ANAHP OBSERVATORY

Brazilian National Association of Private Hospitals

Edition 4/2012 - English Version

ANAHP
ASSOCIAÇÃO NACIONAL DE HOSPITAIS PRIVADOS

Summary

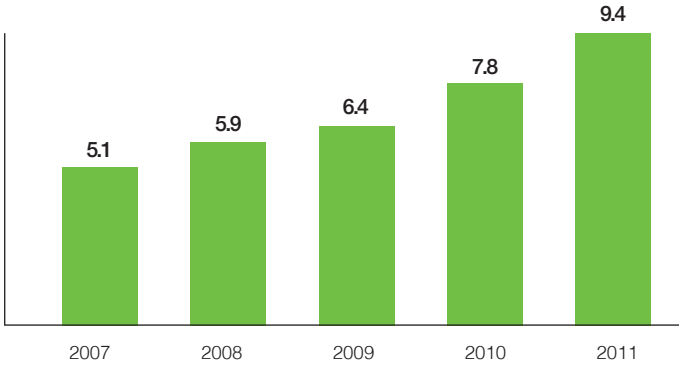
IN **2011** ANAHP hospitals accounted for

14% of total healthcare expenses and

10% of total hospital admissions in the Supplementary Health System

Source: ANS – Supplementary Health Information Book

Revenues



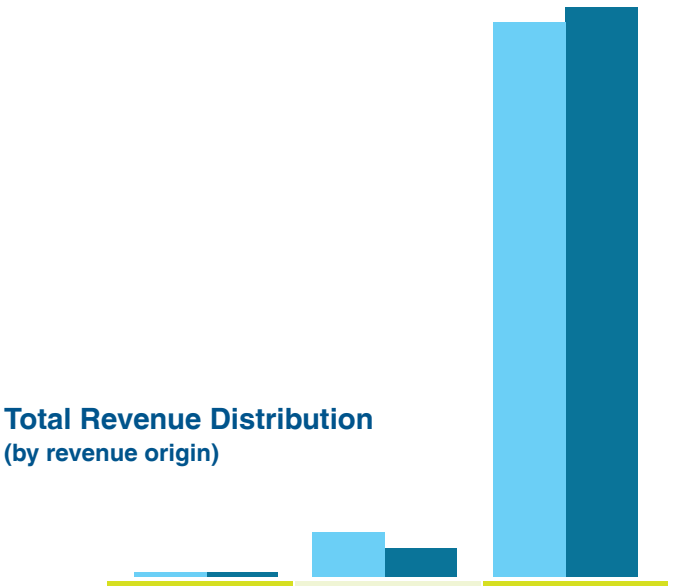
Please note that revenue development depends on sample size, which may vary on a yearly basis.

Gross revenues of the hospitals that participated in the survey reached

9.4 billion

reais in 2011.

Total Revenue Distribution
(by revenue origin)



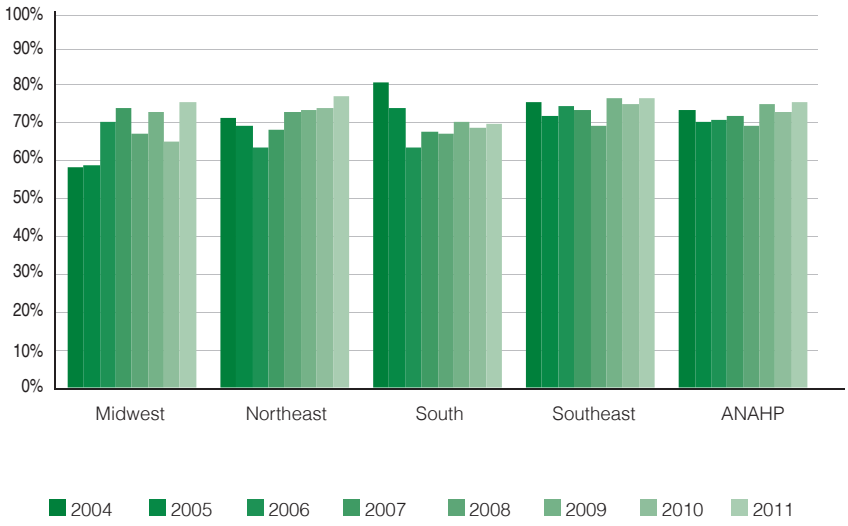
	SUS	Private	Operators
2010	0.8%	7.3%	91.9%
2011	0.7%	4.8%	94.4%

