XXXV
Congreso Nacional de la Sociedad Española de Medicina Interna (SEMI)
IV Congreso Ibérico de Medicina Interna
II Congreso de la Sociedad de Medicina Interna de la Región de Murcia

19-21 Noviembre 2014
Auditorio y Centro de Congresos Víctor Villegas
Murcia

La Gestión Sanitaria en tiempos de crisis.

Sostenibilidad del sistema sanitario público en España

Dr. Manel del Castillo Rey
Gerente Hospital Sant Joan de Déu

Murcia , 20 de Noviembre 2014

Guión

1. **El modelo actual. Resultados. Sostenibilidad**

2. **Las Reformas estructurales**

Guión

1. **El modelo actual. Resultados. Sostenibilidad**

2. **Las Reformas estructurales**

El modelo actual es bueno

1. Accesibilidad
   Equidad

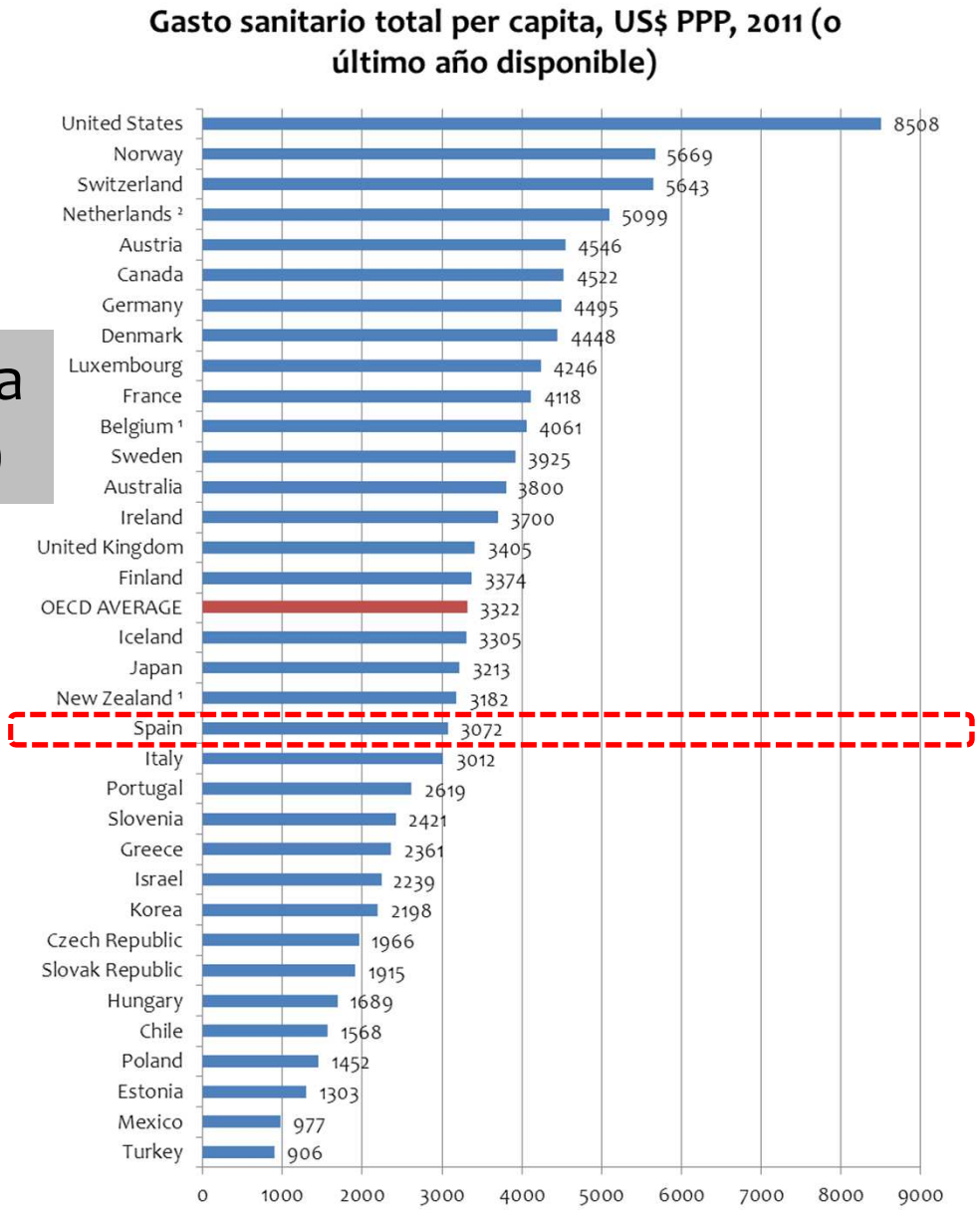
2. Coste unitario
   bajo

El modelo actual es bueno

2

Coste

Gasto/persona inferior a la media OECD (3.072 US $)



OECD Health Data, 2013

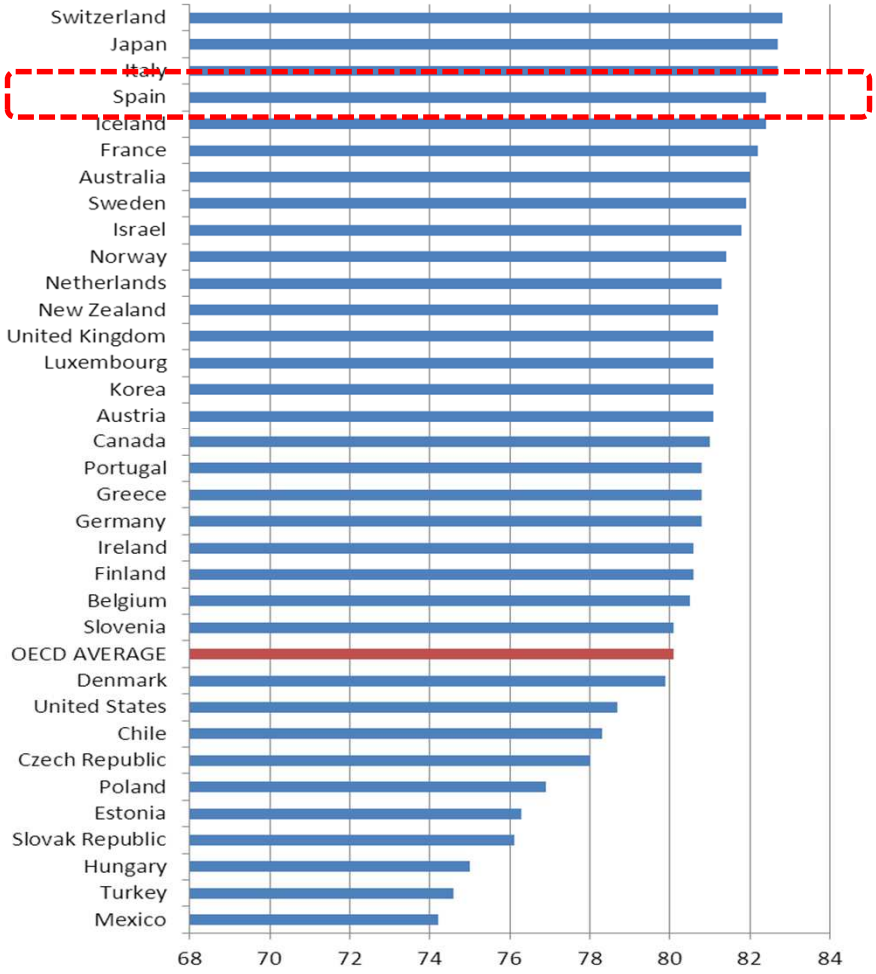
El modelo actual es bueno

1. Accesibilidad Equidad
2. Coste unitario bajo
3. Buenos resultados en salud
4. Buena aceptación poblacional

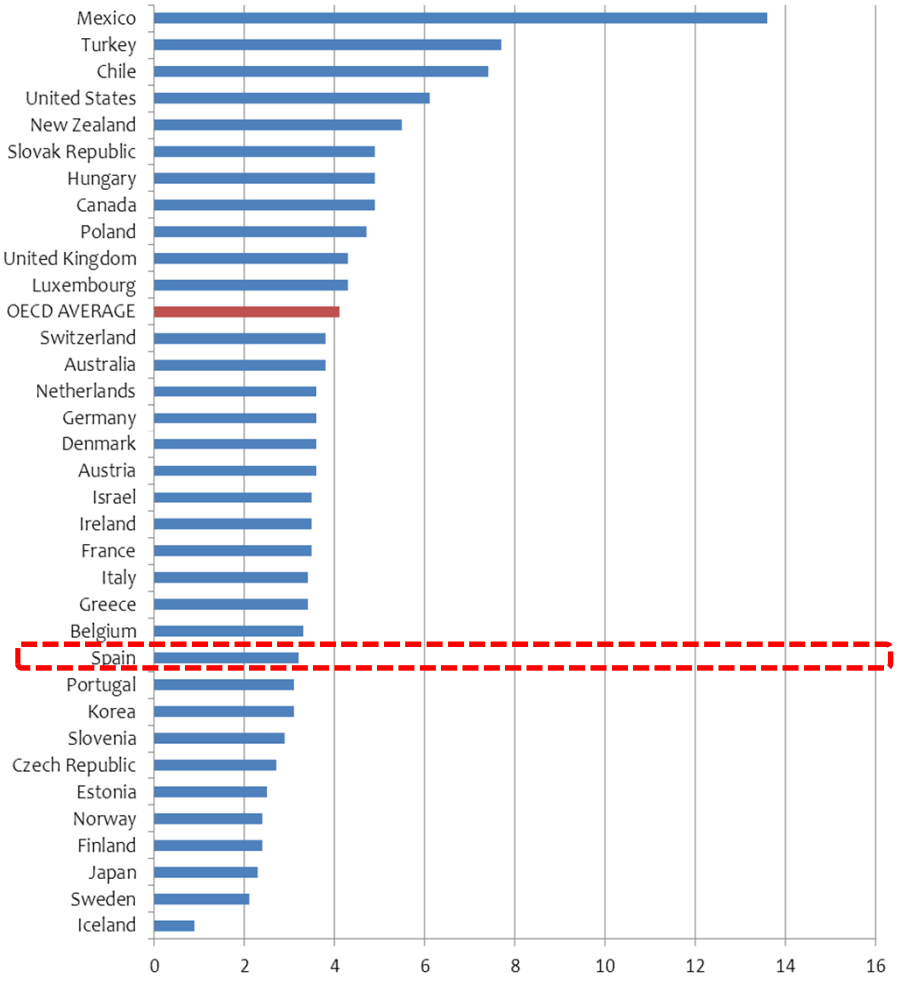
El modelo actual es bueno

3 Resultados en salud

Esperanza de vida al nacer, 2011 (o último año disponible)



Mortalidad infantil, muertes por cada 1.000 nacidos vivos, 2011 (o último año disponible)

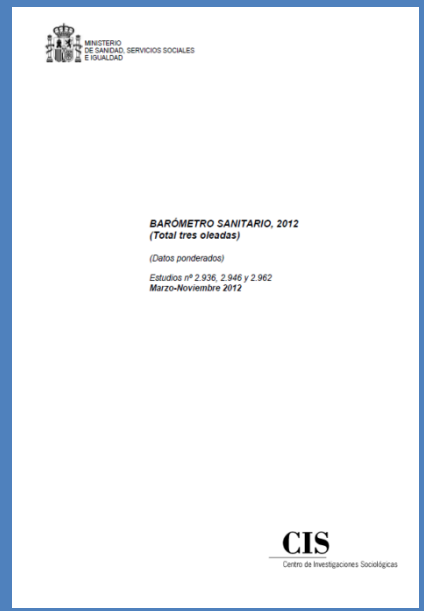


OECD

El modelo actual es bueno

4

Buena aceptación poblacional


MINISTERIO DE SANIDAD, SERVICIOS SOCIALES E IGUALDAD

BARÓMETRO SANITARIO, 2012
(Total tres oleadas)

(Datos ponderados)

Estudios nº 2.936, 2.946 y 2.962
Marzo-Noviembre 2012

CIS
Centro de Investigaciones Sociológicas

Pregunta 2

Vamos a centrarnos ahora en el tema de la sanidad. De las siguientes afirmaciones que aparecen en esta tarjeta, ¿cuál expresa mejor su opinión sobre el sistema sanitario en nuestro país?

En general, el sistema sanitario funciona bastante bien	22.9
El sistema sanitario funciona bien, aunque son necesarios algunos cambios	47.7
El sistema sanitario necesita cambios fundamentales, aunque algunas cosas funcionan	23.6
Nuestro sistema sanitario está tan mal que necesitaríamos rehacerlo completamente	5.0
N.S.	.7
N.C.	.1
(N)	(7729)

70,6

El modelo actual es bueno

1. Accesibilidad Equidad
2. Coste unitario bajo
3. Buenos resultados en salud
4. Buena aceptación poblacional

Retos de futuro

Sostenibilidad

Fragmentación y complejidad

Paciente experto y exigente

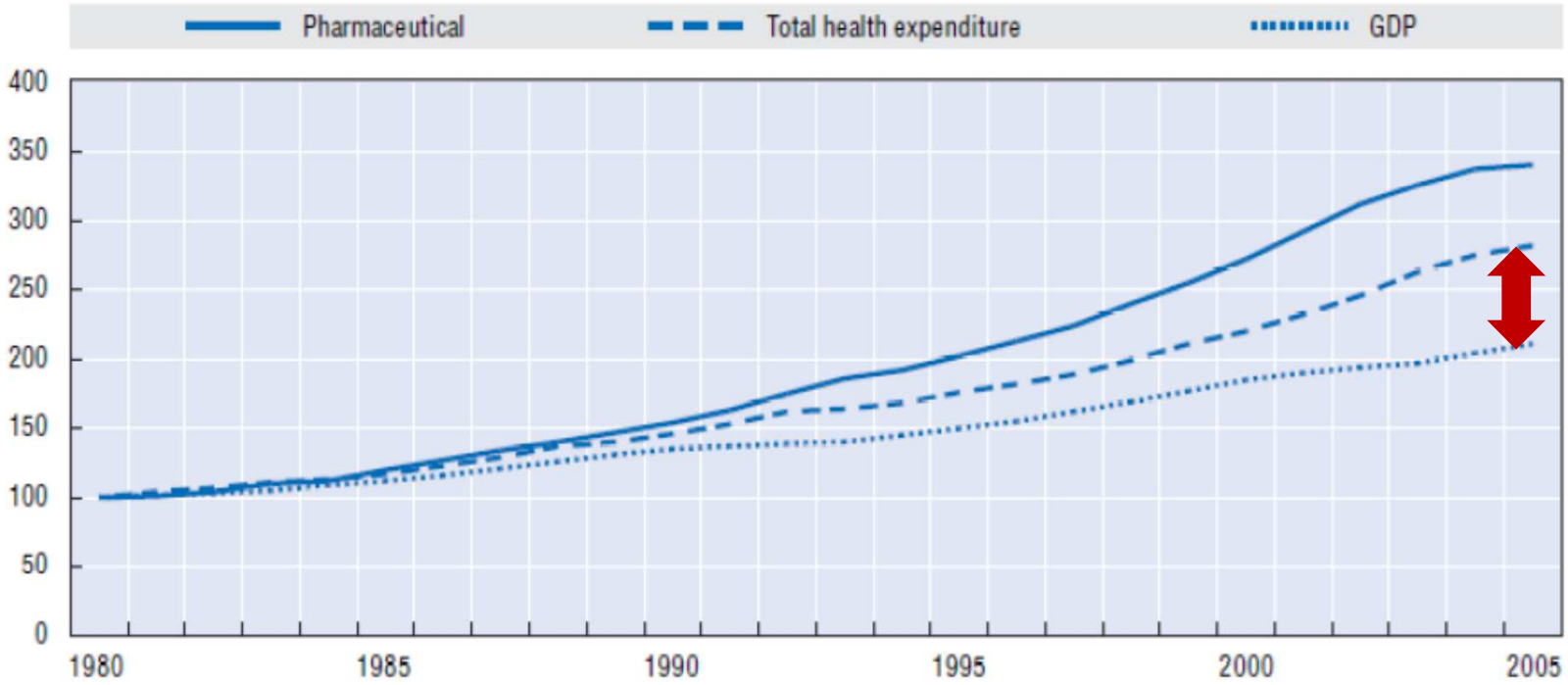
Retos de futuro

Sostenibilidad

Problema: sostenibilidad

Figure 1.7. **Trend growth in pharmaceutical and total health expenditure for 15 OECD countries, and GDP, 1980-2005**

1980 = 100

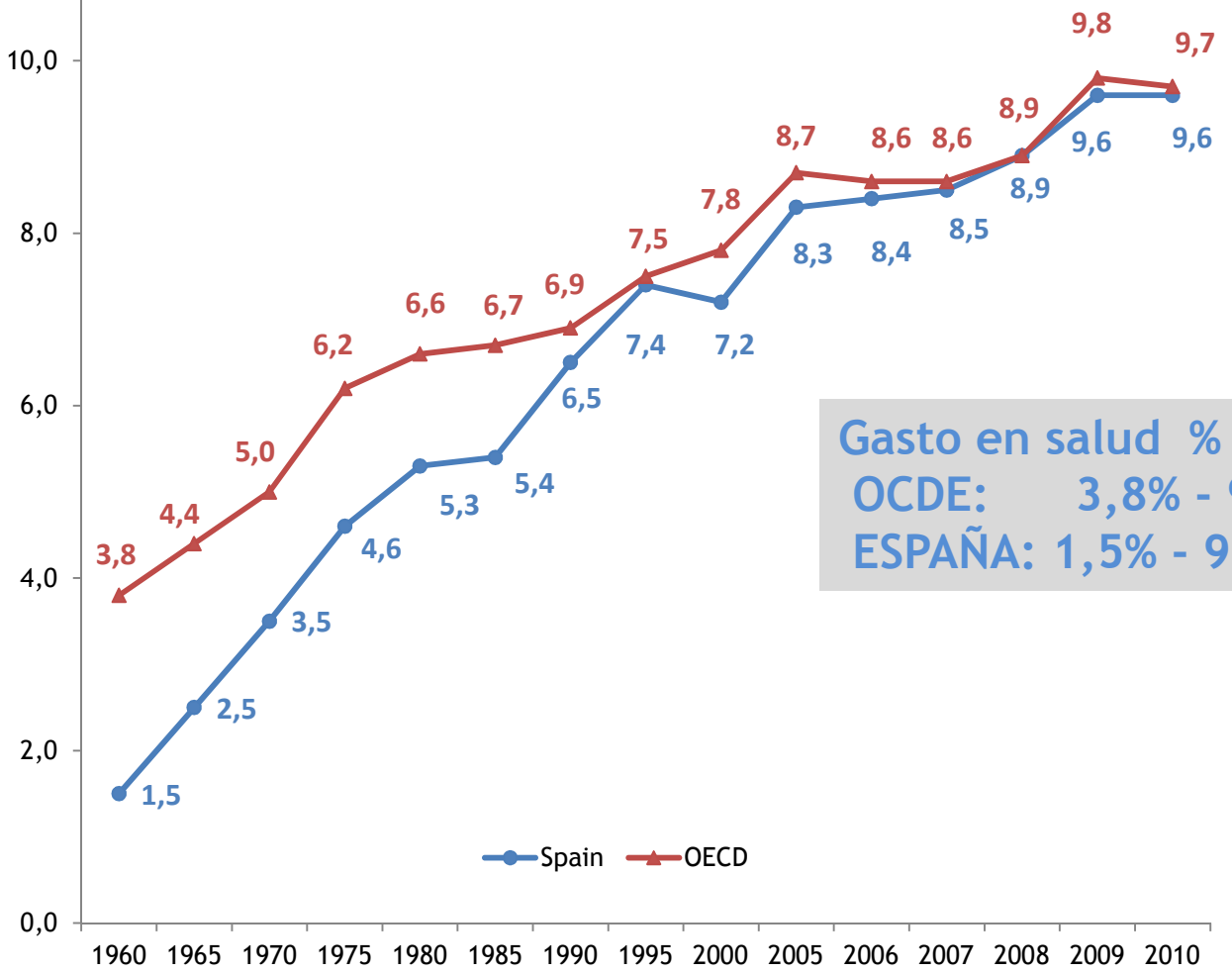


Note: Indexes were calculated using national currency units at 2000 GDP prices. Pharmaceutical expenditure is excluded from total health expenditure.

Source: *OECD Health Data 2007.*

Problema: sostenibilidad

Gasto total en salud (% del PIB) en España y la OECD



Gasto en salud % del PIB
OCDE: 3,8% - 9,7%
ESPAÑA: 1,5% - 9,6%

- Fuente: Elaboración propia a partir de datos de: *OECD Health Data 2012.Version June 2012*

Problema: sostenibilidad

* Cifras provisionales

MSPSI. Gasto sanitario público. Total consolidado. Principio de devengo y Eurostat

Retos de futuro

Sostenibilidad

Fragmentación y complejidad

Fragmentación y complejidad

Ciencia y Caridad, Picasso

133 People to take care of the patient

The Patient

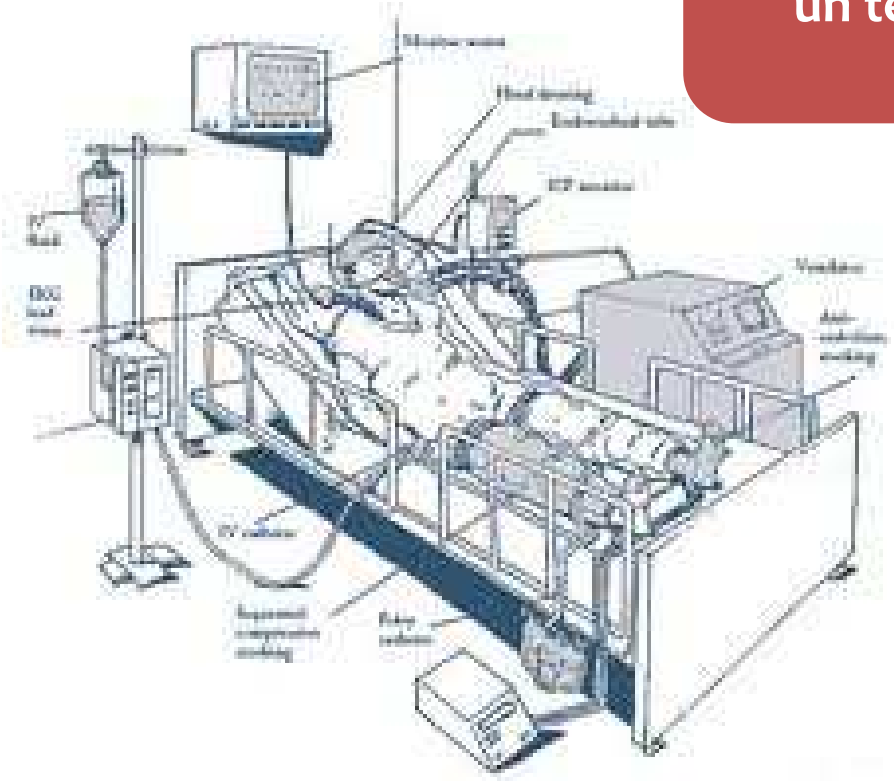
"Medicine used to be **ineffective,** but **simple and safe**".

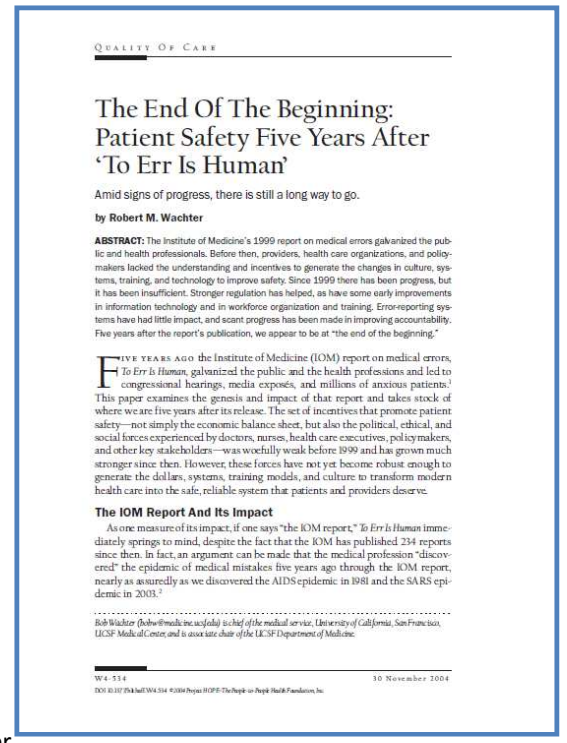
"Now is **effective,** but **complex and relatively dangerous**".

Sir Cyril Chantler, Lancet 1999, 353:1178-81

Ejemplo: Paciente en UCI

Un paciente de la UCI experimenta una media de 1,7 errores diarios, un tercio de los cuales pueden ser fatales. Health Affairs





QUALITY OF CARE

The End Of The Beginning: Patient Safety Five Years After 'To Err Is Human'

Amid signs of progress, there is still a long way to go.

by Robert M. Wachter

ABSTRACT: The Institute of Medicine's 1999 report on medical errors galvanized the public and health professionals. Before then, providers, health care organizations, and policymakers lacked the understanding and incentives to generate the changes in culture, systems, training, and technology to improve safety. Since 1999 there has been progress, but it has been insufficient. Stronger regulation has helped, as have some early improvements in information technology and in workforce organization and training. Error-reporting systems have had little impact, and scant progress has been made in improving accountability. Five years after the report's publication, we appear to be at "the end of the beginning."

FIVE YEARS AGO the Institute of Medicine (IOM) report on medical errors, *To Err Is Human*, galvanized the public and the health professions and led to congressional hearings, media exposés, and millions of anxious patients.[1] This paper examines the genesis and impact of that report and takes stock of where we are five years after its release. The set of incentives that promote patient safety—not simply the economic balance sheet, but also the political, ethical, and social forces experienced by doctors, nurses, health care executives, policymakers, and other key stakeholders—was woefully weak before 1999 and has grown much stronger since then. However, these forces have not yet become robust enough to generate the dollars, systems, training models, and culture to transform modern health care into the safe, reliable system that patients and providers deserve.

The IOM Report And Its Impact

As one measure of its impact, if one says "the IOM report," *To Err Is Human* immediately springs to mind, despite the fact that the IOM has published 234 reports since then. In fact, an argument can be made that the medical profession "discovered" the epidemic of medical mistakes five years ago through the IOM report, nearly as assuredly as we discovered the AIDS epidemic in 1981 and the SARS epidemic in 2003.[2]

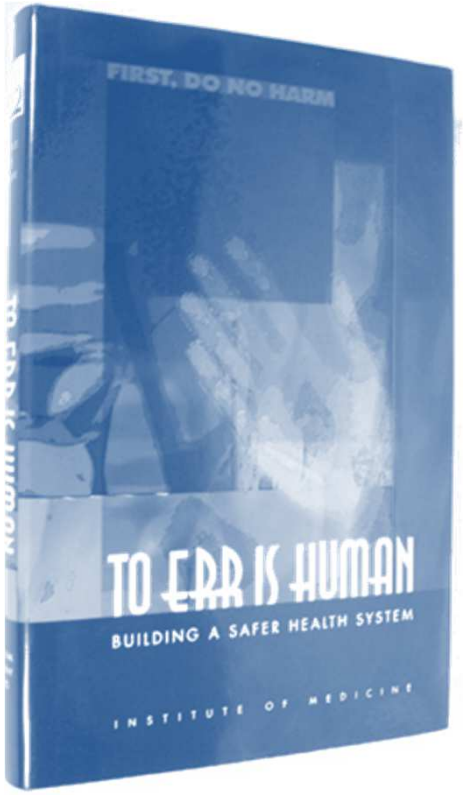
Bob Wachter (bobw@medicine.ucsfdu) is chief of the medical service, University of California, San Francisco, UCSF Medical Center, and is associate chair of the UCSF Department of Medicine.

DOI 10.1377/hlthaff.W4.534

Fuente: Health Affairs. The End of the Beginning: Patient Safety Five Years After `To err is Human´. Robert M. Wachter

El Instituto de Medicina concluyó que el sistema de salud americano era peligroso para los pacientes

Institut of medicine 1999



Errores asistenciales:

- Un millón de lesiones
- 44.000 – 98.000 muertes /año
- Coste 79 billones $/año

Desde 1999 se han hecho muchos esfuerzos en temas de seguridad

…pero los resultados no son los esperados a nivel global

5 años

Prologue

Five Years Later—Are We Any Safer?

Brent C. James

The Institute of Medicine (IOM) released *To Err Is Human: Building a Safer Health System*,[1] its seminal summary of preventable patient injuries suffered within American hospitals, on November 29, 1999. This report was unique in one important way: it was the first IOM report directed as much to the general American public as at the U.S. government, the health care industry, members of the healing professions, and health policy experts. While evidence documenting high rates of treatment-associated injury and mortality have appeared in the peer-reviewed medical literature since the 1950s, neither the health professions nor the health care industry have ever prioritized patient safety as a critical imperative. The IOM's Committee on the Quality of Health Care in America, which produced *To Err Is Human*, sought—through its new public relations direction—to force patient safety to the pinnacle of the policy and care delivery improvement agendas. The committee set a goal of reducing fatalities associated with hospital-based care delivery by 50 percent within 5 years.

Five years have passed. A few institutions have reached the initial IOM goal for some injury sources (for example, Brigham & Women's Hospital in Boston for adverse drug events [ADEs]; Intermountain Health Care's LDS Hospital in Salt Lake City for ADEs and for postoperative wound infections; and Johns Hopkins University Hospital in Baltimore and Vanderbilt Hospital in Nashville for central venous catheter-associated infections). However, as a country, progress has fallen far short of the IOM's ambitious goal. Some members of the original IOM committee have publicly decried the lack of substantial progress,[2,3] citing a continuing inability by the United States to hold patient safety at the center of a national health care reform agenda. For example, even though more than 30 percent of a random sample of physicians responding to a survey reported that they or a member of their immediate family had experienced significant injuries when receiving care, physicians still see patient safety as a low priority.[4]

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES

Objetivo: Reducir los errores que pueden prevenirse en un 50%

5 años más tarde no ha mostrado la evolución esperada…

…pero los resultados no son los esperados a nivel global

10 años

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

Temporal Trends in Rates of Patient Harm Resulting from Medical Care

Christopher P. Landrigan, M.D., M.P.H., Gareth J. Parry, Ph.D., Catherine B. Bones, M.S.W., Andrew D. Hackbarth, M.Phil., Donald A. Goldmann, M.D., and Paul J. Sharek, M.D., M.P.H.

