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EDITORIAL

Value in health: the urgent mindset change needed to avert the collapse of contemporary medicine

Valor em Saúde: a mudança de mentalidade inadiável para evitar o colapso da medicina contemporânea

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Every day in my office, I make the same uncomfortable observation: a large part of the problems affecting medical care today are not technical in nature. There is no lack of knowledge, technology, or diagnostic resources. What is increasingly missing is time, continuity of care, and real accountability for patient outcomes.

We are living in a paradoxical time in medicine. Never before have we had this level of technological sophistication, diagnostic precision, and therapeutic capacity. At the same time, we are witnessing a growing distancing from the very essence of medical care, with direct consequences for the quality of care, the sustainability of health systems, and the well-being of healthcare professionals.

What we are facing is not merely a financial or organizational crisis, but the exhaustion of a mindset that has guided medical practice in recent decades. The productivity-focused model, centered on volume, fragmentation of care, and operational metrics, has proven incapable of meeting patients' true needs. In this context, the concept of Value-Based Healthcare (VBHC) emerges not as a management fad, but as an ethical, clinical, and civilizational necessity[1-3].

The structural error of the volume-oriented model

For decades, health systems have been organized around a simple question: how much can we produce? How many appointments, how many tests, how many procedures?

Although this model has increased access to healthcare in certain contexts, it has come at a high price. It encourages increasingly short consultations, repeated tests, fragmented care, and a lack of longitudinal accountability for patient outcomes. When the system pays for output, it inevitably encourages speed, and speed is seldom compatible with high-quality care.

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Received: January 31, 2026. **Accepted:** February 20, 2026.
Funding: No specific financial support was available for this study. **Conflict of interest:** None of the authors have any potential conflict of interest to disclose.
How to cite: Valente R. Value in health: the urgent mindset change needed to avert the collapse of contemporary medicine. eOftalmo. 2026;12(1):1-3.
DOI: 10.17545/eOftalmo/2026.v12.001

Porter and Teisberg demonstrated that health systems falter when they are organized around processes, departments, and specialties rather than structured around clinical conditions and the outcomes that truly matter to patients throughout the care cycle[1]. Porter later consolidated this idea by defining value as the relationship between relevant outcomes and the costs required to achieve them[2].

Reducing costs without improving outcomes does not create value; rather, it diminishes the quality of care[2].

The common misconception: equating value with payment

Despite its clear conceptual basis, Value in Health has often been mistakenly reduced to remuneration models or performance-based contracts. This simplification helps explain the many frustrated attempts to implement value-based systems.

Porter and Lee emphasized that the adoption of VBHC depends on strategy, clinical leadership, and cultural change, and not on isolated tools[4]. When this structural transformation does not occur, initiatives labeled as "value-based" tend to remain limited to administrative projects, with little impact on actual clinical practice[3].

Value in Health does not begin with the contract. It begins with the reorganization and integration of care, the systematic measurement of relevant clinical outcomes, and long-term accountability for the patient.

Ophthalmology as a reflection of this challenge

This distinction is particularly evident in ophthalmology. We have highly effective interventions, such as cataract surgery and glaucoma treatment. However, their impact is dramatically reduced when they are implemented in systems that do not favor health education, therapeutic adherence, and continuous follow-up.

A technically perfect surgery becomes worthless if patients do not understand their treatment, fail to return for follow-up, or abandon chronic therapy. Without continuity of care, there is no sustainable outcome. Without an outcome, there is no value—this is a central principle of the VBHC framework[1,2].

Technology, artificial intelligence, and the risk of dehumanization

The rapid advancement of technology and artificial intelligence adds another layer to this debate. Algorithms have already demonstrated high diagnostic accuracy in various ophthalmic diseases, increasing access and efficiency. This progress is real and desirable.

However, as argued by Larsson, isolated technological solutions often fail when they are implemented within systems designed for production rather than patient-centered care[5]. Technology only generates value when it improves outcomes or reduces costs for the same clinical result, a concept originally established by Porter[2].

Competing with machines is, by definition, a losing battle. The sustainable solution is to strengthen what cannot be automated: contextual clinical judgment, empathy, attentive listening, and long-term accountability. Technology should free physicians from excessive workload, never replace them as the central agents of care.

Health education: the often neglected link

Another essential pillar in generating value is health education. Sustainable outcomes depend directly on patients understanding, engaging with, and adhering to their treatment, particularly those with chronic conditions.

In ophthalmology, evidence from Brazil shows that the absence of structured and stable eye health education policies compromises the impact of otherwise effective interventions[6]. No education means no adherence; no adherence means no outcomes; and no outcomes mean no value.

Vander Nat and Lee emphasize that the maturity of VBHC involves building learning communities that include professionals, patients, and institutions in a continuous process of shared responsibility for care[7].

Hard evidence: Value in Health is viable

Value in Health is not merely an abstract concept. Real-world experiences, particularly in Brazil, demonstrate that reorganizing care based on relevant clinical outcomes, care integration, and systematic cost analysis across the care cycle is feasible and effective.

In a study published in NEJM Catalyst, Ferrari et al. described the experience of an integrated Brazilian ophthalmology system that adopted VBHC principles, including the measurement of clinical outcomes, integration of care, and longitudinal cost analysis. The results showed improved outcomes, reduced waste, and greater patient satisfaction[8].

The non-negotiable principle

Finally, it is essential to reaffirm what must never be forgotten: the patient is the true purpose of healthcare. Care models, technologies, and metrics only make sense when they serve to relieve suffering, restore function, preserve autonomy, and improve quality of life.

Whenever a system forces a physician to choose between doing more and providing better care, a fundamental structural problem exists. Value in Health does not solve all the challenges of contemporary medicine, but it brings the profession back to the right question: what outcomes truly matter to those we care for?

Answering this question honestly is the first step toward preventing the collapse of medicine as a human practice.

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