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THE ROAD TO HEALTHCARE SUSTAINABILITY

Attainment of universal health coverage (UHC) has become a priority for Latin America (LA) governments, but increasing coverage unavoidably comes with rising healthcare costs and the challenge of fostering efficiencies.

LA Ministries of Health (MoHs) have made efforts to manage the rising healthcare costs and attain financial sustainability, but despite these efforts the four largest markets based on 2018 Gross Domestic Product (GDP) in the region – Argentina, Brazil, Colombia and Mexico – remain behind the Organization for Economic Co-Operation and Development (OECD) average in Total Healthcare Expenditure as % of GDP and the Pan American Health Organization (PAHO) / World Health Organization (WHO) Public Health Expenditure as % of GDP target, which are viewed as benchmarks for sustainability.

Universal health coverage (UHC) has become a priority across governments in Latin America (LA) and the largest economies in the region based on 2018 GDP – Argentina, Brazil, Colombia and Mexico – have made significant strides to improve healthcare for patients over the past 30 years. For example, in 1988, Brazil approved a landmark reform to create a unified public tax-based system (‘Sistema Unico de Saude’) which increased the percentage of the population covered from 50% to 100%, bringing healthcare to millions [1]. Fragmented healthcare systems like those found in Argentina, Colombia and Mexico have also taken steps to guarantee the right to health by creating solidarity schemes with benefit packages that serve as a safety net for the informally employed and unemployed. For example, in Mexico ‘Seguro Popular’ was created as a public insurance scheme for the informally employed and unemployed [2]. In Colombia, the ‘Plan de Beneficios de Salud con Cargo a la UPC’ (PBS UPC) guarantees access to basic healthcare services to patients with subsidized affiliations [3]. Even in markets such as Argentina, which traditionally had a fragmented network of public hospitals providing services to the entire population, the Ministry of Health (MoH) announced in 2016 the creation of the ‘Cobertura Unica de Salud’ (CUS) to improve access and quality of services for the uninsured [4]. These efforts to increase the percentage of the population covered and improve access to pharmaceuticals and services have significantly improved health outcomes and increased average life expectancy of patients in the region [5].

Although coverage for the entire population has almost been achieved in Argentina, Brazil, Colombia and Mexico, the road to equitable access has proven to be challenging as LA MoHs attempt to balance
constrained budgets with the increasing demand for services and the rapid rate of innovation that, in some cases, comes with a high price tag. In the face of rising costs, LA MoHs have made efforts to promote efficient allocation of resources and increase healthcare spending to attain financial sustainability. However, despite these efforts, key countries in LA have not achieved the PAHO / WHO public health expenditure as % of GDP target that was defined as part of the ‘Strategy for Universal Access to Health and Universal Health Coverage’ in 2014 (Figure 1) [6, 7]. Additionally, key countries in LA remain behind the Organization for Economic Co-Operation and Development (OECD) average – which is also viewed as a benchmark of sustainability in the region – in terms of total healthcare expenditure as percentage of GDP (Figure 2). Gaps between the PAHO / WHO targets and OECD average, and Argentina, Mexico, Colombia and Brazil levels suggest that the healthcare systems are underfunded, and challenges exist that have to be overcome before the region becomes sustainable. Inadequate financing in light of rising costs of care and inefficient resource allocation are only some of the key hurdles.

This working document aims to outline LA’s key hurdles to healthcare sustainability as well as propose a set of solutions that mutually benefit both LA MoHs and the pharmaceutical industry.

