2015 Volume 51 Number 2
www.ihf-fih.org

International Hospital Federation

World Hospitals and Health Services

The Official Journal of the International Hospital Federation

Health Care Reform in Latin America and Implications for the Hospital Sector

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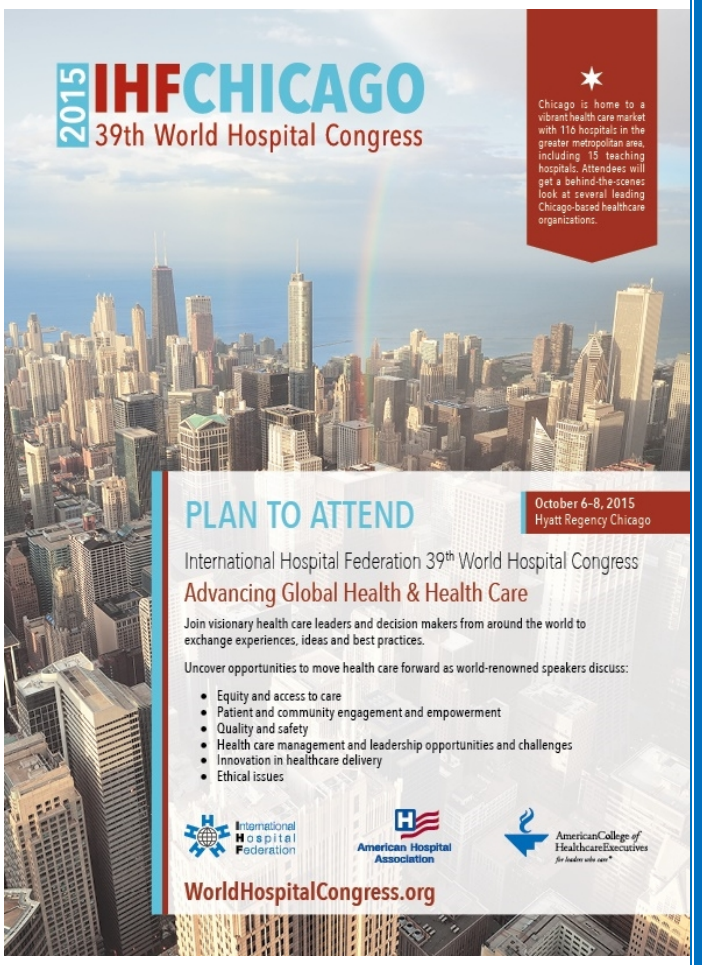

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1233 Bernex (GE), SWITZERLAND

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Subscription Office
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c/o 26 Red Lion Square, London WC1R 4AG, UK
Telephone: +44 (0) 20 7969 5500
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ISSN: 0512-3135

Published by Nexo Corporation
for the International Hospital Federation

Via Palmiro Togliatti 73 A/1, 06073 Corciano (Pg) - ITALY
Telephone: +39 075 69 79 255
Fax: +39 075 96 91 073
Internet: www.nexocorporation.com

Subscription
World Hospitals and Health Services is published quarterly. The annual subscription to non-members for 2015 costs £175 or US$280. All subscribers automatically receive a hard copy of the journal, please provide the following information to james.moreno@ihf-fih.org:
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World Hospitals and Health Services is listed in Hospital Literature Index, the single most comprehensive index to English language articles on healthcare policy, planning and administration. The index is produced by the American Hospital Association in co-operation with the National Library of Medicine. Articles published in World Hospitals and Health Services are selectively indexed in Health Care Literature Information Network.

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Health Care Reform in Latin America and Implications for the Hospital Sector

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As described in the lead article by Reynaldo Holder and Ricardo Fabrega from the Pan American Health Organization (PAHO), the push for reforms towards expanded access for the whole population to health care in Latin America presents an exciting yet formidable challenge for the countries in the.

Mobilizing the needed funding for such expanded coverage in access to affordable health care and securing equity across different population groups is the topics that most often grabs the attention of both national policy makers and the international development agencies like PAHO, the Inter-American Development Bank (IADB) and World Bank. Who will pay for the additional care for millions of people and how can policy makers endure that the vulnerable part of the population will not be left out?

At an economic rate of growth rate of 5 percent in real terms over the next 10 years, this translates into an increase of over 50 percent in the total resources for the health sector. Even with a significant shift in relative spending towards primary health care, the hospital sector will be one of the main beneficiaries of this growth in spending.

As the size of the middle class in many countries in the Latin America region increases, some of the growth in the hospital sector is likely to be consumer driven thought both direct out-of-pocket spending in private hospital facilities and intermediated by through better health insurance coverage with spending in both the public and private hospital sectors. Expansion in social health insurance and publicly funding health care will equally put a pressure on the public sector. The epidemiological and demographic shift from infections to chronic diseases and ageing of the population will contribute to increased costs pressures on the spending side as ageing populations will need more secondary prevention and specialized care for diseases such as diabetes, hypertension, cancer, cerebro-vascular and cardiac disease.

As was seen during the recent global health care conference convened by the International Finance Corporation (IFC) in Prague, the private hospital sector in Latin America is struggling under the growth pressures of the region. Consumer demand is there. And increasingly larger segments of the population no longer have barriers to access for such care because of subsidized health insurance (both private and public). As noted in the article by Ioan P. Cleaton-Jones from the IFC, although the hospital sector in Latin America is expanding, it remains less developed than in some other emerging markets like Malaysia, India and South Africa.

The reasons are well known. Expanding capacity to handle the increasing consumer demand for health care in the region will require a massive investments not just in the infrastructure of the hospital sector, but also of the other sub sectors of the health care such as training of skilled staff, pharmaceuticals, medical technology, health information systems, health insurance, and public health services. Given the long lag period in hospital planning, the many years needed to train skilled doctors, nurses and other staff and the time needed to commercialize developments in the life sciences and technology sectors, most countries need to start now to prepare for 2025.

As seen in the articles that are showcased in this issue covering the experiences in Argentina, Brazil, Colombia, and Mexico these trends in health care Latin America present tremendous opportunities for policy makers, health care providers, funders, investors, and the population alike. If the anticipated economic growth and resulting increases in resources in the health sector can be translated into strategic investments in critical areas of need, millions of people will benefit from improved access to quality health services over the coming decade.

Although what is happening in Latin America is specific to that region of the world, they reflect global trends that require new and innovative approaches to the way health care is funded and delivered.

The 39th World Hospital Congress, which is hosted this year by the American Hospital Association and American College of Healthcare Executives in Chicago from October 6 to 8, provides a unique opportunity for IHF members and others to learn more about these opportunities and challenges for the hospital sector and health systems across the world.

http://www.worldhospitalcongress.org/en/

In addition to sessions on specific topics like university hospitals, local hospitals, and competencies for healthcare management, 16 different countries from around the globe will present their challenges and achievements. Latin America will be well represented echoing the topics presented in this special edition of the Journal. The Congress provides an opportunity to put the challenges and innovations seen in the Latin America region into a global perspective.

PAHO'S Strategy for Universal Access to Health and Universal Health Coverage: implications for health services and hospitals in LAC

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ABSTRACT: Moving towards Universal Access to Health and Universal Health Coverage (UAH/UHC) is an imperative task on the health agenda for the Americas. The Directing Council of the Pan American Health Organization (PAHO) recently approved resolution CD53.R14, titled **Strategy for Universal Access to Health and Universal Health Coverage**. From the perspective of the Region of the Americas, UAH/UHC "imply that all people and communities have access, without any kind of discrimination, to comprehensive, appropriate and timely, quality health services determined at the national level according to needs, as well as access to safe, affordable, effective, quality medicines, while ensuring that the use of these services does not expose users to financial hardship, especially groups in conditions of vulnerability".

PAHO's strategic approach to UAH/UHC sets out four specific lines of action toward effective universal health systems. The first strategic line proposes: a) implementation of integrated health services delivery networks (IHDSNs) based on primary health care as the key strategy for reorganizing, redefining and improving healthcare services in general and the role of hospitals in particular; and b) increasing the response capacity of the first level of care.

An important debate initiated in 2011 among hospital and healthcare managers in the region tried to redefine the role of hospitals in the context of IHSDNs and the emerging UAH/UHC movement. The debates resulted in agreements around three main propositions: 1) IHSDNs cannot be envisioned without hospitals; 2) The status-quo and current hospital organizational culture makes IHSDNs inviable; and 3) Without IHSDNs, hospitals will not be sustainable. This process, that predates the approval of PAHO's UAH/UHC resolution, now becomes more relevant with the recognition that UAH/UHC cannot be attained without a profound change in healthcare service and particularly in hospitals.

In this context, a set of challenges both for hospitals and for the first level of care based on the experience of hospital and healthcare services managers and the vision they have for hospitals in IHSDNs is presented.

Moving towards Universal Access to Health and Universal Health Coverage (UAH/UHC) is an imperative task on the health agenda for the Americas.

The Directing Council of the Pan American Health Organization, after region-wide debates raging from national consultations to meetings at different levels of the governing bodies, recently approved resolution CD53.R14, titled ***Strategy for Universal Access to Health and Universal Health Coverage***. From the perspective of the Region of the Americas, Universal Access to Health and Universal Health Coverage (UAH/UHC) "imply that all people and communities have access, without any kind of discrimination, to comprehensive, appropriate and timely, quality health services determined at the national level according to needs, as well as access to safe, affordable, effective, quality medicines, while ensuring that the use of these services does not expose users to financial hardship, especially groups in conditions of vulnerability"[1].

1 PAHO, Resolution CD53.R14, Strategy for Universal Access to Health and Universal Health Coverage. Pan American Health Organization, October 2014.

Thus stated, UAH/UHC constitutes a progressive and challenging goal that aims to strengthen health systems based on the values of primary health care (PHC) - the right to health, equity and solidarity – in the attainment of health and wellbeing for all people.

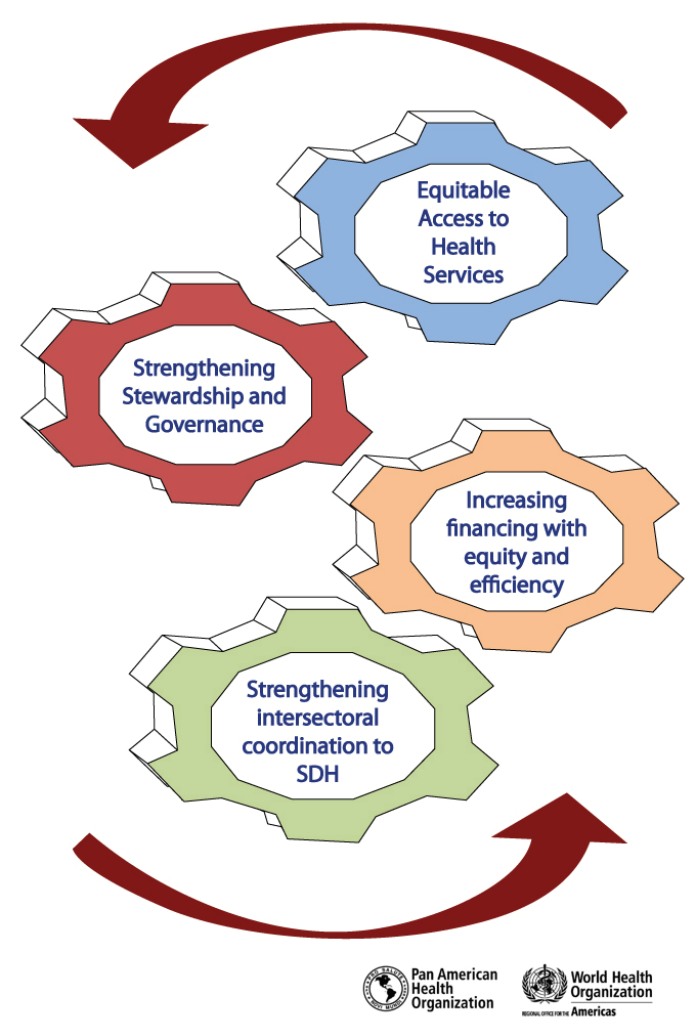
PAHO's strategic approach to UAH/UHC sets out four specific lines of action toward effective universal health systems:

- Strategic line 1: Expanding equitable access to comprehensive, quality, people- and community-centered health services.
- Strategic line 2: Strengthening stewardship and governance.
- Strategic line 3: increasing and improving financing with equity and efficiency, and advancing toward the elimination of direct payments that constitute a barrier to access at the point of service.
- Strategy 4: strengthening multisectoral coordination to address the social determinants of health that ensure the

sustainability of universal coverage.

These four strategic lines depict a harmonious proposition (see figure # 1) and provide key elements for building health systems that meet the objectives countries of the region have set as goals. The first of these lines addresses the need to expand equitable access to comprehensive, quality, people- and community-centered health services. As part of this first line of transformation, the implementation of the integrated health services delivery networks (IHDSNs)[2] based on primary health care is the main proposal of the LAC countries to reorganize, redefine and improve health care services in general and the role of hospitals in particular.

Figure # 1: Four simultaneous and Interdependent Strategic Lines



An important debate initiated in 2011 to redefine the role of hospitals in the context of the proposed configuration of IHSDNs and the emerging UAH/UHC debate. This process, that predates the approval of the resolution, becomes more relevant now under the recognition that UAH/UHC cannot be attained without a profound change in health service and particularly hospitals.

The debates at that time included the participation of a large number of hospital managers and health services experts from 28 countries of the Americas in a plural number of meetings and consultation at the national level and two regional workshops held in 2012. These meetings and consultations were structured around the discussion of innovative ideas put forward by a group of hospital and health services managers in a publication[3].

As a result, three main propositions were agreed upon:

1. IHSDNs cannot be envisioned without hospitals;
2. The status-quo and current hospital organizational culture, makes IHSDNs inviable;
3. Without IHSDNs, hospitals will not be sustainable.

In other words, the suggestion is that hospitals will continue to be viable only if they work within an integrated network of comprehensive and multi-level health services, and integrated networks will be viable only with hospitals that provide support to all levels of care while responding to the health needs (not only curative) of the population.

In this context, consensus emerged on a set of challenges in moving towards hospitals in IHSDNs. These challenges are based on the experience of the participants and the vision they proposed for the future of hospitals in IHSDNs, including:

- Improved **governance at the level of national health authority, the integrated networks and the hospital,** encouraging the participation of people and communities in decision-making process, emphasizing this as an opportunity for good management and clinical governance.
- Promote the adoption of new mechanisms for allocating resources and incentives that promote cost-effectiveness, a culture of good performance and operating in networks.
- Conceive and become part of a **new model of care** that promotes integrated care processes, with an emphasis on keeping people healthy and fostering the involvement of families and communities.
- Promote **team approaches** and coordinated work with professional teams at the community level.

2 PAHO. Integrated Health Service Delivery Networks: Concepts, policy options and roadmap for implementation in the Americas. Pan American Health Organization, 2010.

3 Artaza Barrios O, Méndez, CA; Holder Morrison, R; Suárez Jiménez, JM. Redes integradas de servicios de salud: el desafío de los hospitales. Organización Panamericana de la Salud, ed. Santiago, Chile: OPS; 2011

- New **policy approach** for the adoption and introduction of technologies and infrastructure based on proven sustainability and cost-effectiveness.
- And all of the above will require effective **change management** at all levels that ensures the implementation of policies leveraging leadership and new organizational cultures.

Similarly, the hospital operating in an integrated network, will require the strengthening of the first level of care, as the UAH/UHC resolutions proposes in SL1, in the following key and essential aspects:

- That the population has ample coverage of health promotion and risk prevention services, and adequate continuous care so that people do not arrive at hospitals when it is too late;
- That healthcare providers at the first level of care are competent and have available the technical capacity to provide services and avoid unnecessary referrals;
- That services at the first level of care are available 24/7 in order to ensure continuity of care;
- That the first level of care teams follow up discharged patients to improve recovery and reduce preventable relapses and readmission;
- That the first level of care have mechanisms to ensure and provide reliable information;
- That the first level of care foster inter-sectoral relationships that allow support of socially complex cases for which the hospital is not prepared and for addressing the social determinants of health; and
- That the first level of care provides public health surveillance and interventions.

Finally, it is necessary to keep in mind that many of these proposals may require continuous adjustment and new options, knowledge, technology, and interdisciplinary synergy. The demands of the population are constantly changing and exert pressure on the health system shaping its transformation. In this ever changing context, hospitals must undertake the challenge to re-define their role in integrated networks to ensure sustainability and increase their contribution to the health and wellbeing of our societies.

ACKNOWLEDGEMENT:

The authors wish to express their gratitude to Economist Claudia Pescetto for her review and very helpfull comments to the original draft.

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Private hospitals in Latin America – An investor's perspective

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ABSTRACT: Private hospitals are expanding in Latin America, but the industry is less developed in this region than in some other emerging markets. Groups of hospitals are emerging in countries such as Brazil, Mexico, Colombia and Peru. However, they haven't reached the size of hospital groups in Malaysia, India and South Africa. They also remain domestically focused, while companies from the aforementioned three emerging markets outside Latin America have expanded to multiple other countries and have listed on stock exchanges to access more capital to finance their expansion. It is very likely that these trends seen in other emerging markets will manifest in Latin America as it continues to develop.

Over the past 15 years in which my organization, IFC, has been investing in private sector health services, we have witnessed a slow, but continual, evolution in private hospitals in Latin America. Indeed, Latin America is where we first cut our teeth investing in this industry. Today, we have the benefit of experience investing in the same industry in emerging markets in other regions of the world, such as Asia, Eastern Europe and Africa. With the benefit of this experience, it's interesting to contrast what we see happening elsewhere with what is, and is not, happening at this point in Latin America.

To investors with a global perspective of emerging market healthcare, one of the key features that stands out is the structure of the private hospital industry. It remains very fragmented in most Latin American countries, with most private hospitals still stand-alone entities, either as for-profit entities or non-profit foundations. The former are most often owned by a family or a tightly-knit group of doctors with senior management most often drawn from within that family or group of doctors rather than the hiring of professional management.

