OPINION ARTICLE
ARTIGO DE OPINIÃO

Value-based healthcare: will it work?

Saúde baseada em valor: será que isso vai dar certo?

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This JBES special issue discusses "efficiency in healthcare systems". To start a subject, it is always good to establish some definitions.

Efficiency may be defined as *the rational use of means available to achieve a predetermined objective*. Another definition is *the ability to achieve desired objectives and goals with the least possible expenditure of resources*. Where is the search for greater efficiency in healthcare-associated with *Value-Based Healthcare* – VBHC?

In my opinion, it will depend on two basic definitions: 1. what are the healthcare goals we want to achieve, and 2. what do we understand by Healthcare Value?

Ahluwalia *et al.* (2017) conducted a systematic review of publications in English in the period between 1999 and 2016 to identify which concept best defines the goals of high-performance healthcare organizations, concluding that none of them permeated all organizations consistently. The definition of high performance was expressed in different dimensions across articles, most frequently for the quality dimension (93% of articles), followed by cost (67%), access (35%), equity (26%), patient experience (21%) and patient safety (18%). Most articles used more than one dimension to define high performance (75%), and the most paired dimensions were quality and cost (63%) (Ahluwalia *et al*., 2017).

Using the term "quality" as a dimension that establishes the objectives of efficiency requires a new depth of philosophical character: what is defined by "healthcare quality"? Quality is, in a broad definition, the perception a person or group has about the usefulness of a good or service received and the trade-offs[1] required to obtain them. And within healthcare systems, all too often, trade-offs result from choices made on behalf of these individuals/groups by decision-makers in healthcare organizations. And, of course, there will always be some people who will agree with the choice, while another will disagree. It is the presence of a positive balance between groups that disagree versus those that disagree with a choice that ultimately defines the value of a healthcare choice.

The mention of the terms "access" and "equity" as objectives to reach high performance in healthcare organizations is more related to a social point of view. It may be understood as the capacity of the healthcare system or organization to include the most significant possible number (perhaps all) of individuals from a collectivity (community), providing them the same level of goods and services. It is an objective of extremely high value from an ethical and humanistic point of view. Still, it requires a significant trade-off to be achieved: to waiver individual results in favor of the

1 Trade-off defines a situation in which there is a conflict of choice, i.e., when the option of an alternative (e.g., spending money on good treatment) implies abandoning another alternative (e.g., using the same money to go on vacation).

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collective impact. With current resource levels (financial, human, and technological), achieving the best possible individual goals without sacrificing collective goals will not be possible. Just as it will not be possible to reach the best results of access and equity at the same time as all individual goals, in all diseases, are achieved with the best resources available. There would not be the money to pay for those simultaneously.

Still, about the Ahluwalia *et al.* (2017) publication, the cost is the second most frequently mentioned item in the articles used in the review. It is the key that starts the discussion about efficiency and value-based healthcare. No one is unaware that healthcare costs have grown disproportionately faster than other inflation indicators, and this fact is regarded as a considerable risk to the sustainability of healthcare systems. Regarding this increase in healthcare costs, criticisms addressed to the pharmaceutical and medical equipment & devices industries are also frequent and well-known. They are continually launching innovations on the market, whose prices spiral up and without a relationship between cost and effectiveness justifying it.

There is a frisson in the air about Value-Based Healthcare. Like other movements that preceded it, such as Evidence-Based Medicine (EBM), Managed Care, and Pharmacoeconomics, it is hailed by many people as the new opportunity to control the progression of healthcare costs and improve the quality of results. There is no doubt that other methodologies have made significant contributions, but since they emerged (approximately in the years 1972 (Cochrane, 1972), 1973 (Patel; Rushefsky, 2006), and 1986 (Mauskopf, 2001), respectively), costs continued to rise. In Brazil, according to the IESS - Institute of Supplementary Health Studies (IESS – Instituto de Estudos Da Saúde Suplementar, 2021), between 2010 and 2020, the median of health care inflation in the private sector was 15 .9% (ranging from 7.6% to 20.6%), against median inflation (measured by the IGP-M) of 7.3% (ranging from -1.17% to 23.1%) (Mariano, 2021).

Costs increase is a severe problem, considering what is said about the threat hanging over the sustainability of healthcare systems (something that also seems logical and reasonable to me, but that I have heard since I graduated in the 80s). But what bothers me the most is that there is no such great concern with the quality of healthcare outcomes, especially in Brazil. I will emphasize the phrase "such a BIG concern with the quality of results". I am not claiming or even implying that we do not have healthcare quality in Brazil, and I intend to say that none of us has factual data to attest that the healthcare system in Brazil has the quality that it should provide. How could we want to increase the value of healthcare interventions if we do not even know how these results are currently presented?