**FIGURE 1: PUBLIC HEALTH EXPENDITURE AS % OF GDP IN 4 LA MARKETS [8, 9]**

**PUBLIC HEALTHCARE EXPENDITURE AS % OF GDP IN 4 LA MARKETS (2015)**
FIGURE 2: TOTAL HEALTH EXPENDITURE AS % OF GDP IN 4 LA MARKETS [10, 8]

TOTAL HEALTHCARE EXPENDITURE AS % OF GDP IN OECD VS. 4 LA MARKETS (2015)
DEFINING HEALTHCARE SUSTAINABILITY HURDLES

LA MoHs face common healthcare sustainability issues: rising cost of innovation, increase in demand for healthcare services, epidemiological shift with an unfinished agenda on communicable diseases, constrained or stagnating healthcare budgets, inadequate healthcare expenditure as percentage of GDP, healthcare system fragmentation, inadequate use of resources and weak prevention programs.

WHO describes a sustainable healthcare system as ‘a health system that ensures equitable access to essential medicines, vaccines and technologies’, while ‘raising adequate funds for health to ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them’ [11].

Given the rapid increase in population and continuous increase in healthcare demand, the LA region faces a situation where healthcare systems cannot provide the services required by law to meet the needs of the population being covered. To change this situation, new strategies to meet the growing demand are needed. However, the first step to identifying sustainable solutions is to understand what the challenges are.

Healthcare sustainability challenges in LA can be classified in two categories: demand and supply hurdles.

DEMAND HURDLES

Populations in LA continue to have growing needs for new technologies and services to treat both communicable and non-communicable diseases, leading to a continuous increase in consumption of healthcare resources. The increase in demand and healthcare resource consumption is driven by:

- INCREASE IN THE NUMBER OF PATIENTS COVERED
  The increase in the population covered is multifactorial and driven by two factors:
  Push for UHC – Since 1990 the World Health Organization (WHO) has urged countries in LA towards UHC and, as a result, countries have implemented a series of healthcare reforms with the aim of increasing equity and coverage. Four of the major markets in the region – Argentina, Brazil, Colombia and Mexico – have made meaningful progress towards UHC and the entire population is almost covered. Endorsement by LA MoHs of the 2030 Sustainability Development Goals put forth by the United Nations (UN) in 2015 suggest that attainment of equitable access to healthcare services will continue to be a priority in the healthcare agenda of MoH in the LA region [12]. However, attainment of UHC comes with the hurdle of having to provide care to a higher number of patients [13].

Evolving Demographics – The population in LA markets is young compared to advanced economies, but
population aging is expected to accelerate in the region. Today LA women have on average a little more than 2 children, which is three times less than the average in 1950. At the same time, higher living standards and better access to care have increased life expectancy in the region to 75 years. This combination of falling birth rates and rising life expectancy will lead to a situation where there are fewer active people to support a growing number of dependents. Additionally, an aging population is also at higher risk of disease and complications likely leading to higher cost of care [14].

* EPIDEMIOLOGICAL SHIFT—FROM ACUTE TO CHRONIC

Although the region is not free of communicable diseases, they have become less preponderant over time and no longer pose the greatest threat to public health. Instead, the LA region is well advanced in its epidemiological transition and there is little doubt that non-communicable diseases will replace communicable disease as the primary cause of morbidity and mortality. Two factors are believed to be the central drivers of this trend: the aging population and the increase in overweight and obesity rates [15].

Non-communicable diseases are likely to increase budgetary pressure and healthcare demand because they are chronic in nature, often do not have a cure and are associated with multi-morbidity, thus requiring continuous treatment.

* RISING COST OF INNOVATION

Innovative therapies can have high price tags, which can pose a hurdle to access especially among cost-driven market segments in LA. The rising cost of innovation in LA can be explained by the rising cost of research and development (R&D) and inflation:

**R&D Costs** - In 2015, 56 new medicines were launched, while there are currently over 7,000 compounds at different stages of development globally. The gap between the two numbers highlights the complexity of pharmaceutical R&D and the hurdles that have to be overcome before compounds can be developed into safe and effective medicines. Pharmaceutical companies carry out years of costly studies to demonstrate that treatments are safe and effective: finding hospitals and clinics to participate, recruiting patients who fit precise descriptions, tracking their health in minute detail for years while ensuring they take their medications, and then combing through heaps of data that will determine whether doctors can prescribe them [16]. This is why it can take between 10 to 15 years to develop a new medicine and only about 12% of compounds that enter clinical trials result in an approved medicine [17].

