Opportunities and Challenges of Value-Based Health Care: How Brazil Can Learn from U.S. Experience

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SUMMARY

The movement toward value-based care is occurring in many countries 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 health care dollars are spent on the most effective interventions. In this Viewpoints article, we present the value-based care transformation that is currently in its infancy in Brazil, which 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 U.S. 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 country will travel on its own path to value-based health care, but the opportunity to learn from each other presents one of the best chances for success.

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The Brazilian Unified Health System (SUS) is one of the largest and most complex public health systems in the world and ensures comprehensive, universal access, and free health care for the entire population of Brazil. SUS provides universal access to the public health system without discrimination. Comprehensive health care has become a right for all Brazilians from pregnancy to the end of life, focusing on health with quality of life and aiming at prevention and health promotion. However, the SUS is not the only health care coverage option in Brazil. The private sector in Brazil currently covers 22.5% of the Brazilian population, yet this sector accounts for 57% of all health care 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 Agencia Nacional de Saude (ANS), a government agency, and are classified into several types, which comprise different forms of operation, such as health maintenance organizations, health insurers, self-insured companies, philanthropies, and medical cooperatives. In November 2018, according to data from ANS, Brazil had 746 health plans, with 47.38 million beneficiaries.[1,2] The total health care expense in Brazil is approximately 8.2% of the gross domestic product: 4.4% is from private expenses, and 3.8% is from public expenses. These data were published by World Bank at Aspectos Fiscais da Saúde no Brasil (Fiscal Aspects of Healthcare in Brazil) in 2018.[3] In 2019, medical expenses for private health plans were R$ 854.82 annually, which represents about U.S. $213.00 (1 U.S. dollar = 4 Brazilian Real).[4]

In Brazil, the predominant reimbursement model in private sector health care is 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. In order to meet the health care needs of a growing population but also control spending, Brazil needs to evolve its payment models toward value-based health care and could use the United States as an example.

Movement toward value-based health care has started in Brazil, but progress is slow. The Private Hospital National Association (ANAHP) is implementing ICHOM (International Consortium for Health Outcomes Measurements) standards for heart failure, stroke, and hip and knee osteoarthritis. Some ANAHP hospitals have already set up value-based health care departments to run this project. This is a good start, but the majority of hospitals are not measuring costs, just outcomes. The regulatory agency for private health plans (ANS) began discussions on value-based payment models in 2019.[5] The public sector has started to discuss value-based health care, although there is no practical implementation yet.

In 2019, a not-for-profit organization called IBRAVS (Brazilian Value-Based Health Care Institute) was created to discuss value-based health care in Brazil. 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 value-based health care projects to be submitted by hospitals, health plans, pharmaceutical and device manufacturers, and other health care players. The publication of the selected projects will be presented at a Second Latin American Congress on value-based health care in the beginning of 2021. In addition to the submission of value-based health care projects, IBRAVS will present monthly webinars featuring prominent health care professionals who are on its advisory board to align and spread value-based health care concepts and ideas for enactment in Brazil.

One of the greatest challenges to implementing value-based health care in Brazil is capturing the right data to measure value. Other challenges include a fragmented system and

changing provider and payer mindsets from decades of focus on a supply-driven model to a more patient-centered system. How Brazil can build these measurement systems and begin the transition to value-based care may depend on learning from those countries that have begun their own transitions.

The U.S. Evolution to Value-Based Health 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.[6] 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.[7,8]

A core component of the U.S. transformation has been the ability to measure elements of care.[9] The U.S. health care marketplace, even today, is notoriously fragmented, with myriad private payers, health systems, and other stakeholders. Layered atop this confusing setup are government payers and diverse reimbursement methodologies. However, performance by the variety of U.S. health care stakeholders is now being measured 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).[9] 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 U.S. transition to value continues apace, with 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 U.S. system, such as 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 such diverse disease areas as high cholesterol, rheumatoid arthritis, oncology, and diabetes for pharmaceutical products. The U.S. 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 U.S. Experience

One aspect of U.S. experience that Brazil can learn from is beginning with 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, the government, and private payers and say, "We've been collecting this information; why are you paying hospital A the same as you are paying hospital B when hospital A outcomes are much worse than hospital B?" That question will begin to instill a mindset of paying for quality while also stoking the competitive nature of hospitals and providers to deliver better health care.