ABSTRACT

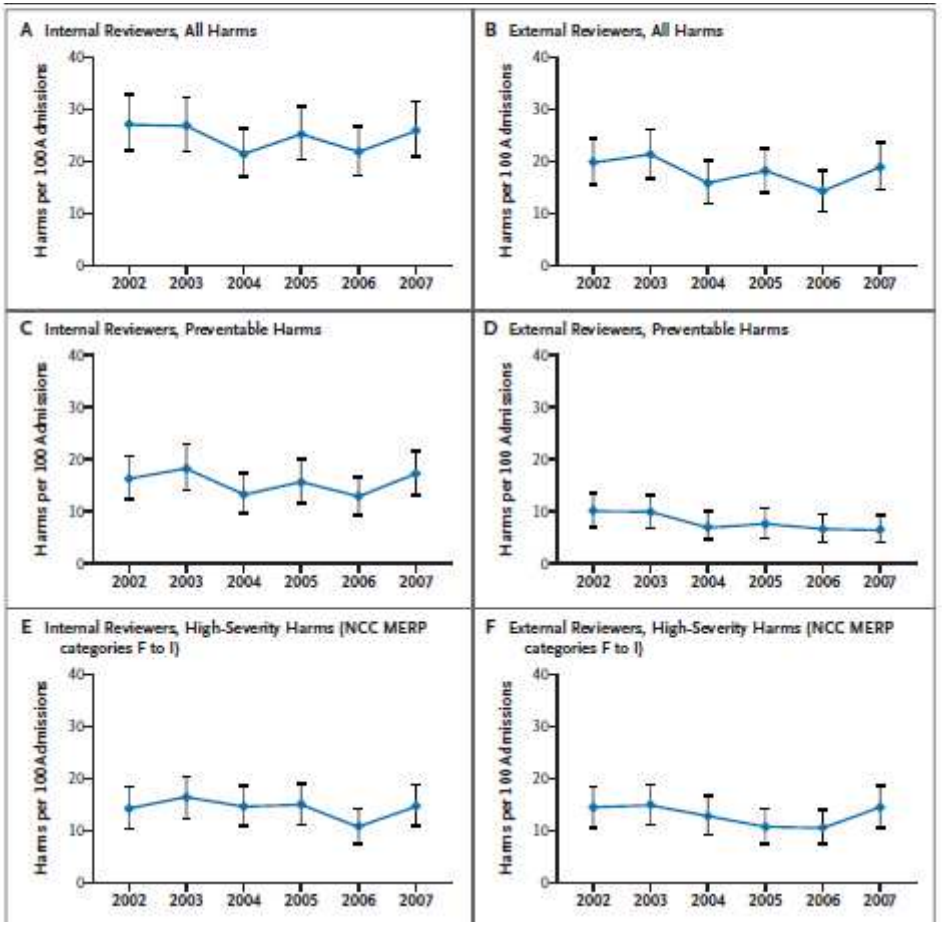
BACKGROUND

In the 10 years since publication of the Institute of Medicine's report *To Err Is Human*, extensive efforts have been undertaken to improve patient safety. The success of these efforts remains unclear.

METHODS

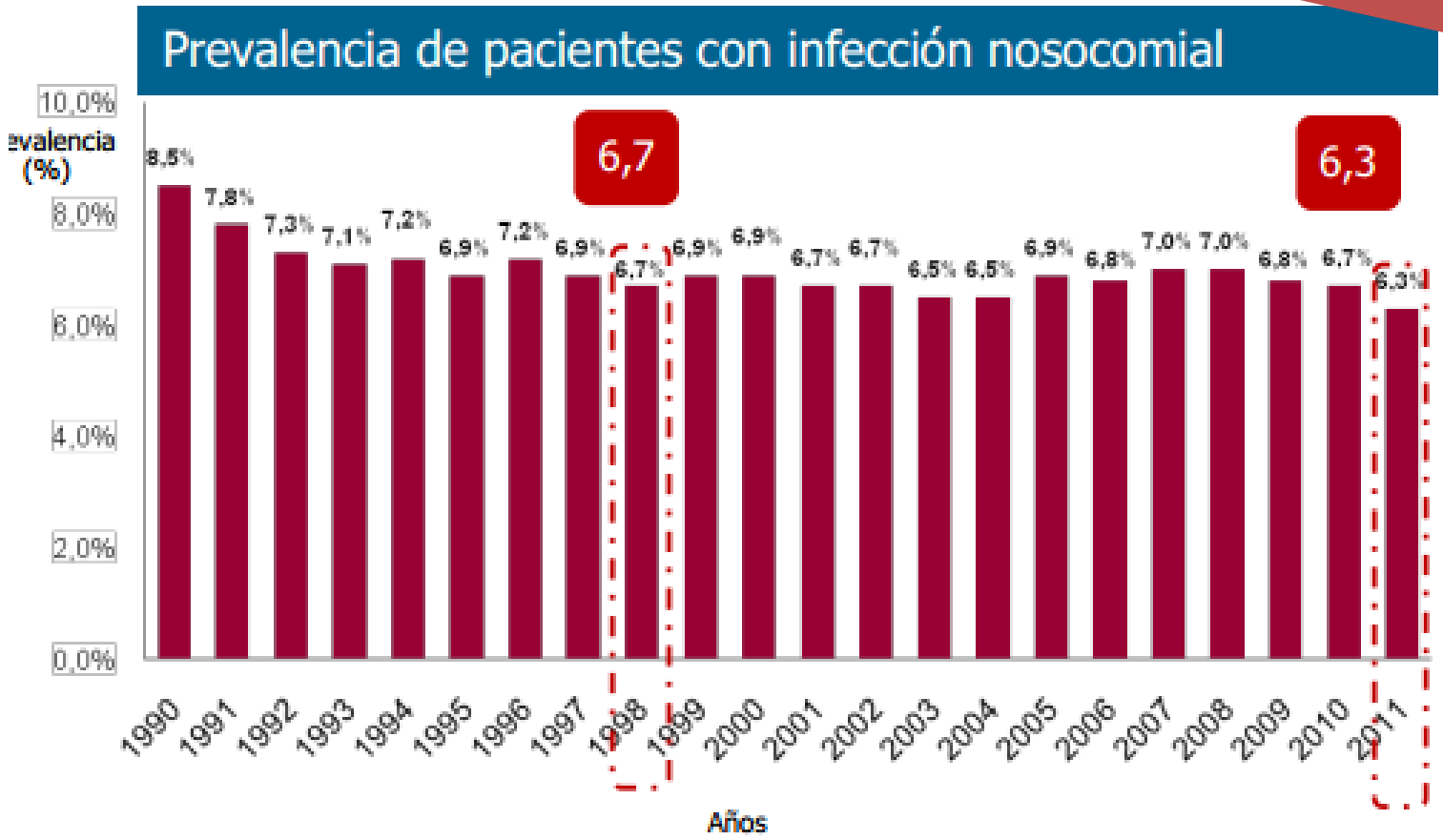
We conducted a retrospective study of a stratified random sample of 10 hospitals in North Carolina. A total of 100 admissions per quarter from January 2002 through December 2007 were reviewed in random order by teams of nurse reviewers both within the hospitals (internal reviewers) and outside the hospitals (external reviewers) with the use of the Institute for Healthcare Improvement's Global Trigger Tool for Measuring Adverse Events. Suspected harms that were identified on initial review were evaluated by two independent physician reviewers. We evaluated changes in the rates of harm, using a random-effects Poisson regression model with adjustment for hospital-level clustering, demographic characteristics of patients, hospital service, and high-risk conditions.

Tasas de errores, errores prevenibles y errores muy graves por 100 ingresos hospitalarios



… pero los resultados no son los esperados a nivel global

España

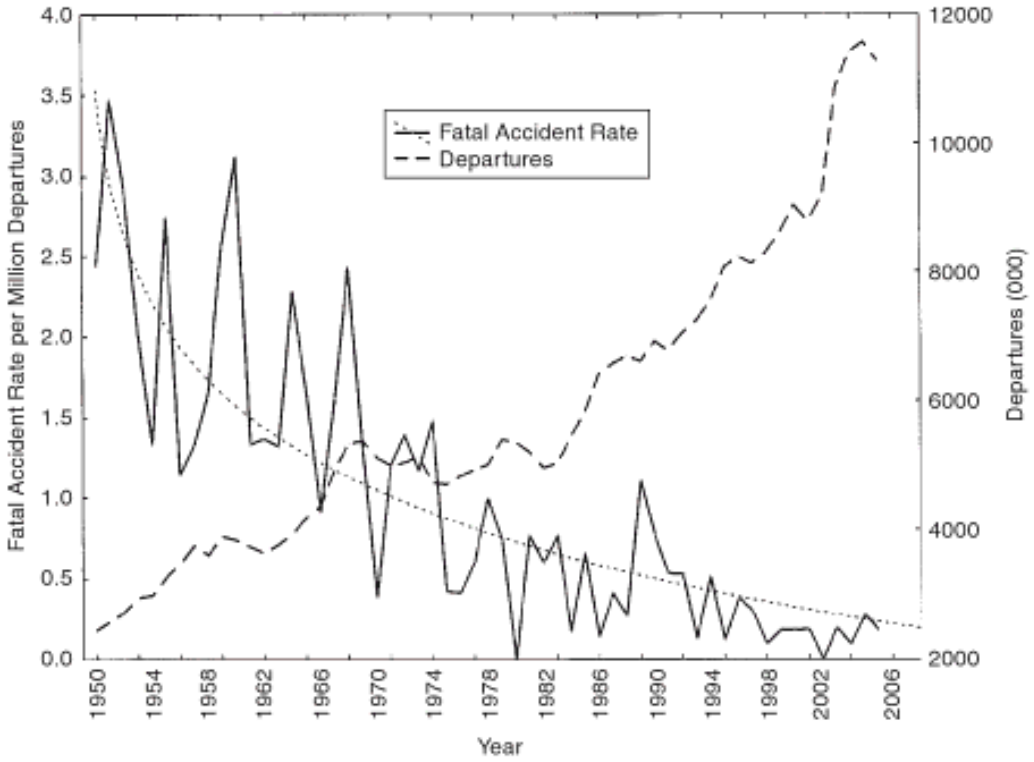


Fuente: EPINE

El lento progreso del sector salud contrasta con el avance del sector aviación

CAST | The Commercial Aviation Safety Team

Tasa de accidentes fatales en aviación



[Source: Handbook of Statistical Analysis and Data Mining; Nisbet, Elder, Miner, pp 378]

Si la aviación tuviera la tasa de errores que tiene la sanidad, equivaldria a un **accidente de jumbo diario (≈ 400 pasageros)**

Retos de futuro

Sostenibilidad

Fragmentación y complejidad

Paciente experto y exigente

Mayor acceso de pacientes a información sanitaria

2003

19%

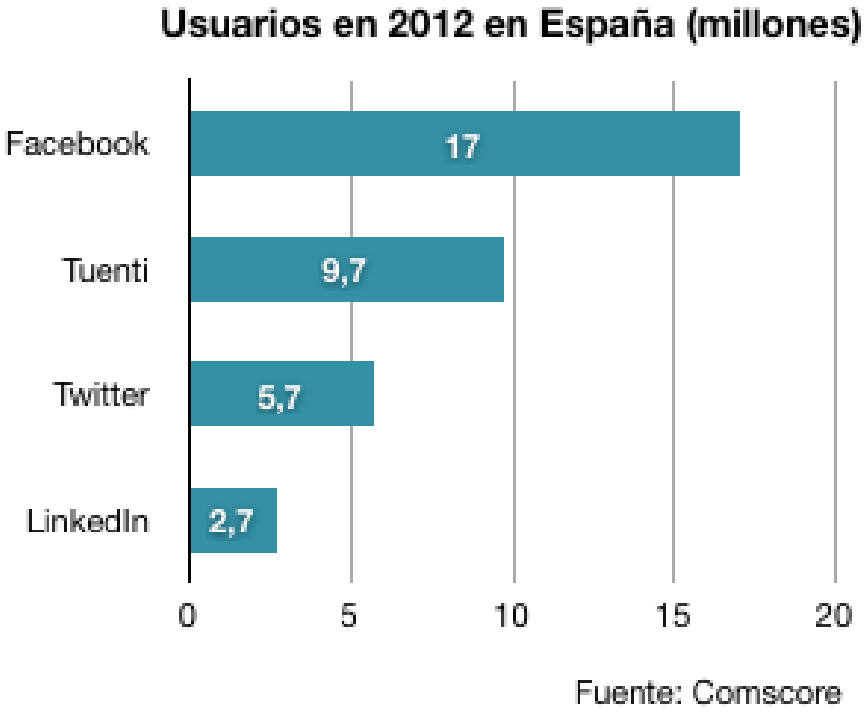
2012

57%

Mayor acceso de pacientes a información sanitaria

Mayor participación de los pacientes

Redes Sociales



Fuente: Comscore

78%

jóvenes españoles usan redes sociales a diario (2012)

66%

al menos una vez al día (2012)

Mayor acceso de pacientes a información sanitaria

Patient Opinion

NHS choices

Rate My Hospital.ie
from irishhealth.com

HOSPITAL FOOD
Dear hungry patient, submit your "delicious" hospital food here !

Mayor participación de los pacientes

CureTogether
Open Source Health Research

patientslikeme

SugarStats

DailyStrength

Inspire together we're better

estudiabetes.com

Retos de futuro

Sostenibilidad

Fragmentación y complejidad

Paciente experto y exigente

¿Qué hacemos?


Under Any Conditions
From the authors of the best selling book
Our Iceberg Is Melting
John Kotter
and Holger Rathgeber

Que reformes ?

OECD Health Policy Studies

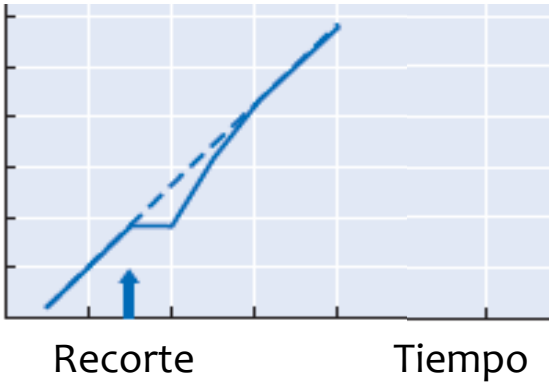
Value for Money in Health Spending

OECD

Reformas estructurales

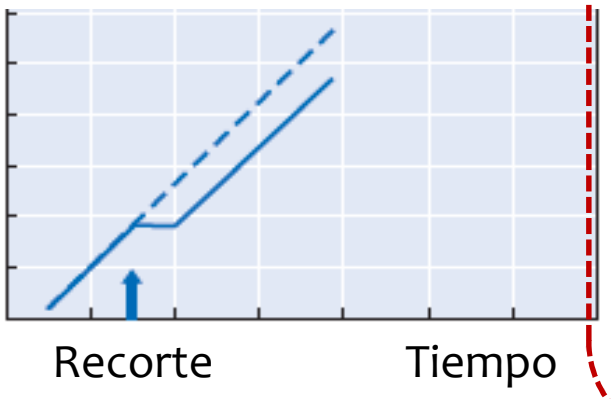
Escenario 1: Actuación puntual

Gasto sanitario



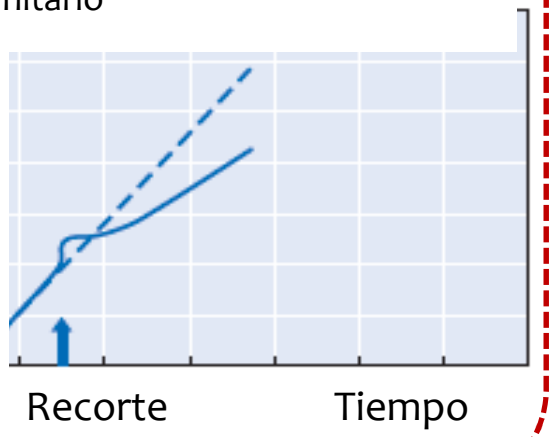
Escenario 2: Presión mantenida

Gasto sanitario



Escenario 3: Medidas estructurales

Gasto sanitario



1 Recortes

2 Reformas

Fuente: *Value for Money in Health Spending*.OECD

Reformas estructurales

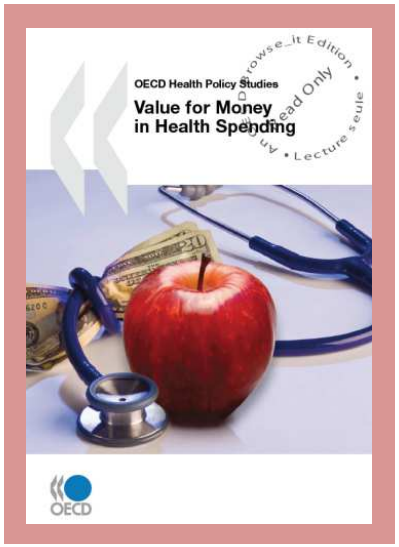
* Cifras provisionales

MSPSI. Gasto sanitario público. Total consolidado. Principio de devengo y Eurostat
http://www.msssi.gob.es/estadEstudios/estadisticas/sisInfSanSNS/pdf/egspGastoReal.pdf

Reformas estructurales

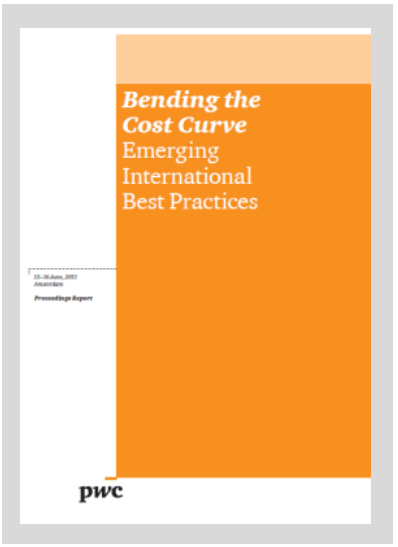
Propuestas globales

Informe OECD.
Value for Money



Informe The Economist.
Future of Healthcare

Informe PwC. Bending
the cost curve

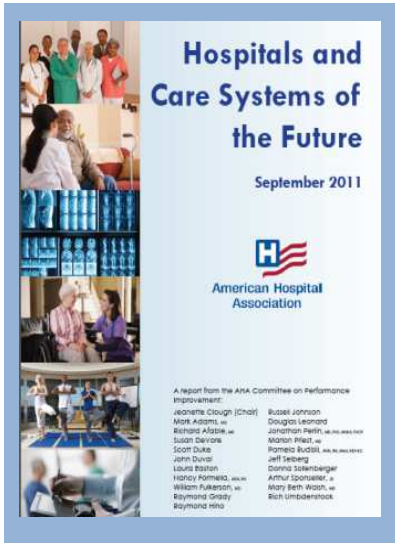


Informe EIH. Health
Challenges

Reformas estructurales

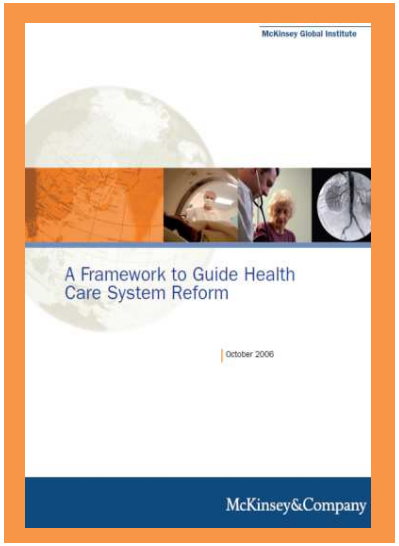
Propuestas globales

Informe AHA

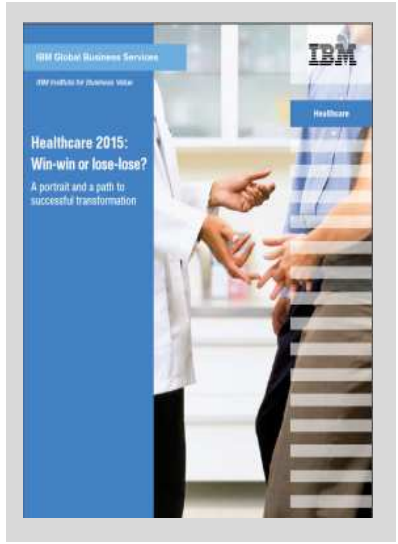


Healthcast 2020
PwC

Informe McKinsey. Framework to guide Reform



Healthcare 2015: Win-win or lose-lose? IBM IBV

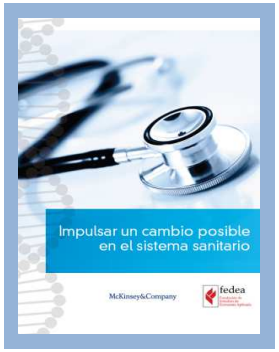


Reformas estructurales

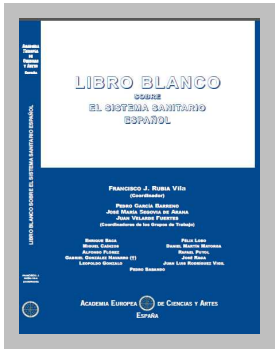
Propuestas España

Informe Abril

Informe FEDEA-McKinsey. Cambio posible



Informe Academia europea Ciencias y artes: "Libro blanco"



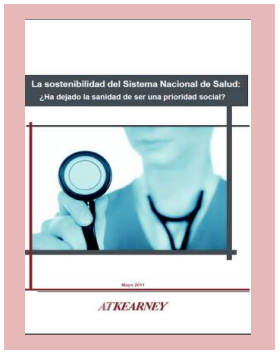
Informe PWC: Diez temas candentes de la Sanidad Española

Informe Antares Cons. "Sostenibilidad del sistema sanitario"

Informe Bernat Soria, 2011

Informe Fundación Bamberg: Modelo de futuro de Gestión de la Salud

Informe AT Kearney. Estudio Sostenib. SNS



Guión

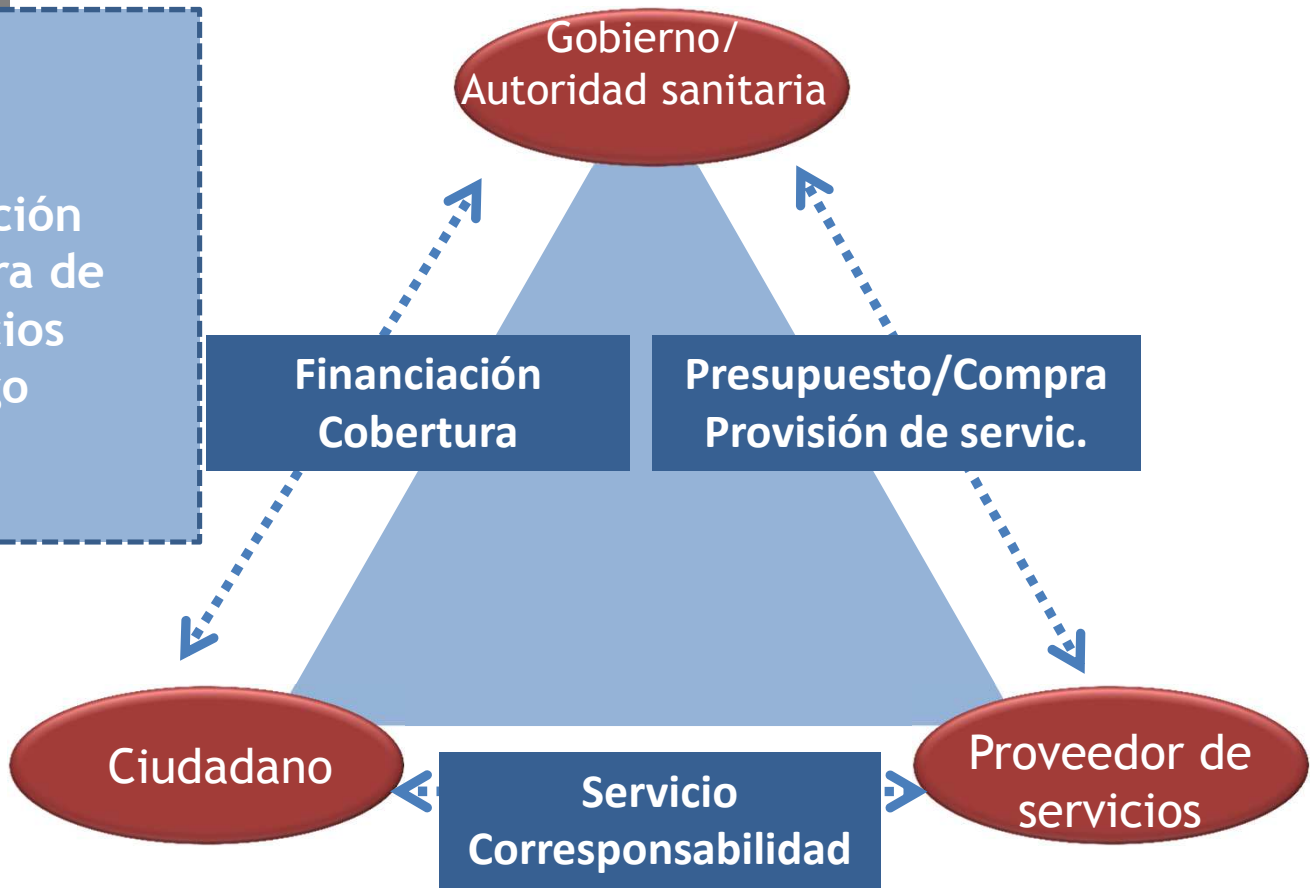
1. El modelo actual. Resultados. Sostenibilidad

2. Las Reformas estructurales

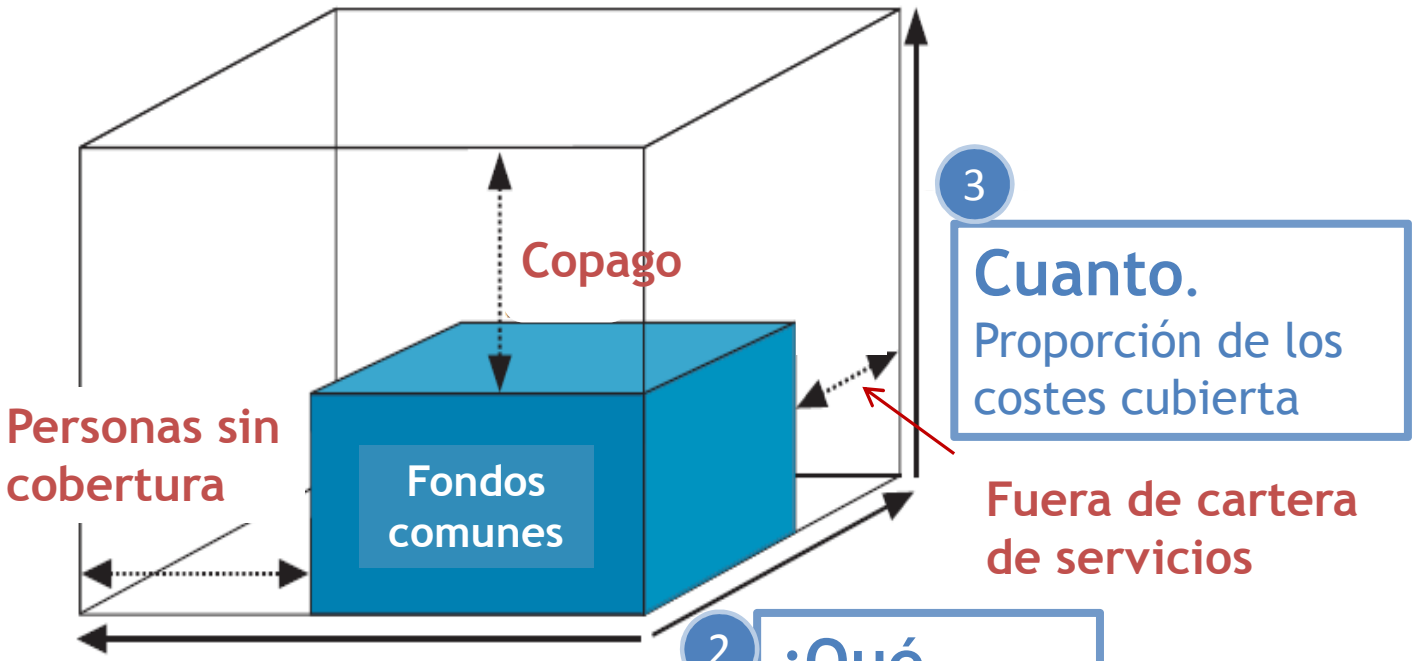
Reformas estructurales

MACRO

- ✓ **Cobertura**
  - **Población**
  - **Cartera de servicios**
  - **Copago**



Cobertura

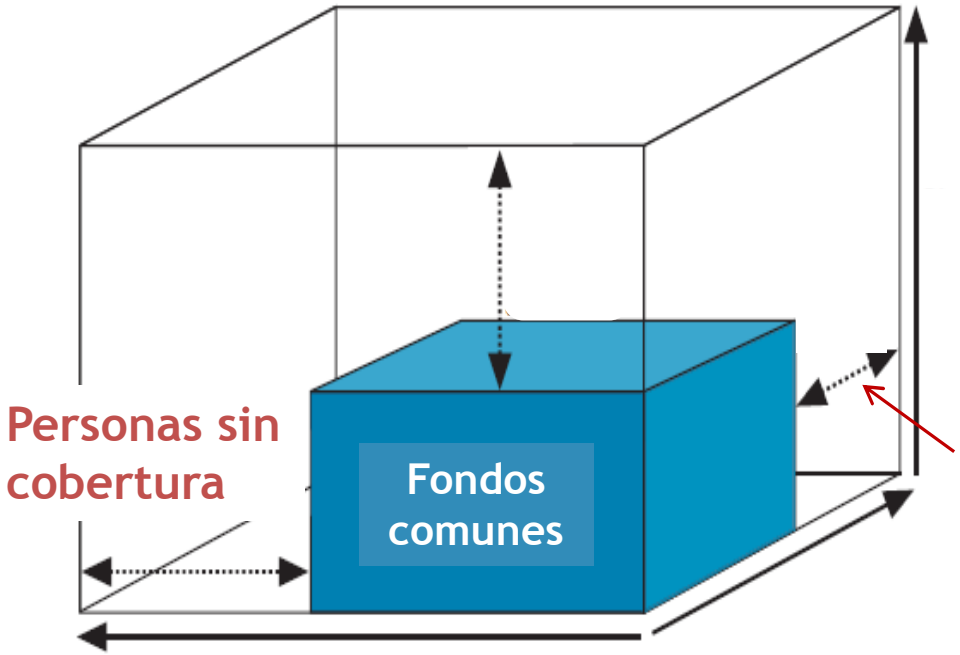


3 **Cuanto.** Proporción de los costes cubierta

1 **¿Quién** está cubierto?