Revenue
(by type of payment source)

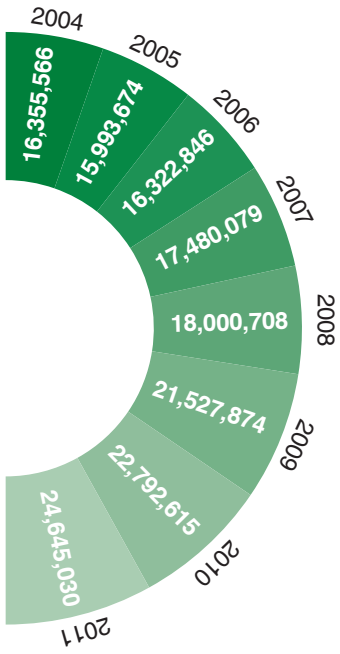
Health Plan Operator	2011
Insurance Co.	38.5%
Self-managed	29.9%
Group Medicine	15.5%
Medical Cooperative	16.1%

Hospital Occupancy Rate

Geographic Region	2004	2005	2006	2007	2008	2009	2010	2011
Midwest	59.3%	59.8%	71.5%	74.8%	68.4%	73.8%	66.0%	76.4%
Northeast	72.6%	70.2%	64.4%	69.1%	73.8%	74.4%	74.8%	78.3%
South	82.0%	75.0%	64.5%	68.8%	68.4%	71.4%	69.8%	70.9%
Southeast	76.9%	73.1%	75.8%	74.6%	70.5%	77.9%	76.0%	77.5%
ANAHP	**74.6%**	**71.2%**	**71.9%**	**72.9%**	**70.6%**	**76.1%**	**74.1%**	**76.9%**



Total Exams – Laboratory and Imaging



Source: SINHA/ANAHP 2011

Accreditations/2011

Type of Accreditation	ANAHP	Brazil	% ANAHP
National Accreditation Organization - ONA	32	153	21%
Joint Commission International - JCI	11	19	58%
Accreditation Canada	8	15	53%
National Integrated Accreditation for Healthcare Organizations – NIAHO	2	3	67%

Source: ANAHP Study of associated hospitals, 2011; ONA at www.ona.org.br; Accreditation Canada at www.iqg.com.br; JCI at www.cbacred.org.br; NIAHO at www.dnv.com.br

ANAHP in numbers

Development of Average Payment Receipt
(by region)

Geographic Region	2006	2007	2008	2009	2010	2011
Midwest	45.1	67.8	66.6	67.9	72.2	68.4
Northeast	52.4	66.7	61.8	63.8	57.1	58.6
South	103.7	113.4	95.4	93.0	102.3	97.9
Southeast	67.0	65.3	67.4	69.3	85.8	95.9
ANAHP	**66.8**	**71.8**	**69.2**	**70.7**	**81.8**	**72.4**

Source: SINHA/ANAHP 2011.

Distribution of Surgeries
(by complexity)

Beds	2006	2007	2008	2009	2010	2011
Outpatient	12.9%	12.3%	11.4%	12.2%	9.5%	10.1%
Major surgery	25.9%	27.4%	26.2%	25.6%	24.2%	26.5%
Medium surgery	34.5%	33.2%	36.7%	33.8%	38.0%	34.5%
Minor surgery	21.2%	21.4%	20.3%	22.9%	21.1%	22.9%
Special surgery	5.5%	5.6%	5.4%	5.5%	7.2%	6.0%

Source: SINHA/ANAHP 2011.

WITH

9,071

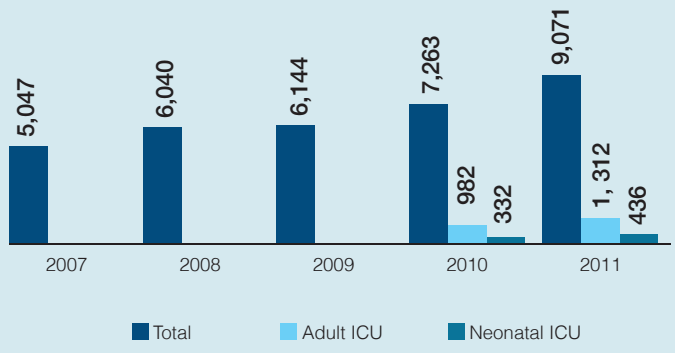
Available Beds

in the beginning of 2011, ANAHP represented **7.1%** of private beds in the Supplementary Health System in Brazil.

