

The Health Reform of Brasília, Brazil

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Abstract *This paper aims to show a set of strategies and care management and organization actions that have been undertaken in what was conventionally called the Health Sector Reform of the Government of the Federal District in the period 2015-2018, which was based on the strengthening of primary health care, the organization of secondary care, the establishment of the health regulatory complex, the proposed regionalization and decentralization, the systematization of contracting and contractual implementation, and the proposal and establishment of a new management model for the main public hospital in Brasília.*

Key words *Unified health system, Health policy, Federal district, Primary health care*

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Introduction

The Federal District's Unified Health System has different characteristics from the rest of the country. The main difference is in the dual nature of the DF as a federative entity, accumulating functions of State and Municipality, which is especially relevant in the context of public health and sanitary federalism. While in many aspects this merger of competencies reduces the conflicts found in other units, on the other hand, competences and responsibilities of the management of the State Health Secretariat of the Federal District (SES-DF), which always had a centralizing feature, increase against the current public management trends.

Also, Brasília has a constitutional fund, financial resources allocated by the Federal Government because it is home to the country's capital, which is for public safety, health and education. These funds have brought some reassurance to health accounts in the past. However, with the significantly higher demand for public health, due to the aging of the population and the advancement of chronic diseases and the economic crisis that the country is experiencing, resources have become insufficient to maintain this regularity of accounts, as in other states and Brazilian municipalities.

Perhaps this relative balance of past accounts has not generated a due incentive to the organization of the health network, to optimize cost and quality. We found a system whose users' gateway was almost exclusively hospital emergencies and six Emergency Care Units (UPAs) out of a total of twelve that had been proposed, built without staff planning. They functioned on temporary contracts, later forbidden by Justice, and overtime. Primary care worked was disorganized. Family health coverage was one of the worst in Brazil, about 28%, and even where there were teams, the strategy was carried out without the attributes that characterize it and give it efficiency. Each health center or facility had a different set of services. Focus specialists, mostly clinicians, gynecologists and pediatricians, but also anesthesiologists, surgeons and others, worked according to their agendas. Some places were equipped with a family health team, placed in improvised spaces in traditional centers, to justify paying bonuses that increased salaries of all crowded servers by 30% in units with at least one program staff. Local law ensured payment in these cases, which distorted the goal of stimulating family health strategy.

Also, decisions were made that ignored a possible deterioration of the economy, which brought us to the situation we found in early 2015. In 2013, a district law was enacted and reduced the workload from 24 to 20 weekly hours for health technicians, only implemented in 2015. Years earlier, the same had happened with high-level professionals. Laws were also enacted to grant salary increases that were not in line with the reality of public accounts.

Brasília pays the highest salaries in Brazil for health professionals, four to six times more than the national average in some categories. This led, at the beginning of this administration, to the absurd situation of more than 80% of the health budget being used for the payment of personnel. There was no availability to fund the supply of medicines and other supplies, maintenance of structures and equipment, or payment for outsourced services, such as cleaning, surveillance and hospital feeding. To complicate matters, a debt of around R\$ 600 million until 2014 was levied by the previous government, calculated in 2015, as commitments for products and services delivered were canceled. This debt hindered the procurement processes, which are already slow in the direct administration, governed by Law 8666 of 1993, incompatible with the response time required in public health. Not even the salaries of 2014 were committed, and the government started with a workers' strike and salary payment by installments.

Most federation units have for years moved toward decentralized management models based on performance, goals and results, and with regional autonomy and more flexible legal and administrative structures. Brasília was late in this discussion, keeping the large direct administration structure centralized in virtually every unit of the network.

In short, this was the situation found in 2016: unpayable debt at that time; personnel expenses above the prudential limits of the Fiscal Responsibility Law, hindering the replacement of pensions and dismissals; low budget, due to the national economic crisis of the last years; insufficient labor force for health demand; disorganization of the network with weak and fragmented primary care and lack of organized secondary level; weak service regulation; obsolete management model. Also, there has always been resistance from unions, enforcement authorities and local political forces to the innovation attempts required to change the course of this story.