This pattern was the norm in other emerging markets too in the past, but has been changing over the past decade, with single facilities increasingly becoming part of larger groups or chains of facilities to gain economies of scale. We have also witnessed the increasing professionalization of management and a growing number of hospital and health services companies expanding to multiple countries. Curiously, much of this evolution of multi-national hospital companies is coming out of emerging markets, not developed ones. However, this trend hasn't yet taken hold in Latin America.

We have also witnessed several emerging market hospital companies listing on stock exchanges to deepen their access to capital, which is very important for growth in a capital-intensive industry such as this. Recent examples include: International Healthcare Holdings' dual listing in Malaysia and Singapore, Fortis Healthcare in India, Life Healthcare in South Africa and Mitra Keluarga Karyasehat in Indonesia. Similar IPO activity in the hospital sector remains notable by its absence in Latin America.

The private sector plays a significant role in the delivery of health services, including hospital services, in several Latin American countries. In Brazil, for example, over 33% of hospital spending is from private insurance, almost all of which ends up at private hospitals, while some 56% of the SUS public system spending on hospitals goes to private hospitals. In total, approximately 70% of total spending on hospitals is spent at private sector hospitals (La Forgia and Couttolenc, 2008). Brazil has a lot of hospitals, about 7,400, of which roughly 4,800 or 65% are in the private sector. Despite this large number, there are very few groups or chains of hospitals in Brazil and the private hospital sector remains very fragmented. There are, in fact, only two groups of any scale. Amil, a health insurer that also owns a chain of hospitals, and is now a subsidiary of United Healthcare from the US, and Rede D'Or São Luiz, which has 29 hospitals. Neither is publicly listed, although Amil used to be prior to its acquisition by United Healthcare.

Contrast this with another middle-income country across the Atlantic, South Africa, where there are 3 large hospital groups, all publicly-listed and with sufficient sophistication and scale (these are all multi-billion dollar companies by revenue) that two have expanded to Western Europe and one to Asia and Eastern Europe. Netcare expanded to the UK and is now the largest private sector hospital group in both countries, while

Medi-Clinic expanded to Switzerland, where it owns the largest private Swiss hospital group, Hirslanden. Life Healthcare expanded to India where it owns 46% of Indian hospital group Max Healthcare and more recently has begun acquiring hospitals in Poland. This international expansion follows domestic consolidation in which the 3 groups own about 80% of the South African private hospital market.

Why compare Brazil with South Africa? Surprisingly, there are many similarities between the two countries. They are at a broadly similar level of economic development: annual gross domestic product (GDP) per person (measured at purchasing power parity or PPP, also sometimes called "international dollars") in South Africa is $13,250, while Brazil has overtaken it in recent years and is now $16,050 (Economist Intelligence Unit Country reports, May 2015). They also spend similar proportions of their GDP on health: 8.9% in Brazil and 8.7% in South Africa (WHO, 2014). Both have significant private health insurance industries that operate in parallel to the public system and the majority of expenditure in private hospitals is from insurance, not patients paying cash out-of-pocket.

There are, in fact, several reasons why one might expect Brazil to have produced larger hospital groups, not South Africa. In Brazil, about 27% of the population has private health insurance, compared to only 16% in South Africa. Brazil's population is almost 4 times larger than South Africa and it also has a system of universal public health insurance which is sophisticated enough to contract with the private sector for services. South Africa has no such public health insurance system. In short, Brazil's private hospital market is bigger.

One important difference between the two markets, however, is that, until the law changed in January of this year, Brazil did not permit foreign ownership of private hospitals (with the exception of insurers owning hospitals to treat only their own insured patients). South Africa had no such restriction, permitting hospital groups to list on public markets and foreigners to purchase their stock. This gave them deeper capital markets to tap and invest on a large scale.

Do the similarities suggest that South Africa's experience of hospital industry consolidation foreshadows what may happened in the future in Brazil? Possibly. It is remarkable that there are several large companies in this industry in the smaller of these two markets. Recent opening up to foreign ownership in Brazil may lead to more investment in capacity as well as to consolidation via mergers and acquisitions.

Two other Latin American countries that have some similarities with South Africa raise the same question: namely Colombia and Peru. Colombia has a very similar size population to South Africa (roughly 48 million versus 53 million) although Peru is smaller at about 31 million. Again, as with Brazil, both are at a broadly similar level of economic development: Colombia's PPP GDP per person, at $13,070 is almost identical to South Africa's $13,250, while Peru's is a bit lower at $10,840 (Economist Intelligence Unit Country reports, May 2015) and both have shown good economic growth in the past 5 years. Colombia's economy grew by an average 4.8% annually, and that of Peru by 5.8%, both much faster than South Africa's 2.4%(Economist Intelligence Unit Country reports, May 2015), yet both are at an earlier stage in the growth and development of private hospitals. Interestingly, Colombia has a more private-sector friendly regulatory environment for health care. For example, it permits private sector medical schools, which South Africa does not, and has almost universal health insurance coverage and a level playing field between private a public sector hospitals in that both get paid by the same insurance mechanism, with no direct subsidization of operating budgets by government.

Despite significant issues with the system of administration of health insurance in Colombia via entities named "EPS", a lot has been achieved in terms of improved health outcomes. Life expectancy, for example, is now 79 years, which is the average for high-income countries. By this measure, Colombia is now on par with the much wealthier United States. Nonetheless, the level of development of private hospitals in both countries continues to be considerably behind that of other middle-income countries like Brazil, South Africa, Malaysia and India. This very likely indicates some considerable opportunity in Colombia and Peru for the development of the private hospital industry. Indeed, there are some early indications that this might be beginning. There are a few small groups of 2-5 hospitals appearing in Colombia and some new investment occurring in Peru too, with a few new hospitals and small chains appearing, of similar magnitude.

Another feature of Latin American private hospitals is that, so far, there is little cross border activity in this sector, presumably due to the lack of many hospital businesses of the scale that has emerged in some Asian countries or in South Africa. Let's consider some of the Asian examples for a moment. International Healthcare Holdings (IHH), headquartered in Malaysia, is now one of the world's largest hospital operators and has expanded to Singapore, Turkey, India, China, Hong Kong, Brunei, Vietnam, UAE, Macedonia and Iraq. Fortis Healthcare is very much focused on the large Indian market, but has expanded from India to the United Arab Emirates, Mauritius and Sri Lanka. Apollo Hospitals, in addition to its large Indian chain of hospitals, has hospitals as joint ventures or management contracts in Mauritius and Bangladesh. Bumrungrad International Hospital in Thailand has recently expanded to Mongolia and previously invested in Philippines, while Chindex's United Family Hospitals brand in China has also expanded to Mongolia. Further West, Saudi German Hospitals has expanded from its home market in Saudi Arabia to Egypt

and Yemen.

In contrast, in Latin America, Banmedica of Chile has expanded to Peru, but there is still little other cross-border investment in the Latin American hospital sector. Yet, there is a steadily rising middle class in Latin America, with economic growth at a more modest pace than in many Asian countries, but, in terms of income levels and evolution of health coverage and payment mechanisms, a better ability to pay for care than in many emerging Asian countries.

Mexico, the second-largest Latin American economy after Brazil, now has a handful of hospital groups such as Star Medica and Grupo Angeles, but so far none with the scale or ambition to expand to other markets like the companies mentioned in Asia and South Africa. Companies that invest across border in Latin America have developed in other aspects of the health services industry. Examples include EMI and Medical Developers. EMI is an ambulance and home medical service based in Colombia and operating in six Latin American countries, which was recently acquired by Danish ambulance company Falck. Medical Developers is an Argentine company operating radiation oncology centers in six Latin American countries, which was acquired some years ago by 21st Century Oncology (formerly Radiotherapy Services) from US. The existence of these groups points to the possibility that such businesses may also develop in the future in hospitals, as they have elsewhere in the world.

Latin America does not feature as prominently as, say, Asia, on the radar of international investors in private hospitals, but this may be an overlooked opportunity. Given the hospital companies that have emerged in Malaysia, India, South Africa and Saudi Arabia, that have become chains and then trans-national players, it is likely that at some point we will see similar hospital groups develop in Latin America. We can expect to see greater professionalization of management, investment in new capacity and merger and acquisition activity to produce hospital chains with greater economies of scale, public listing of such companies and cross-border expansion.

AUTOBIOGRAPHY

Dr. Ioan P. Cleaton-Jones is Principal Health Specialist at IFC, a member of the World Bank Group. He focuses on emerging market private healthcare. He has advised health projects in 31 countries in the Americas, Asia, Africa and Europe, with investments totaling more than $1.1 billion, including debt, equity (private and public) and mezzanine finance. Ioan has science and medical degrees from the University of the Witwatersrand, Johannesburg, South Africa and an MBA from the University of Southampton, UK.

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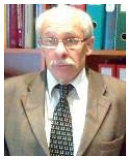
Argentina.
A country of contrast and paradox



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ABSTRACT: In Argentina, health is not considered a state policy, and it does not benefit from effective action in all areas of government. The budget is essentially used up by structural costs, and despite having made progress in some areas such as vaccinations, there is little impact on the community as a whole from the promotion of health and the prevention of prevalent chronic illnesses linked to metabolism and lifestyle. The biggest health expenditure is private, including so-called "out-of-pocket spending," which leads to inequality, with over 40% of the population without explicit health coverage. In the national system, coverage is linked to formal employment and Obras Sociales and is essentially managed by trade unions. Social determinants therefore continue leading to illness, which the health system then attempts to cure at enormous human and financial cost. Recommendations of international bodies (PAHO, WHO, FLH, IHF) stress the importance of organising state and private RISS, but very little has been done in this regard.
Right to healthcare is already required, but it's a long way from being sufficient. The whole population needs to be provided with explicit and effective universal health coverage, in order to ensure healthcare access and equality, and organise healthcare networks which make awareness, promotion, prevention, and rehabilitation more effective for all, using existing, high-level structural and human resources.

INTRODUCTION. In a few months' time, Argentina will face a national election which is crucial for its future and which will begin to take shape in a few weeks.

Its citizens, however, do not view "health" as one of the most pressing topics.

Both health and education ranked lowest in a list of the 10 most important subjects (work, inflation, insecurity).

Consequently, the political parties who rely on real options for the next elections are not prioritising health in their political plans.

From a professional viewpoint, this is understandable, given that health only becomes an issue when you are ill.

But the leadership did not address these topics. It's well-known that the population finds itself in a supply and demand dichotomy, and that the governing state should define the **"necessities"** for state policies, the issues which should be considered in all the government's policies, and this should include health and education.

Argentina continues to vehemently debate these technical topics from an ideological perspective and contrary to international experience, health is still discussed as a matter of **principles**: "ethically, there should be no profit," many affirm. Reality shows that this isn't about principles, but **goals** and results: that is to say, improving the health of all citizens.

Currently, the Argentinian state spends approximately 90% of the total health budget on structure, which has a limited impact on the community as a whole. Incidentally, education is in a similar position, with an average of 92% of its total budget assigned to structure.

The funding allocated to health promotion and illness prevention is very small, even though this is where a much more significant impact could be seen with more limited investment than needed for structure.

Barriers to access and social determinants continue to lead to illness, which health services then try to cure at enormous human and financial cost.

DEMOGRAPHICS

In terms of size, Argentina is the 8th largest territory in the world and has the 32nd largest amount of inhabitants: 0.6% of the world total. The country is home to all climates, tropical, subtropical and also very cold, but with sunny days unlike any other latitude in the world.

Despite its extensive territory, Argentina has one of the lowest population densities per km2, and only 42 million inhabitants in total.

It ranks 119th for population growth and has a very low birth rate, which has led to its population doubling in the last 50 years, while in the rest of the world it has doubled in only 30 to 35 years.

It's a desert, yet at the same time an overpopulated nation in its large cities.

It has both very rich (centre) regions and very poor regions, but its greatest social problem is found in the suburbs, which can spread to the large cities they border.

The country sleeps in cities but lives off the countryside, which is one the most productive, technologically advanced and innovative in the world. Yet it dreams of a vigorous industrial sector which currently remains deficient and subsidised due to its very low productivity and competitiveness, and a very small internal market.

SOCIAL ECONOMY

In the last decade, consumption has grown in the country but development has yet to materialise.

27% of the population live below the poverty line (according to the Social Debt observatory of the Universidad Católica Argentina) and around 5% of its inhabitants live below the abject poverty line.

One of the country's greatest failures is its lack of official, reliable statistics.

The country has an unemployment rate of 10%, and 45% of the population work outside of the formal economy and therefore lack explicit health insurance.

Despite being an almost deserted country in terms of population, it still suffers from the service problems seen in countries with greater over-population and higher concentrations of citizens. The sanitation infrastructure which was very advanced at the start of the 20th century has stagnated and little has been done in the last few decades. Sewers and the water system, as well as transportation services are mostly deficient, widely subsidised and without equivalent results.

In one of the countries with the largest reserves of water in the world and also with almost all of its population concentrated in a few cities, there are a high percentage of families who cannot access drinking water from the water system, or sewer networks, or who live in precarious homes or even those close to rubbish dumps or contaminated land or rivers.

HEALTH AND EDUCATION

While it is understood that the right to health is required, this is very far from being sufficient. Given that health coverage in Argentina is structured through formal employment, only 40% of the active population who are currently working have health insurance, with an additional 10% of people accessing healthcare through voluntary social security contributions to private businesses.

This occurs across many territories. There are 24 provinces, some of which are richer or poorer than others, some of which invest more or less in health, and some of which have more or less coherent programs than others, but they are always different from each other and have distinct administration.

However, it is the various unions of the Obras Sociales and the public hospitals that treat people, those who supplement the state and provide care for more than 50% of the population, even when efforts are not coordinated.

Directly or indirectly, it's always the whole community that finances health, but in the state sector it can be difficult to know the costs. The private-managed health, Obras Sociales, and private hospitals must analyse their costs and results in minute detail and their "profits" become useful for reinvestment and attracting new capital from very complex and very high risk businesses. For this reason, there are no soft loans, subsidies or fiscal stimuli for investment in the sector. The sector has become severely under-financed and the costs of employees and supplies have increased in line with general health and inflation.

Instead of concluding that it is important to make use of existing capabilities (in structure, technology, and human resources), new hospitals and mega-structures are constructed where they already exist, at extremely high costs.

This is a matter of state governance: setting out definitions and objectives, working on inequality, accessibility, explicit universal health coverage, transparency, financial equilibrium, and cooperation between state and private bodies which in terms of techniques and tools would translate into integrated networks.

The country as a whole pays dearly for its lack of organisation and lack of quality and for the fact that its significant technological innovation is not oriented towards true necessities.

Argentina has one of the lowest birth rates in the world and has experienced both demographic and epidemiological transitions. The country's most common causes of morbidity and mortality are non-infectious chronic illness, cardiovascular diseases, tumours, accidents and COPD. Cases of diabetes are rising and combined with sedentary lifestyles and tobacco consumption, it is predicted that non-infectious epidemics will increase significantly. Argentina is not ranked among the 30 countries with the highest rates

of smoking, nor does it have one of the highest rates of alcoholism, but these issues are becoming increasingly common.

The situation in the northern regions and the suburbs of cities is relatively different, given that infectious diseases, above all Chagas disease and parasitosis, among others, still have a high prevalence.

Deaths from traffic accidents are not decreasing in Argentina as they are in almost all other developed countries of the world, and are instead increasing, although in general Argentina is not among the 30 countries most affected by the death of young people.

Argentina has one of the highest rates of HIV in Latin America, although growth of the epidemic appears to have stabilised. Cases of tuberculosis have intensified, including both those related and unrelated to AIDS.

Argentina is not within the top 20 countries for abortion rates, but it has one of the highest caesarean/childbirth ratios. The number of teenage pregnancies has increased, with all the implications this has for the risks of pregnancy and childbirth in those under 20, and often including those much younger than this, as well as the effects this may have on the future of these mothers and families. It is well-known that a young woman who studies delays marriage and maternity greatly, strengthens her independence, and has more options available for her future.

The country is ranked no. 24 for gender equality, although in recent years levels of domestic violence and gender violence have been high and continue to increase.

Infant mortality (IM) and maternal mortality (MM) are high, particularly in the most unprotected regions of the country: the north (19%) and the suburbs of large cities, yet relatively low in the city of Buenos Aires (6-7%) and in the south and centre of the country.

Argentina did not reach the UNDP objectives in 2013.

Argentina is one of the countries with the highest level of investment in health in relation to its GDP, but due to inefficiency, it remains clearly behind Chile, Uruguay, and Costa Rica in in terms of IM and MM.

These indicators become increasingly shocking when we consider that Argentina invests much more than Chile and Uruguay, and only achieves half of the objectives reached by these countries, demonstrating a high level of inefficiency.

There is a considerable difference between the highest and lowest income provinces (8 times) which is one of the largest in the world, clearly surpassing inequality in countries such as Mexico and Brazil, among others.

In terms of life expectancy, the country is ranked no. 39, with 75 years.

For every 1,000 inhabitants, the country has 3.5 doctors, but less than 1 nurse.

Instead of having 4 nurses for every doctor, the nurse/doctor ratio is exactly the opposite and along with Uruguay, Argentina has the worst ratio in Latin America in this regard, which only increases costs and negatively affects treatment for illness.

Argentina spends 9 or 10% of its GDP on the health sector but the state (national, provincial, municipal) invests no more than 20% of this total. Moreover, the greatest expenditure is in the form of out-of-pocket spending which demonstrates very poor organisation and great inequality, given that most of those affected are the poorest citizens who do not have explicit medical coverage and therefore have to turn to the state-governed hospitals.

Argentina has incorporated technology very quickly, but without planning, which has led to an excess of medical apparatus and significant distortions in price structures (supply/demand), as well as distortions in the health market in general, which once again has high costs and does not contribute to eliminating access barriers.

Its level of integrated health networks is very low and competitive bodies still prevail over cooperative and ancillary organisations which put people at the centre of the system.

The fractured nature of clinical practices and the low level of clinical protocols or guides contradict with the high level of its professionals.

Argentina invests 90% of its budgets in structure and the impact of investment is therefore poor, whereas if allocated to the prevention of disease and promotion of health and the environment, the results would be much greater for the community in general. The country has begun to approach the subject of risk factors for chronic illnesses seen across the globe and has started to promote healthy habits, but there is a lot still to be done.

CONCLUSION

Argentina continues to define itself in the same way it has for decades: as an “intermediate” country between the most and least developed countries, between the richest and poorest countries of the world, despite being very far from these extremes.