The right measure is one that is reliable and consistent, but also is viable or easy to measure. When we talk about selecting appropriate criteria for Brazil's transition to value-based health care, 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.

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 it is. However, when you compose the right metrics, you can have a broader view of 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 weight them because one measure may be more important than others. Brazil can analyze which health care issues are most pressing to its health care spending and focus initial measures on these areas.

There are some initiatives for measuring value currently underway in Brazil. One of them is called EVS (Value-Based Healthcare Score), which creates quality measures while considering process, outcomes, and patient experience and relates those composed measures with costs. 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 data and changes over time for EVS may be useful in bringing more Brazilian stakeholders on board to embrace value-based health care.[10]

Another lesson learned from the United States is that there must be an influential stakeholder (e.g., large payer or the government) to support value-based health care and publish success stories. Why doesn't Brazil's Health Ministry and ANS join efforts to establish quality and value measures and suggest

incentives for prescribers and hospitals to adopt value-based care 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 measures that would be used to evaluate the processes and outcomes from a hip replacement.

We 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 to support a primary care program in Brazil. Why not invite ANS to join the discussion and establish some metrics not just for the public sector, but also for the private sector? This standardization would be good for the whole market. A third party, agreed on by all stakeholders, may also reduce any mistrust between different health care 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.[11] 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 from fee-for-service to any model of value-based payment will cause a profound change on the provider side, since the providers will have to bear some risks. Payers will not assume that all providers are efficient and higher performers. Providers will be evaluated using objective data, which have been input by providers and health systems, and informed by outcomes and trends in population health data. The U.S. system is also doing this with data from hospital and provider performance, which is increasingly visible to payers and consumers, 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 pharmaceutical and device manufacturers in value-based health care can be challenging but vital. Many of the performance- and value-based contracts are between payers and providers, so the manufacturers are not necessarily directly involved. However, manufacturers are affected when providers and hospitals ask questions of manufacturers, such as outcome expected, cost-effectiveness, and different value metrics if a drug is changed.

Essentially, IBRAVS and its advisory board are discussing a deeper involvement besides merely discount agreements. The manufacturers have an opportunity to participate in value-based health care projects that support 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 different reimbursement arrangements such as a risk-sharing or value-based contract. Value-based 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 SUS. Nusinersen, used to treat spinal muscular atrophy, is the most expensive drug ever incorporated by the SUS.[12]

On the other hand, in the private sector we are involved with (or aware of) a project composed of breast cancer patients. In this project, the payer, the provider, and the manufacturer have met and are discussing how they can track those patients and follow them on their journey within the health care system. An interesting aspect of this project is that the implementation of the analytics tools is outsourced by the manufacturer to a third-party company that is responsible for collecting data, producing measures, and disclosing them to the stakeholders. For the first time, the manufacturers, payer, and provider are discussing together what is best for the patient and how it can be measured.

The next step of the movement towards value-based health care is to develop a risk-sharing contract between payers and manufacturers, along 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, knowledge, 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.[13] 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.

Conclusions

For Brazil, the new decade promises to be one of change for health care. The predominantly fee-for-service system must evolve for Brazil to continue to care for its population, both publicly and privately insured. The U.S. experience, particularly the introduction of measurement systems and performance rewards may be a way for Brazil to drive its own evolution to value-based health care. However, doing so will require the engagement of a broad set of Brazilian stakeholders, including hospitals, payers, providers, and government agencies. Despite the challenges, evolution is possible and imperative. Value-based health care will not only help with the delivery of cost-effective care but will ultimately benefit the most important health care stakeholder of all: the Brazilian patient.

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