

OBSERVATÓRIO ANAHP

Associação Nacional de Hospitais Privados

English Version



Edition 03 | 2011





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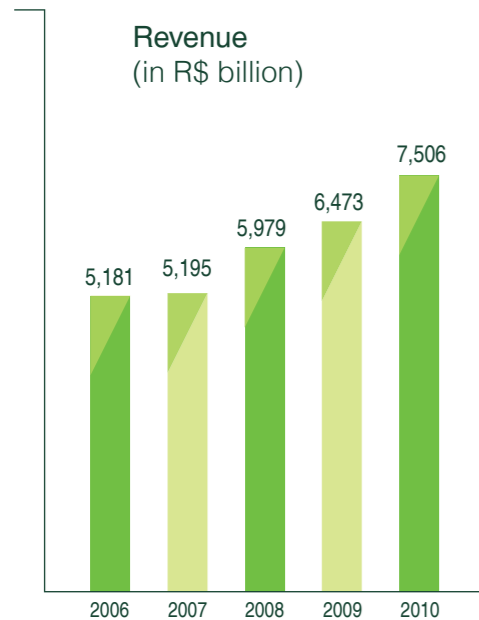
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Gross revenue of the hospitals that participated in the survey reached

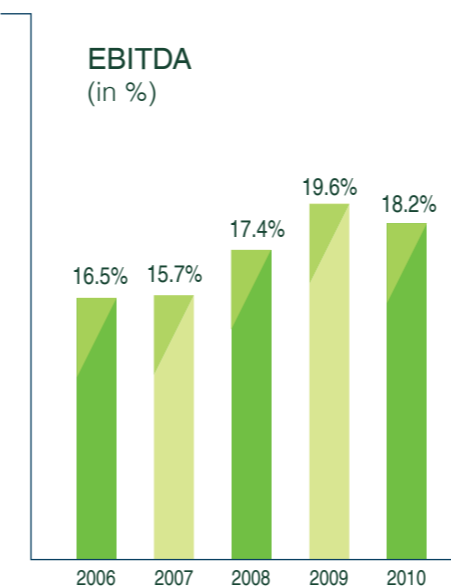
7.5 billion

reais in 2010, a **16%** growth over the previous period.

7,355

Installed Beds
At the beginning of 2011 ANAHP represented **6%** of existing private beds in Brazil's supplementary health system.

Source: ANS – Supplementary Health Information Book, Dec./2011

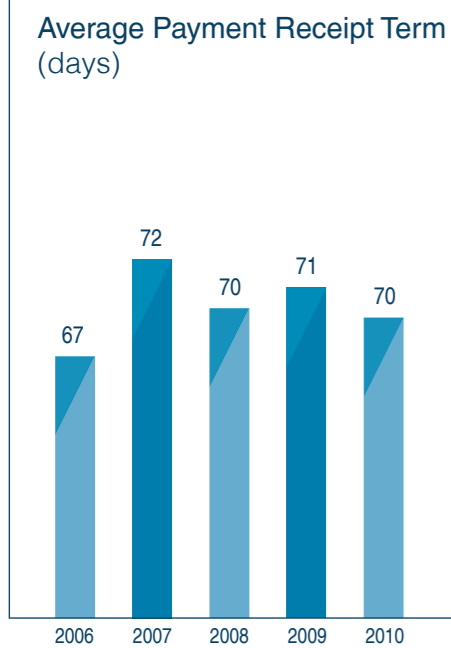


IN **2010** ANAHP hospital accounted for

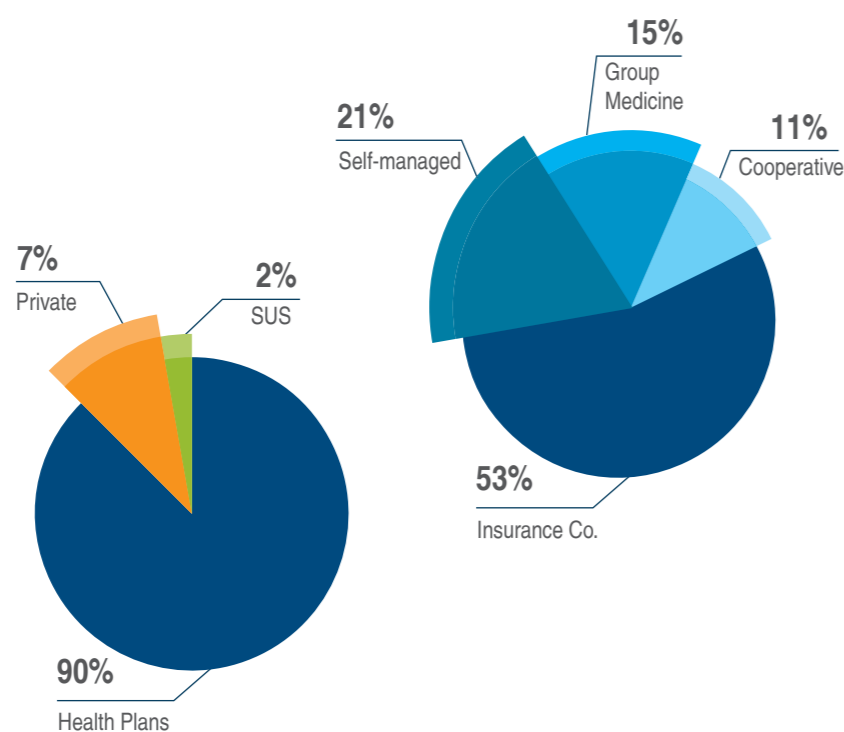
14% of total healthcare expenses and

10% of total hospitalizations in the Supplementary Health Industry.

Source: ANS – Supplementary Health Information Book



Revenue by Type of Payment Source (2010)



Accreditations in Hospital Institutions

Type of Accreditation	ANAHP	Brazil	% ANAHP
Organização Nacional de Acreditação – ONA	31	148	21%
Joint Commission International – JCI	7	14	50%
Accreditation Canada – AC	6	11	55%
National Integrated Accreditation for Healthcare Organizations – NIAHO	1	2	50%

Source: ANAHP survey with Associated Hospitals; ONA at www.ona.org.br; Accreditation Canada em www.iqg.com.br; JCI at www.cbacred.org.br; and NIAHO at www.driv.com.br.



Projeto Parcerias



Diamond



Gold



Silver



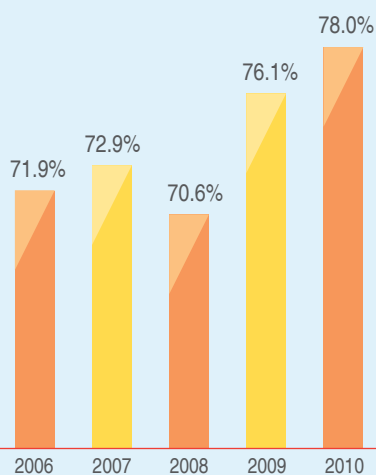
ANAHP

in numbers

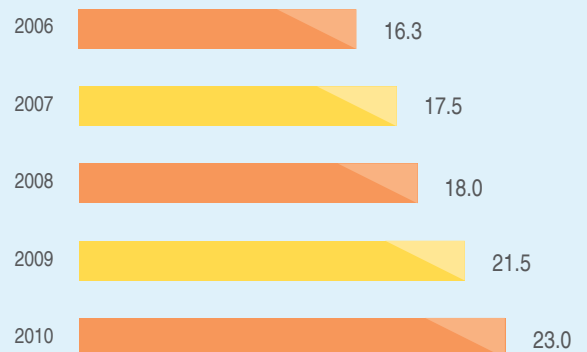
Breakdown of Surgeries (by degree)

	2006	2007	2008	2009	2010
Outpatient	12.9%	12.3%	11.4%	12.2%	9.5%
Large Degree	25.9%	27.4%	26.2%	25.6%	24.2%
Medium Degree	34.5%	33.2%	36.7%	33.8%	38.0%
Small Degree	21.2%	21.4%	20.3%	22.9%	21.1%
Special Degree	5.5%	5.6%	5.4%	5.5%	7.2%

Average Occupancy Rate



Total Tests – Laboratory and Imagery (millions)



Source: SINHA/PMPA, 2010

*Competência,
é nosso princípio
ativo.*

NÓS, DA SANOFI-AVENTIS,
TEMOS O ORGULHO DE OFERECER
SEMPRE O MELHOR PARA UMA EQUIPE
MÉDICA TÃO BEM PREPARADA.

sanofi aventis

O essencial é a saúde

Message to the reader



The Brazilian Private Health System experiences an historical phase in the country's development. The priorities of the current government include bringing health to center stage of discussions and developing a positive agenda involving the public and private sectors.

In 2010, health plan users totaled 45.6 million beneficiaries, according to ANS – National Supplementary Health Agency. This number stands for 8.7% growth in comparison with 2009. The industry's revenues exceeded R\$ 71 billion.

Based on this scenario, the need to develop mechanisms to assess and measure health services output becomes indispensable. The government itself has worked on the development of indicators to assess quality and assure access to services offered by SUS – Unified Health System. Aware of the need to seek alternatives that may contribute to the exchange of information in the industry, in 2009, ANAHP published the first edition of ANAHP Observatory, the yearbook that stood for the maturity of SINHA – Hospital Indicators System, and PMPA – Best Healthcare Practices Project. Nowadays, more developed and with more consistent data, this publication of ANAHP indicators and analyses, in its 3rd edition has become an important lookup instrument for the market and has further highlighted ANAHP's importance as a reference in the industry.

One can state that 2010 was a highly productive year for our entity. Apart from the improvement of this publication, among other noteworthy initiatives, ANAHP actively took part in discussions about the financial compensation model, together with the Regulatory Agency and all other representative entities, in the quest for better alternative commercial relations in the system. The National Health

System's (ANS') Workgroup has already greatly progressed in decision-making, and in 2011 the issue continues as a priority on the industry's agenda. The importance of involving the medical class in the discussions was also extensively covered in 2010, since it is our belief that only through dialogue among the parties involved will it be possible to reach a fair decision favoring everyone.

After having been on ANS' agenda for two years, the accreditation of Health Service Operators, another important chapter in the private sector's history, will be finalized in 2011. The initiative aims at defining accreditation norms, seeking efficiency in services provided, by publishing performance indicators, always concerned about offering private health service users quality services compatible with their needs and in tune with modern age medical and hospital practice. The year 2011 represents an historical moment for ANAHP, which is celebrating its first decade of existence. Founded on May 11, 2001, ANAHP was created to defend the interests of the industry and build on progress made by private institutions to beyond the boundaries of Supplementary Health, benefitting all Brazilians. Ten years went by, and when looking back, one can see that we are complying with the expectations of the 23 associated hospitals, which undertook concrete steps to the realization of this great dream. There is still a lot to accomplish, because changes have but just begun. However, we will continue to develop our projects with the feeling that we are complying with our duty, which is to disseminate the private sector's best practices in health services in the market. The ANAHP Observatory is an example of the Association's commitment to its objectives.

Finally, I wish to thank all parties involved in the production of this material, in particular the Associated Hospitals that, on a day-to-day basis, contribute to the success of ANAHP's activities.

I trust you will enjoy the reading!

Henrique Moraes Salvador Silva
President of ANAHP's Deliberative Council

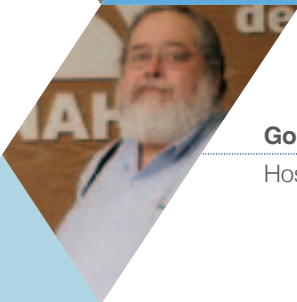
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Observatório ANAHP Masthead

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Gráfica Revelação

Ten years of transparency

"Life can only be understood backwards, but it must be lived forwards."

Soren Kierkegaard

As you know, in 2011, ANAHP is commemorating ten years of intensive membership activity, always looking for the best solutions, for management and participative models, and as concerning relations among managers and technical staff of its members, but, more importantly, for increasing the degree of competitiveness of its associated hospitals. Fostering the exchange of experiences has been essential for discussion fora within ANAHP, to always and increasingly present important input for the national thinking about hospital management, whether from the business or clinical perspective.

Our "Observatory" publication, in its third edition, well expresses the thinking of Danish philosopher and theologian Soren Kierkegaard. For years we have been gathering information about our hospitals: financial, operational, clinical, and institutional data, and for many years we have publicized our data and analyses in the most transparent manner possible. However, all this data and information portrays the past of our hospitals. Hence, our pronounced obsession in receiving the data in due time, because, with your historical perspective, we can actively and positively intervene, contributing by aggregating our technical, clinical and managerial activities, so as to assure a new, more improved and positive quality cycle for our clients.

ANAHP's and ANAHP Observatory's contribution to the market is unequivocal. We have transparently presented our indicators, thereby fulfilling our objective of accountability vis-à-vis society, our partners, our technical staff, and health authorities. In the effort to foster the Hospital Accreditation movement, whether related to member hospitals or to

the Brazilian hospital market, we strongly believe that the publication of our technical-operational information and on assistance quality, along with comparative indices, will meet the demand for reliable information that may be used for comparisons and as a benchmark for the market in general and for our hospitals in particular.

As is customary, in this edition of ANAHP Observatory, we present four introductory articles intended to consolidate initiatives worked on in 2010. We are herein publishing a survey conducted in our hospitals on clinical governance (a topic we will still often touch upon) in which, once again, we show the pioneering efforts of our medical managers. In addition, after a concise analysis of the supplementary health market, we present two retrospectives covering the last ten years: the development of some strategic aspects of our hospitals and the current design of Corporate Governance in our Institution, as well as an analysis of the extent to which this model, in permanent development, is beneficial for opening up our participative structure and developing new leaders and talents who will assure ANAHP's perpetuity.

ANAHP Observatory is the result of the constructive effort of many persons and it stands for what it is on account of this collective construction effort. I wish to mention several colleagues who decisively contributed to this endeavor. They are: Sérgio Bento, Valdesir Galvan, Pedro Palocci, Denise Schout, Miguel Cenderoglo, Evandro Tinoco and Daniel Coudry. They are all authors of magnificent analyses that undoubtedly greatly contributed to the publication's content. I trust that in mentioning them, all other participants will feel that they too are being praised and remembered. There is something magic about this process that results from the many invisible hands that produced this Observatory, which will for that reason be eternally honored.

Francisco Balestrin

Editor of the ANAHP Observatory

ANAHP celebrates its 10th anniversary and consolidates Governance model

Presence in the health industry's main discussion forums and increase in representativeness of associates are the Association's accomplishments in its first decade



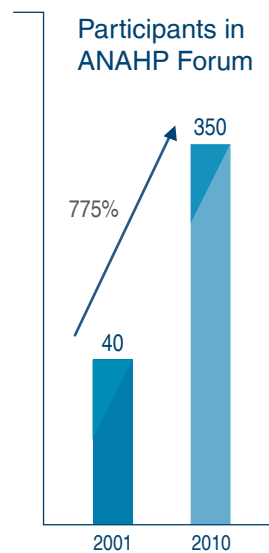
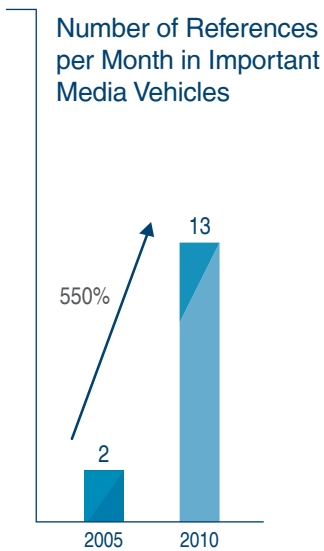
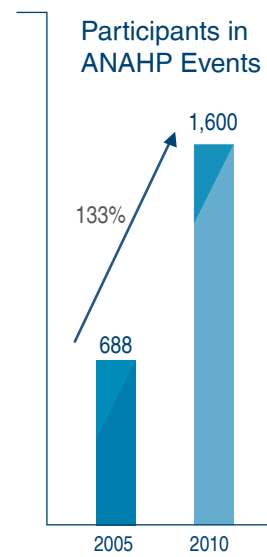
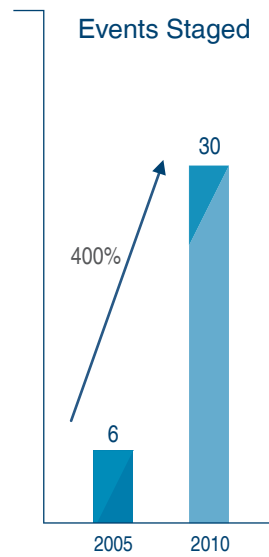
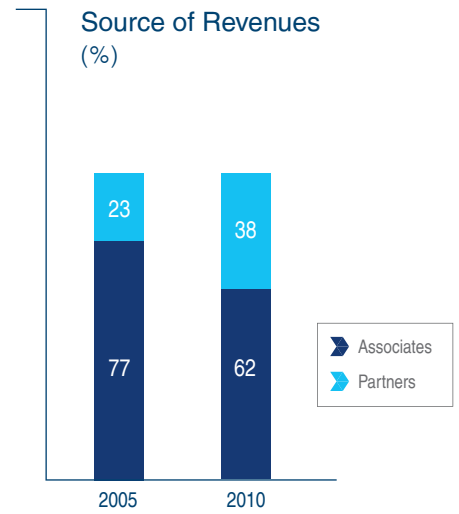
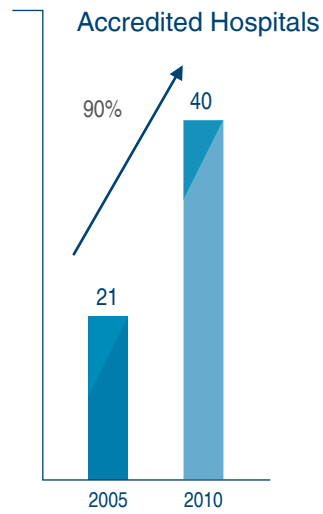
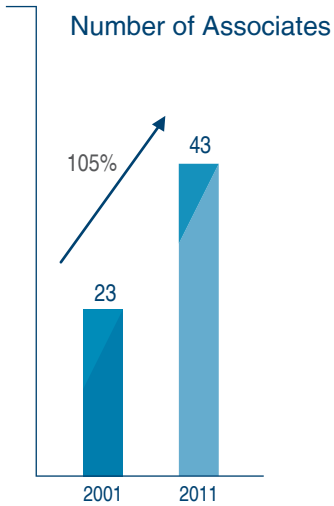
Increased participation of associates allowed the appearance of new talents in the Association, who will surely be the leaders in coming years and will assure ANAHP's continuity and perennality.

The year 2011 has a special meaning for the ANAHP – Associação Nacional de Hospitais Privados (National Private Hospital Association). In the second semester, upon celebrating its first decade of existence, it will consolidate itself as an important association of the National Health segment, with activities not only in Brazil, but also in renowned discussion fora of the industry abroad.

The balance of these ten years reveals ANAHP's maturity, achieved through consistent work of its executives and associates and projects that nowadays are a reference for the entire Supplementary Health Industry, as is the case of SINHA – Sistema Integrado de Indicadores Hospitalares (Integrated Hospital Indicators System) and indicators of PMPA – Indicadores do Projeto Melhores Práticas Assistenciais (Indicators of the Best Healthcare Practices Project), consolidated in this ANAHP Observatory, in its third edition. The Association enters 2011 with more participative internal management and a strengthened external image, not only due to the number of staged events, but also due to its constant appearance in the country's main communication media vehicles.

In its ten years of activity, ANAHP did not deviate from its guiding principles, instituted by the "Charter of Brasilia", and was wise in perfecting Corporate Governance over time, so as to allow intensive participation of talents and individuals who, albeit not members of the entity's management bodies, have contributed valuable expertise and knowledge to the Association's projects. Another important item to be emphasized is the leadership role of ANAHP and its recognition in the Supplementary Health market, the result not only of the work performed by its current management, but also by preceding management teams, that allowed ANAHP to mature, in combination with what is state-of-the-art and innovative in the health market.





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» Corporate Governance

To expand the representativeness of its associates, by alternating its leaders and setting up a tactical-operational model that would warrant empowerment of professional management. This was the main objective of the Corporate Governance model adopted by the ANAHP at the end of 2009, and consolidated last year and in 2011.

The ANAHP's Deliberative Council understood that there is a big difference between representation and representativeness: representation can occur through any person designated to perform that role; representativeness, on the other hand, can only occur through who in fact is empowered to that end, and who, in the case of the Association, are its associates, mainly through the Deliberative Council".

This new model, more participative in nature, was adopted by the Association in 2009, after a survey conducted among associates showed the need to optimize aspects involving governance, make the qualification criteria for associated hospitals clearer, and expand its representatives' participation in decision making.

ANAHP's current model of representativeness was validated by a revision of its by-laws. The new document sets forth that for each four associates of a same region of the country there would be a seat in the Association's Deliberative Council. Currently, the ANAHP has nine council members, distributed according to the number of associates in each region.

To become a member of the ANAHP, a candidate institution must comply with some eligibility criteria, including: the ONA III Accreditation, or JCI, or Accreditation Canada or even NIAHO, and be a hospital that provides mainly supplementary medical services, while not being controlled, directly or indirectly, by health plan operators.

Guided by the Code of Best Practices in Corporate Governance, which sets the system's principles, the change also involved consultancies. The work related to the definition of the strategic planning was coordinated by Foundation Dom Cabral (Dom Cabral Foundation), which laid down the strategic pillars and

guidelines: the generation of competences, communication, and institutional representativeness.

Deloitte defined the tactical plan, proposing a new model of tactical-operational management led by an executive director (CEO). The Executive Director role entails the necessary mandate for performing in this function, with focus on implementing the strategic planning developed within the Deliberative Council with the participation of the Associated Hospitals, as well as the administrative attributions. The management model put in place is distinct in that it is process-oriented rather than people-oriented, assuring the Institution a legacy of longevity. The target for 2011 is to have all processes documented, standardized and integrated, supported by obtainment of the ISO 9001 certification.

Within the new Organizational Architecture, three programs were defined: Technical-political Sustentation, Sectorial Relations and Innovation and Management. From these, 13 strategic projects were derived, which are carried out by specific workgroups. Members of Management, members of the Council, and mainly representatives of Associates take part in such workgroups, aggregating value to programs and their projects, in work performed in an esprit de corps setting.

The new model allows disseminating good management practices among its associates while also representing a benchmark in an industry lacking the systematization of good practices. Nowadays, the ANAHP is present in the main discussions taking place in the Supplementary Health Industry.

In 2011, the ANAHP will promote the 1st Private Hospitals National Congress (see box), and will also propose a new remuneration model for Private Hospital Services, apart from instituting a Teaching and Improvement Program. The Associação will also publish a commemorative Book on the 10 years of ANAHP and a Clinical Governance Manual containing recommendations made by the Association.

ANAHP stages Congress in 2011

As part of the commemorations of ANAHP's ten years, the Association will, in 2011, stage the 1st Private Hospitals National Congress. The event, the result of an unprecedented partnership with Hospitalar Feira e Fórum, is expected to bring together some 800 people.

The Congress' theme will be "The importance of Private Hospitals in Health – Today and Tomorrow", and as discussion axes: Management, Care and Strategy.



Eurofarma
segmenta

TECNOLOGIA E INOVAÇÃO JUNTAS EM UMA EMPRESA 100% BRASILEIRA.

Em janeiro de 2011, a Eurofarma adquire a empresa Segmenta, líder de mercado em SPGV (soluções parenterais de grande volume), e cria a Eurofarma Segmenta, uma empresa 100% nacional, voltada exclusivamente para o mercado hospitalar. A nova empresa une a destacada atuação em marketing e vendas da Eurofarma e a liderança de mercado da Segmenta, e chega para ser referência no fornecimento de produtos aos hospitais das redes pública e privada.

Com cerca de mil colaboradores, a Eurofarma Segmenta atuará em todas as possibilidades de consumo hospitalar, o que inclui um amplo portfólio de produtos como antibióticos, anticoagulantes, anestésicos e SPGV, além dos sistemas de infusão, drogas diluídas e a linha ASA (saneantes, antissépticos e cosméticos).

Além disso, a empresa tem plano de internacionalização, seguindo a visão do Grupo Eurofarma, que pretende estar em 2015, entre as três maiores farmacêuticas do país em participação de mercado, com produtos inovadores próprios, cobrindo 90% do mercado latino-americano. Com isso, o mercado hospitalar se beneficiará de um elevado padrão de qualidade e serviços.



Fábrica Fabril SPGV, ASA e Moléculas para Saúde - Ribeirão Preto/SP



Complexo Industrial de Inovação/SP

Risk management and safety evidence clinical governance in ANAHP hospitals

To invest in safety in the healthcare environment warrants excellence in healthcare for patients



According to the study, 97% of the organizations have reporting processes freely accessible by all professionals in the hospital.

The involvement of top echelons in risk management, the existence of criteria established to manage such risks and the creation of a department responsible for such issues are some of the characteristics of ANAHP associated hospitals. This conclusion is presented in a survey conducted in these organizations, with the objective of defining a detailed diagnosis of risk management activities in the hospitals.

The survey, conducted based on a questionnaire, involved the participation of 32 hospitals, or 80% of ANAHP hospitals in 2010.

Of the associated hospitals that responded to the survey, 78% have a department responsible for risk management. In 84% of the entities participating in the study, top echelons participate in the risk management process. (Graph 1).

The participation of technical directors in leading healthcare teams is essential to implement the changes necessary and to ensure the involvement of doctors. This process is one of the actions that characterize an organizational model for the clinical staff, which is focused on clinical governance. This concept entails as premises, in the first place, the patient, followed by quality and safety, alignment of the clinical staff with healthcare management strategies, corporate sustainability, and organizations' transparency.

The participation of the technical directors in leading healthcare teams is essential for implementing the necessary changes to assure doctors' involvement in this process.

The survey, conducted in September 2010, attempted to identify the following aspects related to risk management: how hospitals are organized; reporting processes relative to adverse events; activities related to notifications, information recording in patients' health records and in the system; guidance and means to manage cases of falls, pressure ulcers,

phlebitis, allergies, thromboembolism, bronchial aspiration, surgical site marking, emotional vulnerability, loss of catheter, accidental extubation and blood transfusion.

The survey was performed based on a form drawn up by a team of professionals of several hospitals. The form was filled out by the technically responsible individuals in the quality sector and validated by the organizations' technical director. According to the survey, in 97% of the organizations there exist reporting processes with unrestricted access to all professionals in the hospital. Adverse events are critically analyzed in 29 (91%) of the organizations. Risks and adverse events are identified and assessed. Then, corrective actions are planned and implemented in most of the hospitals that responded to the survey.

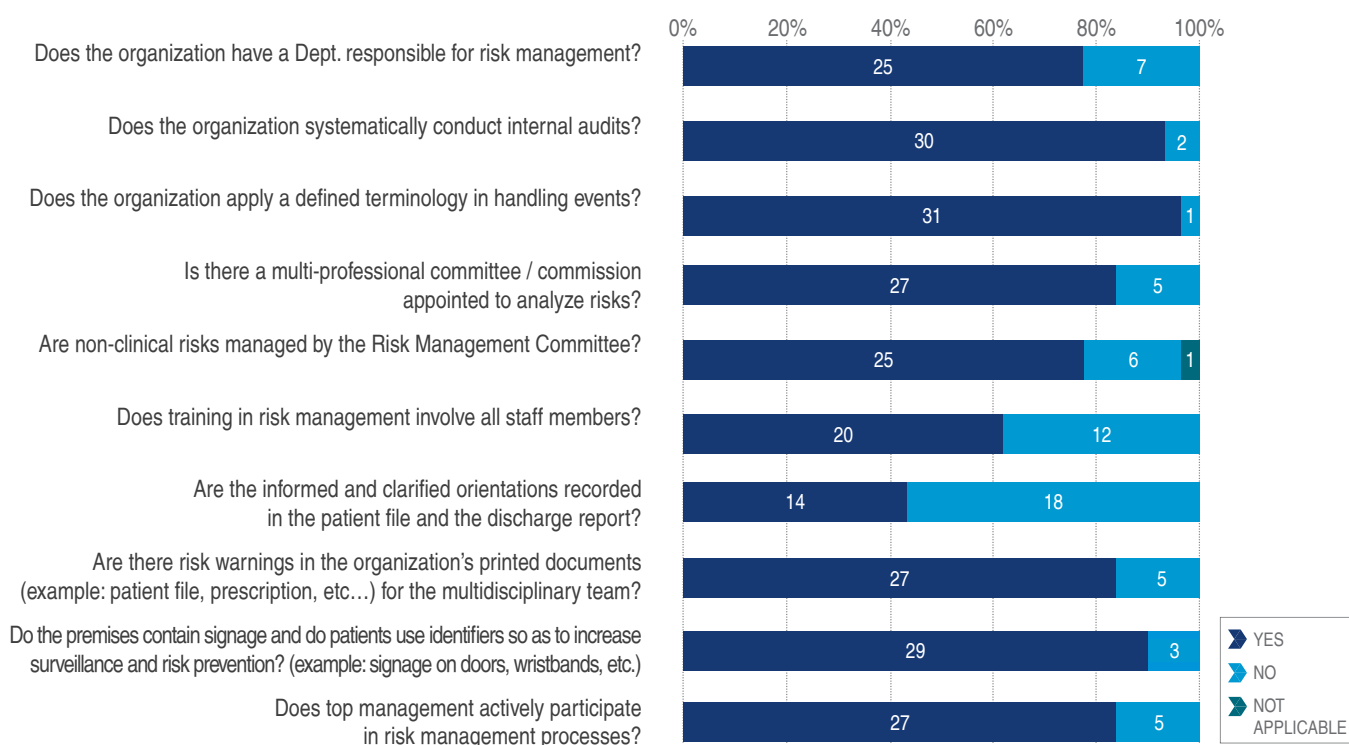
Risk of falls (94%), risk of pressure ulcers (88%), accidental extubation (97%), loss of catheter (81%), medication error (97%) and transfusional reactions (97%) are processes requiring coordinated interventions by different professionals involved in the direct care of patients. (Graphs 2, 3).

The conclusions of the study ratify the track record of investments in the qualification of human resources and nursing services in ANAHP hospitals. Human Resources information and indicators, such as nursing and nurses per bed and the number of hours of training, are indicative of this kind of emphasis on the management and qualification of human resources. In providing care to a patient, nursing care in particular plays a key role with respect to the control and recovery of hospitalized persons. Nursing care is viewed as one of the pillars in the prevention of adverse events.

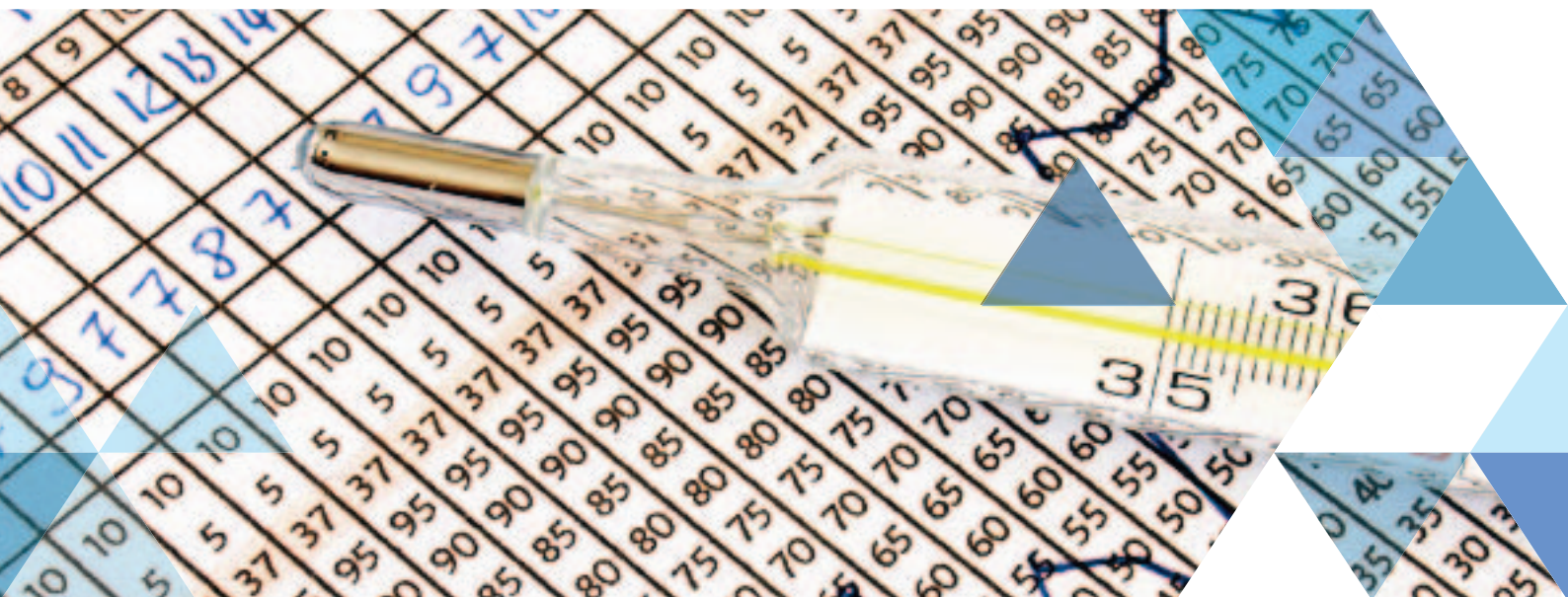
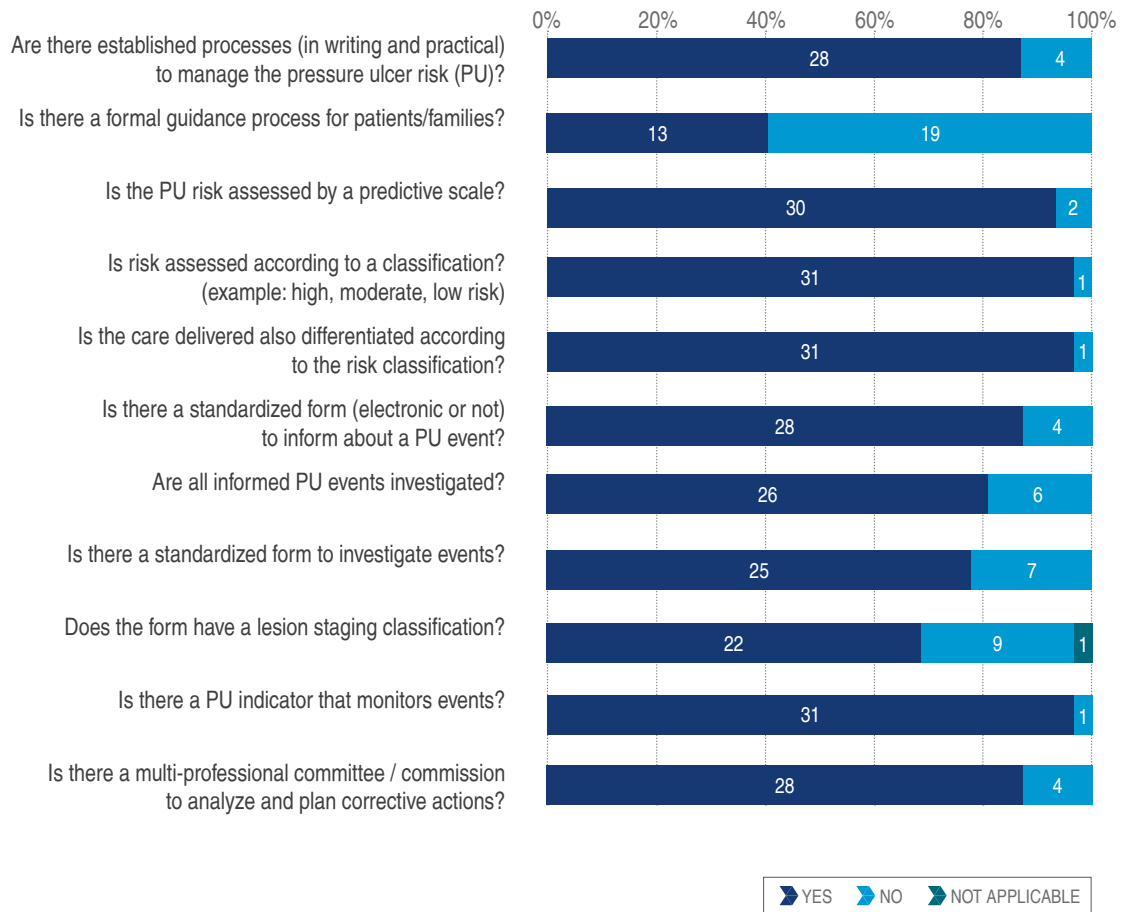
Nowadays, the prompt recovery of a hospitalized patient is related to the performance of other health professionals in the direct care of a patient. The role of physiotherapists, nutritionists, clinical pharmacists is increasing, with an important impact on reducing length of stay and the degree of dependence of patients upon discharge.

Quality programs and external accreditation processes value and emphasize the implementation of risk management in hospitals. For those that are a reference in servicing more complex cases, these programs are strategic.

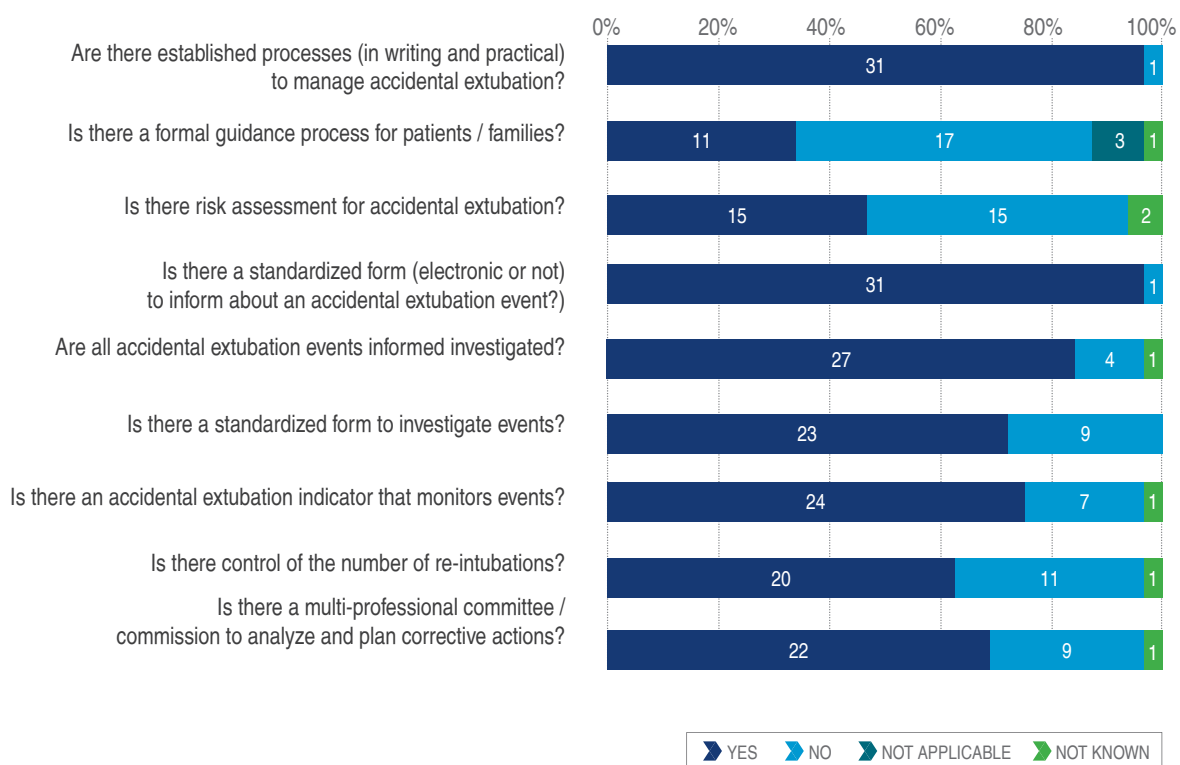
Graph 1 – General Risk Management Processes



Graph 2 – Pressure Ulcer Risk



Graph 3 – Accidental extubation

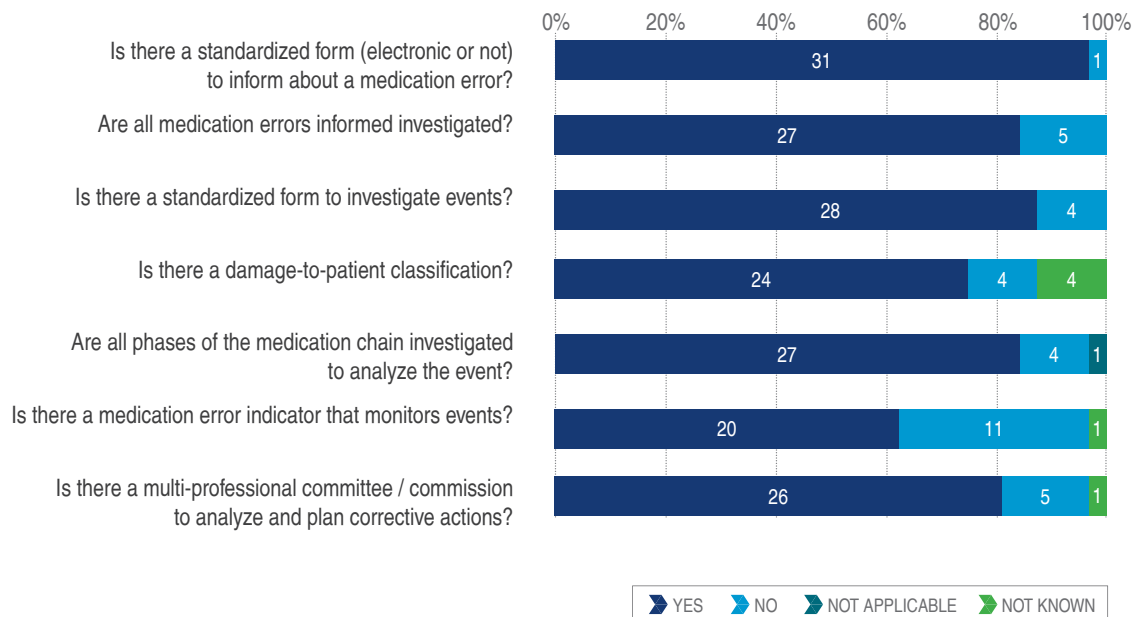


With respect to medication errors, an event of major impact on the outcome of patient care, of the 31 hospitals that monitor this kind of event, 87% investigate all cases and assess all phases of the medication chain. Of those that monitor medication errors, 65% use indicators to monitor this event (Graph 4). Due to this discovery, this indicator is being standardized and will be included in the Healthcare Best Practices Project.



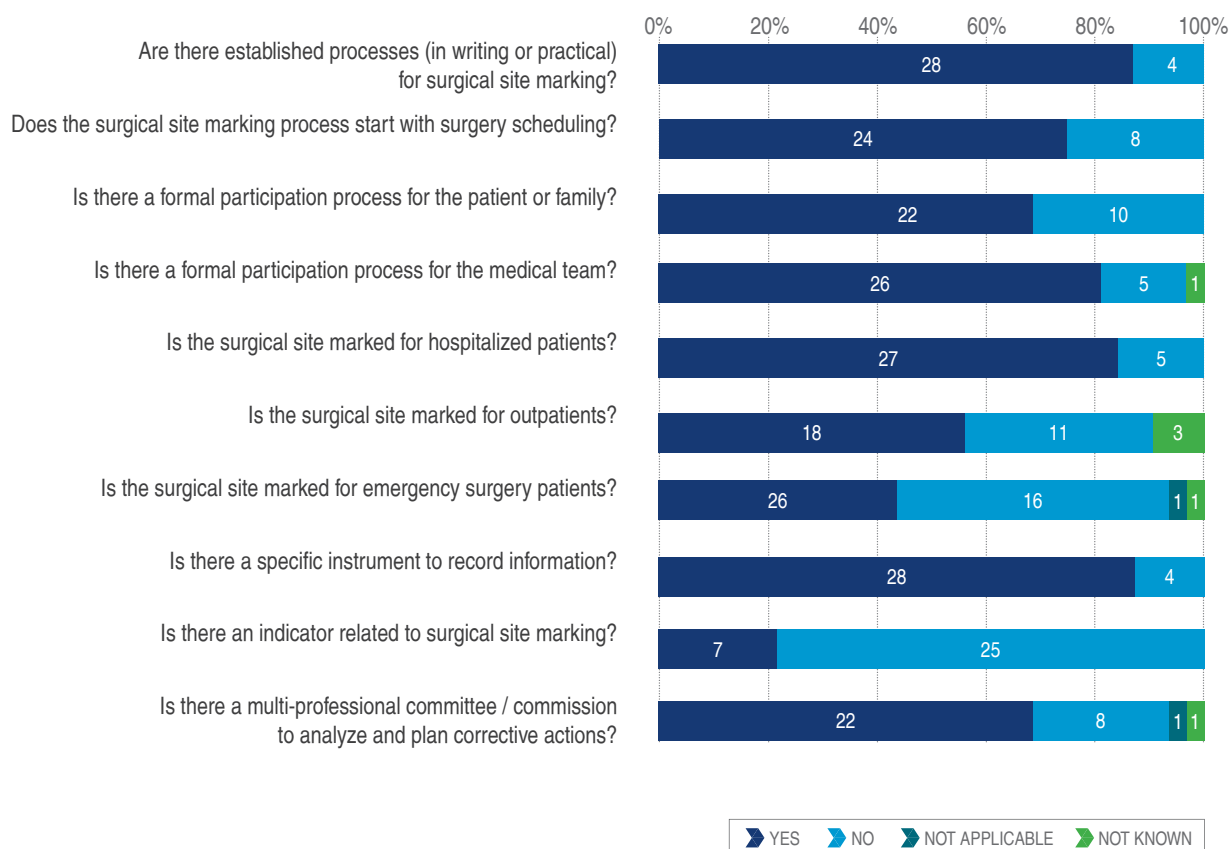


Graph 4 – Medication errors



Another very relevant aspect is the implementation of the surgical check-list in hospitals, which can be assessed by the surgical site marking routine. This is an event in which doctors, surgeons and anesthetists are directly involved. Surgical site marking is practiced in 88% of the hospitals. Of those performing this procedure, 64% also do so when performing outpatient surgeries.

Gráfico 5 – Surgical Site Marking



Some of the processes must be improved in the hospitals, such as risk of phlebitis, allergy detection, thromboembolism prevention, bronchial aspiration and assessment of emotional vulnerability. Most of the hospitals – 53% to 65% - have reporting and investigation processes for these events, however this result is below what is considered standard. There are no documents with information to families for most adverse events. This institutional communication gap identified in the survey resulted in the organization of a workgroup to elaborate a draft text to be adapted by the hospitals. Recording in the patient's chart of the information given and prevention recommendations made is not being done either, in a systematic manner, in most hospitals. Prevention, through risk assessment, and quick identification with corrective action plans are determining factors to ensure safety for patients and reduce the social and economic impact of this kind of event.

Organizing the clinical staff under the coordination of technical directors provides sustainability to such investments. In another investigation conducted in the hospitals in January 2011, one can observe that 60% of the associated hospitals had performance assessment programs for independent doctors working in the hospital. In addition, 91% monitor good practices, such as the filling out of patient records, compliance to institutional clinical protocols, good prescription practices, clinical indicators, and continuous education, among other aspects of professional activities in the hospitals. These results point to the role of clinical governance in ANAHP hospitals. To invest in this type of program with involvement of top management defines these organizations' main strategy and how they are involved in offering services in accordance with the best standards of efficiency, quality and safety.

Private health market grows 8.7% in 2010

Industry took advantage of the Brazilian economy's positive performance last year, having achieved the best result since the creation of ANS (National Health Agency) in the year 2000



The increase in the employment level and growth of income undeniably resulted in social and political repercussion, increasing the public's confidence in one's personal and collective future.

The outstanding performance of the Brazilian economy last year, combined with the reduction of the unemployment level and the increase in per capita income led to positive results for the supplementary health industry. The increase in the number of beneficiaries, growth of the average amount of monthly installments and of operators' revenues are some of the indicators evidencing the promising phase of the private health market.

