O Sistema Único de Saúde para o Seculo 21

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Seminário APS: Estratégia Chave para a Sustentabilidade do SUS
Brasília
17-18 de abril, 2018
Scope of Presentation

• Introducing ideas to strengthen SUS drawing on Brazilian and global experience
  – Survey of the OECD experience
  – Collection of data and information on Brazilian innovation
  – Options for new delivery and payment arrangements

• Promoting and measuring quality, performance and outcomes

• Drawing on global evidence in developing

• Building accountability into the delivery and financing of health care
Rethinking SUS for the 21\textsuperscript{st} Century

SUS = \textbf{major accomplishment} the right to health in Brazil

Current SUS \textbf{insufficient to meet healthcare challenges of 21\textsuperscript{st} century.}

\textbf{New disease burden pattern requires new approaches}

- Chronic diseases that need constant surveillance
- Aging will accelerate the burden of non-communicable diseases
- Costs are rising due to inefficiency and low quality
Challenges of the SUS Model
Strengths of Current SUS Model

• Served Brazil well for over 30 years
• Based on the concepts of *universalidade, igualdade e integralidade*
• Acknowledged health as important for social inclusion
• Propelled investments in historically underserved municipalities, states and regions

• Reduced health inequities through *Estratégia Saúde da Família* (PSF) and other initiatives
• Successful programs: OS Hospitals, PSF, National Transplant Program, tobacco control, HIV/AIDS, malaria and infectious disease control
Weaknesses of Current SUS Model - Processes

- No limitations or priority setting of what services should be provided → “everything for all”
- Coordination of care is theoretical
  - Referral and counter-referral rare
- Over use of hospitalization
- Rigidity in rules, payment and procedures → stifles innovation
- Low productivity in the health system → high cost
  - Inadequate use of nurses
  - Lack of trained SUS managers
  - Inflexibilities in HR management
Weaknesses of Current SUS Model - Gaps

- Quality culture and quality priority missing elements
- Complexity and rigidity of financing arrangements
- Spending level less important than how funding is used

Data systems separate and vertical
- Prevents tool for effective oversight of performance
- No electronic health records
- Efficiency measures absent
- Lack of monitoring and evaluation
Organization of SUS Today:

without networks, coordination of care or accepted standards of quality
Fragmentation of care within and across public and private sectors

Low efficiency in primary, secondary and tertiary care

Undermines quality

Causes unnecessarily high costs due to hospital-centric model

Leads to shortage of resources for needed services because the model is expensive

Perpetuates inequality
Quality of Care
Adverse Events in Brazilian Hospitals

• In Brazil, between 104,187 and 434,112 deaths/year are associated with adverse events in hospital care
• Controlling adverse events will raise quality

Adverse events are expensive:
• They costs private hospitals between R$ 10.9 and R$15.6 billion annually
• No comparable data for SUS hospitals are available

Source: Couto 2017; IESS 2016
Public Hospitals in Brazil

• Similar findings in seminal hospital study in Brazil
• Hospitals absorb 70% of total health spending
• The typical Brazilian hospital is:
  – small (<50 beds)
  – low complexity
  – inefficient both absolutely and relatively

• Average hospital occupancy rate in SUS is only 37%
• 30% of hospitalized patients could be treated at lower level of care
• Low average hospital occupancy rate → availability of beds in the public system would increase if average productivity of hospital beds improved

Source: La Forgia e Couttolenc 2009
World Management Survey: Quality and Efficiency in Delivery

Hospital Management Scores across Countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>3</td>
</tr>
<tr>
<td>UK</td>
<td>2.8</td>
</tr>
<tr>
<td>Sweden</td>
<td>2.7</td>
</tr>
<tr>
<td>Germany</td>
<td>2.6</td>
</tr>
<tr>
<td>Italy</td>
<td>2.5</td>
</tr>
<tr>
<td>Canada</td>
<td>2.5</td>
</tr>
<tr>
<td>France</td>
<td>2.4</td>
</tr>
<tr>
<td>Brazil</td>
<td>2.2</td>
</tr>
<tr>
<td>India</td>
<td>1.9</td>
</tr>
</tbody>
</table>

Bars represent the average management scores by country on a scale 1-5.