2 **¿Qué** cartera de servicios se cubre?

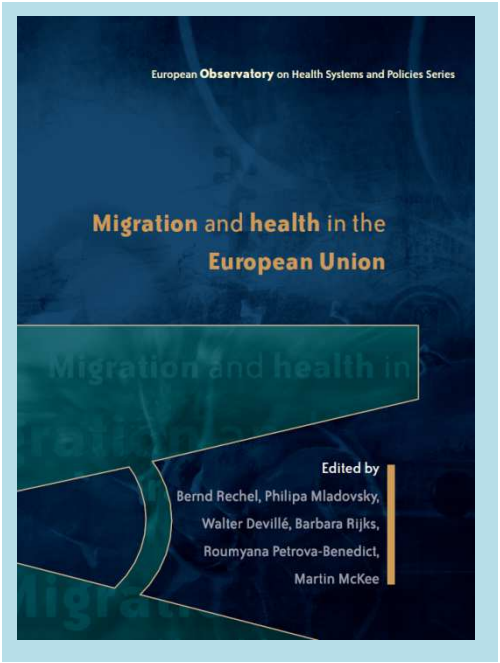
Cobertura



1 **¿Quién** está cubierto?

Población cubierta

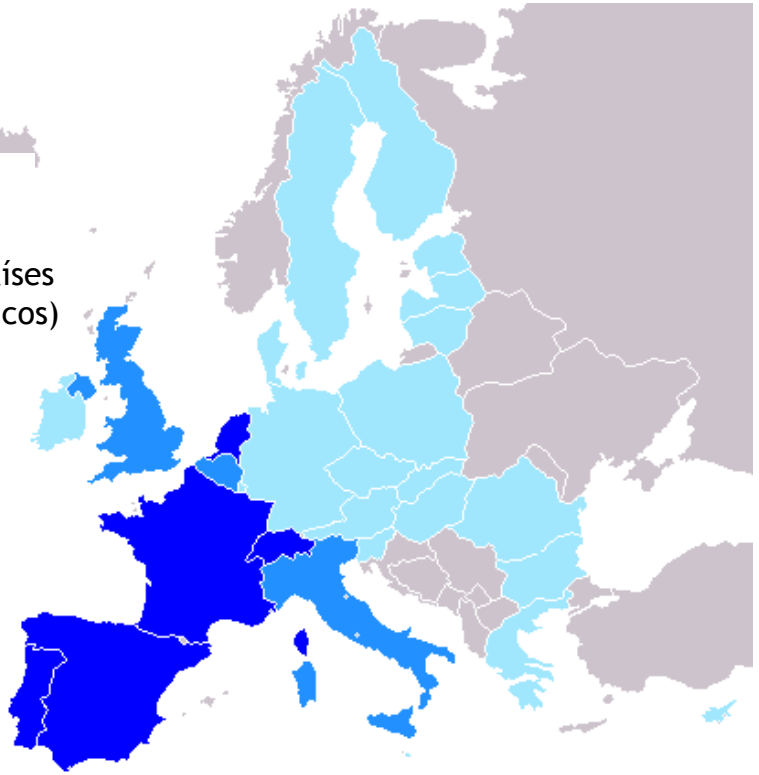
Acceso de los inmigrantes sin documentación a los servicios de salud



Acceso total
(Suiza, España, Francia, Holanda y Portugal)

Acceso parcial
(Bélgica, Italia, Reino Unido)

Ningún acceso
(Europa Central y del Este, Países Bajos, Nordicos y Países Bálticos)

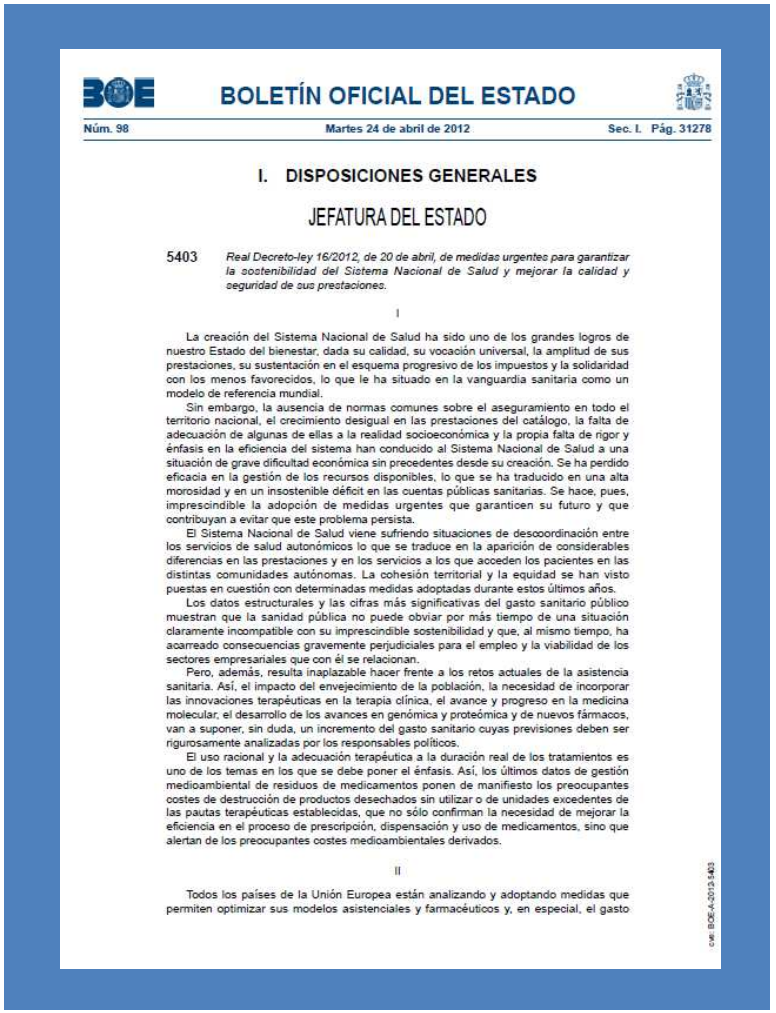


* Austria, Bulgaria, Chipre, República Checa, Dinamarca, Estonia, Finlandia, Alemania, Grecia, Hungría, Irlanda, Letonia, Lituania, Luxemburgo, Malta, Polonia, Rumanía, Eslovaquia, Eslovenia, Suecia

Fuente: Migration and health in the European Union, 2010. European Observatory on Health Systems and Policies

Cambio en los requisitos de cobertura

Real decreto ley 16/2012, de 20 de abril, de medidas urgentes para garantizar la sostenibilidad del Sistema nacional de Salud y mejorar así la calidad/seguridad de las prestaciones.



BOLETÍN OFICIAL DEL ESTADO
Núm. 98 Martes 24 de abril de 2012 Sec. I. Pág. 31278

I. DISPOSICIONES GENERALES

JEFATURA DEL ESTADO

5403 *Real Decreto-ley 16/2012, de 20 de abril, de medidas urgentes para garantizar la sostenibilidad del Sistema Nacional de Salud y mejorar la calidad y seguridad de sus prestaciones.*

I

La creación del Sistema Nacional de Salud ha sido uno de los grandes logros de nuestro Estado del bienestar, dada su calidad, su vocación universal, la amplitud de sus prestaciones, su sustentación en el esquema progresivo de los impuestos y la solidaridad con los menos favorecidos, lo que le ha situado en la vanguardia sanitaria como un modelo de referencia mundial.

Sin embargo, la ausencia de normas comunes sobre el aseguramiento en todo el territorio nacional, el crecimiento desigual en las prestaciones del catálogo, la falta de adecuación de algunas de ellas a la realidad socioeconómica y la propia falta de rigor y énfasis en la eficiencia del sistema han conducido al Sistema Nacional de Salud a una situación de grave dificultad económica sin precedentes desde su creación. Se ha perdido eficacia en la gestión de los recursos disponibles, lo que se ha traducido en una alta morosidad y en un insostenible déficit en las cuentas públicas sanitarias. Se hace, pues, imprescindible la adopción de medidas urgentes que garanticen su futuro y que contribuyan a evitar que este problema persista.

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Los datos estructurales y las cifras más significativas del gasto sanitario público muestran que la sanidad pública no puede obviar por más tiempo de una situación claramente incompatible con su imprescindible sostenibilidad y que, al mismo tiempo, ha acarreado consecuencias gravemente perjudiciales para el empleo y la viabilidad de los sectores empresariales que con él se relacionan.

Pero, además, resulta inaplazable hacer frente a los retos actuales de la asistencia sanitaria. Así, el impacto del envejecimiento de la población, la necesidad de incorporar las innovaciones terapéuticas en la terapia clínica, el avance y progreso en la medicina molecular, el desarrollo de los avances en genómica y proteómica y de nuevos fármacos, van a suponer, sin duda, un incremento del gasto sanitario cuyas previsiones deben ser rigurosamente analizadas por los responsables políticos.

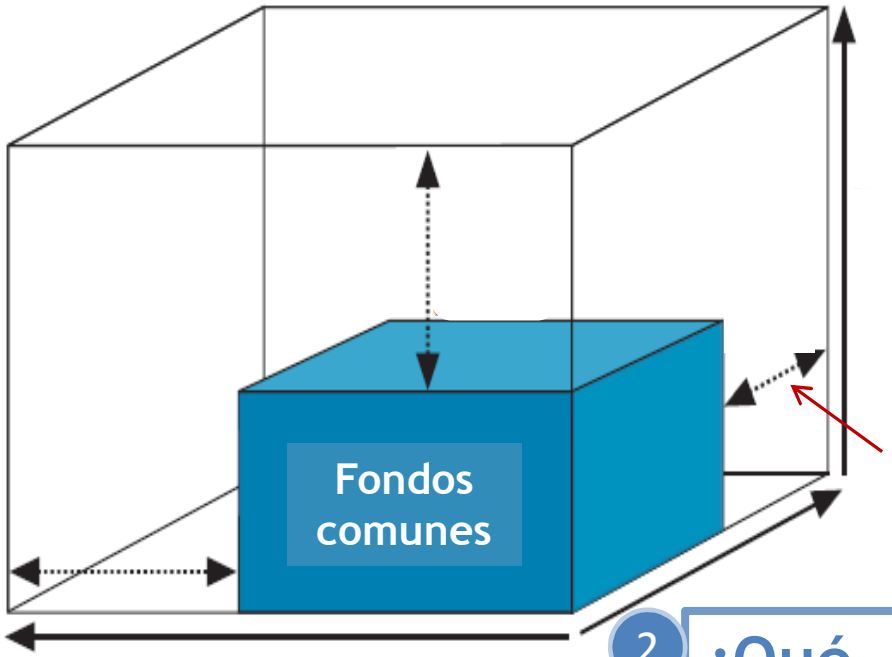
El uso racional y la adecuación terapéutica a la duración real de los tratamientos es uno de los temas en los que se debe poner el énfasis. Así, los últimos datos de gestión medioambiental de residuos de medicamentos ponen de manifiesto los preocupantes costes de destrucción de productos desechados sin utilizar o de unidades excedentes de las pautas terapéuticas establecidas, que no sólo confirman la necesidad de mejorar la eficiencia en el proceso de prescripción, dispensación y uso de medicamentos, sino que alertan de los preocupantes costes medioambientales derivados.

II

Todos los países de la Unión Europea están analizando y adoptando medidas que permiten optimizar sus modelos asistenciales y farmacéuticos y, en especial, el gasto

cve: BOE-A-2012-5403

Cobertura



Fuera de cartera de servicios

2 **¿Qué** cartera de servicios se cubre?

Cartera de servicios

Nivel de cartera de servicios

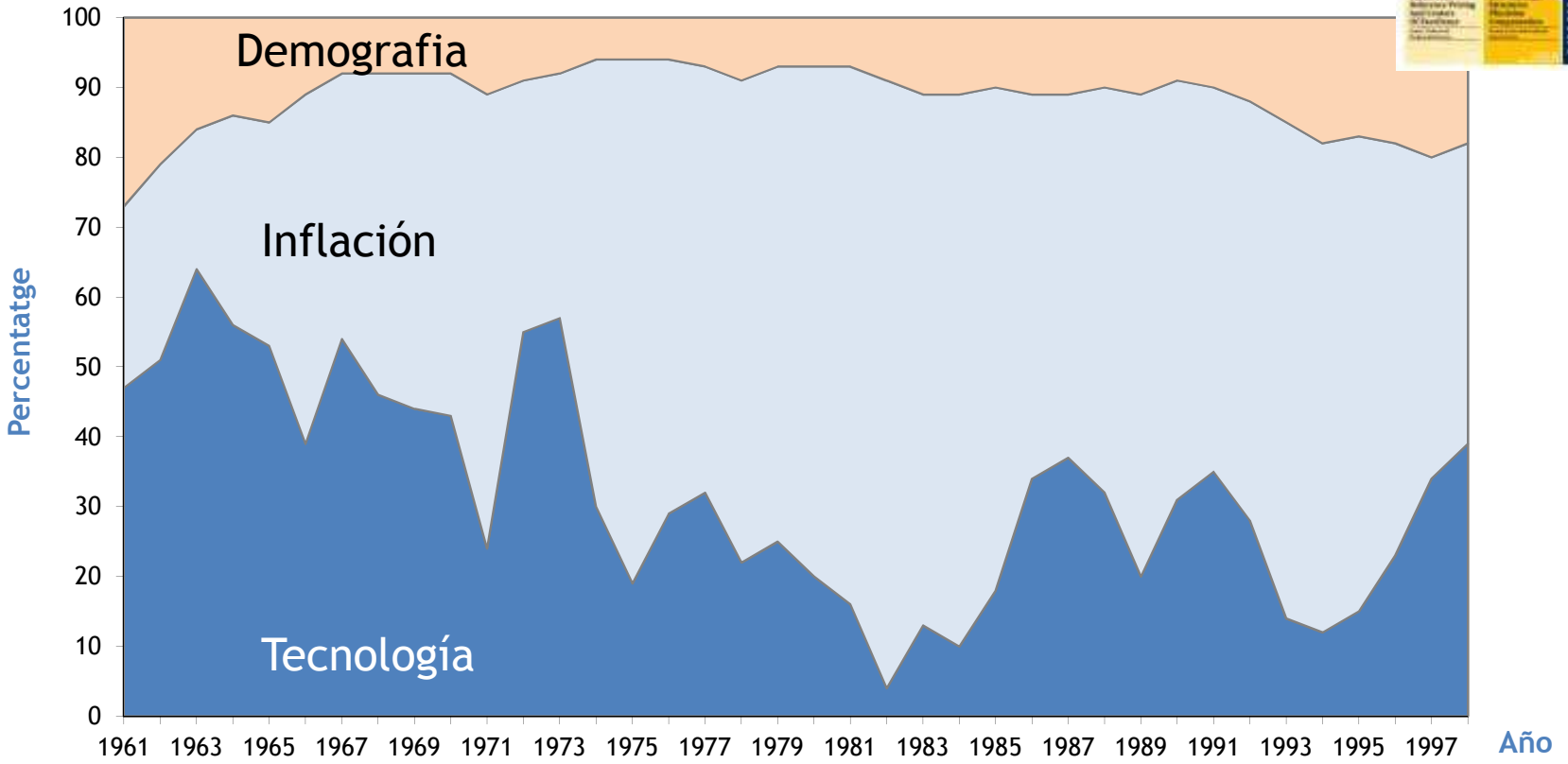
Problema: Incorporación nuevas tecnologías

* Prótesis, Sillas de ruedas,..

Nuevas tecnologías: 33% -50% del incremento del gasto sanitario

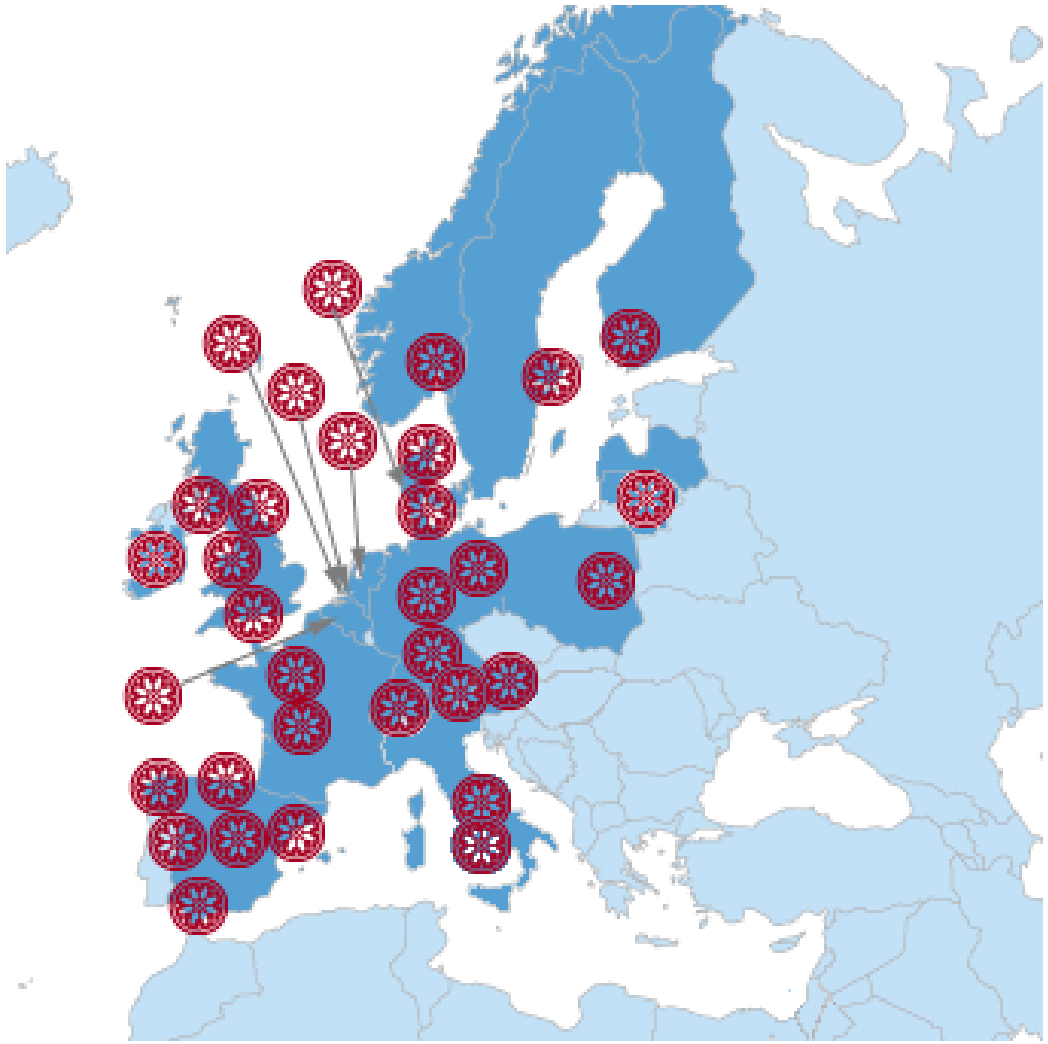
HealthAffairs

Porcentaje de los componentes que explican el incremento de gasto sanitario (Health Affairs 2001)



Fuente: *Mohr PE, Mueller C et al. The impact of Medical Technogy on Future Health Care Cost. The projet Hope Center fo Health Affairs.* 2001

Agencia de evaluación de Europa*



País	Agencia
Austria	GOG
	LBI-HTA
Belgium	KCE
Denmark	DACEHTA
	DSI
	HTA-HSR/DHTA
Finland	FinOHTA
France	CEDIT
	HAS
Germany	DAHTA @ DIMDI
	G-ba
	IQWiG
International	INAHTA
Ireland	HIQA
Italy	Age.Na.S
	UVT - HTA Unit
Lithuania	VASPVT
Norway	NOKC
Poland	AHTAPol
Spain	AETS
	AETSA
	AVALIA-T
	CAHIAQ
	OSTEBA
	UETS
Sweden	SBU
Switzerland	MTU-SFOPH
The Netherlands	CVZ
	GR
	ZonMw
United Kingdom	NICE
	CRD
	HIS
	NETSCC, HTA - NIHR
	NHSC

•Todos tienen excepto: República Checa, Luxemburgo, Turquia, República eslovaca
• Fuente: INAHTA

NICE, Reino Unido

NHS
National Institute for
Health and Clinical Excellence

1. Equipo de expertos independientes
2. Ámbito nacional
3. Caracter ejecutivo de las recomendaciones positivas
4. Recomendación negativa: decide el financiador

Metodologia:

QALY: cuantos meses o años de vida adicionales de calidad acceptable puede ganar una persona como reultado de un tratamiento.

£ por QALY: El coste de utilizar el medicamento para dar un año de la mejor calidad de vida disponible

Cost	
< 20.000 £/año	Suele recomendarse
> 20.000 £/año	Se tienen en cuanta otros factores
> 30.000 £/año	Aprobación excepcional

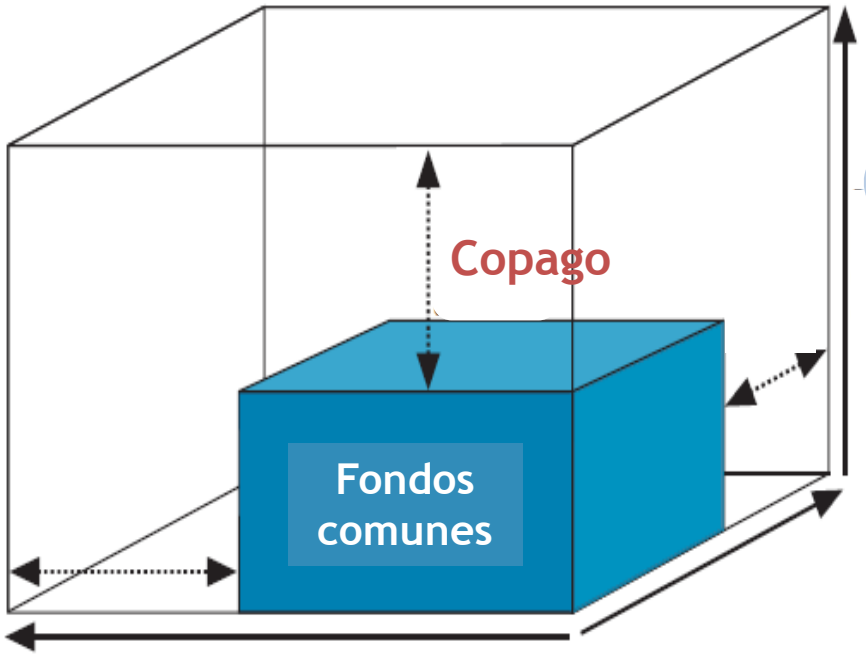
Agencia de evaluación en España

- ✓8 agencias
- ✓Decisiones no vinculantes
- ✓No criterios coste-efectividad
- ✓Orientadas a medicamentos

Agencia de Evaluación Tecnológicas Sanitarias de España

Fuente: Sostenibilidad Financia del sistema Nacional de salud. Antares Consulting.

Tres dimensiones a considerar en la cobertura



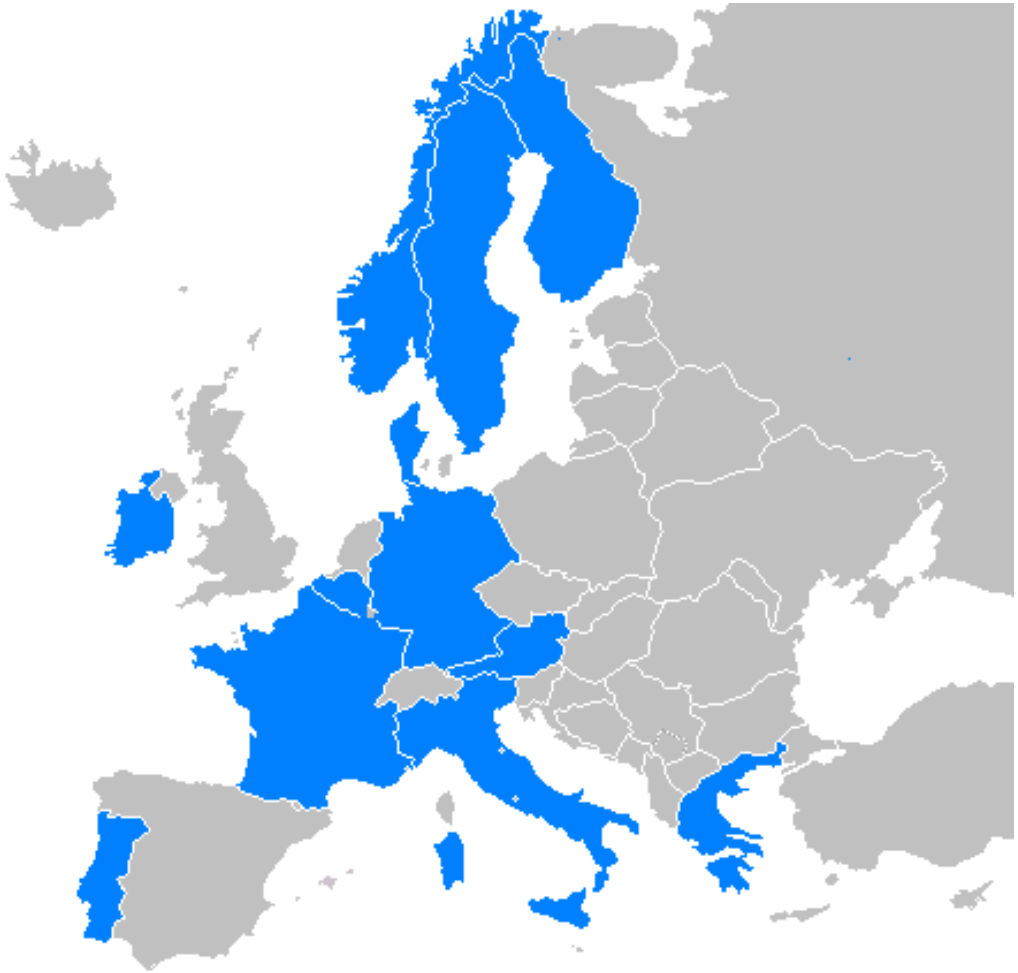
3

Proporción de los costes cubiertos

Copago

3 España: No copago en la atención sanitaria

- ✓Europa: copago habitual
- ✓España: no copago



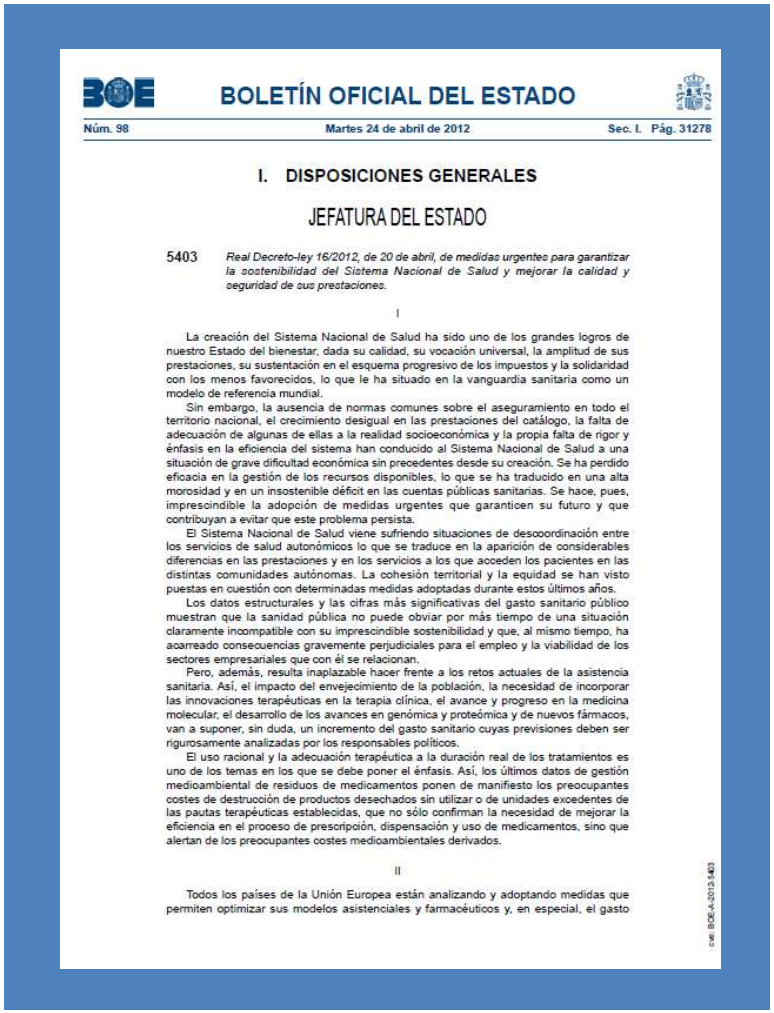
Países con copago en atención sanitaria

Copago en la atención sanitaria en Europa

Copago en los principales países europeos

	Primaria y especializada	Hospitalización	Medicamentos	Bucodental
Suecia	✓	✓	✓	✓
Dinamarca	✓	✓	✓	✓
Francia	✓	✓	✓	✓
Alemania	✓	✓	✓	✓
Austria	✓	✓	✓	✓
Belgica	✓	✓	✓	✓
Finlandia	✓	✓	✓	✓
Irlanda	✓	✓	✓	✓
Luxemburgo	✓	✓	✓	✓
Portugal	✓	✓	✓	✓
Grecia	✓	✗	✓	✓
Italia	✓	✗	✓	✓
España	✗	✗	✓	✓
UK	✗	✗	✓	✓