Objectively, it has gone backwards in relative terms both in its worldwide position and its position in Latin America, in comparison with the standing it had a century ago, and most strikingly without having suffered great natural disasters, wars, or other catastrophes.

Around 40 years ago, Argentina and Japan were the two most difficult countries to define.

Today, Japan is absolutely defined and determined in its growth, despite its lack of territory, tiny islands, overpopulation, lack of food and petrol, savage tidal waves and shocking and repeated atomic crises and its most astonishing lack of complaint.

Yet Argentina seems singularly determined to continue its chronic waste of energy, money and time.

Ironically and not without sadness, some people say that: “Argentina is the only country in the world... which decided its own development.”

However, in the extreme south of this continent of comfortable climate, there are still people who take pride in its wide middle class sector, where technical, professional and cultural capabilities in general, as well as ambition to acquire further skills and education show continued strength.

This is very encouraging and it is well-know that many investors in the world remain attentive to the country's development in order to carry out investments, including in the health sector.

For this reason, it's vital to place greater emphasis on the human being, on health and disease prevention, rather than on illness.

Not to work impulsively, but through programs.

Health should be considered in all areas of the government. It's not state-run or private: it's public.

Pluralism and diversity are riches that, when applied correctly, guarantee equity, accessibility and universal health coverage.

Health represents 10% of the world's economy; it is a very dynamic sector with a very high level of innovation. Argentina has the capability in human resources and existing structures to surprise people by taking a big leap forward; it just needs to do... what must be done: Universal Health Coverage, accessibility and equality.

The state must stop seeing the sector as a means for income collection and begin seeing it first as a health service. Cooperation between state and private health management, in effective health networks, according to the needs of the community.

As an essential service sector which will never close its doors, it will generate employment and development and could contribute to mobilising the country in general.

BIOGRAPHIES

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Enrique Tonelli is a specialist in legal advice on management in health care institutions; monovalent and polyvalent health centers with inpatients, nursing homes and mental health clinics, day hospitals and outpatient clinics. Member of the Technical Management team at CONFECLISA and legal advisor to various entrepreneurial houses of the health sector.

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Hospital 360°

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ABSTRACT: There are forces that are greater than the individual performance of each hospital institution and of the health system structure of each country. The world is changing and to face up to the future in the best possible way, we need to understand how contexts and emerging trends link up and how they affect the hospital sector. The Colombian Association of Hospitals and Clinics, ACHC, has thus come up with the Hospital 360° concept which uses hospitals capable of anticipating changing contexts by means of the transition between present and future and takes on board the experience of global, socio-economic, demographic, political, environmental and technological fields as its model.
Hospital 360° is an invitation to reinvent processes and institutions themselves allowing them to adapt and incorporate a high degree of functional flexibility.
Hospital 360° pursues goals of efficiency, effectiveness and relevance, but also of impact and sustainability, and is coherent with the internal needs of hospital institutions and society for long-term benefits.

In response to a constantly changing world, the Colombian Association of Hospitals and Clinics, ACHC, is proposing the Hospital 360° concept as a hospital model capable of anticipating changing contexts through a transition between present and future producing the added value that such exploration can give. This process validates change because it takes on board the experience of the global, socio-economic, demographic, political, environmental and technological fields. Processes and the institutions themselves can thus be reinvented allowing them to adapt and incorporate a high degree of functional flexibility.

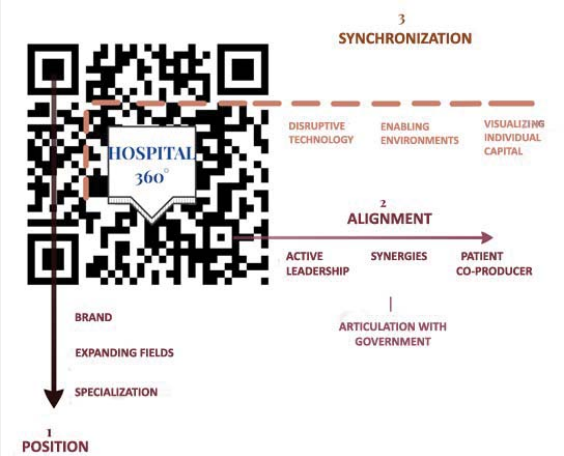
The Hospital 360° concept encompasses three dimensions:

Position: This notion reflects the work of the institutions in terms of patient perception and experience in relation to hospital performance and the services it provides.

Alignment: A reference to the ideal coherence between the institution's internal objectives since the address until the connection with the rest of hospitals, and the needs and goals of Government and service users.

Synchronization: This relates to the coordination of the various processes which operate simultaneously to ensure the functioning of the institution. These processes are favored by disruptive technology and the use of ICT, enabling environments and intellectual capital.

Illustration No. 4, conceptual structure Hospital 360°



1.1 Position

1.1.1 Brand

'Brand' building should be an institutional goal. According to Gowri Shankar, there are 4 elements involved in building a brand:

1. Singularity

Potential differentiators include:

- centers of excellence for specific services;
- heritage / history in the community;
- awards for excellence;
- use of high-end technology.

2. Leadership:

- professional reputations;
- service scope – specializations;
- Value chains.

3. Operational excellence:

- human resources - professional and efficient;
- processes - simplified, focused on users, enhanced technology;
- communication – effective;
- quality - clinical outcomes / success rates.

4. Relationships focused on users:

- user selection;
- moderation of expectations — understand, define and strengthen key expectations;
- adhesion;
- consistency in service and sensitivity to special needs. (SHANKAR, 2014).

As far as singularity is concerned: what marks your hospital or clinic out? It might be a center of excellence, have a history of working with the community, have won awards or use certain technologies.

Secondly, your hospital must be a leader in something: what niche does the hospital work in with excellence, service scope, interlocking value chains and professionals with excellent reputations?

The third factor, operational excellence, refers to quality. Ultimately the key to the concept of branding is the user focused relationship. You cannot simply wait for users to select your hospital. You must identify a number of target groups because brand creation in the health sector is a matter of promoting the best patient experience. (Dunn, 2011)

1.1.2. Expanding fields

Anticipation is a key exercise by means of which hospitals can develop methods for management, control over the entire medical condition flow and support patients at home ensuring continuity of care.

One of the most illuminating concepts in recent literature is the Liquid Hospital or H_2O Hospital model. This metaphor shows hospitals leaving the state of solidity behind, extending outwards into the community and should be thought of as the basis for expansion[1].

A range of action can be implemented for this purpose such as:

- Home hospitalization: significantly reducing costs and length of patient stay;
- Omni-Hospital: based on remote monitoring of patients;
- Shared Medical Appointments: consists of simultaneously treating a group of chronic patients with similar medical conditions;
- High resolution express centers: an out-patient care process establishes diagnoses together with corresponding treatments in a single day (Escuela Andaluza de Salud Pública, S. A., 2012).

Expanding fields seeks to prompt hospitals to reflect on their practices and go beyond the traditional in-patient model. We must move towards care services and treatment for: chronic disease, special diseases and specific groups.

1.1.3 Specialization

General hospitals will always exist, but they may not be the majority in the future because ultimately we will have to define which branches of knowledge each will specialize in. As far as specializations are concerned, hospitals can be super-specialized and/or multi-specialized. Examples currently exist of services offered by super-specialized centers which can be centers of excellence based on a specific medical condition, a single body organ, an anatomical system or a complete disease. These centers can also specialize in managing specific medical conditions.

1.2. Alignment

1.2.1. Active leadership

Hospitals must have an alignment. It is suggested that they first determine the optimum qualities of the individual in charge of 'aligning', i.e. the CEO, manager or director of the hospital.

The CEO of the hospital is responsible for overseeing its day-to-day operations. He or she is the moral leader who articulates the hospital's mission and community vision and also leads the way in the development of its strategic vision and policies.

Managers must ask themselves if they are really leading morally and understand that an ethical dialogue in all professions and specializations in response to the community is needed.

We recommend that board of director members and hospital managers take on board the proposal cited by John Punnoose (2014) in his article "Assessing the ever changing roles and responsibilities of a hospital CEO":

- creating a positive and productive culture through leadership;
- providing and modeling standards for operational excellence;
- recruiting and retaining qualified staff;
- assuring top quality patient care delivery;
- implementing clinical policies and procedures;
- ensuring compliance with hospital policies as well as government rules and regulations;
- developing relationship with internal and external stakeholders;
- maintaining strong financial performance.

This is the ideal order of priorities. Hospitals in many

1 The Sant Joan de Deu hospital (HSJD) embodies this new concept of health with the creation of **The Liquid Hospital, H_2O**. The distinctive "liquid" here refers to the range of medical care in all forms and possible directions in an attempt to achieve better results, using ICT 2.0 technologies as intermediaries for this purpose. See http://www.hsjdbcn.org/

parts of the world give priority to financial considerations when this element should be a derivate of compliance. Positive leadership is one which models standards for operational excellence, employs and retains qualified and trained personnel and makes sure that all this serves to ensure top quality service provision.

Other features of leadership that should be mentioned are: the ability to be inspiring and strategic complemented with technical and technological skills allowing leaders to act as agents of change motivated by a mentality of ongoing improvement. Finally, leaders must have undisputable codes of ethics, especially in the light of the concept of accountability in the heyday of communications and social networking.

1.2.2 Synergies

With a view to redefining competition in the sector health and directing the development of a system of efficient provision of services, hospitals and clinics must establish synergies with specialized networks, schools and patients associations.

As far as integrated service networks are concerned, hospitals have to join forces with other institutions on their own initiative and agree on areas of interest and services to be developed.

In relation to administrative aspects, efforts to develop this point must first establish the technical requirements for interconnection. Of course, this will standardize processes and policies and mean that health professionals will require not only in-house training but also training in other networks with greater competence or knowledge. An ideal would be moving towards a concept of community or consortium as the starting point for combating traditional institutional fragmentation.

1.2.3 Dialogue with the government

Government plays a natural regulatory role in the health sector. This role encompasses both buyers and providers of health services and involves it in seeking to coordinate the processes necessary to ensure the proper functioning of the system, the establishment of minimum standards for provision and payment systems as well as quality assurance mechanisms.

Some of the key points in ongoing dialogue with the government are:

- planning service provision;
- quality mechanisms;
- public-private partnerships;
- contract rigidity or flexibility;
- flow of resources;
- rates;
- community health project integration between institutions and local authorities, among others.

It is, however, undeniable that governments need assistance in performing their regulatory roles better and thus it is imperative that hospitals work together with them to generate policies which are comprehensive and consistent with the reality of the hospital sector.

A case in point illustrating the utility for the government and the institutions of an intelligent aligned dialogue is the establishment of price controls and price-setting processes.

1.2.4 Patient co-producer

This is an area with great potential for change. The intention is that patients will no longer be passive service users. In 360° Hospitals, patients have to be co-producers and to speak their minds and in this process the most important thing is not information acquisition but conversing with people who can convey us many things.

The promotion of knowledge sharing is a fundamental part of the forecasting exercise and requires a new delivery model. Patients must not simply be partners in their illnesses but co-producers of their own health. This is a completely new concept, a partnership concept of fearless equality, because all the pressure from society is going to turn back.

1.3. Synchronization

This refers to a number of characteristics, skills or tools that this model requires in order to function.

1.3.1. Disruptive Technologies

The theory of disruptive innovation was developed in 1997 by Christensen who argued that companies entering a market and offering relatively simple and straightforward solutions can displace powerful companies and leaders in that market.

When they are successful, disruptive innovations are incorporated into performance, progressively shifting the products or services offered by traditional companies. Innovation can occur at the product level (best experience, increase in benefits, changes in price and value) or in the business model (production model, distribution model, model of earnings). (Christensen, Bohmer, & Kenagy).

In general disruptive technology is important if it succeeds in generating change in the management of related processes in health care and health outcomes in general. The crisis in health care is deep-rooted, however disruptive revolutions offer a number of opportunities for the management of systemic transformation. A couple of examples:

- Match the skill level of the clinician to the difficulty of the medical problem. This strategy promotes the need of primary care physicians to move upwards and not compete with those at the bottom or ensures specialists stay in their niche, teaching more basic levels without directly providing simple services which others should be performing.
- Optimize investment in high-end complex technologies and use technologies which simplify complex problems. Instead of focusing on complex solutions for complex problems, research and

development should focus on simplification.

1.3.2. Environment friendly practices

Two approaches: 1. approach based on staff, and 2. evidence-based design

Both approaches focus on considering that health facilities must be re-designed in their sustainable development aspects so that they positively impact on institutions and people and reduce negative noise, pollution, toxicity and waste emission impacts and creating opportunities for energy and water consumption reduction.

Effective hospital infrastructure design should help to reduce medication errors, lowering nosocomial infections, reducing accident levels, shortening timeframes and stages, removing unnecessary patient transfers and improving workflows.

A range of action can be implemented in this regard:

- Understanding the functional lifetime of the hospital's buildings. There is an urgent need for more adaptable buildings allowing for changes in design, function and volume and the inclusion of multi-function spaces (soft) along with complex areas that make adapting the hospital buildings to changing needs possible.
- The adoption of intelligent architecture such as, for example, 'lean' design models allowing walls in a health center to be removed leading to the fragmentation of care, in order to work differently with multidisciplinary care teams and minimize patient movement. (Shuman, 2007) (Ulrich, 2006).
- Designing hospital infrastructure and health facilities must be reinvented as a function of work environments conducive to the welfare of the institution's staff, patients and environment.

1.3.3. Visibility of intellectual capital

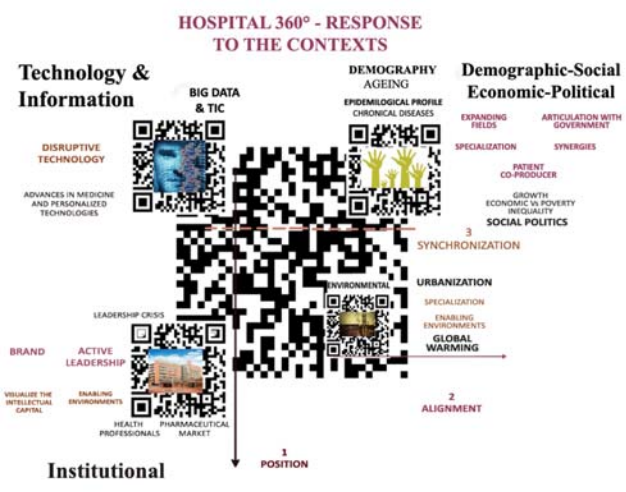
Over the past 25 years, the most valuable assets have moved from being tangible assets to intellectual capital assets based on knowledge (intangible).

There are three elements involved in intellectual capital in the health sector: education and development of employees, the working environment and patients' attitudes toward health care centers. (Gamble, 2013)

Action to be implemented to make visibility progress include:

- Hospitals and health systems should use intellectual capital rather than financial capital to boost their growth. This includes medical patents and inventions as well as more fluid elements such as processes and models of care or know-how.
- Promoting teamwork, communities of practice and other forms of social learning to create intellectual capital by institutions.
- Development of medical research and research and development.

Illustration No. 5



To conclude and summarize, the Hospital 360° proposal must be understood as a response to the contexts that are being generated in the world today. It pursues goals of efficiency, effectiveness and relevance, but also of impact and sustainability, and its objectives are consistent with the internal needs of the institution but also of society with a view to long-term benefits contributing to building a better world.

BIOGRAPHIES

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Operating private hospitals in Mexico

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ABSTRACT: Mexico is one of the richest countries in Latin America and over the last several decades there have been many changes in the healthcare delivery systems, from universal healthcare coverage for all Mexicans to the fast paced expansion of private healthcare. Like many countries, Mexico has both private and public health systems and hospital administrators are facing challenges on multiple fronts in addition to facing exciting new opportunities. In this article you will get a bird's eye view of this ever changing panorama. How the new growing middle class consumerism has impacted physicians, health insurance and private healthcare industry.

INTRODUCTION. In the past few decades, the healthcare system in Mexico has seen significant advances including achieving universal health coverage for all Mexicans in 2012. This covers approximately 100 million people in Mexico and it took less than ten years to achieve. Prior to this health care reform, about 50% of the population had no access to healthcare [(1)].

Mexico's healthcare reform comes from Article 4 of the Federal Constitution, which assigns the right of everyone to health protection. This healthcare reform passed a Social Protection System for Health called Sistema de Protección Social en Salud, (SSPH), that offered subsidized, publicly provided health insurance to more than fifty million Mexicans who were not covered by social security. The operational program of the new system is the national health insurance program, Seguro Popular. The Seguro Popular provides access to a package of comprehensive health care services.

The Seguro Popular financial structure is a co-responsibility between federal and state governments, since there is no employer financial responsibility, and through contributions from families which is tied to income. Families in the two lowest tenths of the income distribution do not contribute. Today Mexicans, regardless of their socioeconomic status, can have access to public healthcare by programs that are subsidized or partially subsidized by the Mexican Government. These programs are overseen by the Secretary of Health.

Health services for the employed Mexicans are provided through specific public hospitals and clinics [(2)], the largest of these is the Instituto Mexicano del Seguro Social, (IMSS). The IMSS is partially subsidized by the employee, the employer and the Federal Government. The second largest government healthcare insurance in the social security system is for the state workers; Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado, (ISSSTE). Other government institutions that offer health services for their employees include National Defense, Secretaría de la Defensa Nacional, (SEDENA), Mexican Armed Forces, Instituto de Seguridad Social para las Fuerzas Armadas Mexicanas, the Navy, Secretaría de Marina, (SECMAR) and the national oil company, Pemex.

Mexico is also experiencing an economic recovery with a gross domestic product (GDP) growth of $1.3 Trillion USD in 2014, with a continued growth in the middle class.

Some estimate that nearly half of Mexico's population is considered middle class, however, according to the Mexico Statistic Institute, Instituto Nacional de Estadística y Geografía (INEGI) reported that 39% of Mexico's population is middle class.

Many typical middle class couples are postponing parenthood and have chosen careers at the university level such as engineers, physicians, lawyers, etc. The family in Mexico is also changing; they are older parents, having fewer children and later in life.

The IMF reported in 2012 that real growth in personal disposable income in Mexico was 3.6% by comparison to 3.4% in Brazil and 1.7% in the US.

