OPINION ARTICLE
ARTIGO DE OPINIÃO

Opportunities and challenges of value-based healthcare: how Brazil can learn from the United States' experience

Oportunidades e desafios da saúde baseada em valor: como o Brasil pode aprender com a experiência dos Estados Unidos

César Luiz Abicalaffe[1], Jeremy Schafer[2]

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ABSTRACT

The movement toward value-based care is an evolution occurring in many nations of the world. The increasing population, longer life expectancy, and rising cost for high-tech care necessitates that government and private payers around the world devise new ways to ensure that healthcare dollars are spent on the most impactful interventions. In this viewpoint, we present the case of the value-based care transformation that is currently in its infancy in Brazil. Brazil has a mix of private and public payers but still largely reimburses based on a fee-for-service model. We contrast that with recent experience in the United States, where value-based care is slowly but surely becoming the norm. The Brazilian system has many opportunities to learn from the US shift to value-based care – including the development of quality measures, transition to value-based payment, and leveraging data to rank performance across Brazilian Health Systems. Pharmaceutical manufacturers in Brazil can play a role as well, with value-based agreements and partnerships with payers. Each nation will travel on its own path to value-based healthcare, but the opportunity to learn from each other presents one of the best chances for success.

Palavras-chave:
saúde baseada em valor, valor em saúde, sistemas de pagamento

RESUMO

O movimento em direção à saúde baseada em valor é uma evolução que ocorre em muitas nações do mundo. O crescimento populacional, o aumento da expectativa de vida e o custo crescente com uma saúde de alta tecnologia exigem que os pagadores públicos e privados de todo o mundo criem novas maneiras de garantir que os gastos com saúde sejam feitos nas intervenções de maior impacto. Nesse ponto de vista, apresentamos o caso da transformação da saúde baseada em valor, que está atualmente em sua infância no Brasil. O Brasil possui pagadores públicos e privados e ainda paga os serviços na maioria das vezes no modelo de pagamento por procedimento. Comparamos isso com a experiência recente nos Estados Unidos, onde a saúde baseada em valor está, de maneira lenta, mas segura, se tornando a norma. O sistema de saúde brasileiro tem muitas oportunidades de aprender com a mudança ocorrida nos EUA para um modelo de saúde baseado em valor – incluindo o desenvolvimento de medidas de qualidade, a transição para pagamento baseado em valor e a melhoria dos dados para avaliar o desempenho nos sistemas de saúde brasileiros. As indústrias de produtos farmacêuticos no Brasil também podem desempenhar um papel, com acordos baseados em valor e parcerias com pagadores. Cada nação seguirá seu próprio caminho para uma saúde baseada em valor, mas a oportunidade de aprender um com o outro possibilita melhores chances de sucesso.

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1. MD and MSc in Health Economics. President of IBRAVS (Brazilian Institute for Value-Based Healthcare) and CEO of 2iM S/A.
2. PharmD, MBA. Senior vice president at Precision for Value, a healthcare.
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Corresponding author: César Luiz Abicalaffe. Rua Duque de Caxias, 638, Curitiba, PR, Brazil. CEP: 80530-040. Telephone: +55 (41) 99926-0806. E-mail: cesar.abicalaffe@ibravs.org

Current state of reimbursement and value in the Brazilian healthcare system

The private sector in Brazil currently covers 22.5% of the Brazilian population, yet this sector accounts for 57% of all healthcare spending in Brazil, including out-of-pocket expenses. Private health care is accessed either through employers or as supplemental insurance purchased by individuals. Private health plans are regulated by ANS (*Agência Nacional de Saúde Suplementar*, a government regulatory agency) and are classified into several types, which comprise different forms of operation, such as HMOs (Health Maintenance Organizations), health insurers, self-insured companies, philanthropies, and medical cooperatives. In November 2018, according to data from ANS and ANAHP (*Associação Nacional dos Hospitais Privados* – Private Hospitals National Association), Brazil had a total of 746 health plans with a total of 47.38 million beneficiaries (ANS, n.d.; ANAHP, 2019). The predominant reimbursement model in private sector healthcare in Brazil is still fee-for-service. However, momentum is growing for other models of payment, such as capitation and Adjusted Global Budget Payment, a fixed reimbursement for a period of time in a specific patient population.