Today, the cost of developing a successful medicine can exceed, according to some studies, USD 2.6 billion compared to USD 179 million in the 1970s [18, 19]. The rising R&D costs stem from increased failure rates, more stringent testing requirements, higher patient out-of-pocket (OOP) costs and longer development times [20]. In addition, pharmacovigilance requirements are becoming stricter, raising the investment costs in a given medicine as long as it is being marketed.
Despite these challenges, the pharmaceutical industry continues to be a heavy investor in research and development. It is estimated that the pharmaceutical industry spent nearly USD 149.8 billion globally on R&D in 2015 [21]. Of all sectors, the pharmaceutical industry has consistently invested the most in R&D, even in times of economic turmoil and financial crisis. Compared with other high-technology industries, the annual spending by the pharmaceutical industry is 5.5 times greater than that of the aerospace and defense industries, 5 times more than that of the chemicals industry, and 1.8 times more than that of the software and computer services industry [22]. However, innovation cannot continue to happen without regulatory and access healthcare framework that protects and rewards innovation.

 Economic Turmoil & Inflation – Some LA markets have faced an economic recession and devaluing currencies over the last 5 years. In the face of inflation, costs of goods tend to increase, but in countries like Argentina and Peru the cost of healthcare is rising at a faster rate than inflation [23, 24]. In Venezuela, the Pharmaceutical Federation of Venezuela estimates that the country is suffering from an 85% shortage of medicine due to the economic crisis, which has forced Venezuelans to go looking for medicines on the black market. Even if they find the right medicine, these are often smuggled from Brazil or Colombia and sold at hyperinflated prices that most patients cannot afford [25, 26].

 SUPPLY HURDLES

 A reduction in government funds coupled with lagging technological advances leads to a reduced level of resources for the general population. The following supply hurdles have been identified:

* CONSTRAINED OR STAGNATING HEALTHCARE BUDGETS

Healthcare budgets across LA markets have remained largely constrained or stagnant over the past few years. For example, in Mexico the 2019 national budget proposal increases government health expenditure by 0.53% in absolute values, but given the inflation rate there is a real reduction of 3.2% compared to 2018 [27, 28]. While in Argentina, the 2019 national budget proposal increases government health expenditure by 29.4% in absolute values, but given the inflation rate there is a real reduction of 2.2% compared to 2018 [29, 30].

* INADEQUATE HEALTHCARE EXPENDITURE AS % OF GDP

In the ‘Healthy Nations, Sustainable Economies: How Innovation can Better Ensure Health for All’ report, the Group of Twenty (G20) Health and Development Partnership highlights that underinvestment in healthcare can seriously impair growth and economic performance and presents a major long-term challenge for public budgets [31].

In 2015, health expenditure as percent of GDP was 6.2% in Colombia, 5.8% in Mexico and 8.9% in Brazil compared to the OECD average (excluding Mexico) of 8.9% [9, 10]. The gap is larger when comparing the public healthcare expenditure as percent of GDP,
which was 4.4% in Colombia, 3.0% in Mexico and 3.9% in Brazil compared to the PAHO / WHO target of 6.0% and OECD average (excluding Mexico) of 6.6% in 2015 (Figure 3) [8]. It is expected that expenditure as a percent of GDP will need to grow by at least by 2% to meet the demands of the populations in Colombia, Brazil & Mexico.

*HEALTHCARE SYSTEM FRAGMENTATION*

Most markets in LA have a fragmented healthcare system, where each subsystem has their own way of financing and delivering healthcare. The problem is that when these subsystems operate independently from one another, they create major gaps in the provision of health services, often leaving out the poorest patients. Overall, fragmented health systems are less efficient, and provide fewer resources to those who need care the most, leading to health inequities throughout a country [32, 33].

