Rev Bras Cir Cardiovasc 2008; 23(4): 570-571

Specialty Outpatient Clinics: agility and resolution

AME: Ambulatório Médico de Especialidades - agilidade com resolutividade

Valdecir C. TADEI[1], Domingo M. BRAILE[2]

RBCCV 44205-1034

Descriptors: **Health management. Health administration. Health policy, planning and management.**

Descritores: **Gestão em saúde. Administração em saúde. Políticas, planejamento e administração em saúde.**

In Brazil, the struggle to build an universal, accessible and quality health system can be mistaken at first for an effort to redemocratize of our country, and may be characterized by a resistance to the conservative movement regarding public policies of the last decade.

In 1986, the most important health political event of the second half of the Twentieth Century occured: the VIII National Health Conference. In this event, the basis of a new public health system was established with the following official themes: health as a duty of the State and a civil right, national healthcare system reform, and the sector's budget.

Thus, the effort toward healthcare reform was responsible for creating the Unified Health System (SUS) in 1988 as a social and political process that requires a democratic environment for its establishment in the healthcare field, which has significant character of cultural change. Founded upon ideological conventions, the healthcare system is based on an expanded concept of personal, family, and community health care.

Basic principles emerge from SUS: universal and equal access to services; community participation, decentralized regional and hierarchical network administration, whose healthcare actions should be developed according to the guidelines provided by Article 198 of the Brazilian Federal Constitution. These guidelines should meet principles such as universal access to health services at all levels of care, integral care (understood as consistent actions and preventive and curative services, individual and collective, required for each case at all levels of system complexity), disclosure of informations about the potential of health services and their use by the user, and equality in healthcare without prejudice or privileges of any kind. Currently, SUS is responsible for the care of 78% of the Brazilian population, with the remaining 22% cared for by the private healthcare system [1].

In this context, the São Paulo State Government regulated the partnership between the State and philanthropic entities by Complementary Law No. 846, June 4 1998. They stipulated that these entities had at least 5 years of experience in the administration of health services, with recognized quality and a commitment to the population being served. The interested entities that have met the stipulated prerequisites were classified as Social Health Organizations, and earned the right to be able to sign a Management Contract with the State Health Secretary with a new responsibility for the management and operation of hospitals and other public health organs via public appointment.

In the healthcare field, this model is already consolidated

1. Assistant Professor of the Anesthesiology Discipline - São José do Rio Preto Medical School (FAMERP); Director of the XV Regional Health Department (DRS XV) - São Paulo State Health Secretary
2. Full Professor of the UNICAMP; Director of Post-Graduation Department of São José do Rio Preto Medical School (FAMERP); Editor of the Brazilian Journal of Cardiovascular Surgery

Article received on July 7th, 2008
Article accepted on October 24th, 2008

in countries like Spain [2] and Canada [3]. Like SUS, the Canadian system is funded through general taxation (taxes); however, healthcare services are provided and administered by non-profit organizations according to the requirements of the public sector, which controls the entire system [4].

In Brazil, this model became an innovative alternative, established by the São Paulo State Government, through the coordination of the Department of Health Services Recruitment within the office of the São Paulo State Secretary of Health. The following Brazilian states have also studied this model or already have hospitals managed by Social Health Organizations: Bahia, Minas Gerais, Pará, Espírito Santo (remaking the Law) and Mato Grosso (studying the law).

The search for new strategies for the improvement of public management of health services has been a subject of debate in Brazil since the establishment of SUS. Public-private partnerships are among the alternatives used in an attempt at greater efficiency in the implementation of public healthcare services. The São Paulo State Secretary of Health's experience using this new model of healthcare management via Social Healthcare Organizations has shown good results in terms of efficiency quality of care, and financial resourcefulness, proving this action to be a success on the part of public healthcare management by SUS/SP [5].

Results of a study performed by a team from the Latin American and Caribbean Regional Office Poverty Reduction and Economic Management Unit of the World Bank showed the efficiency and quality of Social Health Organizations in the São Paulo State when compared with the state hospitals under direct administration. This model is an important management tool in improving hospital care in Brazil [6].

Currently, 20 state hospitals are functioning under Social Health Organizations and are distributed throughout São Paulo State, offering a total of 4013 beds including Intensive Care Units (ICUs), in addition to consultations and complementary exams for a variety of specialties.

Recently, an agreement was approved between the São Paulo State Secretary of Health and Santa Casa de Misericórdia of Votuporanga, São Paulo (qualified as a Social Health Organization) to regulate the progress of actions and healthcare services in the first Specialty Outpatient Clinics of the state.

Considering the regional needs for care by specialist physicians, the establishment of Specialty Outpatient Clinics restores principles such as universality, integrality and equity of care. It also improves the quality of care, because the patient is served in the same region, with immediate solutions for medium or high complexity in outpatient clinics and referrals to hospital medium or high complexity medical centers if necessary. In the Specialty Outpatient Clinics of Votuporanga in the period from January to August this year, 7,901 consultations and 8,542 exams - both cardiological or cardiac - were performed.. Among this total, only 128 patients were referred for surgical treatment. For the remaining patients, Outpatient solutions were available.

REFERENCES

1. Braile DM. Opinião. SUS 20 anos - II; 2008. [citado 2008 Maio 24]. Disponível em: URL:http://www.diarioweb.com.br/artigos/body_artigos.asp?idCategoria=35&idNoticia=108285

2. Labrador JRR, Benedicto AS. Salud pública y sostenibilidad de los sistemas públicos de salud. Rev Esp Salud Pública. 2006;80:475-82.

3. Barata LRB, Mendes JDV. Organizações sociais de saúde: experiência bem-sucedida de gestão pública de saúde do Estado de São Paulo. Rev Adm Saúde 2006;8(31):47-56.

4. Quinhões TAT. Novos padrões gerenciais no setor público no sistema de saúde canadense. In: Cadernos ENAP – Reforma do Estado no setor de saúde: os casos de Catalunha, Canadá, Reino Unido e Estados Unidos. Rio de Janeiro:Escola Nacional de Administração Pública;1997. p.47-71.

5. Barata LRB. Entrevista. Rev Adm Saúde 2005;7(28):74-8.

6. Banco Mundial. Unidade de Redução da Pobreza e Gestão Econômica da Região da América Latina e Caribe. Relatório Nº 35691-BR. Brasil: Melhorando o desempenho no setor saúde: lições das inovações do Estado de São Paulo e da Cidade de Curitiba. 29 de Março de 2006.