España: RD 16/2012 de 20 de abril



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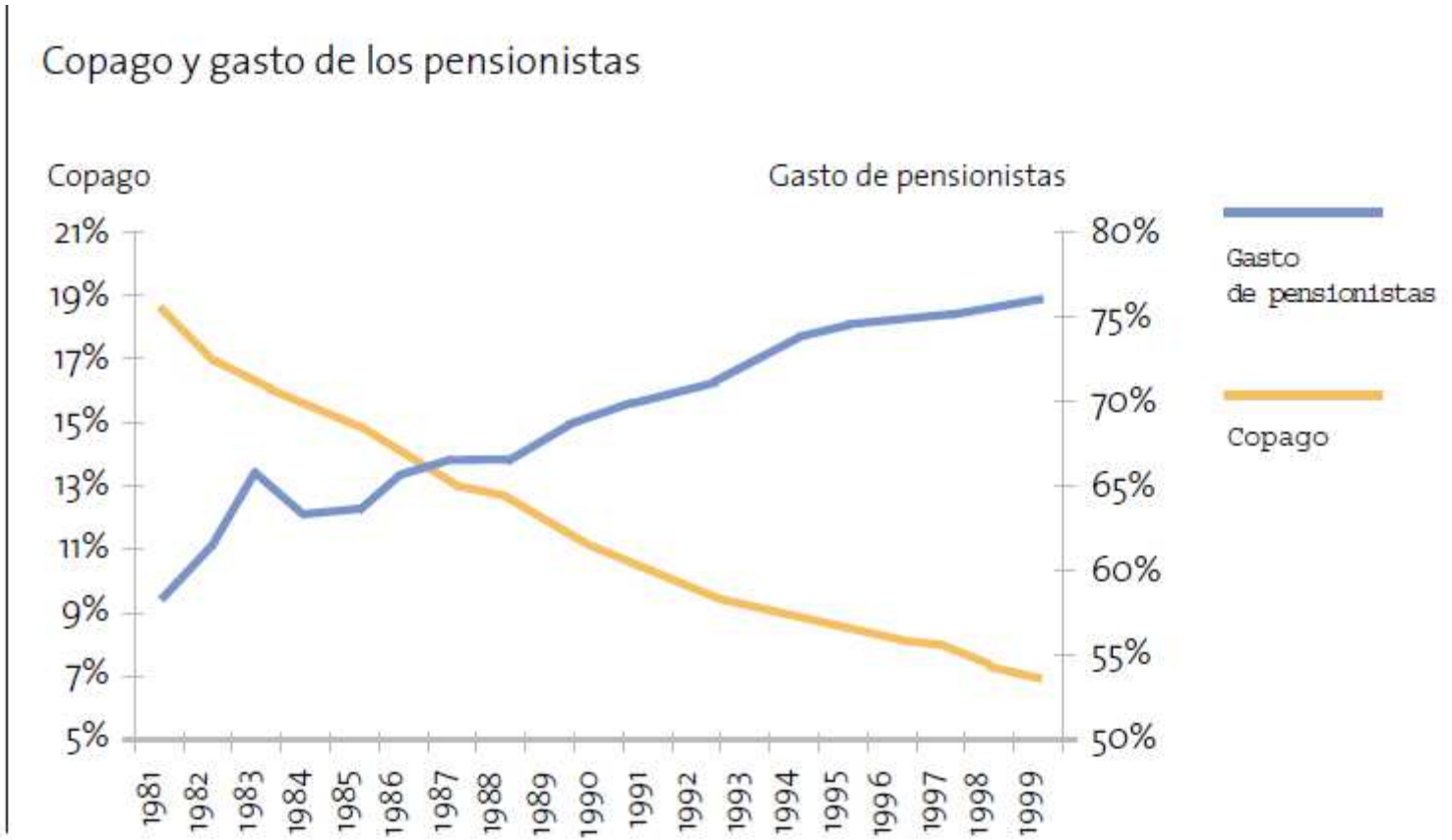
cve: BOE-A-2012-5403

Aumento del copago

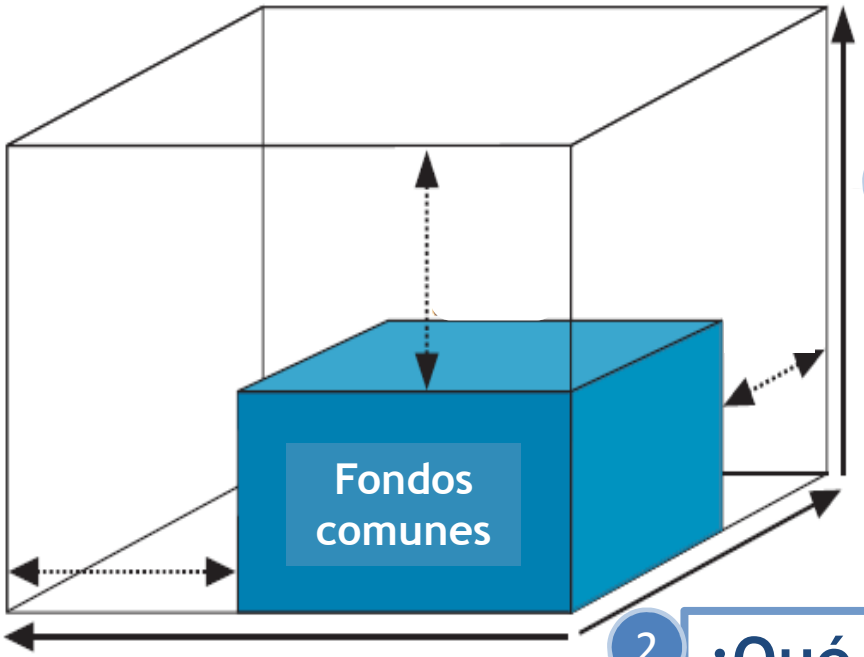
España: Copago en farmacia.
Disminución contribución efectiva en fármacos

Incremento del gasto en farmacia y aumento progresivo de la parte gratuita



Fuente: La industria farmacéutica en cifras. Informe NERA: Farmaindustria

Cobertura



3

Cuanto.
Proporción de los costes cubierta

1

¿Quién está cubierto?

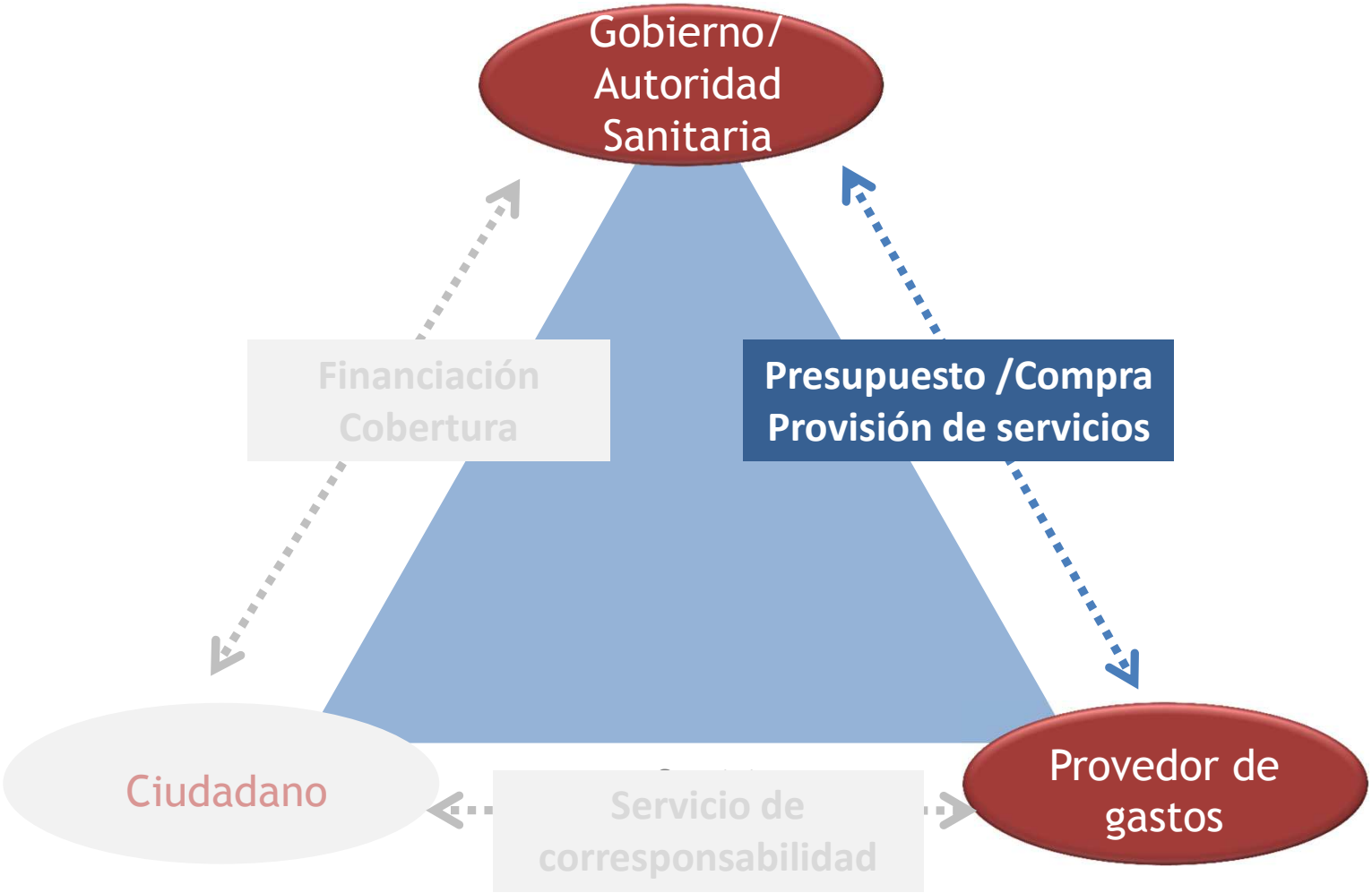
2

¿Qué cartera de servicios se cubre?

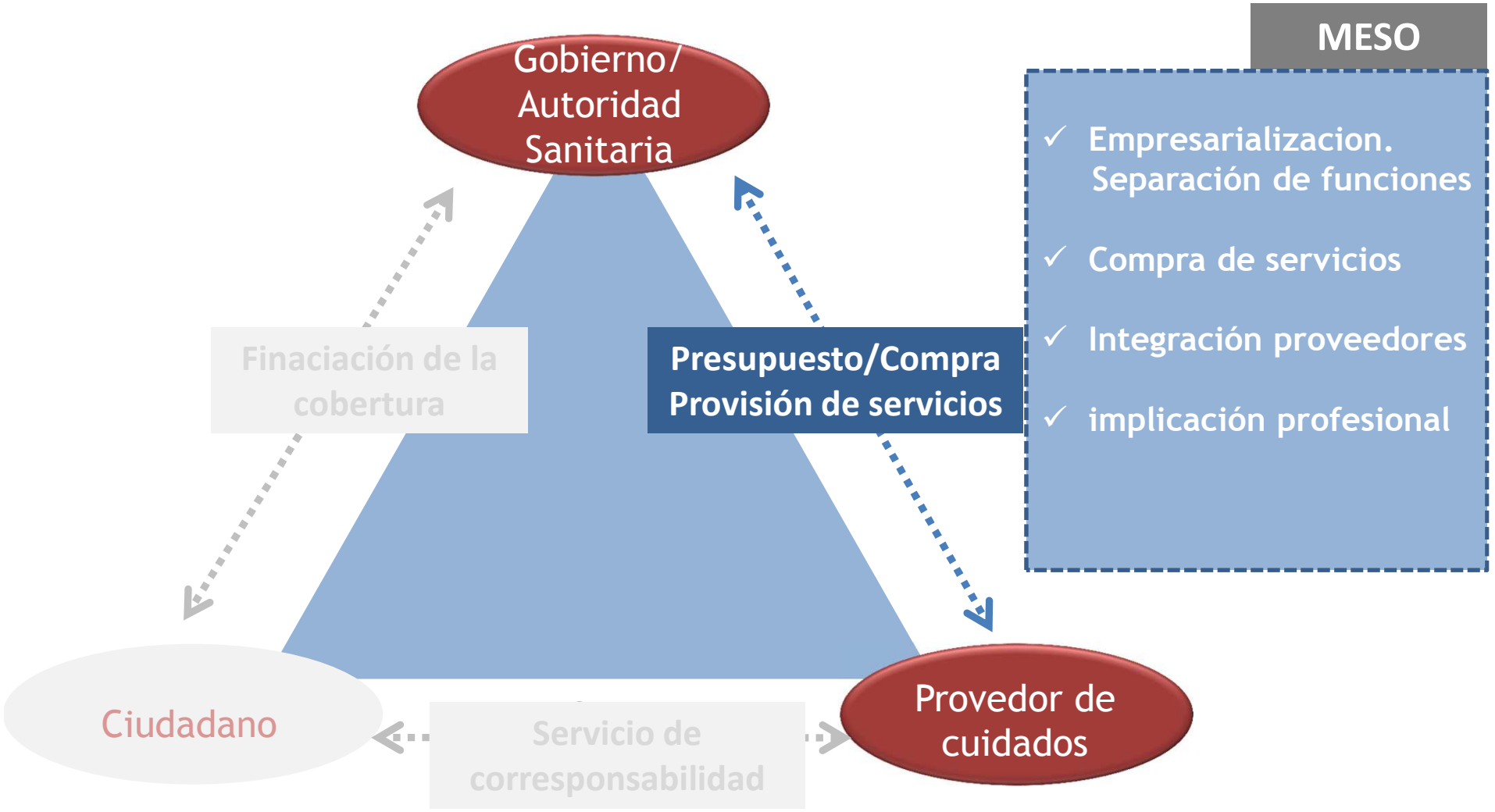
Cobertura


Gratuidad del servicio
Incremento costes nuevas tecnologías
Cartera ilimitada

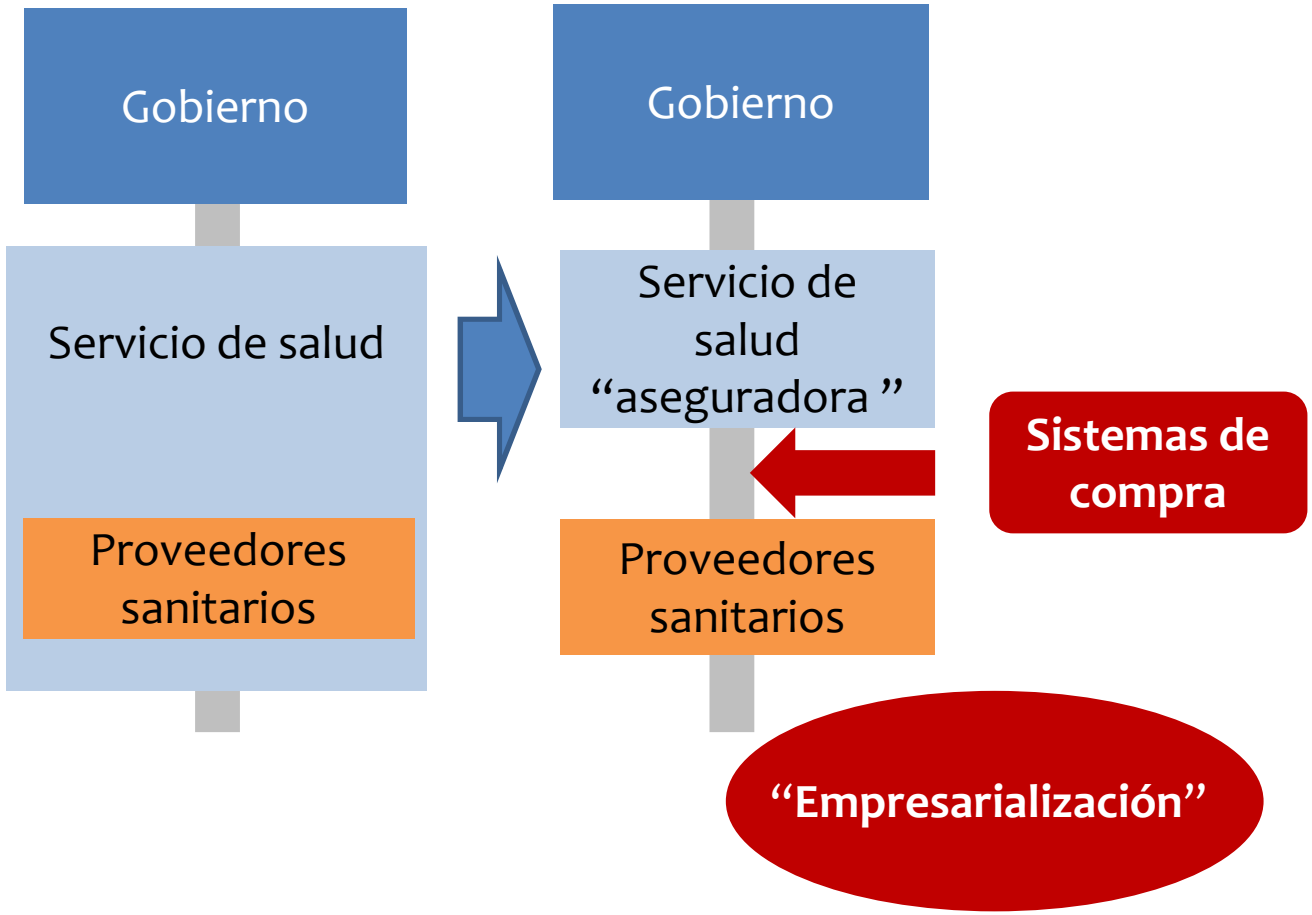
Áreas de actuación. Reformas



Áreas de actuación. Reformas

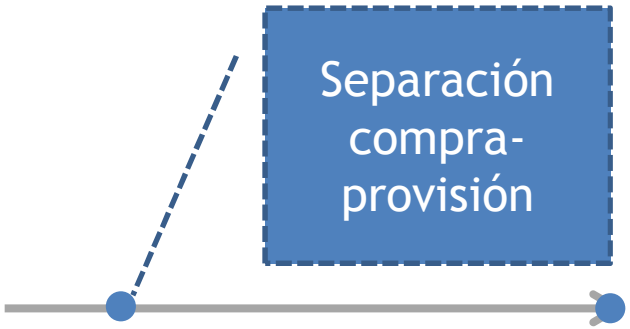


Sistemas de compra de servicios
Separación compra-provisión

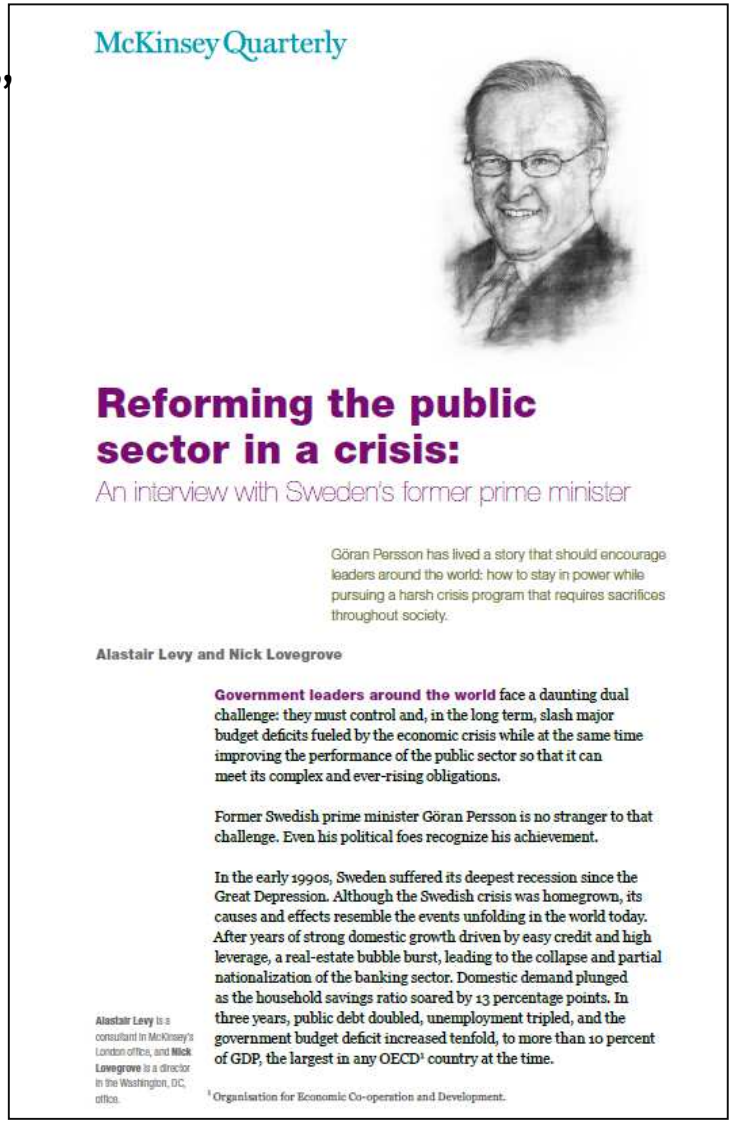


Separación de funciones/empresarialización

✓A partir de 1991 creación del “mercado Interno”
✓Introducción de la separación compra-provisión



Suecia
Finlandia
Nueva Zelanda
UK
Francia
Noruega
España (informe Abril)



McKinsey Quarterly

Reforming the public sector in a crisis:

An interview with Sweden's former prime minister

Göran Persson has lived a story that should encourage leaders around the world: how to stay in power while pursuing a harsh crisis program that requires sacrifices throughout society.

Alastair Levy and Nick Lovegrove

Government leaders around the world face a daunting dual challenge: they must control and, in the long term, slash major budget deficits fueled by the economic crisis while at the same time improving the performance of the public sector so that it can meet its complex and ever-rising obligations.

Former Swedish prime minister Göran Persson is no stranger to that challenge. Even his political foes recognize his achievement.

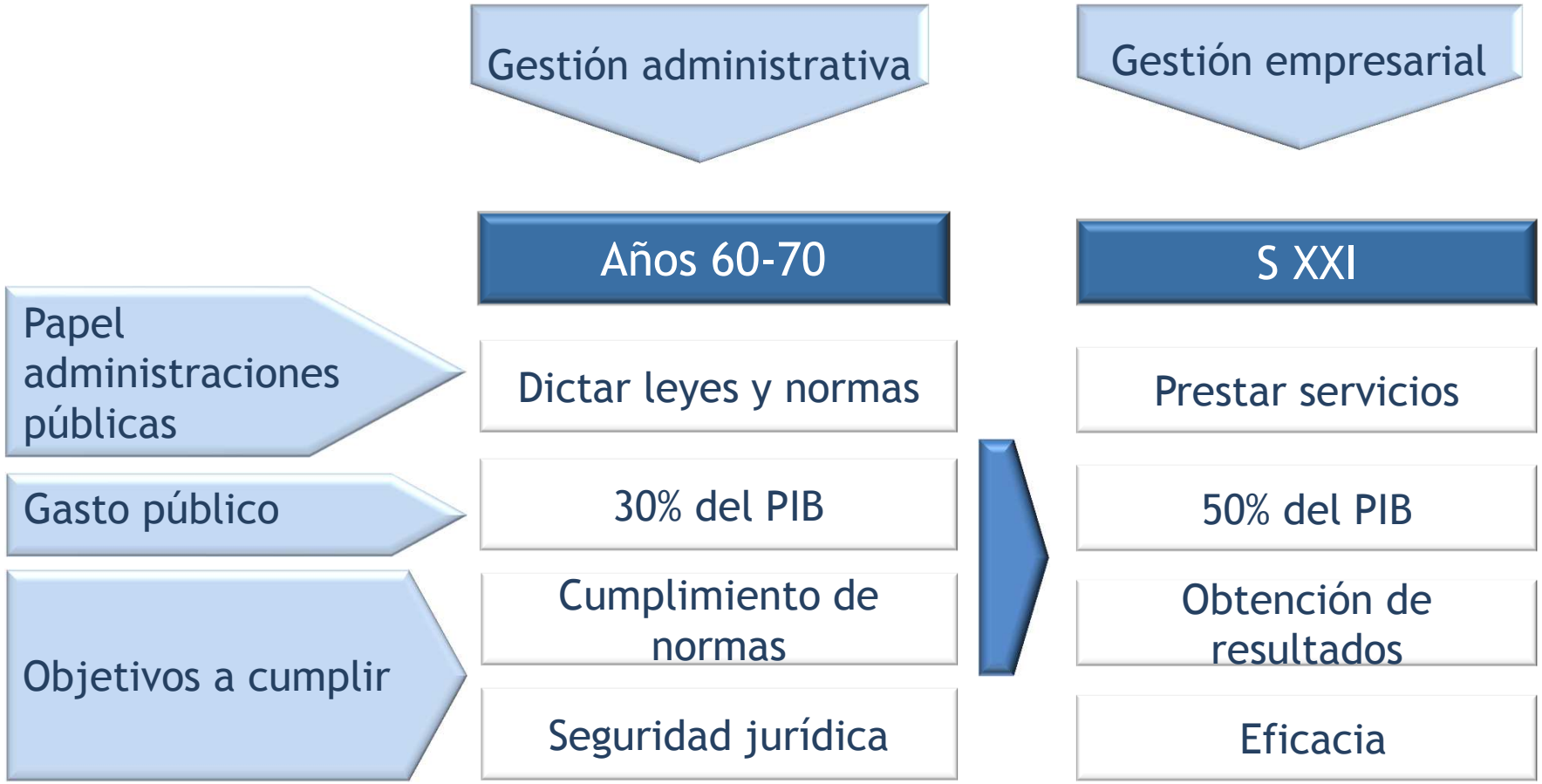
In the early 1990s, Sweden suffered its deepest recession since the Great Depression. Although the Swedish crisis was homegrown, its causes and effects resemble the events unfolding in the world today. After years of strong domestic growth driven by easy credit and high leverage, a real-estate bubble burst, leading to the collapse and partial nationalization of the banking sector. Domestic demand plunged as the household savings ratio soared by 13 percentage points. In three years, public debt doubled, unemployment tripled, and the government budget deficit increased tenfold, to more than 10 percent of GDP, the largest in any OECD[1] country at the time.

Alastair Levy is a consultant in McKinsey's London office, and **Nick Lovegrove** is a director in the Washington, DC, office.

[1] Organisation for Economic Co-operation and Development.

