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Hospital Performance in Brazil
The Search For Excellence

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Hospitals are at the center of the health care universe in Brazil. When ill, many Brazilians go straight to the hospital for want of a “family doctor” or primary care network. Hospitals are a critical part of the government’s budget, absorbing nearly 70 percent of public spending on health. Hospitals influence the ebb and flow of politicians’ careers—when hospital mishaps hit the headlines or the limelight falls on high-performing hospitals. Hospitals are at the forefront of policy discussions in Brazil. The discussions reflect their promise as centers of technological innovation and medical advances as well as widespread concern about their cost and quality. Brazilian hospitals are important to many people for many different reasons. What makes hospitals important is easy to understand. What makes hospitals deliver quality care efficiently—or not—is much harder to grasp.

Challenges to Brazil’s Hospital System

Brazil’s hospital system is pluralistic. An array of financial, ownership, and organizational arrangements encompass both the public and private sectors. Brazil has a long tradition of public financing of private facilities. The system is also highly stratified. A few hospitals are world-class centers of excellence; they serve the minority, the well-off. “Substandard” best describes most hospitals, the ones serving Brazilians who cannot pay out of pocket or afford private insurance. These hospitals, many dependent on public financing, deliver inefficient, poor-quality care, judging from the available data.

Hospitals, though the de facto health care delivery system in Brazil, have received scant attention as health care organizations from either policy makers or researchers until recently. Since the mid-1980s, the development of health policy in Brazil has focused on decentralizing service delivery, reducing financial disparities, and achieving universal access to basic care. Issues of hospital performance, however defined, have been left mainly to the individual facility.

In 2004 a publication by the Ministry of Health (Ministério da Saúde, MS) on hospital reform sounded the call for change. It was the first MS document to focus entirely on the hospital sector. The publication opened a national discussion on hospital problems, performance, and potential. The document outlined broad policy “directions” that are aligned with a subset of policy recommendations specified in the current study. The MS called upon research and hospital communities to collaborate with it to strengthen the...
analyses and help develop a vision and a strategy for hospital reform. It is in this spirit of collaboration that this volume is produced

MAIN POLICY MESSAGES

1. Enhancing the Autonomy and Accountability of Public Hospitals

Any efforts to improve the quality and efficiency of public hospitals will rely on increasing the motivation and “proactivity” of their managers. Under current conditions, even the best-motivated and trained managers will have a tough time raising performance. Too many key decisions are made outside the hospital. Rigid constraints on management undermine efforts to increase accountability. To bring autonomy to the vast majority of public hospitals, it will be necessary to develop and test hospital conversion strategies (to autonomous organizational arrangements) against Brazilian and international experience. Though a necessary ingredient, autonomy alone cannot drive performance in public hospitals. Also needed are service contracts, contract enforcement, performance-based financing, flexible human resource management, and a robust information environment.

What can be done?

Enhancing the Autonomy and Accountability of Public Hospitals

- Develop a strategy, regulatory framework, and implementation plan to convert direct and indirect administration facilities to alternative organizational arrangements that possess autonomous authority and flexible human resource management.
- Formulate an investment policy that promotes the application of autonomous organizational arrangements in any new public hospital.
- Establish a public-private program to strengthen governance arrangements in private hospitals under contract with the SUS, including regulatory reform and enforcement, strengthening of contracting, and stimulating competition.

2. Wielding Funding Power to Influence Hospital Behavior

Government and private payers of hospital care are not using funding to its fullest potential to influence hospital behavior. In some cases, funding arrangements hamper performance. Most funding is unlinked to performance and gives no incentive to cost consciousness. Although no payment system is perfect, many countries have linked payments to treatment costs based on diagnosis, adjusted for severity. In the United States, the diagnosis-related groups (DRGs) payment system has been found to improve efficiency and control costs.

Brazil’s Authorization for Hospitalization (Autorização de Internação Hospitalar, AIH) system can serve as a foundation for a DRG-based hospital payment system. In moving toward DRGs, the first order of business is to align AIH rates with costs. Developing a robust DRG-based payment mechanism would also reduce distortions from the fragmentation of payment systems—if private (and public) payers switch to the same payment basis. However, accountability for hospital performance requires more than performance-based funding (or autonomy). Contracting arrangements are needed to define the content of funding arrangements and thereby link funding to performance. Also, successful hospital contracting requires contract management and enforcement. Global budgeting efforts combined with contracting are underway in a handful of states and municipalities. These promising initiatives have been shown to raise performance.
3. Improving Coordination among All Providers

