Value-Based Healthcare: Is It Just Another Buzzword?

Soins de santé axés sur la valeur : est-ce juste un nouveau mot à la mode?

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Abstract

The concept of value-based healthcare has been gaining traction, with several issues of *Healthcare Policy* discussing the agenda and highlighting pockets of excellence. However, we currently have no shared common goal that would define value-based healthcare. Furthermore, we have major limitations in measuring both the cost and benefit components of the concept of value, irrespective of the definition. It is time to make progress, which will include a recognition of the need to engage the public in a discussion around the values of the Canadian healthcare system and the federal government taking a hands-on role for the accountability of value as an outcome.

Résumé

Le concept de soins de santé axés sur la valeur gagne du terrain. En effet, plusieurs numéros de *Politiques de Santé* abordent la question et en soulignent les regroupements d'excellence. Cependant, il n'y a actuellement aucun objectif commun pour définir en quoi consistent des soins de santé axés sur la valeur. De plus, il y a d'importantes limites quant à la mesure des coûts et bénéfices associés au concept de valeur, et ce, indépendamment de la définition retenue. Il est temps de faire des progrès, et cela comprendra la reconnaissance du besoin d'engager le public dans une discussion sur les valeurs du système de santé canadien et sur le rôle du gouvernement fédéral pour tenir compte de la valeur en tant que résultat.

Introduction

Healthcare costs in Canada continue to rise. Healthcare spending reached $265.5 billion in 2019 (CIHI 2020). As a share of gross domestic product (GDP), healthcare spending has increased from 5.2% in 1981 (IFSD 2019) to 11.5% in 2019 (CIHI 2020). In addition, healthcare now, on average, represents 37% of each provincial budget (CIHI 2020). The COVID-19 pandemic has accelerated spending growth; the long-term impact of this spending increase on healthcare costs' growth trajectory is unknown but is anticipated to be substantive (The Conference Board of Canada 2020).

Increased healthcare spending comes at the expense of other social spending and may not improve health. Calls to *bend the cost curve* are often motivated by concerns that healthcare spending will overtake governments' abilities to spend money on other social services (Marchildon and Di Matteo 2014). Other social services, such as education, are vital to our productivity and are also highly correlated with health outcomes (Conti et al. 2010; Dutton et al. 2018). In addition, a 2019 survey found that Canadians are worried about healthcare more than any other national issue (CMA 2019). In addition to being costly, the Canadian healthcare system is not producing leading outcomes when compared with other international systems. For example, the Canadian healthcare system ranks second to last overall among Organisation for Economic Co-operation and Development countries (OECD 2021). Notably, Canada also ranks second to last in equity, health outcomes and performance versus spending when compared with 12 selected peer countries, including the UK, France, Australia and the US (Schneider et al. 2021). This underscores the need to focus on value: What are we getting for the resources we invest in healthcare?

Value-based healthcare is gaining traction. There have been several issues published by *Healthcare Policy* that reflect on the agenda and highlight pockets of excellence. In this commentary, I reflect on the macro policy questions that I believe are hindering the widespread adoption of value-based healthcare. While the issues herein require substantial investment and time, I believe that a renewed focus on these issues is crucial at this moment in time to capitalize on the significant push for change amplified by the COVID-19 pandemic.

What Is the Goal?

To think strategically about achieving a goal within a specific budget, the goal needs to be clear. What are we trying to achieve with the resources being allocated? At times, the goal may be stated as to achieve the most health for a population. However, current care and policy conversations make it plain that this is not the goal. If we were simply pursuing the most health, we would not be paying for multiple procedures and treatments; instead, we would be investing heavily in the social determinants of health or, at the minimum, effective mental healthcare. The way we are currently allocating our budget demonstrates that we prioritize acute illness care over care that may maintain health.