Hospital survey assesses the following kinds characteristics:

- Hospital layout and patient flow
- Patient pathway management
- Standardization and use of clinical protocols
- Personnel decisions and independence of medical and administrative staff
- Accountability of managers
- Effective deployment and use of staff
- Continuous improvement culture

Source: Bloom et al 2013
# Quality of Care

<table>
<thead>
<tr>
<th>Country</th>
<th>Year</th>
<th>Nosocomial Infection Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brasil (2008)</td>
<td></td>
<td>29.2%</td>
</tr>
<tr>
<td>Brasil (2012)</td>
<td></td>
<td>28.9%</td>
</tr>
<tr>
<td>Brasil (2004)</td>
<td></td>
<td>20.9%</td>
</tr>
<tr>
<td>Canada (2009)</td>
<td></td>
<td>12.4%</td>
</tr>
<tr>
<td>Portugal (2012)</td>
<td></td>
<td>10.5%</td>
</tr>
<tr>
<td>EU Average (2014)</td>
<td></td>
<td>8.0%</td>
</tr>
<tr>
<td>Germany (2016)</td>
<td></td>
<td>4.6%</td>
</tr>
<tr>
<td>US (2015)</td>
<td></td>
<td>0.8%</td>
</tr>
</tbody>
</table>

*Studies cover mixed facilities, except for Brasil, 2008 and EU that are ICU only

SUS Weaknesses Define Priorities and Offer Directions for Change

• A focus on patients and chronic disease management in healthcare delivery
• Use the financing system to incentivize improved healthcare delivery performance
• Responsive to citizens and patients

• Improved use of technology through a single Health Management Information System (HMIS)
• Ensure accountability of SUS
• Upgraded quality
Global Trends in Healthcare Delivery
OECD health systems promoting quality and patient-centered integrated care

• Evidence on high incidence of adverse events, inadequate outcomes, and gaps leading OECD countries to **restructured healthcare systems**

• Aging and the increase in chronic disease and multi-morbidities – require a **focus on integrated care** across providers to ensure continuity of care

• Renewed **focus on quality of care** – measurement, monitoring, incentives → higher quality

• Ensuring **accountability**

Sources: OECD 2017; WHO 2013; IOM 2001; IOM 2002
“Accountability” é um termo Anglo-Saxon e da língua inglesa

Pode ser traduzido para o português como responsabilidade com ética e remete à obrigação, à transparência, de membros de um órgão administrativo ou representativo de prestar contas a instâncias controladoras ou a seus representados

Otro termo usado em português é responsabilização

Source: Revista Brasileira de Ciências Sociais, 2007
Distribution of US Healthcare Costs across Patients – mirrors evidence for the OECD

Source: National Institute for Health Care Management Foundation analysis of data from the 2013 Medical Expenditure Panel Survey
<table>
<thead>
<tr>
<th>Country/Area (Source)</th>
<th>Geographic Scope of Evidence</th>
<th>Summary Description of Evaluated Initiatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>US -- Accountable Care Organizations (ACOs)</td>
<td>Nationwide</td>
<td>Strong emphasis on integrate, coordinated care for defined population, good data, quality, accountability</td>
</tr>
<tr>
<td>(Muhlestein 2014)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Portugal (Almeida Simões 2017)</td>
<td>Nationwide</td>
<td>Overhauled the healthcare delivery system to focus on quality, the structure to support it and accountability</td>
</tr>
<tr>
<td>Spain, Catalonia (Lewis and Kouri 2004)</td>
<td>Regional</td>
<td>Integrated, coordinated care model, with data and cultural reset, good data, accountability</td>
</tr>
<tr>
<td>Spain, Basque Country (Contel 2015)</td>
<td>Regional</td>
<td>Another Spanish model designed around an innovative payment system, data and coordinated, integrated care</td>
</tr>
<tr>
<td>Australia, Gold Coast (Connor 2016)</td>
<td>Part of one city</td>
<td>Innovative approach to integrated care, good data, testing alternatives</td>
</tr>
<tr>
<td>Germany, Kinzigtal (Hildebrandt 2010)</td>
<td>Region of a state</td>
<td>Small pilot with impact on coordinated primary care focused on specific, high frequency chronic conditions</td>
</tr>
</tbody>
</table>
United States – Major Reform Components
Affordable Care Act (Obamacare)