Indeed, we have several islands of excellence of professionals and healthcare institutions. But, observing the greater frequency of healthcare services, all statements we may make, in favor or against the system, will result from impressions, samples, and personal concepts. We do not have systems (and I am not referring specifically to computerized systems) that allow us to capture the reality of healthcare for specific diseases, limiting ourselves to data on mortality.

How can we implement any significant Value-Based Healthcare process if the data we have as a starting point is unsatisfactory or non-existent? For example, how can we provide a Value-Based Healthcare project to reduce morbidity and mortality associated with ischemic stroke (CVA) if the most available information is hospitalizations and deaths? These data are limited to events that do not allow a longitudinal assessment of patients' journeys, from their first CVA occurrence to death. Such data include every case leading to premature death or survival with sequelae recorded as death without considering CVA as the root cause.

But suppose that was the only cause of my pessimism about Value-Based Healthcare. In that case, I could even believe that it would not be difficult for the participating healthcare systems to organize themselves to start recording and evaluating diseases more profoundly to investigate both the results of actions and omissions that occur throughout the incidences. Such knowledge would make it possible to qualify and quantify the effects and determine their causes to generate more efficient interventions. If it is impossible to apply such ideas to all, at least some of the most critical diseases could be chosen to start a movement of an authentic search for improvement.

The primary issue is that few agents at the forefront of this movement in Brazil are seeking the Value-Based Healthcare philosophy core, which is to provide, as far as possible, the best results for patients at the lowest cost. The main quest is cost control.

The difference between controlling expenses and providing the best results at the lowest cost seems clear, at least to me. If the objective is focused on controlling expenses, any intervention is inefficient, as any financial value above zero is an expense. However, we could discuss how to execute that delivery more efficiently by knowing the expected result. To make this statement clearer, I will resort to a metaphor: if I am going on a trip and do not have a city as my goal, the simple act of starting the car to travel is priceless inefficiency, but if I go from São Paulo

to Rio de Janeiro, I may set as goals to make this trip with the shortest road time, or with minor fuel consumption, or by the fastest route, or in the safest way, or even with a combination of these goals.

The same could be said for CVA treatment. We may set some objectives about this medical condition: to reduce its incidence, its morbidity, and mortality, or modify some specific parameters, such as the rate of patients with sequelae or improve the quality of life, as well as assuming other required premises, such as the time horizon of the evaluation. At first, we could measure the occurrence rates of these indicators and compare institutions, regions, or even countries, to know what the possible and desirable values are to be achieved for these rates. With this data in hand, we could assess the costs and outcomes currently observed in our institutions and determine how we could improve our results.

Analyzing this mockery of a project that I mentioned, it is easy to see that it will imply new costs, starting with the costs associated with measuring and comparing results, which is little practiced among us. It will require implementing improvements in the processes, which could advance even on primary factors, such as campaigns to raise population awareness on risk factors for CVA and increase the efficiency of emergency care provided by ambulances, reduce the time between the event, and the first care. It will be necessary to optimize the infrastructure to professionals and equipment to provide the proper care for each case, from the first presentation to the chronic care of patients with sequelae, with the integration of all levels of the healthcare and social assistance systems. The main objective would be to reduce the morbidity and mortality of people who will consist mainly of individuals whose average age varies between 53 and 68 years in Brazil (Santos; Waters, 2020). This age group comprises people who will generate high and prolonged costs if they survive the CVA with severe sequelae, often being indirect (loss of work capacity and need for caregivers, for example). Which will affect the healthcare system? Which costs will be absorbed by patients and their caregivers? The analysis of most healthcare systems rests on this issue. Suppose there is no favorable cost-benefit ratio for adopting effective measures to reduce morbidity. In such cases, maintaining patients with CVA sequelae might be lower than the costs to adopt effective measures to reduce the occurrence of sequelae.

For such reasons, Value-Based Healthcare needs to be understood much more as a philosophy than the application of new remuneration models, which is the facet of this concept most frequently presented. There is a lot of talk about remuneration models for risk sharing, payment for bundles, capitation, and others. Still, any of these models will be insufficient to provide actual healthcare value if the outcomes of interest to the patient are not considered the final product to be delivered. These models appear, at first, as ways of not placing all the business risk and the financial burden of health interventions on the payer's shoulders. Still, ultimately these models need to demand value delivery to the patient.

Defining "outcomes of interest to the patient" is perhaps the most challenging part of this approach. The ICHOM (International Consortium for Health Outcomes Measurement), an international organization promoting the VBHC (Value-Based Healthcare), has created different outcomes of interest for many diseases.[2] They are built through the collaboration of professionals from other areas (according to the condition). Outcome sets are specific for each disease, and the main objective of creating them is to provide a guideline for measuring outcomes that are perceived as valuable for each condition. In addition, the establishment of well-defined sets of outcomes for each disease allows the results obtained in institutions, regions, or even countries to be compared with each other. It will enable these separate entities to compare themselves. When identifying the one that obtains the best results for specific outcomes, they seek to reproduce the good practices that led to this quality. And so, the feedback provides the possibility of continuous improvement of care and constantly increasing value for patients.

