, 2025. https://www.bcg.com/publications/2015/medical-devices-technology-procurement-unexpected-driver-value-based-health-care

25. New EU-procurement rules to ensure better quality and value for money | News | European Parliament. January 15, 2014. Accessed June 30, 2025. https://www.europarl.europa.eu/news/en/press-room/20140110IPR32386/new-eu-procurement-rules-to-ensure-better-quality-and-value-for-money

26. Value-based Healthcare. Diabeter.com. Accessed November 14, 2025. https://diabeter.com/research/value-based-healthcare/

27. Witkowski ML, Bernstein DN, Riegler JS, Aanstoot HJ, Akkerman M. A Novel 10-Year Value-Based Contract to Improve Type 1 Diabetes Care in the Netherlands. NEJM Catal. 2025;6(4):CAT.24.0487. doi:10.1056/CAT.24.0487

28. Diabeter wins ValueBased HealthCare Prize 2017. Diabeter.nl. Accessed November 14, 2025. https://diabeter.nl/en/the-diabeter-way/news/diabeter-wins-valuebased-healthcare-prize-2017/

29. National Health Authority (NHA). Volume-Based to Value-Based Care: Ensuring Better Health Outcomes and Quality Healthcare under AB PM-JAY. Published online 2022.

ABOUT APACMED

The Asia Pacific Medical Technology Association (APACMed) represents manufacturers and suppliers of medical equipment, devices and in vitro diagnostics, industry associations, and other key stakeholders associated with the medical technology industry in the Asia Pacific region. APACMed's mission is to improve the standards of care for patients through innovative collaborations among stakeholders to jointly shape the future of healthcare in Asia-Pacific.

For more information, visit www.apacmed.org

ABOUT VISTA HEALTH

Vista Health is a global value-based healthcare agency founded in the Asia-Pacific region, supporting APACMed in this policy memo. Our approach to VBHC is based on recognising the need for every part of the health ecosystem to share in the health benefits, and to be financially successful and sustainable, reflecting their positive contribution.

For more information, visit https://vista.health/