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

ANAHP Beds
(absolute numbers per year)

Beds	2007	2008	2009	2010	2011
Total	5,047	6,040	6,144	7,263	9,071
Adult ICU	NI	NI	NI	982	1,312
Neonatal ICU	NI	NI	NI	332	436



*43 hospitals in 2011.

Source: SINHA/ANAHP 2011.

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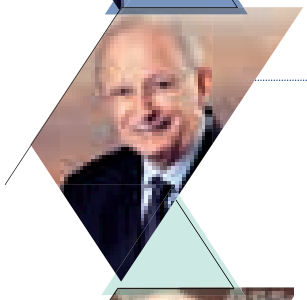

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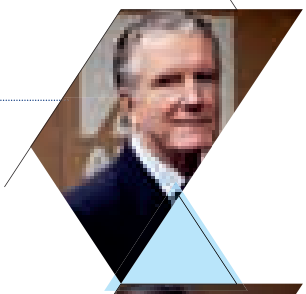

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Observatório ANAHP Masthead

Observatório ANAHP is an annual publication of ANAHP – National Association of Private Hospitals.

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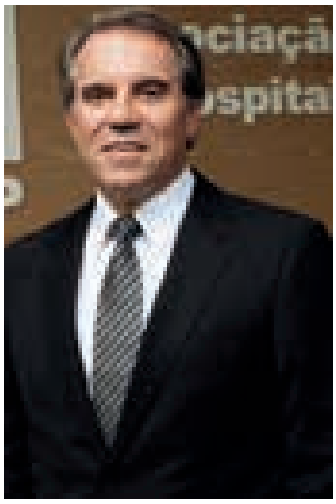
MESSAGE TO THE READER



"… health, no doubt, is the first good and the foundation of all other good in life …"

René Descartes

In the last decade, the Brazilian health system has experienced major transformations. Economy globalization has increased company competitiveness, making quality a prerequisite for survival. This reality can be observed in all fields, including hospital organizations. Health professionals have perceived that only by caring about the quality of their services can they provide long term sustainable growth.

In view of this reality, one can observe the increase in the number of hospitals engaged in seeking certifications that attest the quality of their services. ANAHP members, for example, hold more than 50% of all international accreditations granted to hospitals in Brazil and 21% of the national ones. These numbers show the commitment of our associates to quality and reinforce the pioneering role of ANAHP, whose objectives include continuous improvement of service quality and dissemination in Brazil of the concept of health as a greater value.

The private healthcare industry has showed significant growth in the last 10 years, presenting average annual growth of 4% in number of beneficiaries, totaling 47.6 million Brazilians in 2011. To keep up with this constantly changing marketplace, mechanisms to assess and measure healthcare output and service quality have become mandatory.

Regulatory agencies and the Ministry of Health have started to perceive the importance of assessing health services in the country. In 2006, Agencia Nacional de Saude Suplementar (National Supplementary Health Agency - ANS) started monitoring the quality of Health Plan Operators, and more recently, in compliance with Normative Resolutions 267 and 275, the Agency has been working on the development of the Qualification of Health Service Providers (QUALISS), an initiative supported by ANAHP, trade associations and other representative bodies of the private health industry.

Observatório ANAHP, a consolidated yearbook in the health market, and an important instrument for consultation and benchmarking in the industry, was created to contribute to the exchange of information and to set comparative criteria among health institutions. The publication, now in its 4th edition, originated from the Integrated Hospital Indicator System (Sistema Integrado de Indicadores Hospitalares ANAHP - SINHA) and the Best Healthcare Practices Project (Projeto Melhores Práticas Assistenciais - PMPA), respectively created in 2002 and 2004. Nowadays, based on a consistent historical series, Observatório ANAHP has efficiently fulfilled its main objective to provide periodic and permanent indicators, intended to serve as means to assess and monitor healthcare and to foster improvement processes in supplying medical hospital services with quality and safety.

It is important to point out that 2011 was highly productive for ANAHP. In addition to active participation in discussions and decisions that have directly affected the industry, the organization of the I National Private Hospital Congress (CONAHP), and the celebration of ANAHP's 10th anniversary, we ended the year with the election of the current Deliberative Council for the Triennium 2012-2014.