Coordination—among hospitals and between hospitals and other types of providers—is critical to improving quality. It will also raise efficiency and broaden equity by rationalizing the supply of hospital beds and expensive medical technologies. Coordination is handicapped in Brazil by: the decision-making and financial independence granted to states and municipalities; the absence of ties with private providers outside the Unified Health System (Sistema Único de Saúde, SUS); fragile public administration; and general ineffectiveness of coordinating instruments such as Integrated and Negotiated Programming (Programação Pactuada e Integradad, PPI). Considering the monetary and quality costs of this fragmentation, Brazil would benefit greatly by applying mechanisms to enhance coordination related to hospital services. Coordination can be pursued through funding-based contractual arrangements, pooling funding and creating regional command structures with decision-making authority over resource allocation across municipalities, or by tightening regulations governing relations among providers. Some states and municipal consortia are already experimenting with one or more of these mechanisms. These experiences can provide the basis for effective coordination. To reduce duplication and waste of infrastructure and equipment, two final elements are needed, a policy-based investment strategy and a system for vigorous technology assessment and allocation.

4. Raising Service Quality to Acceptable Standards in All Hospitals

Government is responsible for ensuring quality in all hospitals, public and private alike. Quality standards already exist in the form of licensure requirements and government-sanctioned accreditation systems. Unfortunately, their implementation has been meager. To gain compliance, the SUS and private health plans could institute time-bound funding conditionality, linking financing to licensure and accreditation, following the example of a number of countries that use the power of the purse in this way.

Achieving standards, however, does not in itself guarantee quality. Many critical actions needed to improve quality of hospital services take place at hospital level under the leadership of hospital management. These include establishing continuous quality improvement programs involving performance assessments, effective teamwork, use of information technologies, incorporation of evidence into practice, development and use of clinical guidelines, and coordination of care within the hospitals as well as with providers at other levels. Hospitals acting alone may not get far with these elements. Continuous quality improvement requires a systematic ap-

What can be done?

**Enhance leverage of funding flows to increase efficiency, cost consciousness, and quality.**

Enhance leverage of public funding flows (SUS) by:
- Implementing new payment systems (such as global budgets linked to performance) for public hospitals that replace the line-item budget and build in strong incentives for quality and efficiency enhancement.
- Improving contractual arrangements by applying instruments that specify volume and type of services and priority targets, linking a proportion of payment with performance, and enforcing compliance with agreed targets.
- Upgrading AIH / SIA system, aligning payment with costs, and gradually converting it to DRG-like system.
- Improve regulation of private health plans / insurer—to constrain cost shifting (enhance cost containment and fiscal discipline), payment system consistency, and incentives for hospitals / managers.

**Pursue systematically service coordination and capacity configuration.**

- Develop and implement state-level master plans for care coordination and establishment of regional networks.
- Strengthen national strategy for rationalizing hospital supply, including transformation or closure of small hospitals.
- Strengthen policy-based investment financing for hospitals, based on regulatory approval or investment master plans.
- Develop a national system for technology assessment and allocation.
proach with a solid national support system that includes policies and strategies to enhance quality, support for systematic research on patient satisfaction and evaluation of clinical practices, and the establishment of institutions through public-private partnerships to measure, monitor, and benchmark quality and provide guidance and support to individual hospitals. Finally, there is a need to address the low quality of some medical schools and strengthen institutional capacity to address medical malpractice.

5. Improving the Reliability of Basic Managerial Information

The absence of reliable information about quality, efficiency, and costs of hospital services underlies all issues and hampers any effort to improve performance. Without this information, policy makers as well as public and private payers are flying blind. This situation is untenable. There is an urgent need to develop and install standardized systems to measure costs and quality. These systems should focus on essential information for decision making and be designed with the needs of the local manager in mind. At the same time, the systems should be based on standards to allow cross-hospital and cross-state benchmarking.

What can be done?

**Raise quality standards in all hospitals.**

- Develop and implement a three-pronged national strategy for quality assessment and improvement founded on system support, accountability mechanisms, and organizational development.
- Institute a rigorous national licensing exam for medical school graduates.

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Can Brazil improve the performance of its hospitals? The evidence presented in this volume suggests that the answer is yes. However, it will take strong leadership, coordinated efforts of federal, state, and municipal governments, direct engagement with the private health sector, and systematic but continuous vision, policies, and actions. Such enabling factors have been generally weak or absent in the Brazilian health system. Promising initiatives have often been gutted or scrapped after changes of government.