Primary health care reform – *Converte*

Strengthening Primary Care as a basis for the functioning of the health system has been known to be relevant for forty years, ever since Alma-Ata. The importance of investing in Primary Health Care (PHC) for all societies, with great potential to contribute to the Sustainable Development Goals, is now reaffirmed to promote more sustainable and equitable human progress¹. In Brazil, recent studies confirm the correlation between investment in Primary Care and better demographic indicators, especially life expectancy, which was not repeated in other levels of care².

The first major challenge for structuring the health care network in Brasília was the organization of Primary Health Care (PHC), to fulfill its essential and derivative attributes. Thus, the program of converting all PHC models adopted in the DF into the Family Health Strategy (ESF), known as *Converte* or *ConverteAPS*, was launched.

Also, it was necessary to reorganize the PHC work system, to effectively install the ESF model throughout the DF. Ordinance nº 77³, of 2017, was published, which, besides stating the PHC/ESF concepts and attributes, also brought the primary health facilities (UBS) operating norms. The work process explicitly involved qualified listening, risk classification, clinical programming care and in self-referrals and made it clear that the patient's contact point as a health system would become primary care.

However, the publication of regulations, albeit based on the best literature and with correct orientations, would never be sufficient to promote such an extensive reform. The available workforce had never been organized that way, and much resistance had to be expected, as indeed it did.

Converte was based on the use of the existing workforce in Brasília's PHC for the structuring of family health teams (eSF), although there was no budget available to recruit new full teams, and some were convinced that the multiple care models were harmful to PHC. In 2016, PHC was staffed by 328 physicians, 408 nurses and 1,046 nursing technicians, besides family health teams, which could be used in the ESF.

Ordinance No. 78⁴ was enacted together with Ordinance No. 77³ and paved the way for the precepts of Ordinance N° 77 to be fully implemented. PHC physicians and nurses who were not working in teams were offered the option of participating in family health training so that they

could exercise the basic competencies to attend to the population they were to take on. Transition teams, formed by a clinician, a gynecologist, a pediatrician, three nurses and six nursing technicians were also established. These transition teams should promote internal matrix-based strategies, besides formal training, to be divided into three ESFs by the end of the process. A deadline for the conversion of transition teams into eSF was set, considering the objective of establishing a single PHC model, and not creating yet another model to coexist with previous ones.

In this process, nurses were widely accepted. However, the resistance of the physicians was significant, and only a third of them chose to join *Converte*. Professionals who did not join were relocated to other levels of care, and 300 appointments of family doctors were made in the reserve register of the public examination held in 2014. About 160 of them remain in the SES/DF cadres today. At the end of the training process, 110 physicians were approved in the evaluation of the use of the training and requested the change of specialty to Family and Community Medicine (MFC) in the position of doctor. It should be noted that, until then, SES/DF had never required residency or a specialist qualification to enter MFC's career. *Converte's* training was not intended to train MFC specialists, but rather to provide the core competencies so that they could work in the APS, stimulating continuing education.

With the massive adherence of nursing, the change of specialty of physicians and appointments of family doctors, family health coverage grew in a little more than a year from about 30% to 69.1%, with 549 eSFs.

Expanded coverage, with sufficient teams mainly in the most vulnerable regions of the DF, the challenge was the quality of service and the resilience of the teams. Therefore, at the end of 2017, the requirements for admission to MFC's career changed, and a residency or a specialist degree was necessary. The position of family and community nurse was also created. In the first half of 2018, the first public examination was held for family doctor specialists and family nurses. On July 31, 2018, 59 family doctors were appointed to complete the nursing-only teams. The family nurses approved in the public examination may be appointed only in 2019 to compose new teams and continue to expand coverage, because, due to challenges to the call for competition, there was no time to approve this examination before the deadline given by the electoral legislation.

The challenge of quality in PHC also involves the training of UBS staff and managers, which will be promoted continuously, starting with partnerships with DF teaching and research institutions, which is at an advanced stage of discussion.