Value-Based Health Care (VBHC) is a current topic discussed in the majority of sectors of healthcare. Unfortunately, most of the discussion remains in theoretical fields in Brazil with minimal action taken to date. Movement to VBHC is starting. The Private Hospitals National Association (ANAHP) is implementing ICHOM (International Consortium for Health Outcomes Measurements) standards for Heart Failure, Stroke, and Hip and Knee Osteoarthritis. Some of ANAHP hospitals have already set up a VBHC department to run this project. This is a good start, but the majority of them are not measuring costs, just the outcomes. The regulatory agency for private health plans (ANS) started discussing value-based payment models in 2019 (ANS, 2019). The public sector is starting to discuss VBHC, although there is no practical implementation yet.

In 2019, a not-for-profit organization was created to discuss VBHC in Brazil. It is called IBRAVS (Brazilian Value-Based Health Care Institute). Its mission is to consolidate, validate, and standardize patient outcomes information in order to improve the provision of care based on value. IBRAVS will call for proposals of VBHC project proposals to be submitted by hospitals, health plans, pharma and device manufacturers, and other healthcare players. The publication of the projects selected will be presented at a Second Latin American Congress on VBHC in the beginning of 2021. Besides the submission of VBHC projects, IBRAVS will have monthly webinars featuring prominent healthcare professionals who are on its Advisory Board to align and spread VBHC concepts and ideas for enactment in Brazil.

One of the greatest challenges to implementing VBHC in Brazil is to capture data to measure value. Due to fragmented system as well as the health care information systems available in Brazil which main focus are in billing process and inventory control, the challenge to have data is even worst then to have the right data to measure value.

There are other challenges, the most impactful, besides accessing the data, are the following: changes in providers' and payers' mindset from decades of focusing in a supply-driven model to a more patient-centered system; transparency – there are strong regulation and political restrictions about what can be disclosed for patients compromising their ability to choose and increase the information asymmetry; aligning the interests between stakeholders due to the culture of a zero-sum relationship that hovers in the sector; among others.

How Brazil can build these measurement systems and begin the transition to value-based care may depend on learning from examples of those nations that have their own transition underway.

The US evolution to value-based care

The evolving U.S. health care landscape may provide lessons for Brazil as the Brazilian system begins a transformation from volume-based payment to that based on value. After World War II, employer-sponsored health plans proliferated in the United States, moving health care spending away from consumers and toward employers. The introduction of Medicare and Medicaid in the 1960s further expanded coverage and made the U.S. government a significant stakeholder in health care spending (CMS, n.d.). However, as costs began to grow, U.S. purchasers increasingly asked what they were getting for their money. In the decades that followed, successive pieces of legislation, including the Employee Retirement Income Security Act and the Affordable Care Act, began to introduce the concept of quality and payment based on outcomes in U.S. health care (KFF.org, n.d.; NCSL, 2011).

A core component of the US transformation has been the ability to measure elements of care. The US healthcare marketplace, even today, is notoriously fragmented with a myriad of private payers, health systems, and other stakeholders. Layered atop this confusing setup are government payers and diverse reimbursement methodologies. However, the variety of US healthcare stakeholders are now being measured on performance by an equally varied set of performance metrics. Health plans have the Healthcare Effectiveness Data and Information Set (HEDIS); Medicare plans have the Five-Star Quality Rating System; health systems have measurement programs such as the Hospital Readmission Reduction Program; and individual providers have the Medicare Access and CHIP Reauthorization Act (MACRA) (Meola, 2019). Many of these measurement systems began voluntarily or with mandatory reporting but no effect on reimbursement. As stakeholders became accustomed to reporting data, payers

such as the Centers for Medicare & Medicaid Services introduced pay-for-performance reimbursement. By gradually introducing measurement and reporting, U.S. payers gradually got health care stakeholders on board, making it easier to attach performance to reimbursement in later years.