This growing middle class desires goods and services that their parents didn't have. Additionally, the middle class has the disposable income that impacts many different market sectors, such as retail shopping in upscale stores such as Palacio de Hierro and Liverpool and luxury automotive dealerships such as Mercedes and BMW. The purchasing power of the middle class is also evident in increased housing and restaurant spending as well.

This growth of consumerism, albeit still considered more practical than their U.S. counterpart has also influenced the growth of many private healthcare insurance companies in Mexico. This is because many Mexicans complain that government healthcare providers have less specialists, less technology, more wait times and crowded emergency rooms.

Therefore, many middle-class Mexicans purchase private healthcare insurance in order to have access to private healthcare. These insurance companies have many different policies for different socioeconomic level consumer and their families.

Many familiar brands such as BUPA, ING, New York Life, AXA and MetLife are doing businesses in Mexico to provide many Mexican's including the middle class with private Health Insurance and compete with their Mexican counterparts such as Grupo Nacional Provencial (GNP).

As of 2013 approximately 7% of the population was covered under comprehensive private health insurance (mainly upper-class and the wealthy), however today that number continues to grow. This growth has occurred so rapidly that in just a few years MetLife has become the largest Health Insurance Company in Mexico, just as Walmart became the largest employer, all made more possible by the growth of the middle class.

Insurance companies have become very sophisticated, particularly over the last decade. Although many are still using a fee for service and capitation models, many began using bundle packages almost a decade ago for chronic disease management and there is a move to capitated population health models.

EXPOSITION

Private hospitals have been around in Mexico for several decades. Many private hospitals began as small physician owned family businesses and their bed capacity and services reflected their size. Some would say they were seen as an opportunity for physicians to control their own destiny in a rapidly changing environment and deliver their brand of healthcare to their community. Many of these hospitals attracted a specific patient population depending on the specialties of the founders. Today it is still not uncommon to see many of these private hospitals being managed this way in Mexico that average in size from a dozen to forty beds with limited technology and low complexity services, however still providing a vital service to their communities. These hospitals are typically managed by a medical director who in many cases is still a practicing physician; many with no formal hospital management training.

As private hospitals grew in the larger industrial cities such as Mexico City, Guadalajara, Monterrey, etc., so too did the size of the private hospitals. These private hospitals in these larger cities offered their communities broader range of cutting edge technology and medical services. These larger hospitals typically have bed counts that range from one hundred to two hundred beds. It would be a mistake however to assume that these hospitals are easier to manage then their US counterpart of equal size if judged by the bed count alone.

These hospitals attract the very best physician specialists and with them come the privately insured patients, self-pay patients as well as the upper middle class members of the community. These patients are unsatisfied with the longer wait times in emergency room, limited access to specialists and cutting edge technology of some government hospitals.

In order to meet the expectations of their customers such as patients, physicians and insurance companies these hospitals have to perform efficiently and with a high degree of customer satisfaction. Considering the patient population that these hospitals attract, it's not uncommon to find that these hospitals have an average length of stay (ALOS) of three (3.0) days or less. If the hospitals operated with a 5-6 day ALOS they would need to nearly double their physical plant capacity, bed count, overhead and cost structure.

Within the last decade an outward migration of these types of private hospitals are moving into other cities in Mexico, such as Hermosillo, Puebla, and Chihuahua. This growth, of private hospitals in other smaller markets, is fueled by the current growth of the middle class and expansion of more sophisticated private integrated healthcare systems such as Grupo Angeles, StarMedica and CHRISTUS Muguerza to mention a few. Even with this growth and outward migration the industry remains fragmented. The expansion and growth of private hospitals increases the competition and also creates challenges for hospital administrators.

Recruiting and retaining qualified specialist has always been a challenge for all hospitals and like many other countries in Latin America, Mexico has a shortage of medical specialists. Hospital Administrators have used many different recruitment techniques for attracting physicians such as providing them with medical office space at cost, incentive physician loyalty programs and forgiveness loans if they relocate to remote areas of Mexico.

Hospital administrators face the same cost control challenges that their colleagues around the world do. How successful they are at managing labor and supply costs while continuingly improving services in this ever increasing competitive environment will determine the success or failure of these private hospitals.

Compounding the matter is the fact that many of the ancillary labor force, that all hospitals need, are becoming harder to recruit and retain. For example, it is difficult to attract and keep professionals for laboratory, pharmacy,

blood bank and nursing. Mexico's educational system produces very talented individuals in these fields but the demand is outpacing the supply and there are very few technical schools that serve as the choice between high school and university-level education.

Another challenge that is facing both the physician specialists and these private hospitals in the new age of consumerism exhibited by this growing middle class is the use of the internet and social media. The use of social media and the Internet has brought a new level of access of personal medical information to these discerning consumers and they are more likely now to select a hospital and a specialist based on information they gathered on the internet than their parents did a generation ago. As a result, many specialists market themselves on the internet in Facebook, YouTube, etc. and the majority of private hospitals have dedicated department staff specifically to provide consumers with social media information and together with digital media and marketing departments, work on new and better search engine optimization strategies.

CONCLUSION

In today's health care arena, Mexico private hospital administrators are facing challenges on multiple fronts in addition to facing exciting new opportunities. The uniqueness of these changes is that they are occurring at a rapid rate. A growing middle class that is well-educated well-informed and with more disposable income has higher expectations of physicians and private hospitals. Physician specialists, who are in short supply, work independently and are typically not in group practice that are themselves at the top of their profession and look for hospitals that can provide them with the cutting-edge technology they need and the amenities their patients demand. These physicians are typically credentialed at more than one hospital and from time to time demonstrate their elastic loyalty by moving their practice and patients to a hospital who meets their needs. There are also new entrants into the health care space, like retail pharmacies that offer very low cost medical exams.

This is the panorama of ever evolving market forces facing today's hospital administrators in Mexico and those who can successfully navigate through this will find themselves shaping the future of healthcare delivery in Mexico.

BIOGRAPHY

Joseph Barcie, M.D., MBA is the corporate senior vice president of international operations of CHRISTUS Health, one of the largest Catholic, not-for-profit health care systems, comprised of more than 60 hospitals and long-term care facilities in U.S. and six states in Mexico and Chile. Dr. Barcie, originally a medical researcher, changed his career to hospital administration after earning his MBA in Healthcare Administration at University of California, Irvine. Dr. Barcie has over 25 years' experience in Hospital Administration and held other senior level hospital positions both in the US and in Latin America.

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Brazil's Mixed Public and Private Hospital System[1]

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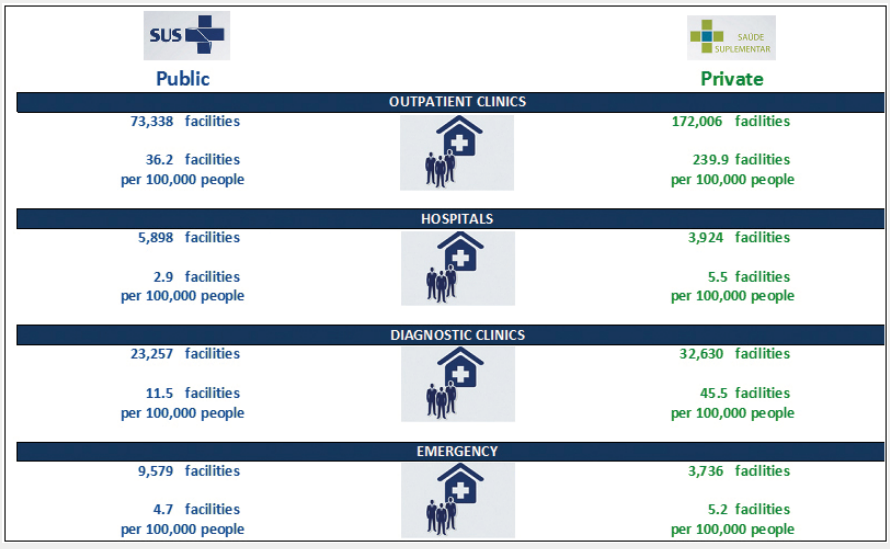
ABSTRACT: Brazil's hospital sector is vibrant and growing. Under the 1988 Brazilian constitution all citizens have the right to health care, anticipating the global commitment to Universal Health Care. Brazil's public sector prides itself on having one of the world's largest single payer health care systems, but complementing that is a significant and larger private sector that is seeing big increases in investment, utilization and prices. This article outlines the structure of the hospital system and analyzes the nature and direction of private health sector expansion. Twenty-six percent of Brazilians have private health insurance and although coverage is concentrated in the urban areas of the Southeastern part of the country, it is growing across the nation. The disease burden shift to chronic diseases affects the nature of demand and directly affects overall health care costs, which are rising rapidly outstripping national inflation by a factor of 3. Increasingly costs will have to be brought under control to maintain the viability of the private sector. Adaptation of integrated care networks and strengthening of the public reimbursement system represent important areas for improvement.

Providers and Payers in the Healthcare System.

The hospital sector has approximately 6300 general and specialized hospitals, ranging from small, low quality public and private hospitals to world class private and public research hospitals. A large segment of the private market is made up of small, inefficient facilities that are costly to operate (La Forgia and Couttolenc 2008). Most private hospitals provide services to public and private patients, as it is shown in Figure 1.

1 Thanks to Alex Spevak for expert research assistance for this paper and the associated PowerPoint.

Figure 1: Summary of Public and Private Health Care Facilities in Brazil, 2014



Source: IESS 2015; SIA/SUS

There are approximately 450,000 hospital beds in Brazil (38.3% in public and 61.7% in private hospitals), and the government finances over 70% of all hospitalizations. The number of beds has declined over the past decade from 2.9 beds per 1,000 population In 2000 to 2.3 in 2009 (OECD, 2014).

Brazil devoted 9,7% of its GDP to health in 2013, with health expenditure per capita of US$ 1,454 (PPP adjusted) (WHO 2015). The Single Unified Health System (Sistema Unico da Saude - SUS) is a national program financed by federal, state and municipal governments (though much of the funding comes from federal transfers to states and municipalities) that covers hospital and outpatient care. The federal government jointly with states conducts a highly successful home-base outpatient program targeted at low income households, the Family Health Program (Programa de Saúde da Familia, PSF), now named Estratégia de Saúde da Família (ESF).

As decentralization has taken hold the federal role has been diminished as the over 5,500 municipalities receive funds earmarked for health and the 27 states have taken responsibility for some aspects of health care. Recent laws determine the shares of federal (49%), state (28%) and local (23%) government health care spending. However, public spending represents only 47 percent of all health care expenditure.

Private health insurance covers roughly 40 percent of private health expenditure and out of pocket the rest. The distribution suggests that SUS is not the biggest payer given the multiple other sources of funds for health care (IBGE 2014).

Hospitals represent the center of the health care universe in Brazil representing 67% of all spending, and 70% of public spending. SUS provides the lion's share of hospital services: 68 % of all admissions, 73% of emergency care, and 67% of hospital-based ambulatory care (SIA/SUS).

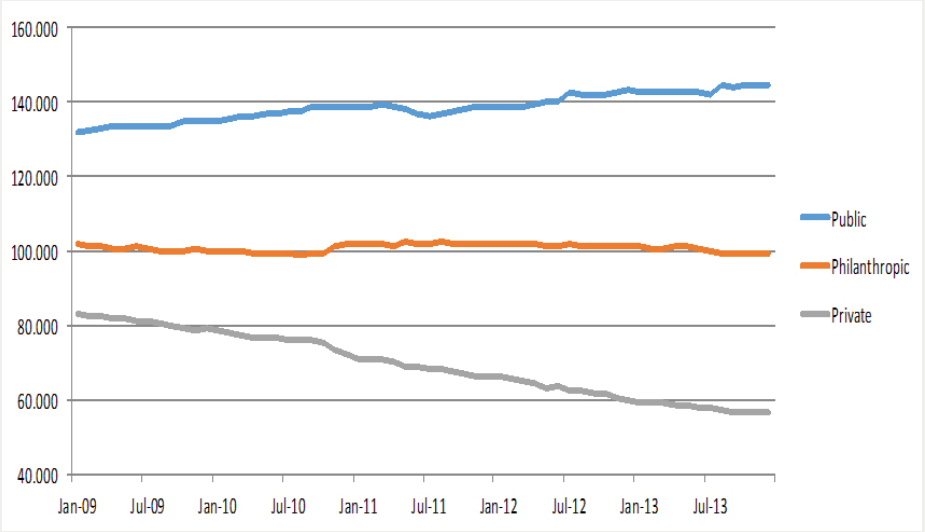
Public funds finance facilities operated by government (46%) via the federal prospective reimbursement system, AIH (Autorização Internação Hospitalar – Authorization for Hospital Admission). These specific, procedure-based payments are supplemented by direct salary payments to public sector workers. In some instances global budgets and fee for service payments are relied upon. The mix is determined by the type of government payer, eg federal, state or municipal payment. Public servants operate and staff the vast majority of public hospitals and, as in most public systems, government provides some in-kind inputs.

In 54% of hospitals AIH reimburses non-profit facilities for patient care at reimbursement rates identical to those at public hospitals though without commensurately paying for staff as in public run and operated hospitals. Six private high-complexity Centers of Excellence provide highly specialized training, clinical referral and services to hospitals nationwide. These high end referral hospitals serve the whole country.

An innovative hospital financing arrangement known as "Social Health Organizations" (OSS) is a public-private partnership with public monies, public facilities and private, non-profit management of clinical and non-clinical services in 54 facilities, 27 of which are hospitals, in São Paulo state where the model began and has persisted for 20 years spanning multiple administrations. Other states have adopted variants of the São Paulo scheme and to date roughly 800 hospitals, or over 13% of all public hospitals, are managed by private, non-profit groups. In São Paulo alone 33 non-profit hospital management groups have contracts with the state, and in the state of Minas Gerais it is 57 non-profit groups. In an evaluation of the são Paulo experience, OSS hospitals significantly outperformed publicly owned and managed hospitals on quality, volume, efficiency and patient satisfaction (La Forgia and Couttolenc 2008). While encouraging few states have adopted the discipline and autonomy that have made São Paulo so successful. But that kind of innovation is important to all federal, state and municipal health providers.

About half of SUS spending goes to public facilities. The trend in SUS financing is toward stable financing of non-profit hospitals, increasing expenditures in publicly owned hospitals and a sharp decline in spending on for-profit hospital, as shown in Figure 2. Such divergence moves the health care system to an increasingly separated arrangement, which runs the risk of reducing engagement,

Figure 2: Trends in SUS Payments for Hospitals by Ownership

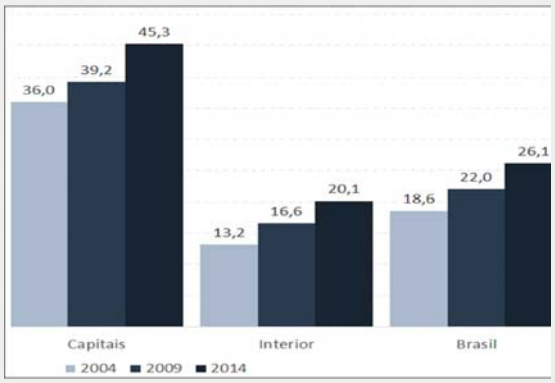


Source: SIA/SUS

support and advocacy for improved performance from the middle and upper classes who increasingly rely on private insurers and providers.

Some of the decline in spending on for-profit hospitals has been made up by the growth in private health insurance. Effectively citizens pay for access to SUS through taxation and they or their employer pay again directly to insurance companies. Health insurance coverage has expanded steadily over the past decade with gains of around 50 percent in both state capitals, where coverage is higher than elsewhere and particularly so in the wealthier southern capitals like São Paulo and Rio de Janeiro, and in the interior where incomes are lower. Much of health insurance coverage is an employer-sponsored benefit and therefore tied to fluctuations in economic growth. Today over a quarter of all Brazilians purchase some form of health insurance, translating into roughly 50 million enrollees.

Figure 3: Trends in Private Health Insurance Coverage 2004-2014 for Brazil, State Capitals and the Interior



Source: IESS 2015

Figure 3 shows the breakdown of the levels and trends in coverage. The growth in the "interior" is impressive as it suggests a rising middle class in historically poor areas, and a willingness to prioritize health insurance over other forms of consumption. These trends fuel demand for private care as private insurance rarely finances public care in Brazil.

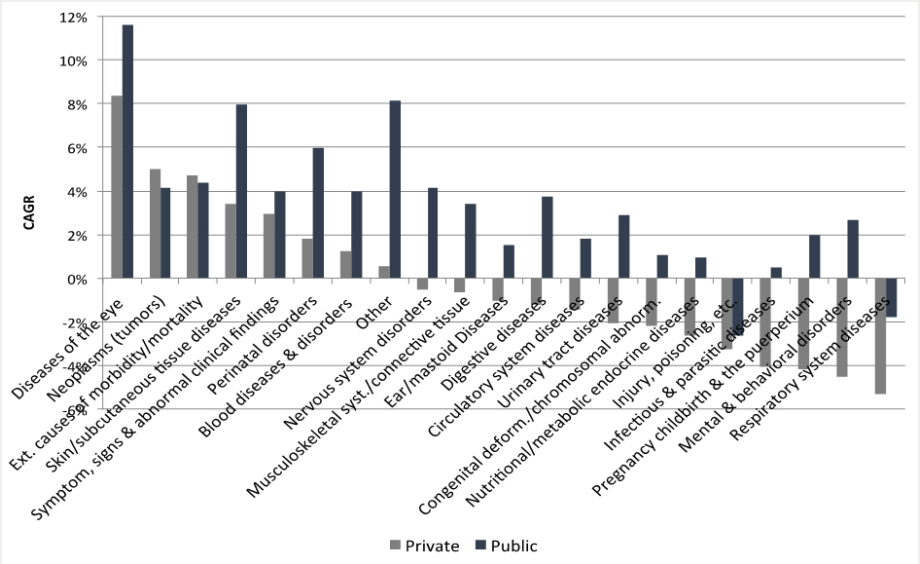
The payer-provider arrangements create awkward incentives that undermine the effectiveness of the overall health system. On the one hand SUS under-reimburses for care under its prospective payment system, AIH, for non-public providers, which has led to a decline in the number of participating philanthropic facilities as many of these hospitals have been forced to close. On the other hand, citizens with private insurance do not compensate public hospitals for their care reverting instead to public insurance coverage. Public reimbursements that cover costs, and a requirement that public hospitals charge private insurers would make the system more balanced and compensate providers fairly.