Among the indicators showing the good result of 2010 is the solid growth of the number of medical health plan beneficiaries.

The number of beneficiaries reached 45.6 million, an increase of 8.7% in relation to 2009, and the highest annual growth in the number of beneficiaries since the ANS was created in 2000.

Revenues from services rendered by operators of medical-hospital health plans in 2010 reached R\$ 71.1 billion, a 10.7% higher result than in 2009. The average ticket amount, on the other hand, which is the average amount of a monthly health plan installment, reached R\$ 124.14, a 6.9% expansion compared to the previous year. This performance follows the

Brazilian economy's positive trend. We were one of the countries less adversely affected by the economic crisis that began in August 2008 and lasted during most of 2009. After facing the largest and most severe turbulence since the Great Depression of the 1930's, the world economy initiated a recovery process last year.

Whereas in 2009 world output decreased 0.6%, in 2010 the estimate of the International Monetary Fund (IMF) is that the world economy grew 4.8%.

The recovery pace, however, was not uniform. While emerging economies on average grew 7% - mainly due to the outstanding performance of the BRIC economies (Brazil, Russia, India and China), the developed economies grew only 2.7%.

In the developed countries, consumers, whose confidence was shattered by the perverse effects of the crisis that destroyed the wealth and savings of uncountable families, restricted the consumption of goods and services, favoring savings and retirement plans. Notwithstanding the recovery observed in 2010, the economy of developed countries still faces high unemployment levels, while also adopting more fragile monetary policies and running up huge fiscal deficits. Some European countries even incur the risk of defaulting on their foreign debt, which shows that the recovery is not uniform and consistent.

This whole scenario is aggravated by another factor: the increase of general price indices, resulting from commodity price increases, particularly oil, whose barrel price is coming close to pre-crisis levels.

For 2011, the perspectives are that the recovery process will continue, albeit at a slower rate. IMF projections point to a 4.2% growth of world output, with a decline in the activity level of both developed and emerging economies.

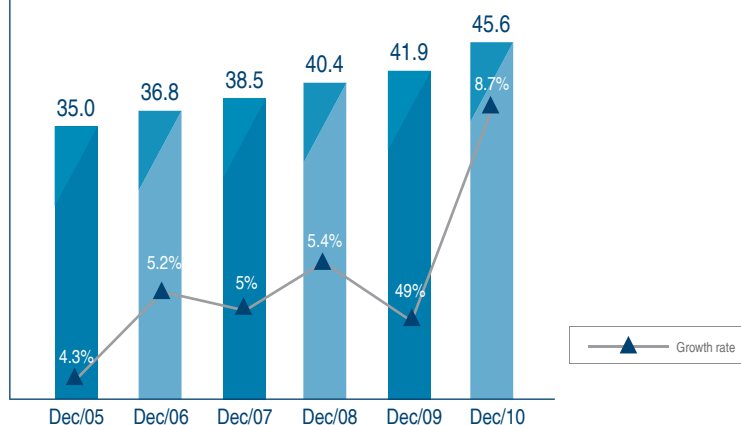
The Brazilian scenario, however, is more favorable. After a 0.6% decline in 2009, the country's GDP grew 7.5% in 2010, reaching R\$ 3.67 trillion. It appears Brazil is already the world's seventh economy, having surpassed Italy. Per capita income grew by 6.5%, while family consumption went up by 7.5%. Accelerated growth in 2010 resulted in the unemployment level reaching 6.0%, the lowest since 2003, when the

historical series began. The increase in employment and income levels had unequivocal social and political repercussion, increasing the confidence level of the masses in their personal future and that of society. Consumer spending increased strongly, along with the growing and rapid elevation of debt levels in broader segments of the population, even though the investment rate is still low: 18.4% of GDP.

For 2011, the expectation is that GDP will grow between 4% and 5%. Some factors are reason for concern: inflation, which in the aggregate is above the target set by the National Monetary Council, which has resulted in continuous increases of the base interest rate by the Central Bank, the increase in government spending, the imbalance of foreign trade accounts, and an overvalued exchange rate, which, while contributing to control inflation, reduces the competitiveness of Brazilian industrial goods exports. The challenge we face is how to conciliate accelerated growth with inflation under control. This macroeconomic equilibrium situation will require an investment rate above 20% of GDP, which has never been reached since we stabilized our currency in 1994.

Nevertheless, the Supplementary Health market is expected to continue growing. For 2011, the outlook is positive, with the upholding of the growth trend, the increase in the number of beneficiaries, albeit at a reduced pace.

Graph 1 – Development of the number of beneficiaries (in millions)



Source: ANS – Supplementary Health Information Book – March/2011





Collective Plans X Individual Plans

Following the trend of previous years, the increase in the share of collective plans in relation to the total number of medical-hospital health plan beneficiaries, resulted in that at the end of 2010, 74.2% of supplementary health beneficiaries were tied into collective plans. Considering new plans, marketed since January 1999, this share is of 78.9%. This situation stresses the importance of the sponsor entity (employers, class entities, for example), that actually pays the bill/cost of services rendered.

Coverage Rate

Notwithstanding the impressive growth in the number of beneficiaries in recent years, the coverage rate of the Brazilian population with access to medical-hospital health plans is still low, having reached 23.9% of the total. Although this is one of the major aspirations of Brazilian families, employment and income restrictions have prevented this rate from increasing at a faster pace. Another important aspect that merits consideration of all who perform in Supplementary Health, is that within the scope of purchasing decisions of social classes C and D, the value of health still has a lower rate of appeal, for instance, in comparison with the purchase of a cell phone. Currently, the quantity of cell phones in the country exceeds the Brazilian population headcount.

Table 1 – population coverage rate by location and major regions
(in december 2010)

Region	Total	Capital City	Metropolitan Region Around Capital City	Interior
North	9.8%	22.3%	20.6%	4.3%
Northeast	10.6%	29.3%	23.8%	5.4%
Midwest	15.7%	25.1%	20.7%	10.2%
South	23.3%	50.4%	36.8%	19.3%
Southeast	37.1%	57.2%	47.1%	30.3%
Brazil	23.9%	42.2%	36.6%	18.2%

Source: ANS – Supplementary Health Information Book – March/2011

Market Concentration

Market concentration by large organizations is a phenomenon resulting from the globalization process and the increase in competition among companies. In the Supplementary Health segment, mainly in the area of medical-hospital health plan operators, the concentration level has grown each year. At the end of 2010, little more than half (50.3%) the total of beneficiaries were concentrated in 36 operators, which represented 3.5% of the total in operation in the country.

Table 2 – Concentration Level Of Medical-Hospital Health Plan Operators

Nr. of Beneficiaries	% Part.	Nr. of Operators	% Part.
4,745,043	10.4%	2	0.2%
9,952,687	21.8%	6	0.6%
14,143,871	31.0%	11	1.1%
18,226,540	40.0%	19	1.8%
22,297,390	50.3%	36	3.5%
31.888.961	70.0%	112	10.8%
40,999,357	90.0%	347	33.3%
45,570,031	100.0%	1,041	100.0%

Source: ANS – Supplementary Health Information Book – March/2011

On the other hand, of the 1,183 active medical-hospital health plan operators at the end of 2010, 139 had no beneficiaries in their portfolios and only 88 (equivalent to 7.4% of the total of active operators) had more than 100,000 beneficiaries, a quantity considered by analysts as minimal to assure adequate financial equilibrium in the long-term.

Revenue Development on Rendered Services and Average Ticket Value

As mentioned before, the year 2010 was exceptional when one analyzes growth in the number of beneficiaries of medical-hospital health plans, which reached 8.7%, the largest annual rate since 2000. Revenues from rendered services (monthly health plan installments) also grew considerably, having reached R\$ 71.1 billion, 10.7% above the 2009 figure.

Table 3 – Development of Revenues from Services

Modality	2009 (R\$ 000's)	2010 (R\$ 000's)	Growth Rate
Self-managed	7,581	8,324	9.8%
Medical Cooperative	23,241	25,856	11.3%
Philanthropy	1,506	1,678	11.4%
Group Medicine	19,520	21,260	8.9%
Insurance Co.	12,404	13,979	12.7%
Total	64,252	71,097	10.7%

Source: ANS – Supplementary Health Information Book – March/2011

Table 4 – Development Of Average Ticket Value By Medical-Hospital Health Plan Operator Size

Operator Size	2009 (R\$)	2010 (R\$)	Growth Rate
Small Size (up to 19,999 beneficiaries)	95.92	106.96	11.5%
Medium Size (20,000 to 99,999 beneficiaries)	105.07	113.96	8.4%
Large Size (100,000 or more beneficiaries)	123.37	130.30	5.6%
Total	116.11	124.14	6.9%

Source: ANS – Supplementary Health Information Book – March/2011

As the average revenue amount increases, the growth rate increases less during the analyzed period. This difficulty can be explained by income restrictions or pressure from collective plan sponsor entities at the time when monthly plan installments are adjusted.

Sinistrality And Administrative Expense Development

For medical-hospital health plan operators the year 2010 resulted not only in exceptional growth in the number of beneficiaries and revenues from services rendered, but also in a relative decrease in health service expenses, allowing for a reduction in the sinistrality rate, which reached 81.1% compared to 83.0% in 2009.

Albeit still below the technically recommended rate of 75%, this reduction is good news for the commercial relation between service providers and operators, given that it is likely to reduce price negotiation conflicts.





Table 5 – Sinistrality Rate by Operator Modality

Modality	2009	2010
Self-managed	94.4%	89.2%
Medical Cooperative	82.4%	80.3%
Philanthropy	82.7%	79.5%
Group Medicine	79.1%	78.9%
Insurance Co.	83.6%	81.2%
Geral	83.0%	81.1%

Source: ANS – Supplementary Health Information Book – March/2011

Within the cost structure of medical-hospital health plan operators, another aspect that merits attention are administrative expenses that encompass, in addition to commercial expenses, the cost of regulation, which involves the operational relation with service providers – auditing, authorizations center, materials authorization center, among others. This cost of regulation is a growing factor, which burdens overhead cost (administrative cost) of both operators and service providers, while not aggregating any value to the supplementary health service chain.

Table 6 – Administrative Expense Share in Revenues From Services Rendered by Medical-Hospital Health Plan Operators

Modality	2009	2010
Self-managed	13.7%	14.4%
Medical Cooperative	15.4%	14.9%
Philanthropy	107.2%	85.8%
Group Medicine	16.5%	15.4%
Insurance Co.	7.7%	7.3%
Total	16.2%	15.2%

Source: ANS – Supplementary Health Information Book – March/2011

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Strategic Management shows its strength in associated hospitals

The complexity of current hospital organizational structure requires the use of strategic management to allow hospitals' management to set the routes to follow, aimed at their survival and sustainability



The main objective of the survey in which 70 managers of 25 associated hospitals participated was to identify the strategic management practices adopted by these institutions

Most executives of ANAHP's associated hospitals make decisions collectively, based on formal planning. Executives of these institutions are mostly administrators, with an educational background in management, who value investments in technology, while in no way neglecting cost control.

These are conclusions of a survey conducted by Professor Luciana Faluba Damázio, of Universidade Federal de Minas Gerais and Foundation Dom Cabral.

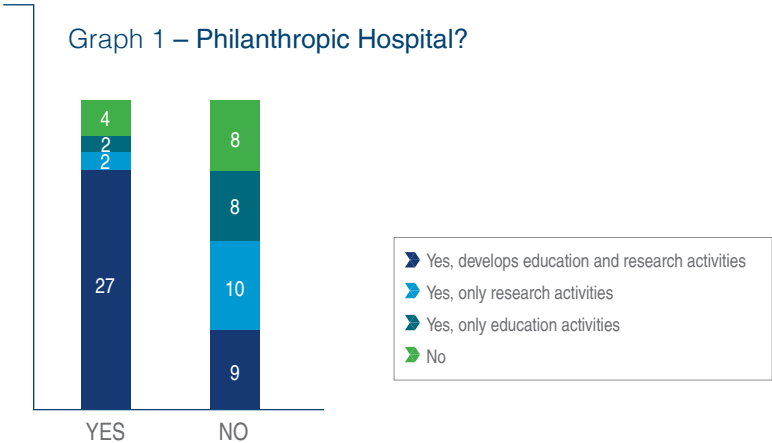
The study investigated strategic management practices developed by executives of the institution's associated hospitals.

The main objective of the study, of which 70 managers of 25 associated hospitals participated, was to identify the strategic management practices adopted by these institutions. To conduct the study, Professor Luciana used a quantitative approach, in which the managers responsible for the clinical, financial, human resources, market and general areas of all hospitals associated at the time the study was conducted (between mid-November 2010 and January 2011) were invited to participate. Data collecting occurred by each respondent filling in a questionnaire sent to an internet link specifically developed for that intent.

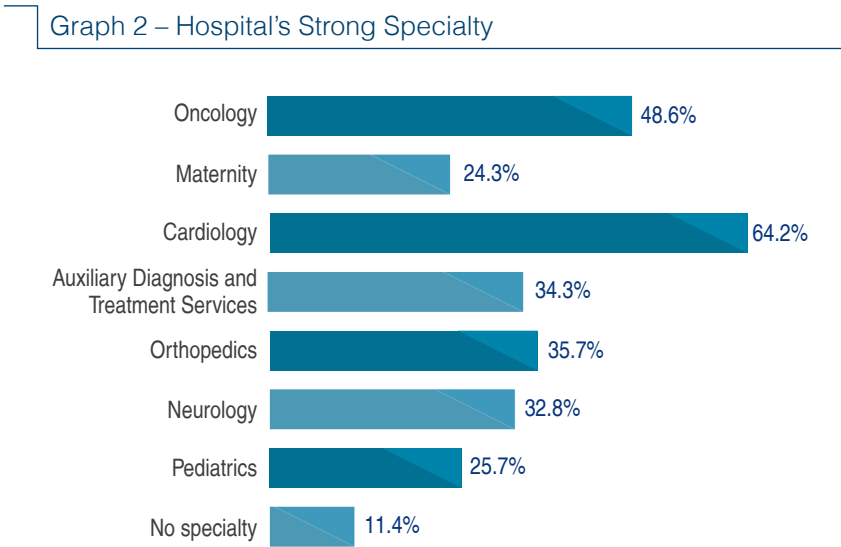
According to the researcher, "the complexity of current hospital organizational structure – the variety of medical specialties, high technological development, and new ways of looking after patients -, along with changes in the external environment of these institutions (alterations in the country's demographic profile and in the profile of diseases, for example), require strategic management to allow hospital executives to define the routes to be followed, for the sake of their survival and sustainability."

Another conclusion of the study refers to investments in education and research activities, which are indicative of an organization's potential to innovate. According to the conclusions

of the survey, the crossing of data on the results concerning the type of hospital and the development of education and research activities showed that philanthropic hospitals invest more in the development of education and research activities, as shown in the graph below.



Although they are general hospitals, the interviewees were asked whether the hospital focused on any specialty, with the objective of assessing in which areas the hospital is investing, what is a priority in terms of strategy for these institutions, and also if they are aligned with environmental trends. Cardiology stood out as the specialty mentioned by more than half the interviewees (64.2%), followed by Oncology, also with a high referral rate (48.6%).



Source: Survey conducted in ANAHP hospitals, 2010

As related to respondents' profile, 68.5% of the interviewees stated to hold positions in their institutions' top management, in the following capacities: CEO, director and superintendent. Therefore, they are fully qualified to provide information on strategy formulation in their hospitals, as shown in the table below:

Table 1 – What is your Position/Job?

Answer Options	%	Quant.
CEO	25.7	18
Director	25.7	18
Superintendent	17.1	12
Manager	22.9	16
Coordinator	8.6	6
TOTAL	100	70

The survey showed that most of them mainly had an education background in Administration, showing a trend towards professionalization of management in these hospitals. Corroborating this statement, when asked about their education in management, even if it was not the main option, 88.6% of the interviewees confirmed they had such background. The tables below show the results.

Table 2 – What Is Your Main Education Background? (Undergraduate Degree)

Answer Options	%	Quant.
Medicine	25.7	18
Nursing	5.7	4
Administration	31.4	22
Psychology	10.0	7
Economy	7.1	5
Other	20.0	14
TOTAL	100	70

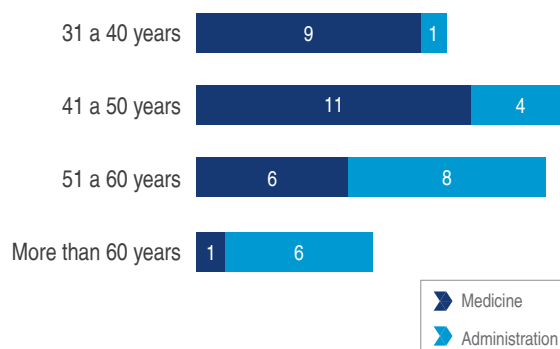
Table 3 – Do you Have an Education Background in Management? (Undergraduate, Graduate, Specialization Degree)

Answer Options	%	Quant.
Yes	88.6	62
No	11.4	8
TOTAL	100	70

Further on the education of managers, 61% of the respondents stated they are the CEO of their institutions and have a background mainly in Administration, while only 27% mentioned Medicine as their main background. All interviewees who stated to be the CEO of their institutions also stated to have an education background in Management – even if in some cases it was not their main background. This reiterates the degree of professionalism of these institutions' management.

The analysis of age versus education background, reiterated the trend towards professionalism of the hospitals' management, since 73.7% of the interviewees, who stated to have their main education background in Medicine, are older than 51 years, and 74% of the interviewees who stated to have Management as their main background are in the age bracket of 31 to 50 years, as can be seen in the graph below.

Graph 3 – Age



On actual strategic management practices, one noted a trend towards acting in broad and expanding markets, performing environmental monitoring, and developing new products and services.



Table 4 – Relation with the market

Variable	Survey Grade	Description
Environmental Monitoring	4.89	The closer to 7, the higher the trend towards much time used for environmental monitoring.
Product Development	4.49	The closer to 7, the higher the trend towards the development of new products and services.
Market Dominance	5.73	The closer to 7, the higher the trend to act in broad and expanding markets.
Growth Options	4.54	The closer to 7, the higher the trend to aggressively enter new markets with new service offers.

The investigation on strategic management practices associated with the development of internal practices showed that technology is a major concern of hospital executives. However, when asked about the willingness to innovate, as opposed to cost control, the managers were prudent and showed a trend towards cost control. With respect to the qualification of the institution's workforce, one noted a trend towards more specialized education.

Table 5 – Internal Processes

Variable	Survey Grade	Description
Technology Input	5.66	The closer to 7, the higher the trend towards technological input.
Innovation	3.89	The closer to 7, the higher the trend towards innovation.
People	5.73	The closer to 7, the higher the trend towards managers' competence being viewed as broad and entrepreneurial.

Strategic management aspects related to the management model's constitution were also analyzed and the survey showed a somewhat more conservative position of hospitals as concerns the variables comprising this issue.

Table 6 – Management Model

Variable	Survey Grade	Description
Dominant Coalition	3.57	The closer to 7, the higher the trend towards concentrating on the development of new services and expansion into new markets.
Planning	4.54	The closer to 7, the higher the trend towards preparing for the future seeking development opportunities for new services and markets.
Structure	2.57	The closer to 7, the higher the trend towards the structure being organized as autonomously run businesses.
Control	4.84	The closer to 7, the higher the trend towards processes being decentralized and participative.

With respect to the strategy formulation process developed in the hospitals, the analysis showed that in the sample universe surveyed the strategy process takes place as follows: decisions are, for the most part, deliberated upon, or planned and formally registered. They also tend to be more rational than intuitive and made collectively.

Table 7 – Decision Model

Aspect	Average
Degree of intent	6.06
Degree of formalism	5.60
Degree of rationality	4.98
Degree of individualism	1.90

To understand why some strategic choices produce better results than others is the key issue in strategic management field research, particularly in the universe of private organizations, tuned to the logic of generating revenues to assure the survival of the business. An organization's strategy concept is essential for its maintenance and survival in the market. Some organizations develop strategies that are more successful than others. To understand this may help improve the strategic processes of all other organizations, given that, in general, organizations tend to take as a model other organizations they perceive as being more authentic or successful.



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Economic-Financial Analysis

Total revenue of associated hospitals that took part in the survey reached R\$ 7.5 billion



When analyzing the average receivables payment term of ANAHP hospitals, the indicator shows 70 days, i.e., more than two months for payment receipt of hospital bills.

► Total revenue of ANAHP hospitals

Total revenue of the 30 ANAHP hospitals that took part in the SINHA - Hospital Indicators System Project last year reached R\$ 7.5 billion. Average revenue per hospital reached R\$ 250.2 million, a 23.7% growth in relation to 2009, while having upheld the growth trend of recent years (in 2009, this indicator increased 15% in relation to 2008). Projected to the end of 2010 for all ANAHP members, total revenue would be R\$ 10.3 billion. Of this amount, 90.3% (equivalent to R\$ 9.3 billion) result from services rendered to health plan beneficiaries.

Since expenses incurred with services rendered by health plan operators reached R\$ 57.6 billion in 2010, one concludes that ANAHP hospitals shared 16.1% of total expenses incurred with services rendered by health plan operators last year. This share shows the relevance of the Association, which at the end of last year had 41 associated hospitals (currently there are 43). According to the March 2011 edition of the Supplementary Health Information Book of the ANS (National Health Agency), in December 2010, 1,408 general hospitals were actively servicing private health plans in the country. ANAHP hospitals accounted for 2.9% of this total revenue, equivalent to 16.1% of all Supplementary Health expenses incurred with rendering services.

Total revenue distribution by region

The distribution of total revenue by region shows a larger quantity of hospitals in the southeast region in the associated hospital composition, reflecting the higher concentration of health plan beneficiaries in this region.



Total revenue distribution by type

As shown in previous editions of the ANAHP Observatory, the declining trend remains in terms of revenue from daily rates and fees, in contrast with the increase in hospital inputs. On the other hand, revenue from diagnosis and therapy services has maintained a share of between 11% and 12% since the beginning of the study. However, the associated hospitals have, over time, expanded the offer of diagnosis services, to the extent in which technology in this segment progresses. To keep diagnosis and therapy service revenue at the same level, notwithstanding the increase in the volume of tests, reflects ANAHP hospitals' difficulty in adjusting prices of these services in the period analyzed.

The imbalance in revenue composition of the Association's members, with the continuous decrease in revenue from daily rates and fees – albeit this is the revenue component that best reflects their core business, i.e., rendering health services –, is even more pronounced in some regions of the country, as is the case of the northeast, where this type of revenue corresponds to only 15.4% of associates' total revenue in the region.

The realignment of hospital revenue, with the right pricing of daily rates, is one of the themes under discussion in ANS' workgroup "Remuneration Models", in which the ANAHP has been a participant since the group was created.

Total revenue distribution by source of payment

The distribution of total revenue of the ANAHP hospitals by source of payment has remained essentially the same as in previous years, with health plan operators representing, in 2010, 90.3% of total revenue; services rendered to private patients, 7.3%, and to patients of SUS (Unified Health System), 2.4%.

It is important to highlight the recovery of the insurance modality, which reached 47.5% in 2010, with significant growth in relation to previous years. A decrease also occurred in the share of the group medicine and self-managed modalities. In the case of the group medicine modality this decrease in share can be explained by the intensive verticalization process in progress in this type of health plan operator.

It is interesting to compare the distribution of total revenue of the ANAHP hospitals with the revenue composition from services rendered by health plan operators according to operator modality in 2010:

Table 1 – Revenue by Source of Payment

Operator modality	Share of Revenue from Services Rendered in 2010
Insurance co.	19.7%
Self-Managed	11.7%
Group Medicine	29.8%
Medical Cooperative	36.4%
Philanthropy	2.4%

Source: ANS – Supplementary Health Information Book, March/2011

Whereas insurance companies have a share of only 19.7% of the Supplementary Health market, measured in terms of health plan monthly installments, the share of ANAHP hospitals in this regard is 47.5%, in the same analyzed period.

Average price development of ANAHP hospitals

The analysis of the average hospital price development is always a difficult task because unlike a commercial or industrial activity, in which products are always the same, in a hospital each same procedure case performed entails different characteristics compared with any other case – whether due to clinical characteristics or demographic ones related to the patient, or due to the performance of different medical teams, or even due to reduced standardization in the use of inputs and service protocols.

The SINHA project adopted two indicators to measure average prices of associated hospitals: the average net revenue per patient/day and net average revenue per discharge.

In the analyzed period, the average net revenue per patient/day increased 7.6%, a modest one in view of inflation indicators in the same period. In comparing this growth with the price variation of ANS-authorized monthly health plan installments in the same period, one notes that the Agency's adjustment reached 27.11% (the IGP-M index, in the same period, increased 29.45%).

The net average revenue per discharge, in the same analyzed period, increased 25.86%, but even so, less than the variation of adjustments authorized by ANS and as due to the IGPM index variation. One should note that the net average revenue indicator due to discharge is much less uniform than the net average revenue per patient/day, due to the great variety of pathologies treated in the ANAHP hospitals.



Expense distribution in ANAHP hospitals

The distribution of ANAHP hospitals' expenses has varied little in the period analyzed in this edition. This phenomenon had already been noted in previous editions of the Observatory. One should, however, highlight a 1.2 percent increase in the item Personnel Cost between 2009 and 2010. Other variations are of little relevance.

As analyzed in a previous edition of the Observatory, it is important to compare the revenue structure of ANAHP hospitals with their expense structures, to assess the distortion that exists nowadays in the model used to charge for hospital services.

Table 2 – Correlation revenue/expenses

Type of revenue		Type of Expense	
Daily Rates and Fees	27.4%	Personnel Cost	38.5%
		Other Inputs	3.6%
		Support Contracts	6.5%
		Utilities	2.6%
		Maintenance	2.1%
		Subtotal	53.3%
Hospital Inputs	54.0%	Insumos Hospitalares	31.2%

Source: ANS – Supplementary Health Information Book – March/2011 / SINHA – ANAHP, 2010

Although the correlation of expenses with the type of revenue presented in the table above is an approximation, because it considers consolidated data, one can assess the distortion in the composition of hospital revenue: the cost allocated to revenue from daily rates and fees is 94.5% higher for this revenue, whereas the cost of hospital inputs is equivalent to 57.8% of that respective revenue.

Average receivables receipt term and rejection rate

The average receivables receipt term of associated hospitals remained practically stable in the last three years, varying between 69 and 70 days. This receipt term is too high in comparison with other segments of economic activity, burdening the hospitals' financial management, mainly when taking into account the country's high financial cost.

When analyzing the distribution of the average regional receivables receipt term, one notes that in the country's south this indicator was 94.75 days, i.e., more than three months longer than the receipt term of hospital bills.

Undoubtedly, this is an item that must be on the discussion agenda of ANS' Technical Group assessing the adoption of new remuneration models. It is difficult to understand why health plan operators need so long to analyze and process hospital bills, mainly now, in light of the adoption of computer systems for invoicing on the part of service providers.

Another important aspect to be analyzed in the relation between hospitals and health plan operators is the rejection phenomenon. In 2010, the rejection rate of ANAHP hospitals was 2.6%, slightly better than in 2009 (2.8%).

When considering an average receivable receipt term of 70 days and a financial cost of 2% per month, the financing cost for such term is 4.67%. When adding to this cost the rejection rate cost, one comes up with a revenue loss of 7.6%, which directly impacts the associated hospitals. Surely this reality will need to be reviewed as hospitals adopt remuneration models that increase their operational risk.

EBITDA

ANAHP hospitals' EBITDA in 2010, calculated on net revenue, showed a 2% reduction, whether measured by the average or the median. Thus, based on the average, while in 2009 the indicator was 19.6%, in 2010 it dropped to 18.2%. When considering the median, in 2009 it was 17.5%, compared to 16.1% in 2010.

Table 3 – Total Revenue Development of ANAHP Hospitals

Year	Total Revenue (in R\$ million)	Number of Hospitals	Average Revenue per Hospital (in R\$ million)
2006	5,180.9	33	157.0
2007	5,195.1	33	157.4
2008	5,979.3	34	175.9
2009	6,473.7	32	202.3
2010	7,506.1	30	250.2

Source: SINHA – ANAHP, 2010

Table 4 – Distribution of Total Revenue
(by type)

Type of Revenue	2006	2007	2008	2009	2010
Daily Rates and Fees	31.7%	33.1%	30.3%	29.4%	27.4%
Hospital Inputs ⁽¹⁾	44.8%	46.3%	48.6%	50.9%	54.0%
Diagnosis and Therapy	12.0%	11.1%	12.6%	11.6%	11.3%
Other Services	3.0%	2.9%	2.5%	3.2%	3.0%
Outras Operacionais	8.5%	6.6%	6.0%	4.8%	4.3%

(1) Hospital Inputs include: hospital materials, medical drugs and medical gases

Source: SINHA – ANAHP, 2010



Table 5 – Distribution by Revenue Region
(by type – 2010)

Type of Revenue	Midwest	Northeast	South	Southeast	ANAHP
Daily Rates and Fees	28.5%	15.4%	20.6%	30.0%	27.4%
Hospital Inputs ⁽¹⁾	54.4%	56.5%	50.7%	53.3%	54.0%
Diagnosis and Therapy	11.2%	20.7%	13.9%	9.7%	11.3%
Other Services	3.3%	3.7%	4.4%	3.3%	3.1%
Other Operational Revenue	2.7%	5.9%	10.4%	3.8%	4.4%

(1) Hospital Inputs include: hospital materials, medical drugs and medical gases

Source: SINHA – ANAHP, 2010

Table 6 – Distribution of Total Revenue
(by source of payment)

Source of Payment	2006	2007	2008	2009	2010
Health Plan Operators	91.0%	90.0%	91.0%	91.0%	90.3%
Insurance co.	42.1%	42.0%	41.8%	40.7%	47.5%
Self-Managed	23.1%	20.8%	19.4%	23.0%	19.2%
Group Medicine	16.0%	18.6%	18.4%	16.8%	13.6%
Medical Cooperative	9.8%	8.6%	11.4%	10.4%	10.0%
Private	7.0%	8.0%	7.0%	7.0%	7.3%
SUS (Unified Health System)	2.0%	2.0%	2.0%	2.0%	2.4%

Source: SINHA – ANAHP, 2010

Table 7 – Net Average Revenue Development
(per patient/day⁽¹⁾)

Geographic Region	2006	2007	2008	2009	2010
Midwest	982	993	1.127	1.681	1.329
Northeast	2.234	2.056	2.118	2.476	2.480
South	1.453	1.546	1.600	1.768	1.744
Southeast	2.607	2.604	2.713	3.220	3.445
ANAHP	2.304	2.141	2.118	2.488	2.478

(1) In the table the median rather than the average was used based on statistical criteria.

Source: SINHA – ANAHP, 2010

Table 8 – Net Average Revenue Development
(per discharge⁽¹⁾)

Geographic Region	2006	2007	2008	2009	2010
Midwest	3.973	4.270	5.110	7.192	4.962
Northeast	9.564	8.758	9.276	8.814	11.289
South	7.668	7.679	7.423	8.152	7.823
Southeast	9.192	8.344	9.305	12.742	11.467
ANAHP	8.386	8.322	9.170	10.239	10.555

(1) In this table, the median rather than the average was used based on statistical criteria.

Source: SINHA – ANAHP, 2010

Table 9 – Distribution of ANAHP Hospital Expenses

Type of Expense	2006	2007	2008	2009	2010
Personnel Cost	37.1%	37.5%	36.8%	37.3%	38.5%
Hospital Inputs ⁽¹⁾	29.6%	30.5%	30.1%	30.9%	31.2%
Other Inputs	4.3%	3.9%	3.6%	3.7%	3.6%
Technical and Operational Contracts	7.6%	8.3%	8.3%	7.1%	6.5%
Support and Logistics Contracts	3.5%	3.7%	4.2%	4.2%	3.9%
Utilities	3.7%	3.3%	3.0%	2.7%	2.6%
Maintenance and Technical Assistance	1.9%	2.2%	2.1%	2.1%	2.1%
Depreciation	4.6%	4.7%	5.0%	5.1%	4.9%
Other Expenses	7.7%	5.9%	6.9%	6.8%	6.7%

(1) Hospital Inputs include: hospital materials, medical drugs and medical gases
Source: SINHA – ANAHP, 2010

Table 10 – Distribution of Expenses by Geographic Region (2010)

Type of Expense	Midwest	Northeast	South	Southeast	ANAHP
Personnel Cost	29.0%	40.6%	38.9%	38.5%	38.5%
Hospital Inputs ⁽¹⁾	28.0%	31.4%	30.6%	31.6%	31.2%
Outros Insumos	0.9%	3.7%	4.4%	3.7%	3.6%
Technical and Operational Contracts	6.8%	5.8%	8.5%	6.4%	6.5%
Support and Logistics Contracts	5.5%	2.4%	4.9%	4.0%	3.9%
Utilities	3.2%	3.2%	2.4%	2.5%	2.6%
Maintenance and Technical Assistance	1.1%	2.6%	1.8%	2.1%	2.1%
Depreciation	10.4%	3.2%	4.6%	4.9%	4.9%
Other Expenses	15.0%	7.2%	3.9%	6.5%	6.7%

Source: SINHA – ANAHP, 2010

Table 11 – Average Receivables Receipt Term Development by Region
(in days)

Geographic Region	2006	2007	2008	2009	2010
Midwest	45.09	67.80	66.56	67.86	68.16
Northeast	52.44	66.71	61.79	63.83	64.85
South	103.69	113.45	95.39	93.03	94.75
Southeast	67.03	65.33	67.42	69.35	67.99
ANAHP	66.81	71.79	69.19	70.69	69.91

Source: SINHA – ANAHP, 2010

Table 12 – Rejection Rate Development by Region
(% of net revenue)

Geographic Region	2006	2007	2008	2009	2010
Midwest	4.1%	5.8%	6.3%	5.5%	4.5%
Northeast	3.2%	2.4%	1.3%	1.1%	1.6%
South	7.8%	4.2%	5.6%	3.1%	2.8%
Southeast	3.2%	3.2%	2.9%	2.7%	2.5%
ANAHP	3.9%	3.4%	3.3%	2.8%	2.6%

Source: SINHA – ANAHP, 2010

Graph 1 – EBITDA



Source: SINHA – ANAHP, 2010

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Operational Analysis

Growth in hospitalizations in Intensive Care Units pressures hospitals' installed capacity



In 2010, total surgeries per room decreased, both in relation to the average (-7.5%) and in relation to the median (-11.5%).

Intensive Care Unit hospitalizations on average increased 22.1% (Table 1) in the share of total hospitalizations in ANAHP hospitals in 2010, resulting in that between 2009 and 2010 the growth rate of the number of ICU adult day-patients was higher than that of total day-patients (Graph 1).

Table 1 – ICU hospitalization rate development

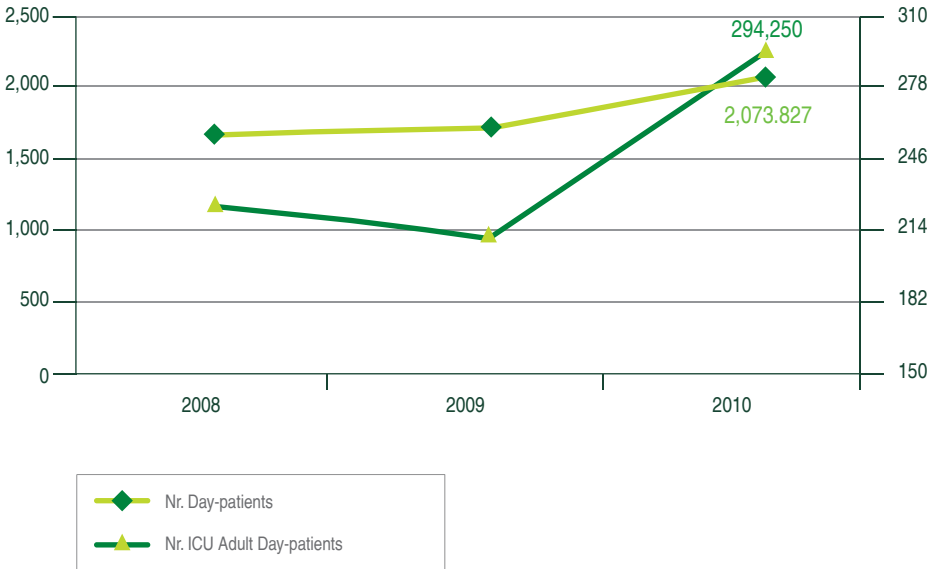
ANAHP	2006	2007	2008	2009	2010	Varição 2009/2010
Average	12.0%	12.6%	13.1%	14.0%	17.1%	22.1%
Median	11.6%	10.1%	9.8%	9.6%	9.8%	2.0%
N (sample)	31	34	36	34	33	-2.9%

This development is pressuring the hospitals' installed capacity, as evidenced by the increase in the Average Occupancy Rate, which went from 76.1% in 2008 to 78% in 2010 (Graph 2), and caused an average occupancy of 85% in ICUs and a decrease in hospital bed turnover (Graph 3), reflecting on the average hospital stay rate (Graph 4). The effects of this growth are also perceived in the increase in the number of tests per hospitalization, which developed in a magnitude of 8.7% (Table 2). Growth in hospitalizations occurred in practically all regions, but more in the Midwest, with an almost double share (Graph 5). This movement may reflect the population's aging, increasing the number of severe cases requiring more intensive care, which, in turn, is

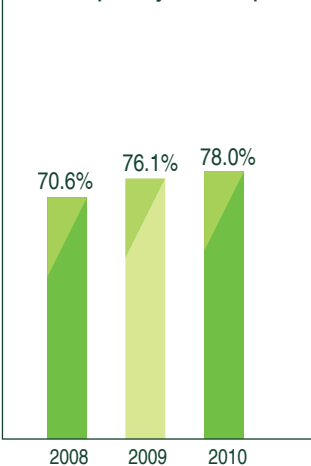
typical of longer-staying patients, confirmed by the fact that the hospital stay rate of more than 90 days increased in the last three years by 40.9% and the share in total hospitalizations went from 0.3% to 0.7% (Graph 6).

Gráfico 1 – Patient Development

(day/year)



Graph 2 – Hospital occupancy development



Graph 3 – Bed Turnover Rate



Graph 4 – Average Stay Time Development

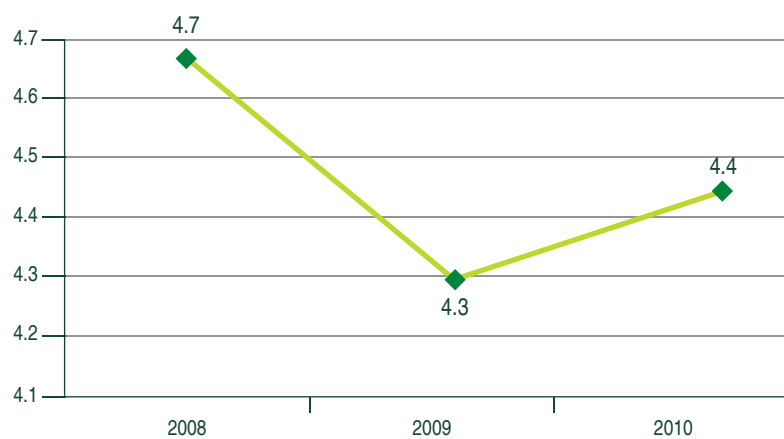
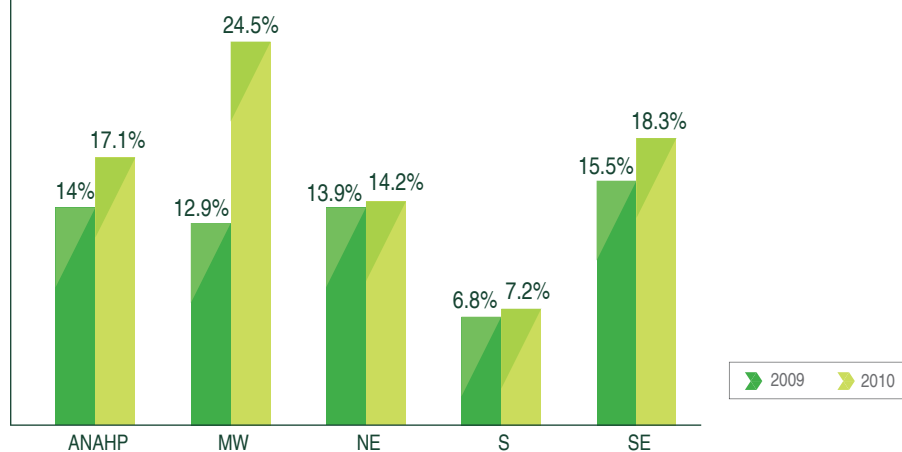


Tabela 2 – Tests per Hospitalization Rate
(by year)

ANAHP	2006	2007	2008	2009	2010	Variation 2009/2010
Average	23	23	23	25	27	8.7%
Median	24	22	24	23	25	8.1%
N (sample)	32	32	32	31	33	6.5%

Graph 5 – ICU Hospitalization Share
(by region)



Graph 6 – Patient Quantity and Share Development > 90 days



In 2010, total surgeries per room decreased, both in relation to the average (-7.5%), and in relation to the median (-11.5%) – Table 3. One should emphasize that, in 2010, the share of medium degree surgeries increased by 12.3%, replacing small degree surgeries, which decreased by 7.8% in relation to the total number. This movement occurred in practically all regions (Table 4). Another topic to highlight is the slight reduction in surgery patients, consolidating the trend towards increasing the share of clinical patients. This pattern took place in three of the country’s four regions (Graph 7).

Table 3 – Surgeries per Room (per year)

ANAHP	2006	2007	2008	2009	2010	Variation 2009/2010
Average	823	856	953	931	861	-7.5%
Median	789	784	897	896	793	-11.5%
N (sample)	31	31	35	33	32	-3.0%

Graph 7 – Surgery Patient Development (by region)

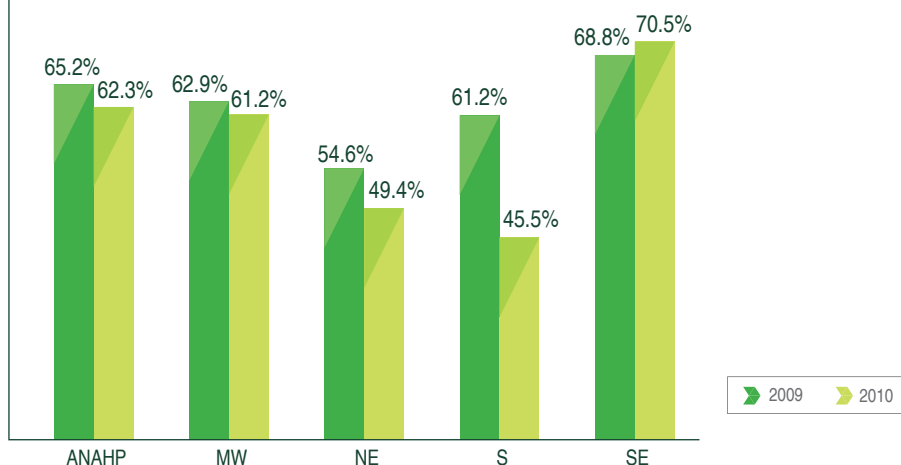


Table 4 – Surgery Degree
(by region 2009/2010)

Region	Degree	2009	2010	Variation 2009/2010
ANAHP	Outpatient Medical Office	12.2%	9.5%	-21.9%
	Medium Degree	33.8%	38.0%	12.3%
	Small Degree	22.9%	21.1%	-7.8%
	Special/Large Degree	31.1%	31.4%	1.0%
MW	Outpatient Medical Office	8.7%	8.6%	-0.3%
	Medium Degree	38.6%	40.4%	4.7%
	Small Degree	22.1%	20.5%	-7.3%
	Special/Large Degree	30.6%	0.0%	-100.0%
NE	Outpatient Medical Office	5.4%	11.3%	108.8%
	Medium Degree	38.6%	40.4%	4.7%
	Small Degree	22.1%	20.5%	-7.3%
	Special/Large Degree	30.6%	30.4%	-0.6%
S	Outpatient Medical Office	32.6%	30.3%	-7.0%
	Medium Degree	17.1%	19.3%	12.9%
	Small Degree	29.8%	22.4%	-25.0%
	Special/Large Degree	20.5%	28.0%	36.6%
SE	Outpatient Medical Office	8.1%	4.5%	-45.0%
	Medium Degree	38.6%	42.4%	10.0%
	Small Degree	22.6%	23.2%	2.8%
	Special/Large Degree	30.7%	29.8%	-2.9%

Concerning the number of tests, a 6.7% increase occurred in 2010 compared with 2009 (Table – 6) brought about by demand from hospitalized patients. This can be observed in the growth of the test/hospitalized patient rate that developed from 25 in 2009 to 27 in 2010 (base: Average – Table – 7), slightly increasing the share of internal tests (58% – Table 8). This is probably the reflex of the increase in ICU hospitalizations. Analyzing the relation test per hospitalization per region (Graph 9), one observes that the Midwest (MW) and the Southeast (SE) were the regions that most caused this increase, whereas for the SE, 2010 was the second consecutive year of increase (Table 9).