We intend to continue the outstanding work developed by the previous administration, thereby fulfilling the entity's ultimate mission: to disseminate best practices in the private healthcare system.

Finally, I would like to thank all those who have participated in the preparation of this highly informative material, particularly the members of the Editorial Committee and the colleagues who took part in creating this edition: Ary Ribeiro, Fabio Peterlini, Katia Magni and Nea Miwa Kashiwagi.

Enjoy the reading.

Francisco Balestrin

President of the Deliberative Council

Reform of the hospital remuneration model for the supplementary health system - ANAHP view

In changing the remuneration model, it is essential to be clear about what quality means for system users.

It is necessary to introduce changes to encourage transformation from volume-based payment to value-based payment.

Is it necessary to reform the remuneration model of hospital service suppliers in the Brazilian supplementary health system? Yes, because the current model predominantly leads to focusing on output and volume when providing services. As stated in the document of the Technical Group of Agência Nacional de Saúde Suplementar (National Supplementary Health Agency - ANS) ANS Sistemáticas de Remuneração dos Hospitais que Atuam na Saúde Suplementar: Diretrizes e Rumos (Rio de Janeiro – June/2011): "The industry has a remuneration logic that privileges a perverse cost/benefit relation, with high administrative costs, which generates no added value in the provision of better healthcare services to the beneficiaries". It is necessary to introduce changes that stimulate the system to transform volume-based payment into value-based payment. This is a fundamental reorganization: to discuss remuneration models based on quality and cost/effectiveness, and to seek structural changes that allow us to go in the direction of value-based payment, defined as the relation between healthcare quality and the price paid for it. Within this perspective, it is important to analyze experiences of changes made in the past, in Brazil and in other countries. From the experience with several health systems in the world,

it is known that the predominant remuneration model may be a potent inducer of change in healthcare practices. Such induction may be good or bad for a patient or user of the system, who should at all times be the focus of all initiatives, for the sake of their own good. For example, in the United States, the introduction of managed care had an impact on the decrease of health expenses, but at the cost of evident dissatisfaction of system users, i.e., patients did not experience the change as something good. The main message from this experience is that the focus was on the reduction of expenses and not on the generation of value, which should not be ignored when one seeks to change the remuneration model in the Brazilian supplementary health system.

The change process of the remuneration model is a point of convergence among industry participants and, furthermore, is an item on the ANS' regulatory agenda. It is adamant to follow the right premises, and assuming the commitment of the participants to the basic concepts explained above, the changes may serve as inducing tools for the industry's development to improve healthcare and expand access to supplementary health.

One of the reasons for distortions in the current remuneration model is shown by Figure 1 below. The left column generally represents the current reality: there is no logical sequencing between healthcare standard, its costs and its price, and hence, its remuneration.

What is predominant is the fragmentation of these processes. One of the pillars of the model's change, shown in the bottom part of Figure 1, is the focus on medical management, leading to reduction in healthcare variability and the formulation of standards (whenever possible), and hence, the logical sequencing of costs, prices and remuneration.

In addition to what is shown in Figure 1, it is important to understand that another conceptual element must be introduced to change the model: the concept of VALUE, defined as the relation between quality (comprising result, safety and healthcare experiences, duly measured) and payment (total cost of treatment). Refer to Figure 2.

Having healthcare management as the first step in the process, defining the remuneration for the offered service, and introducing the "value" equation are the components for a succeessful reform of the remuneration model in the Brazilian supplementary health system.

The document Guidelines and Directions (Rio de Janeiro Round) identifies the following change premises, which are fully transcribed below:

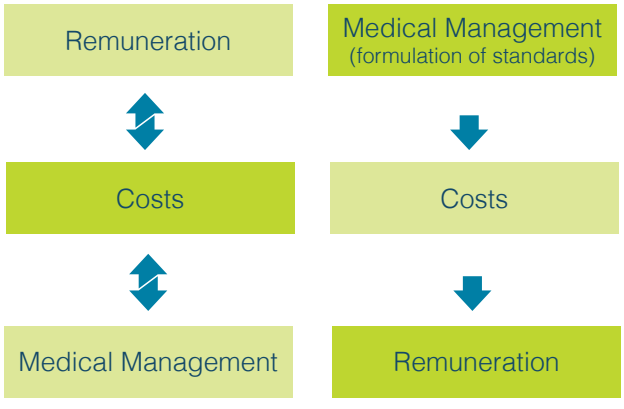
» **Enhanced Services Perception –** increase in selection power by beneficiaries should occur based on the comparison of the best cost x quality x effectiveness relation, as well as the perception of the potential aggregated value of services received.