It is one of the existing and already in practice ways to achieve reasonable healthcare goals. Then, the challenge of achieving these financially efficient results arises, something that is not easy in Brazil since participants of the healthcare systems have been interacting asynchronously (some want to increase the expenses volume, while others prefer to reduce or control such increase), in addition to not being able to enter into agreements other than those of "zero-sum game", where one wins, the other loses.

The metrics that measure the efficiency of healthcare entities are almost always linked to financial performance, resulting from high prices or large production volumes – and when I refer to this fact, I am not just mentioning materials and medicines. We do not have information about which institutions have the best (or even the worst) rates of clinical outcomes, which brings all choices of service providers into the realm of opinion and external appearances.

Since I talked about opinions, this item would form a separate chapter, especially when discussing patients' perceptions of value. In general, the value perceived by

2 https://www.ichom.org/standard-sets/#standard-sets

healthcare service users is measured by indicators with little or no direct relation to healthcare, such as attendance time, complaints, and the number of providers available, with little or no correlation with the quality of healthcare outcomes achieved. Another factor that substantially impacts the perception of value regarding healthcare interventions is the patient's expectations about results. Some seem frustrated for not having the benefits they expected to get, affecting the perception of value about the professionals and organizations involved.

Any relevant change in the models currently in use in Brazilian healthcare will also have to consider the professionals' satisfaction, particularly physicians. It is relatively evident but always important to mention that the success of any activity depends on the engagement of the people involved. I think these professionals' satisfaction should be measured to guide decision-making that maintains an adequate level of pleasure with working conditions and, of course, earnings.

An essential item for those who progress in implementing remuneration models using Value-Based Healthcare principles is collecting information. The objective evaluation of results is a key to justifying the investments (monetary, time, and expectations) in these changes. Without these measurements, there are no conditions to say the desired value is being delivered and even fewer conditions to evaluate the improvements obtained, if any. And, of course, it is only with an adequate measurement that it is possible to verify if there are possible corrections or improvements, especially if the data collected are shared with other institutions.

Comparing the results obtained between different institutions is also a concern, as there is no culture of data sharing in Brazil, especially in the healthcare area. Everything that matters in healthcare outcomes is confidential, mainly because data is not collected, but also because of a fear of judgment. Bad results could be seen as incompetence or even guilt that perhaps should not be in the face of the context. By this last situation, I mean complex clinical cases, therefore very prone to bad results, but due to ignorance or bad faith of the judges, could destroy reputations or give rise to even worse consequences. In evaluating healthcare interventions, the exposure of data on results could not be a mere presentation process since the context could be decisive in obtaining results. For instance, it is not appropriate to expect that a tertiary-level hospital, which is referred to receive the most complicated cases of a given pathology, presents treatment costs and mortality rates equal to a secondary-level hospital that deals with mild to moderate cases complexity.

The last but not least important factor that hinders the process implementation, which increases the value and efficiency of healthcare in Brazil, is the distorted relationships between entities of the healthcare systems. One of the largest and most well-known distortions is the commercialization of medicines and devices. Service providers earn profits through the difference between the purchase values (actual prices) and the reimbursement values (list prices) of these items. This practice started decades ago as a way found by healthcare service providers to compensate for the low amounts paid for other care items (consultations, exams, hospitalization rates, surgeries, etc.). Over time such practice was consolidated among all entities of healthcare systems. It involved the input suppliers to such an extent that the reformulation of these financing relationships between payers and service providers has become something as complex as trying to reconcile the interests of all these participants (everyone wants to win, and no one gives up their share).

While it is not impossible to find a way to reorganize these relationships and make them less toxic, there will have to be a break in current compensation models and information processes, which creates uncertainty on all sides. For this reason, such changes will have to start as small pilot projects, with their successes and mistakes serving as lessons for future projects.

In short, I would say that I foresee considerable barriers to the implementation of a Value-Based Healthcare philosophy, as I have explained throughout this text. My opinions, herein expressed, could and should be the target of criticism and counterarguments, as I am generalizing issues that may not be as pessimistic as I am mentioning. Another criticism that I should receive is not suggesting solutions to such difficulties. And, if I do not, it is because I believe that the most significant problem to overcome will be the intention of simply reducing or controlling costs and increasing profits, which I have observed in most healthcare system participants (including those who provide inputs to the system). When this culture's priorities shift to a genuine concern for disease control and patient well-being, I will feel more optimistic about Value-Based Healthcare.

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