Fuente: Financing Health Care in the European Union. Challenges and Policy Responses. European Observatory on Health Systems and Policies, 2009

La necesidad de la gestión pública empresarial



Formas de gestión pública

GESTIÓN DE SERVICIOS PÚBLICOS:

1. Gestión directa
   - •Gestión indiferenciada
   - •Servicio público personalitzado
   - •Sociedad pública mercantil
   - •Consorcio
   - •Fundación
2. Gestión indirecta
   - •Concierto
   - •Concesión
3. Gestión mixta
   - •Gestión interesada
   - •Sociedad de Economia Mixta

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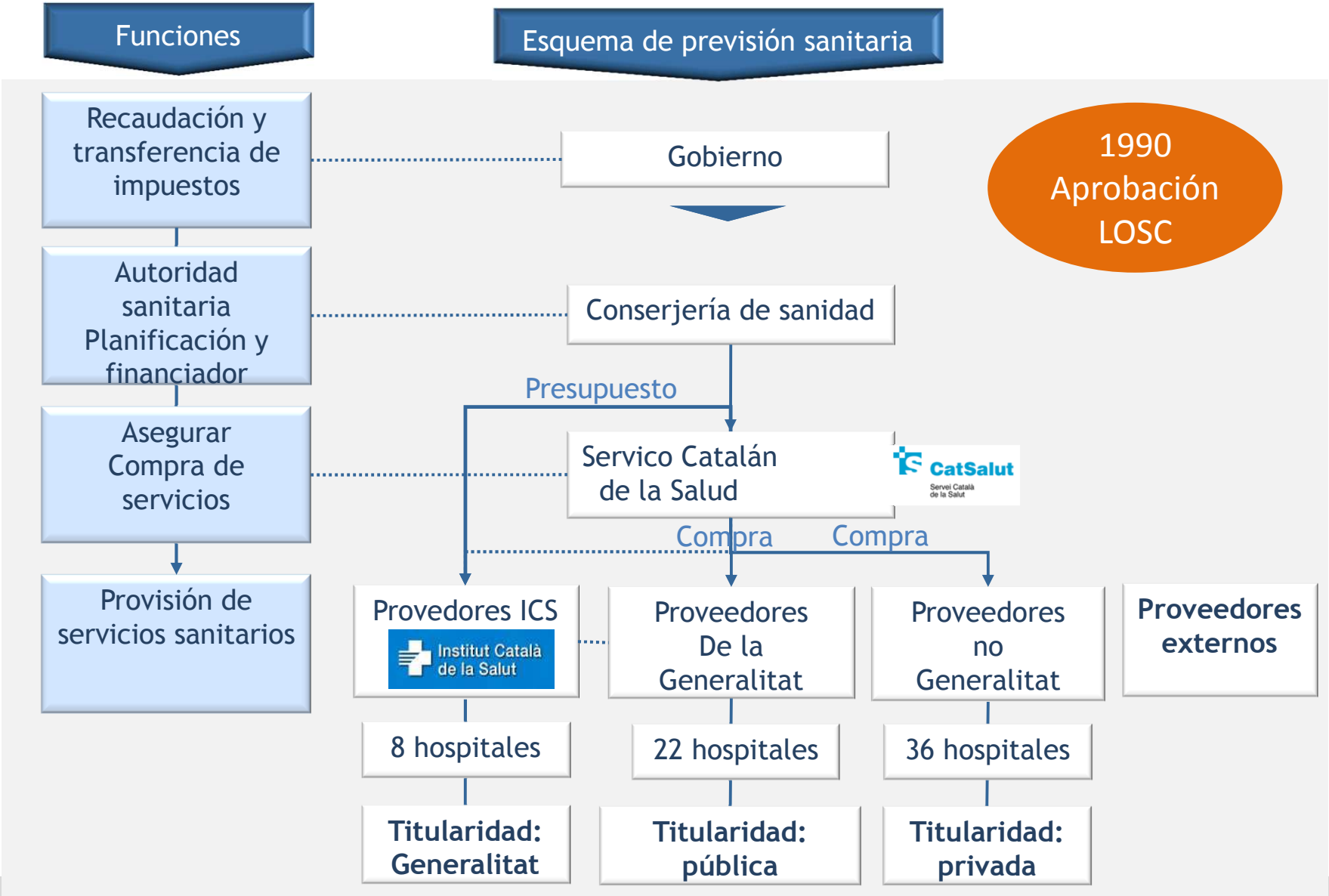
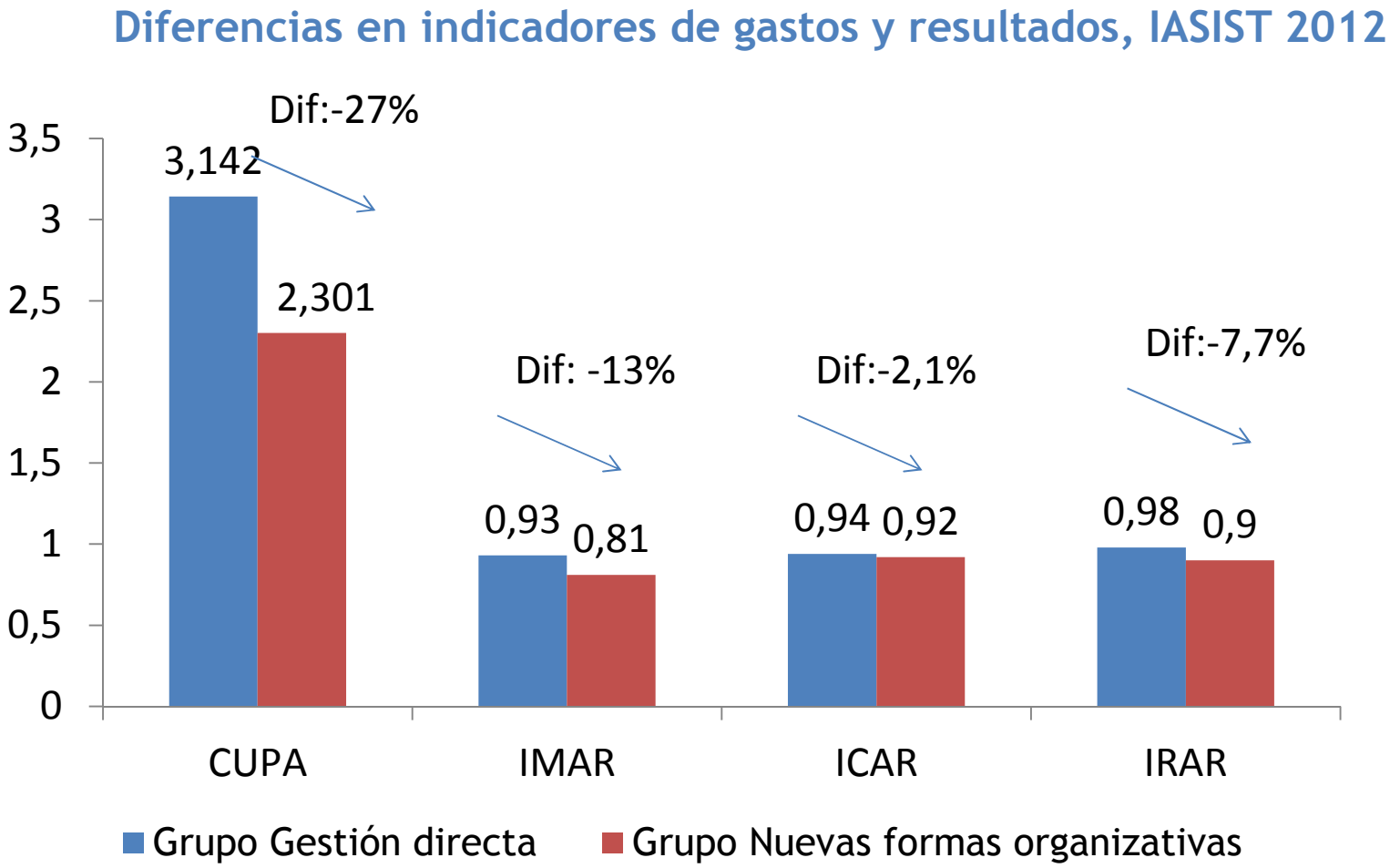
   - •Sociedad de Economia Mixta

Cataluña: Sistema de separación compra-provisión



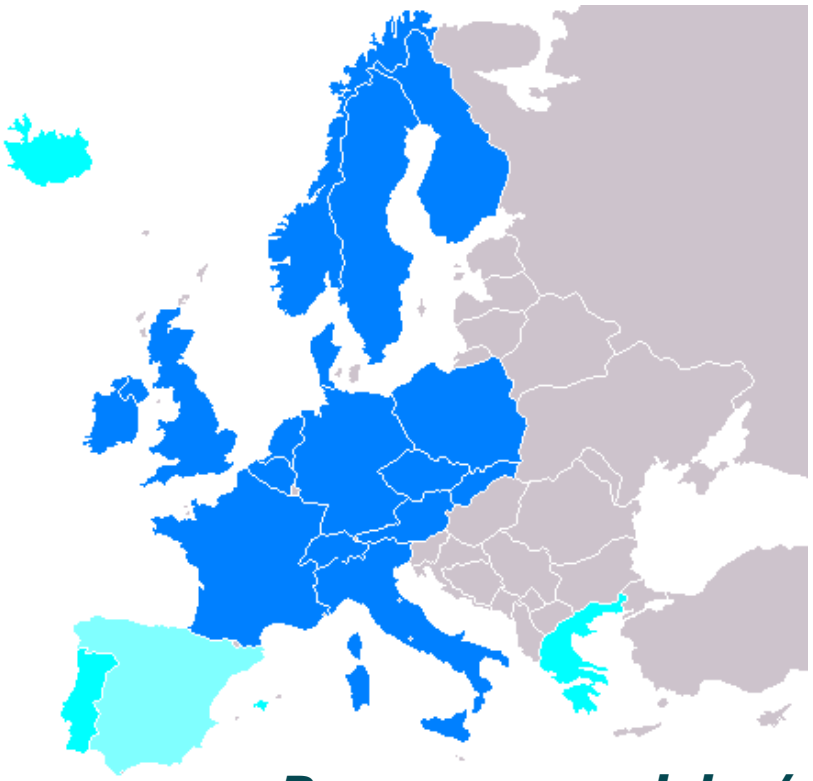
Diferencias en los resultados entre centros con la gestión directa y concertados



Fuente: Evaluación de resultados de los hospitales en España según su modelo de gestión. IASIST

Modelos de relación laboral en Atenció Primària

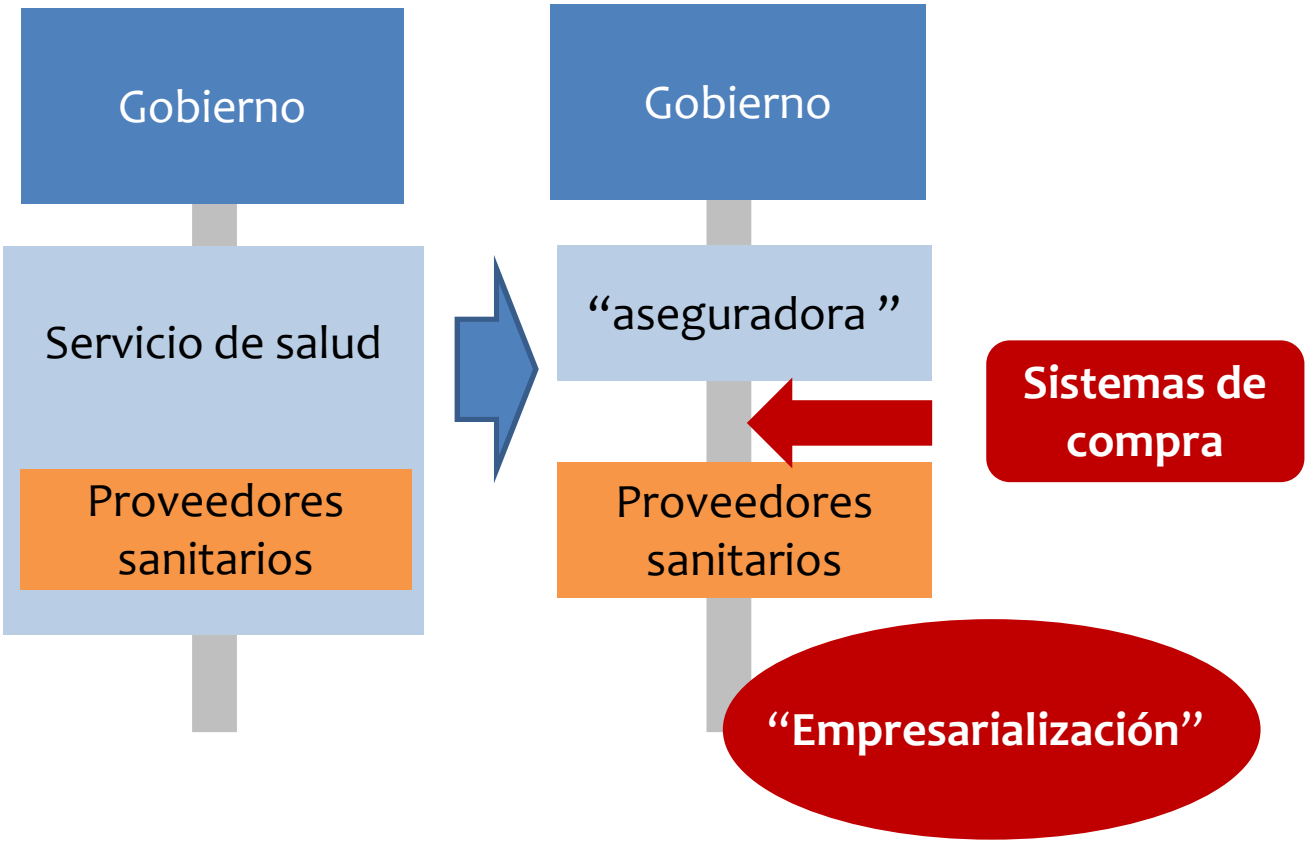
Sistema de retribución Atención Primaria (Sistema Público)	
Alemania	Pago por servicio
Austria	Pago capitativo
Bélgica	Pago por servicio
Holanda	Pago por servicio + Pago capitativo
Luxemburgo	Pago por servicio
Francia	Pago por servicio
Dinamarca	Pago capitativo + Pago por servicio
Eslovaquia	Pago capitativo
Irlanda	Pago capitativo + Pago por servicio
Italia	Pago capitativo
Noruega	Pago por servicio + pago capitativo
UK	Pago capitativo + Pago por servicio
Suiza	Pago por servicio
Polonia	Pago capitativo
Finlandia	Salario Pago capitativo
Suecia	Salario Pago capitativo
Portugal	Salario
España	Salario
Grecia	Salario
Islandia	Salario



Pago por servicio /cápita

Pago por salario

Sistemas de compra de servicios
Separación compra-provisión



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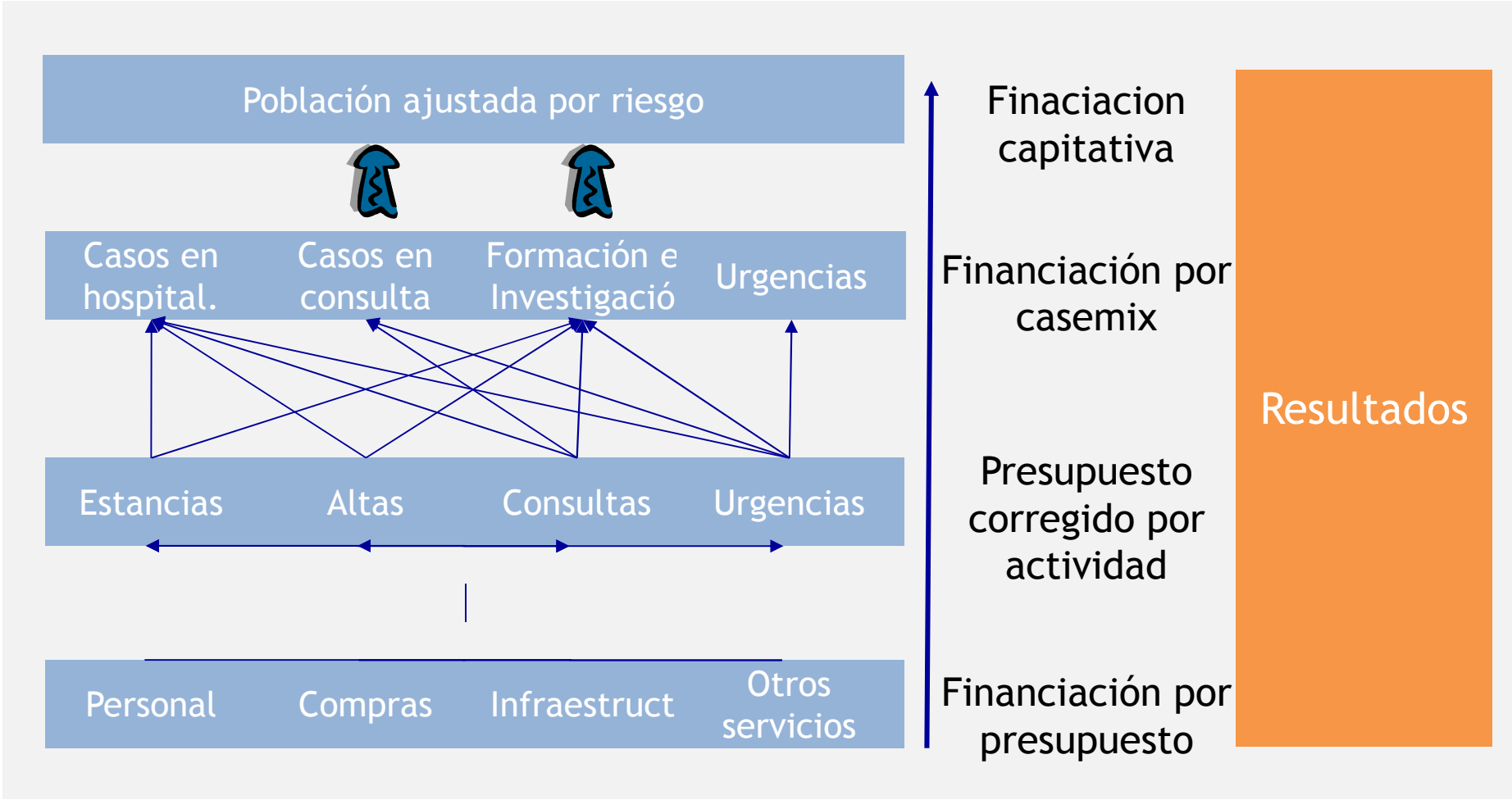
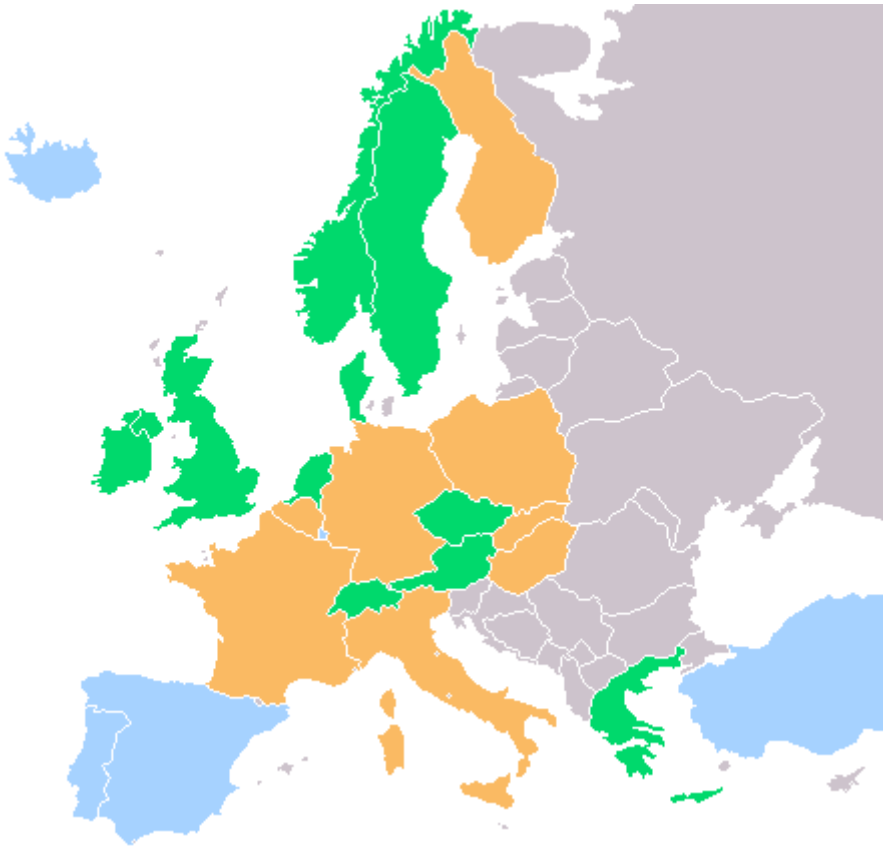


* Antares Consulting

Compra de servicios

Presupuesto	España Turquía Islandia Luxemburgo Portugal
Presupuesto más actividad	República Checa Dinamarca Irlanda Holanda Noruega UK Suecia Austria Grecia Suiza
Actividad	Bélgica Finlandia Francia Alemania Hungría Italia Polonia República Eslovaca

Formas de pago a proveedores europeos



** Health System Institutional Characteristics. A survey of 29 OECD countries. 2010.*

Tendencia actual: Introducción de resultados en los contratos con los centros sanitarios

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

Effects of Pay for Performance on the Quality of Primary Care in England

Stephen M. Campbell, Ph.D., David Reeves, Ph.D., Evangelos Kontopantelis, Ph.D., Bonnie Sibbald, Ph.D., and Martin Roland, D.M.

ABSTRACT

BACKGROUND
A pay-for-performance scheme based on meeting targets for the quality of clinical care was introduced to family practice in England in 2004.

METHODS
We conducted an interrupted time-series analysis of the quality of care in 42 representative family practices, with data collected at two time points before implementation of the scheme (1998 and 2003) and at two time points after implementation (2005 and 2007). At each time point, data on the care of patients with asthma, diabetes, or coronary heart disease were extracted from medical records; data on patients' perceptions of access to care, continuity of care, and interpersonal aspects of care were collected from questionnaires. The analysis included aspects of care that were and those that were not associated with incentives.

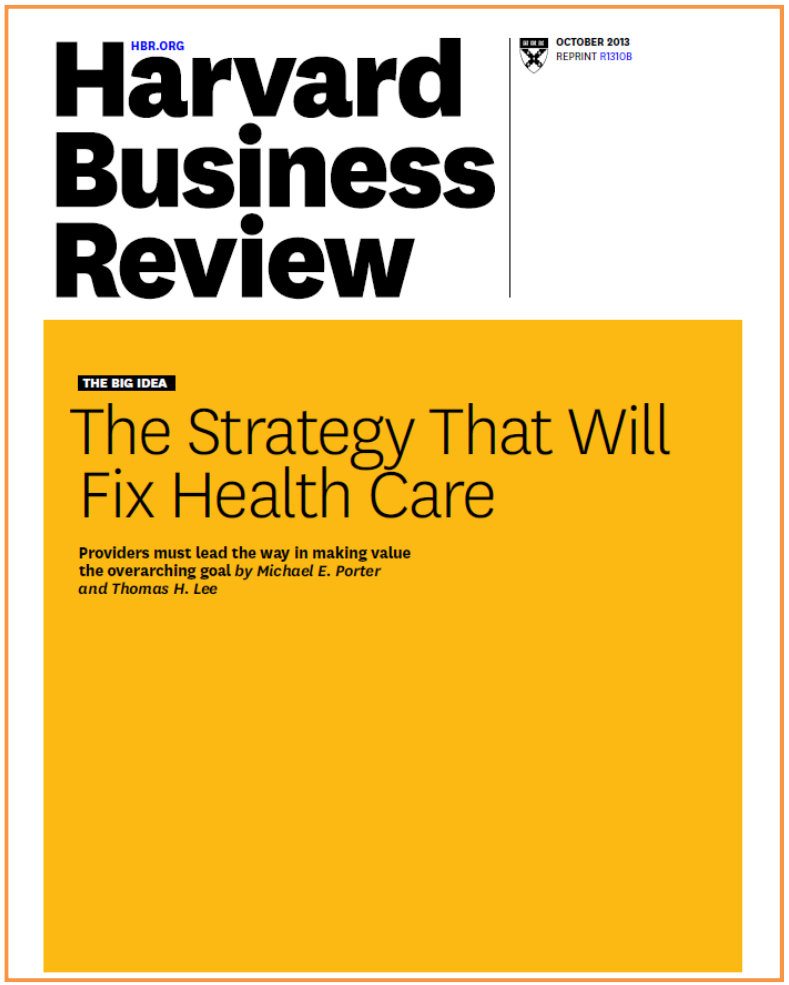
RESULTS
Between 2003 and 2005, the rate of improvement in the quality of care increased for asthma and diabetes (P<0.001) but not for heart disease. By 2007, the rate of improvement had slowed for all three conditions (P<0.001), and the quality of those aspects of care that were not associated with an incentive had declined for patients with asthma or heart disease. As compared with the period before the pay-for-performance scheme was introduced, the improvement rate after 2005 was unchanged for asthma or diabetes and was reduced for heart disease (P=0.02). No significant changes were seen in patients' reports on access to care or on interpersonal aspects of care. The level of the continuity of care, which had been constant, showed a reduction immediately after the introduction of the pay-for-performance scheme (P<0.001) and then continued at that reduced level.

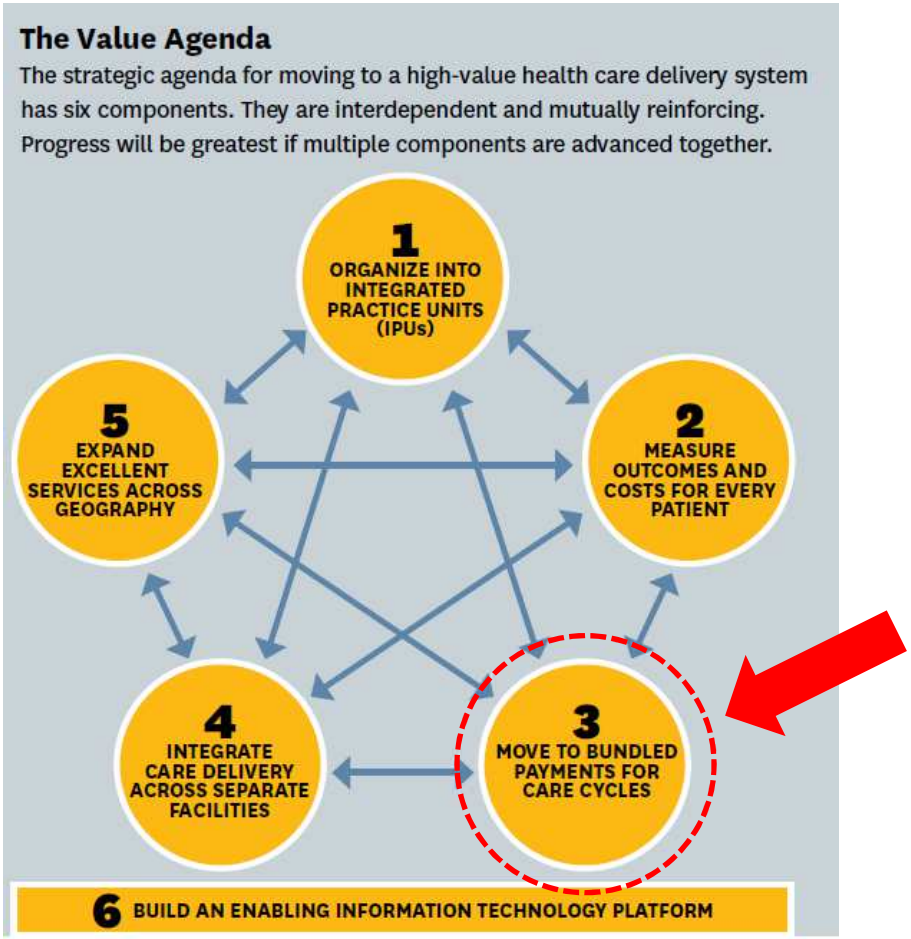
CONCLUSIONS
Against a background of increases in the quality of care before the pay-for-performance scheme was introduced, the scheme accelerated improvements in quality for two of three chronic conditions in the short term. However, once targets were reached, the improvement in the quality of care for patients with these conditions slowed, and the quality of care declined for two conditions that had not been linked to incentives. Continuity of care was reduced after the introduction of the scheme.

El nuevo esquema **aceleró las mejoras** de indicadores para dos o tres condiciones crónicas **a corto plazo**

No obstante**, a medio plazo,** la **mejora** de los indicadores **disminuyó** así como los indicadores de **otras patologias** que no se habían ligado a objetivos.

Compra de servicios

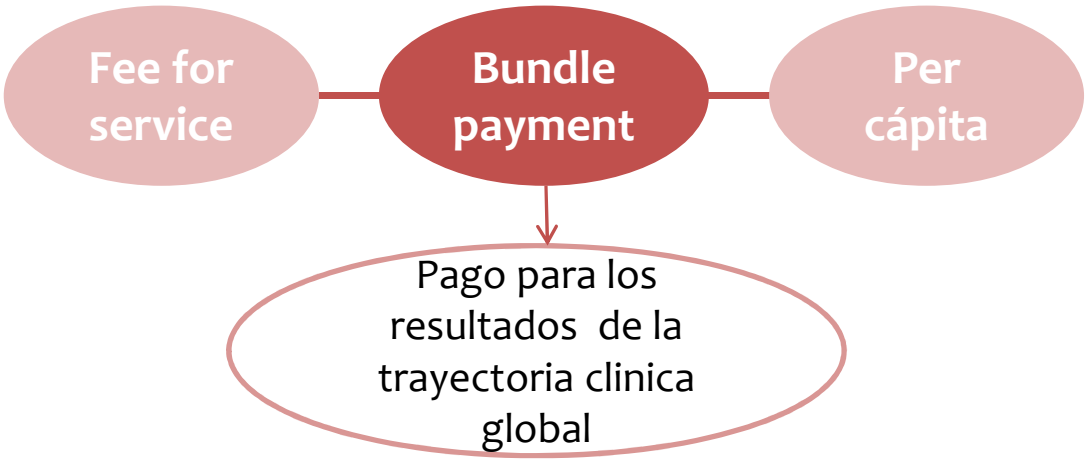




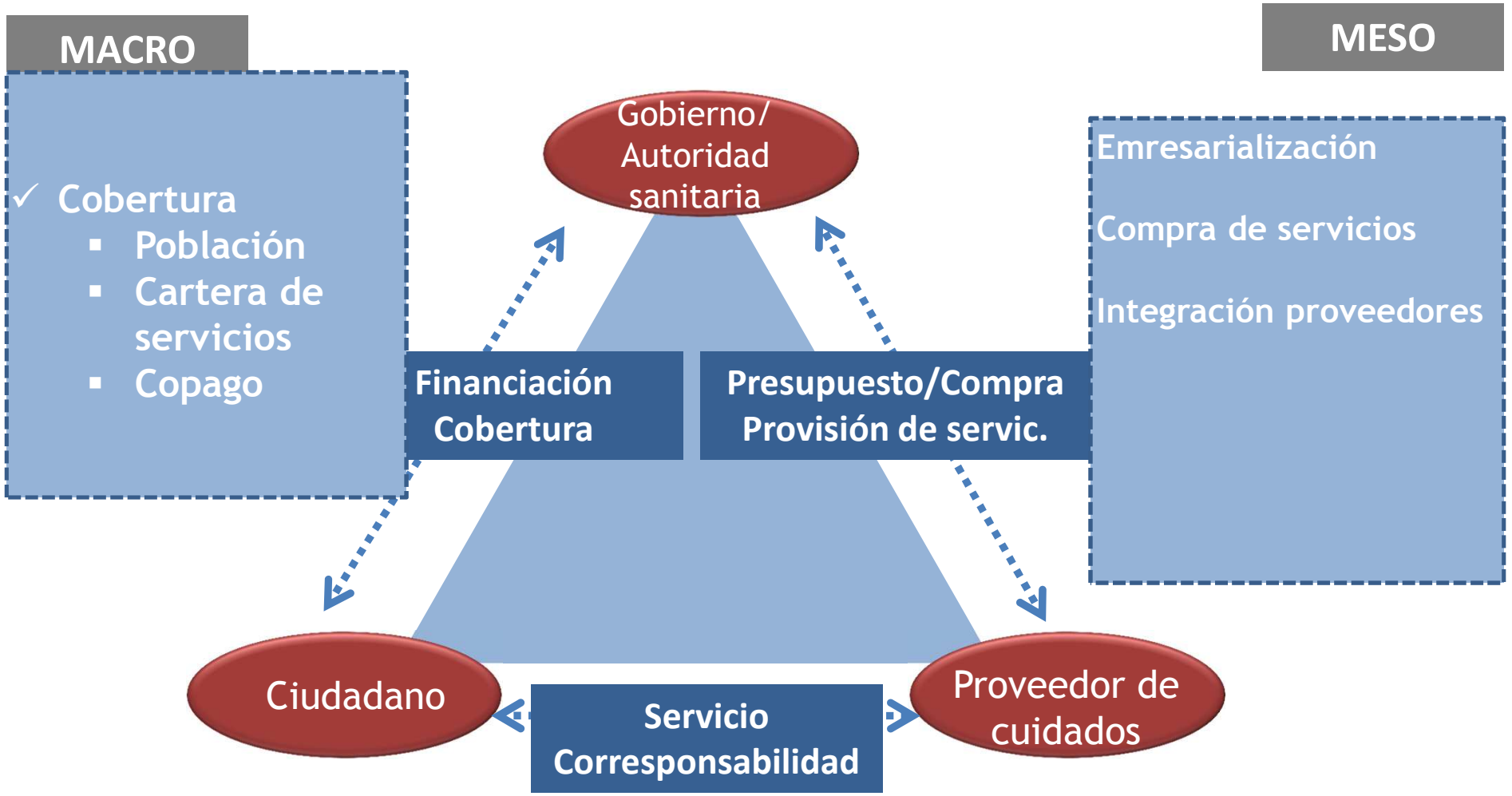
Compra de servicios- Bundle payment

"Bundle payment" (USA). Affordable care act. 2010

Reembolso **"en base a los costes previstos para episodios de cuidados claramente definidos"**



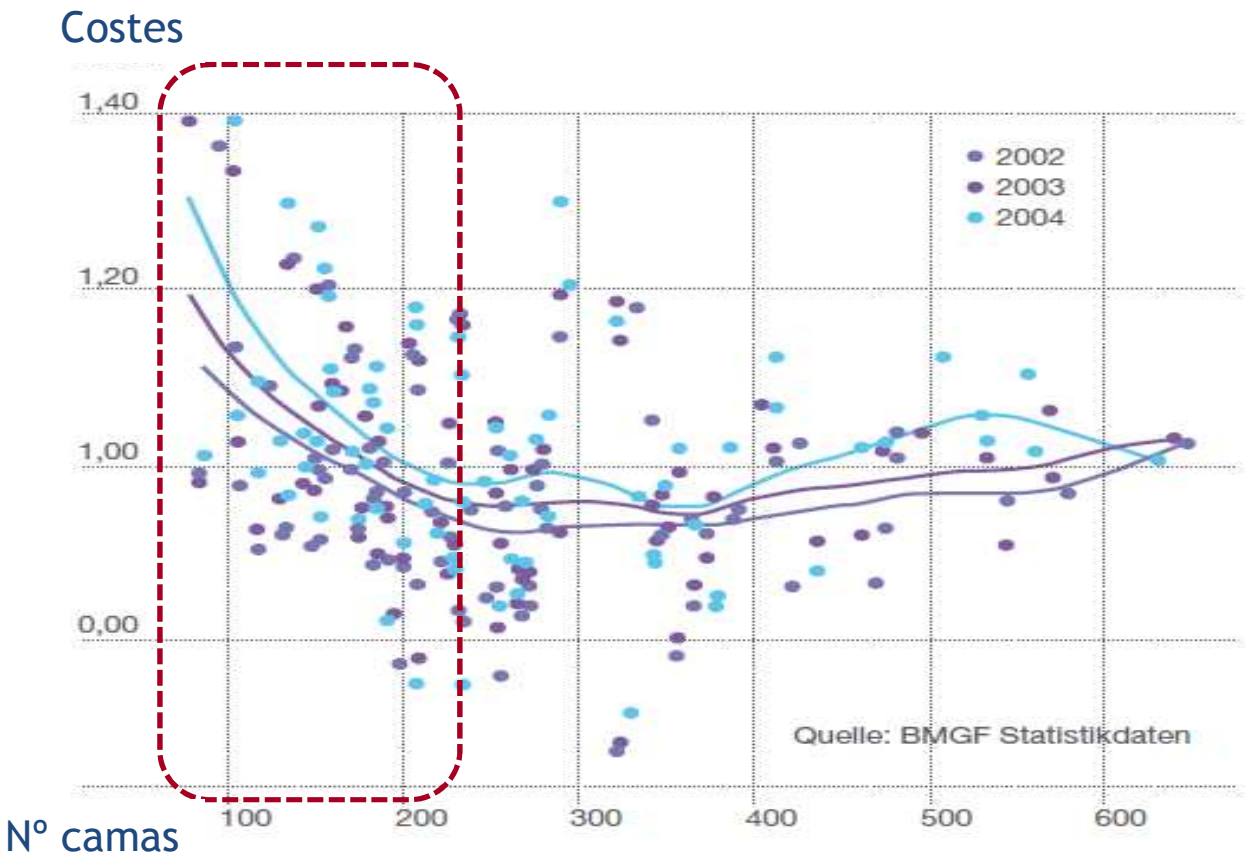
Reformas estructurales y barreras



Integración horizontal

Aumento del coste medio al disminuir el tamaño de hospital

Relación entre coste medio y tamaño de los hospitales en varios países europeos



Fuente: Sostenibilidad Financiera del sistema Nacional de salud. Antares Consulting.