Table 5 – Births Development
(per room per year)

ANAHP	2006	2007	2008	2009	2010	Varição 2009/2010
Average	496	529	523	545	524	-3.8%
Median	446	478	517	456	456	0.1%
N (sample)	20	20	20	21	21	0.0%

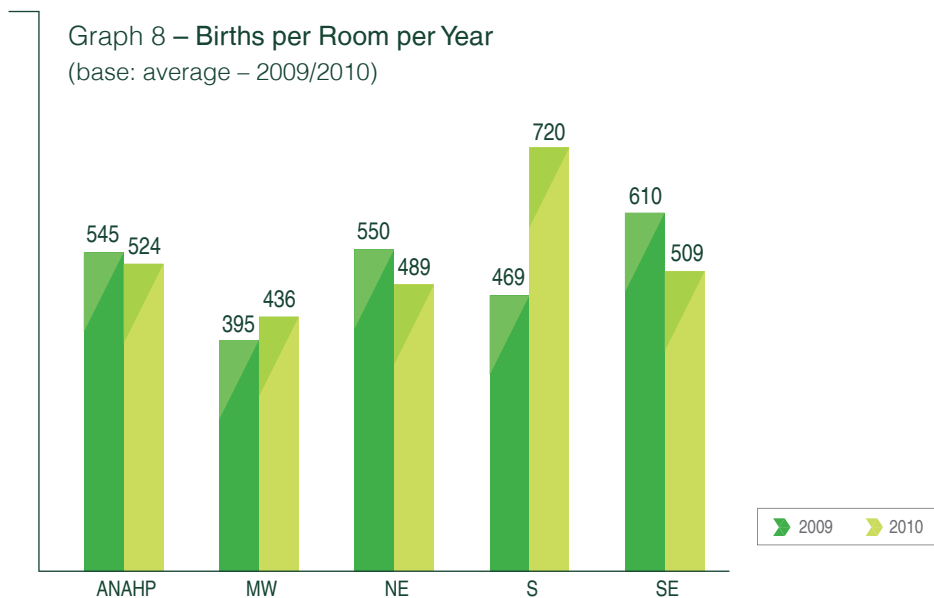


Table 6 – Test Quantity Variation

ANAHP	2009	2010	Varição 2009/2010
Total de Exames	21,527,874	22,978,022	6.7%
Amostra	34	31	-8.8%

Table 7 – Tests per Hospitalized Patient per Year

ANAHP	2006	2007	2008	2009	2010	Variation 2009/2010
Average	23	23	23	25	27	8.7%
Median	24	22	24	23	25	8.1%
N (sample)	32	32	32	31	33	6.5%

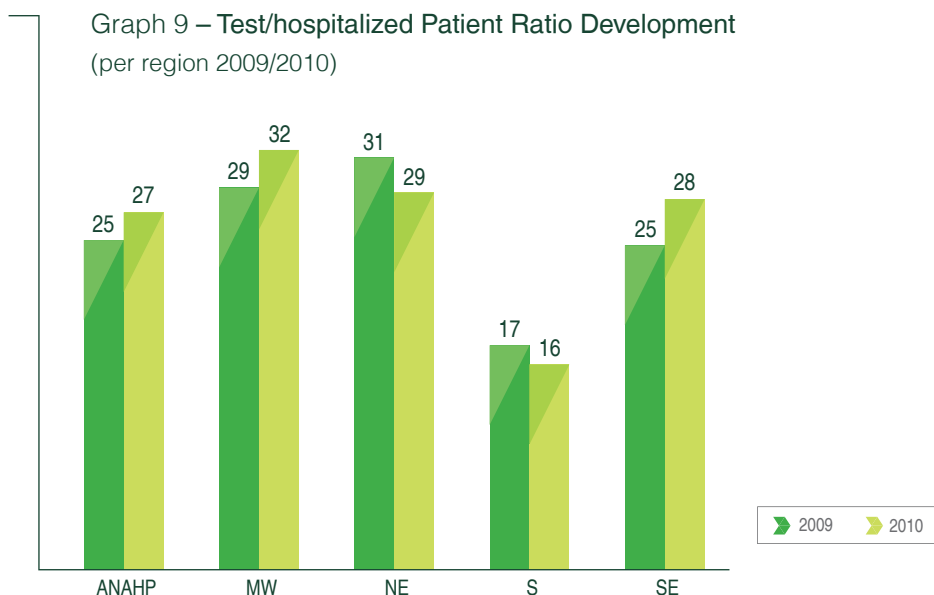


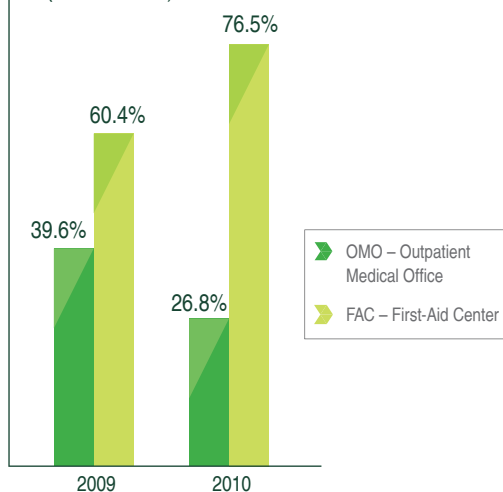
Table 8 – Test Quantity Share by Type
(by region 2009/2010)

Região	Type	2009	2010	Variation
MW	Internal Tests	58%	70%	12 pp
	External Tests	42%	30%	-12 pp
	N	4	4	-
NE	Internal Tests	45%	56%	11 pp
	External Tests	55%	44%	-11 pp
	N	5	4	(1)
S	Internal Tests	41%	38%	-2 pp
	External Tests	59%	62%	2 pp
	N	4	4	-
SE	Internal Tests	64%	60%	-4 pp
	External Tests	36%	40%	4 pp
	N	21	19	(2)
ANAHP	Internal Tests	57%	58%	1 pp
	External Tests	43%	42%	-1 pp
	N	34	31	(3)

Table 9 – Tests per Hospitalized Patient
(per year – southeast region)

SE	2006	2007	2008	2009	2010	Variation 2009/2010
Average	21	23	21	25	28	14.8%
Median	18	20	20	21	24	14.8%
N (sample)	19	20	21	19	20	5.3%

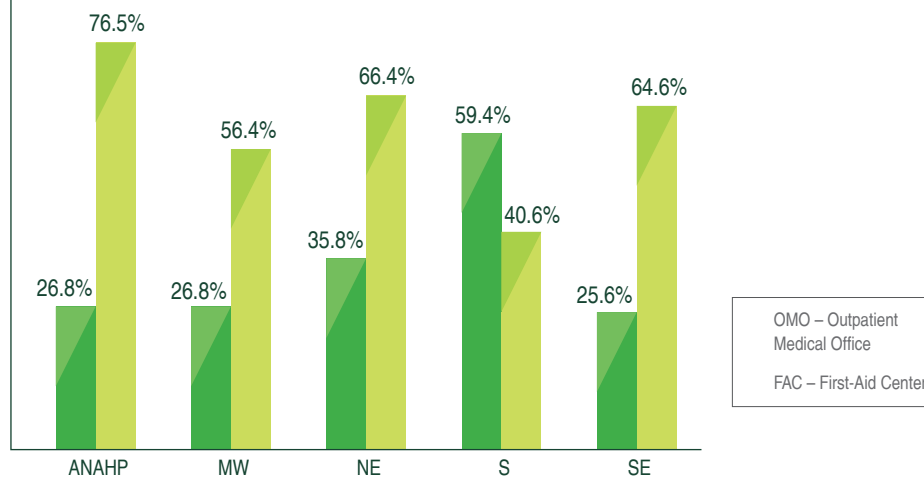
Graph 10 – Variation of
OMO x FAC consultation rate
(2009/2010)



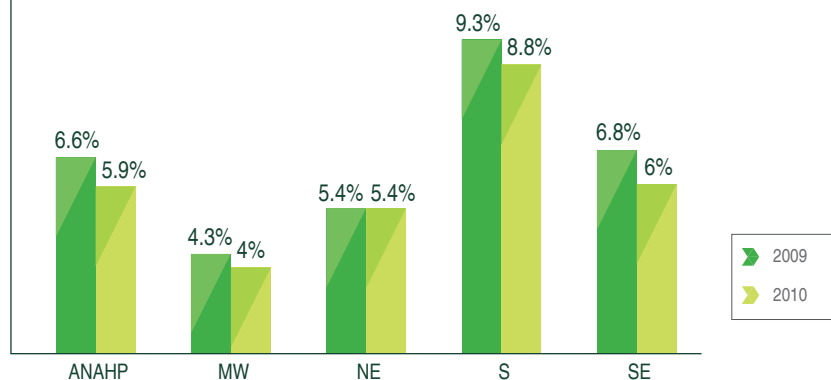
The distribution between consultations in outpatient medical office facilities and emergency rooms in 2010 reinforces evidence that first-aid center (FAC) infrastructure is being used as outpatient medical office facilities, with an increase of the consultation rate in first-aid centers (+26.6%, base: average) and a decrease of the consultation rate in outpatient medical office facilities (-32.4% base: average – Graph 10). This configuration of a higher share of first-aid centers is only different in the South (Graph 11).

In 2010, one noted a decrease in the share of emergency consultations resulting in hospitalizations, both with respect to the average (-10.5%) and the median (-6.2%). This pattern was observed in almost all regions (Graph 12). Probable cause is the H1N1 flu, which pressured emergency services, bringing about an increase in the conversion rate in 2009. As to the number of hospitalizations originated in FACs, there was a decline, with the exception of the northeastern region, in which this kind of cause increased in 2010, in comparison with 2009 (Graph 13).

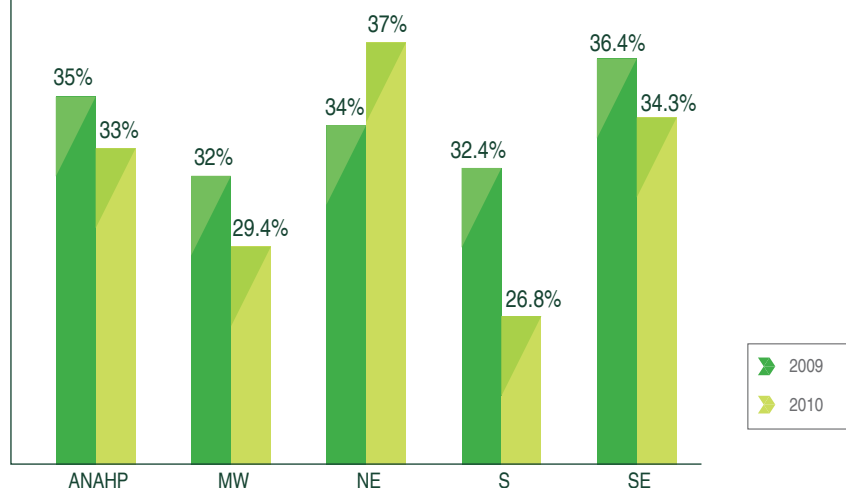
Graph 11 – Consultation Rate
(by region)



Graph 12 – FAC Consultations Resulting in Hospitalization
(by region)



Graph 13 – FAC-Originated Hospitalization Rate
(by region)



With respect to the number of FAC-originated hospitalizations a decrease took place, except for the Northeastern region, where this type of origin increased in 2010 in comparison with 2009.



People Management

ANAHP hospitals invest in the professionalization of their employees



The workforce with a higher education in ANAHP hospitals increases to 30%.

The ANAHP Hospital Indicator System's (SINHA's) human resource indicators show that associated hospitals are investing more in the professionalization of their employees.

This trend is compatible with that of other sectors of the Brazilian, and even the world economies, in which one observes the valorization of the companies' main asset, in particular when the activity occurs in the service sector. This movement took place mainly after 2008, when the most severe crisis of modern capitalism occurred, in the United States.

Education, after said period, experienced an immediate reflex, with the intensive replacement of employees with a basic or intermediary education, by others of higher educational levels, whereas in the years 2009 and 2010 alone, this boost in the number of people who concluded a higher education course was of 36% at the undergraduate and of 2% at the graduate levels. At the same time, there was a 43% decrease in the educational level that encompasses junior high school and incomplete primary education, whereas at this lower educational level the reduction in the number of people was in the range of 32% of the total workforce.

Table 1 – Educational Level (in %)

	2006	2007	2008	2009	2010
Total Completed Graduate Course	4.93	4.42	4.26	4.57	4.66
Total Completed Higher Education	18.69	17.97	17.58	18.14	24.61
Total Completed Junior High School Education	58.15	62.05	64.54	64.05	59.09
Total Completed Primary School Education	13.32	11.77	9.60	9.45	9.06
Total Incomplete Primary School Education	4,90	3,79	4,01	3,80	2,57



In 2010, the indicator that measures the nurse-bed rate showed stability in comparison with the last two years, possibly having reached the ideal level in terms of patient healthcare and safety. Last year, the average nurse-bed rate observed in the hospitals that took part in the survey was 0.59, the same figure observed in 2009.

Table 2 – Nurse-Bed Rate

	2006	2007	2008	2009	2010
Average	0.54	0.51	0.55	0.59	0.59
Median	0.42	0.46	0.50	0.59	0.55



On the other hand, in terms of the nurse-bed rate for Nursing Specialists and Assistants, one observes a decrease from 2.17 in 2009 to 1.91 in 2010, but this figure must be analyzed in more detail because it reflects a trend inversion in the last five years.

Table 3 – Nursing Specialists and Assistants per Bed Rate

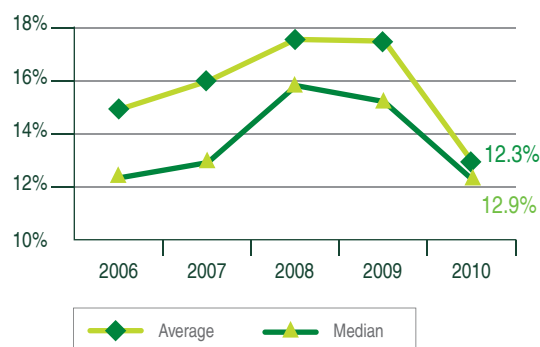
	2006	2007	2008	2009	2010
Average	2.07	2.03	2.05	2.17	1.91
Median	2.09	2.03	2.04	2.11	1.98



Economic stability achieved in recent years in our country had an important reflex in employment stability and resulted in a major decrease (26%) of the Turnover Rate in relation to 2009. The median of this indicator also decreased considerably, by 19%.

Table 4 – Turnover Rate (in %)

	2006	2007	2008	2009	2010
Average	14.9%	16.0%	17.5%	17.5%	12.9%
Median	12.4%	13.0%	15.8%	15.2%	12.3%



The Absenteeism Rate reached the high average of 2.6%, with a 24% increase in relation to 2009. This rate, which was already at a high level in 2008, may be the worrisome reflex of double work shifts, when one compares this data with studies conducted in some ANAHP hospitals, to be found in the book *Melhores Práticas de Gestão de Pessoas* (Best People Management Practices), published by the Association in 2010.

Table 5 – Absenteeism Rate

	2006	2007	2008	2009	2010
Average	1.8%	1.9%	2.1%	2.1%	2.6%
Median	1.6%	1.4%	1.3%	1.9%	2.0%



The increase in employee training hours in 2010 may be indicative of a solution adopted by hospitals for this kind of problem.

Table 6 – Hours of Training
(in hours per year)

	2006	2007	2008	2009	2010
Average	26.0	28.0	23.8	23.4	25.1
Median	27.4	26.4	22.8	18.9	20.4



It should be emphasized that there are innumerable situations that may interfere negatively with this indicator. Such causes are the object of separate studies in People Management in ANAHP hospitals, which in due time will be analyzed and publicized.

The Occupational Accident with Sick Leave Rate inverted the increasing trend observed from 2008 to 2009 and settled at the lowest levels of the past five years, decreasing to the average of 16 per one million worked hours, in comparison with 18 events observed in the previous period. The median of this rate decreased even more, from 15.8 to 11 events per one million worked hours, a reduction of 30%.

Table 7 – Occupational Accidents With Sick Leave
(nr. of accidents per 1 million hours)

	2006	2007	2008	2009	2010
Average	16.3	19.4	16.4	18.0	15.9
Median	17.6	14.7	11.0	15.8	10.6

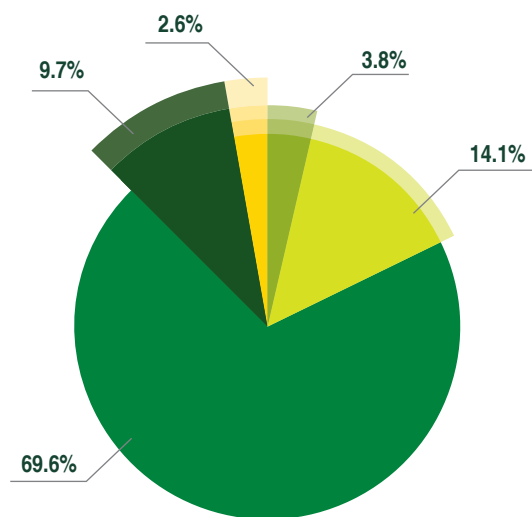


As mentioned in the beginning of this analysis, the major data on change in the hospital industry since 2008 refers to the change in the workforce's educational level, in which completed graduate level education increased by 2%, and by 36% relative to completed undergraduate education, as compared with a decrease in all other educational levels, along with a notable decrease in the number of employees with an incomplete primary school education (32%). If added to the decrease in the total number of employees with less than a complete junior high school level education, this decrease reaches 43%.

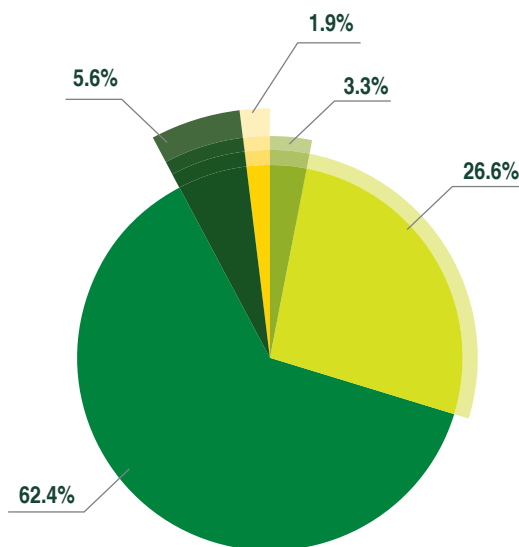
The quality and quantity of information on the SINHA Project have been more intensively monitored in recent years so that a more precise analysis of the causes and relations of these indicators is possible, in order for them to also be utilized as objective transformation tools of these rates at increasingly higher qualification levels, allowing for quality improvement of the services rendered.

Educational Level

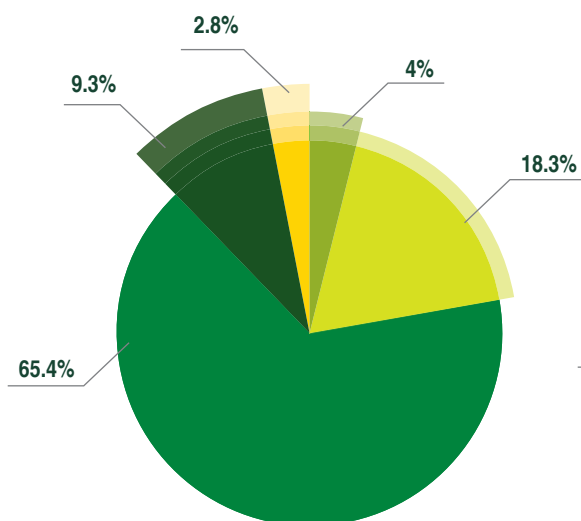
(by region 2010)



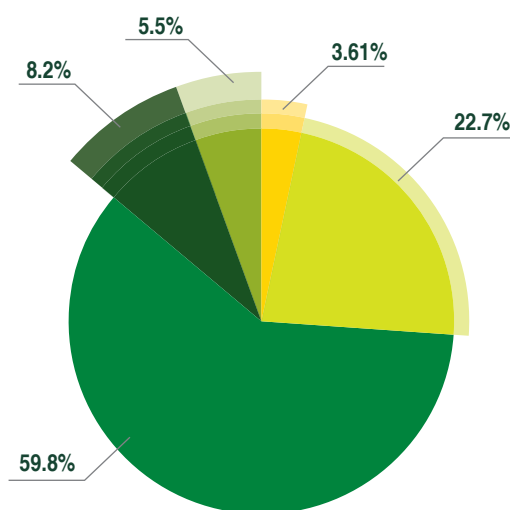
Midwestern Region



Northeastern Region



Southern Region



Southeastern Region

- ▶ Completed Graduate Course
- ▶ Completed Higher Education
- ▶ Completed Junior High School Education
- ▶ Completed Primary School Education
- ▶ Incomplete Primary School Education

Source: SINHA, 2010



Health Services Management

To foster, support, and disseminate Clinical Practice excellence in associated hospitals and the health market



Accreditation processes and participation in the Healthcare Best Practices Project improve diagnosis recording both in patient files and in information systems.

The “PMPA” – Healthcare Best Practices Project – is one of ANAHP’s initiatives, whose scope is to foster, support, and disseminate clinical practice excellence in associated hospitals and in the health market.

Having begun in 2003, the Project aims at implementing clinical protocols based on evidence and on disseminating good practices among associates. Beginning in 2007, a set of data and indicators monitored on a monthly basis and intended to assess health services performance of hospitals was incorporated, including the monitoring of clinical protocols for certain diseases.

During 2010, six Project meetings took place, with active participation of the technical directors and technical staffs of hospitals. Three of the meetings took place away from ANAHP headquarters, at Hospital Vita Curitiba, Hospital Copa D’Or and Hospital São Camilo Pompeia.

One of the aspects that differentiate and qualify the work of these projects is the involvement of technical directors and the contribution of technical staffs of associated hospitals. Such contribution is the main gain of the projects and has a determining role in building the system to follow up on and implement improvements resulting from this work. Since 2004, 24 hospitals regularly send data and very actively participate in the development of the activities.

Since January 2011, 43 hospitals became ANAHP associates. These hospitals’ structure and their respective complexity characterize these organizations as mostly (81%) large size hospitals (between 150 and 500 beds) or extra-large size (more than 500 beds), all other hospitals being of medium size. Considering Ordinance Nr. 2224 of the Health Ministry (MS), which classifies hospitals and allots points according to the healthcare service complexity,

type and number of beds for intensive care, number of operating rooms, and attention provided to high risk pregnant women. 75% of the hospitals score higher on these requisites and fall into category 4, the most complex level in the health service structure offered.

Reiterating these characteristics, in a survey conducted at the beginning of 2011, to which 35 associated hospitals responded, 49% of the hospitals had teaching and research institutes, while 34% had teaching and research centers (83% of the total), evidencing the large investment made in generation of knowledge in these hospitals and the important role of qualifying the workforce, particularly training resident physicians. In this survey, one observed that 66% of the hospitals develop teaching programs aimed predominantly at qualifying specialist physicians and nurses in several specialty fields. The comparison with the same type of assessment in previous years showed that such activities increased in the hospitals.

Technical directors in the hospitals have worked in an integrated manner, building a distinct clinical management body in the hospitals, which has allowed progress in implementing good healthcare practices and achieving safety and quality objectives as recommended by the Institute for Healthcare Improvement.

Some factors have contributed to transform organizations' culture, increasing efficiency of clinical protocols and effectiveness for patients. Among them are setting activity guidelines for the Organization of the Clinical Staff, as well as assessing professionals' performance, in addition to using criteria of quality and safety and involving healthcare teams under the leadership of physicians in the implementation and monitoring of established clinical protocols.

The Healthcare Best Practices Project has compiled data and indicators since January 2007. During this period, evaluation criteria were included according to the need to perfect analyses, taking into account hospitals' increased information capacity, while seeking

to meet quality and safety objectives set forth in the international literature.

In the analyzed series, the quality of information entered in the hospitals' information system as related to diagnoses at the time of discharge were progressively improved. In the beginning of the series, 26% of the cases had no registered information. In 2010, however, this rate decreased to only 5%, approximately.

Accreditation processes and participation in the Healthcare Best Practices Project improve diagnosis records both in patient files and in information systems.

One of the indicators used to assess the quality of clinical diagnosis records is the rate of unspecific diagnoses (proportion of cases included in the chapter on Signs and Symptoms). Over time, one notes the increase of this rate, whereas in recent years, it has remained at around 6% of hospital discharges. The number is significant and must be reduced, because the higher the precision of the clinical record, the lower the risk to healthcare. Investments in the qualification of the workforce registered as qualified in the Medical Filing Service, the exclusion of physicians from the codification process and the expansion of the use of clinical data in management can radically change this result. Thus, there are gains for the organizations' clinical outcomes and for the safety of each particular patient.

Throughout the period, 12 large diagnostic groups represented 80% to 90% of hospitals' demand: Pregnancy, Childbirth and Puerperium, Neoplasms (cancer), Digestive Tract Diseases, Circulatory System Diseases, Genitourinary Diseases, Respiratory System Diseases, Signs and Symptoms, Factors (reasons for seeking help unrelated to diseases, such as specific procedures – extraction of pins and bolts in Orthopedics, Colostomy Closures, and normal newborn babies), Musculoskeletal System Diseases, Lesions and Poisoning (fractures and lesions resulting from accidents and external causes), Infectious Diseases and Perinatal Diseases.

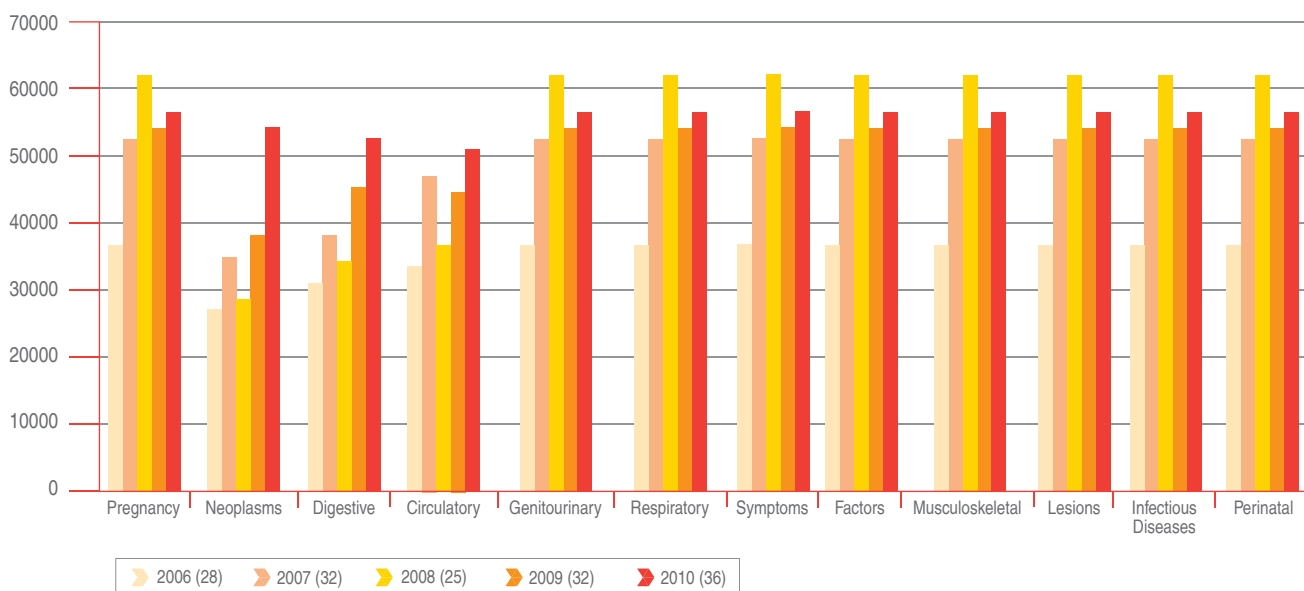


Table 1 – Annual distribution of hospital discharges according to main diagnosis by IDC chapter
(ANAHP Hospitals – 2004 to 2010)

IDC Chapter	Year										Var. 09/10
	2006 (28)		2007 (32)		2008 (25)		2009 (32)		2010 (36)		
	Nr.	%	Nr.	%	Nr.	%	Nr.	%	Nr.	%	
Pregnancy	36,866	11.4	51,983	12.4	61,023	16.6	53,125	12.1	54,771	11.1	3.1
Neoplasms	27,342	8.5	34,718	8.3	29,648	8.1	37,361	8.5	53,256	10.8	42.5
Digestive	30,639	9.5	38,959	9.3	34,317	9.3	44,317	10.1	52,336	10.6	18.1
Circulatory	36,308	11.2	45,644	10.9	37,402	10.2	44,525	10.2	51,534	10.4	15.7
Genitourinary	29,101	9.0	39,122	9.3	37,673	10.2	46,561	10.6	49,989	10.1	7.4
Respiratory	23,531	7.3	28,945	6.9	26,440	7.2	32,687	7.5	35,803	7.2	9.5
Symptoms	16,778	5.2	22,080	5.3	21,713	5.9	26,240	6.0	29,155	5.9	11.1
Factors	5,869	1.8	22,809	5.4	28,461	7.7	21,261	4.9	28,073	5.7	32.0
Musculoskeletal	16,742	5.2	20,884	5.0	21,299	5.8	24,450	5.6	27,315	5.5	11.7
Lesions	15,797	4.9	22,212	5.3	20,226	5.5	25,121	5.7	27,125	5.5	8.0
Infectious Diseases	9,158	2.8	10,081	2.4	8,607	2.3	9,471	2.2	12,627	2.6	33.3
Perinatal	6,753	2.1	10,567	2.5	11,948	3.3	8,549	2.0	10,676	2.2	24.9
Endocrine	6,441	2.0	8,339	2.0	6,656	1.8	8,264	1.9	10,470	2.1	26.7
Nervous System	7,150	2.2	8,663	2.1	6,815	1.9	8,373	1.9	9,909	2.0	18.3
Skin	3,340	1.0	4,548	1.1	4,055	1.1	4,766	1.1	5,109	1.0	7.2
Congenital	2,415	0.7	3,137	0.7	2,943	0.8	3,458	0.8	3,907	0.8	13.0
Eyes and Eye-related	3,359	1.0	3,656	0.9	2,978	0.8	2,943	0.7	2,689	0.5	-8.6
Blood	1,668	0.5	2,004	0.5	1,812	0.5	2,005	0.5	2,217	0.4	10.6
Ear-related	1,366	0.4	1,704	0.4	1,471	0.4	1,665	0.4	2,096	0.4	25.9
Mental	1,057	0.3	1,282	0.3	1,003	0.3	1,145	0.3	1,307	0.3	14.1
No information	41,612	12.9	38,806	9.2	1,086	0.3	31,189	7.1	24,380	4.9	-21.8
Total	323,292	100.0	420,143	100.0	367,576	100.0	437,476	100.0	494,744	100.0	13.1

Graph 1 – Annual Distribution of Hospital Discharges According to Main Diagnoses

(IDC chapter – 10th review) – ANAHP Hospitals – 2005 to 2010



For each diagnostic group one notes different trends over time. Between 2010 and 2009, the number of hospital admissions varied 13%. However, this variation partly occurred due to the entry of new hospitals. When new hospitals are excluded, the annual variation increased 6%. When comparing the number of discharges in 2010 with that in 2006, among the 24 hospitals that regularly sent data, the growth in hospital admissions was approximately 16% in the period (about 3.2% per year).

Neoplasms, Digestive Tract Diseases and Genitourinary System Diseases ranked first among diagnoses requiring elective surgical interventions. Circulatory and Respiratory System Diseases and Infectious Diseases predominantly ranked first among the reasons for hospitalizations for clinical treatment.

Hospitalizations classified as Lesions and Poisoning are mainly acute events, in general related to external causes, such as falls, accidents and contusions treated in ER settings by orthopedists. Musculoskeletal System Diseases are mostly cases with a chronic evolution requiring elective surgical interventions intended for diagnoses or treatment.

It is interesting to analyze the Pregnancy, Childbirth and Puerperium situation, together with the Perinatal Disease chapter. These chapters are related to mother-child healthcare or Perinatology. It is also important to call attention to the Factors group. In some hospitals, information systems register separate charts for normal newborn babies. For this reason, in the group of children under age 15, the large number of records is related to normal newborn babies.

In recent years, with respect to the Perinatology area, one notes a shift in age of first-time pregnancy in the female

population. This social-cultural change, proven by data obtained from birth reports projected on the entire population (the number of first time pregnancies of women over the age of 30 is increasing, whereas the proportion of pregnant women in the age bracket 20 to 29 years is decreasing, albeit it is the predominant group in the population), is even more evident when the better educated and socially and economically better-off group is selected, whose coverage by supplementary healthcare is also more significant.

The impact of this change implies, on the one hand, greater risk (higher incidence of comorbidities and complications) for mother and child during pregnancy, requiring better antenatal care; and, on the other hand, higher chances of prematurity and complications during childbirth.

Another aspect to be highlighted is the increase of in vitro fertilization interventions, usually performed on women over 30 years, which contribute to increase twin births and prematurity.

To corroborate the above statements, Table 2 and Graph 2 show the distribution by gender and age bracket of patients admitted in ANAHP hospitals in 2009 and 2010.

In the analysis of diagnoses by age bracket, one can observe that in 2009, as well as in 2010, the group of women in the age group 30 to 44 is much more numerous than that of women aged 15 to 29. This finding is not similar to what is observed in the population in general, even when adjusting for the better educated group. Thus, this indicates that the associated hospitals are a reference in caring for high-risk pregnant women and premature babies, of low birth weight, who require critical care in neonatal ICUs.



Women are significantly more predominant in the reproductive age bracket. In the brackets under 15 years and in the 60 to 74 age group, men make up the largest group. Gender and age information that was ignored shows in a small proportion, but this does indicate inconsistencies in file data entries in the systems. Such non-conformities must be corrected to increase database reliability and to diminish inadequacies in file data entries in the information system.

Table 2 – Distribution of Hospital Discharges by Gender and Age Bracket
(ANAHP Hospitals – 2009)

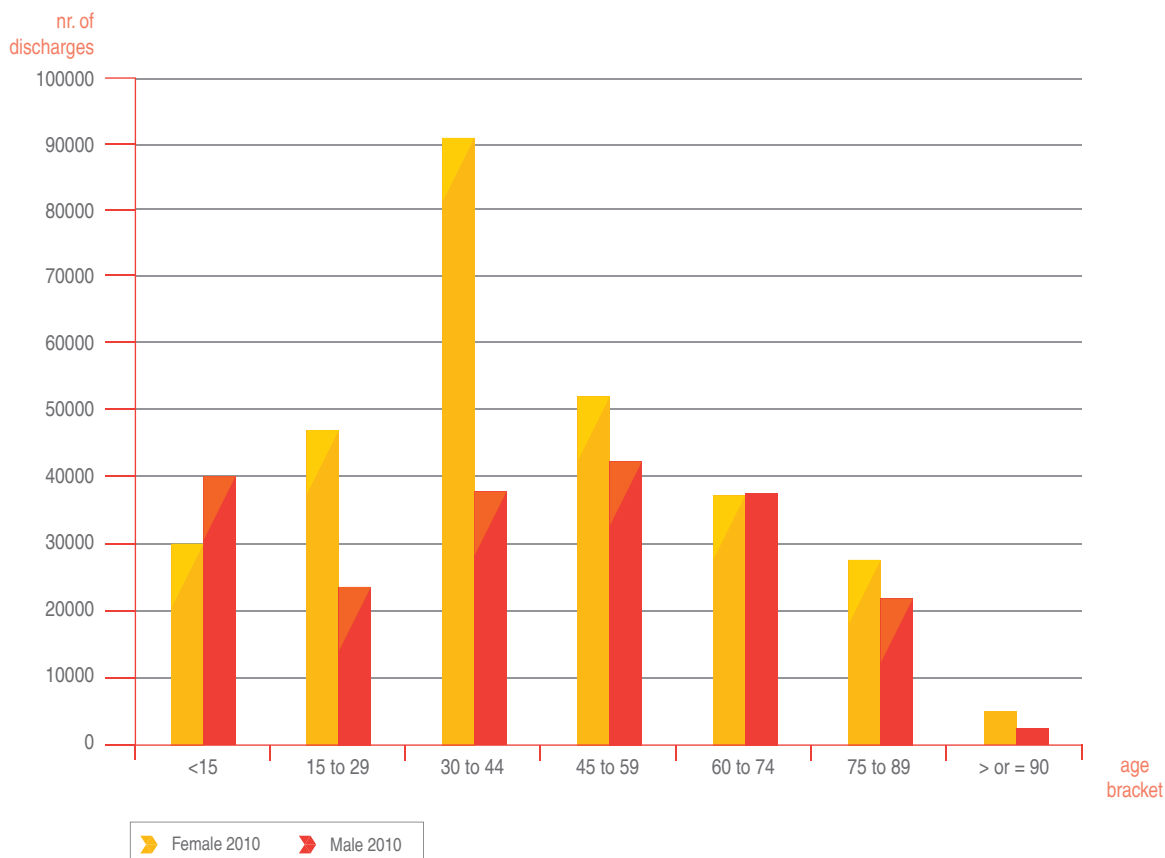
Age Bracket (in years)	2009 (32)							
	Gender						Total	
	Female		Male		Ignored			
	Nr.	%	Nr.	%	Nr.	%	Total	%
< 15	23,065	8.8	31,399	17.8	26	20.0	54,490	12.5
15 to 29	46,152	17.7	21,219	12.1	15	11.5	67,386	15.4
30 to 44	83,807	32.1	31,480	17.9	30	23.1	115,317	26.4
45 to 59	46,998	18.0	37,512	21.3	29	22.3	84,539	19.3
60 to 74	33,064	12.7	32,618	18.5	21	16.2	65,703	15.0
75 to 89	24,197	9.3	19,526	11.1	7	5.4	43,730	10.0
> or = 90	3,558	1.4	1,711	1.0	1	0.8	5,270	1.2
No information	525	0.2	515	0.3	1	0.8	1,041	0.2
Total	261,366	100.0	175,980	100.0	130	100.0	437,476	100.0

Table 3 – Distribution of Hospital Discharges by Gender and Age Bracket
(ANAHP Hospitals – 2010)

Age Bracket (in years)	2010 (36)							
	Gender						Total	
	Female		Male		Ignored			
	Nr.	%	Nr.	%	Nr.	%	Total	%
< 15	30,263	10.5	39,817	19.4	12	15.6	70,092	14.2
15 to 29	46,451	16.1	23,817	11.6	13	16.9	70,281	14.2
30 to 44	90,441	31.3	42,502	18.0	15	19.5	127,363	25.7
45 to 59	52,068	18.0	37,585	20.7	21	27.3	94,591	19.1
60 to 74	37,205	12.9	32,618	18.3	11	14.3	74,801	15.1
75 to 89	27,474	9.5	21,884	10.6	4	5.2	49,362	10.0
> or = 90	4,373	1.5	2,105	1.0	0	0.0	6,478	1.3
No information	883	0.3	892	0.4	1	1.3	1,776	0.4
Total	289,158	100.0	205,509	100.0	77	100.0	494,744	100.0

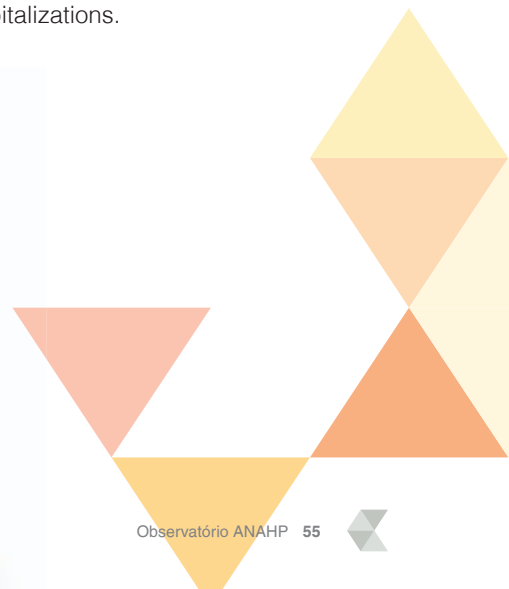
Age Bracket (in years)	Var. 10/09
< 15	28.6
15 to 29	4.3
30 to 44	10.4
45 to 59	11.9
60 to 74	13.8
75 to 89	12.9
> or = 90	22.9
No information	70.6
Total	13.1

Graph 2 – Distribution of Hospital Discharges by Gender and Age Bracket
(ANAHP Hospitals – 2010)



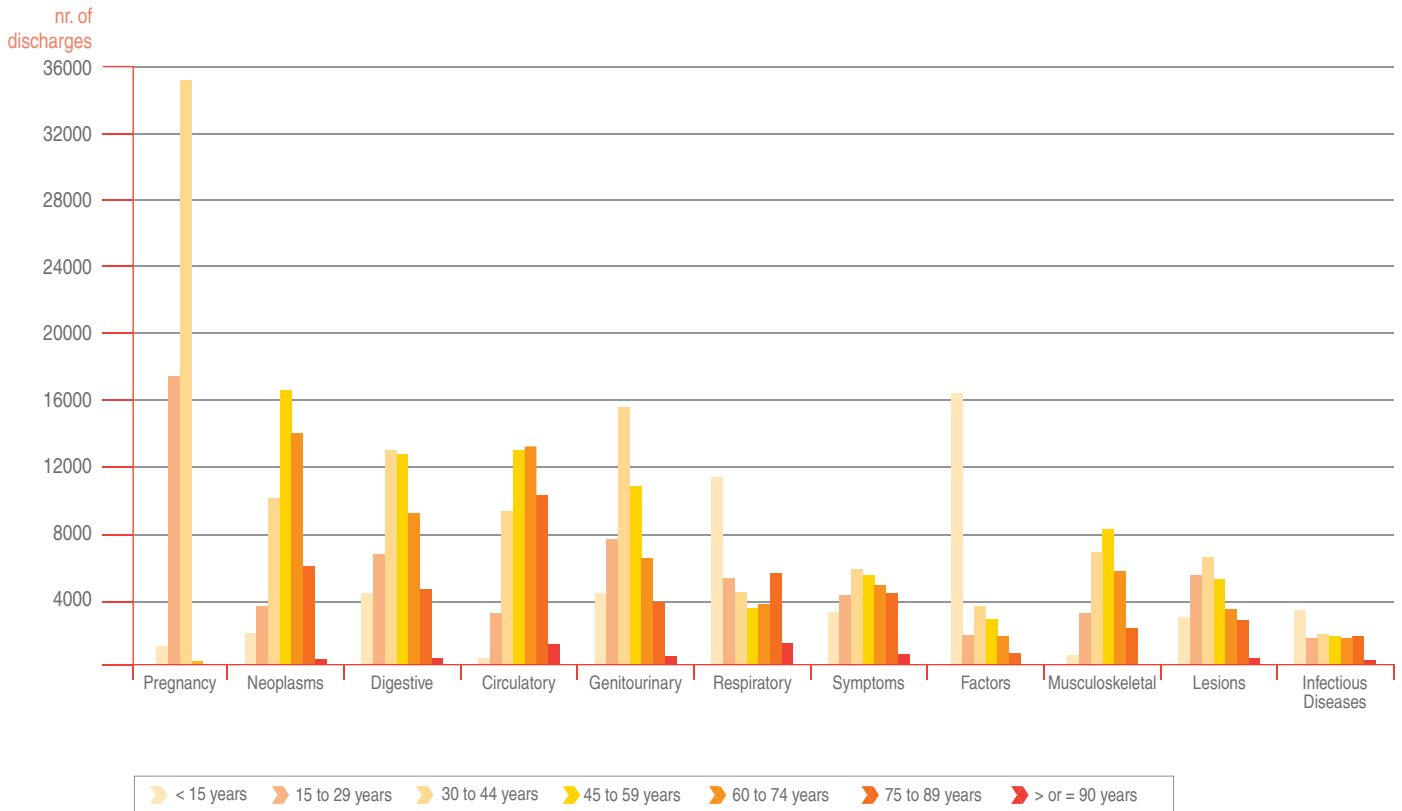
It is interesting to note the proportion of women in the 30 to 44 age group hospitalized due to pregnancy, childbirth and puerperium. This statement reinforces previous ones. In the age groups 15 to 29 and 30 to 44, Genitourinary System Diseases and Digestive Tract Diseases are also frequently the reason for hospitalization. The most common procedures for the Digestive Tract are: video-laparoscopic cholecystectomy and inguinal herniorrhaphy procedures. (Table 3, Graph 3). In children under age 15, Factors and Perinatal Diseases are predominant, followed by

Respiratory System Diseases. Circulatory System Diseases, Neoplasms and Musculoskeletal System Diseases are concentrated in age brackets above 45 years – with a high incidence above 50 years. Circulatory System Diseases are the main cause of hospital admissions in the 75 to 89 age bracket, whereas Ischemic Heart Diseases, Congestive Heart Failure and Cerebrovascular Diseases are the main pathologies affecting this group. In the age bracket 90 years+, Circulatory and Respiratory System Diseases are the main cause of hospitalizations.



Graph 3 – Distribution of Hospital Discharges by Main Diagnoses and Age Bracket

(ICD chapter – 10th review) – ANAHP Hospitals – 2010



In Table 4 we show the Average Length of Stay (ALS) by diagnosis, grouped in chapters (International Disease Code – 10th review) and in Graph 4 the ALS by most frequent diagnoses. The overall average length of stay in associated hospitals has remained at 4.2 days in recent years.

Diagnoses can be grouped in three large groups for the sake of ALS assessment. The first group comprises Pregnancy, Factors, Genitourinary, Digestive Tract Diseases and Musculoskeletal Diseases, whose ALS varies between 2.5 and 3 days. Obstetric and surgical procedures pull down the length of stay. Of the diagnoses related to surgical procedures, the ones affecting the genitourinary system have the shortest average length of stay.

The second average length of stay group comprises Circulatory and Respiratory Systems Diseases, followed by Neoplasms and Symptoms. The ALS varied from 4 to 6 days, whereas Respiratory System Diseases showed a tendency to increase ALS to 6 days. The chapter Signs and Symptoms and ill-defined Diseases, which comprise unspecific diagnoses, is expected to decrease, increasing the detail and specification levels of clinical records. With investments in improving the precision of clinical records in

the information systems, the recovery of clinical information for research purposes and the safety of patients and the hospital enjoy considerable gains. The objective is that they reach the mark of 2% of total hospital discharge diagnoses. The third group comprises Perinatal Diseases and Infectious Diseases, whose ALS varied between 5 and 8 days, with a higher weight for Perinatal Diseases. Although this group represents about 5% of demand, its contribution to the ALS is significant. Managing pathological newborn babies, assuring critical care of excellence and homecare for these children have become alternatives to improve this patient group. With respect to Infectious Diseases, the management of Sepsis, in particular the implementation of sepsis protocols in associated hospitals, has contributed to diminish the ALS and improve services provided in these cases, as can be seen in the data of the Healthcare Best Practices Project. Another essential aspect is hospital infection control, which has also been the aim of intensive work in hospitals and shows highly positive results. One aspect to emphasize is the antibiotic sparing, as well as the increasingly more frequent prospect of early discharge, providing antibiotics until the end of treatment or doing patient follow-up in a day-hospital setting.

