JOURNAL OF THE AMERICAN COLLEGE OF CARDIOLOGY
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PUBLISHED BY ELSEVIER

VOL. 70, NO. 7, 2017
ISSN 0735-1097/$36.00
http://dx.doi.org/10.1016/j.jacc.2017.06.050

GUEST EDITORS' PAGE

Value-Based Health Care in Latin America

An Urgent Discussion

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Cardiovascular diseases (CVDs) represent a major health problem worldwide (1,2). In Latin America, the epidemiological transition that evolved earlier in Europe and the United States will present significant challenges for the management of the increasing burden of CVD (1,2). Recent research showed that the economic costs of just 4 heart conditions in Latin America may total more than US$30.9 billion annually (3).

This economic landscape constitutes a challenge for all health care stakeholders, who need to urgently consider innovative ways to deliver care that safely reduces population-wide health spending and to reward health care provider-based value. The status quo—the predominance of the fee-for-service payment system, based on volume and prices of the items and services provided—ultimately rewards quantity over quality, and is therefore unfit for addressing any of these challenges (4).

In this scenario, moving toward value-based health care (VBHC) has emerged as an alternative for the sustainability of the system. Value in health care can be defined as a relation between outcomes and costs needed for achieving those outcomes (5).

Regarding outcomes, most of the hospitals are still collecting and reporting basic clinical outcome measures, such as in-hospital mortality and complication rates. For delivering value, hospitals should consider new performance metrics that are more meaningful to patients. These may be Patient Reported Outcome Measures (PROMs), such as quality of life and functional status, as well as Patient Reported Experience Measures (PREMs), such as the patient's perception of care quality and if he or she would recommend the hospital to family and friends (6,7).

Importantly, outcomes should be measured over the full care cycle of a medical condition, and costs should comprise the total costs used to care for a patient's condition over this cycle. Issues such as the appropriateness of care, avoiding overuse and underuse of therapies, and eliminating waste throughout the care cycle should also be considered (**Figure 1**) (5,6,8,9).

In VBHC, it is assumed that there will be value-based competition among different heath care providers, and for this purpose, it is required that different institutions measure the same standardized outcomes over the whole care cycle. Such standardization together with transparency are essential elements of VBHC that allow comparisons (benchmarking), which may affect different stakeholders: patients who will prefer providers based on their expected outcomes and their share of the cost; providers that will prioritize areas where they deliver superior outcomes at competitive prices; payers that will negotiate contracts based on results; and suppliers that will market their products on value, considering risk-sharing, and showing improved outcomes relative to costs (5,6,10).

National and international clinical registries, such as the American College of Cardiology's National Cardiovascular Data Registries, provide clinical

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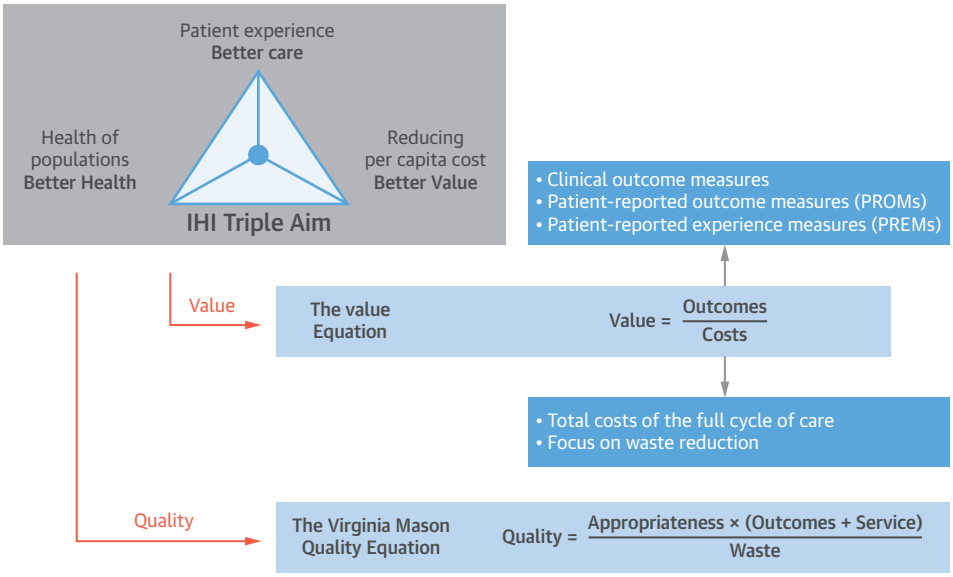
FIGURE 1 **The Triple Aim and the Quality and Value Equations**