2.- Exceso de oferta de hospitales universitarios en España

Tabla 5. Número de hospitales universitarios por millones de habitantes

Fuente: Antares Consulting.

País	Hospitales Universitarios	Población	N habitantes por H.U.
España	54	46.661.950	864.110
Francia	32	64.351.000	2.010.969
Suiza	5	7.783.000	1.556.600
Bélgica	7	10.666.000	1.523.714

Fuente: Sostenibilidad Financiera del sistema Nacional de salud. Antares Consulting.

Integración organizacional: fusiones de hospitales universitarios en otros países

Suecia, 2004: Fusión de dos hospitales universitarios de Estocolmo para crear el Karolinska University Hospital

KAROLINSKA
University Hospital

Creación de uno de los hospitales universitarios más grandes de Europa

Mantenimiento de dos sedes (Solna y Huddinge)

Razones para la fusión:

- ✓Ahorro de costes
- ✓Excelencia en la investigación (2.100 investigadores; 3.200 artículos en revistas científicas/año)

Table 2: Key figures of university hospitals

	KH (2003)	HUH (2003)	KUH (2004)
Turnover (€M)	560	455	1030
Staff	8362	6565	15 393
Beds	1045	1089	1700
Visits	845 018	611 962	1400 000
Discharges	59 998	46 787	104 361
Year established	*1940*	*1972*	*2004*

Fuente: Competing Logics in Hospital Mergers. The Case of the Karolinska University Hospital, 2011

Integración organizacional: fusiones de hospitales universitarios en otros países

UK: Fusión de dos hospitales en Londres para crear el Guy's & St Thomas

Dos de los hospitales universitarios más antiguos y conocidos de Londres, parte del NHS, en las proximidades de Lambeth and Southwark

Hospitales separados y rivales antes de la fusión

Tras fusión:
✓900.000 contactos con pacientes/año
✓Ingresos de 930 millones £ (2009/10)

FIGURE 1
Map of other large NHS Community Services Providers

1172 — **St. Thomas Hospital**

1725 — **Guy's Hospital**

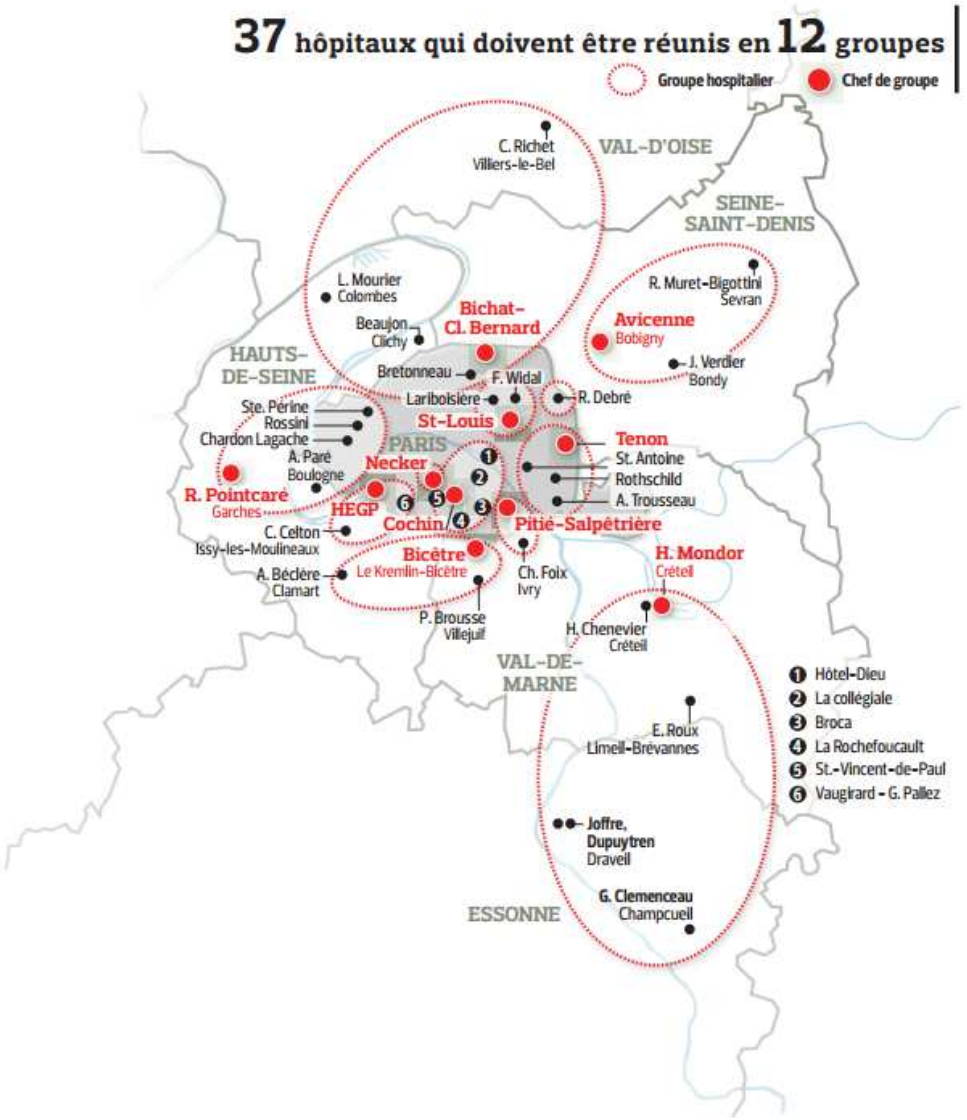
1993 — **Fusión de los dos hospitales: Guy's & St. Thomas Foundation Trust**

2005 — **El hospital recibió el máximo de tres estrellas por el cuarto año consecutivo en el esquema de evaluación del rendimiento nacional para el NHS**

2008 — **El hospital fue calificado como "excelente" por la calidad de servicios y por la gestión financiera por la CQC**

Integración organizacional

Francia: Concentración de los hospitales de Paris.
37 hospitales que pasan a 12 grupos



Integración vertical

Ejemplos de integración vertical

Nacional. Areas integradas

INSALUD

Cataluña: OSIs

Badalona Serveis Assistencials

Corporació de Salut del Maresme i la Selva

CONSORCI SANITARI DE TERRASSA

CONSORCI SANITARI DEL MARESME

Valencia

ribera salud grupo
El Modelo Alzira
un modelo de salud

marinaSalud

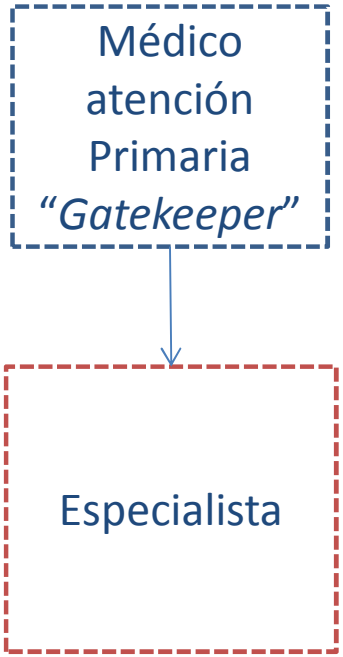
Experiencias: modelos con un nivel mayor de integración

KAISER PERMANENTE®

- Consorcio de gestión integrada. Proveedor de 8 regiones de EEUU. “HMO” (*Health Management Organization*)

- Integrado por dos tipos de organizaciones:

Kaiser Foundation Health Plans (KFHP)	Permanente Medical Group
Ofrece planes y seguros de salud	Organización que pertenece a médicos y que provee los cuidados médicos para KFHP



Experiencias: modelos con alto nivel de integración

KAISER PERMANENTE

Prácticas:

1. Integración real entre niveles
2. Atención de pacientes en el nivel más coste-efectivo (Minimizar el tiempo que los pacientes pasan en hospitales de coste elevado)
3. Sistemas de Información sofisticados y eficientes
4. Médicos asalariados (para evitar procedimientos innecesarios)

Algunos resultados:

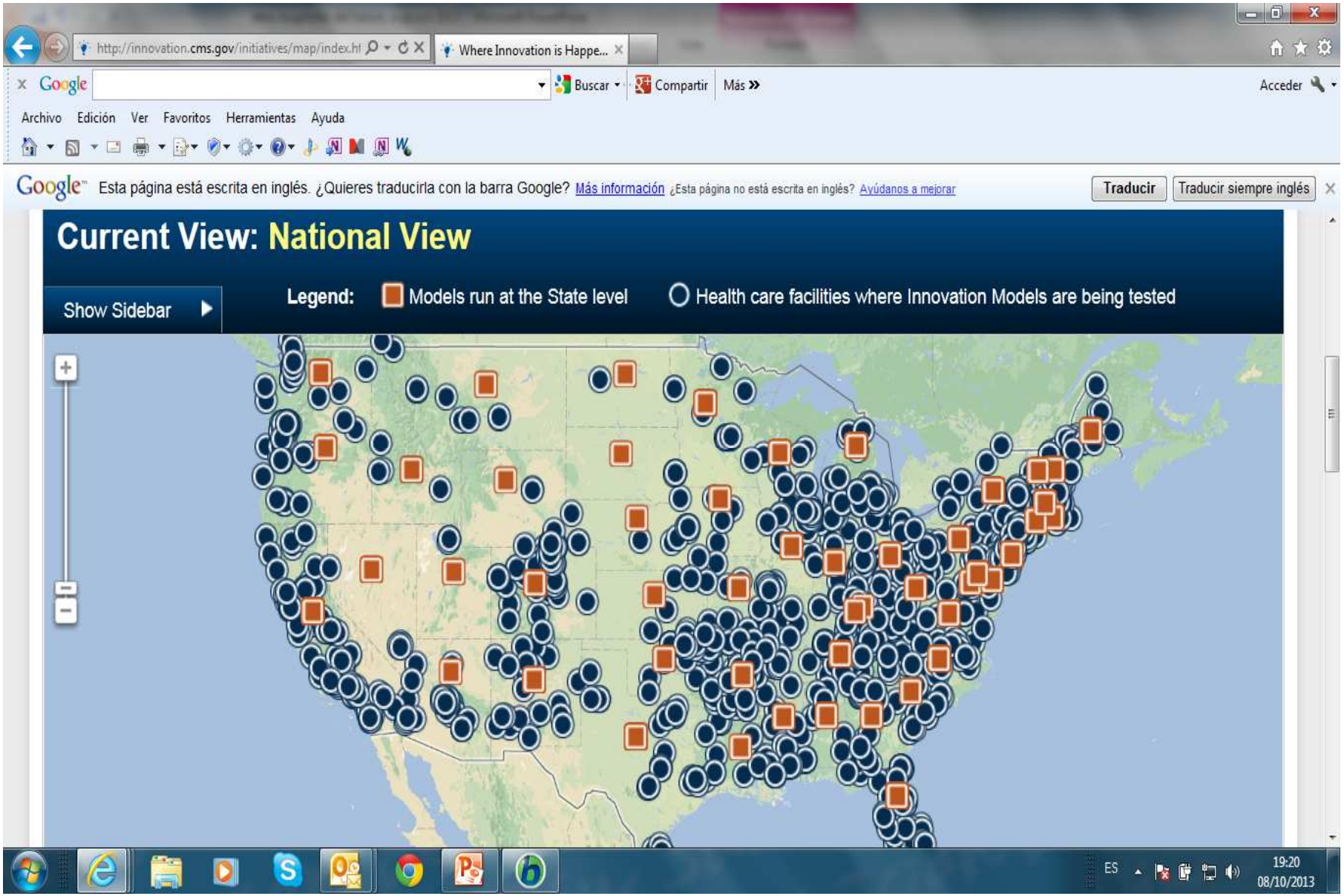
- Énfasis en prevención y programas para crónicos
- Menor Nº de ingresos hospitalarios: 1/3 camas que usan en el NHS*
- Menor Estancia Media
- Tiempos de espera para ver un especialista en NHS: 6 veces más que en KP

Experiencias: Modelos con alto nivel de integración

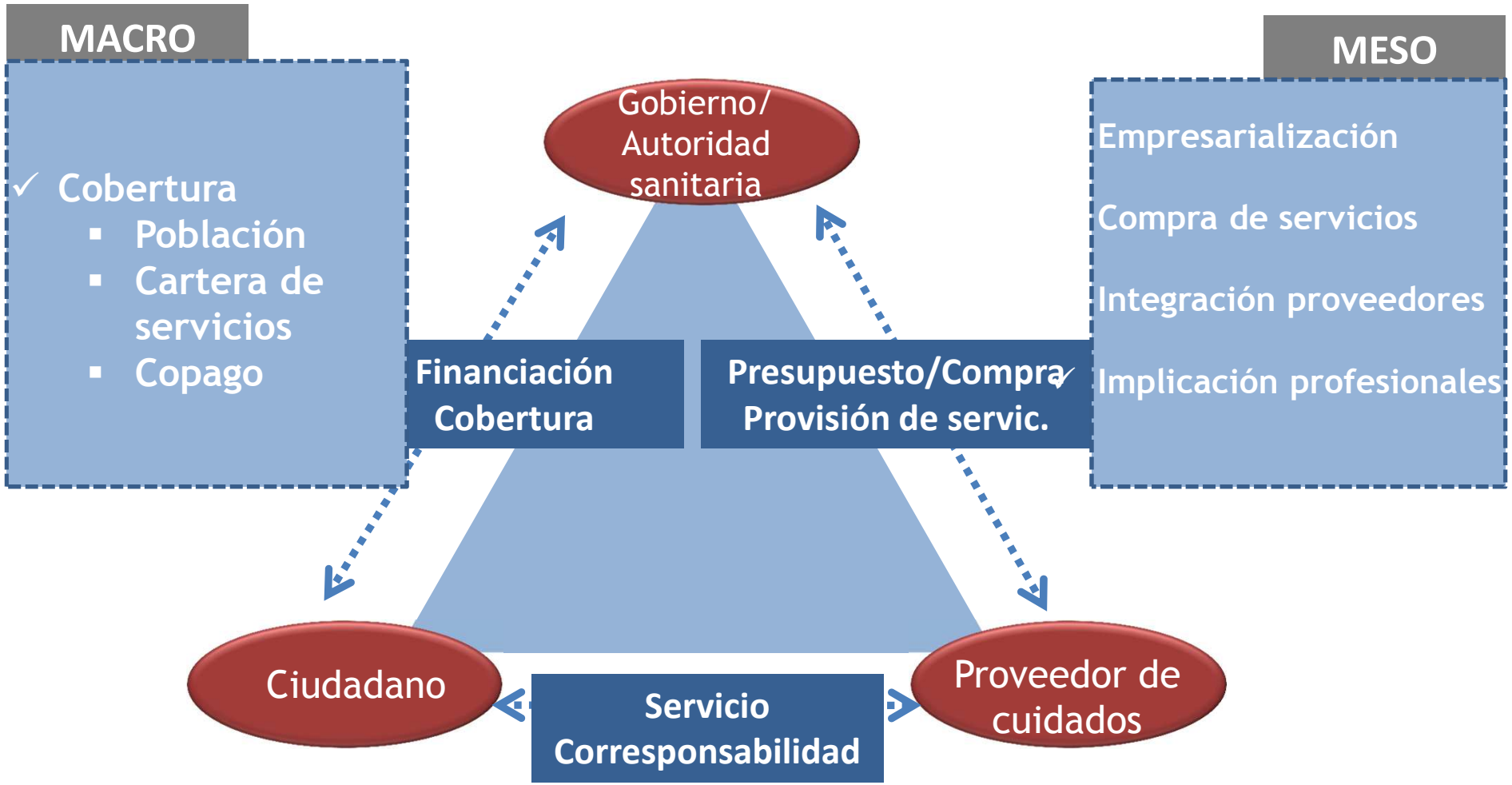
"ACO. Accountable Care Organization"

- Integración de proveedores de diferente titularidad para prestar cuidados de salud a una población determinada.

1. **Cuidados integrados con la participación de un gran número de proveedores**
2. **Estructura formal legal que capacita la administración**
3. **Capacidad para sumar resultados y costes**
4. **Pago ligado a las métricas de calidad**


http://innovation.cms.gov/initiatives/map/index.ht
Where Innovation is Happe...
Google
Buscar
Compartir
Más
Acceder
Archivo Edición Ver Favoritos Herramientas Ayuda
Google™ Esta página está escrita en inglés. ¿Quieres traducirla con la barra Google? Más información ¿Esta página no está escrita en inglés? Ayúdanos a mejorar
Traducir
Traducir siempre inglés
Current View: National View
Show Sidebar
Legend:
Models run at the State level
Health care facilities where Innovation Models are being tested
ES
19:20
08/10/2013

Reformas estructurales y barreras



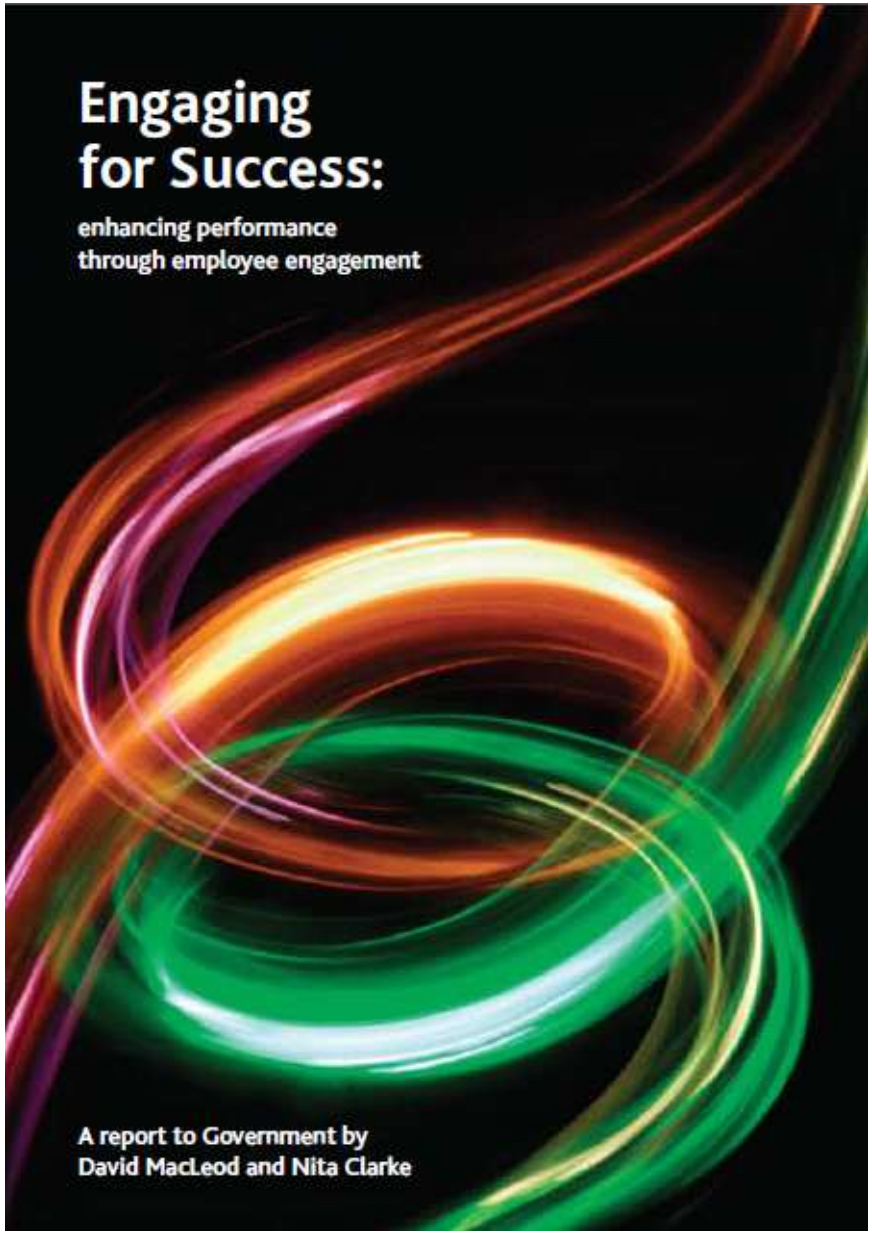
¿Que nos dice la literatura ?

El compromiso tiene impacto en los resultados

El compromiso se puede medir

El compromiso es gestionable

El compromiso tiene impacto en los resultados



Chapter 1

Employee Engagement – What, why and how

1 This chapter summarises our findings on the importan to the UK, looks at some of the barriers to engagemen characteristics, and outlines our recommendations to t

2 The following chapters detail more of the evidence abo the barriers (chapter 3) and some of the factors that lie behind successful engagement (chapter 4). Our recommendations in full can be found in chapter 5.

3 This report is about unlocking people's potential at work and the measurable benefits of doing so for the individual, the organisation and, ultimately, for the UK.

4 It is about retaining and building on the commitment, energy and desire to do a good job that characterises most people, that 'first day at work' feeling, to maximise individual and organisational performance.

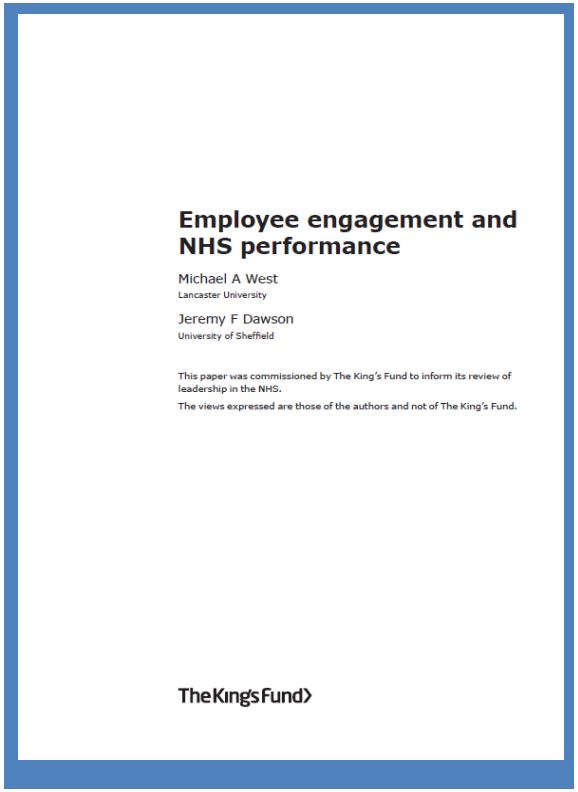
5 Business and organisations function best when they make their employees' commitment, potential, creativity and capability central to their operation. Clearly, having enough cash, and a sensible strategy, are vital. But how people behave at work can make the crucial difference between business and operational success or failure.

6 Employee engagement strategies enable people to be the best they can at work, recognising that this can only happen if they feel respected, involved, heard, well led and valued by those they work for and with. As a representative of the home insulation company KHI put it: *"employee engagement is when the business values the employee and the employee values the business"* (submitted via the review's online call for evidence).

7 Engaged employees have a sense of personal attachment to their work and organisation; they are motivated and able to give of their best to help it succeed – and from that flows a series of tangible benefits for organisation and individual alike.