Trends in Health Services and Costs in Private Hospitals

The rise in chronic conditions and other non-communicable diseases across Brazil has contributed to a shift in hospital demand toward more complex treatments that on average are more costly than traditional complaints. The shifts can be seen in Figure 4 showing growth and declines in mortality rates for selected diseases in both the public and private sectors. Infectious parasitic diseases, respiratory illnesses and complications of pregnancy are falling in the private sector and declining in relative importance in the public sector, reflecting improved living conditions, rising levels of education, and improved preventive measures. Neoplasms, perinatal disorders and diseases of the eye, skin and blood have replaced the simpler complaints that claimed lives in the past. As a result, the trend is toward more specialty treatments many of which are long term chronic conditions like cancer, cardiovascular disease and diabetes, three of the most important sources of morbidity and mortality in Brazil today (SIA/SUS). And as experience in the OECD suggests, these conditions also drive up costs.

While individual costs for treatment cannot be obtained for either the public or private sector, aggregate figures for the private sector suggests sharp increases in the average costs of diagnosis and treatment. Indeed, in 2013 the private health care inflation rate of 16 percent far

Figure 4: Growth in Mortality Rates by ICD-10 Code 2009-2013



Compound annual growth rate calculated as: $CAGR(t_0,t_n) = (V(t_n) / V(t_0))^{\frac{1}{t_n - t_0}} - 1$

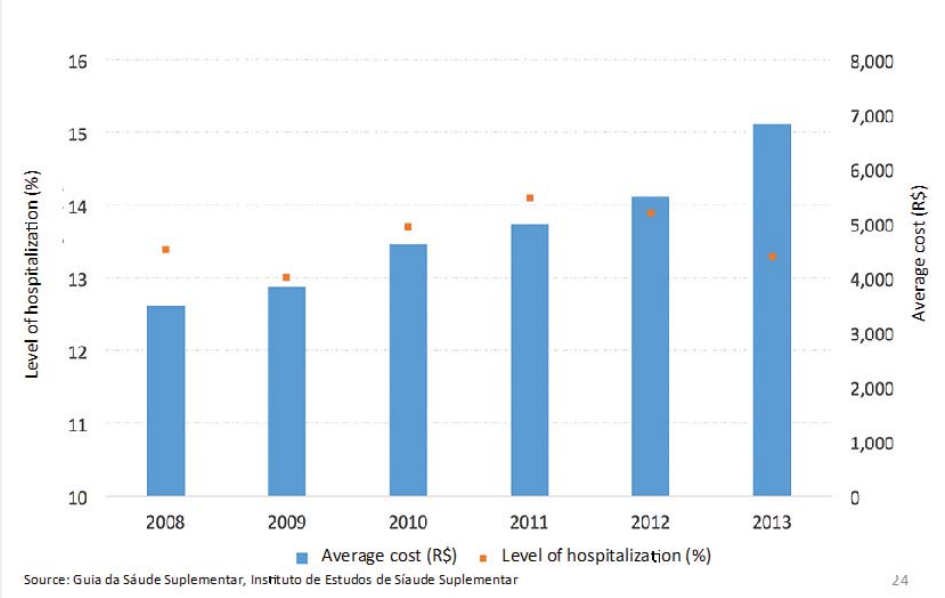
Source: SIH/SUS

outstripped the 5.9 percent national rate of inflation (IESS 2015). This is a trend observed since 2007 and while the level of difference has fluctuated divergence appears to be accelerating. Some costs can be passed on to the insured but there is a limit. Spiraling costs risk losing enrollees and compromising future enrollee growth.

Only part of the cost spiral can be attributed to shifts in the disease burden. Heavy investment in high technology also contributes. Brazil has 6.7 MRIs per 1,000 population, more than the UK, Australia and Chile, and over three times as many as Mexico. It has more CT scanners per 1,000 population than Chile, Canada, France and the UK, and again more than three times that of of Mexico (OECD 2014; IESS 2014). Given the high correlation between supply of high technology and cost escalation these circumstances effectively build in higher costs.

The age distribution of private insurance enrollees balances 22.6 percent of children under age 18 with 23.1 percent over the age of 59, which is also likely to lead to higher costs. Given the high proportion of older enrollees and longer life expectancies health insurers face cost pressures from utilization (IESS 2015). Finally, hospitals face virtually no incentives to contain costs or improve efficiency, both necessary to control expenditures and volume of services.

Figure 5: Use and Average Cost of Hospitalizations Covered by Insurance, 2008-2013

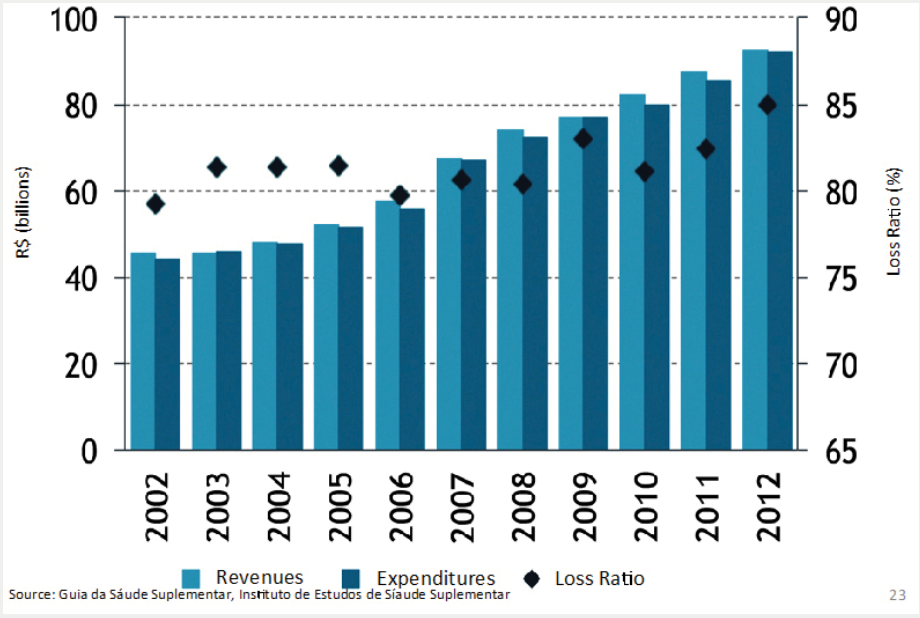


Source: IESS 2015

Figure 5 compares the growth in average costs and the level (or percent) of hospitalizations. Cost increases are outpacing the rate of hospitalizations, and the latter have begun to decline in the last few years, which is consistent with the cost increases described above.

However, such rapid cost escalation risks profit levels if revenues do not keep pace. Indeed, the real risk is losses. This is indeed the trend in profits and loss. The private sector's loss ratios are starting to rise in response to reduced hospitalizations and rising costs, as shown in Figure 6. Revenues and expenditures moved in tandem over a decade between 2002 and 2012 but loss ratios have risen steadily since 2007, a worrisome trend that will need to be addressed by the industry to ensure

Figure 6: Revenues, Expenditures, and Loss Ratios for Private Health Insurers, 2002-2012



Source: IESS 2015

long term solvency. The rising costs pose a challenge to both private insurers and providers as costs cannot increase indefinitely, but serious efforts will be needed to reign in spending and raise efficiency among insurers and providers alike.

Conclusions

Despite efforts to establish a single health care system, the current structure can best be described as mixed and fragmented. Government finances via SUS less than half of all health care with the balance covered by private health insurance or out of pocket payments. Hospitals represent 70% of SUS spending.

It's prospective payment system, AIH, offers one of the few incentives for hospital efficiency. Despite up-coding and other irregularities it remains the preferred method of hospital payment, which suggests the need for improving and expanding its application. For example, ensuring that costs and reimbursements are aligned will be key to its effectiveness and acceptability among private providers. AIH could also be adopted as a tool to encourage improvements in quality much like the US Medicare system that is currently driving up quality through specific incentives embedded in reimbursement rates. In the same vein ensuring that hospital are paid for the services they provide is fundamental but private insurers often don't pay for public hospital care and public insurance shortchanges private hospital providers. This deserves attention.

The trend toward integrated networks of care in response to the rise of chronic conditions, and the commensurate need for continuity of care has not yet been embraced in most of Brazil. Hospitals continue to focus on episodes of illness with few linkages to outpatient services. This applies to both the public and the private sectors, but will become increasingly important to both in order to raise quality and control costs in both networks.

Costs will need to be controlled if the private health sector is to remain viable and to expand. Double digit inflation when overall price increases hover around 5 percent will become an issue for insurers and the insured, the question is when. The implications could inflict damage to the image and economic health of private hospitals. Closing low volume, high cost small hospitals should be part of the solution but improved management, a focus on efficiency and value, and more consistent adherence to protocols could all contribute to higher productivity and quality. Bolstered accreditation and oversight could be helpful to both identify waste and promote improved performance, which in turn would contribute to lower.

Finally, consumers and patients deserve a bigger role and stronger voice to become part of the solution and to contribute to improved hospital and hospital network performance. This is a future agenda item but shouldn't be forgotten.

BIOGRAPHIES

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Challenges and Perspectives for Tertiary Level Hospitals in Bolivia: The case of Santa Cruz de La Sierra Department

ANDRÉ MEDICI
SENIOR HEALTH ECONOMIST AT THE WORLD BANK

ABSTRACT: Current legislation transferred public tertiary hospitals in Bolivia from the Municipalities to the Regional Level. However, the Regional Governments are experiencing technical and financial constraints to reform infrastructure, modernize equipment and introduce reforms to allow better governance, management and sustainability of these hospitals. This article summarizes the recent experience of the Government of Santa Cruz de la Sierra in Bolivia where five tertiary hospitals and one blood bank (most of them in precarious working conditions) had been transferred in 2012 from the Municipal Government of Santa Cruz (the capital) to the Regional Government of Santa Cruz. To face the challenges, the Regional Government of Santa Cruz implement several improvements, such as contract new clinical and administrative personal, increase hospital budgetary autonomy, outsource hospitals' auxiliary services, take measures to eliminate waiting lists and make several new investments to modernize and equip the hospitals. The World Bank was contracted to evaluate the future financial sustainability of these investments and to advice the Government to propose changes to increase the hospitals' management performance. The article describes the remaining challenges in these hospitals and the proposals from the World Bank Study. In the area of quality of care, the main challenge is to improve client satisfaction and continuous outcomes monitoring and evaluation according quality standards. In the area of Financing, the challenge is how to assure the sustainability of these hospitals with the current level of health financing and the insufficient financial transfers from the National Government. In the area of Governance, reforms to streamline and simplify internal processes need to be introduced in order to establish mechanisms to increase transparency and accountability, allowing the hospital to have a good administration and adequate participation of the main actors in the guidance of the institution.

Recent Economic, Social and Health Achievements in Bolivia.

Bolivia is the poorest country of South America, but performed very well on reducing poverty and inequality rates in the last decade. According the World Bank indicators, poverty decreased from 63 to 39 percent of the population, and extreme poverty from 37 to 19 percent, between 2002 and 2013, respectively. Income inequality in Bolivia, measured by the Gini coefficient, fell from 0.60 to 0.49 in the same period.

Recent economic growth in Bolivia has been markedly pro-poor. Average per capita household income grew by 4.6 percent per year, while the average income of the poorest two quintiles increased by 9.4 percent, between 2002 and 2013. Progress went beyond gains in income, as living conditions of the poor improved significantly along several non-monetary dimensions. Access to basic services such as electricity, drinking water and sanitation was significantly improved.

In the health sector, considerable gains in reducing maternal and child mortality were achieved in the last two decades. The maternal mortality ratio declined from 510 to 200 deaths per 100,000 live births between 1990 and 2013, and under-five mortality also declined from 120 to 41 deaths per 1,000 live births from 1990 to 2011. Bolivia also reduced its under-2 child mortality rate due to severe

malnutrition by 80 percent in the same period.

The three key drivers of the improvement in basic health indicators in Bolivia are: (i) structural reforms in the health delivery model, including changes in programs and health systems governance, new health infrastructure and policies for expanding coverage from 1990 to 2003; (ii) financial protection reforms with a pro-poor provision of free maternal and child care services through the creation of a public health insurance program, using results based financing to pay providers since 1996, and; (iii) cultural adaptation to ensure greater access to and acceptance of health services by the indigenous population, which is the majority in most of the country´s departments and municipalities. Box 1 describe the main reforms in Bolivia Health System from 2002 to 2013. Despite these progresses, Bolivia health system still have several challenges: (i) the health delivery model has quality loopholes and shortages of staff; (ii) health facilities and equipment in remote areas are scarce or inexistent and there is poor organization of the demand flow and reference and counter reference processes; (iii) existing financial protection schemes are incomplete and do not cover all population groups, and; (iv) besides the increasing of health financing per capita (from US$227 to US$ 371 between 2005 and 2013), the health financing as percentage of GDP is below the average of Latin American and Caribbean Countries.

Box 1 - Health Policy Reforms in Bolivia: 2002-2013

- **2002–07:** EXTENSA Program – Health Coverage Extension to all;
- **2003**: Universal Mother and Child Health Insurance (SUMI);
- **2006**: Zero Malnutrition Program;
- **2008**: Community and Intercultural Family Health Policy (SAFCI);
- **2009:** Bono Juan Azurduy – Cash transfer associated to the delivery of mother-child and reproductive health services;
- National Strategic Plan for the Improvement of Maternal, Perinatal and Newborn Health;
- National Sexual and Reproductive Health Strategic Plan;
- **2013**: Integral Health Services Law (Law 475, Dec. 2013).

Health services in Bolivia have different responsibilities according levels of government: (i) Municipalities are in charge of promotion, prevention, primary care and secondary level hospitals; (ii) Regional Governments (8 Departments) are responsible to enforce local health regulations by the Regional Health Services (SEDES) and, since 2010, to finance and manage the tertiary level hospitals (high specialization and complexity care), which were transferred from the Municipalities, and (iii) Central Government is responsible by the financing transfers to regional and municipal levels and to issue national health norms, regulation, monitoring and evaluation.

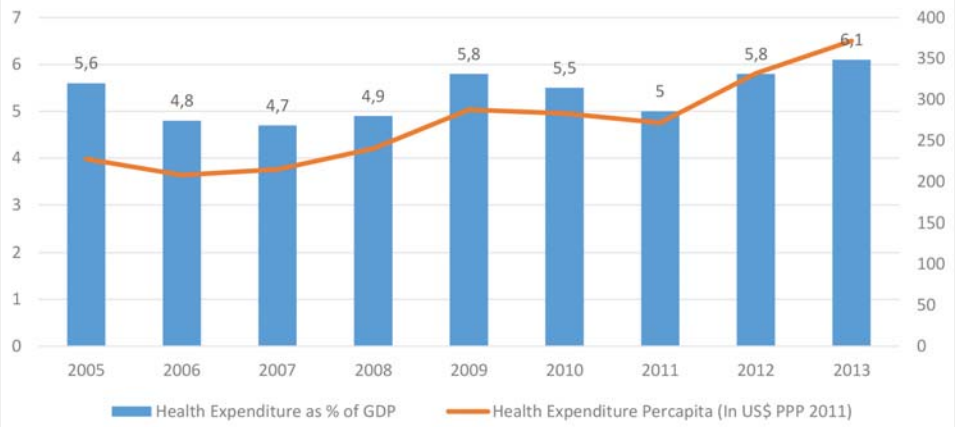
The Path to Health Decentralization and Tertiary Hospitals in Bolivia

With the reforms introduced in 2010, the regional governments (Departments) were enabled for managing and finance tertiary hospitals and other health facilities such as blood banks. Currently there 30 tertiary hospitals are distributed in the 8 Departments. In 2010 (before the transference) these hospitals spent US$ 102 million in recurrent costs: 53% financed by central government transfers; 21% from municipal funds; only 4% from regional government funds and 22% from fees paid by public and private health insurances and individuals.

As consequence, the Department of La Paz received the highest number of hospitals (seven), being followed the Department of Santa Cruz de la Sierra. All hospitals were in precarious conditions requiring investments to renovate infrastructure and equipment and to modernize administration and information systems. Consequently, in the following years, the share of regional financing of the tertiary hospitals increased very fast and the trend is to absorb an important share of the Department revenues.

According to the new regulations, Departmental governments are in charge to formulate and approve the Departmental Health Plan, in accordance with the Nation's Health Development Plan and to manage and regulate tertiary level hospitals and the organization of health networks at Departmental Level. But many of the

Graphic 1: Evolution of Health Expenditures in Bolivia as a Share of GDP (2005-2013)



Source: World Bank Indicators (http://databank.worldbank.org/data/home.aspx?t=home) Accessed on July 14, 2015.

regulations regarding how the tertiary hospitals will be integrated with other levels of care and will be financed are still unclear, demanding technical assistance to create better governance and stewardship for them.

Facing the Short-Term Challenges of the Tertiary Hospitals in Santa Cruz

Santa Cruz pursuit the highest share of the Bolivian Gross Domestic Product. However, most of the Government revenues depend on transfers from the Central Government associated with taxes on oil, gas and mining.

The Regional Department of Santa Cruz received in January 1st 2013, five hospitals and one blood Bank from the government of the City of Santa Cruz in precarious conditions (Japanese University Hospital, Hospital San Juan de Dios, Maternity Percy Boland, Children's Hospital "Mario Ortiz Suarez, Cancer Hospital, and the Blood Bank). Since receiving the management of these hospitals, the Ministry of Health of the Department of Santa Cruz took management decisions, and made investments that allowed critical solutions for the urgent problems in the administration of these hospitals, which weakened the quality and efficiency of the services delivery to the population. The main measures taken by the Ministry of Health were the following:

Human Resources: Most of the workers of these tertiary hospitals had unstable employment contracts, generating conflict, low productivity and unnecessary transaction costs. By assuming the management of these hospitals, the Departmental Government faced a series of labor disputes such as strikes and stoppages of physicians and hospital officials, affecting the timely healthcare delivery to the population. Only in 2012, 62 days of strike occurred in tertiary hospitals. To solve this problem, the Regional Government shift unstable contracts by long term contracts with the Hospitals, paid by the Departmental public resources, avoiding interruptions in services provision and suspending strikes.

