Why value-based drug contracts remain a rare sight in Europe

Written by The Life Science Feed Editorial Team · Published 10 November 2026 · Edited by Mara Voss

> The concept of value-based contracting in pharmaceuticals, where payment for a drug is tied to its real-world performance, has long been touted as a solution to rising healthcare costs and a means to ensure patient benefit. But for all the discussion, these agreements remain an outlier in the European pharmaceutical market, rarely moving beyond pilot programs or niche applications. The promise of aligning incentives between payers and manufacturers has consistently collided with the practical realities of healthcare systems.

KEY TAKEAWAYS

- The Pivot: Despite widespread theoretical support, value-based contracts for pharmaceuticals have not become a standard practice in European healthcare systems.
- The Data: Implementation challenges, particularly around data collection and outcome measurement, have consistently hampered broader adoption.
- The Action: Clinicians should understand that while these models aim to improve patient outcomes, their current rarity means traditional payment structures largely dictate drug access and pricing.

Value-based contracting (VBC) in pharmaceuticals aims to link the price paid for a drug to its actual clinical effectiveness or the outcomes it delivers for patients. This model contrasts sharply with traditional fee-for-service or volume-based purchasing, where payment is fixed regardless of patient response. The theoretical appeal is clear: if a drug works well, the manufacturer is rewarded; if it underperforms, the payer's financial risk is reduced. This approach seeks to shift some of the financial burden and risk from healthcare systems to pharmaceutical companies, particularly for high-cost innovative therapies.

The underlying premise of VBC is that not all patients respond equally to a given treatment, and therefore, payment should reflect the actual value delivered. This can manifest in various forms, such as outcomes-based agreements, where payment is contingent on achieving specific clinical milestones (e.g., reduction in hospitalisations, disease remission rates), or coverage with evidence development (CED) schemes, where initial coverage is granted while further real-world data is collected to confirm long-term efficacy. These models are designed to address the inherent uncertainty in drug efficacy when moving from controlled clinical trials to diverse patient populations in routine practice. The challenges in implementing new healthcare policies often mirror the difficulties seen in VBC.

The Data Dilemma

One of the most significant hurdles to widespread VBC adoption is the complexity of data collection and analysis. For a VBC agreement to function, there must be robust, reliable, and accessible data to measure patient outcomes accurately.

This requires sophisticated IT infrastructure, interoperable electronic health records (EHRs), and standardised outcome measures across different healthcare providers and regions. Many European healthcare systems, while advanced in many respects, still struggle with fragmented data systems that make tracking individual patient outcomes over extended periods a formidable task. Without clear, consistent data, determining whether a drug has met its agreed-upon value threshold becomes subjective and prone to dispute.

The specific clinical endpoints used in VBC agreements also present a challenge. While some outcomes, like hospitalisation rates or mortality, are relatively straightforward to measure, others, such as quality of life improvements or disease progression in chronic conditions, are more complex. Defining these endpoints, agreeing on their measurement, and attributing them solely to the drug in question (rather than other confounding factors like concomitant therapies or lifestyle changes) adds layers of complexity. This is particularly true for rare diseases, where patient numbers are small and outcome data can be sparse, as highlighted in discussions around hurdles for rare disease patients.

Operational Complexities and Trust

Beyond data, the operational complexities of VBC are substantial. Negotiating these contracts requires significant time and resources from both pharmaceutical companies and payers. Each agreement often needs to be tailored to a specific drug, patient population, and healthcare system, making standardisation difficult. This bespoke nature means that scaling VBC across multiple drugs or regions is not simply a matter of replication. Legal and regulatory frameworks also need to adapt to accommodate these novel payment models, which often do not fit neatly into existing procurement laws or reimbursement policies.

Trust between payers and manufacturers is another critical component. For VBC to succeed, both parties must be willing to share sensitive data, agree on performance metrics, and commit to long-term collaboration. A lack of transparency or perceived unfairness in the negotiation or execution of these contracts can quickly erode trust, leading to reluctance to engage in future agreements. The pharmaceutical industry, accustomed to predictable payment models, has also been hesitant to fully embrace VBC, citing concerns about administrative burden, potential revenue volatility, and the risk of being penalised for factors outside their control, such as patient adherence or physician prescribing patterns. Even for established therapies, the administrative load can be substantial, as seen with the comprehensive Oxford Handbook of General Practice, 5th Edition, which details the myriad considerations in routine care.

The Financial and Ethical Dimensions

The financial implications of VBC are also a point of contention. While payers see VBC as a way to manage budget uncertainty and ensure value for money, pharmaceutical companies worry about the impact on their revenue streams and investor confidence. The upfront investment in developing and launching a new drug is immense, and companies seek a return on that investment. VBC introduces an element of uncertainty into that return, which can be a disincentive, especially for smaller companies or those with less diversified portfolios. The financial models underpinning these agreements are often intricate, requiring sophisticated actuarial analysis to project potential costs and benefits for both sides.