- Medical groups for integrated care and held accountable for quality and cost
- Bonus payments to Medicare HMO Advantage Plans with high ratings
- Quality measures including adjusted DRG payment incentives to reward and punish
- Financial incentives to report data

- Accountable Care Organization
- Value-based purchasing
- Medicare advantage plan bonus
- Physician quality enhancement
United States
US Public Financing of Health Care

43% of health financed by the public sector – identical to Brazil’s percentage

Source: US CMS 2017
United States – Reform Components
Public Incentives for quality and value under ACA

**Alternative Payment Models**

- Accountable Care Organizations
- Shared savings/ blended payments for primary care
- Capitated integrated primary care with accountability
- Bundled Payments to include hospitalization, physicians and post-hospital care

**Payment for Quality and Value**

- Hospital Value Based Purchasing for quality and value
- Readmissions/Hospital Acquired Infections penalties
- Physician payment based on quality and value
- Physician Value Based Modifier for quality and value
United States – Reform Components
Public Innovation in Obamacare 2007

- Major achievement - 20 million people added to public insurance coverage
- Quality foundation of reforms
- Incentives for hospitals, physicians and physician practices with full autonomy -- but holding them accountable
- New payment methods to incentivize performance

- Requirements to install and use electronic health records (EHRs)
- Accountability of providers to raise performance and improve quality of care → bonuses and penalties based on defined targets
- Technical assistance provided by CMS
United States – Reform Components
Accountable Care Organizations (ACOs)

- Public and Private Payers
  - Premiums (Private Insurance)
  - ACO Beneficiaries
    - Capitation with Accountability/FFS
    - Co-Pays

- Accountable Care Organization
  - Contract
  - Shared Savings
  - Provider Savings

- Specialist Providers
  - Shared Savings

Source: Authors based on Goodman 2014
United States – ACO Results
Improvements from Pioneer ACOs

**Quality**
- Outperformed fee-for-service providers on majority of quality measures
- On average 6% increase in quality score in just one year (2014-2015)
- Improved performance on 82% of the individual quality measures

**Costs**
- Nearly $1 billion in program savings over three years
- Annual spending reduction increased from $234 million saved in first year to $429 million saved by the third year

Source: US Department of Health and Human Services 2017
United States – Value-based Payment Component
Paying for Quality and Outcomes Not Volume of Care

Value = \frac{\text{patient health outcomes}}{\text{costs of delivering outcomes}}

1. **Payment reform**: align payment with performance – move away from fee for service to episode-based payment

2. **Information systems** for data on performance and outcomes - for providers, and payers

3. **Standardized performance and outcome measures**: physician hospital and health plan performance

3. **Accountability for performance**: rewards and penalties for performance and outcome assessed based on data

Source: Porter 2009
United States – Value-Based Purchasing Results
Hospital Performance

Sample Indicators

- Flu immunization of patients and health workers
- Heart failure 30-Day mortality rate
- Catheter-associated urinary tract infection
- Communication with doctors
- Medicare spending/beneficiary

Source: US CMS 2009
United States – Value-Based Purchasing Results
Hospital Acquired Infection % Reduction 2010-2015

- Central Line-Associated Bloodstream Infections: 91% reduction
- Post-op Venuous Thromboembolisms: 76% reduction
- Catheter-Associated Urinary Tract Infections: 33% reduction