» **Sustainability –** the adopted mechanisms, as well as the resulting incentives, should contemplate remuneration compatible with the costs of rendering hospital services. Furthermore, criteria to reassess such costs should be previously defined so as to maintain the economic-financial equilibrium of the stakeholders (beneficiaries, operators and service providers), seeking to maintain service quality.

» **Multitude of Forms of Payment –** Brazil is a country of major diversities. Hence, there is no way to define a single form of payment for the different hospital profiles existing in the country, ranging from differences in size, generally defined by number of beds, to differences between general and specialty hospitals. It requires the definition of a remuneration method that considers the needs of different service rendering processes in different structures and profiles, in addition to the results of each institution.

»

Figure 1 – RETURN TO MANAGEMENT CONSISTENCY (Approaching the Problem)



Source: National Supplementary Health Agency (ANS).

Figure 2 – Reconsidered Value Equation for Healthcare

$$value = \frac{quality^{1}}{payment^{2}}$$

1. Composition of patients' results, safety and experiences.
2. Cost for all health services buyers.

Source: Value in Health Care. Current State and Future Directions. HFMA; June 2011, www.hfma.org/ValueProject

»**Doctors' Involvement –** as the main agents responsible for defining the services to be rendered to patients, doctors (clinical staff) should necessarily be in charge of the standardization of clinical guidelines adopted for new remuneration methods. Such guidelines must be designed based on scientific and broadly accepted and practiced evidence

»**Risk Adjustment –** remuneration methods must provide support to risk adjustments to allow for appropriate remuneration level in light of the complexity of different patient profile cases, i.e., the cost associated with a procedure performed on a healthy patient is different from the cost of a procedure performed on a patient with a variety of conditions.

»**Free Competition –** under no circumstances should remuneration methods compromise free competition of hospitals in rendering services. They should provide support for the differentiation of services by means of the quality attributes of each institution, such as: structure and efficiency for healthcare as assessed through its processes, outcomes and patient satisfaction. By the same token, hospitals may practice differentiated prices with operators. These new methods do not intend to define values or even to create price tables for hospital services.

»**Remuneration by Performance –** the new methods should allow the valorization of service providers that perform better, invest in staff's technical capacity, in modernizing their organizational structure, certifications and accreditations, i.e., those that seek to excel, that take the extra mile. They are the ones to be recognized and compensated according to their results.

»**Contracting –** the changes necessary to migrate to new hospital remuneration methods must be reflected and formalized in a contract, in accordance with Normative Resolution 42 of ANS. It is essential to adopt clear rules, seeking to minimize conflict and migration costs, to put into operation the new business rules. The drafting of contracts with such characteristics will enable the creation of trust and commitment in the relationship between operators and hospitals.

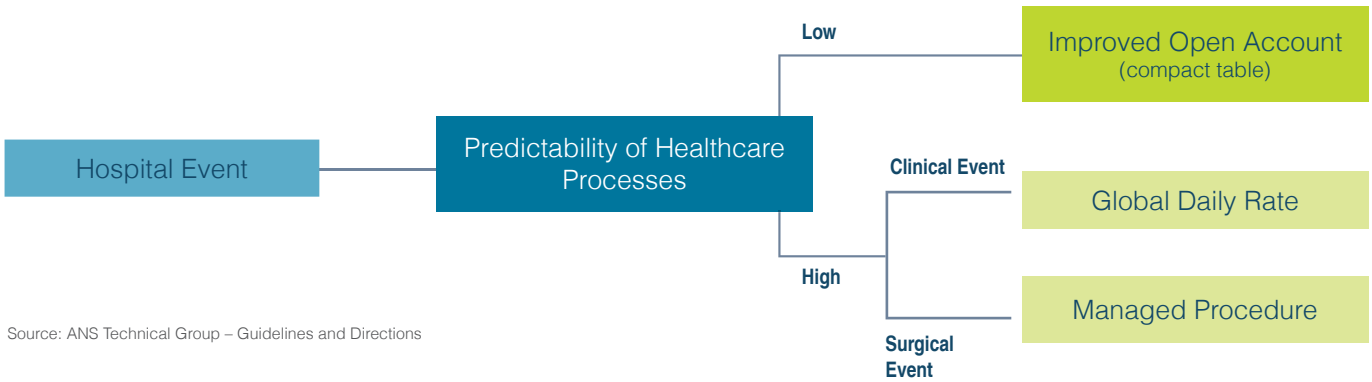
Standardization – the services rendered by hospitals should have a basic descriptive standard. These standards should be based on clinical guidelines set by medical specialty organizations and in line with good management practices.