Ethical considerations also emerge. If payment is tied to outcomes, could this inadvertently incentivise healthcare providers to select patients more likely to respond, potentially excluding those who might benefit but are considered higher risk? This 'gaming' of the system, while not an inherent flaw of VBC, is a potential unintended consequence that

needs careful consideration in contract design. The focus on measurable outcomes might also inadvertently de-emphasise less quantifiable but equally important aspects of patient care, such as patient experience or long-term quality of life improvements that are harder to track. The complexities of healthcare economics and policy are often discussed in resources like The Oxford Handbook of Health Care Management.

Looking Ahead: Niche Applications and Future Potential

Despite these challenges, VBC has found some traction in specific therapeutic areas, particularly for high-cost, curative therapies like gene therapies or CAR T-cell treatments. For these therapies, the high upfront cost and the potential for a one-time cure make outcomes-based payments more appealing and easier to track. For instance, an agreement might stipulate payment only if a patient achieves remission for a certain period. These niche applications demonstrate that VBC is feasible when the stakes are high, the patient population is well-defined, and outcomes are relatively clear-cut. But for the vast majority of pharmaceutical products, particularly those for chronic conditions requiring long-term management, VBC remains a distant prospect. The administrative burden, data infrastructure requirements, and the need for sustained collaboration between often adversarial parties continue to limit its broader adoption. Until these fundamental issues are addressed, value-based contracting will likely remain an interesting theoretical construct rather than a widespread reality in European pharmaceutical markets. The field continues to grapple with how to best integrate new therapies into existing systems, a challenge that extends to targeted therapies for rare causes of obesity and other complex conditions.

CLINICAL IMPLICATIONS

For clinicians, the rarity of value-based contracting means that drug access and prescribing decisions are still largely governed by traditional reimbursement models. While the concept of paying for performance sounds appealing, the practicalities of tracking individual patient outcomes across disparate healthcare systems are simply too cumbersome for most drugs. This means that the focus remains on evidence from clinical trials and established pricing structures, rather than real-world effectiveness influencing payment.

The pharmaceutical industry, for its part, has shown a cautious interest, but the administrative overhead and financial uncertainty associated with VBC often outweigh the perceived benefits. Companies are primarily driven by predictable revenue streams to fund research and development. Until a scalable, standardised, and less burdensome model emerges, they will continue to favour traditional purchasing agreements.

Patients, unfortunately, are often caught in the middle. While VBC theoretically promises better alignment of drug cost with patient benefit, its limited adoption means that the high prices of many innovative therapies continue to be a barrier. The promise of a system where drug payment truly reflects individual patient outcomes remains largely unfulfilled, leaving patients and healthcare systems to navigate the existing, often rigid, reimbursement landscape.

EDITORIAL & AI STANDARDS

AI tools are used to structure and summarise evidence from peer-reviewed primary sources. Articles that carry a signed Editor's take have been read in full by William Lopes. The others are not individually read by an editor, so check the cited source before relying on a figure.

REFERENCES

1. 1. Wallace TC, Bailey RL, Blumberg JB, et al. Fruits, vegetables, and health: A comprehensive narrative, umbrella review of the science and recommendations for enhanced public policy to improve intake. Crit Rev Food Sci Nutr. 2020;60(13):2174-2211. doi:10.1080/10408398.2019.1632258

2. 2. Valdes AM, Walter J, Segal E, Spector TD. Role of the gut microbiota in nutrition and health. BMJ. 2018;361:k2179. doi:10.1136/bmj.k2179

3. 3. Lu L, Zhang Y, Tang X, et al. Evidence on acupuncture therapies is underused in clinical practice and health policy. BMJ. 2022;376:e067475. doi:10.1136/bmj-2021-067475

4. 4. Esmailzadeh H, Mafimoradi S, Gholami M, Mansourzadeh MJ, Rajabi F. E-participation in policy-making for health: a scoping review protocol. BMJ Open. 2024;14(9):e080538. doi:10.1136/bmjopen-2023-080538

5. 5. Amri M, Chatur A, O'Campo P. Intersectoral and multisectoral approaches to health policy: an umbrella review protocol. Health Res Policy Syst. 2022;20(1):21. doi:10.1186/s12961-022-00826-1

6. 6. Koletzko B, Godfrey KM, Poston L, et al. Nutrition During Pregnancy, Lactation and Early Childhood and its Implications for Maternal and Long-Term Child Health: The Early Nutrition Project Recommendations. Ann Nutr Metab. 2019;74(2):93-106. doi:10.1159/000496471

LICENCE & RIGHTS

© 2026 The Life Science Feed. All rights reserved. This content is produced for medical education purposes. It may not be reproduced, distributed, or transmitted without prior written permission from The Life Science Feed.

MEDICAL DISCLAIMER

This content is intended for healthcare professionals only and does not constitute medical advice. Clinical decisions must be made by qualified practitioners based on individual patient circumstances.

FOLLOW THE LIFE SCIENCE FEED

Instagram @lifesciencefeed **LinkedIn** linkedin.com/company/thelifesciencefeed

thelifesciencefeed.com