- 21% fall in hospital acquired infections
- >124,000 lives saved
- US$ 28 billion in savings

Source: AHRQ 2016
United States – Value-Based Purchasing Results
CMS Hospital DRG Penalties for Noncompliance (%)

Period 2014 (FY16)

- Readmissions reduction program: 2
- Hospital Value Based Purchasing (HVBP): 1.75
- IQR/MU (Inpatient Quality Reporting): 2
- Hospital Acquired Infections: 1

Period 2016 (FY18)

- Readmissions reduction program: 3
- Hospital Value Based Purchasing (HVBP): 2
- IQR/MU (Inpatient Quality Reporting): 2
- Hospital Acquired Infections: 1

Source: CMS 2009
United States – Cost Containment Results
Dramatic Reduction in Projected Public Spending

Source: Schoen 2016
Portugal – Reform Components
Integrated Care & Quality Improvement Program

Dedicated Departamento da Qualidade na Saúde, DQS

Comprehensive, system-wide IT architecture – data for use in contracting/monitoring

Primary Care
- Set up Family Health Units (FHUs)
  - 3-8 GPs + multidisciplinary team
- Negotiate targets and indicators
- Autonomy
- Payment linked to performance and quality

Rede Nacional de Cuidados Continuados Integrados
- Integrated Care Pathways/Protocols
- Quality and safety standards

Hospitals
- Rationalization of hospital sector
- New management models
- Greater managerial autonomy
- Negotiated contracts
- New payment models for performance and quality

Source: Simões et al. 2017, OECD 2015
Portugal – Performance Results
Consultation Wait Time Reduction Under FHU model

Source: Fialho 2011

**Wait Times for Medical, Emergency, and Nursing Consultations**

- **Emergency**
- **Ambulatory**
- **Nursing type 1**
- **Nursing type 2**

Minutes spent waiting in waiting room

- FHU
- PHCC

Source: Fialho 2011
## Portugal—Performance Results

### Consultation Wait Time - % Reduction for Primary Care

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultation</td>
<td>84%</td>
</tr>
<tr>
<td>Nursing (MCH, diabetes)</td>
<td>50%</td>
</tr>
<tr>
<td>Nursing (vaccination)</td>
<td>42%</td>
</tr>
<tr>
<td>Emergency</td>
<td>21%</td>
</tr>
</tbody>
</table>

- 9% increase in number of nursing consultations per nurse
- 7% increase in number of medical consultations per physician
- 3,000,000€ savings from total annual cost reduction

Source: Fialho 2011
Spain
Catalonia Integrated Care Pathways for 10 Chronic Illnesses

Catalonia Health Service divided into Health Regions and Basic Health Areas (BHAs)

- BHAs create Integrated Care Pathways (ICPs) for 10 chronic illnesses
- Match hospitals with primary care organizations

MOH regional contracts for regional providers
- Financial incentives for achieving objectives at BHA and individual provider level
- Health Information System across all levels

Source: CatSalut 2015, Contel 2015
Catalonia, Spain - Results
Catalonia Integrated Care Pathways for 10 Chronic Illnesses

Heart Failure Admissions

- 2011: 311 admissions
- 2012: 309 admissions
- 2013: 301 admissions

3% reduction in 24 months

Hospital Admissions for Chronic Conditions*

- 2011: 709.6 admissions
- 2012: 684.1 admissions
- 2013: 652.7 admissions

8% reduction in 24 months

*Includes: COPD, HF, DM complications, asthma, coronary diseases, HTA

COPD Emergency Admissions

- 2011: 244 admissions
- 2012: 230 admissions
- 2013: 212 admissions

13% reduction in 24 months

Note: Measures are “admissions per region”

Source: Contel 2014
Spain
Basque Country Integrated Health Organizations (IHOs)

**Basque Country divided into 13 IHOs**
- IHOs unify hospitals with primary care and specialists within an area
- MoH provides bundled payments to IHOs for chronic illnesses to promote integration
- **Nurse case managers** and a strong information system facilitate inter-level communication
- **Integration assessment tools** identify areas in need of strengthening