Patients also struggle to navigate fragmented health systems, which can lead to delays in diagnosis and treatment initiation, and issues with continuity of treatment. These challenges are associated with late-stage disease presentation and faster disease progression, which can lead to higher treatment costs due to complications, worse clinical outcomes and higher mortality rates. Patients throughout LA have low screening rates, delayed referrals, and sometimes will not even seek medical help because of these barriers.
* INADEQUATE USE OF RESOURCES

Evidence suggests that between 10–30% of healthcare expenditure could be channeled towards better use [34, 35]. The main causes of wasteful resources are:

- **Clinical care waste**: Provision of unnecessary or low-value care that makes no difference to patients’ health outcomes
- **Operational waste**: Occurs when there are unnecessary hospital attendances, inefficient processes within hospitals (e.g., inpatient admission for surgeries that could be performed on an outpatient basis), longer than necessary hospital stays, and less expensive but equally effective alternatives are not used
- **Governance-related waste**: Fraud, abuse, corruption, and high administrative costs can all be signs that the health system is not being managed as well as it could be

* WEAK HEALTHCARE PREVENTION PROGRAMS

The LA healthcare model is based on treatment of disease rather than prevention of disease, with disproportionate emphasis placed on resolving health issues in a hospital setting and not enough training / focus put on primary care. This ‘acute care’ model combined with the increasing rate of non-communicable diseases is likely to lead to poor health outcomes and pose a significant financial hurdle to the region.

In Mexico, for example, if current trends in diabetes and hypertension increase at a rate that is unchanged, an increase of 5–7% of the health budget would be required annually to meet the demand for services. While in Argentina, a 2010 study found that it would be possible to prevent an annual loss of 420,000 healthy life-years to cardiovascular disease and stroke. Avoidable costs would amount to USD 395 million per year [36].
Cost-containment tools implemented to date by LA MoHs focus on controlling the cost of pharmaceuticals, but do not address other hurdles to healthcare sustainability that have been identified.

Additional mutually beneficial approaches to attain healthcare sustainability could be explored by LA MoHs and pharmaceutical companies to address common local hurdles and provide access to innovative therapies.

CURRENT COST-CONTAINMENT MECHANISMS

With the objective to balance increasing demand for innovation with reduced budgets, MoHs and policy makers in LA have explored different cost-containment tools. These tools can be divided into mechanisms aimed at controlling access and mechanisms aimed at reducing cost of healthcare services / pharmaceuticals:

- ACCESS CONTROLS

The implementation of pre-authorization committees for prescriptions of high cost therapies (e.g., ‘Torre de Control’ in Mexico), restrictions on the delivery of high-cost therapies to tertiary centers located in urban areas, and the use of primary care physicians as goalkeepers to access specialists are examples of controls that have been put in place across most LA markets. These controls pose hurdles to effective access to healthcare and have a negative impact on patient outcomes. For example, it is estimated that in Colombia over 45% of prescriptions take over 30 days to be authorized, which can have a harmful effect on disease progression, leading to lower patient quality of life (QoL) and potentially higher costs due to complications [37].

- COST CONTROLS

Reference pricing and competitive procurement are effective tools to control costs, but their formulaic approach to establish the price of pharmaceuticals falls short of recognizing the value of innovation. Health Technology Assessment (HTA) has been implemented in Brazil and Mexico as a tool to inform funding and pricing decisions. While in theory HTA allows for greater recognition of products’ value, lack of robust local data to feed the models and use of low Incremental Cost-Effectiveness Ratio (ICER) thresholds make it almost impossible for innovative therapies to be cost-effective in LA. Controlling costs through reference pricing, competitive procurement, and HTA may deter local investment in innovation and delay launch of innovative products as manufacturers try to protect their price band.