Adapted from Porter (5), Triple Aim (Institute for Healthcare Improvement [IHI]) (8), and Kaplan (9).

outcome benchmarks to hospitals that can be used to drive local quality improvement efforts (11). Another initiative, the International Consortium for Health Outcomes Measurement, has been focusing on both defining global standard sets of outcomes and on creating a Global Health Outcomes Benchmarking Program to gather data from hospitals around the world (10). These initiatives are still in their early stages in Latin America. In Brazil, the International Consortium for Health Outcomes Measurement and the National Association of Private Hospitals are sponsoring a standardization project, starting with the heart failure standard set, that will allow national and international comparisons among hospitals. In the near future, with more Latin American hospitals participating on such programs, regional benchmarks will be available.

Data on payment models is also scarce in Latin America. In a global assessment, which included 4 Latin American countries—Brazil, Chile, Colombia, and Mexico—the results, on average, indicated a low alignment with VBHC. Colombia was the only developing country showing moderate alignment due to recent reforms, including plans to organize care delivery, and because 95% of the population has access to health insurance. Only in Chile and Colombia could the presence of enabling elements for VBHC such as bundled payments, payment for performance (Chile), and quality standardization (Colombia) be nationally observed, where the government and/or major payer(s) were actively collecting patient treatment cost data in some areas (12).

Porter and Lee (13) proposed a value agenda for the implementation of value in health care. The strategic agenda has 6 components: 1) organize into integrated practice units; 2) measure outcomes and costs for every patient; 3) move to bundled payments for care cycle; 4) integrate care delivery across different facilities; 5) expand excellent services across geography; and 6) build an enabling information technology platform (13).

In the real world, however, implementing a value-based health care system is not a simple task. Thus, measuring outcomes and costs for every patient on a few selected medical conditions could be the very first step to implement a value agenda. To move on with the proposed value agenda, a next step we took was the creation of a Value Management Office, an integrated office aiming at disseminating the culture and aligning the concepts of VBHC throughout the hospital system, integrating data from different sources and providing insights to define feasibility of new models of value-based payments for different medical conditions, based on practice and cost variability. In fact, unwarranted care variation affects both outcomes and costs, and a set of interventions has been implemented in our institution aimed at decreasing such variability (14).

The creation of doctor-led multidisciplinary groups to engage physicians and health care professionals in defining evidence-based practices for different medical conditions is 1 such initiative that has helped to reduce waste, improve outcomes, and ultimately provide value for our patients (15).

Finally, the availability of a solid technology information platform, which includes "big data" infrastructure, may accelerate VBHC adoption and help convince clinical and administrative decision makers to pursue a value-based agenda across their organization. In our institution, a big data department has been created with the mission of incorporating the concepts of machine learning into hospital daily routine.

In conclusion, considering the epidemiological relevance and the increasing costs for preventing and treating cardiovascular diseases, VBHC emerges as an alternative for sustainability of the health care system, with reimbursement based on care delivery efficiency. Currently, Latin America is still in its early steps moving toward a VBHC system. Deciding to establish a value agenda and starting with outcomes and cost monitoring seems to be the first step toward implementing VBHC into daily practice. If health care system transformation is needed, and if it is already happening in many countries, we must start our value journey right now.

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