**Basque Country**

- Divided into 13 IHOs
- IHOs unify hospitals with primary care and specialists within an area
- MoH provides bundled payments to IHOs for chronic illnesses to promote integration
- Nurse case managers and a strong information system facilitate inter-level communication
- Integration assessment tools identify areas in need of strengthening

**Source:** Polanco 2015; Jauregui 2016

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Spain – Results
Reduction in Hospital Visits and 30-day Readmissions

<table>
<thead>
<tr>
<th>Year</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visits</td>
<td>180,000</td>
<td>160,000</td>
<td>140,000</td>
<td>120,000</td>
<td>100,000</td>
</tr>
</tbody>
</table>

Barcelona Esquerra BHA: Number of Hospital Visits for 3 Hospitals

<table>
<thead>
<tr>
<th>Year</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmissions &lt;30 days</td>
<td>12%</td>
<td>10%</td>
<td>8%</td>
<td>6%</td>
</tr>
</tbody>
</table>

Bidassoa ICO: Hospital Readmissions <30 days for 1 Hospital (% of admissions)

Source: Font et al. 2016 and Polanco et al. 2015
Thailand
Clustering and Contracting for Primary Care

Defined package purchased from Contracted Units for Primary Care (CUPs)

- 2 primary care network models
- Public hospital-PHC networks
- Capitation payment

CUP managed by a board with representatives of network providers – Board functions:

- Population registration
- Resource allocation among providers
- Fund holders

Continued focus on hospital quality and efficiency

Source: Hanvoravongchai
Thailand – Results
Movement Towards Quality

Accreditation Status, 2003-2012 (Aug 2012)

Source: Tangcharoensathien 2015

Step 0: Beginning accreditation
Step 1: Risk Prevention
Step 2: Quality Assurance & Improvement
Step 3: Accredited, quality culture
Behavior change incentives offered

Source: Tangcharoensathien 2015
OECD Trend: DRG Introduction and Evolution in Europe → DRG-based Budget Allocation, Management and Payment

Year

2010
2005
2000
1995
1990
1985
1980

Country

Austria
England
Estonia
Finland
France
Germany
Ireland
Netherlands
Poland
Portugal
Spain (Catalonia)
Sweden

DRGs used for management and budget allocation

Current DRG System

DRG for hospital payment

Source: Busse et al. 2011
Brazilian Innovations
## Public and Private Innovations in Healthcare in Brazil

<table>
<thead>
<tr>
<th>Program</th>
<th>Quality of Care measured</th>
<th>Financing Incentives for Performance</th>
<th>Integrated Care</th>
<th>Outreach Care</th>
<th>Integrated Data System</th>
<th>Accountability for Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>São Paulo OS Hospitals (LaForgia &amp; Couttolenc 2008)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Programa Saúde de Família</td>
<td></td>
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</tr>
<tr>
<td>Cardiac Telemedicine (Alkmim et al. 2012)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Prevent Senior (2018; HBS 2016)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IAG Saúde (Couto 2018)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UNIMED MG (2018)</td>
<td></td>
<td></td>
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<td></td>
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</tbody>
</table>
Nationwide
Family Health Strategy (FHS)

- Established in 1994, the FHS uses community health workers to provide basic primary care to families at home
- More complex problems are referred to nurses or physicians
- Focus on low income population and predominantly serving small municipalities (92% coverage of municipalities <5,000)
- Program credited with improving clinical outcomes nationally – while reducing hospitalizations
- Improved access and equity

Expansion of FHS by Income Quintiles

Sources: Wadge et al. 2016; Couttolenc et al. 2013
São Paulo
OSS Hospitals

- OS Hospital System an accountability model for other countries
- Contract payments linked to volume and quality targets
- Data reporting requirements
- Internal and external audits
- Accountability for performance and outcomes – penalties for low quality
# OSS Hospital