The US transition to value continues apace with both private and public payers introducing more value-based reimbursement models. In addition, evolving payment models are growing and beginning to address some of the most complex cost issues in the US system, including the Oncology Care Model for cancer therapy. Pharmaceutical manufacturers have joined in as well with the development of value-based contracts with private payers in diverse disease areas as high cholesterol, rheumatoid arthritis, oncology, and diabetes. The US example demonstrates that the transition facing Brazil can be done but it requires the engagement of all stakeholders and it may be a gradual process.

Opportunities for Brazil based on the US experience

One of the aspects that Brazil can learn from the US experience is the strategy of starting disclosure of measures voluntarily or with some bonus. The beneficial aspect is that inevitably separation between entities doing well and those doing poorly will begin to show. When that happens there will be opportunities to bring that data back to stakeholders, government, and private payers and say: "We've been collecting this information; why are you paying hospital A the same as you are paying to hospital B when hospital A outcomes are way worse than at hospital B?" That will begin to instill a mindset of paying for quality while also stoking the competitive nature of hospitals and providers to deliver better healthcare.

The right measure is the one that is reliable and consistent, but viable, or easy to measure. When we talk about selecting appropriate criteria for Brazil's transition to VBHC, less may be more. It means choosing as few metrics as possible to get actionable and relevant results. Brazil should invite feedback from a broad section of stakeholders including payers, providers, and hospitals to obtain not only a relevant standard set but also one that can be measured and reported accurately.

Nevertheless, after choosing the right standards it is important to compose them. When we talk about quality or performance measurement, it is important to understand that just one measure alone does not convey the right understanding about how good or bad one is. However, when you compose the right metrics you can have a broader view about one's performance, quality or, better, value. The challenge is also how to compose those measures the right way. Choosing a reliable, consistent, relevant, and viable option is one aspect. Another aspect is to weigh them, because one measure may be more important than others. Brazil can analyze which healthcare issues are most pressing to the nation's healthcare spending and focus initial measures around these areas.

There are some initiatives in measuring value currently underway in Brazil. One of them is called EVS (*Escore de Valor em Saúde* – in English, Value-Based Healthcare Score), which creates quality measures while considering process, outcomes, and patient experience and relates those composed measures with costs. This EVS yields a single score from 0 to 5. This approach has been used to evaluate value-based payment programs as well as provider performance. Reporting the data and changes over time for EVS may be useful in bringing more Brazilian stakeholders on board to embrace VBHC (2iM Inteligência Médica, n.d.).

Another lesson learned from the US is that you must have an influential stakeholder (large payer, government etc.) to support VBHC and publish success stories. Why doesn't Brazil's Health Ministry and ANS join efforts to establish the quality and value measures, and suggest incentives to prescribers and hospitals to adopt VBHC strategies? Medical and specialty associations can also help establish some measures that are important for a specific clinical condition. For example: the orthopedist medical association can validate the measures that will be used to evaluate the processes and outcomes from a hip replacement.

The authors also suggest involving a third party to help measure value and quality. It is known that the Health Ministry is working with the World Bank in supporting Brazil in the Primary Care program. Why not invite ANS to join the discussion and establish some metrics not just for the public, but also for the private sector? This standardization will be very good for the whole market. A third party, agreed upon by all stakeholders, may also reduce any mistrust between different healthcare stakeholders in Brazil.

Another important aspect is that, today in Brazil, payers do not have the amount of data needed to measure basic value-based metrics. A recent poster presented at ANAHP showed that less than 45% of discharges from the main hospitals have generated enough data to measure performance (Abicalaffe *et al.*, 2018). The conclusion of the study recommended changing the amount of data that is sent from the provider to payers, and it is the regulatory agency that must define what is the minimum. Electronic medical record vendors must be part of this discussion because their systems must capture what is needed to measure value, as well as to have systems that are compatible to send data and/or integrate with the payers and other systems used to collect data

The shift in payment system from fee-for-service to any model of value-based payment will cause a profound change on the provider side. The providers will have to bear some risks. The payers will not assume all providers are

efficient and higher performers. Providers will be measured on objective data, inputted by providers and health systems, and informed by outcomes and trends in population health data. The US system is doing this as well with data on hospital and provider performance becoming increasingly visible to payers and consumers alike, putting pressure on providers to evolve and deliver optimal care.