8 *"You sort of smell it, don't you, that engagement of people as people. What goes on in meetings, how people talk to each other. You get the sense of energy, engagement, commitment, belief in what the organisation stands for,"* is how Lord Currie, former Chair of the Office of Communications (Ofcom) and Dean of Cass Business School, puts it. As a number of business leaders told us, *"You know it when you see it."*

El compromiso tiene impacto en los resultados



Outcomes of engagement

- ✓ Better patient experience
- ✓ Better quality of services
- ✓ Higher quality of financial performance
- ✓ Lower patient mortality and infection rates
- ✓ Lower Absenteeism
- ✓ Lower turnover rates

The NHS Staff Survey ,2009

- 156.951 staff responding
- 388 different trusts

El compromiso es medible.
Estudio opina

Organizaciones involucradas:

Centres participants	Plantilla
Parc de Salut Mar	3.299
Grup SAGESSA	2.347
Althaia (Manresa)	2.051
Consorci Hospitalari de Vic	1.438
Consorci Sanitari de l'Alt Penedès (Vilafranca)	487
Consorci Sanitari de l'Anoia (Igualada)	888
Consorci Sanitari del Maresme (Mataró)	1.750
Consorci Sanitari de Terrassa	2.354
Consorci Sanitari del Garraf	1.143
Consorci Sanitari Integral	3.348
Fundació Hospital Asil de Granollers	1.512
Hospital Sant Joan de Déu	1.648
TOTAL PROJECTE OPINA	**22.265**

12 entidades

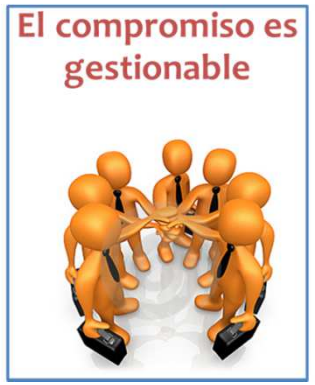
22.265 profesionales

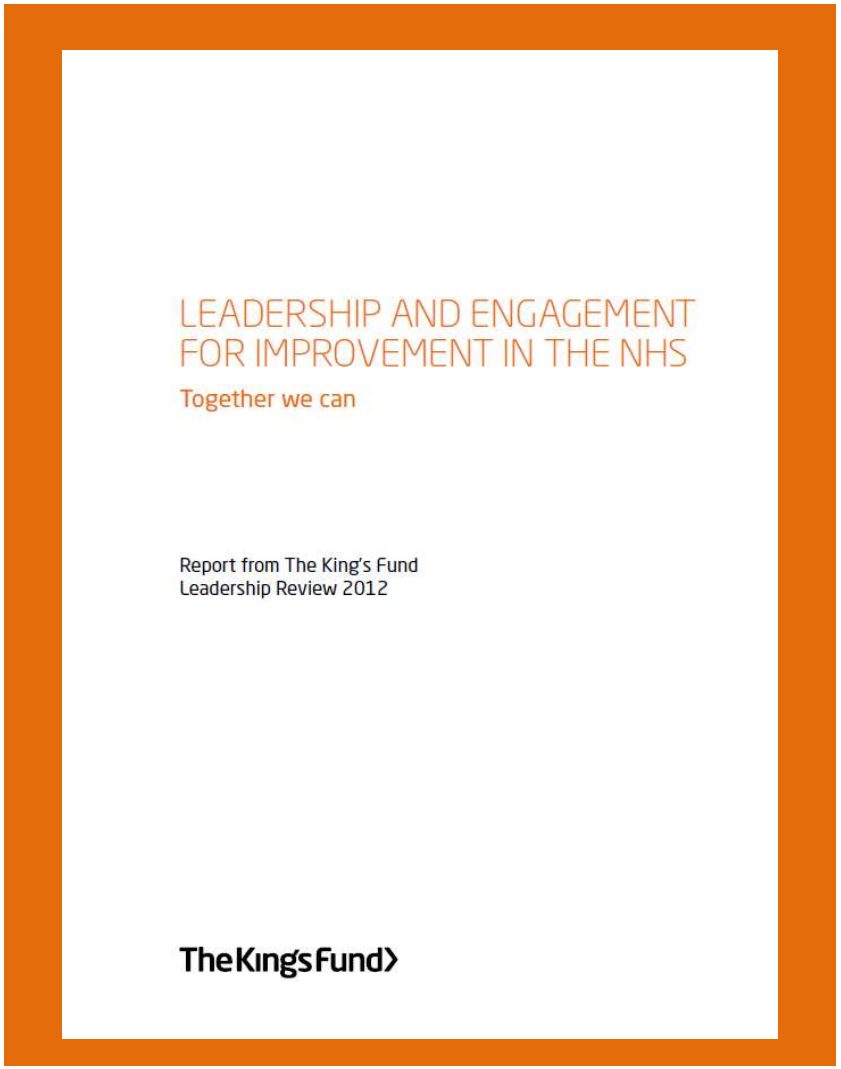
Evaluación del compromiso

Staff feedback

Attitude	Facts 2010	Facts 2012	Sector average
Enthusiastic committed	47 %	50 %	21 %
	71%	**75%**	**54%**
Demanding professionals with huge commitment	24 %	25%	33 %
Skeptics	25 %	22%	29 %
	29%	**25%**	**46%**
Desserters	4 %	3%	17 %

Implicación profesional

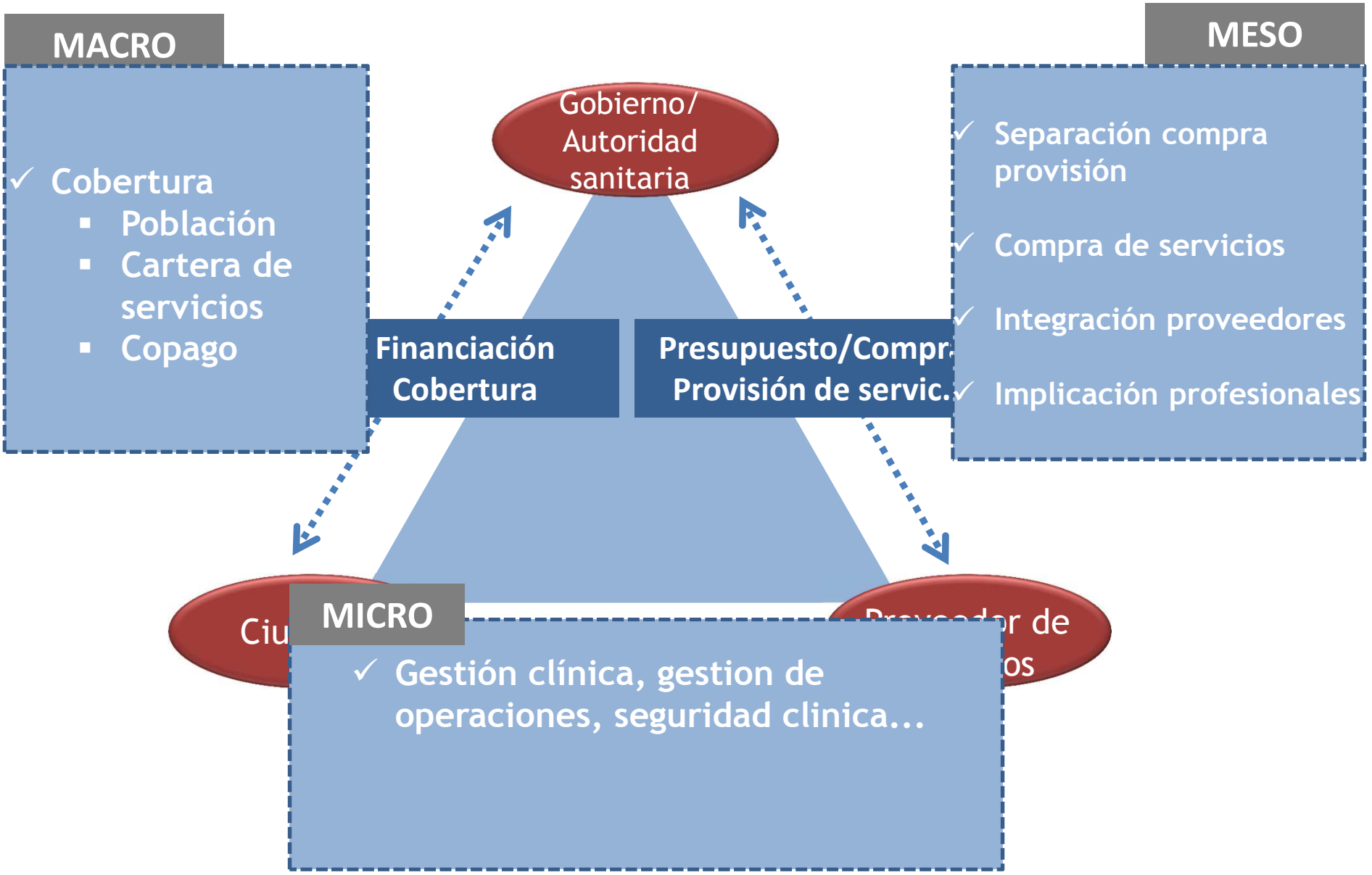




"Necesitamos lideres menos orientados al control y que se centren más en conseguir la implicación de los profesionales… ofreciendo autonomía y soporte…"

El compromiso es gestionable.
Determinantes del compromiso en las organizaciones sanitarias

Reformas estructurales y barreras



Cambio en la medicina

Sir Cyril Chantler, Lancet 1999, 353:1178-81

"Medicine used to be **ineffective,** but **simple and safe**".

"Now is **effective,** but **complex and relatively dangerous**".

Ciencia y Caridad, Picasso

Acciones

Gestión clínica

Gestión de operaciones

Seguridad de los pacientes

Acciones

Gestión clínica

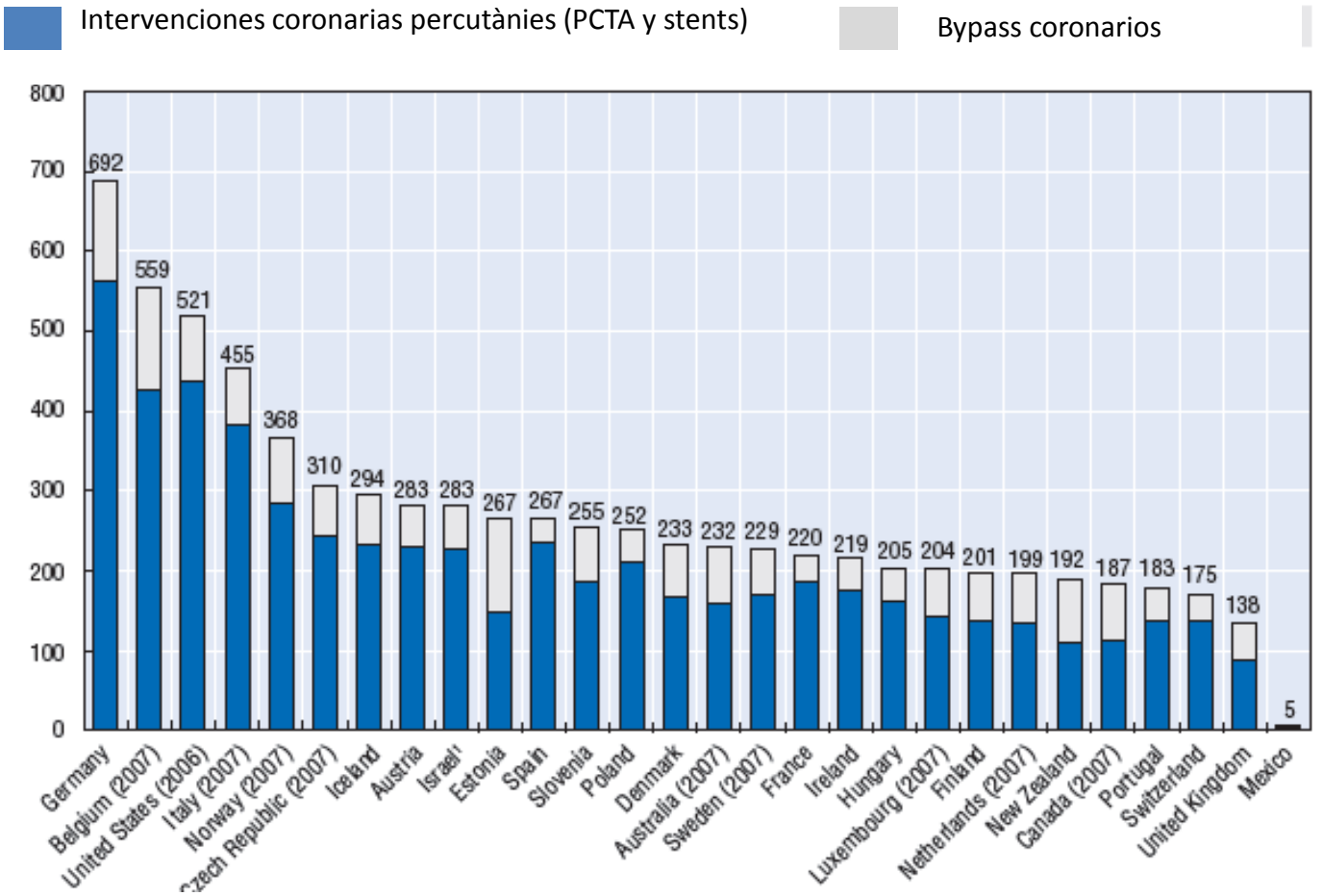
Gestión de operaciones

Seguridad de los pacientes

Gestión clínica

Variabilidad clínica

Procedimentos de revascularización coronaria per 100.000 habitantes, 2008



Font: *Value for Money in Health Spending*, OECD

Gestión clínica

Right care

BMJ

BMJ 2013;346:f1328 doi: 10.1136/bmj.f1328 (Published 27 February 2013)

EDITOR'S CHOICE

Too much medicine

Fiona Godlee *editor, BMJ*

There's a great deal to celebrate in medicine and healthcare, but it's also possible to have too much of a good thing. This week we launch our Too Much Medicine campaign (www.bmj.com/too-much-medicine). As explained in an editorial (doi:10.1136/bmj.f1271), the roots of the campaign go back at least a decade to a theme issue we published in 2002, guest edited by Ray Moynihan, called "Too much medicine?" You can find the entire issue on bmj.com (www.bmj.com/content/324/7342). Much of the content is as relevant now as it was controversial then.

Since then, the evidence of medical excess in rich countries has grown, with increasingly clear documentation of the harms and costs of unnecessary intervention. In the past few years the individuals and groups calling for moderation and scepticism have begun to coalesce into a loose movement, to which the *BMJ* is now signing up. Impressed by the "Less is more" initiative at *JAMA Internal Medicine*, led by its editor Rita Redberg, and by the Choosing Wisely initiative set up by the American Board of Internal Medicine Foundation (doi:10.1136/bmj.f1266), we want to explore the causes and potential remedies of overinvestigation, overdiagnosis, and overtreatment.

As our Editorial points out, this area is complex and under-researched: in many healthcare settings overtreatment and undertreatment coexist. "Because of this and other uncertainties, it will not be easy to communicate effectively about overdiagnosis with professionals and the public. The concept is unfamiliar and counterintuitive to many people." Our contribution will include partnering in an international scientific conference in September (preventingoverdiagnosis.net) and publishing a theme issue early next year.

This week's journal carries its own dose of cold water with which to douse medical enthusiasts. In an editorial, Edwin Gale calls for a serious rethink about the use of GLP-1 agonists in diabetes because of strong evidence of increased rates of pancreatitis among patients taking these drugs (doi:10.1136/bmj.f1263). He asks why drug companies have been so slow to act on the signals and concludes that inviting drug companies to monitor the safety of their own products provides them with the strongest possible incentive for failing to do so. And in the Analysis section, Tom Treasure and Martin Utley question the benefits of surgical removal of pulmonary metastases. The evidence that this invasive procedure improves survival is weak, they say. They call for randomised trials rather than the dubious case series on which current practice is based (doi:10.1136/bmj.f824). One such innovative trial is now under way thanks to a previous *BMJ* paper from these authors.

Also this week, the *BMJ* speaks up for the Liverpool care pathway, which is under attack from the *Daily Mail* and others. We are emboldened to do so by a survey we undertook among palliative care doctors in the UK. As summarised by Krishna Chinthapalli, 91% of respondents thought that the pathway represented best practice for care of the dying patient (doi:10.1136/bmj.f1184). And when asked if they would want to be put on the pathway themselves if they were terminally ill, 90% said yes. This vote of confidence fits with views expressed at a conference in Edinburgh last week (doi:10.1136/bmj.f1303). Helping patients to die with dignity should be done with the same care and openness as anticipating and managing the birth of a child.

Cite this as: *BMJ* 2013;346:f1328

The Lown Institute

News & Articles | Events | Strategic Initiatives | About Us

About the Right Care Alliance

The Right Care Alliance is a major new initiative of the Lown Institute that is designed to change the culture of American medicine from "more is better" to the right care for the right patient. We are developing an international network of clinicians, patients, community organizations, and health care institutions who recognize the epidemic of overuse in American medicine, and who are dedicated to eliminating it, and to ensuring that patients get the care they need.

In April 2012, the Lown Foundation and the New America Foundation convened the Avoiding Avoidable Care conference - the first major medical meeting dedicated entirely to understanding the problem of overuse of medical services. The meeting highlighted the need for active cooperation among clinicians, patient advocates, and policy makers in order to address this pervasive and harmful aspect of medicine. The Right Care Alliance was founded by Lown Institute President, Vikas Saini, Senior Vice President, Shannon Brownlee, and our Advisory Council to facilitate that cooperation.

The Right Care Alliance will be a distinct and complementary voice in the emerging campaign to address overuse. Our strategy is to identify and challenge the cultural aspects of overuse, the underlying attitudes, behaviors, and narratives that have persuaded clinicians and the public that more is better in medicine. We will highlight the issue of overuse as an entry point to a broader conversation about the purpose of health care in our society, the ethical and social responsibilities of the medical profession, and the need for a new social contract between the medical profession, the health care industry, and civil society.

Our Mission

Featured Event

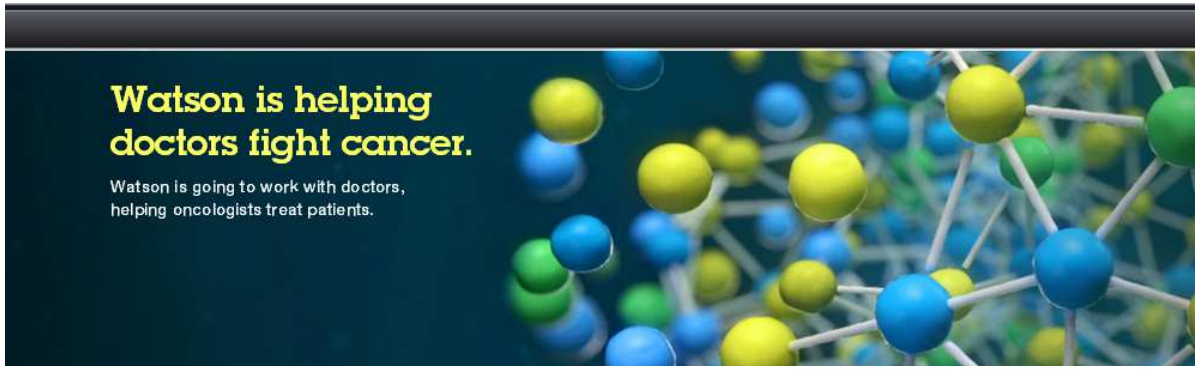
The Lown Conference

From Avoidable Care to Right Care

Big data

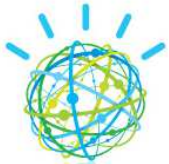

McKinsey&Company
Center for US Health System Reform
Business Technology Office
The 'big data' revolution in healthcare
Accelerating value and innovation
January 2013
Peter Groves
Basel Kayyali
David Knott
Steve Van Kuiken

IBM's Watson



How Watson can address healthcare challenges

Watson uses natural language capabilities, hypothesis generation, and evidence-based learning to support medical professionals as they make decisions. For example, a physician can use Watson to assist in diagnosing and treating patients. First the physician might pose a query to the system, describing symptoms and other related factors. Watson begins by parsing the input to identify the key pieces of information. The system supports medical terminology by design, extending Watson's natural language processing capabilities.



Watson then mines the patient data to find relevant facts about family history, current medications and other existing conditions. It combines this information with current findings from tests and instruments and then examines all available data sources to form hypotheses and test them. Watson can incorporate treatment guidelines, electronic medical record data, doctor's and nurse's notes, research, clinical studies, journal articles, and patient information into the data available for analysis.

Watson will then provide a list of potential diagnoses along with a score that indicates the level of confidence for each hypothesis.

The ability to take context into account during the hypothesis generation and scoring phases of the processing pipeline allows Watson to address these complex problems, helping the doctor — and patient — make more informed and accurate decisions.

Next steps

Learn more about how Watson can help you address your most challenging problems - now and into the future.

The University of Texas MD Anderson Cancer Center - IBM Watson case study (131Kb)

→ MD Anderson Taps IBM Watson to Power "Moon Shots" Mission Aimed at Ending Cancer, Starting with Leukemia

IBM Watson at Work in Healthcare: Helping Researchers Make Breakthroughs (00:00:58)

IBM Watson at Work in Healthcare: Helping Doctors Fight Cancer (00:00:16)

IBM Watson at Work in Healthcare: Helping Med Students Learn (00:00:16)

Featured Case Studies

Two page case study on Memorial Sloan Kettering's work training IBM Watson on oncology diagnosis and treatment(1.2 Mb)

Two page case study on WellPoint's early use of IBM Watson in accelerating healthcare pre-authorization (1.2 Mb)

Recent news

The University of Texas MD Anderson Cancer Center - IBM Watson case study

MD Anderson Taps IBM Watson to Power "Moon Shots" Mission Aimed at Ending Cancer, Starting with Leukemia

→ More Watson news

Join the Watson Conversation

Tweets Blogs Videos Photos

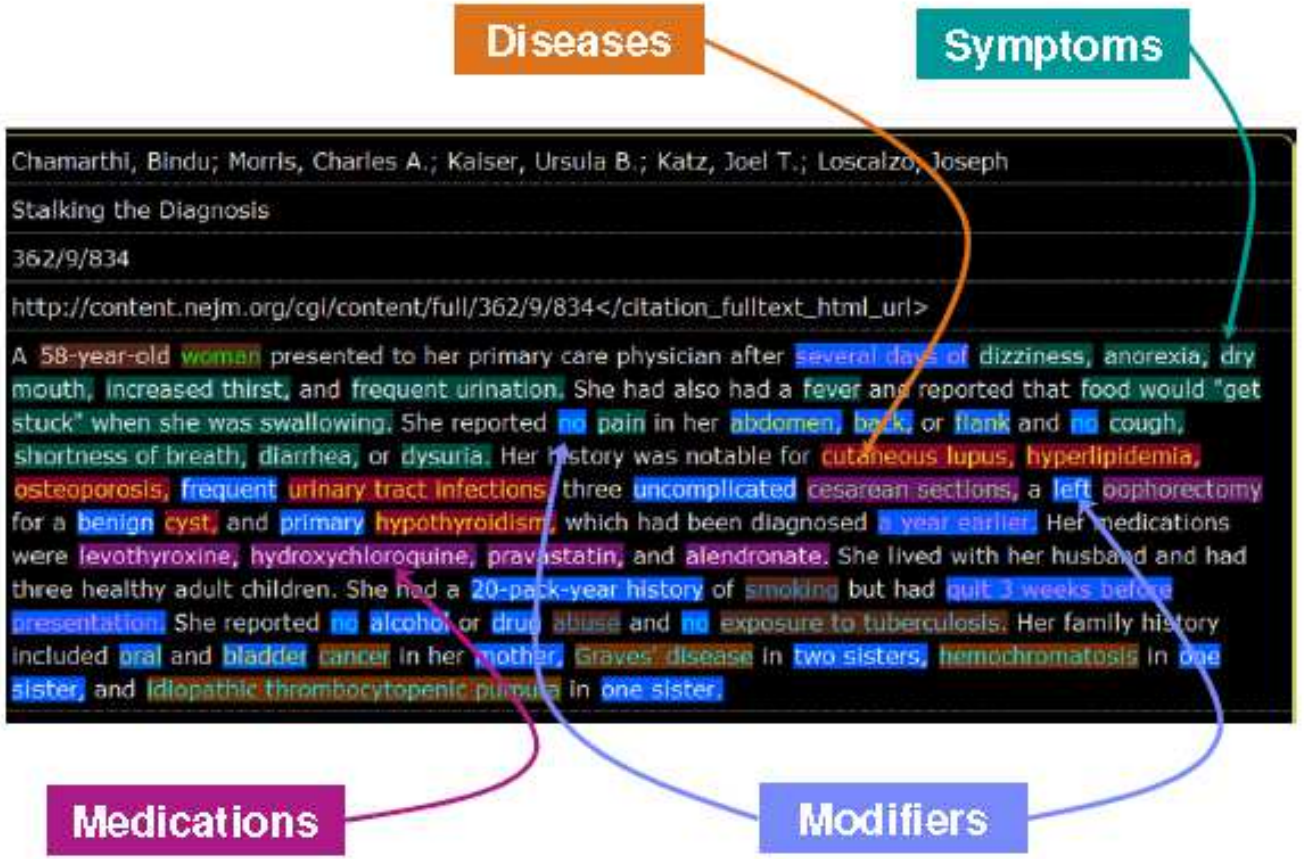
IBM Watson @IBMWatson Jan 17, 5:01 PM
"Developing with Watson APIs" by @developerWorks http://t.co/AWRx4u0UbD #ibmwatson

Joshua DeLancey Jan 17, 4:40 PM
@JoshDeLancey
News alert: IBM Announces $1B Watson Group via @Forbes http://t.co/157lt1fc58 #IBMWatson

Watson utiliza lenguage natural, generación de hipótesis y aprendizage basado en la evidencia para ayudar a los profesionales médicos en la toma de decisiones


$300,000
$1,000,000
$200,000
WATSON

The volume is overwhelming and the language is complex



Acciones

Gestión clínica

Gestión de operaciones

Seguridad de los pacientes

Gestión de las operaciones

Quality Of Care

The End Of The Beginning: Patient Safety Five Years After 'To Err Is Human'

Amid signs of progress, there is still a long way to go.

by Robert M. Wachter

ABSTRACT: The Institute of Medicine's 1999 report on medical errors galvanized the public and health professionals. Before then, providers, health care organizations, and policymakers lacked the understanding and incentives to generate the changes in culture, systems, training, and technology to improve safety. Since 1999 there has been progress, but it has been insufficient. Stronger regulation has helped, as have some early improvements in information technology and in workforce organization and training. Error-reporting systems have had little impact, and scant progress has been made in improving accountability. Five years after the report's publication, we appear to be at "the end of the beginning."

Five years ago the Institute of Medicine (IOM) report on medical errors, *To Err Is Human*, galvanized the public and the health professions and led to congressional hearings, media exposés, and millions of anxious patients.[1] This paper examines the genesis and impact of that report and takes stock of where we are five years after its release. The set of incentives that promote patient safety—not simply the economic balance sheet, but also the political, ethical, and social forces experienced by doctors, nurses, health care executives, policymakers, and other key stakeholders—was woefully weak before 1999 and has grown much stronger since then. However, these forces have not yet become robust enough to generate the dollars, systems, training models, and culture to transform modern health care into the safe, reliable system that patients and providers deserve.

The IOM Report And Its Impact

As one measure of its impact, if one says "the IOM report," *To Err Is Human* immediately springs to mind, despite the fact that the IOM has published 234 reports since then. In fact, an argument can be made that the medical profession "discovered" the epidemic of medical mistakes five years ago through the IOM report, nearly as assuredly as we discovered the AIDS epidemic in 1981 and the SARS epidemic in 2003.[2]

Bob Wachter (bwachter@medicine.ucsf.edu) is chief of the medical service, University of California, San Francisco, and UCSF Medical Center, and is associate chair of the UCSF Department of Medicine.

16 November 2004

Eficiencia

"The greatest improvement

…seems to be the effects of

the division of labour"

Adam Smith, The Wealth of Nations

VS

Coordinación

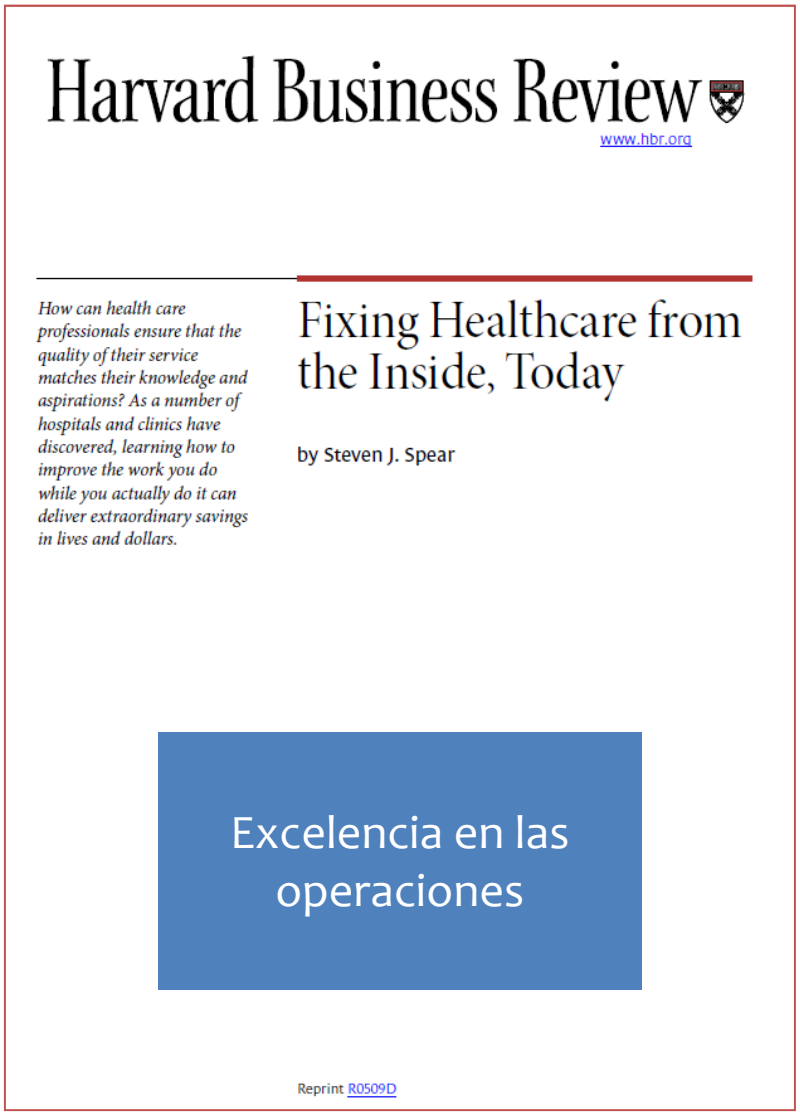
Sin una cultura enfocada a la

gestión de operaciones,

los errores son frecuentes

Health affairs. The end of the begining …

Gestión de las operaciones



Cómo MEJORAR el lento avance en seguridad clínica?


Harvard Business Review

www.hbr.org

How can health care professionals ensure that the quality of their service matches their knowledge and aspirations? As a number of hospitals and clinics have discovered, learning how to improve the work you do while you actually do it can deliver extraordinary savings in lives and dollars.