Overall, existing cost-containment tools have a negative impact on both patients and the pharmaceutical industry and are not sustainable in the long-run. Additionally, existing tools have focused on
reducing the cost of pharmaceuticals, leaving other avoidable healthcare costs (e.g., clinical care waste, operational waste, government waste and missed prevention opportunities) unaddressed. Therefore, there is a need to explore alternative approaches to attain financial sustainability in LA.

ALTERNATIVE APPROACHES TO HEALTHCARE SUSTAINABILITY

Alternative mutually beneficial mechanisms to attain healthcare sustainability could be explored by LA MoHs and the pharmaceutical industry to address the identified supply and demand hurdles and provide access to innovative therapies.

Proposed solutions have been divided between short-term solutions that can be executed within 12 – 18 months and longer-term solutions.

SHORT-TERM SOLUTIONS

Managed Entry Agreements - Managed entry agreements (MEA) are contractual agreements between the pharmaceutical industry and healthcare providers that are introduced when a decisive ‘yes’ or ‘no’ conclusion on pricing and funding cannot be made due to uncertainties about the clinical evidence and / or financial impact of a medicine. Broadly, MEA can be classified as financial guarantees or outcomes-based agreements, but variances in classification and terminology may exist between countries (Figure 4). The common factor is that MEA promote access to medicines by sharing the cost of uncertainty, whether financial or outcomes related, between the healthcare provider and the pharmaceutical industry. Therefore, MEA are an attractive mechanism to achieve access for high-cost / innovative therapies [38].

Implementation Considerations

MEA are not a solution for every therapy, given implementation is not free of hurdles. MEA often require advanced tracking capabilities and / or sharing of patient outcomes. Competitive procurement laws and internal capabilities for tracking free vials / credit notes are other common hurdles across LA markets that should be considered when designing MEA.

Value-Added Services - There is a need for the pharmaceutical industry to move ‘beyond the pill’ and become a healthcare solution provider. There are examples of value-added services (VAS) that have been implemented to date in LA, but these tend to target patients in an attempt to drive drug sales. VAS aimed at patients include providing educational materials that address signs and symptoms of a disease, treatment options, and self-management techniques. Other services involve advice on how to navigate the healthcare system, particularly useful in highly fragmented LA markets such as Argentina. Finally, there are adherence programs, which try to encourage patients to stay compliant with their treatment regimen [39, 40].

Implementation Considerations

The pharmaceutical industry should consider collaborating with LA MoHs to design and offer programs aimed at improving healthcare
sustainability. Potential programs that could foster sustainability include: training programs for in population health management, diagnosis and prevention training in primary care settings, back office administrative support to expedite auditing of prescriptions and minimize delays, infrastructure development support and protocol / guideline development.