Budgetary Autonomy and Management: In the previous situation tertiary hospitals did not have financial management and budgetary autonomy. The Government reversed this situation delegating to the hospital authorities the autonomy to manage budget and finances. However, big purchases of materials and equipment are still centralized by the Departmental Government.

Outsourcing Auxiliary Services: Most of the tertiary hospitals inefficiency were concentrate in the low productivity and high budget consumption of auxiliary services. In order to focus the hospitals authorities in clinical management activities, the Government hired specialized companies to perform the activities of cleaning, food services and maintenance in some tertiary hospitals, with immediate positive effects on improving hygiene conditions, higher user's satisfaction and efficiency. After that, the hospital leadership could concentrate its effort in clinical management decisions;

Eliminating waiting lists: The new administration eliminated waiting lists by implementing phone agendas and tickets collected by patients at the hospital entrance. The hospitals waiting rooms were equipped to ensure highest levels of comfort, with TV screens showing informative videos for the patients on issues related to promotion, prevention and hospital routines and procedures. In the Blood Bank, halls for blood collection and patient recovery were modified according to international standards for these services;

New Investments for Hospital Improvements and Maintenance: The Departmental Government has increased the amount of resources for investment in tertiary hospitals. US $ 23 million were invested in 2013 to update equipment and the resources applied for maintenance were increased. The hospital budgets, which until 2013 were programmed on the basis of historical values updated only by criteria such as inflation, became calculated on cost estimates and real needs in 2014. Thus, it has increased the realism and accuracy of the budget formulation, ensuring greater control and ownership of the resources needed by the hospitals.

Long-Term Challenges for the Tertiary Hospitals

Despite these advances, there are still many challenges to improve *Clinical Management, Quality of Care; Financing and Governance* of the Tertiary Hospitals in Santa Cruz.

In the ***area of clinical management***, the main challenges are: (a) Reduce overcrowding of patients in the corridors and hospitals nurseries and the bed occupancy rate, which is above the appropriate levels (90% to 110%, depending on the specific specialty area); (b) Improve systems for referral and counter-referral of patients, especially in emergencies, which are responsible for the generation of spontaneous demand compromising the quality of service and the mission of the tertiary hospitals; (c) Eliminate problems that lead to frequent cancellation of scheduled surgeries, such as absenteeism and inadequate programming and professional use of the physical space in the hospitals; (d) Reduce drastically or eliminate the attendance of inappropriate demand for primary and secondary care in the hospitals; (e) Improve clinical and inpatient monitoring processes in order to reduce the high and unjustified retention rates in hospital beds and the return of patients due to poorly managed care. It is also necessary to improve clinical management through the use of protocols and guidelines.

In the ***area of quality of care***, the main challenges are: (a) Increase client satisfaction levels and implement systematic processes to monitor and evaluate the hospital outputs; (b) Organize and systematize information systems, improve the processes of administrative and clinical management, according indicators and goals using balance scorecards; (c) Reduce the high levels of hospital infection rates, through measures to improve the safety of patients and training of health professionals in the hospitals; (d) Organize, maintain and update the patients

records and clinical history to ensure updated information on diagnoses and health interventions, allowing those who will report accompanying the patient when referred to lower complexity levels of the health network; (e) Organize and manage career plans, and training and professional training in hospitals, so they can progressively upgrade their knowledge and ensure a better quality of care; (f) Ensure services delivery with the best quality possible, measure clinical achievements and quality, and generate incentives associated with a career plan for health professionals to improve their performance; (g) Develop and implement plans for technological upgrading of the hospital, according to evidence-based processes, and build plans for maintenance and replacement of equipment and physical facilities designed in accordance with demand;

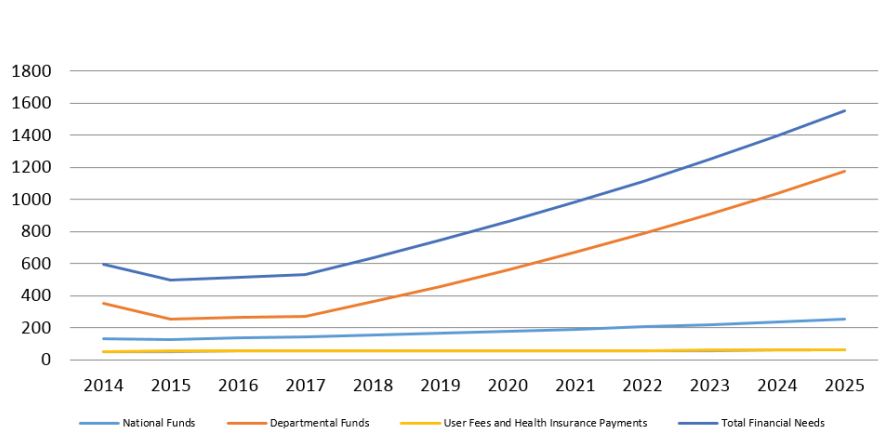
In the ***area of Financing***, the biggest challenge is how to assure the sustainability of the tertiary hospitals with the current level of health financing in Bolivia and the federal transfers. Graphic 2 shows the financial needs of the tertiary care hospitals in Santa Cruz according current trends.

As can be seen, most of the increase in the financial needs will lie on the departmental revenues, which could compromise the financial stability of the Government. In order to revert this situation, the government need to increase efficiency of the hospital management, increase the hospital revenues from users' fees and health insurance and negotiate a better deal with the national government to finance these hospitals. To instrument an action plan to face this challenge, the proposed measures are: (a) Establish an information system to measure the costs of procedures and diagnoses, assessments, cost-efficiency and cost-effectiveness, in order to assess their suitability for payments made by public insurance and co-payments, orders and tickets collected by the hospital; (b) Design processes and payment flows, exploring the diversification of income sources, aiming to reduce payment delinquencies, and; (c) Implement systems for budget preparation and monitoring, including projections for investments in order to calculate the financing needs of medium and long term, depending on the demand, and guide the Secretariat of Health to program investments with the Secretariat of Finance.

In the ***area of Governance***, the main challenge is associated with streamlining and simplifying the internal processes of the hospital, and establishing processes of transparency and accountability that allow the hospital to have a good administration and adequate participation of the main actors in the management of the institution.

During the 2014 year, the World Bank has guided the Government of Santa Cruz to achieve progresses in the implementation of some of the challenges described. This effort will continue in 2015-2016 in order to avoid not an alone solution for tertiary hospitals, but an effective integration of these hospitals in the Departmental Health Networks.

Graphic 2 - Forecasting Financial Needs of Tetiary Care Hospitals in Santa Cruz According Current Trends in Different Sources of Financing (en $ Bolivianos millions)



BIOGRAPHY

Andre Medici is a Senior Health Economist at the World Bank, with over 20 years of experience in health economics, health planning and health policies in developing countries/emerging markets, as consultant until 1995 and as staff of development banking institutions such as the Inter-American Development Bank and the World Bank in Washington DC, since 1996. Previously, he hold lead positions on planning, development and implementation of social policies and evaluation mechanisms in the Brazilian Government, at Federal and State levels, such as Deputy Director of the Population and Social Statistics (Brazilian Statistical Office); coordinator of social policy research at the Institute of Public Sector Economics Development, and Coordinator of the Health Financing Working Group of the Brazilian Commission for Health Reform. He is former president of the Brazilian Association of Health Economics and has strong experience in research and teaching in health policies and health economy in top academic institutions in Brazil and Latin American.

Solving a Health Information Management Problem. An international success story

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ABSTRACT: The management of health care delivery requires the availability of effective 'information management' tools based on e-technologies [eHealth]. In developed economies many of these 'tools' are readily available whereas in Low and Middle Income Countries (LMIC) there is limited access to eHealth technologies and this has been defined as the "digital divide". (1, 2)
This paper provides a short introduction to the fundamental understanding of what is meant by information management in health care and how it applies to all social economies. The core of the paper describes the successful implementation of appropriate information management tools in a resource poor environment to manage the HIV/AIDS epidemic and other disease states, in sub-Saharan Africa and how the system has evolved to become the largest open source eHealth project in the world and become the health information infrastructure for several national eHealth economies. The system is known as OpenMRS [www.openmrs.org].
The continuing successful evolution of the OpenMRS project has permitted its key implementers to define core factors that are the foundations for successful eHealth projects.

INTRODUCTION

- **Information management in health care**

With more than 40 years of combined knowledge and experience the World Health Organisation (WHO) and experts such as Australia's Enrico Coiera have demonstrated that it is now possible to define health in the following manner. 'Information is care'. (3, 4) What does this mean?

Understanding many of the critical factors that relate to the successful implementation of clinical information management systems [eHealth] over 25 years was documented in a special issue of the International Journal of Medical Informatics (1999, Vol. 54). (5)

A more recent publication by Coiera documents the evolution of eHealth systems up to the current era (4)and how these projects may have both benefical and harmful outcomes to patient care. Coiera also addresses the issues why there have been so many failed projects in eHealth under the term, "Why eHealth is so hard?" (6)

The existing evidence also reveals that the escalation in the use of technologies in health care e.g. mobile health (mHealth) has not always led to the improved costs, access to and quality of health care. (7) It may also create harm. (8)

Addressing the meaning of health care information management Tierney describes it in the following manner. (9) In routine care, "clinicians" (which as a group now includes patients) collect data such as patient history, perform physical examinations, create reports, access laboratory data, read X-rays results, and then record these data through the production of notes, operative reports, prescriptions and diagnostic test results. Clinicians are also involved in transmitting these data through various means: through telephone, paper documents, electronic charts and email. Finally, they process this information to arrive at a diagnosis, or deduce a hierarchy of possible diagnoses and initiate treatment(s). This process becomes an iterative cycle of data and information management so that care can be monitored, adjusted and measured.

So how could this extensive knowledge relating to "information management" in health be translated internationally with particular emphasis on LMIC where per capita incomes are often less than $500US per year and health infrastructure is often non-existent, has poor

governance and minimal funding.(9, 10)

- **The problems faced in sub-Saharan Africa in 2000**

In 2000, there were an estimated 40 million people living with HIV/AIDS in sub-Saharan Africa. In one location in Kenya (Eldoret), 50% of hospital beds were filled with people less than 25 years of age dying of AIDS. Poverty, migrating workers, polygamous marriages, poor physical infrastructures and minimal government involvement all contributed to an environment of depression and despair.(2)

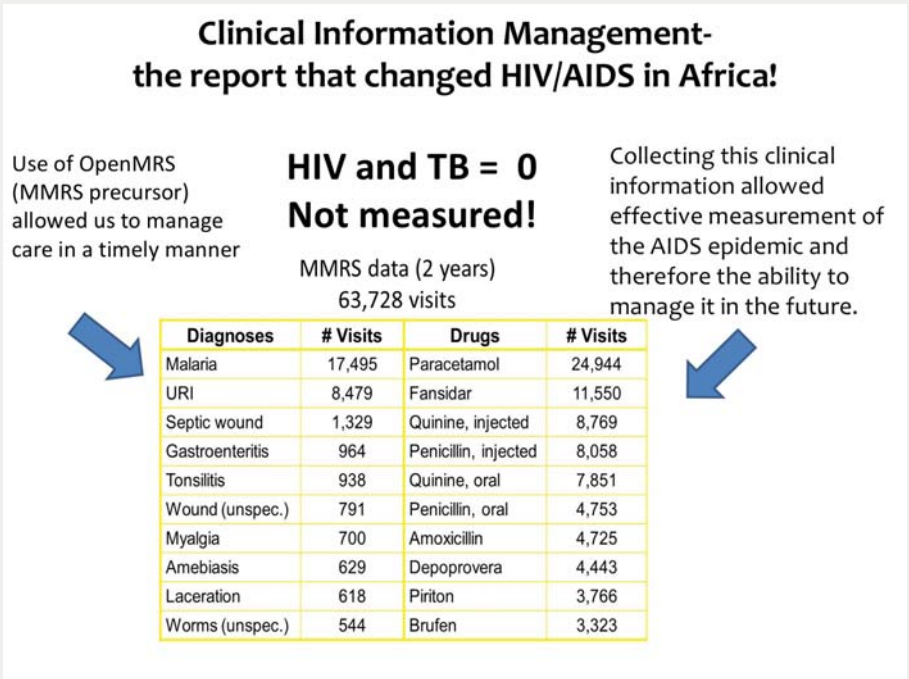
Based on an existing international partnership between the Moi University and the Regenstrief Institute which included myself a request was made from the local Eldoret, Kenya health care teams to implement an ehealth system in a remote clinic near the Moi University Hospital in Eldoret.

- **Developing solutions**

Critical to the success of the initial eHealth project (Mosoriot Medical Record System-MMRS)(11) was the direct collaboration and involvement of the end users at all stages. As Professor William Tierney of the Regenstrief Institute stated *'we sat in the dirt – physically and metaphorically – with the end users for 18 months.'* During this time, it was the end users, most of who were not doctors, entered the clinical care data and produced reports on a range of clinic activities.

After two years, and with data on more than 63,000 patient encounters, the clinical system produced a report that revealed that despite a known 14% prevalence of HIV/AIDS, the incidence of this disease and associated tuberculosis was 0% as measured in the Mosoriot Clinic. (Figure 1)

Figure 1. Diagnosis and resource utilisation report from the MMRS



Diagnoses	# Visits	Drugs	# Visits
Malaria	17,495	Paracetamol	24,944
URI	8,479	Fansidar	11,550
Septic wound	1,329	Quinine, injected	8,769
Gastroenteritis	964	Penicillin, injected	8,058
Tonsilitis	938	Quinine, oral	7,851
Wound (unspec.)	791	Penicillin, oral	4,753
Myalgia	700	Amoxicillin	4,725
Amebiasis	629	Depoprovera	4,443
Laceration	618	Piriton	3,766
Worms (unspec.)	544	Brufen	3,323

So now there existed standardised, reproducible and accessible health information captured and used by the end users that demonstrated core issues related to their health care management.

This powerful information management output promoted the Kenyan government to request that this system be in *'every clinic in Kenya!'* Many were remote, had poor electricity supplies, and staff with poor computer literacy. The system also had to manage millions of patients.

Thus a new system of ehealth was born, the OpenMRS record system.(12, 13) Its initial design and subsequent evolution was through the combined efforts of Professor Paul Biondich and Dr Burke Mamlin of the Regenstrief Institute (http://www.youtube.com/watch?v=CkGyNBYMTxM&feature=related)

From these developments and with the progressive local clinical acceptance and involvement (including leadership) of the OpenMRS project Mamlin and Biondich were able to document what they now considered as the core principles underlying the successful implementation of eHealth systems in both LMIC and developed economies.

These are;

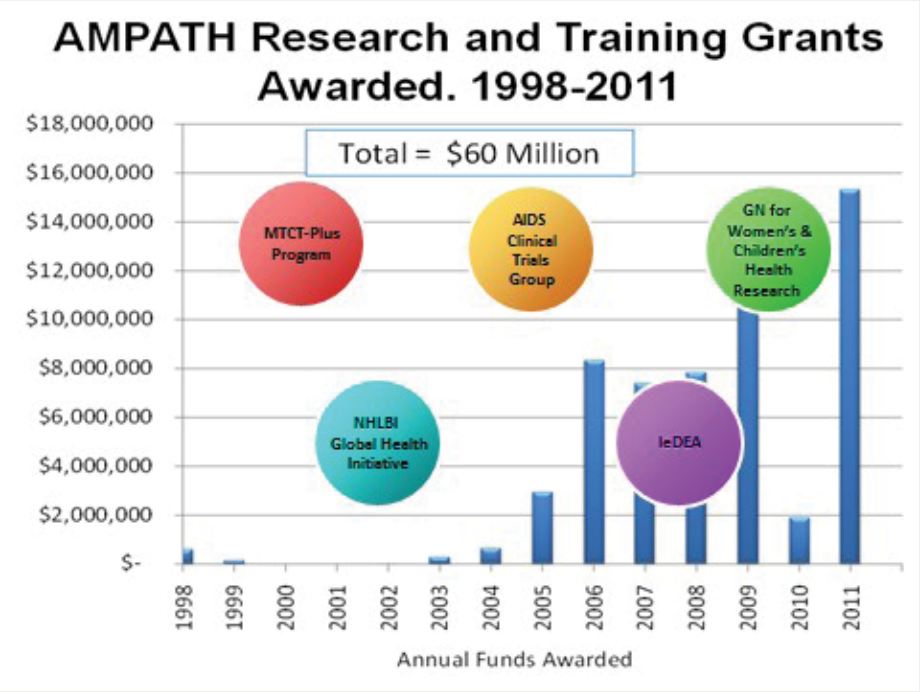
- Collaboration across all levels of the health system
- Scalability/sustainability- the facility to be able to handle millions of patients
- Flexibility-to suit local care management needs and new protocols of care
- Rapid form design that provides system adaptability for end users thus enhancing
- Clinician data entry i.e. Computerised Provider Order Entry (CPOE).
- Use of standards and interoperability-for data sharing and health management
- Support high quality research
- Be web-based and support intermittent connectivity that facilitates data collection
- Low cost (preferably free and open source)
- Clinically useful (*feedback to providers and caregivers is critical. If the system is not* clinically useful, it will not be used).

- **So what happened after 2006?**

Over the period from its inception to 2013 the e-health

system in Eldoret Kenya under the acronym AMPATH (http://www.ampathkenya.org/ and http://youtu.be/1krGBK39G-M) stores and uses more than 120,000,000 coded observations, captured during the direct care process, for clinical decision making, research and health planning. (Figure 2)

Figure 2. Research grant applications for OpenMRS 1998-2011



With collaboration across all health care disciplines and governments the system evolved from a non-existent HIV/AIDS program to a point where the project has become the largest ehealth project in developing nations for the management of all disease states and includes education, prevention and research functionalities. It is also emerging as a significant eHealth system in more affluent economies.