Another significant challenge for consolidating the ESF in the DF is the contracting of community health workers (ACS). The 597 eSFs would require about 3 thousand ACS, and the availability of this professional at the SES/DF is only 1,000, enough to keep the teams qualified at the Ministry of Health. District Law N° 5.237⁵ unconstitutionally made the transposition of workers recruited in the past by private institutions in civil servants, without competition. The Court of Federal District and Territories (TJD-FT) even declared the unconstitutionality of a similar amendment promoted to Organic Law of the Federal District. Also, the statutory legal regime, with admission by public examination, is not the best, considering the nature of the ACS function and the need to be part of the community in which it operates.

For that reason, PL N° 1981 of 2018 was forwarded to the Legislative Chamber of the Federal District, and unifies the functions of a community health worker and an environmental surveillance worker (corresponding to worker fighting against endemic diseases) and creates the public position of community health worker and worker to fight against endemic diseases (ACSCCE), with admission through a public and regional selective process. With the approval of this law, it will be possible to move forward in the recruitment of workers to complete the eSFs.

Regarding oral health, Ordinance N° 341⁶, dated April 12, 2018, was enacted, which, based on the same principles of the ESF, organizes the provision of dental care in primary care.

Also in the context of increasing the quality and sustainability of PHC in the DF, two Ordinances were enacted to organize the Expanded Centers of Family Health and Primary Care (NASF-AB), as per the new National Primary Healthcare Policy (PNAB). As was done in Ordinances 77³ and 78⁴, of 2017, Ordinance SES n° 489⁷, of May 24, 2018, regulates the structuring and operationalization of NASF-AB, with its norms and guidelines, and Ordinance SES n° 496⁸, of May 25, 2018, regulates the process of transition of the teams to the new model.

An effort was made to ensure that this process of conversion was done in a transparent, standardized and technical way in all regulations, so that the changes made could be well understood,

advocated, criticized, revisited and revised at any time, avoiding possible setbacks in the future.

At the same time, other measures were taken based on the premise of PHC as a network manager, such as the structuring of secondary care and the creation of the DF regulatory complex.

Organization of Secondary Care

In the Federal District, specialty outpatient clinics were offered partly within hospitals and partly within primary health care, with physicians of various focal specialties working in health centers and clinics, without uniformity, regulation or work systematization.

The understanding of the benefits of having a secondary level of care, organized separately from primary care and unrelated to hospital care, is not unanimous. For our part, we evaluated that secondary care is not only a form of access to health specialties services, but a permanent education for primary care professionals since the implementation of matrix-based strategies eSFs to increase their resolution is one of their main goals. In the Federal District, the implementation of *Converte* and the decision of a large number of focus primary care physicians not to participate in family health teams reinforced the decision to structure secondary care for the organization of the health network.

On the one hand, we tried not to increase the clash with the professionals made available by *Converte*, which would happen in the event of a sudden change in their outpatient activities, although this happened for some of them. On the other hand, even with the training process promoted within *Converte*, the existence of secondary care could contribute, as seen, to increase the resolution of primary care and deconstruct the culture of dependence of the population of the hospital structure and the emergency room, mainly in this first stages of the consolidation of the ESF. Finally, secondary care will also serve to promote clinical programming care for patients not yet covered by family health, until full coverage is achieved for the entire population.

The administrative structure, which was already regionalized, was created for the organization of secondary care. Besides a Board of Directors in the structure of the Sub-secretariat for Comprehensive Health Care (SAIS), with technical competence, Regional Directorates of Secondary Care were created.

Included in this new level of care were specialty outpatient clinics, some of which were

initially kept inside hospitals, and others in polyclinics, some of which were installed in health centers whose professionals, mainly physicians, had low adherence to *Converte*. The Psychosocial Care Centers (CAPS), the Dental Specialties Centers (CEO) and the 24-hour Emergency Care Units (UPAs) also became part of secondary care, since there was no clarity about the level of care to which they belonged.