**FIGURE 4: SUMMARY OF MANAGED ACCESS AGREEMENTS**

<table>
<thead>
<tr>
<th>MANAGED ENTRY AGREEMENTS</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>NEGOTIATED FUNDING RESTRICTIONS</td>
<td>Funding restricted to a <strong>defined patient sub-population</strong> that meets agreed upon criteria (e.g., disease severity, line of therapy, patient age, genetic markers, etc.)</td>
</tr>
<tr>
<td>UTILIZATION CAPPING</td>
<td><strong>Maximum quantity of a product</strong> (e.g., number of treatment cycles, dose strength, etc.) negotiated per patient; quantity beyond the cap is not funded</td>
</tr>
<tr>
<td>BUDGET CAPPING</td>
<td><strong>Maximum annual budget</strong> negotiated for a given product / group of products; if sales exceed the threshold, manufacturer refunds an agreed percentage (up to 100%)</td>
</tr>
<tr>
<td>PRICE / VOLUME AGREEMENTS</td>
<td><strong>Incremental discounts</strong> applied to a product / group of products based on negotiated volume thresholds</td>
</tr>
<tr>
<td>FIXED PRICING</td>
<td><strong>Fixed price negotiated</strong> for a number of doses of a given product over a defined period of time</td>
</tr>
<tr>
<td>RISK SHARING AGREEMENTS</td>
<td>Manufacturer refunds the cost of the product for patients not reaching a predefined treatment outcome within a given time-frame</td>
</tr>
<tr>
<td>P4P BASED ON OUTCOMES</td>
<td>Agreement that enables a <strong>rebate for costs</strong> upon achievement of a <strong>defined clinical outcome target</strong>; unlike RSA, manufacturer is only paid if a patient reaches the agreed clinical outcome</td>
</tr>
<tr>
<td>P4P BASED ON CARE PROCESS</td>
<td>Agreement that enables a <strong>rebate for costs</strong> upon achievement of <strong>defined healthcare outcomes</strong> (e.g., adherence / compliance target rates)</td>
</tr>
<tr>
<td>FUNDING W/ EVIDENCE DEVELOPMENT</td>
<td>Funding is conditional on <strong>additional data / evidence generation</strong> for the target patient population; if additional data shows expected outcomes, the product is funded</td>
</tr>
<tr>
<td>CONDITIONAL T(X) CONTINUATION</td>
<td>Funding is conditional on a patient reaching a <strong>pre-defined response to therapy</strong>; if response is not reached, patient discontinues therapy at no cost</td>
</tr>
</tbody>
</table>

**P4P**: Pay for Performance; **RSA**: Risk Sharing Agreement; **T(X)**: Treatment
Multi-Stakeholder Coalitions – There is a need to create healthcare coalitions that can serve as a platform for the pharmaceutical industry, LA MoHs, private healthcare providers, patient associations, and medical societies to discuss the challenges the healthcare sector is facing in LA and co-create healthcare policies to overcome identified hurdles and achieve defined common goals. Successful global examples of multi-stakeholder coalitions include Access Accelerated and FIND (Foundation for Innovative New Diagnostics). Access Accelerated is facilitated by the International Federation of Pharmaceutical Manufacturers (IFPMA) and brings together more than 20 biopharmaceutical companies, governments, civil societies and non-governmental institutions to support multi-sectorial dialogue and develop a plan of action to improve access to vaccines, medicines and training for non-communicable disease in low- and middle-income markets (LICMS). FIND is a product development and delivery partnership that brings together R&D companies, academic institutions, and MoHs / disease control programs to develop, license and secure funding for diagnostics for infectious diseases in LICMS [31]. In LA, national coalitions have also been implemented, like the ‘Instituto Coalizão Saúde’ in Brazil which brings together the MoH, private providers, local associations, and the pharmaceutical industry to co-create innovative healthcare policies that contribute to sustainable development. These global and local partnerships can serve as a reference for the creation of additional local coalitions in LA.

Implementation Considerations

Successful coalitions require all members to be transparent and committed to taking an ethical, collaborative and innovation-driven approach to fostering equitable, efficient and sustainable healthcare systems in LA.

Incorporation of Multi-Decision Decision Criteria (MCDA) in HTA – Current HTA approaches in LA have overemphasized cost-effectiveness and ICER ratios. Too much emphasis on cost-effectiveness challenges holistic decision-making in the region given limitations that exist in defining relevant ICER ratios and because it excludes important factors such as innovation, societal burden, disease severity, equity, etc. MCDA is emerging as a new decision-tool that can be incorporated to HTA to better reflect the complexity of the local reality by considering multiple decision factors and stakeholders. MCDA takes into consideration the different institutional contexts while fostering a comprehensive, consistent, transparent and flexible approach. While MCDA is a relatively new concept, it is more than a theoretical decision-making tool. It has been successfully applied to various therapeutic areas and healthcare decisions in countries around the world (e.g., orphan drug assessment in The United Kingdom, Sweden, Denmark, The Netherlands and Scotland). In LA, while literature is sparse there have also been examples of implementation (Figure 5). Examples
of real-world application support MCDA is a valuable tool to foster a fair and transparent decision-making approach that can address the competing demands of patients, payers, the pharmaceutical industry, regulators and policy makers [41, 42].