Finally, patient involvement and empowerment in the value-based health care system must be addressed. The transparency of data and value-based measures is imperative to change the system because it empowers patients to make their own decisions. In Brazil, unfortunately, disclosure of this information to patients is a challenge. However, simply educating patients on the evolution toward value-based health care and the idea that health care in Brazil will increasingly be measured by the quality of outcomes rather than by volume of patients will send a strong message that Brazil is evolving health care for the betterment of patient care. Doing so will grow patient advocacy and help accelerate the change.

Role of pharmaceutical manufacturers in Brazil's value evolution

The participation of the pharma and device manufacturers companies in VBHC can be challenging but vital. Many of the performance- and value-based contracts are between payers and providers. The manufacturers are not necessarily directly involved in that. However, manufacturers are impacted when providers and hospitals ask questions to manufacturers, such as outcome expected, cost-effectiveness, different value metrics if the drug is changed etc.

Essentially, IBRAVS and its advisory board are discussing in Brazil a deeper involvement besides merely discount agreements. The manufacturers have an opportunity to participate in VBHC projects supporting payers and providers in terms of technology, knowledge, and investment in helping stakeholders engage in the patient full circle of care, collecting the right datasets and disclosure of outcomes. Acquiring real-world data benefits manufacturers and can incentivize participation. The access to the right measure allows manufacturers to participate in a different reimbursement arrangements such as a risk-sharing or value-based contract.

VBHC contracts between payers and manufacturers are beginning to emerge in Brazil. In April 2019, a ruling was signed for the inclusion of the drug *nusinersen* in the Brazilian Unified National Health System (SUS). Nusinersen, used to treat spinal muscular atrophy, is the most expensive drug ever incorporated by the SUS (Caetano *et al*., 2019).

On the other hand, in the private sector there is a project running with breast cancer patients. On this project the payer, the provider, and manufacturers have met and are discussing how they can track those patients and follow them in their journey within the healthcare system. An interesting part of this project is that all the implementation of the analytics tools is outsourced by the manufacturers to a third-party company that is responsible to collect the data, produce the measures, and disclose them to the stakeholders. For the first time in Brazil, the manufacturer, payer, and provider are sitting together to discuss what is best for the patient and how they can measure it.

The next step of this project is to develop a risk-sharing contract between payers and manufacturers as well as with the preferred provider. It is known that the one who drives the change is the one who pays the bill. However, what we are discussing in Brazil is that it is possible to stimulate this change by supporting the provider through technology, know-how and tools to deliver value and thus be paid based on value as well.

Private payers in the United States have experimented with value-based formulary models where medication access is primarily determined by the value generated for the health care system through greater cost offsets and reduced health care utilization (Yeung *et al*., 2017). Manufacturers bringing products to Brazil should be prepared to discuss medical cost offsets and any reductions in health care utilization that a product can provide. Payers and providers in Brazil, in turn, can motivate the use of high-value therapies through easier access and higher prescribing.

Summary

The new decade promises to be one of change for healthcare in Brazil. The predominantly fee- for-service based system must evolve in order for Brazil to continue to care for its population, both public and private. The US example, particularly the introduction of measurement systems and rewarding performance, may be one way for Brazil to drive its own evolution to VBHC. However, doing so will require the engagement of a broad set of Brazilian stakeholders including hospitals, payers, providers, and government agencies. Despite the challenges, the evolution is possible and imperative. VBHC will not only aid in delivering cost-effective care but will ultimately benefit the most important healthcare stakeholder of all: the Brazilian patient.

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