## Selected Performance Indicators

### Management
- ALOS for specific services remain within pre-defined ceilings
- Readmission rates
- Social and financial audits

### Quality
- Mortality, medical record and infection commissions are fully operational
- % of deaths analyzed by mortality commission
- % reduction in infection hospital rate

### Patient Satisfaction
- % percent of patient complaints addressed
- Realization of patient satisfaction survey

Source: LaForgia and Couttolenc 2008
### Performance Measures -- OSS and DA Hospitals

<table>
<thead>
<tr>
<th></th>
<th>OSS Hospitals</th>
<th>DA Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n=12</td>
<td>n=12</td>
</tr>
<tr>
<td><strong>Selected Performance Measures</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bed turnover rate***</td>
<td>5.2 [3.7-7.6]</td>
<td>3.3 [1.9-4.8]</td>
</tr>
<tr>
<td>Bed substitution rate***</td>
<td>1.2 [0.1-3.8]</td>
<td>3.9 [1.7-9.7]</td>
</tr>
<tr>
<td>Bed occupancy rate**</td>
<td>81 [52-99]</td>
<td>63 [38-76]</td>
</tr>
<tr>
<td>ALOS**</td>
<td>4.2 [3.8-5.6]</td>
<td>5.4 [4.1-8.1]</td>
</tr>
<tr>
<td>ALOS Surgery*</td>
<td>4.8 [3.0-5.7]</td>
<td>5.9 [2.3-7.7]</td>
</tr>
</tbody>
</table>

\*p<.10; **p<.05; ***p<.01 (Mann-Whitney test)

Source: LaForgia and Couttolenc 2008
Minas Gerais
Telehealth for Cardiology Care

Online training for family doctors

Tests sent to hospital for analysis

Multi-disciplinary team responds to family doctor’s questions within 24 hrs

Cardiology tests conducted by family doctor in UBS

Hospital cardiologist sends analysis and recommendations

Source: Alkmim 2012
Private Sector Innovations Important for SUS

Prevent Senior, São Paulo
• Integrated, team-based, coordinated care
• Focus on high risk
• Incentives for keeping patients healthy and out of the hospital
• Strong data system across all services
• Management central component

UNIMED, Belo Horizonte
• Integrated, coordinated care
• Incentives for keeping patients healthy
• Strong, integrated data system with links to non-UNIMED providers
• Sophisticated payment system
• Management central component
DRGs as Analytic Tool

IAG Saúde has digitalized and categorized 1.5 million discharge records from the private sector, covering more than 200 hospitals.

Analysis of 2017 data finds opportunities for substantive efficiency gains:

- **Reduce length of stay**
  - Private: 28% of cases above median ALOS
  - Public: 80% of cases

- **Increase hospital safety**
  - Adverse events in private hospitals cost R$ 10.9-15.6 billion
  - Adverse events increase patient ALOS by 6.9 days

- **Reduce avoidable hospitalizations**
  - 26% of hospitalizations in private sector avoidable -- could be resolved at lower level of care
  - Account for 23% of total inpatient days

- **Reduce avoidable readmissions**
  - In private sector, 5% of total inpatient days due to avoidable readmissions

Combined, could reduce waste by 42.3%.

Source: Couto 2018
Innovations in Brazilian Healthcare are the Foundation for Networks and Integrated, Coordinated Care

São Paulo OSS Hospitals
- Contrato de Gestão
- Quality data
- Accountability

ESF
- Outreach
- Primary care
- Contact with citizens

MG Cardiac Telemedicine
- Quality measurement
- Integrated care
- Distance care
- Integrated IT

Together, represent the platform for integrated, coordinated care, reducing hospitalizations and raising quality
Integrating SUS Service Delivery
Integrated Care is the Evolving Paradigm for Healthcare

Old Paradigm

Emphasis on specific illness episode
Hospital objective is to fill beds
Public and private payers function separately from providers