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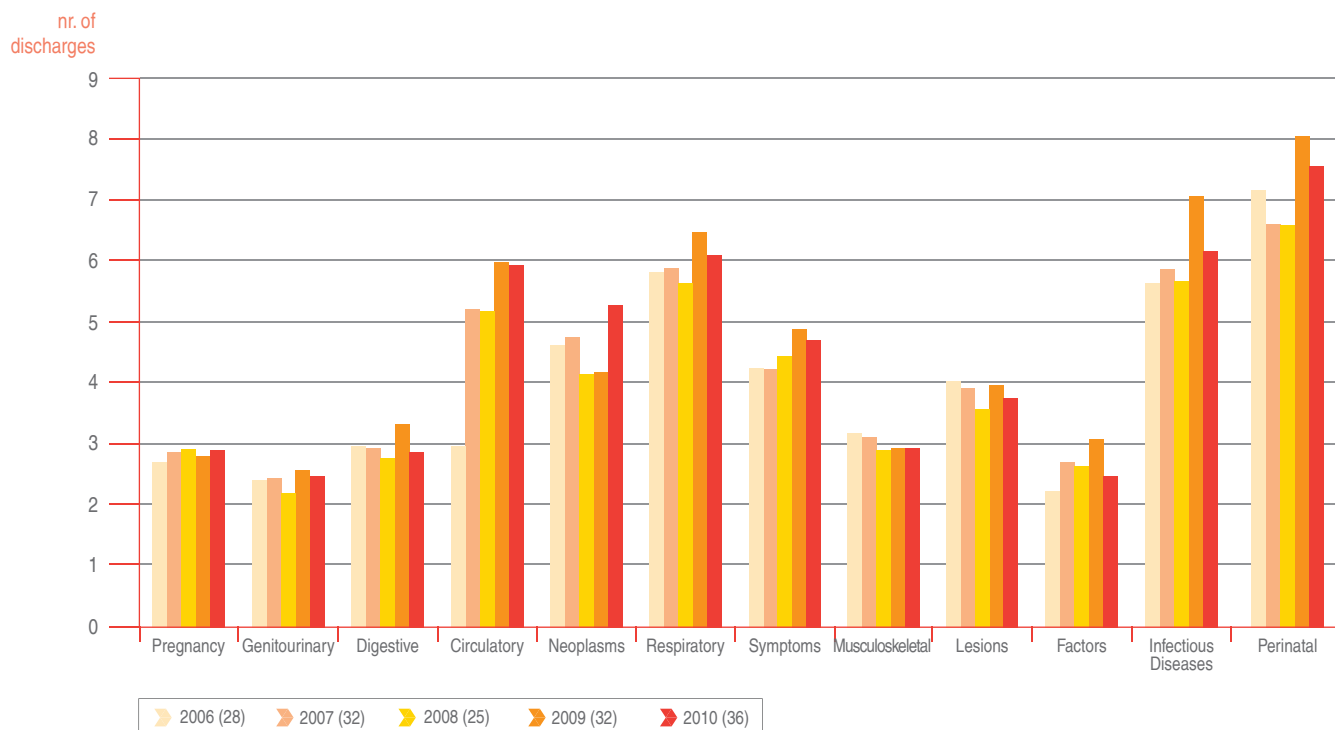
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Table 4 – Distribution of Hospital Discharges According to Main Diagnosis
(ICD chapter – 10th review) – Average Length of Stay (ALS) – ANAHP Hospitals – 2005 to 2010

Chapter	2006 (28)			2007 (32)			2008 (25)			2009 (32)			2010 (36)		
	Nr.	%	ALS	Nr.	%	ALS	Nr.	%	ALS	Nr.	%	ALS	Nr.	%	ALS
Pregnancy	36,866	11.4	2.7	51,983	12.4	2.8	61,023	16.6	2.9	53,125	12.1	2.8	54,771	11.1	2.9
Genitourinary	29,101	9.0	2.4	39,122	9.3	2.5	37,673	10.2	2.2	46,561	10.6	2.6	49,989	10.1	2.5
Digestive	30,639	9.5	3.0	38,959	9.3	2.9	34,317	9.3	2.8	44,317	10.1	3.3	52,336	10.6	2.9
Circulatory	36,308	11.2	5.4	45,644	10.9	5.2	37,402	10.2	5.2	44,525	10.2	6.0	51,534	10.4	5.9
Neoplasms	27,342	8.5	4.6	34,718	8.3	4.8	29,648	8.1	4.2	37,361	8.5	4.2	53,256	10.8	5.3
Respiratory	23,531	7.3	5.8	28,945	6.9	5.9	26,440	7.2	5.6	32,687	7.5	6.5	35,803	7.2	6.1
Symptoms	16,778	5.2	4.2	22,080	5.3	4.2	21,713	5.9	4.4	26,240	6.0	4.9	29,155	5.9	4.7
Musculoskeletal	16,742	5.2	3.2	20,884	5.0	3.1	21,299	5.8	2.9	24,450	5.6	2.9	27,315	5.5	2.9
Lesions	15,797	4.9	4.0	22,212	5.3	3.9	20,226	5.5	3.6	25,121	5.7	4.0	27,125	5.5	3.8
Factors	5,869	1.8	2.2	22,809	5.4	2.7	28,461	7.7	2.6	21,261	4.9	3.1	28,073	5.7	2.5
Infectious Diseases	9,158	2.8	5.6	10,081	2.4	5.9	8,607	2.3	5.7	9,471	2.2	7.1	12,627	2.6	6.2
Perinatal	6,753	2.1	7.2	10,567	2.5	6.6	11,948	3.3	6.6	8,549	2.0	8.1	10,676	2.2	7.6
Nervous System	7,150	2.2	5.5	8,663	2.1	5.6	6,815	1.9	5.7	8,373	1.9	6.4	9,909	2.0	5.8
Endocrine	6,441	2.0	4.6	8,339	2.0	4.4	6,656	1.8	4.2	8,264	1.9	5.1	10,470	2.1	4.4
Skin	3,340	1.0	4.9	4,548	1.1	5.0	4,055	1.1	4.4	4,766	1.1	5.8	5,109	1.0	5.9
Congenital	2,415	0.7	6.6	3,137	0.7	5.1	2,943	0.8	5.1	3,458	0.8	6.1	3,907	0.8	5.4
Eyes and Eye-related	3,359	1.0	0.5	3,656	0.9	0.9	2,978	0.8	0.6	2,943	0.7	1.2	2,689	0.5	1.5
Blood	1,668	0.5	4.9	2,004	0.5	4.9	1,812	0.5	4.8	2,005	0.5	6.4	2,217	0.4	5.5
Ear-related	1,366	0.4	1.8	1,704	0.4	1.9	1,471	0.4	2.2	1,665	0.4	2.5	2,096	0.4	2.3
Mental	1,057	0.3	12.9	1,282	0.3	9.2	1,003	0.3	10.9	1,145	0.3	10.6	1,307	0.3	10.4
No information	41,612	12.9	3.9	38,806	9.2	2.5	1,086	0.3	7.7	31,189	7.1	3.3	24,380	4.9	4.1
Total	323,292	100.0	4.6	420,143	100.0	4.4	367,576	100.0	4.3	437,476	100.0	4.3	494,744	100.0	4.2

Graph 4 – Annual Distribution of Average Length of Stay According to Main Diagnoses

(IDC chapter – 10th review) – ANAHP Hospitals – 2005 to 2010

Monitoring indicators allows evidencing the quality of processes in healthcare and the results of managing clinical practice in ANAHP hospitals, representing a pioneer initiative in terms of information transparency in the private sector. The monitoring system implemented since January 2007 is the first healthcare quality management system for certain diseases viewed as references for the healthcare process. This means they are diseases for which there exist good practice standards expressed in the literature, and the diagnosis and therapeutic algorithm for patients affected by such diseases is directly related to healthcare outcomes and is highly relevant in healthcare.

Among the monitored indicators, the following stand out:

Healthcare performance indicators

- ✦ Overall Occupancy Rate (Patient-Day/Operational Beds-Day*100) – and of Adult ICU
- ✦ Average Stay (Patient-Day/Discharges)
- ✦ Turnover Rate (Discharges/Operational Beds)
- ✦ Substitution Interval (100–Occupancy Rate*Average Stay/Occupancy Rate)
- ✦ Patients Submitted to Surgical Procedures Rate (Surgical Patients/Discharges*100)
- ✦ Surgery per Patient Rate (Nr. of Surgeries/Surgical Patients)
- ✦ Surgical Mortality Rate (Nr. of Surgery Deaths/Surgical Patients*100)
- ✦ Institutional Mortality Rate (Nr. of Deaths >=24hrs/Discharges*100)

These indicators reflect important assessment criteria: efficiency in operational bed management, predominance of activities in hospitals, average complexity of surgical procedures and healthcare results. During 2010, 34 hospitals sent data and information on these indicators. Results of data and indicators are shown in Table 5.

In terms of operational bed management efficiency, hospitals have shown a tendency to a linear increase of occupancy rates, associated with a discrete increase in the average length of stay, but with an important reduction in Substitution interval, which has caused an increase in hospital bed turnover (Table 5, Graphs 5,6,7). The increase in the number of hospitalizations

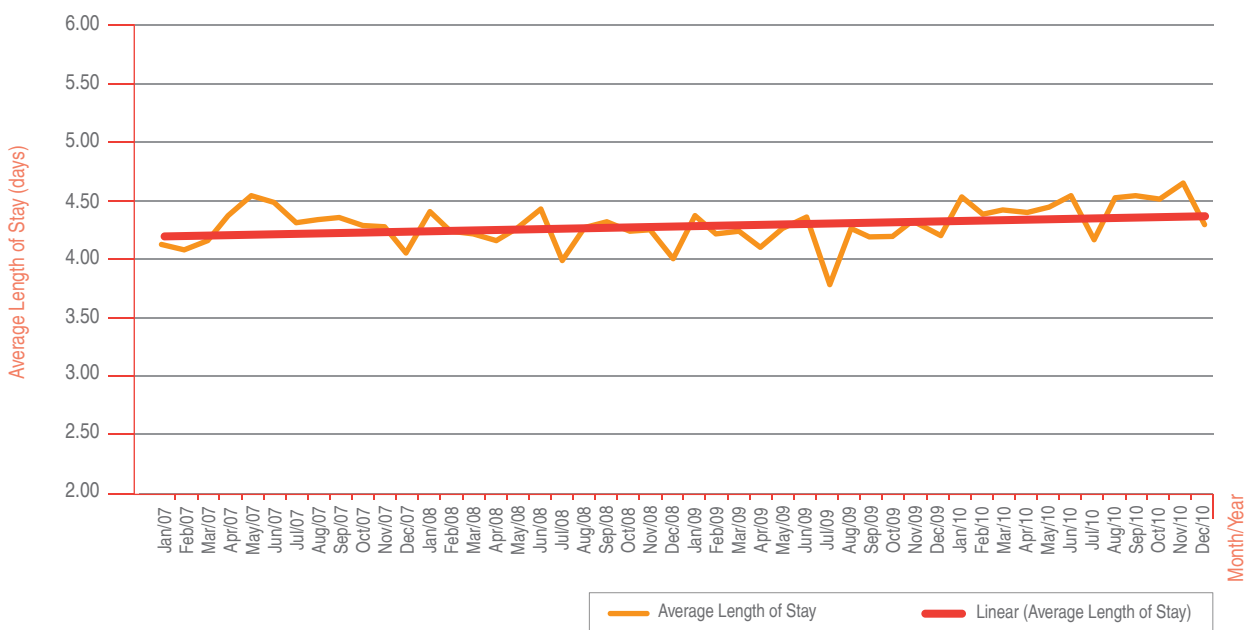


is significant, healthcare complexity is growing, severity of patients' condition (taking the median of patients' age, which grew 5%, as reference) is greater, and the average length of stay remains constant between 4.2 and 4.5 days. This means healthcare management focused on better utilization of beds

in operation. Data on average length of stay, monitored each month by the Project, is consistent with data presented earlier and reinforces the importance of managing the care of certain diseases in order to obtain good clinical outcomes that cause less impact on healthcare cost.

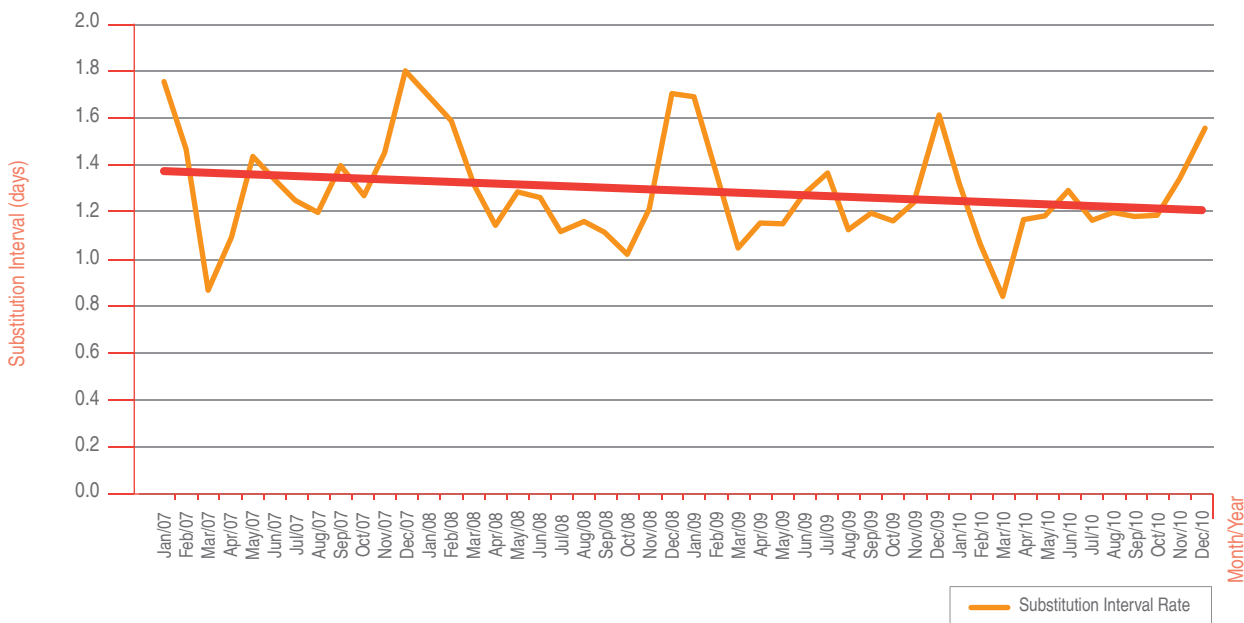
Graph 5 – Monthly Distribution of Average Length of Stay and Linear Tendency

(ANAHP Hospitals – january/2007 to december/2010)



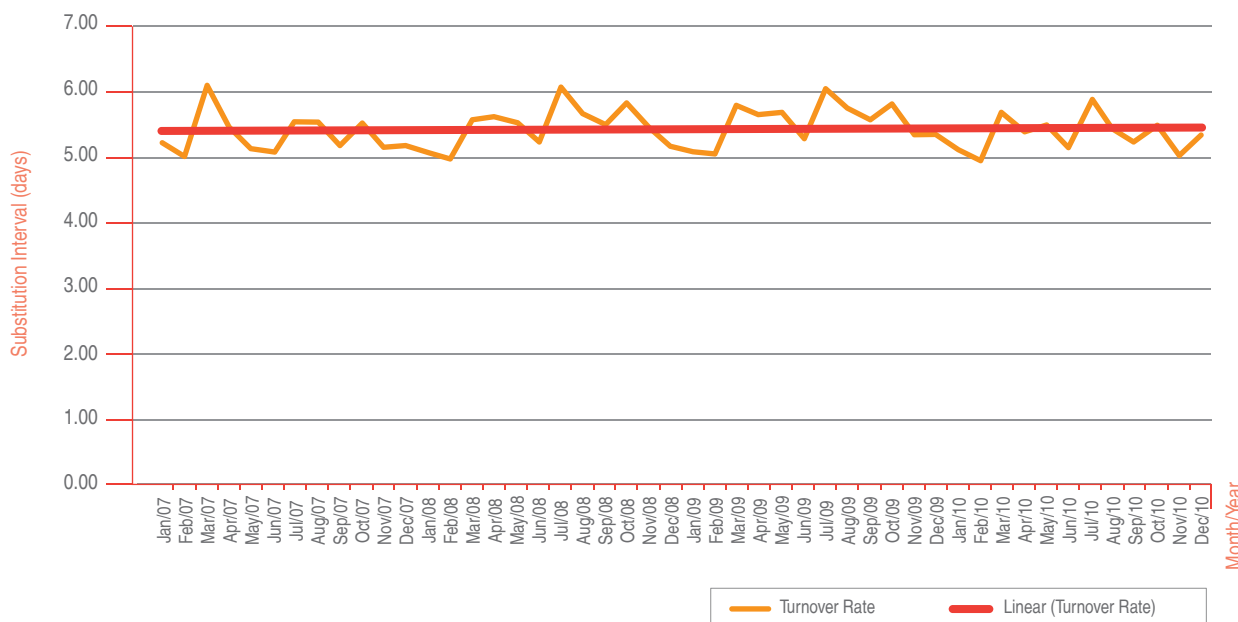
Graph 6 – Monthly Distribution of Substitution Interval Rate and Linear Tendency

(ANAHP Hospitals – january/2007 to december/2010)



Graph 7 – Monthly Distribution of Turnover Rate and Linear Tendency

(ANAHP Hospitals – january/2007 to december/2010)

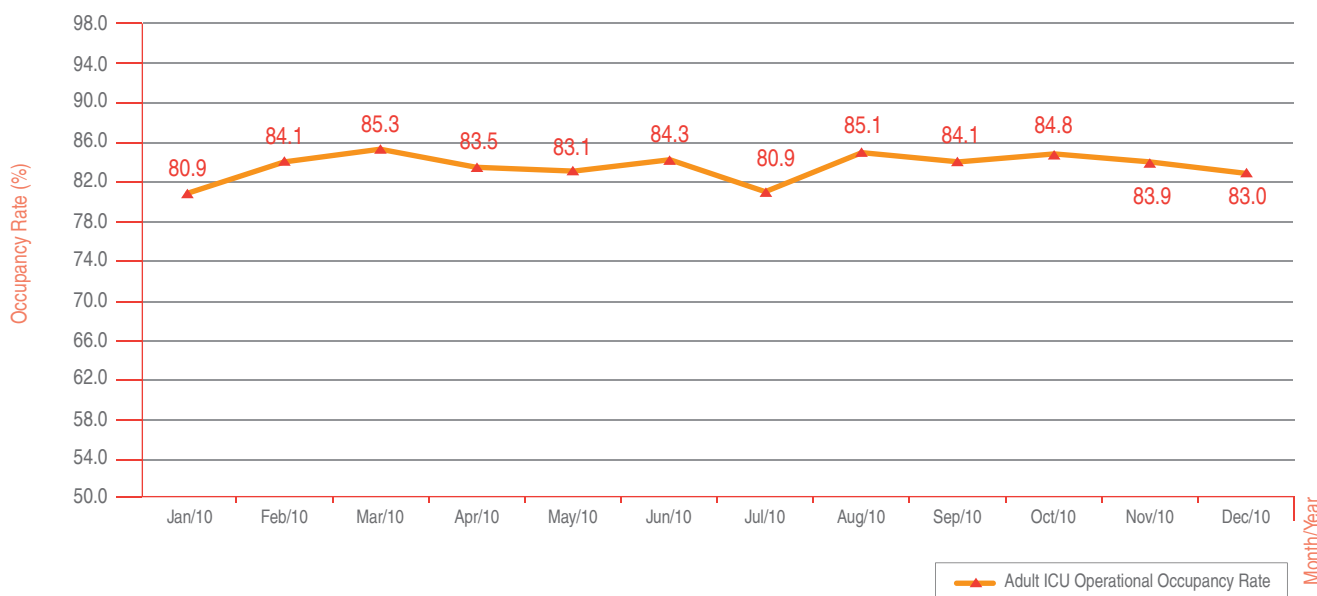


One aspect requiring careful interpretation is the (adult) Intensive Care Unit occupancy rate. Occupancy rates of critical care units for adult patients have shown values between 82% and 85% (Graph 8). The safety limit in the healthcare service environment for any hospital is 85% of the occupancy rate. One observes in this regard much pressure for critical care beds. In recent years, one has observed growth in bed supply in step-down units. In some hospitals, the number of beds in intermediate care areas is double

the number of intensive care beds, showing the importance of this type of bed for service delivery to surgical and high complexity clinical patients, thereby increasing bed turnover for intensive care. Currently, in associated hospitals, intensive care beds correspond to 14% of the total installed beds. In some hospitals, this proportion reaches 30% of the bed total. This trend is also observed in other countries, i.e., growth of clinical hospitalizations requiring intensive and semi-critical treatment.

Graph 8 – Monthly Distribution of the Adult ICU Occupancy Rate

(ANAHP Hospitals – january to december/2010)

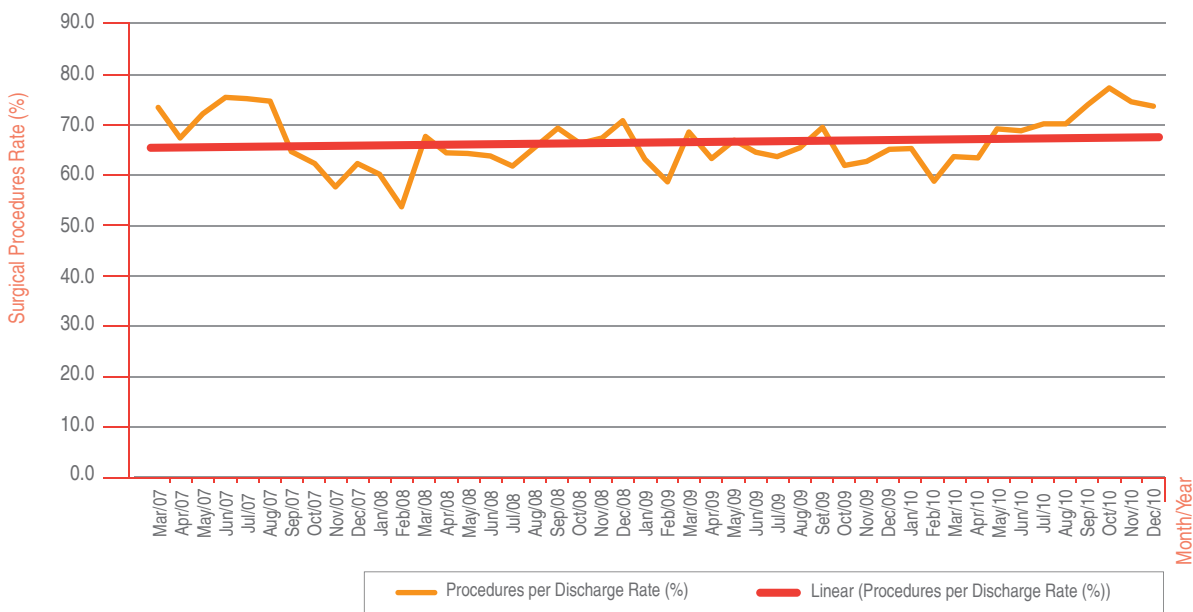


Hospitals' main activity lies in performing surgical procedures, and in 2010 one observes growth in the number of patients submitted to surgical procedures (about 25%) and in the surgical procedures per discharge rate, varying from 63% to 80% of hospital servicing. The number of surgeries per

patient also increased, showing the performance of more medium and low complexity procedures. This rate varied by about 1.27% and increased in relation to 2009 (Table 5 – Graphs 9 and 10).

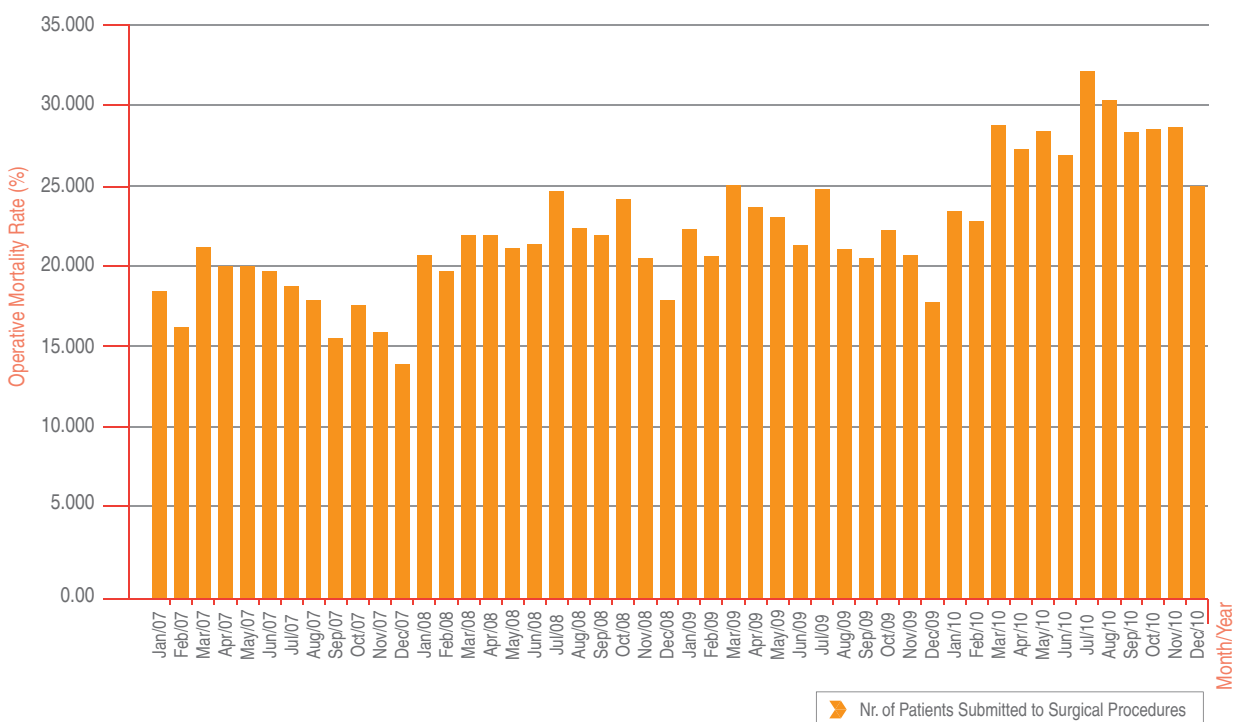
Graph 9 – Monthly Distribution of the Surgical Procedures Rate and Linear Tendency

(ANAHP Hospitals – march/2007 to december/2010)



Graph 10 – Monthly Distribution of the Number of Patients Submitted to Surgical Procedures

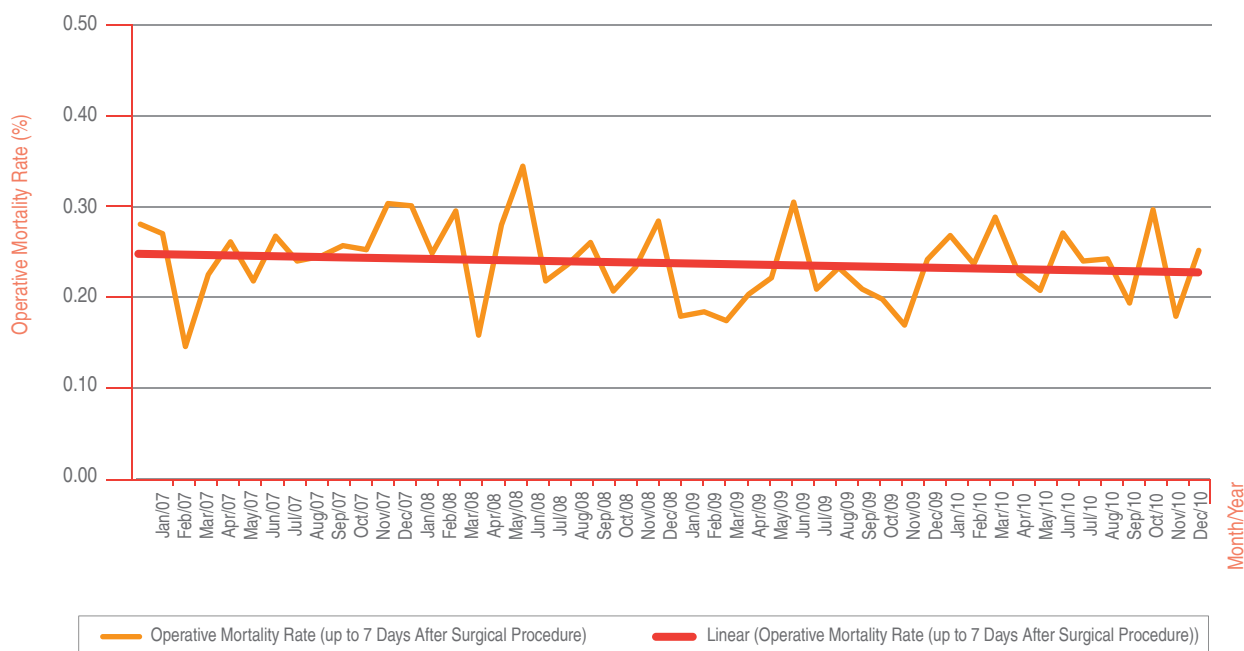
(ANAHP Hospitals – january/2007 to december/2010)



The operative mortality rate is related to procedure complexity and mainly to the anesthetic risk. In 2010, a reduction in procedure complexity occurred, as mentioned earlier. One considers that the anesthetic risk has been increasing in recent years. Albeit this information is not available in the Project, indirect data shows an increase in the age median and prevalent comorbidities, implying greater anesthetic risk. One observes a linear downward trend in operative mortality, evidencing improvement of healthcare outcomes. (Graph 11).

Graph 11 – Monthly Distribution of the Operative Mortality Rate and Linear Tendency

(ANAHP Hospitals – january/2007 to december/2010)



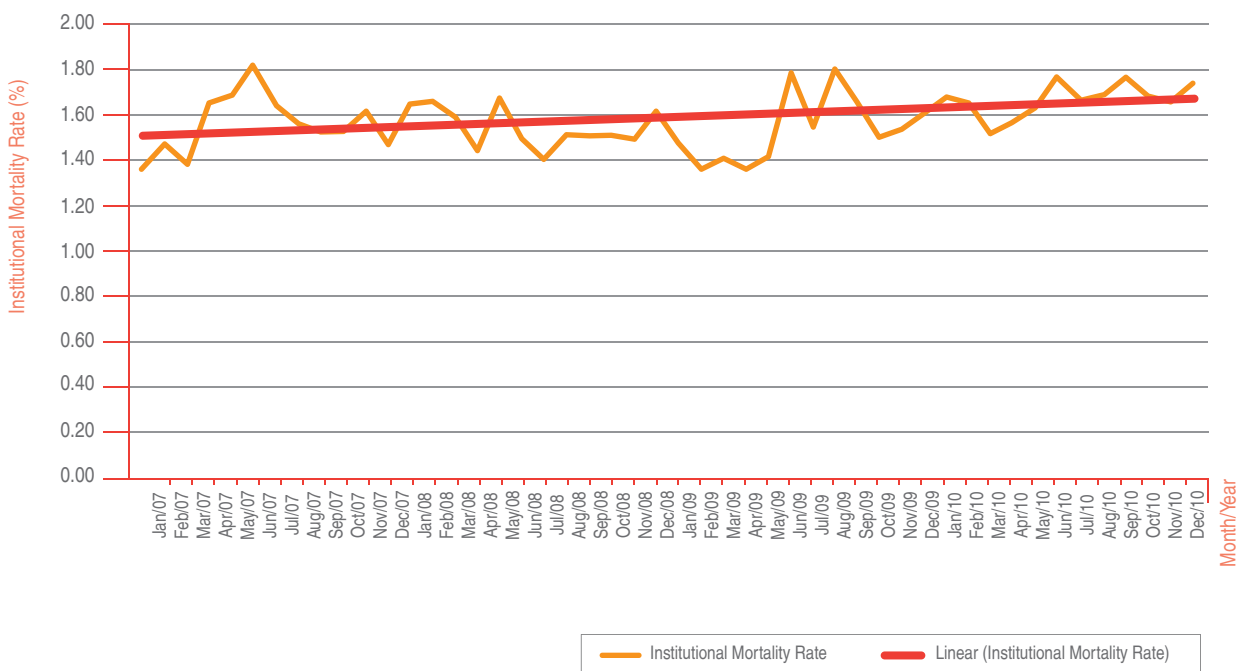
Healthcare Performance

Another outcome-related indicator is the institutional mortality rate. The institutional mortality rates of ANAHP hospitals increased discretely between January 2007 and December 2010 (Graph 12). Values were stable at around 1.7%. This lower variability during the year 2010 may be indicative of better management and healthcare control processes. The increase in the age median and the prevalence of comorbidities could have contributed to a more significant increase of institutional mortality rates.

This did not occur thanks to intensive work by ANAHP hospitals on quality and safety, which will be described in the next section. When one compares the institutional mortality rate values with data of the monitoring system coordinated by the Hospital Quality Committee (HQC) of Associação Paulista de Medicina (Medicine Association of the State of São Paulo), published in PROHASA Indicator Nrs. 58 and 59 for general hospitals, the rates for ANAHP hospitals are lower than the median informed by the HQC (2.8%).

Graph 12 – Monthly Distribution of the Institutional Mortality Rate and Linear Tendency

(ANAHP Hospitals – january/2007 to december/2010)





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A L+M GETS cria e conserva espaços que promovem o melhor estado de bem-estar possível. Entre os diferenciais estão os espaços sempre contemporâneos e em sintonia com as necessidades de cada cliente.

A integração do trabalho centraliza competências e coloca um ponto final nos conflitos e nas desgastantes tentativas de transferência de responsabilidades, tão comum entre projetistas, gerenciadores de obra, construtoras e fornecedores de equipamentos.

A equipe da L+M GETS já atendeu mais de 270 clientes entre cooperativas médicas, operadoras de planos de saúde, consultórios, clínicas e hospitais e realizou mais de 800 projetos. No total foram mais de 1 milhão de m² de arquitetura, ambientação, estrutura, instalações e tecnologia médica, e já entregou mais de 500 mil m² em obras.

PATROCINADOR ANAHP

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Table 5 – Data and Indicators on Performance and Healthcare Quality
(ANAHP Hospitals 2007 to 2010)

Data on operational and healthcare indicators	2007	2008	2009				
				Jan	Feb	Mar	
Nr. of Installed Beds	5,513	6,272	6,453	7,543	7,577	7,620	
Nr. of Operational Beds	5,047	6,040	6,144	7,192	7,310	7,339	
Operational Beds-Day	1,824,735	2,187,619	2,234,514	214,754	197,553	218,989	
Nr. of Operating Rooms	286	331	334	396	400	381	
Nr. of Patients-Day	1,387,365	1,675,829	1,716,441	166,261	159,016	184,026	
Nr. of Hospital Discharges (Discharges+Deaths+External Transfers)	323,830	396,564	408,308	36,785	36,273	41,692	
Nr. of Patients Staying for 90 or More Days	95	129	177	269	268	269	
Nr. of Deaths ≥ 24 Hours	5,054	6,121	6,259	620	602	636	
Total Nr. of Deaths	6,426	7,927	7,594	741	676	751	
Nr. of Patients Submitted to Surgical Procedures	215,608	258,941	264,371	23,503	22,855	28,851	
Total Nr. of Surgeries	Not informed	Not informed	300,105	32,148	30,511	37,297	
Nr. of Surgical Deaths	525	657	552	63	54	83	
Nr. of Operational Beds – Adult ICU	Not informed	Not informed	Not informed	940	937	969	
Nr. of Operational Beds-Day – Adult ICU	Not informed	Not informed	Not informed	28,111	25,502	29,022	
Nr. of Hospital Infections – Adult ICU	3,576	4,296	3,558	279	268	360	
Nr. of Hospital Infections Associated With Central Venous Catheter (“Central Line”) – Adult ICU	582	660	590	46	37	57	
Nr. of Patients-Day – Adult ICU	174,433	223,795	212,063	22,754	21,447	24,765	
Nr. of Catheters-Day – Adult ICU	101,223	134,285	125,427	12,016	11,233	13,188	
Nr. of Operational Beds – Neonatal ICU	Not informed	Not informed	Not informed	316	317	327	
Nr. of Operational Beds-Day – Neonatal ICU	Not informed	Not informed	Not informed	8,925	8,199	9,371	
Nr. of Hospital Infections – Neonatal ICU	Not informed	Not informed	909	67	59	73	
Nr. of Patients-Day – Neonatal ICU	Not informed	Not informed	77,869	7,428	6,655	7,880	
Nr. of Catheters-Day – Neonatal ICU	Not informed	Not informed	Not informed	1,887	1,807	2,251	
Nr. of Clean Surgeries	Not informed	Not informed	144,891	10,583	10,437	12,072	
Nr. of Surgical Site Infections	Not informed	Not informed	759	57	74	92	
Occupancy Rate	76.0	76.6	76.8	77.4	80.5	84.0	
Average Length Of Stay	4.3	4.2	4.2	4.5	4.4	4.4	
Turnover Rate	5.3	5.5	5.5	5.1	5.0	5.7	
Substitution Interval Rate	1.36	1.30	1.28	1.32	1.06	0.84	
Hospital Resident Patient Rate (> 90 Days)	0.4	0.4	0.5	0.7	0.7	0.6	
Institutional Mortality Rate (≥ 24 Hours)	1.6	1.5	1.5	1.7	1.7	1.5	
Surgical Mortality Rate (Until 7 Dias After Surgical Procedure)	0.2	0.3	0.2	0.3	0.2	0.3	
Operational Occupancy Rate – Adult ICU	Not informed	Not informed	Not informed	80.9	84.1	85.3	
Hospital Infection Density Rate – Adult ICU	20.6	19.1	16.7	12.3	12.5	14.5	
Cvc Utilization Rate – Adult Icu	58.0	60.1	59.1	52.8	52.4	53.3	
Incidence Density Rate of Hospital Infection Associated With Central Venous Catheter – Adult ICU	5.7	4.9	4.7	3.8	3.3	4.3	
Operational Occupancy Rate – Neonatal ICU	Not informed	Not informed	Not informed	83.2	81.2	84.1	
Hospital Infection Density Rate – Neonatal ICU	Not informed	Not informed	11.8	9.0	8.9	9.3	
CVC Utilization Rate – Neonatal Icu	Not informed	Not informed	Not informed	25.4	27.2	28.6	
Incidence Density Rate of Hospital Infection Associated With Central Venous Catheter – Neonatal ICU	Not informed	Not informed	Not informed	3.4	4.3	4.1	
Surgical Site Infection Rate	Not informed	Not informed	0.5	0.54	0.70	0.76	
Rate of Procedures per Discharge (%)	66.6	65.2	64.7	63.9	63.0	69.2	
Rate of Surgeries per Patient	Not informed	Not informed	1.1	1.37	1.33	1.29	

2010										
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Annual
	7,643	7,712	7,734	7,694	7,725	7,758	7,604	7,616	7,355	7,632
	7,350	7,435	7,472	7,433	7,229	7,263	7,125	7,138	6,873	7,263
	221,637	229,736	224,622	231,929	225,055	218,685	221,867	215,535	215,138	2,635,500
	381	376	376	377	377	377	365	365	349	377
	175,197	181,345	174,862	181,012	177,701	173,401	175,494	167,471	158,041	2,073,827
	39,778	40,749	38,551	43,613	39,422	38,163	38,908	35,894	36,811	466,639
	236	242	237	254	252	238	239	250	243	250
	627	667	685	729	671	680	659	596	646	7,818
	744	789	818	857	806	797	771	694	782	9,226
	27,333	28,495	27,001	32,231	30,421	28,402	28,600	28,789	25,064	331,545
	34,448	36,105	34,403	41,416	38,392	34,084	34,970	34,102	31,479	419,355
	62	59	73	77	74	55	85	52	63	800
	992	993	999	1,007	999	1,008	982	985	973	982
	29,661	30,591	29,802	30,906	30,397	29,721	30,081	29,192	29,042	352,028
	294	337	314	304	356	302	264	267	320	3,665
	43	55	53	41	41	35	31	43	36	518
	24,781	25,409	25,124	24,998	25,868	24,995	25,512	24,504	24,093	294,250
	13,029	14,181	13,713	13,748	14,361	13,582	13,629	13,032	12,900	158,612
	320	318	318	354	353	358	336	337	326	332
	9,615	9,928	9,574	9,493	10,472	10,235	10,064	9,934	10,056	115,866
	80	67	67	79	60	55	67	74	68	816
	7,448	8,110	8,735	6,948	7,232	7,627	8,167	6,999	7,286	90,515
	2,351	2,513	2,420	1,996	2,156	2,044	1,880	2,138	2,194	25,637
	11,686	12,022	11,509	13,729	13,381	12,237	12,843	11,688	9,931	142,119
	64	68	70	93	77	57	69	70	60	851
	79.0	78.9	77.8	78.0	79.0	79.3	79.1	77.7	73.5	78.7
	4.4	4.5	4.5	4.2	4.5	4.5	4.5	4.7	4.3	4.4
	5.4	5.5	5.2	5.9	5.5	5.3	5.5	5.0	5.4	5.4
	1.17	1.19	1.29	1.17	1.20	1.19	1.19	1.34	1.55	1.20
	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.7	0.7	0.6
	1.6	1.6	1.8	1.7	1.7	1.8	1.7	1.7	1.8	1.7
	0.2	0.2	0.3	0.2	0.2	0.2	0.3	0.2	0.3	0.2
	83.5	83.1	84.3	80.9	85.1	84.1	84.8	83.9	83.0	83.6
	11.9	13.3	12.5	12.2	13.8	12.6	10.7	11.3	13.8	12.5
	52.6	55.8	54.6	55.0	55.5	56.5	55.4	55.3	55.6	53.9
	3.3	3.9	3.9	3.0	2.9	2.6	2.3	3.3	2.8	3.3
	77.5	81.7	91.2	73.2	69.1	74.5	81.2	70.5	72.5	78.1
	10.7	8.3	7.7	11.4	8.3	7.2	8.2	10.6	9.3	9.0
	31.6	31.0	27.7	28.7	29.8	26.8	23.0	30.5	30.1	28.3
	0.5	1.8	1.9	1.5	0.0	2.5	1.7	1.7	0.2	1.9
	0.55	0.56	0.60	0.68	0.57	0.47	0.54	0.59	0.61	0.60
	68.7	69.9	70.0	73.9	77.2	74.4	73.5	80.2	68.1	71.0
	1.26	1.27	1.27	1.28	1.26	1.20	1.22	1.18	1.26	1.26



Healthcare Quality and Safety

Quality and safety indicators were expanded



During 2010, the focus was on presenting ANAHP Hospitals' experiences in Healthcare Quality and Safety.

Associated hospitals are accredited by some external survey system. This forces them to invest in actions that set them apart and warrant quality and safety in providing care to patients.

During 2010, the focus was on presenting ANAHP Hospitals' experiences in Healthcare Quality and Safety. The efforts undertaken by multi-professional technical teams, under the leadership and with the involvement of physicians, notably in critical care units, have been highly productive, with outcomes reflecting a great health care impact.

Quality and safety indicators were gradually expanded. Usually assessed in hospitals on an individual basis, it became essential to standardize in more detail across the organization, to allow for consistency and comparability. With respect to these indicators, 34 hospitals sent data during 2010.

One of the indicators that still merits careful analyses is the surgical site infection rate, given that in 2011 one will invest in standardizing the active search for infections, to improve the comparability of results of this indicator.

Quality and safety indicators must be interpreted in light of the healthcare service structure and the hospitals' healthcare profile. In this respect, they are comparable to large high complexity hospitals. Data and indicators are presented in Table 5.

Indicators monitored by the Healthcare Best Practices Project are:

Quality and Safety Indicators

- ✦ Incidence Density Rate of Hospital Infection (HI) in Adult and Neonatal ICUs
- ✦ Incidence Density Rate of HI Associated with Central Venous Catheter (CVC or "Central Lines") in Adult ICUs



- ✘ Utilization Rate of Central Venous Catheter in Adult and Neonatal ICUs
- ✘ Surgical Site Infection Rate
- ✘ Pressure Ulcer Rate
- ✘ Falls Rate (Including Quasi-Falls)

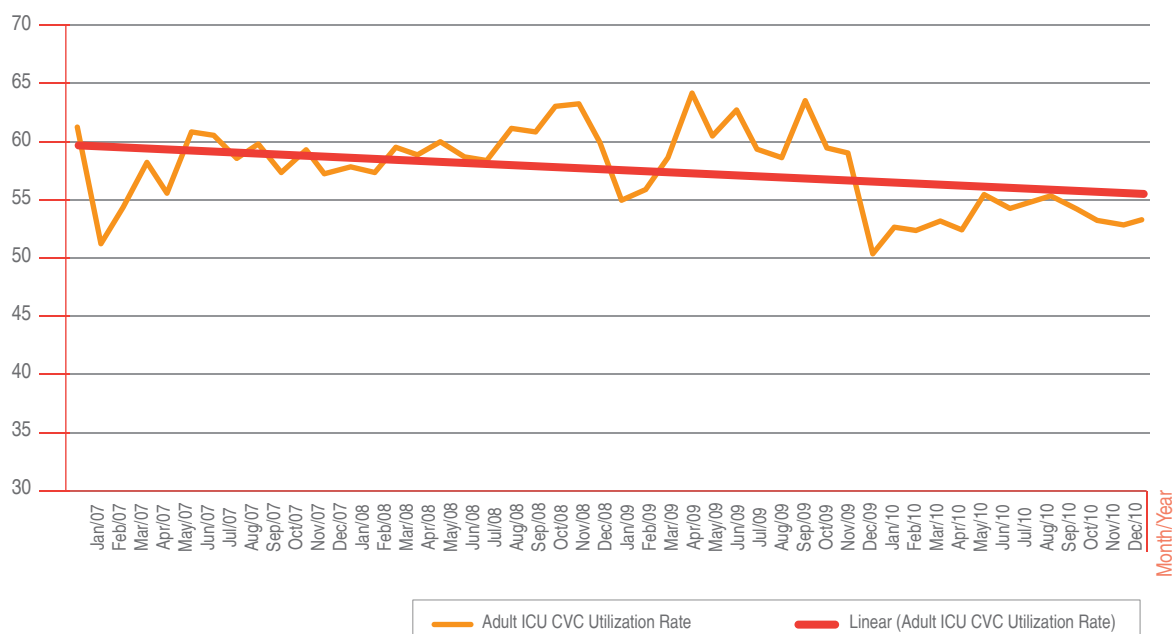
The incidence density rate of hospital infection (nr. of hospital infections/nr. of patients-day x1000) is directly related to the utilization rate of invasive procedures in Intensive Care Units, i.e., the more procedures are used, the higher the risk of hospital infection. The two main types of infection that occur in critical care units are: infections

related to central venous catheters and ventilator-associated infections. Currently, in the Healthcare Best Practices Project, only the incidence density rate of infection associated with central venous catheter is monitored (nr. of hospital infections associated with central venous catheter/nr. of catheters-day*1000). In 2011, the indicators are to be standardized and included to monitor ventilator-associated infections.

One observes a tendency to reduce the central venous catheter utilization rate (nr. of catheters-day/patients-day*100) in adult Intensive Care Units (Graph 13). During 2010, catheter utilization was at about 56% of patients-day admitted in Intensive Care Units for adults.

Graph 1 – Monthly Distribution of the Central Venous Catheter Utilization Rate in Adult ICUs

(ANAHP Hospitals – january/2007 to december/2010)

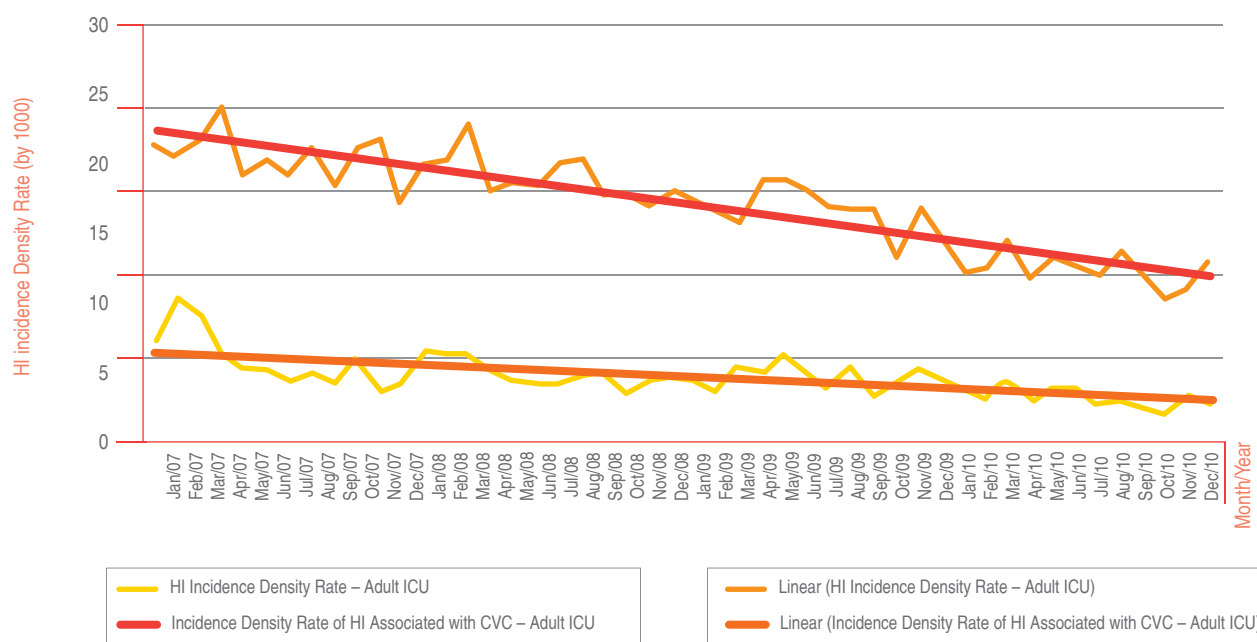


In relation to incidence density rates of hospital infection in adult Intensive Care Units, one notes a significant reduction, also seen in the incidence density rates of hospital infection associated with central venous catheters (Graph 2).



Graph 2 – Monthly Distribution of Incidence Density Rates of HI in Adult ICUs and the Incidence Density Rate of HI Associated with CVC in Adult ICUs and Respective Linear Tendencies

(ANAHP hospitals – january/2007 to december/2010)



These results show improvement of quality in services provided by ANAHP hospitals. The hospital infection indicator parameters targeted are respectively 16/1000 patients-day for the adult ICU hospital infection incidence density rate and 3/1000 catheters-day for the incidence density rate of hospital infections associated with central venous catheters. One should note that the indicator values found in the ANAHP hospital network are below those found in the NHSN (National Healthcare Safety Network), the American hospital infection indicator monitoring system, for the hospital infection incidence density rate and also for the central venous catheter rate. The (linear regression) trends for the two indicators point to a strong decline, however, there is a difference in the linear tendency angle, probably caused by the decrease in the incidence density rates of ventilator-associated infection. The incidence density rate reduction target is close to zero and some hospitals have already reached it, but the task to maintain it low is a difficult one. Decreasing infections, reducing the ICU length of stay, and hence, minimizing complications for patients are a continuous effort of hospitals. This effort has social implications – getting back to productive activities

quicker, at a lower social cost, resulting in significant savings in resources for the health system as well as for the families.