**Implementation Considerations**

Incorporation of MCDA in HTA requires stakeholder alignment on (1) what technologies should be appraised using MCDA, (2) what is the criteria against which technologies should be appraised, (3) how performance in a given criteria should be measured, and (4) weight given to each criterion to measure the overall importance on decision-making. Additionally, incorporation of MCDA in the HTA process should come together with decision-makers taking a patient-centric pro-innovation mindset where clinical benefits and population outcomes are valued.

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**LONG-TERM SOLUTIONS**

**Integrated Health Models** - This solution focuses on building an integrated system that communicates across subsystems to reduce both the duplication of services and the administrative burden associated with fragmentation. An integrated system provides the ability to better coordinate patient care through centralized health records. Integrated care models also allow for increased allocative efficiencies due to an enhanced emphasis on prevention and early diagnosis, thus reducing higher-cost future procedures and their associated complications. Patients requiring additional innovative value-added services would have greater access to meet their needs through enhanced centers of care using novel technologies to promote innovation [43, 44].

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**FIGURE 5: IMPLEMENTATION OF MCDA IN LA [41]**

**EXAMPLES OF MCDA IMPLEMENTATION IN LA**

- **MCDA used by IETS to prioritize which technologies should be evaluated** in the next national formulary (PBS) update
- **MCDA used by CONITEC to prioritize orphan diseases** for development of guidelines and assessment of new technologies
- **MCDA used to evaluate tender offers** by the University of Chile Hospital
- **MCDA incorporated into the MoH’s SUMAR program** that provides maternal-infant care
Implementation Considerations

Integrated health models require all subsystems of the healthcare system to work together and communicate. Markets in LA have discussed plans to integrate their healthcare system, but initiatives have yet to progress beyond the planning stages.

Local Evidence Generation - Promoting local R&D and evidence generation could bring several benefits to LA healthcare systems: (1) R&D grants could attract and maintain skilled workforce that could then contribute to propagating knowledge locally; (2) local clinical trials could provide confirmation of therapies effectiveness in the local setting; (3) local evidence generation could be coupled with the creation of centralized registries to collect long-term outcomes data, which could help track health outcomes and serve as a data source for local economic models.

Implementation Considerations

Significant investments are needed in healthcare infrastructure to replace aging facilities and/or construct new facilities that can enable the implementation of evidence generation programs and centralized registries.
Across LA, demand for health services has outpaced supply. Countries in the region lack the adequate clinical and technological resources and infrastructure to address this increased demand.

To date, LA MoHs have responded to the increasing demand by implementing access and cost controls. However, these tools fall short in recognizing the full value of innovation and could be a deterrent for innovation in the region which could lead to negative economic, humanistic and clinical outcomes. Instead, the region needs to move to a value-based system that is patient-centric and prioritizes long-term sustainability of the healthcare system over short-term cost-cutting. These value-based systems should look at patient care in a holistic way, integrating health promotion, outpatient and inpatient care. They should overcome the expensive and inefficient model that has the hospital as a gravitational center, putting greater focus on health promotion, efficient resource allocation, disease prevention, provider and patient education, integration of the patient into his / her own care and well-being, etc. This shift in paradigm from hospital-centrism and disease-centrism to patient-centrism has the potential to reduce waste, improve population outcomes and patient quality of life.

Through this working document, FIFARMA has outlined a set of short-term (MEA, VAS, Multi-Stakeholder Coalitions, and incorporation of MCDA in HTA) and long-term (Integrated Health Models and Local Evidence Generation) mutually beneficial solutions that LA MoHs and the pharmaceutical industry can explore together to allow for productive movement towards sustainable value-based healthcare systems in LA.
REFERENCES


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