New Paradigm

Care is integrated and continuous across levels of care
Success is keeping patients well and out of the hospital
Payers and providers coordinate
SUS: Integrated, Coordinated Care Model
-- Putting the Pieces Back Together
Network Service Delivery: New Directions

- Acute care model
- Fragmentation
- Hospital-centric structure
- Distorted incentives
- Little accountability

System Change

- Enabling incentive environment
- Paradigm shift in delivery model
- Care coordination/integration
- New roles for hospitals
- Quality measurement and improvement in primary care and prevention
Network Services Focus on Care Management

- Patient is registered with Network – not UBS
- Patient registry (cadastrado)
- Risk stratification with focus on managing high risk, chronically ill population (e.g., diabetes, HBP, COPD, asthma, co-morbidities)
- Team of care providers manage patients in integrated network

- Teams and referral networks ensure continuity of care
- Estratégia Saúde de Família integrated with UBS care teams
- Embrace protocol use
- Integrated information system fundamental
- Reduce need for emergency room and hospitalization
Key Steps to Achieve Integrated Care Networks

Step #1

- Define Network
- Network registers specific population to specific provider(s)
- Network uses patient registries and risk stratification
- Network introduces care management of high-risk patients to monitor chronic conditions
Key Steps to Achieve Integrated Care Networks

Step #2

Build care teams within Networks

Assign roles and responsibilities to care team members

Use care coordinators

Expand the role of non-physicians in patient communication and care

Provide management and clinical training to care teams
Key Steps to Achieve Integrated Care Networks

Step #3

- **Enhance appointment access**
  - Immediate attention to patients effectively manages illness

- **Standardize processes**
  - Standards and protocols for care coordination and patient transition

- **Enhance use of cellphones for**:
  - Appointments
  - Coordination of care
  - Referrals
  - Test results

- **Expand use of telemedicine**
Embedding Quality in SUS Delivery Model

- Establishing a culture of quality
- Accreditation of facilities – important, but not sufficient
  - Currently only 5% of private hospitals have accreditation
- Develop a limited number of core quality measures for different levels of the healthcare delivery system
- Improved and expanded management of healthcare services
- Management training and subsequent use of data to monitor quality
- Authority and management capacity key to change processes and practices to improve quality
Financing and Payment Reform in SUS
Financing Key Principles

- Specific budget criteria
- Focus on quality and outcomes
- Financial autonomy
- Accountability for financial performance
- Reliance on data
Payment Arrangements Central – not just about financial flows

- Incentives in payment arrangements drive change and help achieve objectives
- Payment arrangements offer an opportunity to influence processes and outcomes

- Shifts behavior from focus on volume of care (fee for service) to performance (purchasing for value)
- Changes behavior of providers and patients, if structured properly
- Can improve quality in healthcare delivery
Alternative Payment Arrangements in SUS

- **Capitation and accountability**
  Annual payment to group of PHC providers based on population with adjustments but payment based on with information on performance

- **Value based hospital payment**
  Payment based on the quality of care provided; reimbursements based on value, not volume

- **Bundled payment**
  Predetermined, risk-adjusted payment for full cost of a clinical episode – PHC or PHC and hospital

- **Diagnostic Related Group (DRG)**
  Prospective, case rate payment to hospitals based on primary and secondary diagnoses
Conclusions
Achieving Triple Aim Goals in SUS

Key System Components:

- Focus on individuals and families
- Redesign primary care services and structures
- Population health management
- Cost control platform
- System integration and execution

Source: IHI 2009
SUS for the 21st Century is already Evolving, but More To Be Done

• Innovations in many areas now
• External experiences informative for adapting SUS to systems to address new disease burden
• Pockets of quality improvement exist
• Using payment system to achieve objectives a useful tool
• All imply more and better management

• More autonomy and accountability encourage better performance
• Integrated, coordinated care difficult to achieve but critical to promoting health
• Common information system an overarching requirement if
  -- system is to change
  -- management can improve
  -- accountability to happen
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