The OpenMRS project is a core component of the WHO Millennium Development Goals initiative. (10) [For more information about the OpenMRS record system, go to www.openmrs.org.] It is also the core eHealth system in many countries e.g. the Philippines (CHITS (Community Health Information and Tracking System)-OpenMRS information *https://chits.ph/@10/*) and Bangladesh (http://health.bmz.de/good-practices/GHPC/A_Quiet_Revolution/index.html), and the number of implementation sites continues to increase around the world. (Figure 3)

- **Evaluation**

With the proliferation in the use of eHealth technologies e.g. mHealth there is a need for these projects to be evaluated. The WHO has estimated that >90% of the world's adult population will have a mobile device by the end of 2015 yet few mHealth projects have been shown to improve health care delivery. (7)

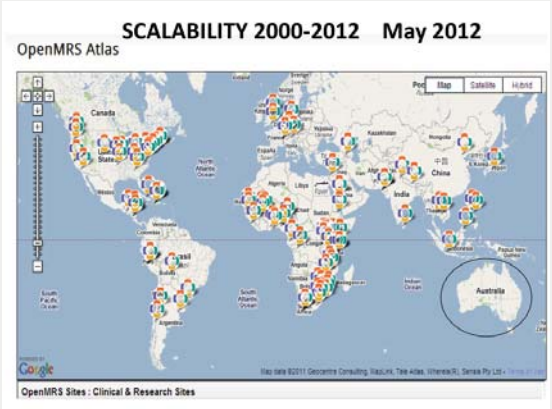
There are several evaluations of the OpenMRS projects and some of these are cited in the following text.

In 2009 Braitstein concluded from her evaluation of the AMPATH (OpenMRS in Kenya) the following:

"Just a few short years ago, the political will, infrastructure, and funding levels for health care in sub-Saharan Africa seemed no match for the relentless devastation from HIV/AIDS. Now HIV/AIDS programs are not only in place but some of them, including the partnership between the United States Agency for International Development (USAID) and the Academic Model Providing Access to Healthcare (AMPATH) are openly speaking of bringing the pandemic to its knees over the next 5 years through widespread screening and effective treatment and prevention of HIV. Successful scale-up of HIV/AIDS programs in the world's poorest countries sends a powerful message: In the public sector, systems of care can emerge that are capable of managing complex chronic diseases. The evolving success story of HIV care programs demands a rethinking of what is possible by applying the lessons learned to unmet needs of those in low income countries who are living with and dying from other diseases." (14)

This statement confirms that an appropriately implemented

Figure 3. OpenMRS locations in May 2012 [http://openmrs.org/atlas/]



eHealth system affects ALL aspects of care delivery. That is treatment, prevention, education and research. The importance of local ownership of the eHealth system is shown in the 2014 video summary of the AMPATH version of OpenMRS. [http://www.youtube.com/watch?v=zkoWdqqHUs4&feature=youtu.be]

- **Lessons learned**

There are many lessons learnt from the OpenMRS/AMPATH projects.

1. They confirm that health care is an information business and its effective management can change care even in the poorest of communities.
2. Capturing clinical data at the time of a patient (client) encounter is critical to successful outcomes and the measurement of resource utilisation in care.
3. End user involvement and ownership during the implementation and design of the eHealth systems is critical.
4. Collaboration across health care disciplines and international boundaries is essential (https://talk.openmrs.org/)

BIOGRAPHY

Terry John Hannan M.B.B.S FRACP, FACHI, FACMI, is a full time practicing Specialist Physician in General Internal Medicine at the Launceston General Hospital where he is also an Associate Professor to the Menzies Research Institute in Hobart.

His roles in e-Health and health reform began with the first successful international translocation of a complex clinical information system from the Johns Hopkins Oncology Centre into the Prince of Wales/Prince Henrys Hospitals in Sydney. (1984-1992)

He is an inaugural Fellow of the Australasian College of Health Informatics (ACHI) and a former College President.

In 2004 he was elected an International Fellow of the American College of Health Informatics (ACMI).

In 2000 he was invited to be a co-founder of the Mosoriot Medical Record System (MMRS) an Electronic Medical Record (EMR) project in Kenya.

This remains a collaborative project between the Moi University in Eldoret Kenya and the Regenstrief Institute in Indiana. The MMRS project led to the development of the Academic Model for the Provision and Access To Healthcare (AMPATH) and the OpenMRS e-record systems (www.openmrs.org).

Currently OpenMRS is the largest open-source web based EMR for developing nations. His main focus has been on end-user acceptability of eHealth technologies.

He is currently a Moderator for two international web-based resource projects GHDonline (www.ghdonline.org) whose aim is to improve health care delivery through global collaboration and the mHealth Working Group (https://www.mhealthworkinggroup.org/).

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Leadership and Innovation in Asia 2015 Volume 51 number 2

Résumés en Français

Stratégie de l'OPS pour un Accès Universel à la Santé et à la Couverture de Santé Universelle : implications pour les services de santé et les hôpitaux dans la région LAC

Aller vers l'accès universel à la santé et à la couverture de santé universelle (UAH/CHU) est un impératif du programme de santé pour les Amériques. Le Conseil directeur de l'Organisation Panaméricaine de Santé (OPS) a récemment approuvé la résolution CD53.R14, intitulée ***Stratégie d'accès universel à la santé et à la couverture de santé universelle***. Du point de vue de la région des Amériques, UAH/UHC « implique que toutes les personnes et les communautés ont accès, sans aucune forme de discrimination, aux services de santé de qualité complets, appropriés et en temps opportun, déterminés au niveau national selon les besoins, ainsi que l'accès à des médicaments sûrs, abordables et efficaces, de qualité, tout en s'assurant que l'utilisation de ces services n'expose pas les utilisateurs à des difficultés financières en particulier les groupes dans des conditions de vulnérabilité ».

L'approche stratégique de l'OPS à UAH / UHC définit quatre lignes d'action spécifiques vers des systèmes universels de santé efficaces. La première ligne stratégique propose : a) la mise en œuvre des réseaux intégrés de prestation des services (IHDSN) basé sur les soins de santé primaires comme stratégie clé pour la réorganisation, la redéfinition et l'amélioration des services de soins en général et pour le rôle des hôpitaux en particulier ; et b) l'augmentation de la capacité de réponse du premier niveau de soins.

Un important débat initié en 2011 entre l'hôpital et les gestionnaires de santé de la région a essayé de redéfinir le rôle des hôpitaux dans le contexte de l'IHSDN et du mouvement naissant UAH/UHC. Les débats ont abouti à des accords autour de trois propositions principales : 1) les IHSDN ne peuvent être envisagés sans les hôpitaux ; 2) Le statu quo et la culture organisationnelle actuelle rendent les IHSDN non viables ; et 3) Sans les IHSDN, les hôpitaux ne seront pas durables. Ce processus, qui est antérieur à l'approbation de la résolution UAH/UHC de l'OPS, devient maintenant plus pertinent avec la reconnaissance que l'UAH/UHC ne peut pas être atteint sans un changement profond du service de soins de santé et en particulier dans les hôpitaux.

En ce contexte, est présenté un ensemble de défis à la fois pour les hôpitaux que pour le premier niveau de soins basé sur l'expérience de l'hôpital et des services de gestion des soins et la vision qu'ils ont pour les hôpitaux dans les IHSDN.

Hôpitaux privés en Amérique Latine - Point de vue d'un investisseur

Les hôpitaux privés se multiplient en Amérique Latine, mais l'industrie est moins développée dans cette région que dans d'autres marchés émergents. Des groupes hospitaliers émergent dans des pays comme le Brésil, le Mexique, la Colombie et le Pérou. Mais ils n'ont pas encore atteint la taille des groupes hospitaliers que l'on trouve en Malaisie, en Inde et en Afrique du Sud. Ils restent également très attachés au marché national, tandis que certaines entreprises de ces trois pays émergents situés hors Amérique Latine se sont développées dans de nombreuses autres régions et sont cotées en bourse afin d'avoir accès à des capitaux plus importants pour financer leur expansion. Etant donné que l'Amérique Latine poursuit sa croissance, il est très probable que ces tendances observées dans d'autres marchés émergents se manifesteront également dans cette région.

L'Argentine. Un pays de contraste et paradoxe

En Argentine, la santé n'est pas une politique d'État, et elle ne bénéficie pas d'une action efficace dans tous les secteurs du gouvernement. Le budget est essentiellement utilisé par des coûts structurels et malgré avoir fait des progrès dans certains domaines tels que les vaccins, il y a peu d'impact sur la Communauté dans son ensemble de la promotion de la santé et la prévention des maladies chroniques répandues liées au métabolisme et au mode de vie. Les plus grandes dépenses de santé sont privé, y compris ce qu'on appelle « dépenses remboursables, » qui conduit à des inégalités, avec plus de 40 % de la population sans couverture santé explicite. Dans le système national, la couverture est liée à l'emploi formel et Obras Sociales et est essentiellement gérée par les syndicats.

Les facteurs sociaux continuent donc à porter la maladie, que le système de santé ensuite tente de soigner avec d'énormes coûts humains et financiers.

Les recommandations d'organismes internationaux (OPS, OMS, FLH, IHF) soulignent l'importance de l'organisation de l'État et privée du RISS, mais très peu a été fait à cet égard.

Le droit aux soins de santé est déjà en place, mais il est loin d'être suffisant. L'ensemble de la population doit avoir une couverture maladie universelle, explicite et efficace, afin d'assurer l'égalité et l'accès aux soins et d'organiser des réseaux de soins qui rendent la sensibilisation, la promotion, la prévention et la rééducation plus efficaces pour tous, à l'aide du niveau de structure existant et des ressources humaines.

Hospital 360°

Il y a des forces qui sont supérieures à la performance individuelle de chaque institution hospitalière et à la structure du système de santé de chaque pays. Le monde change, et pour faire face à l'avenir de la meilleure façon possible, nous

devons comprendre comment les contextes et les tendances émergentes sont connectés et comment ils impactent le secteur hospitalier. L'Association colombienne des hôpitaux et des cliniques, ACHC, a donc mis au point avec Hospital 360° un concept qui utilise des hôpitaux capables d'anticiper l'évolution des contextes au moyen de la transition entre le présent et l'avenir et qui prend en compte, comme modèle, l'expérience dans des secteurs global, socio-économique, démographique, politique, environnemental et technologique.

Hôpital de 360° est une invitation à réinventer les processus et les institutions elles-mêmes leur permettant de s'adapter et d'intégrer un degré élevé de flexibilité fonctionnelle.

Hôpital 360° poursuit des objectifs d'efficience, d'efficacité et de pertinence, mais aussi de l'impact et la durabilité et est cohérent avec les besoins internes des établissements hospitaliers et de la société pour des bénéfices à long terme.

Des hôpitaux privés opérationnels au Mexique

Le Mexique est un des pays les plus riches d'Amérique Latine qui, au cours de ces dernières décennies, a connu de nombreux changements en matière de prise en charge des soins de santé, comme la couverture universelle pour tous les Mexicains jusqu'à l'expansion rapide des services privés. Comme beaucoup de pays, le Mexique dispose à la fois de systèmes privés et publics et les directeurs d'hôpitaux doivent faire face à de nombreux défis tout en étant confrontés à de nouvelles opportunités intéressantes.

Cet article fournit un aperçu de ce milieu en constante évolution. Comment le consumérisme de la classe moyenne émergente a impacté le secteur privé des soins de santé, l'assurance santé et les médecins.

Système hospitalier mixte public et privé du Brésil

Le secteur hospitalier du Brésil est dynamique et en pleine croissance. Selon la constitution brésilienne de 1988, tous les citoyens ont le droit aux soins de santé, anticipant l'engagement mondial pour les soins de santé universels. Le secteur public du Brésil se targue d'avoir un des plus grands systèmes de soins de santé à payeur unique du monde, mais complète un important et le plus grand secteur privé qui voit les fortes hausses de placement, l'utilisation et les prix. Cet article décrit la structure du système hospitalier et analyse la nature et la direction de l'expansion du secteur privé de la santé. Vingt-six pour cent des brésiliens ont une assurance maladie privée et même si la couverture est concentrée dans les zones urbaines de la partie sud-est du pays, il se développe à travers le pays. Le déplacement de charge sur les maladies chroniques affecte la nature de la demande et a un impact direct sur les coûts globaux des soins de santé, qui augmentent l'inflation nationale qui est rapidement multipliée par un facteur de 3. L'augmentation des coûts devra être maîtrisée pour maintenir la viabilité du secteur privé. L'adaptation des réseaux de soins intégrés et le renforcement du système public de remboursement représentent d'importants axes d'amélioration.

Défis et perspectives pour les hôpitaux de niveau tertiaire en Bolivie : Le cas du département de Santa Cruz de La Sierra

En Bolivie, la législation actuelle a passé les hôpitaux publiques tertiaires du niveau des municipalités au niveau régional. Toutefois, pour réformer les infrastructures, moderniser les équipements et faire des réformes pour permettre une meilleure gouvernance, gestion et viabilité de ces hôpitaux, les gouvernements régionaux sont confrontés à des contraintes techniques et financières. Cet article résume l'expérience récente du gouvernement de Santa Cruz de la Sierra en Bolivie où cinq hôpitaux du tertiaire et une banque de sang (la plupart d'entre eux dans des conditions de travail précaires) avaient été transférés en 2012 du gouvernement Municipal de Santa Cruz (la capitale) au gouvernement régional de Santa Cruz. Pour faire face aux défis, le gouvernement régional de Santa Cruz implémente plusieurs améliorations, telles que l'embauche de nouveau personnel clinique et administratif, l'augmentation de l'autonomie budgétaire de l'hôpital, l'externalisation des services auxiliaires des hôpitaux, la prise de mesures pour éliminer les listes d'attente et plusieurs nouveaux investissements pour moderniser et équiper les hôpitaux. La Banque mondiale a été interrogée afin d'évaluer la viabilité financière de ces investissements et de conseiller le gouvernement sur les propositions de changement à faire pour améliorer les performances de gestion des hôpitaux. L'article décrit les défis restants dans ces hôpitaux, ainsi que les propositions de l'étude de la Banque mondiale. Dans le domaine de la qualité des soins, le principal défi est d'améliorer la satisfaction des clients et du suivi continu des résultats, selon les normes d'évaluation de la qualité. Dans le domaine du financement, le défi est de savoir comment assurer la durabilité de ces hôpitaux avec le niveau actuel de financement de la santé et les transferts financiers insuffisants du gouvernement National. Dans le domaine de la gouvernance, des réformes visant à rationaliser et simplifier les processus internes doivent être introduites afin d'établir des mécanismes pour accroître la transparence et traçabilité, permettant à l'hôpital avoir une bonne administration et une participation adéquate des acteurs majeurs dans la direction de l'institution.

Résolution d'un problème de gestion de l'information de la santé. L'histoire d'une réussite internationale

La gestion des soins de santé nécessite la mise à disposition d'outils efficaces de « gestion de l'information » basés sur des e-technologies [e-santé]. Dans les pays développés, beaucoup de ces « outils » sont disponibles, tandis que les pays à bas et moyen revenu (LMIC) ont un accès limité aux technologies de e-santé et ceci a été défini comme « fracture technologique ». (1, 2)

Cet article fournit une brève introduction à la compréhension de base de ce que signifie la gestion de l'information dans les soins de santé et de comme elle s'applique aux économies sociales.

Le cœur de l'article décrit l'implémentation avec succès d'outils appropriés de gestion de l'information, dans un environnement pauvre en ressources, pour gérer des situations d'épidémies de VIH/SIDA et d'autres maladies, dans l'Afrique subsaharienne et comment le système a évolué pour devenir le plus grand projet de e-santé open source au monde et devenir l'infrastructure pour l'information de santé de plusieurs pays. Le système est connu comme OpenMRS [www.openmrs.org]

L'évolution permanente réussie du projet OpenMRS a permis à ses fondateurs clés de définir les facteurs principaux qui sont les piliers de la réussite des projets de e-santé.

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Resumen en Español

La estrategia de la OPS para el Acceso Universal a la Salud y la Cobertura Universal de Salud: implicaciones para los servicios de salud y hospitales en Latinoamérica

El movimiento hacia el Acceso Universal a la Salud y Cobertura Universal de Salud (AUS/CUS) es una tarea imprescindible en la agenda de salud para las Américas. El Consejo Directivo de la Organización Panamericana de la salud (OPS) aprobó recientemente la resolución CD53. R14, titulada Estrategia para el Acceso Universal a la Salud y Cobertura Universal de Salud. Desde la perspectiva de la región de las Américas, AUS/CUS "implica que todas las personas y las comunidades tengan acceso, sin ningún tipo de discriminación, a los servicios de salud integrales, adecuados, oportunos, de calidad, determinados a nivel nacional, según las necesidades, así como acceso a medicamentos seguros, asequibles, eficaces y de calidad, asegurando que el uso de estos servicios no expone los usuarios a dificultades financieras especialmente los grupos en situación de vulnerabilidad ".

El enfoque estratégico de la OPS de AUS / CUS establece cuatro líneas de acción específicas hacia los sistemas de salud universales eficaces. La primera línea estratégica propone: a) la implementación de redes integradas de servicios de salud (RISS) basadas en la atención primaria de salud como estrategia clave para la reorganización, redefinición y mejora de los servicios de salud en general y el papel de los hospitales en particular; y b) el aumento de la capacidad de respuesta del primer nivel de atención.

Un importante debate iniciado en 2011 entre los directores de los hospitales y de salud en la región trató de redefinir el papel de los hospitales en el contexto de las RISS y el movimiento emergente AUS /CUS. Los debates dieron lugar a acuerdos en torno a tres proposiciones principales: 1) las RISS no se pueden plantear sin los hospitales; 2) El statu quo y la cultura organizativa actual del hospital hacen las RISS inviables; y 3) Sin las RISS, los hospitales no serán sostenibles. Este proceso, que es anterior a la aprobación de la resolución AUS / CUS de la OPS, que ahora se hace más relevante con el reconocimiento de que el AUS / CUS no se puede lograr sin un cambio profundo en el servicio de atención médica y en particular en los hospitales.

En este contexto, se presenta una serie de desafíos tanto para los hospitales y para el primer nivel de atención basado en la experiencia de los administradores de los servicios hospitalarios y de salud, y la visión que tienen los hospitales de las RISS.