Thus, after Decree N° 38.982 of April 10, 2018, which created the bodies and positions, Ordinance SES N° 773, dated July 19, 2018, which organized the operation, service portfolios and flows of secondary care was published. This ordinance also provides access to this level of care through regulation and the need for prior planning, through the Specialty Plans, of the Plans of Action of the Thematic Networks for the provision of new services, which were frequently opened without epidemiological criteria, following only the convenience and training of the professional crowded in the unit.

Currently, we have the following equipment in the secondary care structure: 19 Polyclinics, 17 Psychosocial Care Centers, 13 Dentistry Specialty Centers, 2 Regional Laboratories, 1 Day Hospital, 1 Psychopedagogical Medical Counseling Center – COMPP, 1 Specialized Diabetes Center, Obesity and Hypertension, 1 Adolescent Center (“Adolescento”), 1 Specialized Rehabilitation Center, 1 Testing and Counseling Center, and 1 Radiology Center. This structure is not yet fully reflected in the National Register of Establishments (CNES) of the Ministry of Health.

We evaluated that the secondary level of care, at first, tends to grow, with the opening of new polyclinics and the provision of new specialties outside hospitals. However, in the medium term, we expect the trend to reverse, and with the increase in the quality of primary care, secondary care will be less demanded.

Establishment of the health regulatory complex

In Brasília, until 2015, the regulation of public health occurred in a specific way, for some specific services. The ICU beds were regulated, distributed by several SES/DF hospitals and some contracted private units, as well as some more complex exams and seventeen medical specialties whose offer was centralized. There was no regulation of hospitalization beds, urgent and emergency care beds, elective surgeries nor most of the specialties provided by the DF network.

The lack of regulation hinders the population's access to services and favors an unfortunately common situation in such an extensive network: the health professional's appropriation of the service provision. That is, the existence of “owners” of unregulated services, who decide who will be served and with what priority, according to their criteria, which may be fair or not.

In a scenario of higher demand than the provision of public health services, a reality of the whole Unified Health System, regulation is essential to comply with the principle of equity, establishing service priorities, democratizing and giving transparency to queues, and organizing and facilitating access to all levels of care provided by the health network.

With this in mind, the first Regulatory Complex of the Federal District (CRDF) was created, by Decree 38.488⁹, of September 13, 2017, with an administrative structure specialized in the modalities of service provided. This initiative aimed to regulate all the services provided by the SES/DF, except for those provided by Primary Care. One of the objectives is to effectively have PHC, the main client of the Regulatory Complex, as coordinator of care and health care network regulator.

Besides organizing and democratizing access to services, one of the great merits of the process of implementing a regulatory complex is the induction of the construction or incorporation of clinical protocols and the definition of service portfolios of each of the specialties available in the health system. Only with these documents can efficiency be promoted to regulation, avoiding that the chronological criterion of demand is the only one adopted for the provision of specialized services.

Within the DF Regulatory Complex, the first central, regionalized administrative structure of SAMU, which until then did not exist, and the Transplant Directorate was incorporated. Also, a Regulatory Board was created, with hospital admission centers, outpatient regulation, elective surgery regulation, interstate and high-complexity regulation, and a health transportation regulation center to treat in a specialized manner the regulation of these services modalities provided by the SES/DF network.

The system of regulation designed for the DF provides three possible scenarios, depending on the availability of the services. *Overview 1* concerns the regulation of the services for which each of the seven health regions is self-sufficient. In this case, the region itself is responsible for

regulating its patients. *Overview 2* includes services that are not available in all regions, but some of them, and regulation from one region to the other must be in place, through direct agreement, with the participation of the central command. Finally, in *Overview 3*, we would have services of higher technological density, which are only provided by the District Reference Facilities, and whose regulation is the responsibility of the central regulatory body.

It was decided to use the Ministry of Health (SISREG) regulation system as an Information Technology tool, with improvements built in partnership with the Information Technology Coordination of the SES/DF with the technical team of the Ministry of Health. In the second half of 2018, the regulation of elective heart surgeries in two hospitals, namely, the Institute of Cardiology of the Federal District (ICDF) and the Base Hospital Institute (IHB), is already underway.