The Triple Aim has also been put forward as aims that a healthcare system should pursue: improving the health of populations, reducing the per capita cost of healthcare and improving the patient experience of care (Berwick et al. 2008). It was initially developed as required aims that the US healthcare system should pursue to improve the system. The Triple Aim has been expanded to include the Quadruple Aim, which encompasses the provider experience, and, recently, the Quintuple Aim, which incorporates equity (Nundy et al. 2022; Sikka et al. 2015). There is no claim that this framework covers *every* goal of the US healthcare system or that this be the set of aims that *every* healthcare system should pursue, recognizing the different structures (and goals). Yet, the Triple Aim has gathered significant momentum (Ashton 2015; CMA 2010; Saskatchewan Ministry of Health 2012; Health Quality and Safety Commission New Zealand 2013; Tholl and Grimes 2012). It is worth noting, however, that there is substantial variation to and adaption of the concepts within the framework, presumably to respond to the local context and political needs (Mery et al. 2017). For example, in many places, *reducing the cost per capita* has been replaced with the language of *better value* (Mery et al. 2017). Even here, within a widely adopted framework, one only needs to ask the question, "What does this mean?" to realize that we have no shared understanding of the concepts underneath the (buzz) words. The concepts are poorly defined and despite this being set out as the goal of multiple healthcare systems, including several provincial healthcare systems here in Canada (CMA 2010; Saskatchewan Ministry of Health 2012; Tholl and Grimes 2012), the Triple Aim does not yet provide a clear goal against which resource-allocation decisions could be made.

Data

To achieve any marked improvement in value-based healthcare, data are required. As the old adage goes, "What gets measured gets done." There is little hope for improving or integrating value-based approaches without data that can measure and report on value regularly. There are two aspects to value a measure of benefit and costs (Drummond et al. 2015); we need more accurate and consistent data for both. There have been substantial, and important, strides made in the data landscape in Canada. For example, the SPOR [Strategy for Patient-Oriented Research] Canadian Data Platform is an infrastructure that aims to support improved access to data, automation of data analysis and ongoing engagement with diverse citizens (Dahl et al. 2020). This has led to the Data Access Support Hub, which is a "one-stop" data access service portal for researchers (https://www.hdrn.ca/en/dash). While formal evaluation is still required, anecdotally, these initiatives have greatly improved access to data holdings across the country. However, improved access is only one piece of the requirement. To measure value, an investment in data gathering and infrastructure is required.

Microcosting, a methodological approach that uses direct enumeration and costing of every input consumed in the treatment of a particular patient, is regarded as the reference standard for costing (Gold et al. 1996). Yet, only two Canadian provinces (Alberta and

Ontario) routinely generate these data within a limited, mostly urban, geographical area (CADTH 2017). Everywhere else in Canada, gross costing approaches are used. Gross costing is a methodological approach that allocates a total budget to specific services, such as hospital stays, by grouping encounters with similar utilization profiles (Raftery 2000). At an individual level, this approach does not allow for variation. For example, one of the 522 gross cost groupers used in Canada (case-mix grouper code 193) captures myocardial infarction/shock/arrest with a coronary angiogram (CIHI n.d.). Thus, all encounters coded to this grouper code are assigned the same cost. One can imagine that some patient encounters may result in short hospital stays, whereas others may be long, complex encounters with significantly more intense resource use. The gross-costing methodology used by the majority of Canada, indeed globally, is unable to capture these individual patient differences. Without precise costing data, measuring and subsequently managing value is challenging.

Thinking about the benefit aspect, the issues are similar. The data regarding major clinical outcomes, such as death, strokes and heart attacks, are robust. However, if the benefit considered in the value equation includes patient-reported outcomes and patient experience, we need to measure consistently across the system using validated instruments. There are centres and specific hospitals across Canada that are routinely measuring patient-reported outcomes and doing it very well, but data are required at an expanded level across the healthcare system (Alberta PROMs and EQ-5D Research and Support Unit n.d.).