Hospitales privados en América Latina – La perspectiva de un inversionista

Los hospitales privados se están expandiendo en América Latina, pero la industria está menos desarrollada en esta región que en otros mercados emergentes. Varios grupos de hospitales están surgiendo en países como Brasil, México, Colombia y Perú. Sin embargo, no han alcanzado el tamaño de los grupos de hospitales en Malasia, la India y Sudáfrica. También permanecen centrados en el país, mientras que las empresas de los tres citados mercados emergentes fuera de América Latina se han expandido a varios otros países y se cotizan en las bolsas de valores para acceder a más capital y poder financiar su expansión. Es muy probable que estas tendencias que se observan en otros mercados emergentes se manifiesten en América Latina, ya que la región continúa desarrollándose.

Argentina país de contrastes y paradojas

En Argentina la salud no se plantea en los hechos como una política de Estado, y de acción efectiva en todas las áreas de gobierno. El presupuesto se agota básicamente en estructura, aun cuando se ha avanzado en algunas áreas como vacunaciones, hay poco impacto en el conjunto de la comunidad en promoción de salud y en la prevención de las enfermedades prevalentes crónicas dependientes del metabolismo y los hábitos de vida. El mayor gasto en salud es el privado y dentro de este el llamado "gasto de bolsillo" con lo que se observa la inequidad que esto implica ya que más del 40% de la población no tiene cobertura explicita de salud, la que en sistema nacional se haya atada al trabajo formal y las Obras Sociales fundamentalmente bajo el manejo de las organizaciones sindicales.

Los Determinantes Sociales así continúan creando enfermos, que luego se intenta curar a enormes costos humanos y monetarios.

Las recomendaciones de los organismos internacionales (OPS, OMS, FLH, FIH) enfatizan en la organización de RISS estatal privadas pero es muy poco lo que se ha hecho en este sentido.

El derecho a la salud vigente es necesario, pero está lejos de ser suficiente y es necesario dar a toda la población Cobertura Universal de Salud, explicita y efectiva garantizando el acceso y la equidad en salud, organizar redes de salud que hagan más efectiva la atención, promoción, prevención y rehabilitación para todos utilizando las capacidades instaladas tanto en estructura como en recursos humanos que están y son de muy alto nivel.

Hospital 360°

Existen fuerzas que son superiores al desempeño individual de cada institución hospitalaria y a la estructura del sistema de salud de cada país; el mundo está cambiando y si se quiere enfrentar de una mejor manera el futuro, es necesario entender como los contextos y las tendencias emergentes, se vinculan entre sí y cómo afecta al sector hospitalario. La Asociación Colombiana de Hospitales y Clínicas, ACHC, plantea el concepto "Hospital 360°" el cual hace referencia a

un hospital capaz de anticiparse a contextos cambiantes mediante un tránsito entre el presente y el futuro, recogiendo la experiencia de los ámbitos globales, socioeconómicos, demográficos, políticos, ambientales y tecnológicos.

Hospital 360° invita a la reinvención de los procesos y de la institución misma, permitiéndole la adaptación e incorporándole un alto grado de flexibilidad funcional.

El Hospital 360° persigue objetivos de eficiencia, efectividad, pertinencia, pero también de impacto y sostenibilidad, siendo consistentes con las necesidades internas de la institución hospitalaria y de la sociedad, para alcanzar beneficios a largo plazo.

Funcionamiento de los hospitales privados en México

México es uno de los países más ricos de América Latina y en los últimos decenios se han producido muchos cambios en los sistemas de prestación de atención sanitaria, estos van desde la cobertura de salud universal para todos los mexicanos a la expansión a ritmo rápido de la salud privada. Al igual que muchos países, México tiene sistemas de salud públicos y privados y los administradores de los hospitales se enfrentan a desafíos en múltiples frentes, además de enfrentarse a nuevas y emocionantes oportunidades.

Con este artículo usted puede obtener una visión general de este panorama siempre cambiante. Cómo el nuevo consumismo creciente de la clase media ha impactado en los médicos, el seguro de salud y la industria de la salud privada.

Sistema mixto de hospitales públicos y privados de Brasil

El sector hospitalario de Brasil es vibrante y está creciendo. Según la Constitución brasileña de 1988 todos los ciudadanos tienen derecho a la asistencia sanitaria, anticipando el compromiso global de Atención Sanitaria Universal. El sector público de Brasil se enorgullece de tener uno de los más grandes sistemas del mundo de pagador único de Salud, pero teniendo en cuenta que es un importante y más grande sector privado el que está viendo grandes incrementos en la inversión, la utilización y los precios. Este artículo describe la estructura del sistema de hospitales y analiza la naturaleza y dirección de la expansión del sector de salud privado. Veinte y seis por ciento de los brasileños tienen seguro de salud privado y aunque la cobertura se concentra en las zonas urbanas de la parte sur oriental del país, está creciendo en todo el país. El cambio de la carga de morbilidad hacia las enfermedades crónicas afecta a la naturaleza de la demanda y afecta directamente los costos de salud global, que están aumentando rápidamente superando la inflación nacional en un factor de 3. Cada vez los costos tendrán que ponerse bajo control para mantener la viabilidad del sector privado. La adaptación de las Redes Integradas de Atención y el fortalecimiento del sistema de reembolso público representan importantes áreas para mejorar.

Retos y perspectivas para hospitales de nivel terciario en Bolivia: El caso del Departamento de Santa Cruz de La Sierra

La legislación actual en Bolivia ha transferido los hospitales públicos terciarios de los municipios a un nivel regional. Sin embargo, los Gobiernos Regionales están experimentando limitaciones técnicas y financieras para reformar la infraestructura, modernizar los equipos e introducir reformas para permitir una mejor gobernanza, gestión y sostenibilidad de estos hospitales. Este artículo resume la experiencia reciente del Gobierno de Santa Cruz de la Sierra en Bolivia donde cinco hospitales de tercer nivel y un banco de sangre (la mayoría de ellos en condiciones de trabajo precarias) habían sido transferidos en 2012 del Gobierno Municipal de Santa Cruz (la capital) al Gobierno Regional de Santa Cruz. Para hacer frente a los retos, el Gobierno Regional de Santa Cruz implementa varias mejoras, como contratar nuevo personal clínico y administrativo, aumentar la autonomía presupuestaria del hospital, externalizar los servicios auxiliares de los hospitales, tomar medidas para eliminar las listas de espera y hacer nuevas inversiones para modernizar y equipar los hospitales. El Banco Mundial fue contratado para evaluar la sustentabilidad financiera futura de estas inversiones y asesorar al Gobierno en proponer cambios para aumentar el rendimiento de la gestión de los hospitales. El artículo describe los retos pendientes en los hospitales y las propuestas del estudio del Banco Mundial. En el área de la calidad de la atención, el principal desafío es mejorar la satisfacción del cliente y el seguimiento de los resultados continuos y de evaluación según las Normas de Calidad. En el área de la financiación, el reto es cómo asegurar la sostenibilidad de estos hospitales con el nivel actual de financiación de la salud y las insuficientes transferencias financieras del Gobierno Nacional. En el área de la gobernanza, es necesario introducir reformas para agilizar y simplificar los procesos internos con el fin de establecer mecanismos para aumentar la transparencia y la rendición de cuentas, permitiendo que el hospital tenga una buena administración y una adecuada participación de los principales actores en la dirección de la institución.

La resolución de un problema de gestión de información de salud. Una historia de éxito Internacional

La gestión de la prestación de atención de salud requiere la disponibilidad de herramientas eficaces de “gestión de la información” basados en tecnologías electrónicas [eHealth]. En las economías desarrolladas muchas de estas “herramientas” están fácilmente disponibles, mientras que en países de bajos y de ingresos medios (LMIC) hay un acceso limitado a las tecnologías de salud en línea, lo que ha sido definido como la “brecha digital”. (1, 2)

Este documento ofrece una breve introducción a la comprensión fundamental de lo que se entiende por gestión de la información en la atención de la salud y cómo se aplica a todas las economías sociales.

El núcleo del documento describe la implementación exitosa de las herramientas adecuadas de gestión de la información en un medio de escasos recursos para gestionar la epidemia del VIH / SIDA y otras enfermedades en el África subsahariana y cómo el sistema ha evolucionado para convertirse en el proyecto eHealth de código abierto más grande del mundo y convertirse en la infraestructura de información de salud para varias economías eHealth nacionales. El sistema es conocido como OpenMRS [www.openmrs.org]

La continua evolución exitosa del proyecto OpenMRS ha permitido a sus ejecutores claves definir los factores centrales que son las bases para proyectos de salud en línea con éxito.

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中文摘要

泛美卫生组织的“全民保健计划和全民医保计划策略”：对LAC区域中卫生服务和医院的意义

实施全民保健计划和全民医保计划（UAH/UHC）是美洲卫生议程上的重要任务。泛美卫生组织（PAHO）的指导委员会最近通过了题为***“全民保健计划和全民医保计划策略”***的CD53.R14号决议。从美洲区域的角度来看，UAH/UHC“意味着所有公民和社区将由国家一级根据不同的需求会平等地拥有全面、适当、及时和高质量的卫生服务，以及拥有安全、担负得起、有效和高质量的药品，并确保使用这些服务不会为国民造成经济困难，特别是那些经济有困难的团体”。

PAHO实施UAH/UHC的战略方针通过四个方面来形成有效的全民卫生系统。第一条战略方针建议：1）基于主要卫生保健“实施整体卫生服务供应网络”（IHDSNs）作为从整体上重新组织、重新定义和提高卫生保健服务以及特别是医院的作用的主要策略；以及2）加强卫生保健一线的反应能力。

2011年，由这个区域的医院和卫生保健管理人员发起一项重要讨论尝试着去重新定义医院在IHSDNs中的作用和新兴的UAH/UHC运动。这场讨论的结果达成了三个主要提议：1）没有医院的参与，IHSDNs无法实现；2）现状和当前医院的组织文化使实施整体卫生服务供应网络无法生存；以及3）没有IHSDNs，医院将没有可持续性发展。在PAHO的UAH/UHC决议通过之前，就有了这个运动。现在它进一步认识到，如果卫生保健服务，特别是医院，不进行深入改革的话，就不能实现UAH/UHC。

在这样的背景下，根据医院和卫生保健服务管理人员的经验和他们对IHSDNs中的医院的远见，医院和卫生保健一线会面临众多挑战。

从投资角度看拉丁美洲私立医院现状

目前，拉丁美洲的私立医院处于发展态势。但与一些其他新兴市场相比，这一行业在该地区仍显落后。在巴西、墨西哥、哥伦比亚和秘鲁等国，出现了一些医疗集团。但与马来西亚、印度和南非等相比，这些集团的规模还稍为逊色。在客户方面，这些集团主要面向的仍是国内患者。而上面提到的三个新型市场上，医疗公司已经将业务拓展到多个其他国家，并纷纷上市，为下一步扩张赢取更大的资本。随着拉美市场的不断发展，在其他新兴市场的上述发展趋势也有望在拉美出现。

阿根廷，一个有契约精神而又自相矛盾的国家

在阿根廷，健康问题没有被提升到国家政策的高度，因此也就没有从政府各个领域的高效率中获益。这方面的财政预算基本上都用到了结构性成本上。虽然在疫苗接种等某些领域取得了一定的进步；但在改善健康状况和预防同新陈代谢及生活方式相关的流行性慢性病方面，它对整个社会的影响非常有限。包括所谓的“现金支付”在内，健康方面的最大支出项是由私人承担的。这就导致了不平等的现象：整个国家40%以上的人口都没有明确的医疗保险。在国家系统中，医疗保险的覆盖与正式受聘和Obras Sociales相关，而且实质上是由各个工会管理的。

因此，社会性因素导致疾病继续发生；然后，卫生系统再尝试花费巨大的人力与金钱来治疗这些疾病。

国际机构（泛美卫生组织[PAHO]、世卫组织[WHO]、FLH和国际人道主义救助基金会[IHF]所提出的建议强调了组织国家与个人RISS的重要性。但是，这方面的工作几乎还没有开始。

人们已经提出对于卫生保健权利的要求。但要充分拥有这一权利，还有很长的路要走。该国的公民需要明确而有效的全民医保计划，以确保卫生保健的途径和平等性，通过使用现有的高等级结构资源与人力资源来组成卫生保健网络，让大家的意识、宣传、预防和康复更为高效。

360°医院

有些力量，是大于每所医疗机构的个体绩效，或是每个国家健康系统结构的单独绩效的。世界瞬息万变。为了以最好的姿态迎接将来的挑战，我们需要了解各种背景情况和各种新兴趋势是如何相关联的，而它们对于医疗系统又起着什么样的影响。基于此，哥伦比亚医院诊所协会（Colombian Association of Hospitals and Clinics, ACHC）提出了“360°医院（Hospital 360°）”的概念——医院能够通过当前到将来的变化，利用全球化、社会经济学、人口统计学、政治、环境和技术等领域作为其模型，对变化的背景情况作出预估。

“360°医院”是针对全新流程和医疗机构自身的一个机会，让这些机构能接触到高度的功能灵活性，并加以利用。

“360°医院”的宗旨是有效、高效和实用，兼顾影响力和持续性。它与医疗机构和社会的长期利益所相关的内在需求是一致的。

在墨西哥经营私人医院

墨西哥是拉丁美洲最富有的国家之一，近几十年来从覆盖了墨西哥人的全民医疗到私人医疗的快节奏扩张，都使墨西哥的医疗体系发生了非常大的变化。象许多国家一样，墨西哥拥有私人和公共医疗系统，医院的管理者们除了面对激动人心的新机遇外，还要面临着多方面的挑战，

通过本文您将获得这个不断变化系统的全景鸟瞰图，了解不断壮大的新中产阶级消费是怎样影响了医生、医疗保险和私人医疗保健行业的。

巴西的公私混合医疗系统

巴西的医疗行业正处在蓬勃发展之中。根据1988年巴西宪法，巴西的所有公民都有享受卫生保健的权利，这也暗含对全民卫生保健实现全球化的预期。巴西的公共医疗拥有全球最大的统一支付卫生保健系统。但作为公共医疗系统的补充，该国的私人医疗系统非常重要，规模更大，而且在投资额、使用率和服务价格上都有显著增加。本文描绘了这一医疗系统的结构，并分析了私人卫生保健机构发展的本质和方向。百分之二十六的巴西人有私人卫生保健医疗保险。虽然其覆盖面主要集中在巴西东南部的城镇区域，但现在正在向整个国家蔓延。疾病负担正在向慢性病转移这一趋势影响了需求的本质，并直接影响了卫生保健的整体支出。总支出迅速上升，比全国通货膨胀率高出3个百分点。不断攀升的成本必须得到控制，以维持私人卫生保健机构的生存能力。应用整合型卫生保健网络和加强公共卫生保健报销系统代表了服务提升的重要领域。

玻利维亚三级医院面临的挑战和见解：圣克鲁斯部门的案例

玻利维亚现在的法律把三级公立医院从市级转换到了区级。但是，由于面临技术和资金方面的局限，区政府并不能很好地改革医疗结构、增加现代化设备和引入改革机制从而更好地监督、管理和持续发展这些医院。本文总结了玻利维亚圣克鲁斯政府在这方面的最新经验。该政府在2012年把五个三级医院和一个血库（这些机构中的大多数都处于不稳定的工作状态）从圣克鲁斯市级政府下放到了区级政府。为应对这些挑战，圣克鲁斯区政府实施了一些改进措施，如新聘临床和行政人员、加强医院财政独立核算、外包医院的辅助服务、设法消除排队长龙、增加医院设备现代化方面的投资。

他们与世行签订了合同，让世行来评估这些投资计划在将来财政上的可持续性并建议政府提出改革方案来提升这几家医院的管理效果。本文描述了这几家医院所面临的挑战以及世行研究结果所提出的建议。在医疗质量方面，主要的困难是根据质量标准来提升病人的满意度和对结果的持续监控与评估。在资金方面，面临的困难是如何以当前的医疗保健资金和中央政府所提供的有限资金来确保这些医院的可持续性。

在管理方面，需要引入改革机制来协调和简化内部程序，从而建立机制来增加透明度和可靠性，让医院得到更好的管理，让各方面的人员都积极参与到机构管理中去。

解决健康信息管理问题，一个跨国成功故事

要对保健产品和服务进行管理，需要具备基于电子技术的有效“信息管理”工具（eHealth）。在发达国家，有很多现成的这类工具；而在中等乃至低收入国家（LMIC），eHealth技术并非唾手可得。这种情况即所谓的“数字鸿沟”。(1, 2)

本文简要介绍了保健领域信息管理的基本理论，及其在各种经济层次的社会中的应用。

文章主要阐述了在信息贫乏的背景下，使用适当的信息管理工具来对撒哈拉以南非洲有HIV/AIDS及其他病症流行的国家进行管理的情况，以及该系统如何发展为全球最大的开源式eHealth项目，并成为数个国家级eHealth经济体的健康信息基础。该系统的名称为OpenMRS [www.openmrs.org]。

OpenMRS项目成功的发展脚步仍未停止。其主要实施者因此得以制定核心要素，作为成功eHealth项目的基础。

IHF events calendar

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IHF

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2016 IHF 40th World Hospital Congress
Durban, South Africa
For more information, contact sheila.anazonwu@ihf-fih.org

2017 IHF 41st World Hospital Congress
7-9 November, Taipei, Taiwan
For more information, contact sheila.anazonwu@ihf-fih.org

2015

MEMBERS

SWITZERLAND
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November 11, Berne
H+ Les Hôpitaux de Suisse

KOREA
6th Korea Healthcare Congress 2015
November 12 – 13, 63 Convention Center, Seoul, Korea
Korean Hospital Association

GERMANY
German Hospital Conference
November 16 – 19, Düsseldorf
Deutsche Krankenhausgesellschaft

3rd Joint EUROPEAN Hospital Conference
November 19 - Düsseldorf
Organized by: European Hospital and Healthcare Federation (HOPE), the European Association of Hospital Managers (EAHM) and the European Association of Hospital Physicians (AEMH)

For further details contact the: IHF Partnerships and Project, International Hospital Federation, 151 Route de Loëx, 1233 Bernex, Switzerland; E-Mail: sheila.anazonwu@ihf-fih.org or visit the IHF website: http://www.ihf-fih.org

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