The complete roll-out of service regulation will significantly help to organize the network and provide valuable information for health planning at any time.

Regionalization and decentralization

In 2015, the DF began studies to promote the creation of Health Regions, following the line of promoting health regionalization and decentralization. Seven health regions were created by Decree 37.057¹⁰, of January 2016 – North, South, East, West, Southwest, Center-South and Center, each with one or two regional hospitals and several other public facilities, such as UBS, CAPS and polyclinics. Also, the Base Hospital of the Federal District, São Vicente de Paulo Hospital and Brasília Support Hospital were classified as District Reference Facilities (URD), serving the entire population of the Federal District. Regionalization was established by Decree 37.515¹¹, of July 26, 2016. Later, in 2018, adjustments were made, and the Central-North region encompassed part of the Center-South region, creating the Central region, with more uniform epidemiological characteristics. In the same period, the Mother and Child Hospital of Brasília, which was part of the Center-South region, and the Regulatory Complex were also classified as URDs.

After almost two years of discussions between the central command and the regions and several training workshops, regional management agreements (AGRs) were signed at the end of 2017, with targets to be pursued by regional superintendents, who to some extent compare to the

Municipal Health Secretaries in the other States.

The final stage that would complete the process of regionalization and administrative decentralization, that is, effective control over budget execution and contracting, was not completed, because an inability of the regions to maintain administrative structures capable of accomplishing such tasks was identified. Only a small part of the budget is executed directly by the regions, the one corresponding to the PDPAS (Progressive Health Actions Decentralization Program), a small resource, limited to R\$ 8 thousand per item, theoretically used for exceptional situations of lack of materials or small recruitments, but which was essential to maintain the supply of some inputs at various stages.

Public regulations, in particular bids and contracts rules, as they have evolved since 1988, were aimed at avoiding the harmful effects of dishonesty in public management, but failed to give due consideration to the consequences on management as a whole. The consequence is a high level of bureaucratization, which, besides requiring a large number of professionals to analyze and control all processes, imposes a delay of months to years to complete any hiring.

If the central bodies already have great difficulty in completing the processes, the regions, which do not even have such staff and knowledge, would not be able to assume the functions that are now performed centrally. Decentralization, in this case, would not be to distribute power and skills but share the same inefficiency.

Two sets of measures were adopted to address this situation: first, in 2017 and 2018, the systematization of contracting and contractual executions was promoted, with the preparation and publication of the first SES/DF Contracting Regulation and the first Implementation Manual. Second, it was sought to invest in more agile, modern and results-oriented legal-administrative models, such as the establishment of the Base Hospital Institute, an independent social service controlled publicly but governed by private law norms, on which we will discuss later.

Systematization of contracting and contractual executions

Concerning bids, contracting and contractual executions, the situation found in the Federal District was of concern. There was a debt of about R\$ 600 million left over by the previous government, and it had no prospect of being paid for lack of budgetary and financial resour-

es. Also, in March 2016, there were more than R\$ 500 million in expenses without contractual coverage, due to difficulties in carrying out the bidding processes or emergency contracting.

The processes went back-and-forth between technical areas – responsible for the definition of demand, preliminary studies and elaboration of basic projects – and the central contracting areas, with competence to analyze the regularity of the process and to promote the bidding itself. There were cases of processes with twenty different basic projects, which already lasted for years and were not concluded.

In contract executions, liquidation and payment were disorganized and the delay entailed constant threats by companies to cease supply because of financial difficulties. The main problem was the multiplicity of oversight officials distributed across the health facilities and the various gateways of collection documents. The delay in payment, as well as the inability to pay for the expenses of previous years, especially those of 2014 or older, scared the suppliers and increased the number of deserted or failed bids.

The SES/DF Regulation and Contracting Manual (SES Ordinance No. 210¹², dated April 13, 2017) and the first Manual of Contractual Executions (SES Ordinance No. 170¹³, dated April 11, 2018) were published to mitigate these problems. These documents were aimed at increasing the efficiency of processes in direct administration, as well as reducing the time of payment to suppliers, who often complain of the long delays between the delivery of the product or service and the payment.