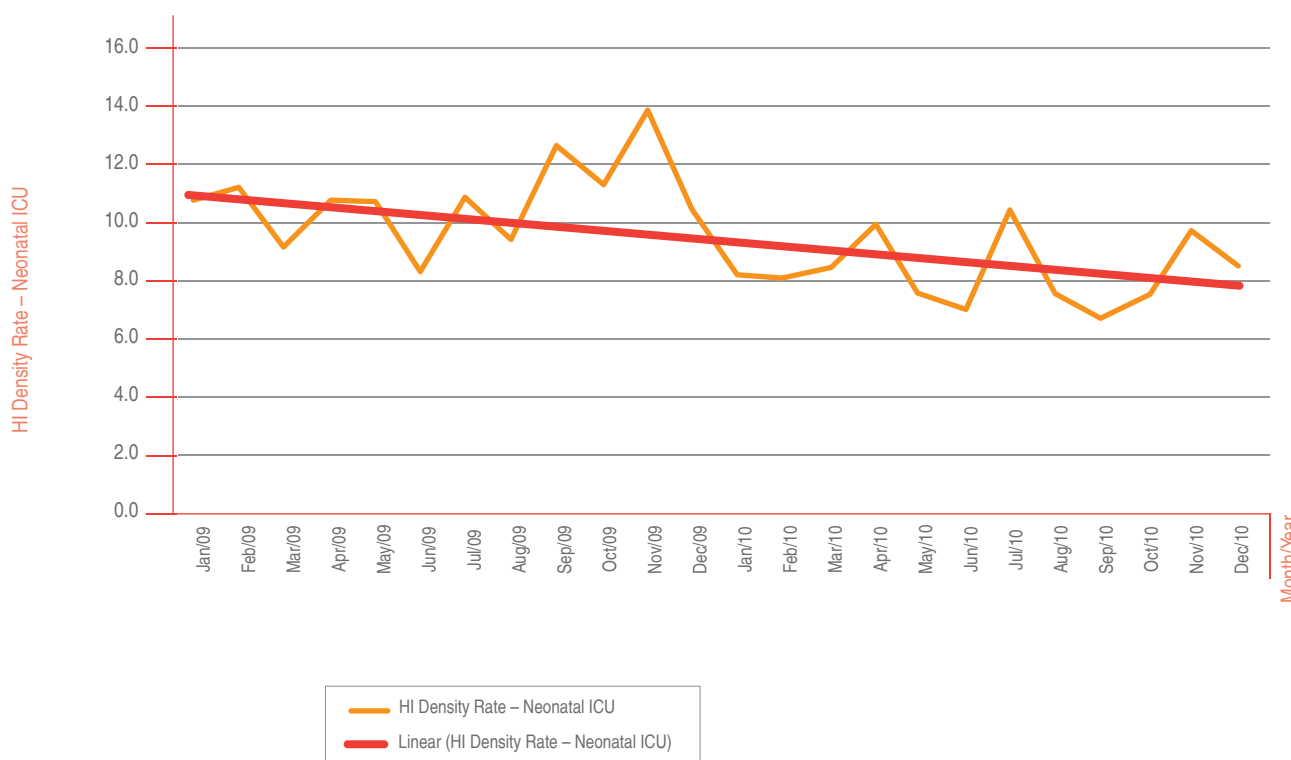
Starting in 2009, indicators related to safety and quality healthcare services provided in neonatal critical care units were included. In the Project, there are 21 hospitals with maternities and critical neonatal beds that supply data and indicators on neonatal healthcare.

Starting in 2010, the incidence density rate of hospital infection associated with central venous catheter was incorporated in neonatal ICUs. Infection incidence density is also related to catheter utilization rate in NICUs. In Table 5 one can notice that 2010 utilization rate values varied between 25% and 30%.

As shown in Graph 3, the hospital infection incidence density rate in neonatal Intensive Care Units has a linear tendency to decrease significantly, varying in 2010 between 7 and 11/1000 catheters-day, well below the figure observed in 2009. The main component is infection associated with central venous catheter, that also shows decreasing results in the comparison between the fourth quarter of 2010 and the first quarter of 2011 (Table 5).

Graph 3 – Monthly Distribution of the HI Incidence Density Rate in neonatal ICUs and Linear Tendency

(ANAHP hospitals – january/2009 to december/2010)

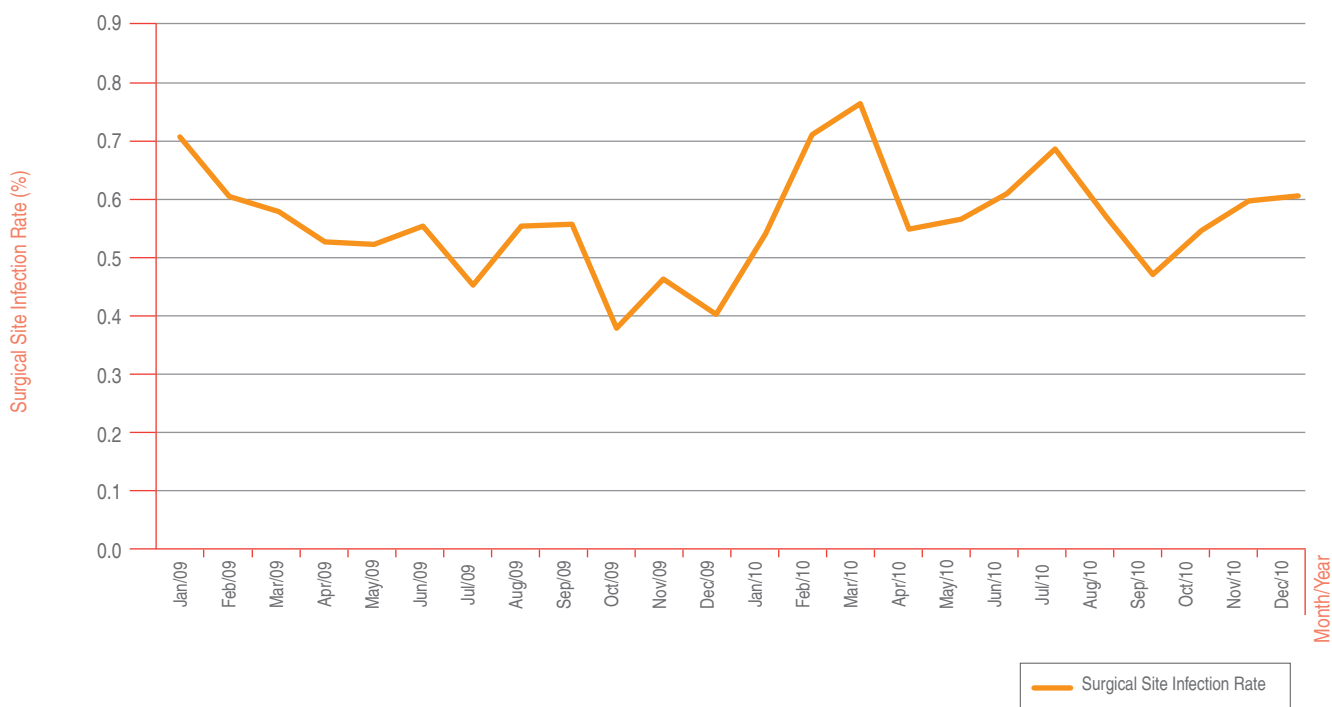


Surgical site infection rate (Graph 4) also started to be monitored in 2009. One observes a variation in this indicator in the 24 months of monitoring, with figures between 0.5% and 0.7%. Outcomes are adequate when comparing with the data in the literature, but data precision needs improvement, given that the standardization of active efforts in hospitals is still inadequate, resulting in limitations for the analysis of this indicator.

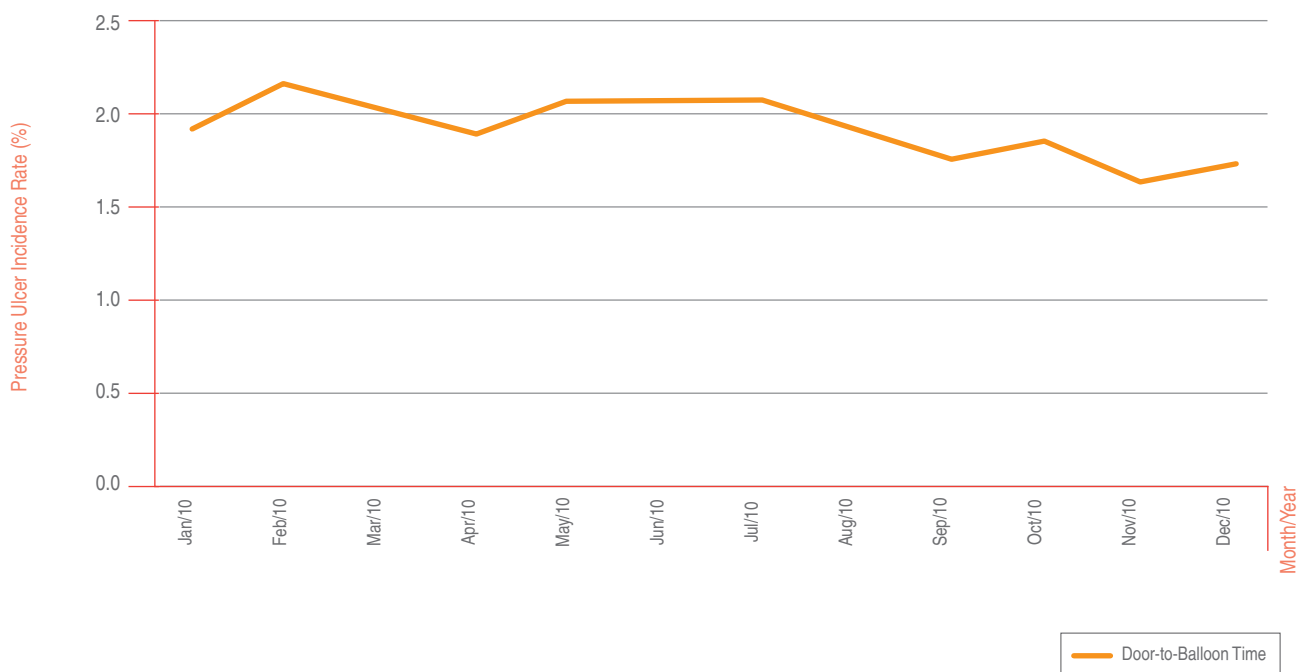
The pressure ulcer incidence density rate, a new indicator that started to be monitored in January 2010, also shows a decline during the period (Graph 5). This reinforces the assessment that safety as well as nursing care quality improved, given that this indicator relates to the quality of care provided by the nursing staff in hospitals.



Graph 4 – Monthly Distribution of the Surgical Site Infection Rate
(ANAHP hospitals – january/2009 to december/2010)



Graph 5 – Monthly Distribution of Pressure Ulcer Incidence Density Rates
(ANAHP hospitals – january to december/2010)



SOLUÇÕES BIONEXO PARA A SAÚDE TÃO INOVADORAS QUANTO ESSENCIAIS

bio|nexo

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Healthcare Protocols

The data collecting and analysis process is constantly improved in periodic meetings



The monitoring of Clinical Indicators allows showing the development and quality of Healthcare Protocols in ANAHP hospitals.

► Healthcare Protocols

The indicators used in the Healthcare Best Practices Project to monitor clinical protocols were selected according to classic criteria for inclusion in a monitoring system based on valid criteria derived from proven clinical guidelines in the national and international literature.

The indicators used are:

Selected Pathologies and their Clinical Indicators

- ✘ Acute Myocardial Infarction (AMI)
 - ✘ Door-to-Balloon Time (AMI with ST-Segment Elevation)
 - ✘ Primary Angioplasty Rate (with ST-Segment Elevation)
 - ✘ Aspirin Rate at Discharge
 - ✘ Average Length of Stay
 - ✘ Mortality Rate
- ✘ Ischemic Stroke
 - ✘ Door-to-Tomography Time
 - ✘ Tomography Rate
 - ✘ Average Length of Stay
 - ✘ Mortality Rate
- ✘ Community-Acquired Pneumonia (CAP) – Adults and Children
 - ✘ Average Length of Stay
 - ✘ Mortality Rate
 - ✘ Adequate Antibiotic Therapy Rate

- ✖ Sepsis
 - ✦ Average Length of Stay
 - ✦ Mortality Rate
 - ✦ Adequate Antibiotic Therapy Rate
- ✖ Congestive Heart Failure
 - ✦ Average Length of Stay
 - ✦ Mortality Rate
- ✖ Video-laparoscopic cholecystectomy and Inguinal Herniorrhaphy
 - ✦ Average Length of Stay in Hours
- ✖ Abdominal Hysterectomy
 - ✦ Average Length of Stay in Days

Acute Myocardial Infarction (AMI):

Circulatory System Diseases are the foremost causes of death in all Brazilian regions and corresponded to a mortality coefficient of 167.6 per 100,000 inhabitants in 2008. Acute Myocardial Infarction is, among Circulatory System Diseases, the second cause of death in Brazil and the first in the South and Southeastern regions. The two main groups comprising Circulatory System Diseases as causes of death are Ischemic and Cerebrovascular Diseases. They are diseases that currently have well-structured national clinical guidelines, proven by specialized institutions.

In ANAHP hospitals, Circulatory System Diseases in recent years represented between 10% and 11% of hospitalization demand. Included are cases of Congestive Heart Failure, with a lower lethality rate, but which entail significant re-hospitalization rates and intensively consume resources.

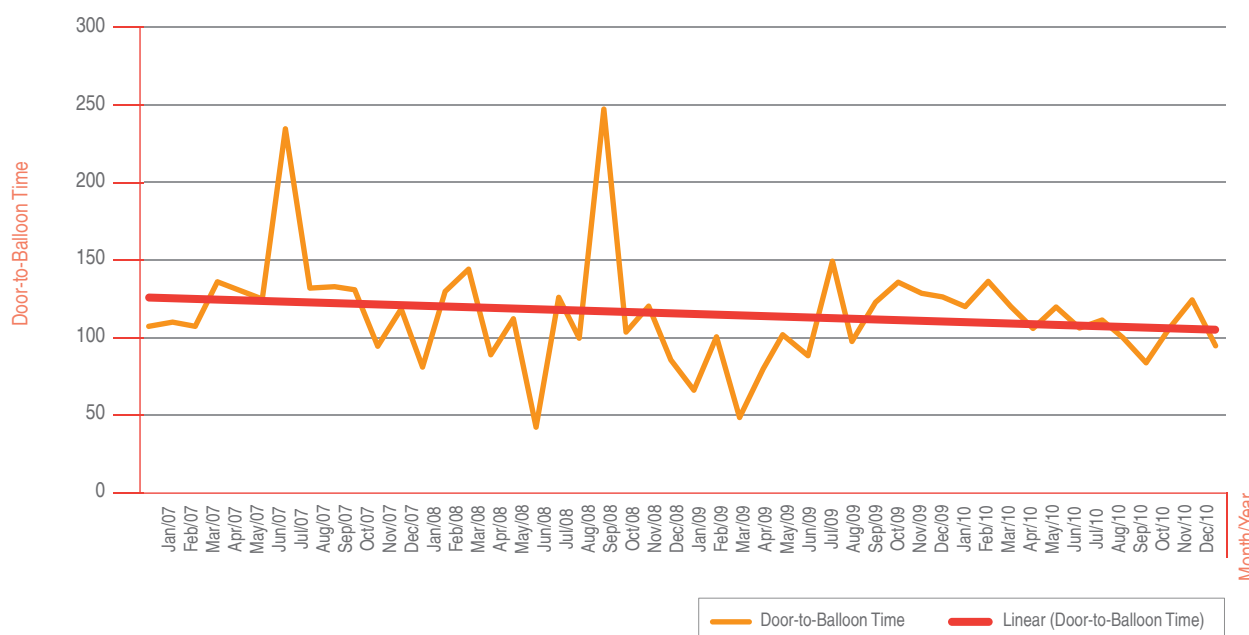
In this large group are Ischemic Heart Diseases – Acute Myocardial Infarction (AMI) is the most common diagnosis – and Cerebrovascular Diseases, of which about 75% of cases are Ischemic Cerebrovascular Accidents (known as Strokes) that, in general, are treated in hospital emergency rooms (ER) and result in higher lethality. For these diagnoses there are well-defined guidelines, and immediately provided care in accordance with good practices leads to more cost-effective outcomes for the organization and for society.

With respect to the precision of collected information, one observes significant improvement in quality and quantity of hospitals that started submitting information on indicators related to Acute Myocardial Infarction (AMI). In 2010, 26 hospitals sent information about this pathology.

Results from indicators on Acute Myocardial Infarction (AMI) show an average door-to-balloon time of 108 minutes (time between arrival at the hospital door and realization of the procedure – Primary Angioplasty), with a decrease in variability during the year and better results when comparing the second semester to the first semester of last year. One considers the best standard of care for this ailment a door-to-balloon time of 90 minutes, which is the target hospitals are trying hard to achieve, and the linear tendency shows this improvement (Graph 1).

Graph 1 – Monthly Distribution of Door-to-Balloon Time and Linear Tendency

(ANAHP hospitals – january/2007 to december/2010)

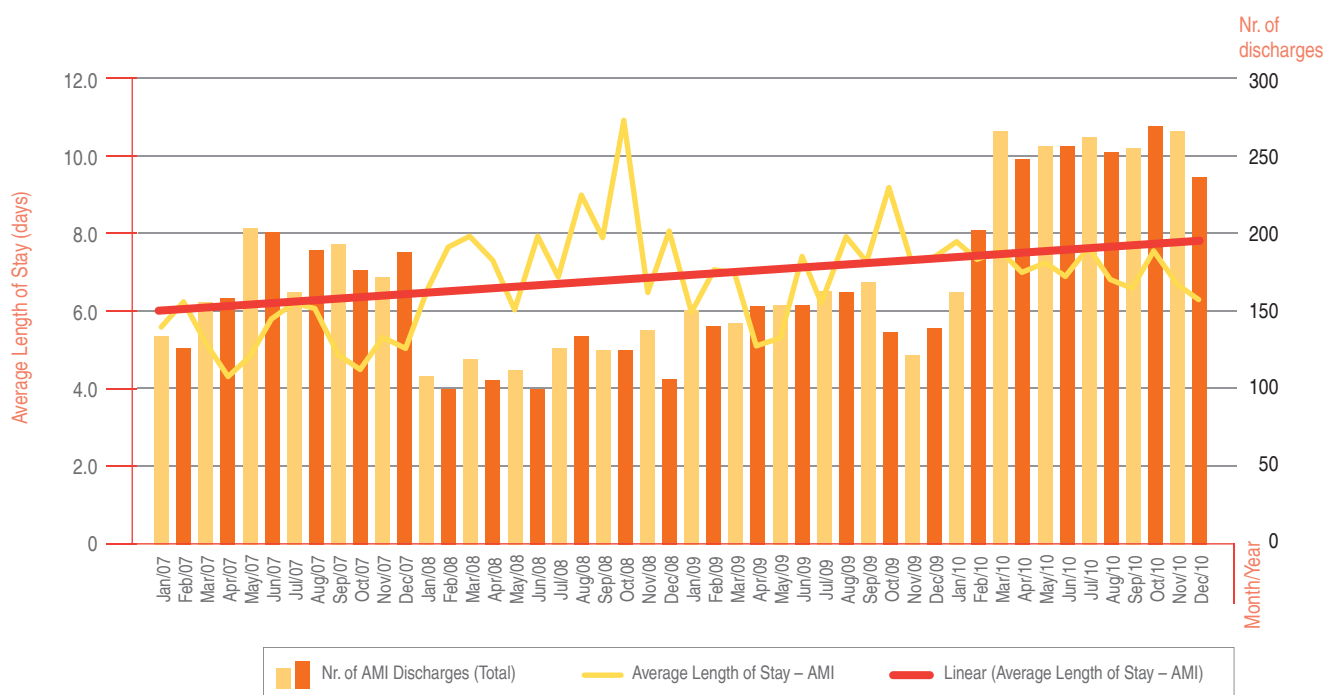




With respect to the service delivery process, the average length of stay considered standard according to international guidelines is 6 to 8 days in AMI cases. In associated hospitals, one notes a significant decrease in this indicator starting in 2009, along with less variability, evidencing standardization of care provided in these cases. The average noted in 2010 ranged from 6.4 to 7.9 days (Graph 2).

Graph 2 – Monthly Distribution of the Average Length of Stay of AMI Patients, Linear Tendency and Number of AMI Discharges

(ANAHP hospitals – january/2009 to december/2010)



The primary angioplasty rate is only monitored in cases of Acute Myocardial Infarction (AMI) with ST-segment elevation. Therefore, the number of cases is lower than the figure shown in Graph 2. In 2010, it varied between 59% and 92%. Therefore, with even higher variation than recommended (Graph 3).

Graph 3 – Monthly Distribution of Angioplasty Rate of AMI Patients with ST-Segment Elevation, Linear Tendency and Number of Discharges

(ANAHP hospitals – january/2009 to december/2010)

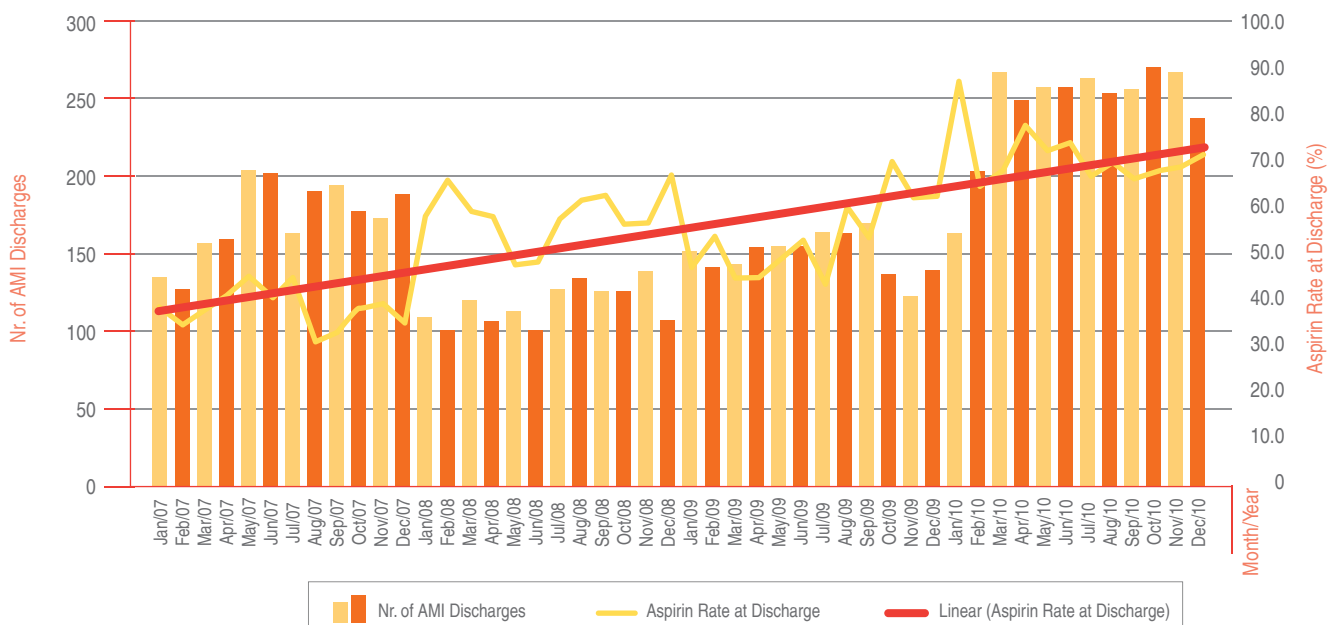


The aspirin prescription rate at discharge shows an upward trend (Graph 4) and less variability in 2010. Rates are above those observed in 2009 and figures varied between 65% and

87%. These results are compatible with other national studies, but below recommended values. International literature refers to an aspirin rate at discharge of 85%.

Graph 4 – Monthly Distribution of Aspirin Rate at Discharge of AMI Patients, Linear Tendency and Number of Discharges

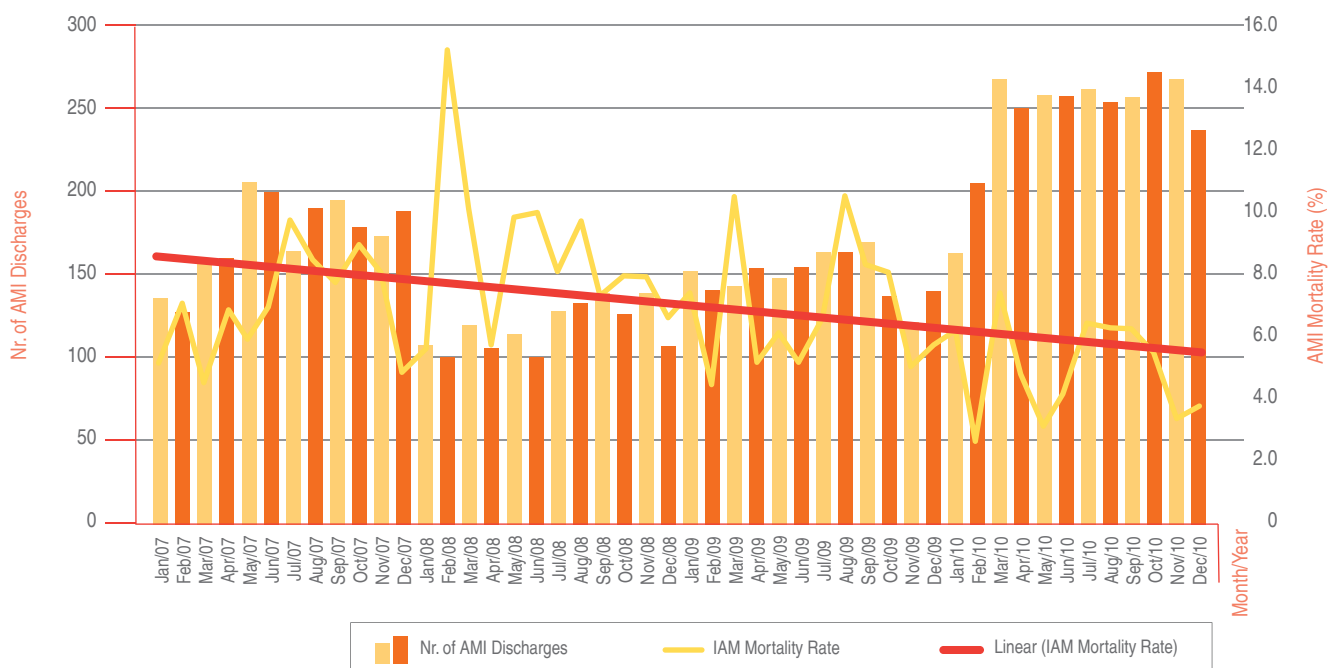
(ANAHP hospitals – january/2007 to december/2010)



The main outcome indicator is mortality rate, which is declining significantly. Considering that there was an increase in observed cases and more precision in data collection, one may suppose that cases are being handled better, mainly when information is jointly analyzed. (Graph 5). The fact that the population is seeking treatment faster as well as timely access to services and diagnoses contributed to lower mortality rates, which indirectly results in lower social cost for the system.

Graph 5 – Monthly Distribution of Mortality Rates of AMI Patients, Linear Tendency and Number of Discharges

(ANAHP Hospitals – january/2007 to december/2010)



Ischemic Stroke

Cerebrovascular Diseases are related to the prevalence of systemic high blood pressure in the population, compliance to anti hypertension treatment and determinant risk factors such as smoking, sedentarism and obesity.

Immediately seeking treatment upon initial symptoms and fast diagnosis of this kind of case when arriving at the ER are secondary prevention actions that define the prognosis and the degree of disability and hence, an individual's quality of life and the social impact on families following the patient's discharge.

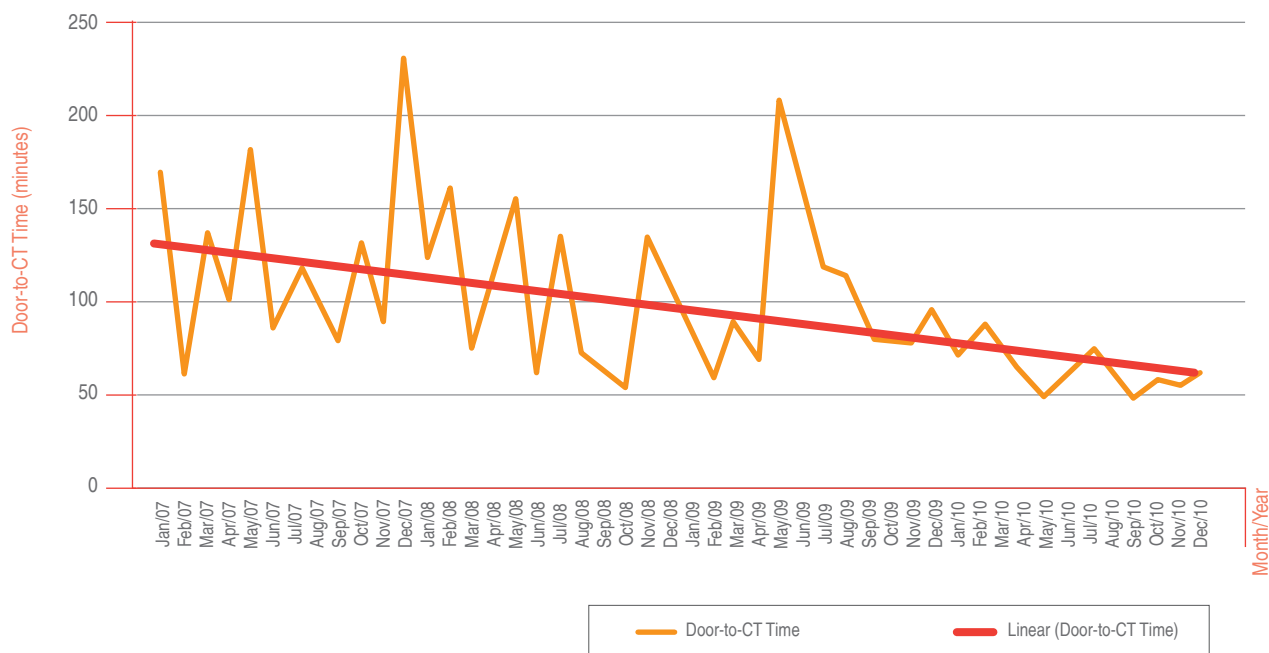
In the case of Ischemic Strokes (Ischemic CVA), diagnostic standardization among healthcare professionals and services, unlike the case of Acute Myocardial Infarction (AMI), is less common, especially in our environment.

Associated hospitals, to a lesser degree, have established protocols for this disease. However, rigor in collecting and analyzing indicators increased over the years.

Indicators of ischemic stroke showed more adequate outcomes in comparison with the standards of best practices as recommended by national and international guidelines.

Door-to-tomography time decreased, showing an increase in effectiveness. The tomography rate is increasing, however it still shows a high degree of variation in the period, thereby hinting at processes not completely standardized. One observes a reduction of mortality rates, with variations during the year from 3.5% to 9.8%, close to the values found in other services of excellence.

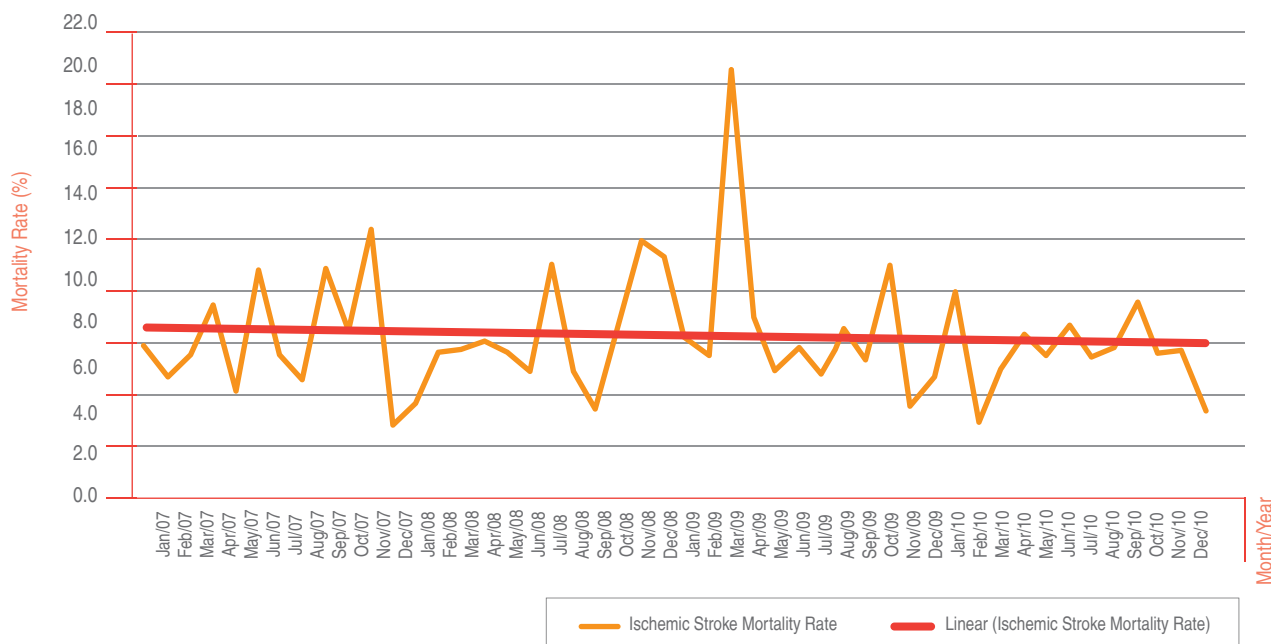
Graph 6 – Monthly Distribution of Door-to-CT Time of Ischemic Stroke Patients and Linear Tendency
(ANAHP Hospitals – january/2007 to december/2010)



Graph 7 – Monthly Distribution of the Tomography Rate in Ischemic Stroke Patients, Linear Tendency and Number of Discharges
(ANAHP Hospitals – january/2009 to december/2010)



Graph 8 – Monthly Distribution of Mortality Rates of Ischemic Stroke Patients, and Linear Tendency
(ANAHP Hospitals – january/2007 to december/2010)



Community-Acquired Pneumonia (CAP)

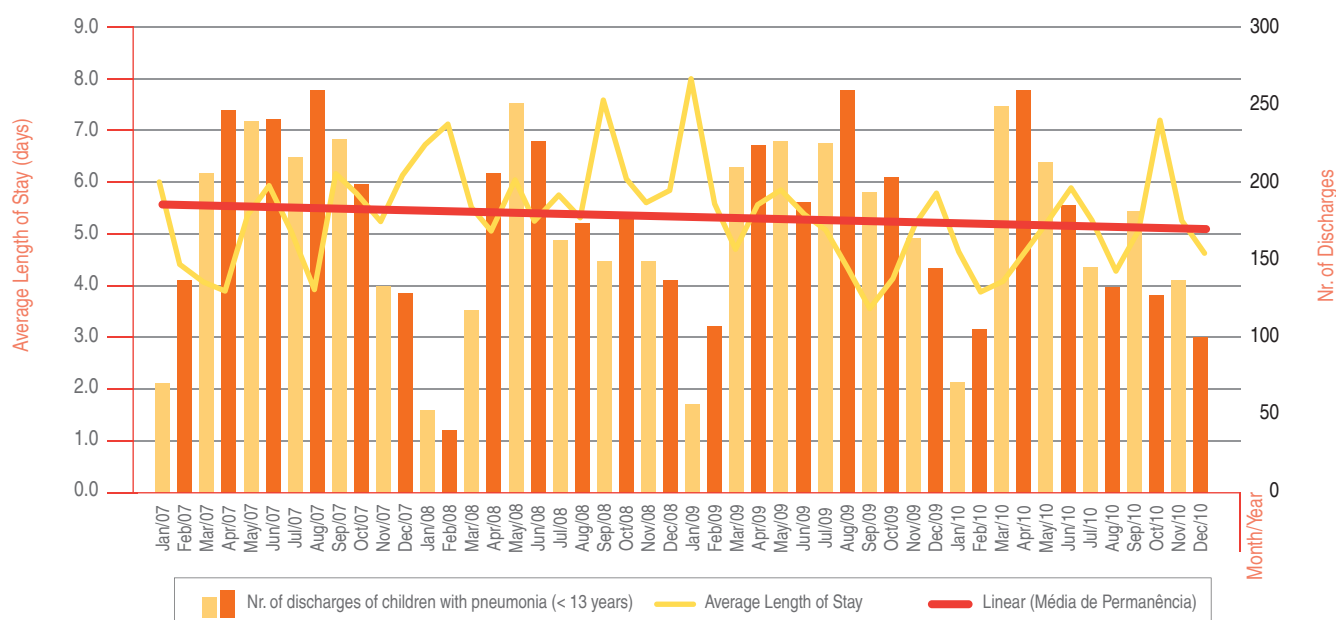
Respiratory System Diseases as a cause of death have increased in our environment, and of these, community-acquired pneumonia is an important cause in children with Underlying Respiratory Diseases (such as asthma and bronchitis) and in the elderly.

The Project monitors protocols for children and adults, with a differentiated focus on individuals over sixty years of age, in whom this disease is more lethal.

One observes seasonal variation in children. Average length of stay shows a discrete reduction during the period. In 2010, it varied between 4.5 and 7.0 days, lower than the results observed in 2009 (Graph 9).

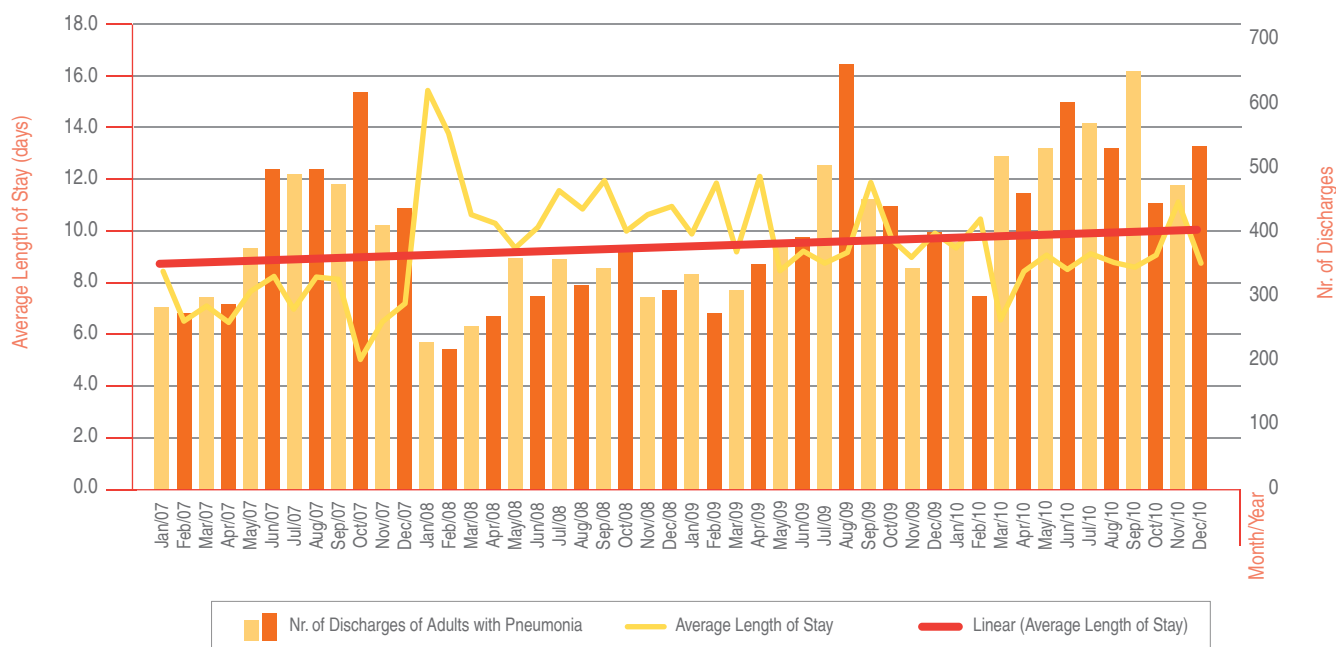
For adults too one observes variation in the average length of stay, with a reduction between 2009 and 2010. Less variability suggests better adjusted protocols (Graph 10).

Graph 9 – Monthly Distribution of the Average Length of Stay of Patients < 13 Years of Age with CAP, Linear Tendency and Number of Discharges
(ANAHP Hospitals – january/2007 to december/2010)



Graph 10 – Monthly Distribution of the Average Length of Stay of Adult Patients with CAP, Linear Tendency and Number of Discharges

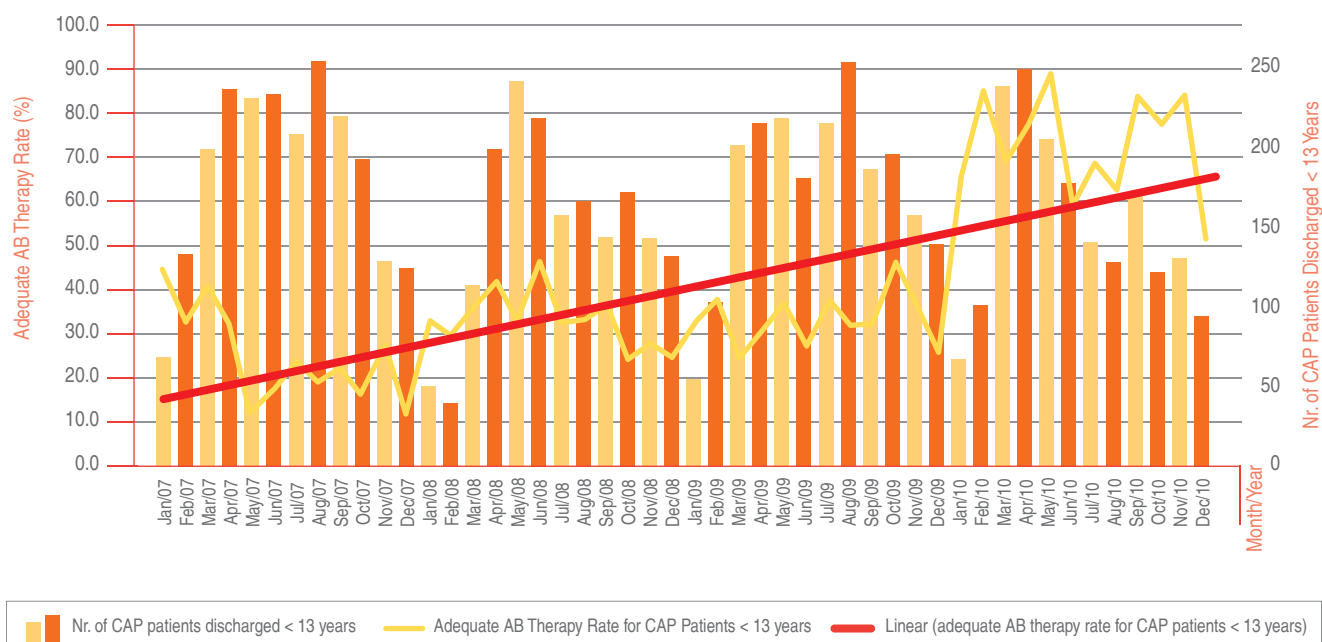
(ANAHP Hospitals – january/2007 to december/2010)



Adequate antibiotic therapy rates (therapy timing, regimen and duration), in compliance with recommended practices, increased for both children and adults (Graph 11 and 12).

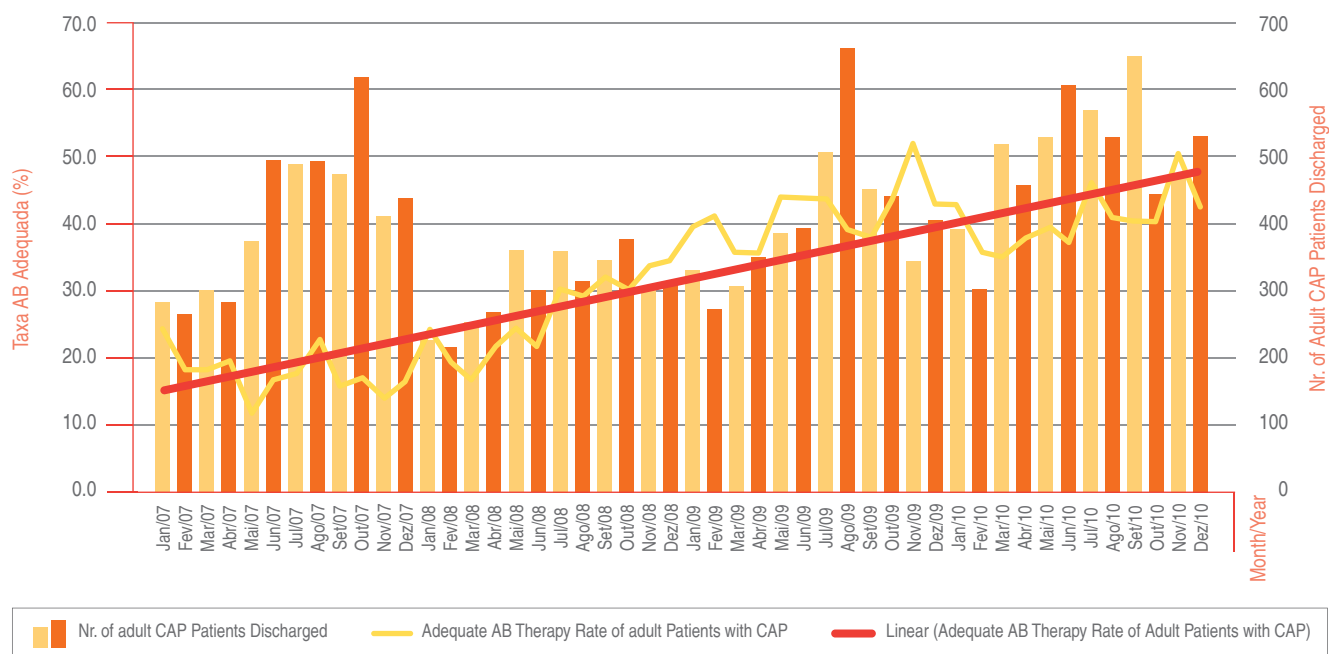
Graph 11 – Monthly Distribution of Adequate use Rates of Antibiotic Therapy in Patients < 13 years with CAP, Linear Tendency and Number of Discharges

(ANAHP Hospitals – january/2007 to december/2010)



Graph 12 – Monthly Distribution of Adequate Use Rates of Antibiotic Therapy in Adult Patients with CAP, Linear Tendency and Number of Discharges

(ANAHP Hospitals – january/2007 to december/2010)



Child mortality rate must be below 1%, according to international guidelines. In participating hospitals in 2010, the average was 0.5%, below the expected one and that measured in 2009. Mortality rates for adults depend on the volume of cases of patients over 60 years of age with this pathology treated in hospitals. In 2010, 66% of patients with community-acquired pneumonia (CAP) were 60+ years old. The average length of stay for these cases was at 8.9 days, ranging from 6.4 to 11.2. For all adult patients, mortality rate was 8.4%, whereas for patients over 60 years this value reaches 12.9%. Information on the result of other indicators monitored by the Project is shown in Table 6.

References – Guidelines and Clinical Protocols

The protocol implementation process in associated hospitals began in 2004, through training and hospitals' joining the program. In 2005 and 2006, visits to and discussions with the associated hospitals took place, in a joint effort with technical teams for the purpose of developing the protocols. The submission and discussion of clinical guidelines, the standardization of the method and the support by the involved hospitals in drawing up flowcharts and algorithms, as well as the monitoring of clinical protocols in each associated hospital, while respecting the organization and characteristics of each hospital, were some of the principles that guided the clinical protocols' implementation.

Below, we present some national and international references (of the last five years) of updated guidelines and clinical protocols for Stroke (CVA), Acute Myocardial Infarction (AMI) and Community-Acquired Pneumonia (CAP), which are subsidies for the "Healthcare Best Practices Project".