Fixing Healthcare from the Inside, Today

by Steven J. Spear

Reprint R0309D

1. Eliminar ambigüedad en el entorno de trabajo
2. Grandes resultados a través de pequeños cambios
3. Simular y experimentar
4. El enfoque "Model Line"

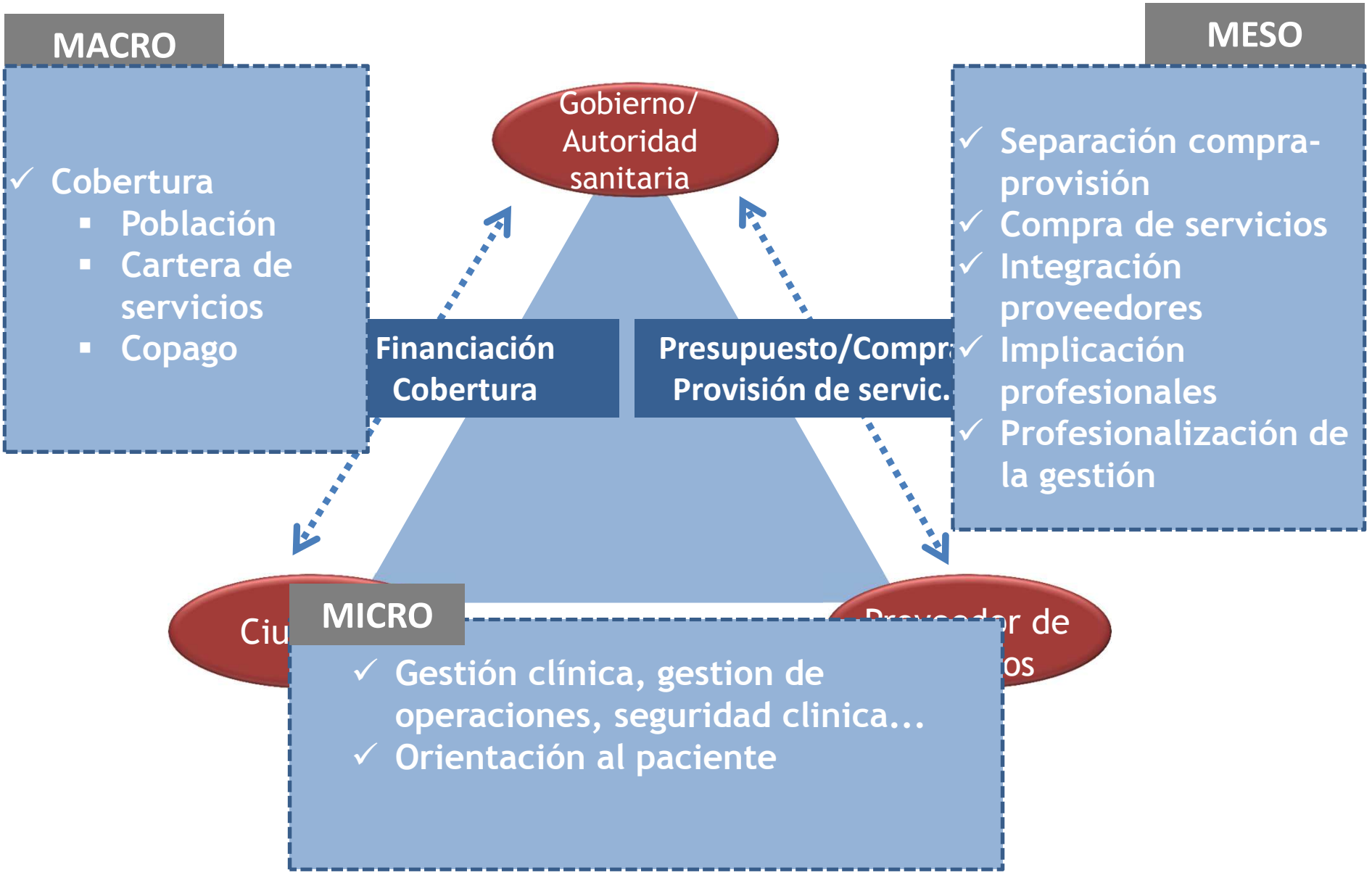
Sistema de producción de Toyota

- ✓ Toyota dice que cada empleado tiene dos trabajos:
  Primero, hacer su trabajo
  Segundo, mejorar su trabajo

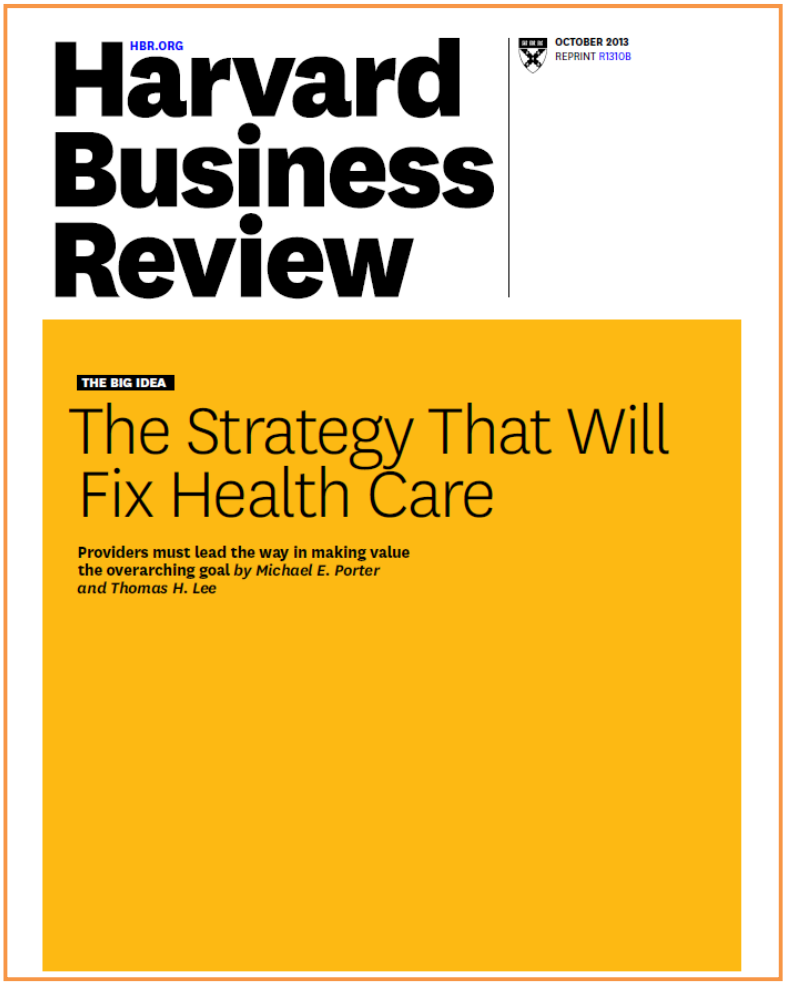
Lean Hospitals

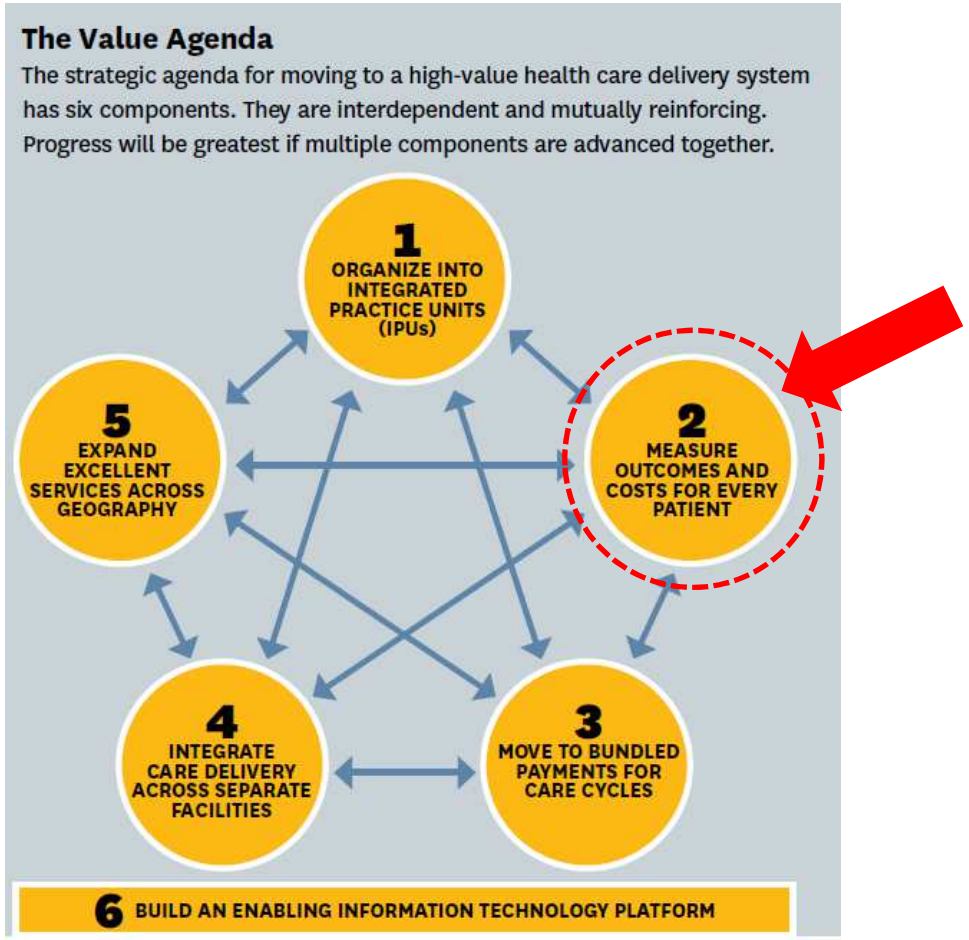
www.leanmaps.com

Reformas estructurales y barreras



Orientación al paciente





Orientación al paciente


GETTING THE MOST OUT OF PROMS

Putting health outcomes at the heart of NHS decision-making

Nancy J Devlin
Director of Research, Office of Health Economics

John Appleby
Chief Economist, The King's Fund

With contributions from
Martin Buxton
Andrew Vallance-Owen
Mark Emberton
Katy Peters
Ray Naden
Alison Barber

The King's Fund

OHE Office of Health Economics

NHS UK: PROMs
(*Patient-reported outcome measures*)

TRADICIONAL:

Mortalidad, readmisiones, … Numero de visitas, CCEE,..

PROMs

Perspectiva del paciente sobre su propia salud

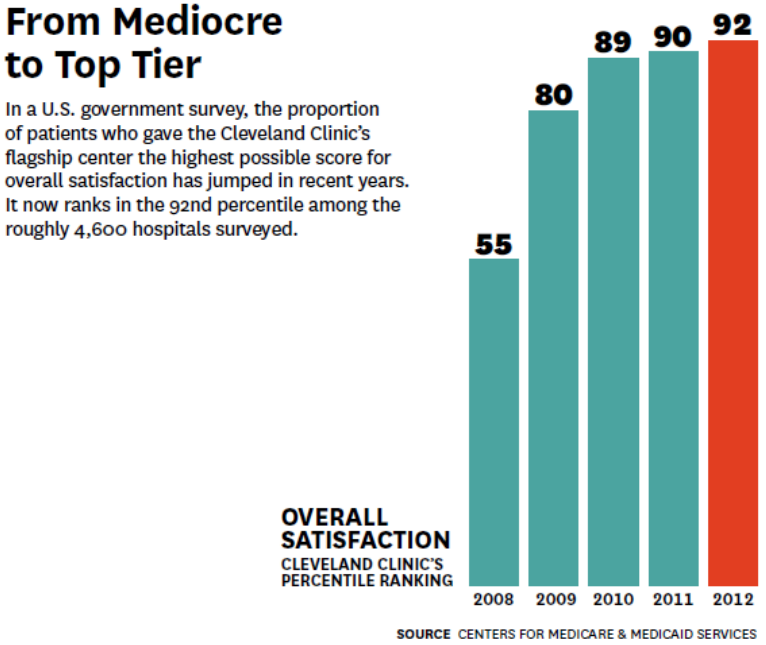
PROMs: Comprende preguntas estructuradas que contestan los pacientes sobre su salud bajo su punto de vista

Orientación al paciente

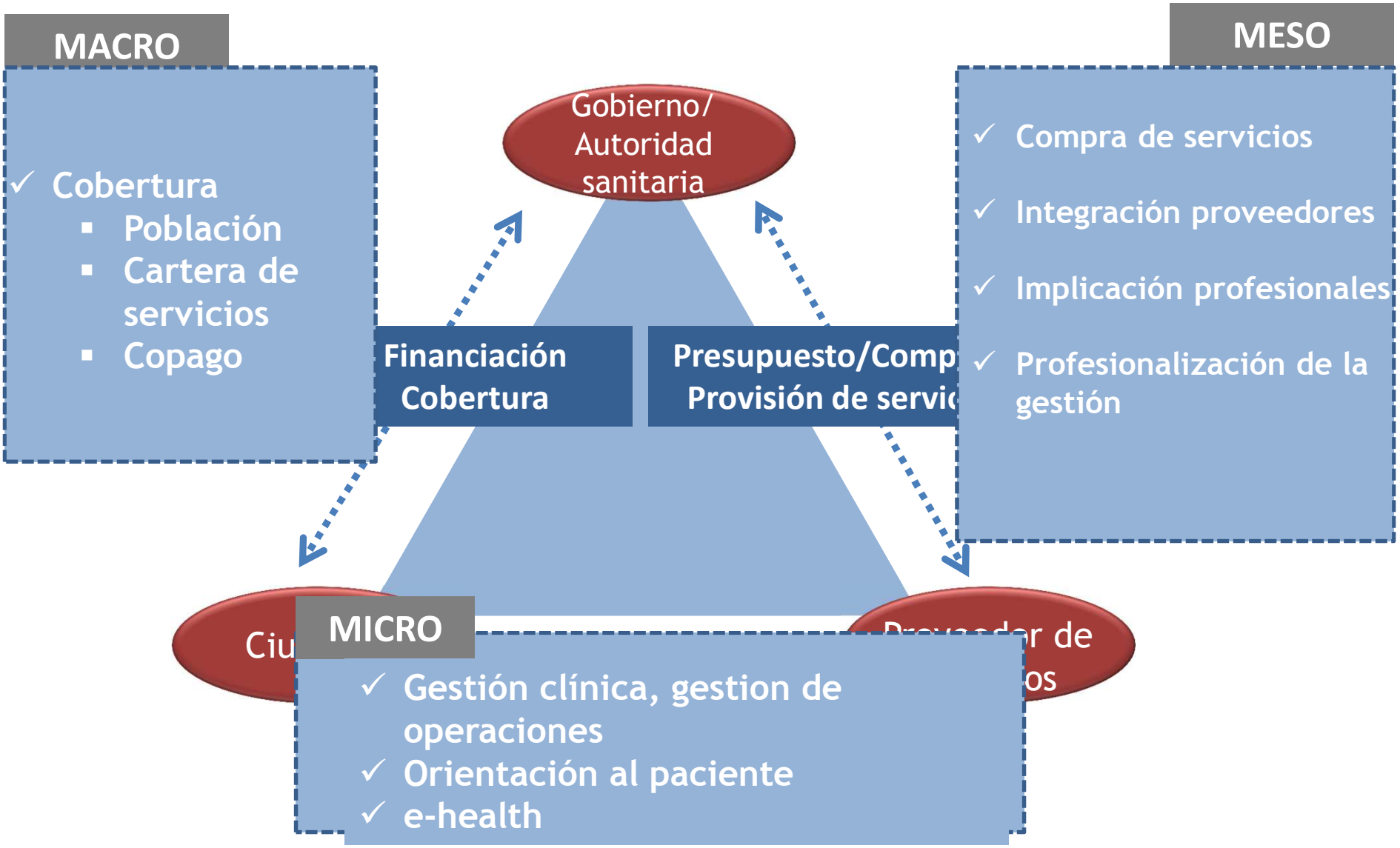
Nuevas figuras orientadas a mejorar la experiencia del usuario:

- ✓ Cleveland Clinic: **Chief Experience Officer**
- ✓ Radbound University Hospital (Holanda): **Chief Listening Officer**

Satisfacción del paciente en Cleveland Clinic



Reformas estructurales y barreras



E-Health:

Telemonitorización

Health Affairs
content.healthaffairs.org

doi: 10.1377/hlthaff.2010.0048
Health Aff July 2010 vol. 29 no. 7 1370–1375

Expand

Improved Quality At Kaiser Permanente Through E-Mail Between Physicians And Patients

Yi Yvonne Zhou[1,*], Michael H. Kanter[2], Jian J. Wang[3] and Terhilda Garrido[4]

[+] Author Affiliations

*Corresponding author

Abstract

The American Recovery and Reinvestment Act identified secure patient–physician e-mail messaging as an objective of the meaningful use of electronic health records. In our study of 35,423 people with diabetes, hypertension, or both, the use of secure patient–physician e-mail within a two-month period was associated with a statistically significant improvement in effectiveness of care as measured by the Healthcare Effectiveness Data and Information Set (HEDIS). In addition, the use of e-mail was associated with an improvement of 2.0–6.5 percentage points in performance on other HEDIS measures such as glycemic (HbA1c), cholesterol, and blood pressure screening and control.

Mejora de resultados en diabetes e hipertensión mediante control vía email

Telemonitorización

Examples of successful post-acute care monitoring programmes include:

- A 2010 Catalan Remote Management Evaluation (CARME) study in Spain compared outcomes of 92 heart failure patients using telemedicine to outcomes from the previous 12 months of care without telemedicine. Researchers found that patient-reported quality of care increased by 62 percent and reported dissatisfaction decreased by 22 percent. The study also reported a 68 percent decrease in hospitalisation (including readmissions) for heart conditions.[34]

68% de disminución en hospitalizaciones en insuficiencia cardiaca

33% de disminución de visitas a urgencias

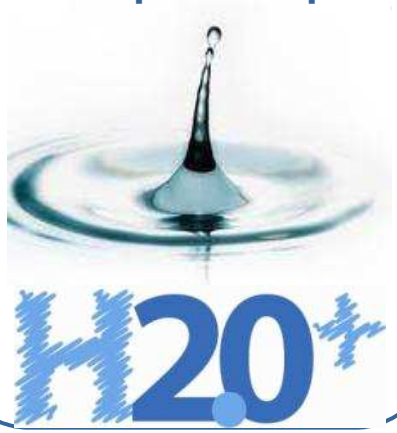
E-Health: Hospital Líquido

Domicili

Altres centres

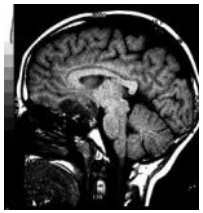
Smartphone

L'Hospital Líquid



Para llegar más lejos y mejor

Telemedicina



Medical devices

Telèfon

Email

Mobile devices

A

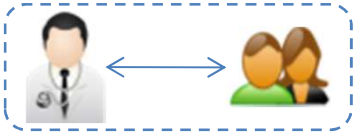
E-HEALTH

TELE-ASISTENCIA

- Visita *Online*
- Tele-consulta
- Tele-rehabilitacion
- Tele-monitorización
- Segunda opinión

TELE-MEDICINA

- Servicios
- ReToc (RetCam)



B

Redes Sociales

facebook

YouTube

twitter

flickr

slideshare

C

Portales temáticos

FAROS
SANT JOAN DE DÉU OBSERVATORIO DE SALUD DE LA INFANCIA Y LA ADOLESCENCIA

guía metabólica

guiadiabetes

APTIC
xarxa social

D

Educacion Virtual

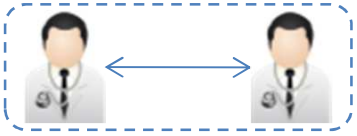
E-LEARNING

5m

Webcasting

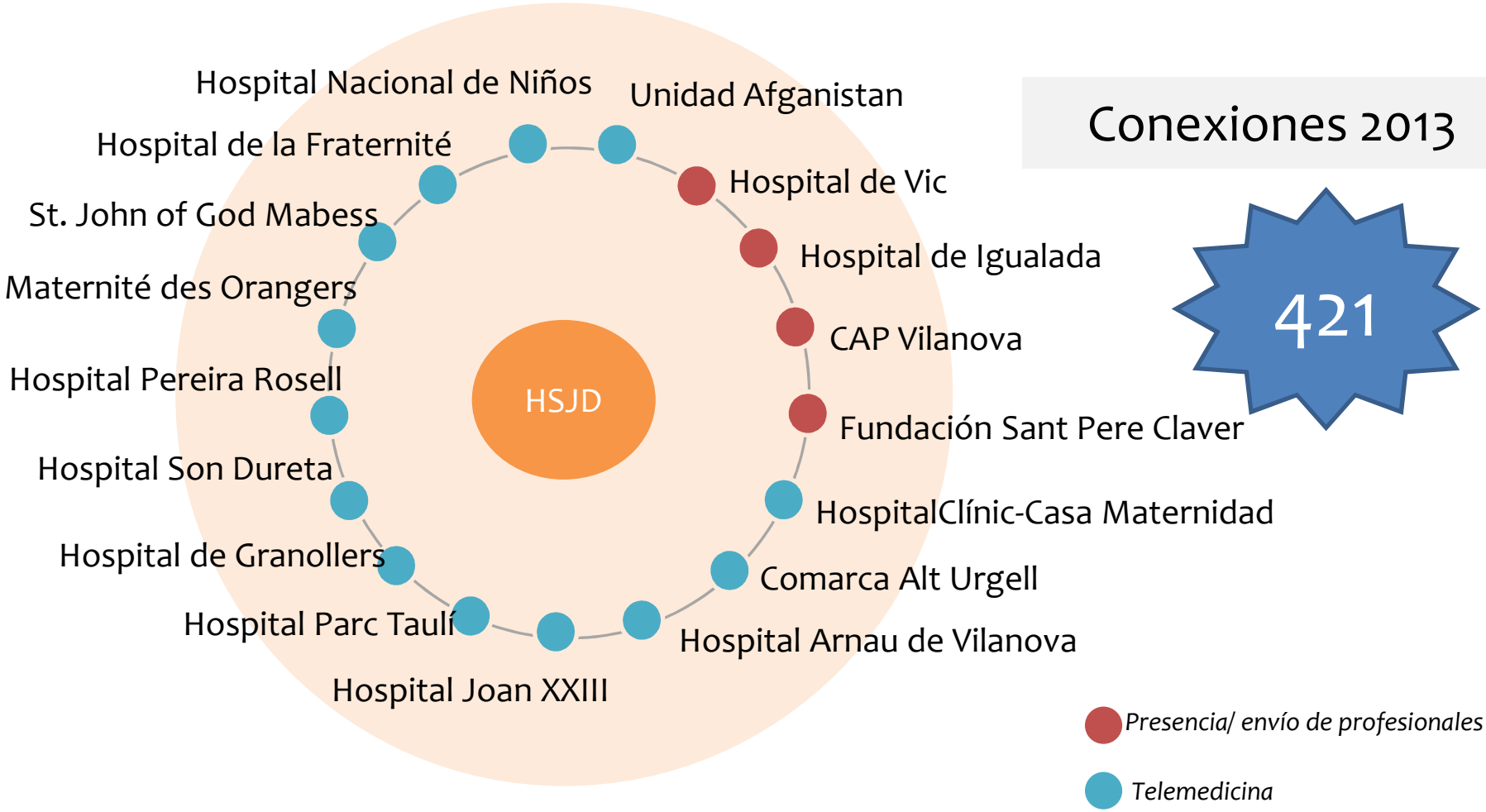
PEDIATRIC OBSTETRIC ADVANCED SIMULATION
Sant Joan de Déu

Portal de Innovación



Portal del paciente

Telemedicina



Portal temático 2.0-Guía Metabólica

- ✓ **Conocimiento seleccionado acerca de las patologías**
- ✓ **Recetas**
- ✓ **Recursos útiles**
- ✓ **Espacio colaborativo** entre pacientes
- ✓ **Consultas On-line**

MULTIPLICAR POR 100 NUESTRO ALCANCE

1.264 actos diarios

132.000 contactos diarios

Guión

1. **El modelo actual. Resultados. Sostenibilidad**
2. **Las Reformas estructurales**
3. **Resumen**

Resumen

Retos

- Sostenibilidad economica
- Fragmentación y complejidad de la asistencia
- Pacientes Expertos y participativos

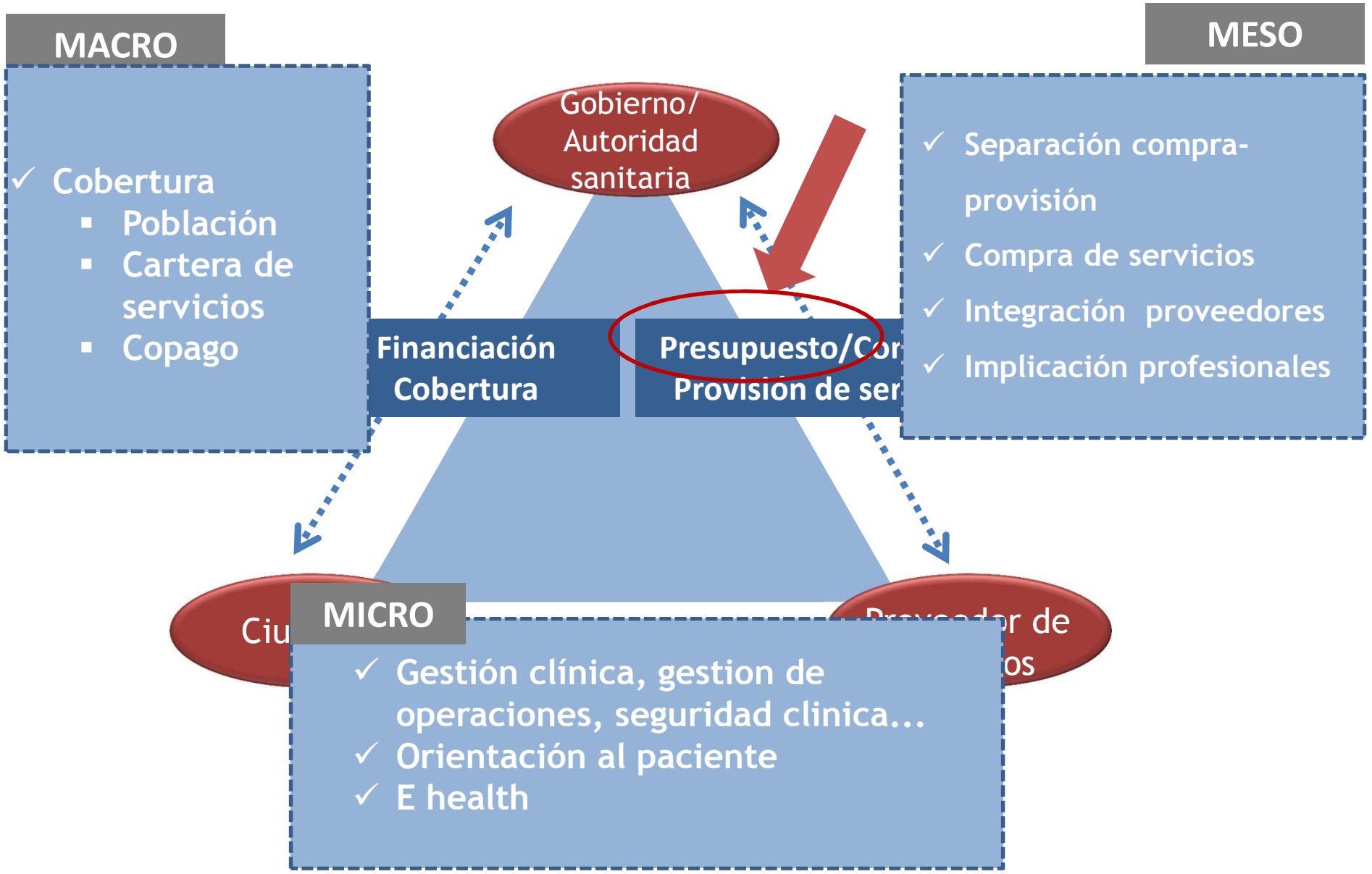
Reformas

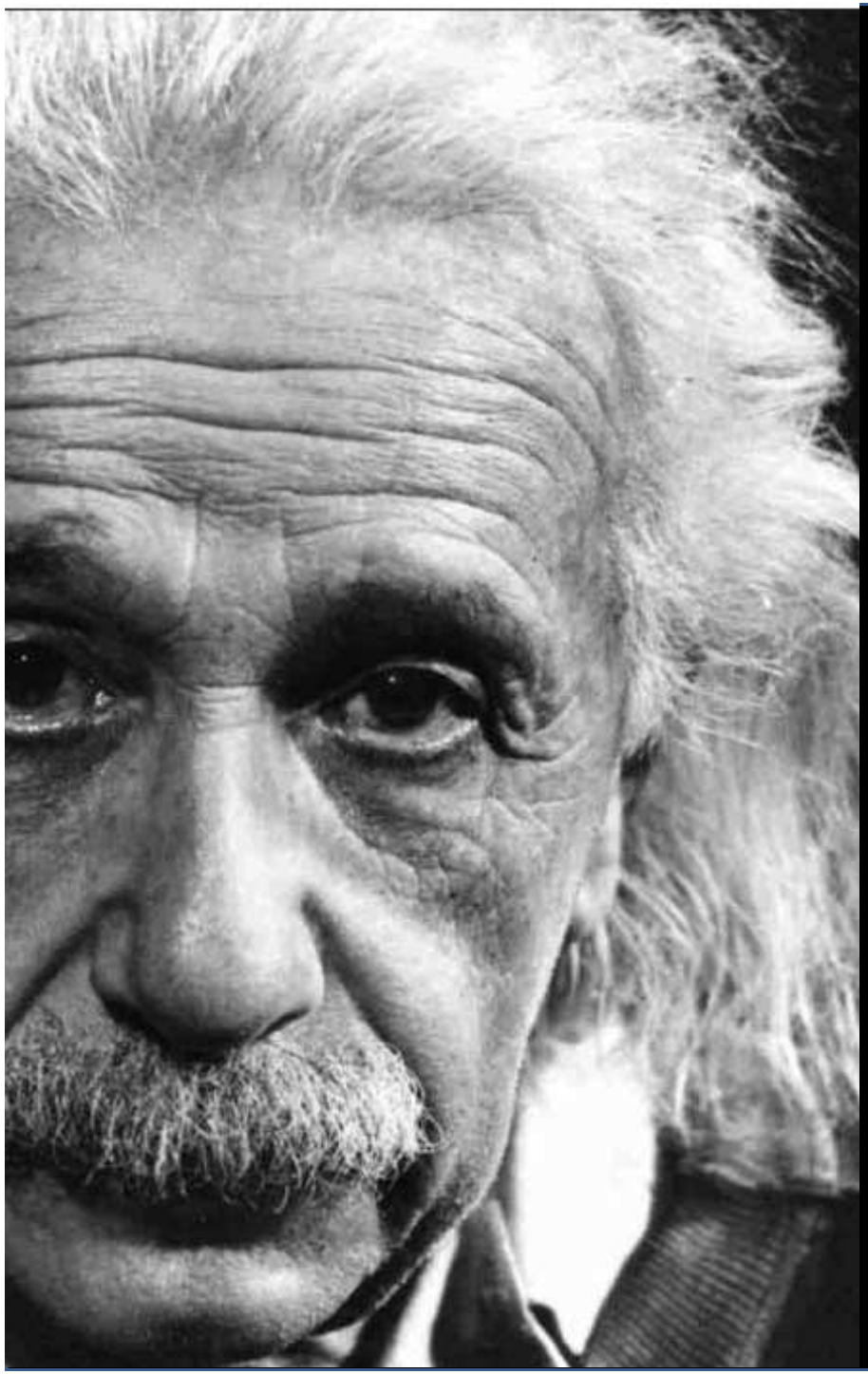
- **Cobertura**
- **Empresarializacion**
  Compra de servicios
  Integración proveedores
- **Implicación profesionales**
- **Gestion clinica y de operaciones**
- **Experiencia Paciente**
  E-health

Barreras

Lobbies políticos, sindicatos, profesionales

Reformas estructurales y barreras





La crisis es la mayor bendición que le puede pasar a las personas y a los paises, porque la crisis conduce al progreso.

Es duranre la crisis cuando nace la inventiva, los descubrimientos y las grandes estrategias.