Thus, the construction of the primary projects and terms of reference began to be made by contractual instrument drafting committees, with the participation of both the respective technical area and the contracting body. The demands were made official and consolidated. The receipt of the collection documents was also centralized and the central executor of the contracts was created, with the support of the local inspectors. Deadlines were established and responsibilities were defined. Indicators monitored the entire process. Also, in 2017, paper processes migrated to electronic process through the Electronic Information System (SEI) developed by the Federal Regional Court of the 4th Region, also reducing the processing time between areas.

Thus, among other measures, it was possible to reduce the time of bidding processes and increase the number of trading sessions, from 230 in 2016 to 336 in 2017, and 355 accumulated

until August 2018, with approximately 2,903 items purchased. Concerning drugs, the processing time for purchase in regular bids since the implementation of the changes from June 2017 to August 2018 was on average 194 days, with 172 days in July and 131 days in August 2018. For medical-hospital material, the time was 216 days throughout the period, 204 days in July and 172 days in August 2018. Besides the higher efficiency of the process, the monitoring of these deadlines, with a monthly presentation of the results, also contributes to their reduction.

Only in the acquisitions carried out in 2018, one can estimate savings of approximately R\$ 39 million, corresponding to the difference between the estimated amounts and the amounts paid on the items purchased. Also noteworthy are savings of approximately R\$ 80 million between 2016 and 2018 related to acquisitions that were carried out through emergency or indemnity contracts and which began to be implemented through regular contracts, bidding for values below the previous ones. However, despite improved contracting rules by direct administration, this model will never have the same efficiency of a legal-administrative structure designed to make public health, with its rules that ensure transparency, efficiency and the agility that is expected and is required of the health system.

Creation of more efficient legal and administrative structures – Base Hospital Institute

The standards that govern direct administration in Brazil are inadequate to the weight attributed to the State in our constitutional model, especially in health, governed by the principles of universality and integrality. Obstacles are imposed not only by laws but an entire system that allows for the constant creation of new rules by oversight agencies. It would be reasonable to imagine that stricter standards would generate a high level of reliability and safety, albeit at the expense of the slow public process, but this is not the case. The bidding law is, along with electoral funding, at the heart of the corruption scandals in the country's recent history. The difficulty generates an opportunity to sell a facility. The legal regimen of the public servant, or the way it is applied, is one of the significant obstacles to advancing in better models of people management, based on results, monitoring, awards for performance and quality.

The effect of this is that public bodies throughout Brazil are far from achieving what

they could in terms of efficiency and results and, in health, there is no room for slowness. The speed of response marks the difference between life and death, between recovery and sequel. The rules of the game, however, are the same. A chemotherapeutic is bought in the same way as if you buy coffee for the department. A health unit is recovered with the same rules as repairing the sidewalk on the corner.

The norms are inadequate and the State must fulfill its duty to make health, in a universal, comprehensive and timely manner. How to make this work out? States and municipalities have sought legal-administrative models with more reasonable rules, such as foundations, public enterprises, autonomous social services, and partnerships with social organizations, all facing resistance from advocates of a “pure state”. Local and federal legislatures, as well as the Federal Supreme Court, recognize the legitimacy of these models for public health, without which the situation would be worse.

The Federal District lags behind this trend, necessary for public health in the 21st century. Almost the entire health system of the DF is still done by direct administration, after the extinction of the Hospital Foundation of Brasília in May of 2000.

We had a single structure with effectively decentralized management, namely, the Children’s Hospital of Brasilia, managed in partnership with a social organization created by the users’ association that built the hospital and donated it to the Public Power. Even without any report of irregularity in seven years of hospital management, high productivity, meeting targets and a level of satisfaction of users above 99% and workers above 93%, there were still attacks by unions and control authorities against its management model, which came to be in real danger in 2018, but was defended by the government and society, and is still in full swing at the moment.