Websites of interest to select and monitor updates of guidelines for clinical practice and clinical protocols: www.guidelines.gov; www.icsi.org; www.sign.ac.uk; cihi.ca e <http://library.nhs.uk/guidelinesfinder/>

Ischemic Strokes (ICVA)

International Guidelines

- J. Donald Easton, MD, FAHA, Chair; Jeffrey L. Saver, MD, FAHA, Vice-Chair; Gregory W. Albers, MD; Mark J. Alberts, MD, FAHA; Seemant Chaturvedi, MD, FAHA, FAAN; Edward Feldmann, MD, FAHA; Thomas S. Hatsukami, MD; Randall T. Higashida, MD, FAHA; S. Claiborne Johnston, MD, PhD; Chelsea S. Kidwell, MD, FAHA; Helmi L. Lutsep, MD; Elaine Miller, DNS, RN, CRRN, FAHA; Ralph L. Sacco, MD, MS, FAAN, FAHA Definition and Evaluation of Transient Ischemic Attack: A Scientific Statement for Healthcare Professionals From the American Heart Association/American Stroke Association Stroke Council; Council on Cardiovascular Surgery and Anesthesia; Council on Cardiovascular Radiology and Intervention; Council on Cardiovascular Nursing; and the Interdisciplinary Council on Peripheral Vascular Disease Stroke 2009;40;2276-2293; originally published online May 7, 2009; DOI: 10.1161/STROKEAHA.108.192218 Stroke is available at <http://stroke.ahajournals.org>

✘ Harold P. Adams, Jr, MD, FAHA, Chair; Gregory del Zoppo, MD, FAHA, Vice Chair; Mark J. Alberts, MD, FAHA; Deepak L. Bhatt, MD; Lawrence Brass, MD, FAHA†; Anthony Furlan, MD, FAHA; Robert L. Grubb, MD, FAHA; Randall T. Higashida, MD, FAHA; Edward C. Jauch, MD, FAHA; Chelsea Kidwell, MD, FAHA; Patrick D. Lyden, MD; Lewis B. Morgenstern, MD, FAHA; Adnan I. Qureshi, MD, FAHA; Robert H. Rosenwasser, MD, FAHA; Phillip A. Scott, MD, FAHA; Eelco F.M. Wijdicks, MD, FAHA Guidelines for the Early Management of Adults With Ischemic Stroke A Guideline From the American Heart Association/ American Stroke Association Stroke Council, Clinical Cardiology Council, Cardiovascular Radiology and Intervention Council, and the Atherosclerotic Peripheral Vascular Disease and Quality of Care Outcomes in Research Interdisciplinary Working Groups Stroke 2007;38;1655-1711; originally published online Apr 12, 2007; DOI: 10.1161/STROKEAHA.107.181486 <http://stroke.ahajournals.org/cgi/content/full/38/5/1655>

✘ Institute for Clinical Systems improvement Diagnosis and Treatment of Ischemic Stroke – Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2010 Jun. 70 p. [190 references] Ninth Edition/June 2010, http://icsi.org/guidelines_and_more/.

✘ Sign (Scottish Intercollegiate guidelines network Management of patients of stroke: rehabilitation, prevention and management of complications and discharge planning – National clinical guideline – Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network – National Government Agency; 2010 Jun. 101 p. (SIGN publication; no. 118). [300 references] ISBN 978 1 905813 63 6; www.sign.ac.uk

Brazilian Guidelines

✘ Martins SCO, Brondani R, Frohlich AC, Castilhos RM, Dallalba CC, Mesquita JB, Chaves MLF, Nasi LA. *Trombólise no AVCI agudo em um Hospital da Rede Pública: a experiência do Hospital de Clínicas de Porto Alegre*. Rev Neurocienc 2007;15/3:219–225

✘ Martins SCO, Brondani R, Friedrich M, Araújo MD, Wartchow A, Passos P, Manenti E, Jaeger C, Rech R, Silveira D, Ruschel K, Nasi LA, Chaves MLF, Ehlers JA. *Quatro anos de experiência no tratamento trombolítico do AVC Isquêmico na cidade de Porto Alegre*. Rev Neurocienc 2006; 14(1):031-036

Acute Myocardial Infarction (AMI)

International Guidelines

✘ Anderson JL, Adams CD, Antman EM, et al. ACC/AHA 2007 guidelines for the management of patients with unstable angina/non-ST-elevation myocardial infarction: a report of the American college of cardiology/American heart association task force on practice guidelines (writing committee to revise the 2002 guidelines for the management of patients with unstable angina/non-ST-elevation myocardial infarction). I Am Coll Cardiol 2007;50:e1-e157. Antman EM, Hand M, Armstrong PW, et al. 2007 focused update of the ACC/AHA 2004 guidelines

for the management of patients with ST-elevation myocardial infarction: a report of the American college of cardiology/American heart association task force on practice guidelines. Am Coll Cardiol 2008;51:210-47.

✘ Institute for Clinical Systems improvement Diagnosis and Treatment of Chest Pain and ACS – Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2010 Oct. 72 p. [155 references] Sixth Edition/October 2010 http://www.icsi.org/acs_acute_coronary_syndrome/acute_coronary_syndrome_and_chest_pain__diagnosis_and_treatment_of_2.html

Brazilian Guidelines

✘ Piegas LS, Feitosa G, Mattos LA, Nicolau JC, Rossi Neto JM et al. Sociedade Brasileira de Cardiologia. *Diretriz da Sociedade Brasileira de Cardiologia sobre Tratamento do Infarto agudo do Miocárdio com Supradesnível do Segmento ST*. Arq Bras Cardiol.2009;93(6 supl.2):e179-e264.

✘ Nicolau JC, Timerman A, Piegas LS, Marin-Neto JA, Rassi A. Jr. *Diretrizes da Sociedade Brasileira de Cardiologia sobre Angina Instável e Infarto Agudo do Miocárdio sem Supradesnível do Segmento ST* (II Edição, 2007). Arq Bras Cardiol 2007; 89 (4): e89-e131.

Community-Acquired Pneumonia (CAP)

International Guidelines

✘ Mandell LA, Wunderink RG, Anzueto A, Bartlett JG, Campbell GD, Dean NC, Dowell SF, File TM Jr, Musher DM, Niederman MS, Torres A, Whitney CG. Infectious Diseases Society of America/American Thoracic Society consensus guidelines on the management of community-acquired pneumonia in adults.

✘ Clin Infect Dis 2007 Mar 1;44 Suppl 2:S27-72. [335 references]. Nazarian DJ, Eddy OL, Lukens TW, Weingart SD, Decker WW, American College of Emergency Physicians. Clinical policy: critical issues in the management of adult patients presenting to the emergency department with community-acquired pneumonia. Ann Emerg Med 2009 Nov;54(5):704-31. [57 references]

✘ Cincinnati Children's Hospital Medical Center. Evidence based care guideline for community acquired pneumonia in children 60 days through 17 years of age. Cincinnati (OH): Cincinnati Children's Hospital Medical Center; 2006 Jul. 16 p. [80 references]

Brazilian Guidelines

✘ Corrêa RA, Cavalcanti FLL, Pereira-Silva JL, Silva RLF, Cardoso AP, Lemos ACM, Rossi F, Michel G, Ribeiro L, Cavalcanti MAN, Figueiredo MRF, Holanda MA, Valery MIBA, Aidê MA, Chatkin MN, Messeder O, Teixeira PJZ, Martins RLM e Rocha RT Comissão de Infecções Respiratórias e Micoses – Sociedade Brasileira de Pneumologia e Tisiologia *Diretrizes brasileiras para Pneumonia Adquirida na Comunidade (PAC) em adultos imunocompetentes* – 2009. J Bras Pneumol. 2009;35(6):574-601

Tabela 6 – Clinical Indicators of Selected Pathologies
(ANAHP Hospitals – 2007 to 2010)

Pathologies	Indicators	2007	2008	2009			
					Jan	Feb	
Acute Myocardial Infarction (AMI)	Door-to-Balloon Time (minutes)	127	111	110	117	134	
	Average Length of Stay (days)	5.4	7.9	7.0	7.9	7.5	
	Angioplasty rate – AMI (%)	28.3	42.1	79.9	58.7	62.1	
	Aspirin rate at discharge – AMI (%)	38.3	58.0	53.6	87.0	64.7	
	Mortality rate – AMI (%)	7.1	8.6	7.0	6.2	2.5	
Ischemic Stroke (ICVA)	Door-to-CT time (minutes)	122	102	97	71	84	
	Door-to-thrombolysis time (minutes)	NI	NI	27	68	59	
	Average length of stay – ischemic stroke (days)	9.1	10.4	11.1	9.8	9.3	
	Tomography rate (%)	22.0	36.7	48.4	69.9	54.8	
	Mortality rate – ischemic stroke (%)	7.7	7.7	8.1	9.8	3.5	
Congestive heart failure (CHF)	Average length of stay – CHF (days)	NI	NI	NI	12.1	9.5	
	Mortality rate – CHF (%)	NI	NI	NI	11.0	12.6	
Pneumonia (CAP) in Children	Average length of stay - Pneumonia < 13 years (days)	4.9	5.6	4.9	4.5	3.7	
	Adequate AB rate - pneumonia < 13 years (%)	22.6	33.2	32.3	64.2	85.1	
	Mortality rate - pneumonia < 13 years (%)	0.5	1.0	0.6	3.0	0.0	
Pneumonia (CAP) in Adults	Average stay - pneumonia adults (days)	7.1	11.1	9.8	9.3	10.3	
	Adequate AB rate - pneumonia adults (%)	17.2	26.8	41.2	41.6	34.3	
	Mortality rate - pneumonia adults (%)	8.5	9.4	9.8	8.9	10.3	
	Average stay - pneumonia > 60 (days)	NI	NI	11.6	13.4	16.5	
	Mortality rate - pneumonia > 60 (%)	NI	NI	13.9	17.4	17.2	
Sepsis	Average length of stay - Sepsis (days)	6.9	13.6	12.0	16.1	24.0	
	Adequate AB rate - Sepsis (%)	12.2	37.6	62.6	55.8	56.8	
	Mortality rate - Sepsis (%)	61.7	27.7	25.8	31.7	29.7	
Surgical	Average length of stay - Hysterectomy (days)	1.5	2.2	1.7	2.8	3.3	
	Average length of stay – VLP Cholecystectomy (hours)	34.0	43.2	34.3	24.5	22.9	
	Average length of stay – Inguinal Herniorrhaphy(hours)	27.0	25.7	17.9	17.8	17.9	

2010											
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Annual
	117	103	117	103	108	96	80	103	122	93	108
	7.7	7.1	7.4	7.0	7.8	6.9	6.7	7.7	6.8	6.4	7.2
	85.7	71.7	84.2	91.5	84.1	74.6	75.0	70.8	76.1	69.6	75.5
	68.0	77.9	72.0	73.5	66.7	69.2	66.0	67.9	68.4	70.9	70.6
	7.5	4.8	3.1	4.3	6.5	6.3	6.3	5.5	3.4	3.8	5.0
	66	62	49	55	70	61	48	56	55	58	61
	130	66	71	108	117	144	52	133	76	127	96
	7.7	9.8	8.8	9.3	9.7	11.9	9.0	9.4	12.8	10.3	9.7
	86.7	74.7	65.7	58.1	98.0	67.6	61.9	49.7	72.0	80.6	70.0
	6.0	7.5	6.6	8.1	6.6	7.0	9.1	6.8	7.0	4.2	6.9
	9.9	17.4	12.3	10.6	13.3	10.5	10.7	12.1	9.4	10.1	11.5
	10.0	12.7	9.6	4.9	8.4	10.6	8.1	11.5	5.2	7.8	9.1
	3.9	4.5	5.0	5.7	5.1	4.1	4.8	7.0	5.1	4.4	4.8
	68.2	76.7	88.8	57.9	67.6	61.4	83.2	76.9	83.7	50.5	73.1
	0.0	0.4	0.0	0.0	0.7	0.0	0.6	0.8	0.8	3.2	0.5
	6.4	8.3	8.9	8.3	8.8	8.6	8.4	8.8	10.9	8.4	8.7
	33.1	35.5	35.6	35.2	43.1	39.2	37.1	38.6	48.2	39.3	38.4
	9.5	8.9	7.5	7.7	9.5	8.1	8.7	8.0	12.3	9.7	9.0
	10.0	10.9	10.9	10.2	11.4	9.8	9.3	10.6	12.4	10.0	10.9
	17.0	13.4	10.6	10.1	14.0	10.9	11.2	10.7	16.3	12.4	12.9
	15.0	20.6	15.8	17.6	14.9	16.8	14.0	14.1	14.2	16.4	16.5
	64.8	61.4	55.9	62.5	73.7	82.8	75.5	74.3	68.2	66.5	67.1
	30.3	26.8	27.7	27.4	21.5	23.1	25.5	22.3	24.6	24.0	25.9
	2.9	2.5	2.7	2.6	2.1	2.6	2.0	2.2	2.5	3.3	2.6
	23.5	28.2	25.7	25.2	21.6	25.7	23.7	27.8	23.5	25.3	24.8
	16.6	22.8	20.9	20.9	23.9	20.8	22.5	19.7	17.2	16.8	19.8



» Casa de Saúde São José
Hospital A.C Camargo
Hospital Alemão Oswaldo Cruz
Hospital Aliança
Hospital Anchieta
Hospital Bandeirantes
Hospital Barra D'Or
Hospital Copa D'Or
Hospital do Coração
Hospital Esperança
Hospital Israelita Albert Einstein
Hospital Mãe de Deus
Hospital Mater Dei
Hospital e Maternidade Brasil
Hospital e Maternidade Santa Joana
Hospital Memorial São José
Hospital Meridional
Hospital Moinhos de Vento
Hospital Monte Sinai
Hospital Nipo-Brasileiro
Hospital Nossa Senhora das Graças
Hospital Nossa Senhora de Lourdes
Hospital Nove de Julho
Hospital Português
Hospital Pró-Cardíaco
Hospital Quinta D'Or
Hospital Samaritano
Hospital Santa Catarina
Hospital Santa Genoveva
Hospital Santa Joana
Hospital Santa Luzia
Hospital Santa Rosa
Hospital São Camilo Pompéia
Hospital São Lucas
Hospital São Luiz Itaim
Hospital Sírio-Libanês
Hospital Vera Cruz
Hospital VITA Batel
Hospital VITA Curitiba
Hospital VITA Volta Redonda
Hospital viValle
Real Hospital Português
Vitória Apart Hospital



Institutional Profile ANAHP Hospitals



Casa de Saúde São José

► Brief History of the Institution

The mission of the Casa de Saúde São José is one of dedication to promoting health; it is a hospital institution maintained by the Associação Congregação de Santa Catarina (The Santa Catarina Congregational Association), the second largest private philanthropic institution in Brazil and a leader in the health sector. The Association controls 34 social programs throughout Brazil, providing health and education assistance, as well as performing pastoral services. Resources for maintaining the institutions are shared and integrated into a self-sustaining system.

Founded more than 80 years ago, the Casa de Saúde São José has strengthened its values and invested in technology and human warmth in order to be the most advanced and specialized high tech treatment center in Rio de Janeiro. As it has the infrastructure to work in as many as 24 medical specialties, it is a benchmark for emergency, cardiac and orthopedic services, apart from diagnostic services and treatment support. Our institution even contains one of the most modern intensive care centers in the country, with a diversity of specialties: neurological, general, coronary, and neo-natal. It boasts 22 surgical rooms and has a capacity to perform up to 2,500 surgical procedures a month, outstanding for its excellence in management and for providing quality services to the “Cariocas” (Citizens of Rio de Janeiro).

To contribute to the maintenance of these services is to be of service to life and to fulfill the mission of Casa de Saúde São José, because for us, life is sacred.

Highlights During 2010 and 2011

The Casa de Saúde São José excels through its commitment to technological innovation, and also through investments of US\$ 3 million for reforming the Diagnostic Imaging Center, including extension and renovation works for the technological park, as well as contracting a digitalized medical imaging system RIS/PACS (Radiology Information System/Picture Archiving and Communication System). As a result of these initiatives, the Casa de Saúde São José intends to further strengthen its high tech organization, which is in accordance with the strategies designed for the organizational extension of the hospital. The expansion will attract new specialties and services of a high tech nature.

The investments made in training the executive staff deserve mention too. In partnership with the prestigious institution Dom Cabral, a business management leadership program was developed during the years 2009 and 2010.

Seeking to guarantee continued quality healthcare and safety for its patients, the Casa de Saúde São José, - the first hospital in the State of Rio de Janeiro to obtain the Hospital Accreditation Certificate issued by the ONA (National Accreditation Organization) – is hoping to obtain International Accreditation in 2011 by the Canadian Council for Health Services Accreditation – CCHSA.

Characteristics

Not profit oriented	
Foundation	1923
Institution's built area	30.000 m ²
Organization of the Clinical Staff	Open
Hospital Accreditation	National Accreditation Organization (ONA III)

Main Indicators

Total nr. of operational beds	(dec-10)	209
Nr. of beds in ICUs	(dec-10)	68
Nr. of registered doctors	(dec-10)	6.032
Nr. of active employees	(dec-10)	612
Nr. of first-aid center consultations	(2010)	1.047
Nr. of outpatient consultations	(2010)	1.000
Nr. of hospitalizations	(2010)	19.929
Nr. of surgeries (except births)	(2010)	22.002
Nr. of births	(2010)	3.032
Nr. of tests performed in the DTC	(2010)	365.485
Gross Revenues (in R\$ million)	(2010)	191.9



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Hospital A.C. Camargo

► Brief History of the Institution

Founded in 1953, the A.C. Camargo Hospital is a national pioneer in oncology and an international benchmark for the study of cancer, and its research and treatment. It is currently treating more than 800 medically identified types of tumor. The hospital operates with an inter-disciplinary healthcare staff of 2,500 professionals, who work cooperatively together in 44 specialized areas. Of these, 400 doctors are specialists in oncology – 80% of them with either a Master's or Doctorate. Another distinguishing factor is the hospital's work in the scientific field, with emphasis on research into the more common types of cancer such as breast, prostate and colorectal, as well as other cancer types directly related to the life styles of specific population groups in the country, such as brain tumors, neck, penis and stomach cancers. The experience and knowledge acquired in the research laboratories are then put into clinical routines for the implementation of new therapeutic methods, with the result that treatments become ever more efficient.

Maintained by the Antônio Prudente Foundation, in 2010 the hospital carried out more than 900,000 medical procedures (hospitalizations, consultations, outpatient treatments, surgeries, radio and chemotherapy, and imaging diagnosis). In the area of teaching and research, the A.C. Camargo Hospital created its first oncological residency in 1953, which has the responsibility for training half the oncologists working in Brazil. More than one thousand oncologists have graduated from the hospital. Today, they treat cancer in various institutions all over Brazil and even overseas. The post-graduate course, created in 1996, is the best in the country for oncology and one of the best in the medical field.

Highlights During 2010 and 2011

The major highlight of 2010 was the inauguration of the A.C. Camargo Ricardo Renzo Brentani Hospital's (CIPE's) – International Center for Research and Teaching, in the presence of the Nobel Prize winner for medicine in 2008, Harald zur Hausen. This area was designed to combine, in one place, the development and management of the institution's research activities. With the start-up operation of the CIPE, the new Solid 4 Ultra High Throughput Sequencer (UHT) entered into operation, the most modern in Latin America until 2010. Also during 2010, the first meeting of A.C. Camargo Global Meeting of Translational Science was held. This is one of the most important scientific meetings in the southern hemisphere, promoted in partnership with Fapesp (The State of São Paulo Research Foundation), which has brought together some

of the world's most respected scientists from the areas of immunology, neuroscience, genomics and oncology. In 2010 too, the Hospital A.C. Camargo made investments to the order of R\$ 70 million to extend and modernize the infrastructure for new accommodation and technology in chemotherapy, the oncology clinic and in the pathological, anatomy and nuclear medicine departments, among others.

During 2011, it is expected to complete the work on the new Tamanadaré Tower Block, which will house a large pediatric complex and more than 120 beds, giving a total of 441 beds for the hospital. In 2011 the Institute's attention will be dedicated even more to patient quality and care.

Characteristics

Not profit oriented	
Foundation	1953
Institution's built area	43.000 m ²
Organization of the Clinical Staff	Open
Hospital Accreditation	National Accreditation Organization (ONA III)

Main Indicators

Total nr. of operational beds	(dec-10)	321
Nr. of beds in ICUs	(dec-10)	36
Nr. of registered doctors	(dec-10)	397
Nr. of active employees	(dec-10)	1.907
Nr. of first-aid center consultations	(2010)	18.220
Nr. of outpatient consultations	(2010)	270.948
Nr. of hospitalizations	(2010)	13.760
Nr. of surgeries (except births)	(2010)	8.996
Nr. of births	(2010)	not applicable
Nr. of tests performed in the DTC	(2010)	1.537.859
Gross Revenues (in R\$ million)	(2010)	404,3

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Hospital Alemão Oswaldo Cruz

► Brief History of the Institution

Founded on September 26, 1897 by German-speaking immigrants, the Hospital Alemão Oswaldo Cruz was conceived with the aim of offering quality medical services to the community as a means of repaying the Brazilian people for the way in which these immigrants had been welcomed. Since its foundation, the institute has maintained its vocation of caring for people, combining this care with meticulous precision, which is reflected by the combined excellence of its comprehensive services within its health chain, which encompasses education, prevention, diagnostics, treatment and rehabilitation.

With five focal areas – circulatory, digestive, osteomuscular, oncological diseases and elderly care – the hospital has developed a permanently progressive path in its search for important clinical indicators, ensuring that it is a benchmark for quality in its sphere of activity.

In 2009, the institution was awarded certification by the Joint Commission International (JCI), guaranteeing a standard of quality and safety in medical-care for its patients, equivalent to the best health institutions in the world. This recognition as one of the best health institutions in Brazil is a reflection of the integrated performance by its competent clinical team with professionals who make up the hospital's staff. Constant investments in the education and training of its medical teams have been instrumental in the recognition obtained by the hospital in various sectors at a national level.

Highlights During 2010 and 2011

In recent years, through the strategic planning which guides its management, the hospital has established its five focal areas of reference, as well as targets for expansion based on the concept of sustainable growth. Among the actions taken to achieve these objectives were the implementation of modern equipment for assessment and improving medical processes, measures for reinforcing relationships with the professional staff and investments for staff training.

In addition to the above, the year 2009 was marked by the expansion of the hospital's units, with the entry into service of new units – an Outpatients' Unit for Social Sustainability, CIAMA – Breast-focused Maternity Institute, in partnership with Pró-Matre Paulista and the Specialization Center of Campo Belo.

Already in 2011, areas such as Cardiology, CDI (Center for Diagnostic Imaging), Orthopedics and Hemodialysis will be extended, gaining new layouts, in order to offer more comfortable facilities and with more advanced resources

for both doctors and patients. The preparations and implementation of a new system of hospital administration should also be highlighted; an Integrated System of Administration for the German Hospital (SIGHA). In addition, the work on a new building in the Paraíso hospital complex will receive significant investments in order that the facilities are in operation by 2012.

Characteristics

Not profit oriented	
Foundation	1897
Institution's built area	72.000 m ²
Organization of the Clinical Staff	Open
Hospital Accreditation	Joint Commission International (JCI)

Main Indicators

Total nr. of operational beds	(dec-10)	239
Nr. of beds in ICUs	(dec-10)	34
Nr. of registered doctors	(dec-10)	5.045
Nr. of active employees	(dec-10)	1.747
Nr. of first-aid center consultations	(2010)	60.214
Nr. of outpatient consultations	(2010)	not applicable
Nr. of hospitalizations	(2010)	16.545
Nr. of surgeries (except births)	(2010)	20.391
Nr. of births	(2010)	not applicable
Nr. of tests performed in the DTC	(2010)	158.203
Gross Revenues (in R\$ million)	(2010)	417,9



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Hospital Aliança

» Brief History of the Institution

The Hospital Aliança S/A was founded in December 1981 with 100% of the paid up capital belonging to the Aliança Insurance Group of Bahia, with the social aim of providing medical and hospital services, as well as the construction of hospitals and complementary installations throughout Brazil.

The Hospital Aliança was inaugurated in 1990, part of a complex formed by its own hospital and a medical center strategically located in the district of Rio Vermelho, Salvador (State of Bahia), with an area of 55,500 square meters and parking for up to 800 vehicles. Following successive extensions since its inauguration, it now has 213 beds available for clinical, surgical and ICU hospitalizations, a medical center with 77 consultants, a convention center, an outpatients' emergency service, diagnostic imaging services and laboratories.

Highlights During 2010 and 2011

The Aliança Hospital expects to have its technological park updated by 2011, as well as to extend its installations, with an increase in the number of beds. A review and implementation of new processes, a program of management skills, strategic planning and integrated budgeting will all be undertaken.

The hospital is also carrying out a Management Development Plan in partnership with the Dom Cabral Foundation.

The hospital recently received the TOP OF MIND SALVADOR award.

Characteristics

Profit oriented	
Foundation	1990
Institution's built area	29.216 m ²
Organization of the Clinical Staff	Open
Hospital Accreditation	in progress

Main Indicators

Total nr. of operational beds	(dec-10)	203
Nr. of beds in ICUs	(dec-10)	42
Nr. of registered doctors	(dec-10)	2.533
Nr. of active employees	(dec-10)	1.659
Nr. of first-aid center consultations	(2010)	66.040
Nr. of outpatient consultations	(2010)	not applicable
Nr. of hospitalizations	(2010)	11.750
Nr. of surgeries (except births)	(2010)	7.075
Nr. of births	(2010)	1.826
Nr. of tests performed in the DTC	(2010)	82.514
Gross Revenues (in R\$ million)	(2010)	208,5

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Hospital Anchieta

► Brief History of the Institution

Founded on September 6, 1995, Hospital Anchieta is one of the most modern private healthcare complexes in the country, thanks to its comprehensive infrastructure of outpatient, diagnostic and hospital back up services for high complexity assistance and care. It is also a benchmark in Quality Management in the healthcare sector: it was the first hospital in Latin America to receive the ISO 9001:2000 certificate, also having been re-certificated in the first half of 2010 for the final version of the internationally respected quality seal, to ISO 9001:2008. In 2006 it became the first hospital in Brazil to obtain the Accreditation of Excellence (Level 3), granted by the Ministry of Health/ONA.

“In practice, a hospital institution that opts for a quality system has, among its principle aims, to offer a high standard of care and safety. This is because each of the models, whether ISO, Accreditation, or PNQ training, is designed to focus on the client and the vision of the market, and to provide the standards for all processes, the assessment of indicators and a commitment to continued improvements”, claims Dr. Délcio Rodrigues, Superintendent.

Highlights During 2010 and 2011

In 2010, after two and a half years from design stage to completion and an investment of R\$ 23 million for the work and equipment, the Anchieta Hospital inaugurated its new and bold Adult ICU. With an area of 2,500 square meters, the Unit has 36 beds, with 15 square meters of space per bed. It also has an internal surgical center, meeting rooms for doctors and families, as well as visitors' facilities.

In 2011, the hospital intends to achieve the following::

- ✘ To join PAEX (Partners in Excellence) – The Dom Cabral Foundation – with the intention of establishing an advanced program for planning and monitoring.
- ✘ The implementation of a new organization model, which will establish itself as a data base center totally dedicated to the client's care and needs, in both administrative and healthcare spheres. One of these features will be the implementation of process management.
- ✘ In February of this year, the Institute's laboratory was awarded the Certificate of Excellence – Gold Category, by the National Program for Quality Control (PNQC) of the Brazilian Society of Clinical Analysis (SBAC), to companies who have maintained a consistent standard of excellence in the previous ten years.
- ✘ The Anchieta Hospital is also anticipating, with an investment of R\$ 8 million, the inauguration of a new

hospital laundry, in addition to the completion of three new floors of apartments for hospitalized patients, for greater comfort and care for patients and visitors, with the focus on improving patient environment. Investment planned: R\$ 8 million.

Characteristics

Profit oriented	
Foundation	1995
Institution's built area	60.374 m ²
Organization of the Clinical Staff	Open
Hospital Accreditation	National Accreditation Organization (ONA III)

Main Indicators

Total nr. of operational beds	(dec-10)	110
Nr. of beds in ICUs	(dec-10)	42
Nr. of registered doctors	(dec-10)	902
Nr. of active employees	(dec-10)	797
Nr. of first-aid center consultations	(2010)	192.551
Nr. of outpatient consultations	(2010)	not applicable
Nr. of hospitalizations	(2010)	10.118
Nr. of surgeries (except births)	(2010)	6.071
Nr. of births	(2010)	1.440
Nr. of tests performed in the DTC	(2010)	66.044
Gross Revenues (in R\$ million)	(2010)	86,1

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Hospital Bandeirantes

► Brief History of the Institution

During 2010, in order to commemorate its 35th anniversary, the Grupo Saúde Bandeirantes (GSB) inaugurated the Novo Hospital Bandeirantes (the New Bandeirantes Hospital), which established new standards in hospital care and high tech medical equipment, placing the Institution among one of the leading hospitals in the country. The Diagnostic and Nuclear Medicine Center deserves mention, as well as the humane intensive care unit (ICU). The Bandeirantes Hospital has obtained certification ONA 3 – National Organization for Excellence and Accreditation (ONA). The Grupo Saúde Bandeirantes (GSB), which is part of the Institution, is made up of two divisions: the private hospital network - Bandeirantes Hospital in Liberdade (São Paulo) and the Leforte in Morumbi; and the network of managed hospitals of Glória Hospital in Liberdade and the psychiatric hospital, Lacan, in São Bernardo do Campo. This chain accounts for 860 beds, 2,300 staff members and around 1,700 surgical procedures a month. The Bandeirantes Hospital, the group's leading unit, is a benchmark in complex medical care, with 'know-how' in the areas of cardiovascular medicine, transplants, specialized surgeries and oncological procedures. In addition to this, its work in the socio-environmental area through the Instituto Saúde Bandeirantes de Responsabilidade Socioambiental (The Bandierantes Health Institute for Socio-environmental Responsibility), is worth mentioning too, for its initiatives with the Programa Socorrista Mirim and the Campanha Óleo Aqui, as well as its training and research programs carried out by the Instituto de Ensino e Pesquisa – the Institute for Training and Research - (IEP-GSB).

Highlights During 2010 and 2011

The year 2010 was noteworthy for being of exceptional importance for the Grupo Saúde Bandeirantes (GSB). In September, the Novo Hospital Bandeirantes was inaugurated. The investments for this project resulted in the extension and modernization and opening of a new diagnostics center with a 1.5 tesla magnetic resonance unit, a 64 channel multi-slice computerized tomographics unit and a women's health center. The nuclear medicine services center was also inaugurated, with 16 channel PET/CET and cintilography equipment and a lodotherapy service with a therapy room that follows all current legal recommendations for this sort of procedure.

One of the significant highlights for the Grupo Saúde Bandeirantes, during the second semester of 2010 was highly exposed in the media, with the commencement of

its first television campaign, celebrating the opening of the Novo Hospital Bandeirantes and the first year of operations in the Leforte Hospital in Morumbi. 2010 also saw the event of the tenth edition of the Intensive Therapy and Cardiology Symposium, - already assimilated into the national scientific agenda – and for the Paulista Hospital Medicine Symposium. In December 2010, the Hospital Bandeirantes was chosen by the Associação Comercial de São Paulo (São Paulo Commercial Association) as the most Distinguished Business Institution of the year. During this same period the Institution counted on the partnership with the Fundação Dom Cabral in the establishment of a new strategic plan, defining guidelines for a bold growth plan in 2011, which will be a year of investment consolidation for the Grupo Saúde Bandeirantes, in both professionals and technology in its ceaseless search for excellence.

Characteristics

Not profit oriented	
Foundation	1975
Institution's built area	30.000 m ²
Organization of the Clinical Staff	Open
Hospital Accreditation	National Accreditation Organization (ONA III)

Main Indicators

Total nr. of operational beds	(dec-10)	204
Nr. of beds in ICUs	(dec-10)	56
Nr. of registered doctors	(dec-10)	2.752
Nr. of active employees	(dec-10)	1.257
Nr. of first-aid center consultations	(2010)	76.013
Nr. of outpatient consultations	(2010)	44.945
Nr. of hospitalizations	(2010)	11.517
Nr. of surgeries (except births)	(2010)	7.242
Nr. of births	(2010)	not applicable
Nr. of tests performed in the DTC	(2010)	not applicable
Gross Revenues (in R\$ million)	(2010)	183

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Hospital Barra D'Or

► Brief History of the Institution

A pioneer in the concept of hospital care, Hospital Barra D'Or combines the newest technology with an irreproachable environment for easing patient concern when looking for hospital services.

It was the first hospital to be inaugurated in the Rede D'Or network and conceived by a group of doctors, engineers and architects. The hospital offers an open environment using bright colors and soft lines, which, in combination with its safe, personalized and highly professional care, makes it all the more outstanding. The Hospital Barra D'Or has beds available for hospitalization, semi-intensive, intensive cardiac, intensive therapy, day emergency and therapeutic units.

The determination to offer an excellent healthcare service motivated the participation of the hospital to undergo various certification processes, and to date, it has been awarded the international certificate by the Canadian Accreditation Board and also by the ONA, level 3.

Highlights During 2010 and 2011

The Hospital Barra D'Or remodeled and changed the environment of the post-operative sector in order to modernize the installations. It also installed more beds and placed the sector closer to the surgical center. A new medical care model was also implemented with the aim of achieving greater mobility and comfort for its patients.

A new ICU was inaugurated with an increase in bed capacity in that unit.

In March 2010, the hospital had its commitment to quality and safety care reaffirmed with the re-certification by the Canadian Accreditation Board.

Characteristics

Profit oriented	
Foundation	1998
Institution's built area	not informed
Organization of the Clinical Staff	Mixed
Hospital Accreditation	National Accreditation Organization (ONA III); Accreditation Canada

Main Indicators

Total nr. of operational beds	(dec-10)	248
Nr. of beds in ICUs	(dec-10)	89
Nr. of registered doctors	(dec-10)	1.500
Nr. of active employees	(dec-10)	1.489
Nr. of first-aid center consultations	(2010)	93.022
Nr. of outpatient consultations	(2010)	not applicable
Nr. of hospitalizations	(2010)	30.525
Nr. of surgeries (except births)	(2010)	6.817
Nr. of births	(2010)	960
Nr. of tests performed in the DTC	(2010)	801.888
Gross Revenues (in R\$ million)	(2010)	not informed



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Hospital Copa D'Or

► Brief History of the Institution

The Hospital Copa D'Or was founded in May 2000, out of the desire to create a new model for hospital care in Rio de Janeiro: a hospital that would combine cutting edge technology with highly qualified professionals and five-star services; a place where patients would feel safe and comfortable with their healthcare.

Located in Copacabana, the southern part of Rio de Janeiro, the Hospital Copa D'Or is recognized for its high standards of quality and identified as one of the most important medical centers in the country. Excellent services, technical competency, constant investment in latest generation technology and treatment carried out with respectfulness and human warmth are the hospital's main trademarks.

The Hospital Copa D'Or was the first private hospital in Rio de Janeiro to be awarded the certificate by the JCI (Joint Commission International) and is comparable with any of the best hospitals in the world.

Medicine is a highly complex subject, and for this reason, it should be noted that the hospital maintains a medical team of the highest academic standard; the professionals' qualifications and specializations having been obtained in some of the most respected teaching institutions for medical healthcare in Brazil and overseas.

There are more than 270 available beds, distributed throughout the sectors for hospitalization, both for intensive and semi-intensive care, pediatrics, an adult and pediatric accident and emergency unit, a coronary unit and a day clinic.

Highlights During 2010 and 2011

The Hospital Copa D'Or, already a benchmark for highly complex treatments, has increased its general ICU unit which is now one of the most modern and comfortable of its kind, in order to meet the standards of excellence set by the D'Or hospital network. In addition to this was the inauguration of new internal installations, reforming a complete floor and extending the laboratory.

Characteristics

Profit oriented	
Foundation	2000
Institution's built area	not informed
Organization of the Clinical Staff	Open
Hospital Accreditation	Joint Commission International (JCI)

Main Indicators

Total nr. of operational beds	(dec-10)	270
Nr. of beds in ICUs	(dec-10)	90
Nr. of registered doctors	(dec-10)	2.000
Nr. of active employees	(dec-10)	1.681
Nr. of first-aid center consultations	(2010)	104.296
Nr. of outpatient consultations	(2010)	not applicable
Nr. of hospitalizations	(2010)	11.521
Nr. of surgeries (except births)	(2010)	7.482
Nr. of births	(2010)	not applicable
Nr. of tests performed in the DTC	(2010)	117.924
Gross Revenues (in R\$ million)	(2010)	not informed



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Hospital do Coração – HCor

► Brief History of the Institution

Classified by the Ministry of Health as a hospital of excellence in Brazil, the HCor – Hospital do Coração – is a non-profit entity, maintained by the Associação do Sanatório Sírio. The hospital has been a benchmark for cardiac care since 1976. HCor is seen as an innovator and promoter of new technology and treatments, as well as a center of excellence in national and international research in the health sector, through its Training and Research Institute – IEP.

Currently it is recognized not only for its excellence in cardiac medicine, but also in various other areas, such as orthopedics, urology and neurology, cardio-pediatrics, fetal medicine, oncology, gastroenterology, sports medicine and nephrology, among others. In addition, HCor is able to count on a modern diagnostics center and highly qualified multi-discipline medical teams.

In order to expand its work further, after forming a partnership with the SUS - Sistema Único de Saúde (Unified Health System) in 2008, HCor launched 22 philanthropic projects in 2009 in conjunction with the Ministry of Health, covering areas within research management, and training and technology for assisting the population in general. It was due to these and other various initiatives that the Hospital do Coração received re-accreditation in 2009 by the Joint Commission International (considered to be the most respected certification body in the health sector), achieving a 98.33% conformity with the 1,138 elements assessed, including a maximum score in the area of quality standards.

Highlights During 2010 and 2011

In 2010, HCor expanded its scope significantly and launched new services and centers, such as, the Sleep Medicine Center and the Otorhinolaryngological Service, both of which count on modern resources that permit clinical diagnosis and treatment, as well as surgery for various pathologies.

Our Plastic Surgery Services (face, rhino-plastics, breast implants, abdominal plastics, lipo-suction, remedial surgery and the treatment of traumas) and the expansion of the Head and Neck Surgical Services departments also deserve a mention, along with a multi-discipline team specializing in treating disorders in those areas.

In 2011, the hospital inaugurated the Obesity Center, in order to offer obese patients diagnostic examinations, nutritional guidance and rehabilitation programs. In March, the Reproductive Medical Center was also inaugurated in order to identify and treat problems that cause both male and female infertility, along with other procedures.

The Teaching and Research Institute – IEP conceived and coordinated the biggest clinical study of its type ever to be carried out, in the area of prevention of contrast induced neo-phopathy; 2,308 patients submitted from 46 public and private hospitals were submitted to this clinical procedure. The Digital Tele-Electrocardiography project has just completed one year's service, accounting for 4,621 electrocardiograms in more than 100 municipalities in the country, through SAMU (Urgent Medical Aid Service). In April, HCor expanded its Pediatric ICU for humane neonatal, lactating and child patient care, as well as a center for adolescents hospitalized for clinical and surgical treatment of congenital cardiopathies.

Characteristics

Not profit oriented	
Foundation	1976
Institution's built area	44.000 m ²
Organization of the Clinical Staff	Open
Hospital Accreditation	Joint Commission International (JCI)

Main Indicators

Total nr. of operational beds	(dec-10)	223
Nr. of beds in ICUs	(dec-10)	40
Nr. of registered doctors	(dec-10)	1.070
Nr. of active employees	(dec-10)	1.895
Nr. of first-aid center consultations	(2010)	30.027
Nr. of outpatient consultations	(2010)	not applicable
Nr. of hospitalizations	(2010)	8.697
Nr. of surgeries (except births)	(2010)	4.496
Nr. of births	(2010)	not applicable
Nr. of tests performed in the DTC	(2010)	1.232.077
Gross Revenues (in R\$ million)	(2010)	252

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Hospital Esperança

► Brief History of the Institution

The Hospital Esperança was inaugurated on the banks of the Capibaribe River, in the capital of the State of Pernambuco and is already nationally recognized as the second largest medical complex in Brazil. The hospital has achieved rapid growth and established its position as one of the most advanced hospital complexes in the country, thanks to the caring treatment that is demonstrated in the panoramic view from all the apartments, suites, ICUs, surgical wing and restaurant. This approach has its origins in the fact that the Institute wanted to give patients, visitors and staff the feeling that they were not in a hospital but in a hotel.

However, there are other factors involved apart from the caring attention given to the design, which are factors linked to ideas strongly supported by the complex in general: innovation, precision and progress. All the work ethics and quality policies are focused on patient safety and care.

The Esperança is the first hospital in Pernambuco to be accredited by the ONA (National Accreditation Organization), and it is nationally recognized for its healthcare service quality. The hospital also seeks to promote the general well-being of its staff through sustainable investments in its technicians and professionals, resulting in a high level of satisfaction and motivation, the hospital's intention being to obtain real gains in productivity and excellence for patient care, as well as fulfilling the company's commitment to both the community and the environment.

Highlights During 2010 and 2011

As a result of the association with Rede D'Or in 2008, new operational processes started to be implemented and developed in Hospital Esperança, which is benefiting from the corporative advantages of this new group. This has resulted in a professional management model that focuses on quality, safety and excellence in patient care. Investments in the order of R\$ 25 million have been made for the construction of a new diagnostic center, restructuring the emergency center for complex cases and for increasing the numbers of beds available for hospitalization wards.

The latest equipment for imaging diagnosis was also purchased. An example of this is the new 64 channel multi-slice tomograph, a new high-field magnetic resonance unit and new hemo-dynamic equipment (Allura FD20)

Another R\$ 10 million were spent on the construction of a building annex to house support areas such as storage space, pharmacy, invoicing and auditing. Investments were

also made in housekeeping and catering; no expense spared for the well-being of patients and their families.

Characteristics

Profit oriented	
Foundation	2000
Institution's built area	not informed
Organization of the Clinical Staff	Mixed
Hospital Accreditation	National Accreditation Organization (ONA II)

Main Indicators

Total nr. of operational beds	(dec-10)	163
Nr. of beds in ICUs	(dec-10)	44
Nr. of registered doctors	(dec-10)	857
Nr. of active employees	(dec-10)	1.280
Nr. of first-aid center consultations	(2010)	82.139
Nr. of outpatient consultations	(2010)	not applicable
Nr. of hospitalizations	(2010)	11.064
Nr. of surgeries (except births)	(2010)	6.646
Nr. of births	(2010)	1.925
Nr. of tests performed in the DTC	(2010)	59.904
Gross Revenues (in R\$ million)	(2010)	not informed

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Hospital Israelita Albert Einstein

► Brief History of the Institution

The birth of the Sociedade Beneficente Israelita Brasileira Albert Einstein - SBIBAE (The Albert Einstein Brazilian/Israeli Fund Raising Society), in the 1950's, resulted from the Jewish community's commitment to offer the population of our country a benchmark in medical practice. Built from funds provided through donations and thanks to the work by a group of dedicated people, the Albert Einstein Israeli Hospital – HIAE was inaugurated on July 28, 1971. From that day on it became a benchmark in treatments using cutting-edge technology and humane care and it also expanded its frontiers with responsible social initiatives and activities in the teaching and research fields.

Focused on the continuous search for excellence in healthcare, the HIAE occupies an outstanding position among Latin-American hospitals, occupying for the second year running first place in the AmericaEconomia ranking of the best Latin-American hospital. Such recognition is the result of being awarded four certificates: The Joint Commission International accreditation; ISO certification in various areas; American College of Radiology certification and College of American Pathologists and American Association of Blood Banks certification. Pioneering on many fronts, the hospital provides medical care which is in complete harmony with international scientific and technological innovation, with an emphasis in the cardiac, neurological, transplant, orthopedic and surgical fields. In addition to this, it is a benchmark for the quality of its clinical team and for its management model. As a leader in the areas of quality and care, the HIAE also played an important historical role in the formation of the National Association of Private Hospitals - ANAHP.

Highlights During 2010 and 2011

The year 2010 was marked by expansion. In October of that year, the HIAE inaugurated the Perdizes-Higienópolis Unit, in São Paulo's Western Zone. This is a modern structure that uses some of the most advanced technologies for diagnostic examinations, treatments and low complex surgical procedures, as well as having a wing dedicated exclusively to women's health care. In the second half of 2010, with investments of up to R\$ 3.5 million, the new Check-Up Unit was also inaugurated, comprising modern diagnostic resources and a highly qualified interdisciplinary team. This resulted in an increase in the number of daily medical procedures, as well as a new methodology for care that makes life easier for those patients passing through the Institution. Another space created was the Moise Safra Auditorium, with 12,000 square

meters distributed between halls and lecture rooms, with the capacity to accommodate up to 500 people, using the latest technology for promoting various forms of events.

In the same year, the hospital blood bank was the first in Latin-America to be accredited by the College of American Pathologists, which insures the promotion of quality and safety in the collection, processing, testing, distribution and administration of blood and its by-products. This accreditation complements those already received by the hospital, such as ISO 9000 and the AABB, awarded by the American Association of Blood Banks. It should also be mentioned that the hospital took first place for the number of liver transplants carried out and also for being a pioneer in cardiac and chest surgeries carried out with the assistance of robots.

Characteristics

Not profit oriented	
Foundation	1971
Institution's built area	173.942,63 m ²
Organization of the Clinical Staff	Open
Hospital Accreditation	Joint Commission International (JCI)

Main Indicators

Total nr. of operational beds	(dec-10)	577
Nr. of beds in ICUs	(dec-10)	57
Nr. of registered doctors	(dec-10)	5.231
Nr. of active employees	(dec-10)	8.655
Nr. of first-aid center consultations	(2010)	108.543
Nr. of outpatient consultations	(2010)	172.934
Nr. of hospitalizations	(2010)	43.241
Nr. of surgeries (except births)	(2010)	33.171
Nr. of births	(2010)	3.448
Nr. of tests performed in the DTC	(2010)	2.979.743
Gross Revenues (in R\$ million)	(2010)	1.093,8

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Hospital Mãe de Deus

► Brief History of the Institution

Founded in 1979, the Hospital Mãe de Deus (HMD) is more than a large hospital. It is a benchmark in highly complex medical care. The Institution is recognized in southern Brazil as a prime example in local healthcare, and on a national basis, as an innovative service provider in both management and medical care.

The hospital focuses its services on both the private patient and the medical insurance sectors. This ensures the sustainability of the Saúde Mãe de Deus System (a network comprising hospitals and health services that combines: eight hospitals; two clinical centers in which the practice of medicine requiring a high degree of perfection is carried out, and a center for oncology radiotherapy). The Hospital Mãe de Deus is an important pillar for the system and contributes towards enabling technological updating, achieving professional qualifications and the expansion and development of various social projects. Established as a center for excellence in medical/hospital care quality, the Hospital Mãe de Deus was the first institution in the southern region of the country to be certificated by the National Accreditation Organization – ONA, achieving the level of excellence. The Superintendent of the Saúde Mãe de Deus System, Claudio Seferin, believes that the high level of competency of the group of professionals, comprising doctors, technicians and administrators, is one of the fundamental factors for obtaining these results. “Our investments are focused on the healthcare needs of the population and for this it is necessary to search for constant specialization in our professionals”, commented Seferin.

Highlights During 2010 and 2011

In February 2011, the HMD inaugurated its hybrid room. This room is equipped with latest generation equipment for hemodynamic and surgical procedures. It also has a new area for cardiac electro-physiology which has constituted an important step for consolidating the Vascular Medicine Institute that covers the areas of cardiology, neurology and peripheral vascular disease, as well as housing an endovascular therapy center and a teaching and research clinic.

Another major innovation occurred through the partnership with MEDTRONIC of the USA for the installation of a technological center in Latin-America having its headquarters in the Hospital Mãe de Deus. Initial benefits resulting from this agreement have already come to fruition. Since the end of October 2010, the new portable tomography equipment has been in operation – ARM - , which is a system that allows obtaining three-dimensional images. When this procedure is coupled to the surgical navigator, it permits neurosurgeons

and orthopedists to offer their patients a very high degree of accuracy and precision in the surgical procedures to be performed, the results of which will already be retransmitted back to the surgical center.