Thinking about Different Perspectives on Value

As we embark on a larger pursuit of value-based healthcare, we must remember that value is subjective. What represents value to one group of people may not match the perspective of another. For example, the Triple Aim as laid out above does not include the concept of equity (Berwick et al. 2008). Equity as one of the central goals of a healthcare system is a reflection of societal values. Furthermore, a quality-adjusted life-year commonly used in drug reimbursement recommendations is often measured using the EQ-5D scale, which includes the dimensions of self-care, mobility, usual activities, pain/discomfort and anxiety/depression (Bansback et al. 2012). It is easy to imagine people and communities who would not adopt this lens to measure the value of their healthcare. This underscores the importance of diverse public involvement and deliberate reflection about how we identify the "value" in value-based healthcare. There are multiple approaches and frameworks that have been developed to understand the different perspectives on values (Leneghan 1999; Mooney and Blackwell 2004); all of them start with listening to communities whom the system is intended to serve.

It has been several decades since the public has been engaged, in a meaningful way, in public discussion and deliberation about what the healthcare system should do. Within the Romanow Commission, citizens were brought together to participate in deliberative dialogue, a method where participants have the opportunity to work through conflicting values and difficult choices in order to reach judgments on an important issue (Maxwell et al.

2003). Participants were asked to consider four scenarios: (1) more public investment in doctors, nurses and equipment, either through tax increases or by reallocating funds from other government programs; (2) a form of private payment for healthcare that proposes a system of small copayments by users; (3) restructuring of healthcare to create a parallel private system; and (4) internal restructuring to reorganize service delivery whereby Canadians would sign up with a healthcare provider network. The results of these deliberations signified that the participants hoped – albeit said in different words – that the system could become a value-based healthcare system. Importantly, this work demonstrated that the public can meaningfully participate in these tough conversations, a point of contention at the time and, arguably, still today. A primary recommendation from the commission is that these dialogues be re-run regularly (Maxwell et al. 2003). Unfortunately, this has not occurred. Such a dialogue now is likely to provide important insight into what the goal of healthcare should be at this time of change. With this, resource decisions could be made to prioritize those goals that would help kick-start the system out of its state of stasis.

Accountability

Finally, for the pursuit of value-based healthcare to become a reality, the outcome of value in the healthcare system needs to be someone's accountability. At the moment, no one is responsible for achieving value, no matter how it is measured within the healthcare budget. There are healthcare executives who may be responsible for value within their organizations but not broadly across the system of care. Of course, there are also ministers of health – provincial, territorial and federal – who control budgets but have no clear responsibility for value. If no one is responsible, little will get done. Until the accountability loop is closed, we are unlikely to see major strides toward value-based healthcare systems.

The question of who *should* be accountable is one of much debate. The federal government holds the purse and sets the terms, while the provinces squarely own the operational responsibility for healthcare. The provinces have made it clear that they do not want the federal government "interfering" (University of Ottawa Law RPS Submitter et al. 2017). However, given how big a piece of the federal budget healthcare is and how important healthcare is to Canadians, it seems unreasonable to expect that the federal government would have no desire to shape healthcare by attaching strings to their funding. Demonstrated in the Health Accord of 2017, where a specified component of the funding within the Canada Health Transfer was earmarked for priorities that the federal government and provinces both wanted to advance (home care and mental healthcare) (Government of Canada 2017), the federal government and provinces can find common ground in the interest of Canadians. The federal government holds the provinces accountable to the principles within the *Canada Health Act* (1985), and at the end of the day, the federal government controls the most powerful tool available – money. If we are serious about value-based healthcare, the federal government must take a hands-on role for the accountability of it as an outcome.

Conclusion

The COVID-19 pandemic has proven to us that many of the barriers to change are artificial, and when the desire for change is aligned across the system, the Canadian healthcare policy environment and healthcare system can change rapidly. For example, the COVID-19 pandemic has facilitated the implementation of stalled or slow-moving policy agendas; the provision of virtual care was implemented rapidly (Webster 2020), data were embedded to support rapid decision making (Neil-Sztramko et al. 2021) and specialist advice services were rapidly implemented to support care (Wake et al. 2020). Each of these changes was implemented within weeks despite multiple pre-pandemic implementation attempts that were bogged down by complex policy landscapes, structures and politics. This implies that the state of stasis of Canadian healthcare is self-imposed. Let us get on with it.

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