By 2016, an attempt was made to expand management contracts with social organizations. Firstly, for the primary care of the largest Administrative Region of the Federal District, Ceilândia, with 460,000 inhabitants, had the lowest family health coverage of the DF, with about 22%. Then, the same attempt was made for the UPA of Ceilândia, due to its low productivity and difficulty in hiring staff. However, there was fierce opposition from the local Legislature and health servant unions, and no progress was made on the project.

In 2017, after a dialogue with various institutions, such as OAB, CRM, Public Prosecutor,

Court of Auditors and Health Council, the Government of the Federal District sent to the Legislative Chamber to establish in our largest unit - Base Hospital - a legal-administrative model capable of bringing effective autonomy, efficiency, transparency and agility in internal processes. The proposal was to create an independent social service, like that already existing in the network Sarah Kubitschek, in the health service of the State of Acre and the Dr. Célio de Castro Metropolitan Hospital of Belo Horizonte, with private law rules in a public control structure.

The bill also incorporated the precepts established by the Federal Supreme Court in Direct Actions of Unconstitutionality n° 1.864, ruled in 2008, and n° 1.923, ruled in 2018, which recognizes the legitimacy of the structure and establishes that this type of parastatal entity is not submitted to the bidding and public tenders’ rules or the statutory legal regime.

Thus, after intense discussion and several public hearings and seminars on the subject, the Legislative Chamber of the DF approved and the governor enacted Law No. 5.899, of July 3, 2017, authorizing the creation of the Base Hospital Institute of the Federal District (IHBDF). This law was regulated by Decree 38.332¹⁵ of July 13, 2017. The Board of Directors, consisting of eleven people and appointed by the governor, approved the IHBDF Statute on August 15, 2017, which was registered in a notary’s office. In December, the Internal Regulation, the Regulation of the Selection Process for Admission of Personnel and the Regulation of Procurement and Contracts were approved. Finally, on January 11, a management contract was signed with SES/DF, and the new management model of the IHBDF was started the next day as an independent social service. All these documents are available in www.instituto-hospitaldebase.com.

It is worth mentioning that in eight months of operation, according to the second quarterly management report presented to the Board of Directors on August 25, 2018, the improved performance and better quality of the services rendered are precise.

The IHBDF reopened 107 beds that were blocked due to lack of personnel or infrastructure, and there were no more beds blocked in the hospital. There were six open operating rooms. Today, after the purchase of equipment, investments in infrastructure and people management, twelve operating rooms are open. The daily number of surgeries rose from about 15 per working day in the month to over 40 in August 2018.

The mean emergency room occupancy fell from 195 to about 120 patients, above the capacity of 83, but with a significant drop due to the flow of surgeries and ward admissions. The number of oncology visits jumped from 10 to 180 per month, which allowed clearing the waiting list for oncology of the Federal District. The IHBDF makes its purchases in 40 days on average, while SES takes an average of six to eight months with the bidding process, and the value of contracting is similar and is 10% lower in some items. Supply and maintenance problems were substantially reduced. Finally, the indicator of user satisfaction jumped from 31% to 65% in the emergency room and from 31% to 72% in the outpatient clinic.

The process of installing and consolidating the IHBDF is still ongoing, but the first results look promising. It is worth noting that the physical structure is the same, the budget is the same as 2015, and the IHBDF operates today with fewer workers than it did before the model change. The difference lies in the rules governing its operation. Standards designed to make health, which increase agility without sacrificing transparency.

We believe that once the model has been fully consolidated, it can be expanded to other DF units, as well as being the object of own studies and serving as a paradigm for other units of the federation.

Conclusion

From 2015 onwards, The DF was submitted to a reform of its health system, to establish a regionalized health care network, regulated from primary care and based on the Family Health Strategy. The challenges were and continue to be many, but the major projects implemented in this period include the creation of the Health Regulatory Complex, the organization of the secondary level of care, the systematization of contracting and implementation processes and the investment in legal-administrative decentralized models, especially the autonomous social service model installed in the Base Hospital Institute, based on results, goals and quality indicators, and with rules that are appropriate to what is required of the Unified Health System.

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