In January 2010, the HMD also celebrated the inauguration of the new Mãe de Deus Cancer Institute. The wing is composed of eight chemotherapy units, five consultation rooms, an oncology pharmacy and various administrative installations which complete the oncology facilities for the Hospital Mãe de Deus, including the eighth floor, along with the Oncology Radiotherapy Center (COR).

On September 1, 2010, the Mãe de Deus Health System (SSMD) assumed the medical-technical management and administration of the Hospital de Pronto Socorro de Canoas (HSPC), and became responsible for restructuring this institution, in order that it might become even safer and more efficient.

Characteristics

Not profit oriented	
Foundation	1979
Institution's built area	51.000 m ²
Organization of the Clinical Staff	Open
Hospital Accreditation	National Accreditation Organization (ONA III)

Main Indicators

Total nr. of operational beds	(dec-10)	428
Nr. of beds in ICUs	(dec-10)	47
Nr. of registered doctors	(dec-10)	3.800
Nr. of active employees	(dec-10)	2.048
Nr. of first-aid center consultations	(2010)	not applicable
Nr. of outpatient consultations	(2010)	138.602
Nr. of hospitalizations	(2010)	16.540
Nr. of surgeries (except births)	(2010)	15.835
Nr. of births	(2010)	1.651
Nr. of tests performed in the DTC	(2010)	1.381.530
Gross Revenues (in R\$ million)	(2010)	226



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Hospital Mater Dei

► Brief History of the Institution

The Mater Dei Hospital was founded on June 1, 1980 with a clear purpose and focus on its commitment to a mission aimed at quality of life. After 30 years following its inauguration the Institution has become a benchmark for hospitals in the State of Minas Gerais and Brazil. It is recognized for its innovation, quality healthcare and efficient management. During these three last decades, certain noteworthy occurrences have been responsible for endorsing this high standard of excellence and credibility, among them, the birth of the first baby in the State of Minas Gerais, in 1989, born through the use of the IVF technique, performed in the Mater Dei Hospital; in 1994 the first illiac stent artery implant in the state was performed at the Mater Dei; the extension to the hospital through the construction of Block II in the year 2000, with 27,000 square meters of constructed floor-space; the achievement of ONA accreditation – Level 3, in 2004, resulting in the Mater Dei becoming the first hospital in Belo Horizonte to achieve this award; obtaining ISO 9001:2000 certification in 2008 and accreditation by the NIAHO (The National Integrated Accreditation for Healthcare) in 2009 – an international certificate used as a model for American healthcare - the Mater Dei was the first hospital outside of the USA to be awarded this certificate.

In 2010, the Mater Dei commenced its expansion plans by purchasing land which will eventually house a new hospital unit with more than 300 beds.

The clinical section will have more than 2,000 health professionals registered and will offer various medical-hospital services, with 334 beds, of which 50 are for the adult ICU unit and 24 beds destined for the pediatric ICU unit.

Highlights During 2010 and 2011

In order to better meet customers' needs, the Mater Dei purchased through a public auction, 7.800 square meters of land in December 2010. It intends to construct a new hospital unit with 12 stories, 7 basement floors, totaling 21 separate floor areas and approximately 310 beds. With the increasing occupancy rate in the present Blocks I and II, current demand for beds is exceeding available capacity. The expansion project has become imperative in order to be able to continue maintaining its high standard of service excellence. It is planned that this new project will house: an accident and emergency unit; an oncology unit; a surgical block; an ICU and a Diagnosis and Therapy unit; a hospitalization unit and a heliport. The location of the new building is both privileged and strategic; it will front onto Avenida do Contorno providing easy access to the metropolitan region and the main routes to Belo Horizonte.

The architectural firm contracted to perform this work, Zanettini, has 50 years of experience in its field and will plan the construction based on sustainable development, with the rational use of electrical energy, preservation of the ecological green areas, using non-polluting technology and through the exploitation of natural resources. Work on the new construction has already commenced and the forecast for its inauguration is sometime prior to 2014. It is estimated that there will be a daily circulation of up to 4,000 people within this new building, as well as an expected increase in the workforce, including doctors, healthcare professionals and administrative and support staff, by more than 50%.

Characteristics

Profit oriented	
Foundation	1980
Institution's built area	35.000 m ²
Organization of the Clinical Staff	Semi-open
Hospital Accreditation	National Accreditation Organization (ONA III); National Integrated Accreditation for Healthcare Organizations (NIAHO)

Main Indicators

Total nr. of operational beds	(dec-10)	328
Nr. of beds in ICUs	(dec-10)	74
Nr. of registered doctors	(dec-10)	2.608
Nr. of active employees	(dec-10)	1.411
Nr. of first-aid center consultations	(2010)	261.832
Nr. of outpatient consultations	(2010)	not applicable
Nr. of hospitalizations	(2010)	20.716
Nr. of surgeries (except births)	(2010)	22.543
Nr. of births	(2010)	2.191
Nr. of tests performed in the DTC	(2010)	1.123.740
Gross Revenues (in R\$ million)	(2010)	210

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Hospital e Maternidade Brasil

► Brief History of the Institution

The concept of the future is as something that is built from the new. But how can the arrival of this future affect people's lives? In many ways, especially if this is linked to the realization of a big dream. Such was the dream of an ambitious group of young doctors in the year 1966. They believed it was possible to offer the community in the region of Santo André, a standard of hospital care equal to that found in any of the best centers of the capital. What started as a simple idea began to take shape and what initially should only have been a general health service, was transformed into the basis of a very substantial and modern hospital: the Hospital e Maternidade Brasil.

Construction started on this hospital in 1967, and on April 8, 1970, the first part of the hospital was inaugurated, comprising two floors with 30 apartments, two operating theatres, two childbirth rooms, a nursery and a recuperation center. However, the project was designed for 6 floors that were built over the years. In conjunction with this, the founders felt a need to invest in sophisticated diagnostic and therapeutic equipment, in order to increase and promote a greater diversity of medical specializations in the services on offer. All of this with the singular aim of seeking improvement throughout the whole process of promoting patient healthcare.

Highlights During 2010 and 2011

The Hospital e Maternidade Brasil was incorporated into the Rede D'Or chain in April 2010, and received technological upgrading (a new magnetic resonance unit, new monitors and respirators) and an additional 14 beds in the ICU, with another 24 beds due in 2011. Four hundred new staff-members were hired and all support equipment underwent maintenance. With the acquisition of another hospital in São Bernardo (Hospital e Maternidade Assunção) and the start of construction of another in São Caetano do Sul (HM São Luiz – São Caetano unit), the Rede D'Or has created a very strong base in the ABC district of greater São Paulo, with a commitment to promoting hospital development and new partnerships with companies from within the region.

Characteristics

Profit oriented	
Foundation	1970
Institution's built area	29.936,73 m ²
Organization of the Clinical Staff	Open
Hospital Accreditation	National Accreditation Organization (ONA II)

Main Indicators

Total nr. of operational beds	(dec-10)	302
Nr. of beds in ICUs	(dec-10)	53
Nr. of registered doctors	(dec-10)	588
Nr. of active employees	(dec-10)	1.908
Nr. of first-aid center consultations	(2010)	237.796
Nr. of outpatient consultations	(2010)	293.675
Nr. of hospitalizations	(2010)	21.177
Nr. of surgeries (except births)	(2010)	16.094
Nr. of births	(2010)	2.972
Nr. of tests performed in the DTC	(2010)	1.207.553
Gross Revenues (in R\$ million)	(2010)	42,7



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Hospital e Maternidade Santa Joana

► Brief History of the Institution

At the end of the 1940's, access to hospital care for pregnant women was still limited in the city of São Paulo. These were times when the majority of babies were born at home. It was this scenario in 1948, which prompted a group of young doctors, recently graduated from the Faculdade de Medicina da Santa Casa (The Santa Casa Medical School) to found the Casa de Saúde Santa Joana, offering greater safety and specialization for pregnant women and their babies. One of these young doctors was Dr. Eduardo Amaro.

The small cottage hospital evolved and became the Hospital e Maternidade Santa Joana. Its vocation for pioneering has remained for the last six decades. After developing the maternity section with an innovative and new concept in hospital architecture and care, at the start of the 1990's, the institute became a benchmark for the treatment of premature and underweight babies and is now a neo-natal ICU with 100 beds, and a highly trained team using cutting-edge technology. It has partnerships with both national and international universities, and the Hospital e Maternidade Santa Joana is also a benchmark for obstetric anesthesia, the care of high risk pregnancies and in the control of hospital infection, as well as having the largest human milk bank in the country. In 2005, it was the first maternity hospital in Brazil to be accredited Level 3 – Excellence, the highest award from the National Accreditation Organization (ONA). During the last six years it has been elected as the best maternity hospital in Brazil.

Highlights During 2010 and 2011

In order to improve its services and technology, the Hospital e Maternidade Santa Joana is extending its installations. Work in hand forecasted to be concluded by November 2011, contemplates a new building in the Paraíso district (Sao Paulo), with entirely new obstetric and surgical centers, totaling 21 operation rooms. In addition to this, the ICUs will be updated and 40 more apartments will be constructed. Upon completion of this extension, the Hospital e Maternidade Santa Joana will have increased its built-up area by 18,200 square meters.

Characteristics	
Profit oriented	
Foundation	1948
Institution's built area	40.000 m ²
Organization of the Clinical Staff	Open
Hospital Accreditation	National Accreditation Organization (ONA III)

Main Indicators		
Total nr. of operational beds	(dec-10)	330
Nr. of beds in ICUs	(dec-10)	104
Nr. of registered doctors	(dec-10)	3.900
Nr. of active employees	(dec-10)	2.200
Nr. of first-aid center consultations	(2010)	41.000
Nr. of outpatient consultations	(2010)	not applicable
Nr. of hospitalizations	(2010)	22.800
Nr. of surgeries (except births)	(2010)	7.700
Nr. of births	(2010)	14.700
Nr. of tests performed in the DTC	(2010)	5.200
Gross Revenues (in R\$ million)	(2010)	not informed



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 www.hmsj.com.br



Hospital Memorial São José

► Brief History of the Institution

The Hospital Memorial São José (HMSJ) complex was founded in Recife on June 2, 1989, with the aims of excelling through quality service and by offering the State of Pernambuco and the northeastern region of Brazil, technological innovations and highly complex procedures – only previously performed outside of Brazil.

The HMSJ has an infrastructure designed to combine within the same complex, six buildings with a heliport, the latest generation equipment and one of the most comprehensive diagnostic centers in Brazil. This allows the patients to undergo any exams or procedures within the hospital complex itself. This places the Hospital Memorial São José (HMSJ) in the forefront as a service provider for the health sector in Brazil.

The Hospital Memorial São José has 151 beds designed to offer maximum comfort for its patients. The complex counts on three surgical centers, one of them being exclusive to the Women's Memorial Wing – a new concept in maternity care devoted to both mother and baby. This is in addition to the emergency multi-discipline and pediatric units, the adult ICU, and the pediatric, neonatal and coronary units. The HMSJ also has Day Hospital for any procedures that do not require more than 12 hours of hospitalization, as well as 15 medical units for covering more diverse specialties. All investments dedicated to construction and cutting-edge technology are closely monitored by the medical and management teams in order to ensure continued professional progress and advancement. The Hospital Memorial São José was the first hospital in Brazil to be awarded ISO 9001:2000 accreditation for nursing in 1999.

Highlights During 2010 and 2011

In 2010, the Hospital Memorial São José intensified its mission to improve management practices, ensuring greater safety for its patients and greater healthcare quality. The HMSJ invested strongly in improving its general procedures, its human resources and infrastructure. This concept included: the acquisition of medical equipment accompanied with the latest cutting-edge technology; the inauguration of one more floor destined for clinical surgery with 13 beds adapted to the latest international hospitalization requirements; the implementation of Client Services - SAC; increasing the number of beds in the ICUs (to a total of 40). This will establish a very distinguished healthcare environment of high complexity. Also deserving mention is the recent launch of our new communication forum, "Vida em Alta" (Life on the

Rise), which is both informative and interactive, stimulating the search for healthy habits and quality of life.

The year 2010 was also a year of consolidation for investment planning and for the extension to the hospital complex. During the year HMSJ also inaugurated the Memorial Clinics, which provide specialized services in the treatment of knee problems – ARTHRO. This resulted in an increase in the healthcare capacity of the hospital for other varied procedures.

During 2011, in order to maintain continuity in investment planning, to the order of R\$ 6 million, the creation of the first virtual medical space in the northeast has been programmed – with the aim of strengthening the processes that seek to achieve excellence in international health standards.

Characteristics

Profit oriented	
Foundation	1989
Institution's built area	25.000 m ²
Organization of the Clinical Staff	Open
Hospital Accreditation	In progress

Main Indicators

Total nr. of operational beds	(dec-10)	151
Nr. of beds in ICUs	(dec-10)	40
Nr. of registered doctors	(dec-10)	585
Nr. of active employees	(dec-10)	888
Nr. of first-aid center consultations	(2010)	58.466
Nr. of outpatient consultations	(2010)	not applicable
Nr. of hospitalizations	(2010)	10.312
Nr. of surgeries (except births)	(2010)	6.756
Nr. of births	(2010)	1.339
Nr. of tests performed in the DTC	(2010)	174.123
Gross Revenues (in R\$ million)	(2010)	73



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www.hospitalmemorial.com.br





Hospital Meridional

► Brief History of the Institution

'Excellence in healthcare'. This is the phrase that best defines the Hospital Meridional, which has a social vision of healthcare, always seeking to contribute to the creation of a more human environment through principles such as cordiality, respect, and ethical and technical competence. During these years the institution has become a benchmark in highly complex procedures and made many scientific achievements, such as the 24-hour neurological center and the diagnostic center which is now totally digital. The hospital has a built area of 14,783 square meters and specializes in heart and liver transplants. The hospital also has a transplant center dedicated exclusively to the preparation and monitoring of candidate transplant patients, transplantees and family members.

These and many other achievements place Hospital Meridional among the largest medical centers in the country. All this is aimed at offering health and well-being through caring services using infrastructure and highly advanced technology.

Highlights During 2010 and 2011

The year of 2010 was one of consolidation and constant scientific development for the Hospital Meridional. In the organ transplant sector, Hospital Meridional performed a rare procedure; the first simultaneous heart and kidney transplant – an unprecedented surgery in the State of Espírito Santo.

During 2010, the hospital also inaugurated the first liver intensive care unit (ICU) in the State of Espírito Santo. This included 11 beds devoted to patients with some sort of liver complication. The Hospital Meridional promoted the creation of the Pólo Espírito Santo da Rede Brasileira de Enfermagem e Segurança ao Paciente – The Espírito Santo Complex for the Brazilian Network of Nursing and Patient Safety - (Rebraensp), with the aim of disseminating safety procedures to healthcare organizations.

During this same period the hospital was recognized by the Ministry of Health as a national benchmark for CVA (Cerebral Vascular Accident) centers, becoming the only center in the state with this title.

Finally, in 2010, Hospital Meridional inaugurated the Centro de Dor Orofacial for typical pathological treatments of temporomandibular articulation and successfully implemented the process of safe surgical procedures. This reaffirmed the hospital's focus on commitment to quality and safety in each service it offers.

Characteristics

Profit oriented	
Foundation	2001
Institution's built area	14.738 m ²
Organization of the Clinical Staff	Open
Hospital Accreditation	National Accreditation Organization (ONA III)

Main Indicators

Total nr. of operational beds	(dec-10)	180
Nr. of beds in ICUs	(dec-10)	52
Nr. of registered doctors	(dec-10)	468
Nr. of active employees	(dec-10)	636
Nr. of first-aid center consultations	(2010)	95.933
Nr. of outpatient consultations	(2010)	60.813
Nr. of hospitalizations	(2010)	10.355
Nr. of surgeries (except births)	(2010)	5.364
Nr. of births	(2010)	102
Nr. of tests performed in the DTC	(2010)	362.758
Gross Revenues (in R\$ million)	(2010)	69,9



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www.hospitalmeridional.com.br



Hospital Moinhos de Vento

► Brief History of the Institution

On October 17, 1912, the General Assembly of the League of Germanic Societies approved the construction of a German hospital in the city of Porto Alegre, which was eventually inaugurated on October 2, 1927. The hospital was designed to cater for all illnesses and patients regardless of race, creed or nationality, preserving German values, language and culture in the State of Rio Grande. Initially, the hospital was administered by German deaconesses, who, in that same year founded the School of Nursing, which still exists today. At the start of the 1970's, the administration was professionalized. In 2004 the hospital doubled its installations and currently it is composed of a Hospital Block, two Clinical Centers and an Education and Research Institute. In addition to this, another unit was inaugurated in 2004, next to the Iguatemi Shopping Center (Hospital Moinhos de Vento Iguatemi) – in São Paulo, which offers, prevention, consultations, diagnostic services and treatment centers. The AHMV (The HMV Association) support units, where social support initiatives for the community are developed, were also integrated. Apart from being the first hospital in the Southern region to receive accreditation from the Joint Commission International in 2002, in 2008 it was recognized as a hospital of excellence for SUS (Unified Health System) by the Ministry of Health. The Restinga and Extreme South project was also started in 2008, which proposes the establishment of a regional healthcare system, primary care and specialized care also, for emergencies and hospital services of medium complexity.

Highlights During 2010 and 2011

For Hospital Moinhos de Vento, the year 2010 saw many improvements that will continue into 2011, with investments in technology, personnel and infrastructure. In 2010 the hospital implemented a new concept for emergency procedures with the extension of the constructed area, increasing the attendance capacity, in parallel with a new support model for risk assessment, reaffirming its commitment to the quality of care provided. During 2011, the other phase of the expansion project for emergency procedures should be concluded. This project contemplates additional 13 beds for the pre-hospitalization unit. Consistent with its policy of keeping up to date with medical care advancement and technology, the Hospital Moinhos de Vento inaugurated a new maternity wing in 2011, which has the most modern facilities for maternity infancy care. The pillars that support this excellent project are the principles of caring, safe practices, technological advancement and quality hospitalization facilities. Within this

context, the HMV counted on 379 beds in 2011, and upon completion of the emergency project it will have 392 beds by the second semester of 2011. Other areas subject to an expansion project are: the endoscopy; the hemo-dialysis; the traumatology; the neurology; outpatient surgical center, and pharmacy and nutrition units. This will qualify the HMV as a national benchmark in healthcare.

Characteristics

Not profit oriented	
Foundation	1927
Institution's built area	86.000 m ²
Organization of the Clinical Staff	Open
Hospital Accreditation	Joint Commission International (JCI)

Main Indicators

Total nr. of operational beds	(dec-10)	335
Nr. of beds in ICUs	(dec-10)	61
Nr. of registered doctors	(dec-10)	4.441
Nr. of active employees	(dec-10)	2.194
Nr. of first-aid center consultations	(2010)	29.668
Nr. of outpatient consultations	(2010)	93.150
Nr. of hospitalizations	(2010)	21.430
Nr. of surgeries (except births)	(2010)	15.505
Nr. of births	(2010)	3.669
Nr. of tests performed in the DTC	(2010)	488.923
Gross Revenues (in R\$ million)	(2010)	259,2



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Hospital Monte Sinai

► Brief History of the Institution

Since its founding in 1994, the Hospital Monte Sinai has invested in becoming a benchmark for highly complex medical care at its Zona da Mata Mineira unit. Its brand has always been linked to entrepreneurship and today it is a model for modern hospital architectural construction and for its quality hospital services. With a history of high investments for cutting-edge technology, the hospital possesses the largest diagnostic center in the region and innovation in medical techniques and procedures are the order of the day. The end result was highly successful in the medical-scientific area and the Monte Sinai became synonymous also in the pioneering area of quality management. Since 2002, its management policy is based on the principles of the National Foundation for Quality. In 2003 its search for excellence resulted in the Monte Sinai being the first hospital in the State of Minas Gerais, to be ONA accredited. The hospital's management model is widely recognized and it won first place for hospitals in the golden awards from the Mineiro Quality Prize awards in 2006. Today, the hospital continues to work on its processes and has maintained its ONA Level 3 rating and is in the process of gaining international accreditation.

Serving more than 2 million inhabitants covering the area of Juiz de Fora, which is the regional health center for the Mata Zone in Minas Gerais, the Monte Sinai regularly receives patients from cities within the Sul Fluminense and Vale de Paraíba regions. Always investing in resources, hospitality and its medical teams, processes are worked with the aim of making the hospital a national benchmark.

Highlights During 2010 and 2011

After the structural changes performed in 2009 in areas giving support to the whole future Monte Sinai Hospital Complex, the largest investment in 2010 was in internal organization. The Quality Management System for the hospital was accredited with ISO 9001:2008 certification by the accreditation company Det Norske Veritas (DNV), with an approach based on risk management (Risk Based Certification™), which demonstrated the hospital's capacity to support areas of greatest risk, as well as its success in the assessment of compliance within the selected standards.

In 2011, the new adult ICU for the Hospital Monte Sinai inaugurated a new concept for humane care in this sector, in addition to extending and modernizing the unit. The space of 1.1 thousand square meters, combines technological evolution with an innovative use of physical space, implanting architectural novelties such as the utilization of natural light, thermal control, the reduction of acoustic stress and other

innovations. The focus is on the physical and emotional care of the patient. To ensure greater safety, a modern central monitoring unit permits the duty physician to control, diagnose and, eventually to intervene in the manner of monitoring, without the necessity of directly interacting with patients, giving them more privacy in their individual apartments. In 2011, the Monte Sinai Medical Center will also be inaugurated. The structure will house 312 consultation units of 36 to 50 square meters each, distributed over two buildings, connected to the hospital by an overhead walkway; 24 shops; a fitness academy; 562 parking spaces; an auditorium with 250 places and three conference halls, and a foyer for scientific events, apart from a food courtyard. This work will complete the expansion project for the Monte Sinai Hospital Complex, which will put the city of Juiz de Fora on the map in respect to the national healthcare scene.

Characteristics

Profit oriented	
Foundation	1994
Institution's built area	28.301,60 m ²
Organization of the Clinical Staff	Open
Hospital Accreditation	National Accreditation Organization (ONA III)

Main Indicators

Total nr. of operational beds	(dec-10)	216
Nr. of beds in ICUs	(dec-10)	48
Nr. of registered doctors	(dec-10)	1.086
Nr. of active employees	(dec-10)	781
Nr. of first-aid center consultations	(2010)	28.681
Nr. of outpatient consultations	(2010)	30.675
Nr. of hospitalizations	(2010)	11.512
Nr. of surgeries (except births)	(2010)	13.327
Nr. of births	(2010)	973
Nr. of tests performed in the DTC	(2010)	869.077
Gross Revenues (in R\$ million)	(2010)	83,5

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Hospital Nipo-Brasileiro

» Brief History of the Institution

The Pro-Construction Commission of Hospital Nipo-Brasileiro (Japanese/Brazilian Hospital), chaired by Mr. Tadashi Takenaka, was constituted in June 1983 after the donation of the plot of land by JAMIC, an organ of the Japanese government. The total cost for the construction of the hospital was US\$ 5.5 million. US\$ 3.5 million of this amount were subsidies from the Japanese Government, while the rest was covered by the funds collected in Brazil thanks to the contributions of the Nikkei community members, the donations of legal entities, and Enkyo's own funds.

Hospital NipoBrasileiro was inaugurated on the 18th of June 1988, the day of the 80th anniversary of Japanese immigration to Brazil. The establishment started its activities on the 19th of September with 30 installed beds. In 1995, the second construction phase was completed with the opening of the R. Jinnai Pavilion. Later, on August 1st, 2004, the Diagnostic Center was opened, and thereby brought about the integration of wards such as the endoscopy and chemotherapy wards, as well as the spirometry division, among others.

Hospital NipoBrasileiro currently has over 230 beds and is renowned as a reference center for minimally invasive surgeries, adopting video and advanced angioplasty techniques. The establishment is keen on constantly perfecting itself, the HNB receives doctors from other countries and sends members of its teams for training courses, programs, and traineeships throughout Brazil and abroad.

Highlights During 2010 and 2011

In 2010, Hospital NIPO launched its new pediatric ambulatory facilities to broaden this specialized service and include another two new services: return and follow-up consultations, which are to take place seven days after the newborn foot examination and the child functional assessment in physiotherapy. Another 11 beds were added to the hospitalization unit and 11 in the pre-hospitalization and post-hospitalization units. To strengthen its social responsibility activities, a covenant was passed between the Municipal Health Secretariat and Hospital Nipo-Brasileiro to set up a tomography unit for users of the hospital emergency wards of the city of Guarulhos. The goal is to conduct 400 image examinations per month to increase the offer by 50% in the municipality. To proceed with the partnership, the hospital also opened the Orthopedic and Rehabilitation Clinic Guarulhos in the same city. The new Unit will offer the following specialties: Orthopedic, Physiotherapy, Acupuncture and X-ray exams. It will continue in 2010 with

social and educational activities through medical assistance and dental care to children in need, as well as income-generating activities for their parents and relatives, health lectures for pregnant women and teenagers to enable and promote the emancipation of the families attended. The hospital is also currently refurbishing and extending the Pediatric First-Aid Unit at the Administration Center. This project will enable the opening of new auxiliary units.

Characteristics

Profit oriented	
Foundation	1988
Institution's built area	not informed
Organization of the Clinical Staff	Open
Hospital Accreditation	National Accreditation Organization (ONA II)

Main Indicators

Total nr. of operational beds	(dec-10)	231
Nr. of beds in ICUs	(dec-10)	33
Nr. of registered doctors	(dec-10)	414
Nr. of active employees	(dec-10)	1.353
Nr. of first-aid center consultations	(2010)	304.020
Nr. of outpatient consultations	(2010)	236.630
Nr. of hospitalizations	(2010)	14.906
Nr. of surgeries (except births)	(2010)	13.295
Nr. of births	(2010)	2.622
Nr. of tests performed in the DTC	(2010)	362.985
Gross Revenues (in R\$ million)	(2010)	not informed



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Hospital Nossa Senhora das Graças

► Brief History of the Institution

Founded in 1953, Hospital Nossa Senhora das Graças is a philanthropic institution owned by Companhia Filhas da Caridade de São Vicente de Paulo. Accredited for its excellence by the National Accreditation Organization, it is a national and international reference in high complexity clinical and surgical treatments such as bone marrow and hepatic transplants.

The HNSG is focused on, and invests in, quality management to offer standards of excellence to its customers. This is why it is renowned for having both clinical and highly specialized functional staff focused on continuously enhancing its scientific and technological organization. Over 2,500 professionals work hard at putting their patients' well-being first by humanizing the healthcare services they provide. As a result, the hospital has a history of accomplishments, dreams come true, winning awards, and of developing a strong sense of commitment.

Moreover, Hospital Nossa Senhora das Graças implements policies of humanization, social responsibility and public-private partnerships in favor of human beings. In 2007, it incorporated the Mater Dei Maternity Hospital of the city of Curitiba, which carried out over 600 obstetrics procedures per month through the SUS (Unified Health System). In 2008, it signed an agreement with the government of the State of Santa Catarina to manage the Dr. Jeser Amarante Faria Maternal and Child Hospital, located in the town of Joinville.

Highlights During 2010 and 2011

In December 2010, Hospital Nossa Senhora das Graças received the Accredited Hospital Certificate of Excellence from the National Accreditation Organization (ONA) which recognizes the quality and safety of the services provided through standardized processes.

Over the last years, the HNSG has implemented and strengthened multidisciplinary healthcare protocols, thereby perfecting its processes by investing in technology and new services while encouraging its employees to be innovative. Thanks to this, it all the more consolidated quality management, obtaining results for the benefit not only of the hospital but also of its clients.

The HNSG, which is now an international reference in bone marrow transplants (BMT), was accredited by the Ministry of Health to perform BMTs from unrelated donors, and is the only private hospital of the State of Paraná to carry out this surgery procedure. Patients are attended by a renowned medical team of the BMT Group and the Pasquini Hematology

'Institute. Heavy investments were made in the structure and functioning for the HNSG to comply with very strict criteria and secure this landmark victory.

Another highlight worthy of notice is the completion of the Differentiated Care Unit. The new space comprises larger rooms and classy suites of top-of-the-line architectural design standards. Besides these differentials, the customers of this unit enjoy a differentiated optional food menu.

Characteristics

Not profit oriented	
Foundation	1950
Institution's built area	39.756,44 m ²
Organization of the Clinical Staff	Open
Hospital Accreditation	National Accreditation Organization (ONA III)

Main Indicators

Total nr. of operational beds	(dec-10)	178
Nr. of beds in ICUs	(dec-10)	34
Nr. of registered doctors	(dec-10)	1.087
Nr. of active employees	(dec-10)	1.116
Nr. of first-aid center consultations	(2010)	97.438
Nr. of outpatient consultations	(2010)	46.411
Nr. of hospitalizations	(2010)	13.266
Nr. of surgeries (except births)	(2010)	8.085
Nr. of births	(2010)	2.102
Nr. of tests performed in the DTC	(2010)	632.149
Gross Revenues (in R\$ million)	(2010)	82,6

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Hospital Nossa Senhora de Lourdes

► Brief History of the Institution

Providing health services in the widest range of segments, Grupo Nossa Senhora de Lourdes is a medical center and hospital complex, located in the district of Jabaquara, in the Center-South Zone of the city of São Paulo, formed by ten colligated companies. The group started in 1958 as a foundation of the Nossa Senhora de Lourdes Hospital, thanks to Dr. Cícero Aurélio Sinisgalli, who wanted the institution to have a name in tribute to a religious figure. After some research, the chosen name to register the establishment was “Nossa Senhora de Lourdes” which, coincidentally or not, is patron of the sick.

From the 90's Nossa Senhora de Lourdes Hospital became a Reference Health Center, forming the Nossa Senhora de Lourdes Group, and opened its colligated companies together with the doctors of its clinical staff.

Nowadays, after having been active for a little over fifty years, the Nossa Senhora de Lourdes Group has equipment of the latest technology, a highly functional physical structure and highly skilled human resources that deliver speedy effective services in all fields of activity, thereby making the Nossa Senhora de Lourdes Group a complete and modern hospital reference center. The following companies make up the group: Hospital Nossa Senhora de Lourdes (1958), Hospital da Criança (1998), Centro Diagnóstico (1997), Angiodinâmica (1992), Lithocenter (1991), Saúde Medicol (1980), Hospclean (1993), CMI – Centro de Medicina Integrada (1994), Interlar HomeCare (1999) and Escola Nossa Senhora de Lourdes (2000).

Highlights During 2010 and 2011

The Nossa Senhora de Lourdes Group closed 2010 with gross revenue of R\$ 250 million.

After completing the entire extension and modernization project of the physical and technology facilities of the hospital, the Group went one step further with its expansion, growth and consolidation project. Besides keeping its certificate of excellence ONA Level 3 for the Nossa Senhora de Lourdes Hospital and the Children's Hospital, it adopted the best corporate governance practices by professionalizing its management, strengthening and consolidating the Group as a national reference in the field of hospital care.

The Faculdade Nossa Senhora de Lourdes (college) was opened to offer undergraduate nursing courses as well as three graduate courses lato sensu. It opened the Integrated Oncology Center with extensive private facilities occupying an area of almost 1,000 m², with a space divided in two

wards, one to attend radiotherapy patients and the other to attend chemotherapy patients.

The year 2011 started with the opening of the new surgical center of the Nossa Senhora de Lourdes Hospital. Thanks to spacious facilities on a built area of roughly 1,800 m² to provide greater comfort to surgeons and staff, the new surgical center is one of the most modern in Brazil and occupies two floors of the hospital, following an investment of R\$ 16 million, including equipment and furniture. The new space comprises 15 rooms, of which two are intelligent rooms, all of which are integrated in a central surgical supply room built following a unique modern and functional architectural design.

Characteristics

Profit oriented	
Foundation	1958
Institution's built area	32.800 m ²
Organization of the Clinical Staff	Open
Hospital Accreditation	National Accreditation Organization (ONA III)

Main Indicators

Total nr. of operational beds	(dec-10)	285
Nr. of beds in ICUs	(dec-10)	55
Nr. of registered doctors	(dec-10)	2.300
Nr. of active employees	(dec-10)	1.544
Nr. of first-aid center consultations	(2010)	250.000
Nr. of outpatient consultations	(2010)	185.000
Nr. of hospitalizations	(2010)	14.500
Nr. of surgeries (except births)	(2010)	13.450
Nr. of births	(2010)	not applicable
Nr. of tests performed in the DTC	(2010)	173.000
Gross Revenues (in R\$ million)	(2010)	250

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www.nsl.com.br





Hospital Nove de Julho

► Brief History of the Institution

Founded in 1955, the hospital Nove de Julho is one of the most important private health institutions in Brazil. It is a benchmark for high tech medicine; the hospital channels its investments into emergency services and the development of specialist centers.

The Trauma Center is one of Brazil's pioneers in private centers for the care of trauma victims, consisting of specialist doctors, a complete infrastructure for an accident and emergency clinic, a surgical center, and an ICU (Intensive Care Unit), which provides expertise, and safe and high quality care for victims. In addition to the trauma center, the hospital is a benchmark for other specialist areas: spinal, functional neurosurgery and pain units; gastroenterology; sports medicine; oncology; orthopedics; urological and renal units.

The year 2010 was marked by the hospital being awarded certificates that recognized both quality and safety in patient care. The institution was awarded International Accreditation – a Canadian model (The Canadian Council for Health Services Accreditation – CCHSA) and following this award the hospital started the process of accreditation for the Joint Commission International (JCI). In addition to these international certifications, the Hospital Nove de Julho was re-certificated for Level 3 – “Accreditation with Excellence” – by the National Organization for Accreditation – ONA.

Highlights During 2010 and 2011

Among recent events, the following on expansion and modernization of the Hospital Nove de Julho deserve mention:

- ✘ Redesigning of all the apartments;
- ✘ New hospitalization wards;
- ✘ Redesigning and expanding the accident and emergency center from 800 m² to 1,600 m²;
- ✘ An advanced emergency unit made up of 10 ICU beds dedicated to the accident and emergency center;
- ✘ Redesigning the diagnostic investigation services area;
- ✘ The inauguration of a new area and technological park for Diagnostic Imaging Services, highlighting the acquisition of a PET-CT system;
- ✘ The inauguration of a specialized medical center;
- ✘ Commencing work on the construction of a new tower block (120 apartments, 6 theaters, 6 basement parking floors and a heliport);
- ✘ Redesigning the facades of Hospital Nove de Julho on Rua Peixoto Gomide and Rua Engenheiro Monlevade;

- ✘ Implementation of a management system for patient information, with an assessment and severity scoring system for intensive therapy – EPIMED;
- ✘ Implementation of a new computerized system for surveillance, risk management and monitoring of good practices in the control of hospital infection – HEPIC.

Characteristics

Profit oriented	
Foundation	1955
Institution's built area	27.218,47 m ²
Organization of the Clinical Staff	Open
Hospital Accreditation	National Accreditation Organization (ONA III); Accreditation Canada

Main Indicators

Total nr. of operational beds	(dec-10)	310
Nr. of beds in ICUs	(dec-10)	70
Nr. of registered doctors	(dec-10)	4.304
Nr. of active employees	(dec-10)	1.467
Nr. of first-aid center consultations	(2010)	92.701
Nr. of outpatient consultations	(2010)	40.966
Nr. of hospitalizations	(2010)	16.538
Nr. of surgeries (except births)	(2010)	12.012
Nr. of births	(2010)	not applicable
Nr. of tests performed in the DTC	(2010)	844.207
Gross Revenues (in R\$ million)	(2010)	289,6



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www.hospital9dejulho.com.br





Hospital Português

► Brief History of the Institution

The Portuguese Hospital is a dream come true, an initiative of successful citizens of the Portuguese community of the state of Bahia who, concerned about assisting their fellow citizens in need, united the Sociedade Dezesseis de Setembro and the Sociedade Portuguesa de Beneficência, to thereby create the Sociedade Portuguesa de Beneficência Dezesseis de Setembro, on August 14, 1859.

With the permit in hand, on May 27, 1863, the King of Portugal, Luiz I, and patron of the institution, granted it the title of Regal, so that it could henceforth be called the Real Sociedade Portuguesa de Beneficência Dezesseis de Setembro.

Thanks to its associates and benefactors, on the 16th of September 1866, the Institution founded the Hospital Português in Alto do Bonfim. In 1927, its management started accepting subscribed partners of any nationality, as well as the spouses and children of the Portuguese. This is why, on May 24, 1929, the Society was acknowledged as an Institute of Public Utility.

In 1931, a new hospital was opened on Avenida Princesa Isabel, more modern, with the capacity to provide assistance to the population in general. From then on, the Hospital Português underwent a series of extensions to translate the high complexity medical care provided, without losing its philanthropic profile.

Highlights During 2010 and 2011

The Hospital Português has started its management restructuring process, focusing on optimizing the assistance provided and clinical staff relations. The clinical staff is now mixed and the assistance areas defined according to the institution's high complexity and philanthropy profile.

Encouraged to create specialty leaderships, communication and contacts were increased between the Institutional Department and clinical staff (and the specialty area leaders). As a consequence, the conditions were set forth to encourage greater involvement of the clinical staff in the management processes and results.

A multi-professional hospital ethics commission was created to organized multi-disciplinary routine meetings to encourage the progressive integration of professional assistance areas and improve assistance processes.

Continued education courses were organized and provided to managers, and training courses were prepared to offer staff full qualification programs.

Characteristics

Not profit oriented	
Foundation	1857
Institution's built area	25.000 m ²
Organization of the Clinical Staff	Open
Hospital Accreditation	National Accreditation Organization (ONA I)

Main Indicators

Total nr. of operational beds	(dec-10)	434
Nr. of beds in ICUs	(dec-10)	88
Nr. of registered doctors	(dec-10)	1.657
Nr. of active employees	(dec-10)	2.588
Nr. of first-aid center consultations	(2010)	25.089
Nr. of outpatient consultations	(2010)	not applicable
Nr. of hospitalizations	(2010)	15.985
Nr. of surgeries (except births)	(2010)	6.090
Nr. of births	(2010)	1.777
Nr. of tests performed in the DTC	(2010)	711.798
Gross Revenues (in R\$ million)	(2010)	242,7



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www.hportugues.com.br





Hospital Pró-Cardíaco

► Brief History of the Institution

Hospital Pró-Cardíaco was founded on November 9, 1959 as a model of a cardiology emergency ward.

It currently has 110 beds for clinical and surgical hospitalization purposes, and its activities have always focused on high complexity. The hospital has always sought to benchmark institutional enhancements in Brazil and abroad by combining quality assistance and innovation. It gained its outstanding ranking on the national scene as a Premium Hospital. Its emergency, intensive and coronary therapy units contributed to achieving these results.

It passed important landmarks along the way: first coronary unit in 1968; first hemodynamic unit in a private hospital in 1980; intensive care unit using modern technology and trans-disciplinary assistance and a surgical center in 1988; and the first chest pain unit in Brazil in 1995.

In 2003, it started pioneer work on trunk cells in ischemic cardiopathy. In 2007, Hospital Pró-Cardíaco was accredited by the National Accreditation Organization - ONA III and was granted the Merit Award in Science and Technology by the Brazilian Society of Cardiology in the following year, to reflect the outstanding scientific contributions of the clinical staff and cardiovascular investigators working at the hospital.

Highlights During 2010 and 2011

Hospital Pró-Cardíaco over the last year adopted a new management model, which gives priority to decision sharing, while focusing on the safety of its staff and patients. In keeping with this line of thought, the hospital invested in the construction of a new cardiovascular intervention laboratory bringing the new concept of hospital care, besides acquiring new low radiation emission hemodynamic devices.

The hospital also invested in the restructuring of the emergency ward: new 200 m² facilities integrate technology, safety, comfort and efficiency, bringing the concept of personalized care, which also becomes apparent in the new VIP area of the hospital, with differentiated hotel services.

Besides the enhanced hotel and technological structure, the institution invested in providing directed attendance in the acute vascular surgical and high complexity neurology wards. For that purpose, a new vascular surgery and a new neuro-intensivist staff were added to the hospital's clinical staff.

In 2010, appraisals were assessed for the National Accreditation Organization (ONA) Level III Hospital Accreditation re-certification, which it received for its excellence, and from which it decided to start the International Accreditation process to obtain the Canadian Accreditation.

The research and teaching division went through a structural and technical remodeling. Trunk cell research was resumed and investments were made in clinical research to design new protocols and lines of study.

Characteristics

Profit oriented	
Foundation	1959
Institution's built area	not informed
Organization of the Clinical Staff	Open
Hospital Accreditation	National Accreditation Organization (ONA III)

Main Indicators

Total nr. of operational beds	(dec-10)	110
Nr. of beds in ICUs	(dec-10)	25
Nr. of registered doctors	(dec-10)	550
Nr. of active employees	(dec-10)	839
Nr. of first-aid center consultations	(2010)	7.996
Nr. of outpatient consultations	(2010)	74
Nr. of hospitalizations	(2010)	4.379
Nr. of surgeries (except births)	(2010)	1.658
Nr. of births	(2010)	not applicable
Nr. of tests performed in the DTC	(2010)	27.575
Gross Revenues (in R\$ million)	(2010)	155



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22280-020
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www.procardiaco.com.br



Hospital Quinta D'Or

► Brief History of the Institution

Hospital Quinta D'Or, which was opened in September 2001, in front of Quinta da Boa Vista, is the result of the refurbishment of the old São Francisco de Paula Hospital. Spaces of the historical building were restored and the entire facility modernized, while keeping features such as its spacious suites and natural lighting in the hallways, which create a cozy and humane atmosphere. Its strategic location has helped it become a reference in clinical emergency and surgical quality attendance in the region.

High complexity medicine is Hospital Quinta D'Or's forte; this is why it maintains a medical team of the highest academic level, trained and specialized, from the most outstanding health teaching institutions in Brazil and abroad. The open clinical staff ensures total quality health care in the widest range of specialties with the acknowledgement from diverse medical societies.

To ensure its high levels of quality and safety, the hospital takes part in certification processes through International Accreditation Canada and the National Certification Organization (ONA), which has already granted the unit a level-3 accreditation.

The 200 or more beds available are distributed throughout the intensive and semi-intensive therapy, pediatrics, maternity, emergency – adult and pediatric and hemodynamic – hospitalization wards.

Highlights During 2010 and 2011

In July 2009, Hospital Quinta D'Or opened the Center for Surgical Treatment of Obesity, which offers a complete package for patients in need of surgical treatment for obesity within a hospital environment, where examinations can be conducted and pre- and post-operative care provided. A new Nephrology Unit was also set up.

By the end of 2009, the Hospital was re-certified in Hospital Accreditation by Accreditation Canada, thereby reaffirming its quality and safety in the care it provides its patients.

In early 2010, a new ward was opened for the Coronary Care Unit. Moreover, the final installation phase of the new building will enable to open the Rede D'Or Oncology Center. The new Center will have a built area of 700 m² in the expanded section of Hospital Quinta D'Or and will host a multi-disciplinary team. The new Center will offer the latest techniques in chemotherapy, radiotherapy and supplementary exams for early diagnoses and tracking, besides offering the most innovative technology in radio

surgery: Novalis™, the only device in the State of Rio de Janeiro and the second in Brazil.

Characteristics

Profit oriented	
Foundation	2001
Institution's built area	not informed
Organization of the Clinical Staff	Open
Hospital Accreditation	National Accreditation Organization (ONA III) Accreditation Canada

Main Indicators

Total nr. of operational beds	(dec-10)	206
Nr. of beds in ICUs	(dec-10)	65
Nr. of registered doctors	(dec-10)	not informed
Nr. of active employees	(dec-10)	not informed
Nr. of first-aid center consultations	(2010)	not informed
Nr. of outpatient consultations	(2010)	not informed
Nr. of hospitalizations	(2010)	not informed
Nr. of surgeries (except births)	(2010)	not informed
Nr. of births	(2010)	not informed
Nr. of tests performed in the DTC	(2010)	not informed
Gross Revenues (in R\$ million)	(2010)	not informed



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20941-150
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www.quintador.com.br





Hospital Samaritano

► Brief History of the Institution

Hospital Samaritano is located in the city of São Paulo, the main metropolis of Brazil and one of the most important financial centers in the world. In this modern and prosperous city, Hospital Samaritano is one of the major centers of excellence in health in Brazil, recognized by the Ministry of Health for the quality of the assistance and services it renders in the field of social responsibility, and more especially for implementing programs for the development of the SUS (Unified Health System).

After opening on January 25, 1894, Hospital Samaritano breached the paradigms by adopting the philosophy of receiving people of all creeds, races and nationalities to fulfill José Pereira Acha's will, when he donated to the Presbyterian Church to have a hospital built to attend everyone indistinctively.

It offers the latest technology in a superb infrastructure setup, managed by a highly qualified medical staff specialized in the fields of clinical medicine and general surgery such as cardiology, neurology, oncology, orthopedics and traumatology, pediatrics, transplants, among other specialties, not to mention the nursing staff dedicated to ensuring differentiated assistance.

Its constant quest for top-quality services enabled the hospital to be granted, in 2004, the International Accreditation Certificate by the Joint Commission International (JCI), an important American organization, which certifies and accredits hospitals worldwide for their quality standards. Winning this international certification consolidated its position as a hospital center of excellence. The Hospital was again accredited by the JCI in 2011.

Highlights During 2010 and 2011

Among the investments made in 2010, the purchase of Digital Mammography Equipment (Selenia model), stereotaxic table (Multicare Platinum model) and the 64-channel PET/CT mCT scanner (mCT S/X 64 Biograph model), among other devices, are noteworthy of notice. In 2010, Diagnosis Medicine showed a 21% growth in the number of exams performed in comparison with 2009. As to its Information Technology, the Institution has now completed a year using the Tasy hospital management system, which allowed for great progress in the optimization of internal processes and in the creation of an electronic patient registry, but also made it possible to start working on obtaining the digital certification process to ensure the authenticity and identity of users without the need for their written signature.

In addition, the Palliative Care Ward for outpatients was opened the very same year, thereby making the hospital one of the first private institutions to display this kind of initiative, as well as a Special Care Unit. This unit focuses on attending adult patients in a critical state, requiring intensive care therapy.

The Samaritan Hospital inaugurated its new hospital building in the first half of 2011. With a 32,000 square meter space spread over 19 floors and a heliport, the building also hosts a Learning, Teaching and Research Institute, which comprises a 200-seat auditorium for conferences, as well as libraries and the new Nutrition and Food Service; 10 surgery rooms to perform high-complexity procedures; hospitalization and intensive therapy beds; 300 new parking spaces; an atrium with services and convenience stores, besides other facilities.

Characteristics

Not profit oriented	
Foundation	1894
Institution's built area	60.000 m ²
Organization of the Clinical Staff	Open
Hospital Accreditation	Joint Commission International (JCI)

Main Indicators

Total nr. of operational beds	(dec-10)	211
Nr. of beds in ICUs	(dec-10)	59
Nr. of registered doctors	(dec-10)	1.383
Nr. of active employees	(dec-10)	1.722
Nr. of first-aid center consultations	(2010)	135.271
Nr. of outpatient consultations	(2010)	not applicable
Nr. of hospitalizations	(2010)	14.500
Nr. of surgeries (except births)	(2010)	10.900
Nr. of births	(2010)	251
Nr. of tests performed in the DTC	(2010)	1.334.654
Gross Revenues (in R\$ million)	(2010)	260,7



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www.samaritano.org.br





Hospital Santa Catarina

► Brief History of the Institution

For over 100 years Hospital Santa Catarina (HSC) has excelled in offering safe, humane healthcare. A reference in Brazil in quality healthcare, the HSC is considered one of the best and better prepared institutions when it comes to performing high complexity procedures in orthopedics, neurology, cardiology and oncology, among other specialties.

Thanks to its modern infrastructure, offering the latest equipment and complete ICUs, and thanks to its specialized staff, Hospital Santa Catarina is able to enhance its processes continuously. This has enabled the institution to be granted the Canadian International Accreditation certificate by Accreditation Canada, as well as the Brazilian Hospital of Excellence Accreditation Certificate from Organização Nacional de Acreditação (ONA).

Hospital Santa Catarina is part of the Associação Congregação de Santa Catarina (ACSC), the second largest philanthropic institution of Brazil according to Kanitz & Associados. The ACSC is made up of 34 Homes, spread out in different sectors of health, education and social assistance.

Highlights During 2010 and 2011

The year of 2010 was a landmark in the history of Hospital Santa Catarina, as it opened, in September, its Radio-oncology, Radiotherapy and Stereotaxic Radiosurgery Unit for the treatment of cancer. R\$ 20 million were invested to equip the space with high-accuracy devices. In December, the Maternity Ward of HSC was elected, for the second time, the best in Brazil and won the Hospital Best Award by the Brazilian Health Marketing Association. This award acknowledges the health professionals' dedication and great care in their work.

The year 2011 already started on a high note with the opening of a new Children's Emergency First-Aid Unit on the 3rd of January. The over 600 m² large facility offers air-conditioned spaces, each with its specific decoration. About R\$ 3 million were invested in this project.

Also in January, the Vila Paulista Restaurant was opened; it is decorated with panels signed by artist Carla Caffé. R\$ 2 million were invested to build the space, which is open to the general public.

In March of this year the HSC will launch its enhancement project. The Institution's Adult Emergency First-Aid Unit will be refurbished to bring more comfort and safety to the hospital's patients.

Characteristics

Not profit oriented	
Foundation	1906
Institution's built area	79.549,24 m ²
Organization of the Clinical Staff	Open
Hospital Accreditation	National Accreditation Organization (ONA III); Accreditation Canada

Main Indicators

Total nr. of operational beds	(dec-10)	321
Nr. of beds in ICUs	(dec-10)	88
Nr. of registered doctors	(dec-10)	6.000
Nr. of active employees	(dec-10)	2.081
Nr. of first-aid center consultations	(2010)	128.872
Nr. of outpatient consultations	(2010)	19.315
Nr. of hospitalizations	(2010)	19.589
Nr. of surgeries (except births)	(2010)	26.583
Nr. of births	(2010)	4.457
Nr. of tests performed in the DTC	(2010)	1.279.029
Gross Revenues (in R\$ million)	(2010)	362,9

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01310-000
(11) 3016-4133
www.hsc.org.br





Hospital Santa Geneveva

► Brief History of the Institution

Hospital Santa Geneveva (HSG) is a time-honored private health institution of the State of Goiás, classified as a general hospital and a reference in heart, bariatric surgeries, as well as general surgical procedures, neurology, orthopedics; heart, kidneys, kidney-pancreas transplants (the only private hospital in Goiás authorized to perform such transplants). Its founder, Dr. Francisco Ludovico, also founded the Medical School at the Federal University of Goiás. Inaugurated in 1964, the hospital is surrounded by a grove and native forest belonging to an environmentally preserved area, and has a built area of 10,000 m², 148 beds in the suites it offers, as well as wards, ICUs, nurseries, a Day Clinic and a 24-hour Emergency Unit. Its surgical center comprises six operating rooms, as well as diagnosis services for: hemodynamics, radiology, tomography, ultrasonography, endoscopy, colonoscopy, ergometry, echography, holter monitoring, mapping, and a clinical analysis laboratory. Its spacious car park can hold up to 250 cars. The hospital is accredited by the Brazilian Accreditation Organization (ONA) (the only hospital to be accredited in the State of Goiás) and offers medical internships in cardiology, general surgery and anesthesiology, all of which are duly authorized by the Brazilian Ministry of Education and Culture (MEC) and maintained through the hospital's own funding. The promotion of all the fundamental values of life – on the basis of broad knowledge and technology using a self-sustaining management model, while developing social and environmental responsibility – is the *raison d'être* of the hospital for both inside and outside patients.

Highlights During 2010 and 2011

The year 2010 was marked by great progress in the management of the HSG, thanks to the commitment of the entire trans-disciplinary team that focused on aligning its management strategies through the integration of risk management. Some investments were made in human capital through continued education programs and graduate courses (Getúlio Vargas Foundation) to train managers and qualify specialized nursing supervisors (ICU, Casualty Department and Infection Control Ward) besides the supervisors' participation in the qualification course for health organizations' Quality Management System Appraisers – recognized by the Brazilian Accreditation Organization (ONA). In terms of infrastructure, the investments made amounted to over R\$1 million to extend and refurbish the entire infirmary as well as various hospital suites. In 2010, the hospital reached the mark of 150 kidney transplants.

Characteristics

Profit oriented	
Foundation	1970
Institution's built area	11.300 m ²
Organization of the Clinical Staff	Open
Hospital Accreditation	National Accreditation Organization (ONA I)

Main Indicators

Total nr. of operational beds	(dec-10)	137
Nr. of beds in ICUs	(dec-10)	19
Nr. of registered doctors	(dec-10)	94
Nr. of active employees	(dec-10)	328
Nr. of first-aid center consultations	(2010)	21.545
Nr. of outpatient consultations	(2010)	57.406
Nr. of hospitalizations	(2010)	7.001
Nr. of surgeries (except births)	(2010)	1.741
Nr. of births	(2010)	37
Nr. of tests performed in the DTC	(2010)	26.602
Gross Revenues (in R\$ million)	(2010)	29,6



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www.santagenoveva.com.br





Hospital Santa Joana

► Brief History of the Institution

In the early 70s, a modern and elegant architectural project was designed using the latest hospitality concepts to inaugurate Hospital Santa Joana, in the context of excellence in healthcare for patients, in combination with safety and comfort. Three decades later, both the customers' and medical community's acknowledgment is a sign of the institution's prestige and prove the courage and determination to break paradigms, implementing new concepts in private health management, which were incorporated by the institution. Even in those days the surgical center was opened having a positive pressure system with special filters installed. The hospital also stood out as the first in Latin-America to have a Tridimensional Biplane Angiography System to perform neurological and cardiac interventions. The maternity ward of Santa Joana Hospital was the first in the area to offer a 24-h pediatric shift, as well as other pioneer initiatives such as the implementation of first-aid care in the ICU and a 24-h Radiology shift in a private hospital in the State of Pernambuco. The hospital was also the first of the private sector to implement a Hospital Infection Control Commission in Pernambuco. Along the course of its history, Santa Joana Hospital developed a permanent investment policy to acquire the latest technology and train its human resources so as to always provide doctors and patients the latest advances, regardless of the field of expertise. This is why the Santa Joana Hospital is now a reference in several specialty and high complexity care fields.

Highlights During 2010 and 2011

Since its very foundation, the actions taken and investments made by the Santa Joana Hospital have always been centered on the continuous enhancement of its services to every day consolidate its ranking among the most modern hospital complexes in Brazil. Here are a few worth mentioning: extension and complete refurbishment of the Oncology Unit, which never ceased to be a reference in customer service and healthcare and is now the most modern unit that can proudly display its cozy architectural design; creation of the Patient Reception and Relations Center, offering hospital hospitality services, besides a Customer Relations Service (CRS) for the registration of the healthcare services provided to patients to ensure differentiated services and promote all the more the well-being of the patients and their relatives, not only during their stay, but also after their discharge. Some of the world's highest resolution equipment was also purchased in the world market. The construction of the new ICU, which occupies an

entire floor of the main building is also noteworthy, as well as the extension of the Hospital Complex, which will allow to increase the number of beds available by 20%, additional parking spaces, and the opening of innovative healthcare services thanks to two new units specialized in urology and orthopedics for the time being, not to mention the opening of a space called Casarão, which encompasses the reception areas, the technical managers department and a lounge for customer events, as well as a restaurant and a cybercafé.

Characteristics

Profit oriented	
Foundation	1979
Institution's built area	16.336,44 m ²
Organization of the Clinical Staff	Open
Hospital Accreditation	In progress

Main Indicators

Total nr. of operational beds	(dec-10)	148
Nr. of beds in ICUs	(dec-10)	47
Nr. of registered doctors	(dec-10)	670
Nr. of active employees	(dec-10)	1.281
Nr. of first-aid center consultations	(2010)	80.272
Nr. of outpatient consultations	(2010)	not applicable
Nr. of hospitalizations	(2010)	10.842
Nr. of surgeries (except births)	(2010)	9.146
Nr. of births	(2010)	1.468
Nr. of tests performed in the DTC	(2010)	156.186
Gross Revenues (in R\$ million)	(2010)	96,5

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 Graças
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 www.santajoana.com.br





Hospital Santa Luzia

► Brief History of the Institution

Grupo Santa Luzia has worked in the field of healthcare for over 40 years, devoted as it is to fully taking care of people thanks to the technical help of a highly qualified medical staff and hospital. This long-established institution has been known in the healthcare sector since 1968, the year Clínica Santa Luzia was founded with only eight beds to attend to patients for consultations and small surgeries in the fields of otorhinolaryngology and ophthalmology.

Its outstanding location in Brasília, in Setor Hospitalar Local Sul (SHLS), the hospital, which belongs to the Santa Luzia Group, currently comprises 165 beds and is one of the largest private healthcare organizations in Brazil's Midwest. A reference in Brazil in high complexity healthcare services, it integrates all the medical assistance required for the promotion and preservation of health. It furthers all necessary assistance during the pre-, intra- and post-hospital care phase, through the provision of outpatient services, first-aid care, diagnosis and therapeutic support, operating block, maternal and child health block, intensive therapy center and hospitalization facilities. For the specialties of cardiology, pneumology and angiology, it has signed a partnership with the Hospital do Coração do Brasil (HCB), of the same Group, and to which the hospital is physically connected by an overhead walkway.

The vision of the Santa Luzia Hospital is "to be an organization of excellence in taking care of people, able to further a deep sense of safety and respect for individuals", which in the course of its 43 years of history created a humane culture among its staff members, providing services focused on the values of concern, respect, continuous enhancement and sustainability.

Highlights During 2010 and 2011

In 2010, Hospital Santa Luzia (HSL) invested substantially in the structural enhancement of its facilities to promote, together with its staff of professionals, safer, more rapid, and more humane assistance.

Part of the money invested was to modernize and transform the emergency department, whose area was increased threefold to meet the growing demand for these services – 13,000 patients are currently attended every month. The new 1,300 m² large First-Aid Service now comprises a hospitalization unit as well as advanced infrastructure for emergency assistance. The sector offers a 24-hour healthcare service in the following specialties: clinical medicine, gynecology, general surgery, orthopedics, pediatrics, neurology and urology and the exclusive Support

Department for Assistance in Severe Cases (called Saga), a program created to guarantee safety and agility in urgencies and emergencies through medical risk assessment.

The rest of the funds invested was allocated in the expansion of the Diagnostic Imaging Center and for the refurbishment of the Clinical Analysis Laboratory, which now has new installations. Still in 2010, the Hospitalization Unit was extended and another 14 beds were added in the renovated rooms, thereby offering safer, more modern and fully equipped suites to its patients.

In 2011, Hospital Santa Luzia will complete the implementation of the advanced electronic medical chart and imaging exams storage, recording and sharing system.

Characteristics

Profit oriented	
Foundation	1968
Institution's built area	not informed
Organization of the Clinical Staff	Open
Hospital Accreditation	National Accreditation Organization (ONA II)

Main Indicators

Total nr. of operational beds	(dec-10)	165
Nr. of beds in ICUs	(dec-10)	49
Nr. of registered doctors	(dec-10)	404
Nr. of active employees	(dec-10)	1.138
Nr. of first-aid center consultations	(2010)	138.796
Nr. of outpatient consultations	(2010)	70.223
Nr. of hospitalizations	(2010)	14.374
Nr. of surgeries (except births)	(2010)	7.869
Nr. of births	(2010)	1.826
Nr. of tests performed in the DTC	(2010)	691.328
Gross Revenues (in R\$ million)	(2010)	not informed



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Hospital Santa Rosa

► Brief History of the Institution

Hospital Santa Rosa, located in the State of Mato Grosso, a region of rapid growth in the western part of Brazil, is following the development of the state and capital city, Cuiabá, with its innovative technological project for the healthcare sector. Founded in 1997, Hospital Santa Rosa is the result of professional dedication, investments and a relentless quest for excellence. The Hospital Santa Rosa complex now occupies two buildings in a prestigious part of town with easy access even for patients from other states such as Rondônia and Acre.

Investing in specialized medicine, efficient in medium and high complexity procedures, it was the first health institution in the state to carry out new surgeries such as kidney transplants, bone transplants and surgeries for Parkinson's disease. It is the only hospital in Mato Grosso to have received the full Hospital Accreditation Certification from the National Accreditation Organization (ONA), Level II.

Highlights During 2010 and 2011

Intellectual capital and human capital come first for Hospital Santa Rosa. This applied philosophy maintains the focus on leadership through the qualification and management of processes, realignment strategies and the implementation of actions seeking excellent results. The investments in human capital reflect on the entire technical and multi-professional team, including medical internship in general surgery, orthopaedic training and internship in physiotherapy, coordinated by the Studies Center.

The recent publication of the magazine Revista Santa Rosa aims to be a tool to promote intellectual growth and inform society. Social responsibility is an initiative whose purpose is to tighten bonds with the community through the Instituto Santa Rosa.

Investing in modern and well equipped facilities, Hospital Santa Rosa also offers comfortable and humane spaces, as well as a higher number of hospitalization and ICU beds to ensure the best healthcare and meet the demand for higher quality service. The architectural design of the first-aid care unit is quite daring and displays a reception area that is not only functional but also comfortable for patients and relatives. More beds and medical offices are now also available.

The investments were aimed not only to have the satisfaction of providing top-quality service, but also to be acknowledged as a first-rate hospital, which, as a result, was rewarded for the fourth time by the state with the Top of Mind 2010 Award as the most renowned hospital in the area.

The awards, investments and dedication of our professionals reflect acknowledgment of a society that seeks high quality care facilities and services. Hospital Santa Rosa is now looking forward to facing not only new challenges in the years to come, but also a set of achievements with the participation of everyone.

Characteristics

Profit oriented	
Foundation	1997
Institution's built area	13.937 m ²
Organization of the Clinical Staff	Open
Hospital Accreditation	National Accreditation Organization (ONA II)

Main Indicators

Total nr. of operational beds	(dec-10)	136
Nr. of beds in ICUs	(dec-10)	34
Nr. of registered doctors	(dec-10)	880
Nr. of active employees	(dec-10)	612
Nr. of first-aid center consultations	(2010)	53.167
Nr. of outpatient consultations	(2010)	not applicable
Nr. of hospitalizations	(2010)	7.258
Nr. of surgeries (except births)	(2010)	6.760
Nr. of births	(2010)	196
Nr. of tests performed in the DTC	(2010)	589.626
Gross Revenues (in R\$ million)	(2010)	36,6



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Hospital São Camilo Pompeia

► Brief History of the Institution

Hospital São Camilo Pompeia is a philanthropic hospital of the chain of São Camilo hospitals of São Paulo, whose main purpose is to contribute to the maintenance of other 43 hospitals of the Sociedade Beneficente São Camilo (SBSC) spread all over Brazil that attend needy communities through the SUS (Unified Health System) in the areas in which they are established. The SBSC maintains other 26 day-nurseries, three social and educational centers, two passage homes, two youth centers and two retirement homes throughout Brazil.

Located in the western part of São Paulo, the Pompeia Unit is a general hospital with the capacity for elective care, emergency care, transplants, and other high complexity surgeries. Thanks to its modern and safe infrastructure, the Unit offers 300 beds and a clinical staff of roughly 4,000 highly qualified registered doctors who attend about 1 million patients per year.

The history of the hospital marks the entry of Província Camiliana in Brazil. Conceived by Father Inocente Radrizzani, Policlínica São Camilo Private Hospital, opened in 1928, was the corner stone of what was to become a comprehensive modern hospital complex. On January 23, 1960, the private hospital was transformed into Hospital São Camilo Pompeia, after having gone through a series of refurbishments and extensions over the years.

Besides the Pompeia Unit, the chain of São Camilo Hospitals of São Paulo also comprises the Santana Unit (with 220 beds) and the Ipiranga Unit (with 120 beds).

Highlights During 2010 and 2011

The São Camilo Pompeia Hospital started the year 2011 with novelties. After opening, in 2010, an eight-story hospital building, the Unit followed through with the extension and revitalization schedule, which led to the opening of a Center of Reference for patients hospitalized for marrow bone transplants, oncology and hematology, with a capacity of 300 beds. The Center comprises a stem cell bank with a great differential: all beds are reversible and can be used in the Intensive Care Unit. If necessary, there is no need to transfer patients, since the beds are already equipped to attend to them. And so, besides avoiding any possible transfer inconvenience, patients have the advantage of continued assistance by the same staff of doctors and nurses with whom they are already familiar.

Elected in 2010 under the Best Award in the “Best Hospital of the Year” category, Hospital São Camilo also stood out in the

scientific field. The I Congress of the São Camilo Hospitals of São Paulo was held in November under the theme “Clinical and Surgery Emergencies”, which received over 100 speakers and about 1,000 participants. The II Congress is already being prepared and will focus on “the Patient’s Safety, Urgency and Emergency”.

After receiving, in February 2010, the Canadian international accreditation certificate, the Pompeia Unit initiated the process to obtain the certification by the Joint Commission International (JCI).

Characteristics

Not profit oriented	
Foundation	1960
Institution’s built area	38.772 m ²
Organization of the Clinical Staff	Open
Hospital Accreditation	National Accreditation Organization (ONA III); Accreditation Canada

Main Indicators

Total nr. of operational beds	(dec-10)	300
Nr. of beds in ICUs	(dec-10)	74
Nr. of registered doctors	(dec-10)	4.098
Nr. of active employees	(dec-10)	1.547
Nr. of first-aid center consultations	(2010)	262.000
Nr. of outpatient consultations	(2010)	91.600
Nr. of hospitalizations	(2010)	17.500
Nr. of surgeries (except births)	(2010)	10.342
Nr. of births	(2010)	912
Nr. of tests performed in the DTC	(2010)	230.441
Gross Revenues (in R\$ million)	(2010)	285,6

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Hospital São Lucas

► Brief History of the Institution

Holding a comprehensive share of the supplementary healthcare market in the interior of the State of São Paulo, Hospital São Lucas is recognized as one of the main top of the line safe medical and hospital care providers of the city of Ribeirão Preto and surrounding area, focused on high complexity procedures.

The hospital was founded through the association of professors and doctors of the São Paulo University Medical School (USP) - Ribeirão Preto, on January 2, 1969. Over the years, Hospital São Lucas developed its activities in the belief that a company of the healthcare sector can only grow and consolidate when applying the highest quality standards and strictest ethics principles, while being fully aware of its social responsibility and role as a health service provider, always concerned about its clients' satisfaction, safety and respect. These values have always paved the way for its actions and guaranteed its commitments.

In October 2001, it became the 7th hospital in Brazil and the first in the interior of the country to receive the Hospital Accreditation Certificate from the National Accreditation Organization (ONA), the entity authorized by the Ministry of Health for the accreditation of hospital institutions and other healthcare organizations.

Highlights During 2010 and 2011

In November 2010, Hospital São Lucas inaugurated the Marrow Bone Transplant Service and performed the first transplant in a private hospital of Ribeirão Preto and surrounding area.

The Marrow Bone Transplant Unit has three confinement beds and can perform autologous transplants of marrow bone as well as other treatments requiring confinement and involving the use of high doses of chemotherapy.

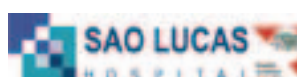
Investments were made to ensure the quality of the care and services provided, as well as the staff's working conditions, through the refurbishment of hospitalization beds, surgical center, ICUs, nursery, first-aid unit, industrial kitchen and laundry. To design a hospital is to articulate in a single building human and technological advancements, so as to positively contribute to patients' and their relatives' emotional condition. The architectural design of the hospital was one of the main accomplishments of the Group's management last year.

Characteristics

Profit oriented	
Foundation	1969
Institution's built area	8.592 m ²
Organization of the Clinical Staff	Open
Hospital Accreditation	National Accreditation Organization (ONA II)

Main Indicators

Total nr. of operational beds	(dec-10)	100
Nr. of beds in ICUs	(dec-10)	22
Nr. of registered doctors	(dec-10)	1.438
Nr. of active employees	(dec-10)	503
Nr. of first-aid center consultations	(2010)	51.071
Nr. of outpatient consultations	(2010)	not applicable
Nr. of hospitalizations	(2010)	5.132
Nr. of surgeries (except births)	(2010)	8.917
Nr. of births	(2010)	not applicable
Nr. of tests performed in the DTC	(2010)	226.424
Gross Revenues (in R\$ million)	(2010)	44,9



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Hospital São Luiz Itaim

► Brief History of the Institution

Founded in 1938, the Sao Luiz network of hospitals is one of the largest in Brazil. The three units located in the capital – Itaim, Morumbi and Anália Franco – provide more than 40 medical, clinical and surgical specialties. In total they account for: 803 beds; 15,000 registered doctors; 4,500 directly and indirectly employed staff; 6,300 hospitalizations/month; 3,300 surgeries/month; 51,000 attendances/month in the accident and emergency units and 13,000 births a year.

In 2010, the D’Or Group – the largest independent hospital and laboratory operator in Brazil, who also makes up part of the Merchant Bank of Grupo BTG Pactual’s portfolio of acquisitions – gained majority control over São Luiz. As a result, the D’Or network, which has a strong presence in Rio de Janeiro (State of Rio de Janeiro), in the ABC region of the Greater São Paulo and in the State of Pernambuco, is now operating with 65 diagnostic units and 17 of its own hospitals (14 in the D’Or network and three units of São Luiz), in addition to two hospitals under its management and another three in the process of construction.

The strategy of the group is that the São Luiz would remain responsible for the management and expansion planning of all units located in the State of São Paulo. Therefore, it currently manages five units, and in addition to three located in the capital, it has also assumed the Hospital e Maternidade Brasil, located in Santo André and the Hospital Assunção, in São Bernardo do Campo. It will also manage the hospital complex that will be built in the city of São Caetano do Sul, which is expected to be ready by 2013.

Highlights During 2010 and 2011

In 2010, following the implementation of various programs that created efficiency in handling processes, improving patient through-put – principally in the surgical center in view of implementing the Lean Six Sigma methodology – and the elimination of waste, apart from improving the cash flow, the São Luiz network was incorporated into the D’Or network, consolidating it into the largest hospital group in the country.

In 2011, apart from maintaining continuity in the Strategic Planning Cycle, it is intended to expand the profit sharing project to all staff members, as well as those in the Jeito São Luiz de Servir (São Luiz’s Way of Serving) program. This initiative is intended to enhance the relationship between staff and the various publics encountered within the institution. There will be specific training in areas such as nursing,

hospitality, nutrition, and administration, with a view to improving the concept of hospitality, the objective of which is to offer efficient services and create channels of communication so that patients and their visitors are comfortable and feel increasingly more welcome by the Institution.

In total, there is R\$ 75 million being invested, with emphasis on physically expanding the capacity for attending in the accident and emergency department, increasing the number of beds available for hospitalization – 39 more – and for modernizing the maternity wing; all in the Itaim unit in Sao Paulo, in addition to modernizing the technology and equipment in all the group’s units.

Characteristics

Profit oriented	
Foundation	1938
Institution’s built area	35.500 m ²
Organization of the Clinical Staff	Open
Hospital Accreditation	National Accreditation Organization (ONA III)

Main Indicators

Total nr. of operational beds	(dec-10)	378
Nr. of beds in ICUs	(dec-10)	37
Nr. of registered doctors	(dec-10)	11.553
Nr. of active employees	(dec-10)	1.689
Nr. of first-aid center consultations	(2010)	133.327
Nr. of outpatient consultations	(2010)	not applicable
Nr. of hospitalizations	(2010)	34.123
Nr. of surgeries (except births)	(2010)	39.013
Nr. of births	(2010)	8.871
Nr. of tests performed in the DTC	(2010)	197.722
Gross Revenues (in R\$ million)	(2010)	308

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Hospital Sírío-Libanês

► Brief History of the Institution

After completing 90 years in 2011, the philanthropic institution Sociedade Beneficente de Senhoras Hospital Sírío-Libanês is a reference worldwide in the field of healthcare; it is formed of Hospital Sírío-Libanês, Instituto Sírío-Libanês de Ensino e Pesquisa (training and research institute) and the Philanthropy Department.

The current main characteristic of Hospital Sírío-Libanês (HSL) is to combine medical and technological excellence with the humane treatment offered to its patients from Brazil and abroad, who turn to the institution in search of diagnosis and treatment in over 60 specialties. This is the result of permanent investments in the modernization of its organization, training of its professionals and development of its medical staff made up of doctors renowned throughout Brazil. Known for its pioneer spirit, it was the first hospital in Latin America to open an Intensive Care Unit.

The institution also comprises the Syrian-Lebanese Training and Research Institute, whose mission is to generate and divulge knowledge as well as qualify professionals, thereby contributing to the excellence of the healthcare provided.

In the field of Philanthropy, the hospital maintains a series of projects for the institutional development of the SUS (Unified Health System). It also promotes activities through the Syrian-Lebanese Social Responsibility Institute, with the Bela Vista District Family Health Program, the Humaitá and Our Lady of Brazil Basic Health Unit staffs, located in the district of Bela Vista, and manages three Outpatient Support Units (AMA) and the Hospital Municipal Infantil Menino Jesus, a reference in pediatrics in the city of São Paulo.

Highlights During 2010 and 2011

Besides the re-accreditation by the Joint Commission International, 2010 was a year marked by the expansion of Hospital Sírío-Libanês (HSL). In São Paulo, a new Unit was opened in the district of Itaim to provide outpatient care, day hospital services, as well as diagnosis and oncology centers. Construction of another Unit has started in Brasília (Oncology), and of the Women's Diagnostic Center on Avenida Brasil, in the city of São Paulo, besides the construction of another hospital in Campinas. These construction sites are part of a project developed to double the capacity of the main hospital unit, with an investment of over R\$ 600 million by 2013.

In technology, the HSL has installed robotic devices which combine computerized angiography, computer tomography and ultrasonography (Artiz-Zeego) as well as the Novalis TX linear accelerator for radiotherapy (the only one in Brazil and

one of five in operation around the world). It also opened the Neurosurgical Suite, equipped with a magnetic resonance imaging system and a neuronavigation system connected to the operating room.

In its Research Department, it added new pieces of equipment and started clinical trials in new fields of knowledge. Two international patents were taken out: for a new piece of equipment and for the use of a new molecule for therapeutic purposes. As for the Philanthropy Department, its partnership with the Ministry of Health enabled it to open the Umbilical Cord and Placenta Blood Bank; in 2011, 12 surgeries for the treatment of Parkinson's disease will have been completed. Cyclotron, in partnership with the Medical School of the University of São Paulo (FMUSP), already produces 18FDG and supplies the PET-CT machines of Hospital das Clínicas, including the one donated by HSL.

Characteristics

Not profit oriented	
Foundation	1921
Institution's built area	90.991,36 m ²
Organization of the Clinical Staff	Open
Hospital Accreditation	Joint Commission International (JCI)

Main Indicators

Total nr. of operational beds	(dec-10)	341
Nr. of beds in ICUs	(dec-10)	51
Nr. of registered doctors	(dec-10)	2.883
Nr. of active employees	(dec-10)	3.740
Nr. of first-aid center consultations	(2010)	66.138
Nr. of outpatient consultations	(2010)	39.207
Nr. of hospitalizations	(2010)	16.996
Nr. of surgeries (except births)	(2010)	16.806
Nr. of births	(2010)	not applicable
Nr. of tests performed in the DTC	(2010)	2.513.942
Gross Revenues (in R\$ million)	(2010)	760,4

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Hospital Vera Cruz

► Brief History of the Institution

Designed and built by Dr. Sylvio Miraglia and Dr. Antônio Figueiredo Starling and by the engineer Dr. Ajax Rabello, the Vera Cruz Hospital (HVC) was inaugurated on April 9, 1949 as the most modern hospital of the State of Minas Gerais. Its mission was to provide resolute and humane medical and hospital assistance developed by highly driven and motivated employees who recognize the high value of customers. HVC is a pioneer in performing cardiovascular operations in Minas Gerais, and is a nationwide reference in the control of hospital infections. The hospital is focused on performing high complexity medicine, whereas its past and current medical staff encompasses people whose name is renowned in the medical circles of Minas Gerais and Brazil, many of whom are university professors that actively participate in representative hospital and medical organizations. Thanks to corporate governance and professional management since 1995, to the use of the Tasy information system since 2000, strategic planning since 2002, sectorial budgeting since 2005, and the adoption of a quality management system since 2006, HVC was assessed by DNV and certified by the National Accreditation Organization (ONA) which granted its full accreditation in 2008 and its accreditation of excellence in 2010, thereby pointing out the noteworthy efforts made in anesthetics and hemodynamics. In 2009, the Vera Cruz Hospital was distinguished for its people management in a study on "Hospitals of Reference" conducted by ITMídia. In 2010, it was again distinguished for sustainability in this year's study.

Highlights During 2010 and 2011

Following its vision of the future, that is, to be a reference in Minas Gerais by 2012 in high complexity, resolute and sustainable medicine, based on quality, and to thereby reinforce its vocation as a pioneer, in February 2011, the HVC opened the first vascular unit ever set up in a private hospital of Minas Gerais for the treatment of patients stricken with cerebrovascular accidents (CVA), acute coronary syndromes, mesenteric artery thrombosis and acute arterial occlusion. Since 2010, the HVC has become a reference in the treatment of CVA thanks to a healthcare service based on the very best and most efficient neurological urgency and emergency ward, considered the only level A center of excellence in the treatment of CVA in Minas Gerais, and ranked second by the Brazilian Society of Cerebrovascular Disease. Moreover, the Vera Cruz Hospital has been

refurbishing its facilities for the past year to provide its medical staff the best conditions to provide excellent high complexity services. In equipment alone, the HVC will invest approximately R\$ 1 million in 2011. This investment includes mainly the substitution of database servers and ICU multi-parameter monitors. The city council of the city of Belo Horizonte also approved the 12,000m² built area expansion project. Considered a success case in budget planning in January 2011 by the magazine *Fornecedores Hospitalares*, the Vera Cruz Hospital now intends to set up a partnership to market the in-house solution it has developed since 2005.

Characteristics

Profit oriented	
Foundation	1949
Institution's built area	8.370 m ²
Organization of the Clinical Staff	Open
Hospital Accreditation	National Accreditation Organization (ONA III)

Main Indicators

Total nr. of operational beds	(dec-10)	153
Nr. of beds in ICUs	(dec-10)	24
Nr. of registered doctors	(dec-10)	353
Nr. of active employees	(dec-10)	700
Nr. of first-aid center consultations	(2010)	119.373
Nr. of outpatient consultations	(2010)	203.812
Nr. of hospitalizations	(2010)	9.525
Nr. of surgeries (except births)	(2010)	9.109
Nr. of births	(2010)	not applicable
Nr. of tests performed in the DTC	(2010)	570.314
Gross Revenues (in R\$ million)	(2010)	61,9

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Hospital VITA Batel

» Brief History of the Institution

The VITA Batel Hospital, located in a prestigious area of the city of Curitiba, was inaugurated in December 2004.

Since its inception, the purpose of the hospital has been to provide ultimate healthcare quality and safety to its patients. After only six years, the hospital received the ONA - National Accreditation Organization's level of excellence award.

The hospital specializes in medium and high complexity treatments and for that purpose is equipped with 88 beds, 23 of which are used in the ICU, which has a general and a cardiology division. The Surgical Center has six operating blocks.

The open medical staff is renowned in the following specialties: cardiology, neurology, orthopedics, general surgery and urology. Its excellence in carrying out bariatric bypass surgeries has made the hospital a reference in the specialty nationwide and abroad.

Another striking characteristic of the hospital is the way it manages its business, more specifically through: the Viver Mais VITA program for the elderly (the best age); alliances with health plan operators, developing health promotion and prevention programs, and the alliance it has set up with the Heart Hospital of Curitiba in 2009, which enabled it to make the VITA Batel program a reference in cardiology.

Highlights During 2010 and 2011

In 2010, as a result of the efforts made in service quality and safety of its patients, which have been ongoing since the hospital's inception, Hospital VITA received the level of excellence certification by the National Accreditation Organization (ONA), thereby proving the high level of healthcare results obtained.

The hospital's nursing staff is acknowledged for excellence of its reception, concern and humane care, and was, for that reason, pointed out as a reference; as a result, it received various awards during 2010. One can mention the award granted by COREN at the state level to the hospital's nursing staff called "Nursing Excellence Award of the State of Paraná" in the Private Hospital category.

From the economic and financial perspective, the hospital obtained its all-time best results ever registered in its history, in terms of revenue, profitability and investments made in the modernization of its facilities.

As to the community, some initiatives were undertaken in CVA prevention and hypertension; the World Heart Day was celebrated; lectures on nutrition were given and walking and running groups were formed. All this work reflects in customers' acceptance and overall satisfaction levels that exceed 92%.

Characteristics

Profit oriented	
Foundation	2004
Institution's built area	6.700 m ²
Organization of the Clinical Staff	Open
Hospital Accreditation	National Accreditation Organization (ONA III)

Main Indicators

Total nr. of operational beds	(dec-10)	88
Nr. of beds in ICUs	(dec-10)	23
Nr. of registered doctors	(dec-10)	963
Nr. of active employees	(dec-10)	353
Nr. of first-aid center consultations	(2010)	52.276
Nr. of outpatient consultations	(2010)	not applicable
Nr. of hospitalizations	(2010)	7.926
Nr. of surgeries (except births)	(2010)	7.534
Nr. of births	(2010)	not applicable
Nr. of tests performed in the DTC	(2010)	244.738
Gross Revenues (in R\$ million)	(2010)	42



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Hospital VITA Curitiba

► Brief History of the Institution

Inaugurated in March 1996, Hospital VITA Curitiba was bought by VITA Participações in June 2000. Its built area of 18,000 m² is located on a plot of land of approximately 102,000 m². It currently has 155 beds and approximately 560 employees. On average, it performs 10,000 emergency procedures per month, as well as 900 hospitalizations and 750 surgeries. It is characterized as a general hospital with an open medical staff of various medical specialties. VITA Curitiba is one of the most modern hospital complexes in Brazil, renowned for its high complexity medical care. The hospital has five perfectly structured vocational areas: cardiology, neurology, orthopedics, pediatrics and urgency medicine. Its organization offers the following services: a Hospitalization Unit, a General ICU, a Cardiac ICU, Pediatrics ICU, Neurological ICU, a General and 24-hour Pediatrics Emergency Department, a Surgical Center, a Medical Office Center, and a Diagnosis and Treatment Support Service.

Highlights During 2010 and 2011

In 2010, the VITA Curitiba Hospital again received level III accreditation (level of excellence) from the National Accreditation Organization (ONA III), as the result of the hard work of its multi-professional staff that continuously further develops the quality and safety of the assistance it provides, while focusing on risk management, the consolidation of strategic protocols and the implementation and publicizing of service packages and ROPS.

The Children's Emergency Ward was separated from the General Emergency Ward to extend the infrastructure available to Pediatric Service Care.

The Emergency Department was therefore extended and general surgeons were hired to attend patients suffering from trauma round-the-clock.

Nowadays, minimally invasive cardiac surgery procedures are also performed.

A Sports Medicine Program was developed to monitor the health of high-performance athletes and patients who practice sports activities.

IT Mídia elected VITA Curitiba as a reference hospital.

As to its involvement in community life, here are some of the initiatives undertaken: CVA prevention and hypertension prevention campaigns, World Heart Day, lectures on nutrition and the formation of walking and running groups.

Characteristics

Profit oriented	
Foundation	1996
Institution's built area	18.164,95 m ²
Organization of the Clinical Staff	Open
Hospital Accreditation	National Accreditation Organization (ONA III); Accreditation Canada

Main Indicators

Total nr. of operational beds	(dec-10)	155
Nr. of beds in ICUs	(dec-10)	44
Nr. of registered doctors	(dec-10)	1.105
Nr. of active employees	(dec-10)	563
Nr. of first-aid center consultations	(2010)	117.992
Nr. of outpatient consultations	(2010)	27.490
Nr. of hospitalizations	(2010)	10.757
Nr. of surgeries (except births)	(2010)	8.796
Nr. of births	(2010)	not applicable
Nr. of tests performed in the DTC	(2010)	475.408
Gross Revenues (in R\$ million)	(2010)	67.8



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Hospital VITA Volta Redonda

► Brief History of the Institution

The VITA Hospital of Volta Redonda stands out in the private healthcare market. It caters to the population of the South of the State of Rio de Janeiro. It currently has 103 beds and approximately 344 employees. It has a modern diagnostic center, a specialty medical center, general ICU, cardiac intensive care unit, and a surgical center with eight operating blocks using the latest technology.

Hospital VITA Volta Redonda excels as a management model with proven results thanks to organized administrative and healthcare work procedures. The service thereby ensures a quick response, the rationalization of costs and sustainability of the business. Its main target is to attain excellence levels in customer care.

Since 2006, its excellence has been recognized by the National Accreditation Organization (ONA III) and therefore it is now a practitioner of the Canadian international accreditation methodology as per Accreditation Canada International, which reinforces the hospital's philosophy through the search for quality and alignment with the quality programs in which it takes part.

Renewing its determination to offer safe healthcare services, the work processes of its Management and Healthcare Safety Center (NGSA) were enhanced through the implementation of the hospital's clinical and non-clinical risk management method, thereby adopting and practicing the internationally approved health relief assistance recommendations.

Highlights During 2010 and 2011

- ✘ Implementation of the Zero Risk Program – focused on clinical and non-clinical risk management;
- ✘ Adverse event management;
- ✘ Adoption of service packages, with proven results. For ex.: the “VAP package” for the prevention of air-conditioner-related pneumonia; prevention of pressure ulcer; advanced treatment for patients with congestive heart failure; prevention of deep venous thrombosis, among others;
- ✘ Participation in the Canadian Accreditation Program: formation of work teams focused on healthcare excellence and safety;

Characteristics

Profit oriented	
Foundation	1953
Institution's built area	11.000 m ²
Organization of the Clinical Staff	Open
Hospital Accreditation	National Accreditation Organization (ONA III)

Main Indicators

Total nr. of operational beds	(dec-10)	103
Nr. of beds in ICUs	(dec-10)	27
Nr. of registered doctors	(dec-10)	346
Nr. of active employees	(dec-10)	342
Nr. of first-aid center consultations	(2010)	86.208
Nr. of outpatient consultations	(2010)	not applicable
Nr. of hospitalizations	(2010)	7.523
Nr. of surgeries (except births)	(2010)	4.541
Nr. of births	(2010)	not applicable
Nr. of tests performed in the DTC	(2010)	456.694
Gross Revenues (in R\$ million)	(2010)	51



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Hospital viValle

► Brief History of the Institution

viValle Hospital started functioning in 1980 as a gastro-clinic and in 2000 as a hospital. In 2006, its name was changed to Hospital viValle, a strong trademark which is gaining more and more fame throughout the Paraíba River valley.

Today the viValle facilities comprise a round-the-clock clinical and orthopedic emergency care unit, an oncology center, a highly equipped surgical center to perform all types of operations, regardless of specialty, a humane ICU with eight beds, the only sterile material center in the area, containing high-technology equipment for the control of hospital infection.

To ensure first-class treatments, Hospital viValle provides its patients with all the comfort and convenience of a hotel by offering the facilities, food, all the way down to the hospital cuisine concept.

The same professional and humane service offered at Hospital viValle is seen at the viValle Medical Center, renowned for the high level of professionalism of its medical and nursing staff that delivers differentiated healthcare services in a wide range of specialty consultations and treatments. The facility also has a viValle Check-Up Service dedicated to the promotion of health through prevention, the delivery of part-time special care services, besides the Pró-Saúde (Pro-Health) Program to help companies manage their employees' healthcare through occupational medicine services.

Highlights During 2010 and 2011

In 2010, Hospital viValle bet on the consolidation of relations between doctors and employees and on the enhancement of the specialized healthcare services provided to its patients. For that purpose, a Permanent Education Department and a Customer Relations Department were set up to render services focusing on and satisfying customers' needs. In addition, the hospital also invested in a Doctor Relations Department to bring viValle closer to the medical staff and make doctors feel all the more at ease and satisfied with their work environment.

The infrastructure of the hospital also had a brush-up last year thanks to the refurbishment of the Clinical and Surgical Oncology Center and of the Clinical Analysis Laboratory.

The 2011 projects are all the more daring, as viValle is starting the second phase of its Master Plan, which includes the extension by 40% of the Emergency and Hospitalization Wards, duplication of the Clinical and Surgical Oncology Center and completion of the Hemodynamics Unit. All in

all, the new phase of the project will encompass an area of 7,234 m².

For the year 2011, besides these achievements, viValle seeks to obtain the level 3 certification of excellence accreditation from the National Accreditation Organization (ONA).

Characteristics

Profit oriented	
Foundation	2000
Institution's built area	4.500 m ²
Organization of the Clinical Staff	Open
Hospital Accreditation	National Accreditation Organization (ONA II)

Main Indicators

Total nr. of operational beds	(dec-10)	53
Nr. of beds in ICUs	(dec-10)	8
Nr. of registered doctors	(dec-10)	1.000
Nr. of active employees	(dec-10)	257
Nr. of first-aid center consultations	(2010)	40.093
Nr. of outpatient consultations	(2010)	13.605
Nr. of hospitalizations	(2010)	3.586
Nr. of surgeries (except births)	(2010)	4.265
Nr. of births	(2010)	not applicable
Nr. of tests performed in the DTC	(2010)	not applicable
Gross Revenues (in R\$ million)	(2010)	44,8



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Real Hospital Português

► Brief History of the Institution

The Real Hospital Português de Beneficência (Portuguese Charity Hospital) in the State of Pernambuco was founded in 1855 by Portuguese Doctor José D'Almeida Soares Lima Bastos, who was then also Chairman of the Portuguese Reading Group of Recife, known as a resistance center for the treatment of the victims of cholera which at the time was decimating Brazil.

In the permit of July 2, 1856, which aimed to officialize the support of Portugal for the Institution, the King of Portugal placed the hospital in Recife under his Royal Protection, an honor he confirmed in 1862. Subsequently, the permit dated November 7, 1907, granted by D. Carlos I, gave the ROYAL title to the Portuguese Charity Hospital of Pernambuco.

Today, the RHP is considered the most extensive center of medical excellence in the North and Northeast of Brazil, being the most prepared for highly complex procedures and best equipped in the area. The hospital complex is made up of: The Real Heart Hospital (RHC) Unit; the Egas Moniz Unit (general emergency department – Real Vida and hospitalization), the Real Mater Unit (maternity hospital), the Infante Unit (pediatrics); the Arnóbio Marques Unit (consultation offices); the José Maria Matos Unit (car park, consultation offices and administration department), the Ambulatory Ward of Maria Fernanda's Charity Hospital and the Boa Viagem Advanced Unit. In addition, the RHP comprises in excess of 50 specialized clinical units and three laboratories.

The Royal Portuguese Hospital is managed by a Management Board made up of members of the RHP Association. Every other year, the board members elect the Provost, or leader, who has the power to make decisions at the hospital and whose role is to set the guidelines to be followed.

Highlights During 2010 and 2011

The year 2010 was marked by heavy investments made in the physical structure and in the renewal of the technology used at the hospital. The Royal Portuguese Hospital acquired state-of-the-art equipment such as a Robot-Controlled Angiography System (ARTIS ZEEGO - Siemens) and the first computed tomography linear accelerator for image-guided radiotherapy in Latin-America, called the "Artiste" by Siemens.

The Endoscopy Department was refurbished and extended, all its equipment replaced and exclusive devices purchased, such as an endoscopic ultrasound unit and an automated equipment disinfection system. The launching of the first Geriatrics Internship Programme of Pernambuco was also

noteworthy, as was the creation of the International Department to organize the Hospital's health tourism procedures.

RHP has received countless awards, some of which are institutional, such as the 2010 Brazilian Company Award, granted by the Latin-American Quality Institute, and the Business Intelligence Award, besides trademark remembrance awards such as "The Trademarks that I Like" and "Trademark Remembrance", granted by the major communication vehicles of the State of Pernambuco.

Beginning in 2011, a new and spacious Analysis Laboratory called RealLab will run round-the-clock using computer processes, and the São João de Deus building will be opened to specifically handle oncology treatments on its 15 floors comprising 314 beds.

Characteristics

Not profit oriented	
Foundation	1855
Institution's built area	117.736 m ²
Organization of the Clinical Staff	Open
Hospital Accreditation	National Accreditation Organization (ONA I)

Main Indicators

Total nr. of operational beds	(dec-10)	584
Nr. of beds in ICUs	(dec-10)	140
Nr. of registered doctors	(dec-10)	11.244
Nr. of active employees	(dec-10)	3.697
Nr. of first-aid center consultations	(2010)	217.132
Nr. of outpatient consultations	(2010)	48.740
Nr. of hospitalizations	(2010)	28.213
Nr. of surgeries (except births)	(2010)	24.070
Nr. of births	(2010)	2.267
Nr. of tests performed in the DTC	(2010)	482.091
Gross Revenues (in R\$ million)	(2010)	308



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Vitória Apart Hospital

► Brief History of the Institution

Vitória Apart Hospital is the fruit of a collective project, idealized by a group of doctors, whose objective was to offer a safe environment and a differentiated hospital concept. The proposition was to offer outpatient, emergency and hospitalization healthcare services at all levels, without having to transfer patients for services and tests to other units.

Founded in 2001, Vitória Apart Hospital performs from simple outpatient procedures in medical offices to organ transplants, while also operating a specialized center for burn treatment, hyperbaric medicine, segmented ICUs and a specialized oncology center. Over the years, the institution accomplished a trajectory characterized as a reference in high complexity medicine in the State of Espírito Santo, combining the structure and technical competence of the country's best centers. Currently, the hospital has 233 hospitalization beds, and during 2011 it will inaugurate another 180 beds, as the result of investments made in expansion works. Of the new total of available beds, about 50 will be in the Intensive Care Unit (ICU).

Highlights During 2010 and 2011

Vitória Apart Hospital invests in a group of differentiated professionals and an organizational structure that allows segmenting functions, with emphasis on Corporate Governance. In 2010, the hospital initiated the "RenoVAHção" [Renovation] project, implementing a series of actions to increasingly strengthen the institution and strategically reposition it in the market.

Among the actions that comprise the project are: implementation of a new Integrated Hospital Management System, focused on the improvement of the institution's clinical, healthcare and administrative processes; the restructuring of the technological park, aimed at modernization and safety; redesigning of internal and third party processes; energy efficiency, warranting environmentally sustainable energy at lower cost; redirecting of the quality and strategic planning policy; retaking the original architectural project; and definition of Human Resources policies, focused on welcoming, maintaining and retaining talents.

In 2010, Vitória Apart Hospital also commemorated first place in consumer preference in the state, upon being elected the best hospital in the State of Espírito Santo, in the "Marcas de Valor" (Value Brands) survey. This survey is conducted by Instituto Futura and Rede Gazeta (affiliate of Globo TV network), and its objective is to show the vision the consumer public has of companies with activities in Espírito Santo.

Characteristics

Profit oriented	
Foundation	2001
Institution's built area	47.845 m ²
Organization of the Clinical Staff	Open
Hospital Accreditation	National Accreditation Organization (ONA III)

Main Indicators

Total nr. of operational beds	(dec-10)	233
Nr. of beds in ICUs	(dec-10)	48
Nr. of registered doctors	(dec-10)	560
Nr. of active employees	(dec-10)	1.030
Nr. of first-aid center consultations	(2010)	85.930
Nr. of outpatient consultations	(2010)	not applicable
Nr. of hospitalizations	(2010)	12.167
Nr. of surgeries (except births)	(2010)	11.298
Nr. of births	(2010)	833
Nr. of tests performed in the DTC	(2010)	not applicable
Gross Revenues (in R\$ million)	(2010)	58,8

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