Figure 3 shows the analytic structure for the implementation of new methods for hospital remuneration (Guidelines and Directions, ANS Technical Group). It is intended to be aligned with the logic shown in Figure 1 and the definition of the appropriate form to remunerate services based on the degree of predictability of the healthcare process, i.e., the healthcare process characteristics define the remuneration modality, which is a major step towards a new remuneration model.

In processes of low predictability or high variability of outcomes that cannot easily standardize services and inputs, we should maintain an "open account" for billing purposes. In the new model, as proposed by the Technical Group in the so-called Sao Paulo Round, it was suggested to adopt the composition of a price table for daily rates and a smaller number of items, in comparison with most tables currently in use. Some items that used to be charged separately were grouped together and were called "compact table". It is important to point out that one of the premises for change is maintaining the economic-financial balance in the existing relations, and that materials, medical drugs and medicinal gases (inputs) would continue to be charged separately in "open accounts", unless otherwise set forth in specific agreements made by the involved parties. "Compacting" is not a means to reduce expenses for health plan operators, nor to reduce service providers' revenues, neither is it a mechanism to increase revenues for service providers and increase expenses for operators. This "simplification" of the collecting process of the open accounts intends to reduce the cost of transactions between operators and service providers, such as for example, providing easy closure of unpaid bills and reducing the funds necessary for audit processes.

In healthcare processes of high predictability or low variability, i.e., in which higher degree of standardization of the use of inputs and services can be attained, it is recommended the adoption of fixed price modalities, in the form of global daily rates and managed procedures.

Figura 3 – Analytic Structure of New Hospital Remuneration Methods



Source: ANS Technical Group – Guidelines and Directions

The remuneration method for Managed Procedures has been the object of the third round of ANS Technical Group. According to the participants, there is a fundamental difference between "package" concept (old model) and "managed procedure" (new model).

The "package" predominantly follows the pricing of services by means of the retrospective analysis of average financial values of accounts, without necessarily having any relation with the technical base underlying the surgical procedure.

On the other hand, the "managed procedure" has its pricing based on protocols/technical guidelines and clinical guidelines, created together with the hospital's clinical staff, i.e., first the hospital defines the healthcare and administrative initiatives to perform the entire surgical treatment process and, based on this technical foundation, calculates the related costs and the prices and then seeks to establish contractual agreements with healthcare operators.

Evidently, the changes in progress require greater risk sharing between health plan operators and hospital service providers, with higher risks for service providers. It is also evident that considering Brazil as a whole, there is significant asymmetry in the negotiating power of service providers and operators, with the latter yielding more power. Within this context, some assumptions should be followed so that changes do not cause an imbalance, running the risk of having an unfeasible system.

They are:

a) Celebrating contracts for all agreements, always complying with all contractual items set forth by ANS norms;

b) Defining criteria for applying price adjustments for contracted services;

c) Implementing new models with pilot projects, enabling measurement and assessment of impacts and promoting the necessary adjustments and course corrections.

It is a challenging time for hospital management on a broader scale, involving organizing and managing the clinical staff, healthcare results, and the improvement of operational controls and economic-financial management. In order to meet these challenges, investments in healthcare information capacity and economic-financial systems become essential.

Improvement of clinical staff management seems to be the greatest challenge, given that it involves the alignment of interests of the clinical staff and the hospital, in addition to organizing relationship programs with the clinical staff, in order to structure a synergistic and common agenda for service providers (hospital, diagnostic medicine, and medical services).

How hospitals performing in the Brazilian supplementary health system can get prepared for this setting

Some items to be observed in planning and when undertaking actions:
Competence in management, with focus on healthcare management (multi-professional staff);
Use of technological tools that integrate clinical data and revenue and cost information, producing management indicators;
Higher degree of risk sharing among operators and service providers;
Transference of margins from materials and medical drugs to service items (daily rates and fees);
Purchasing of "high cost" materials follows a different process and flow compared with the current one, subordinated to use standards technically and commercially determined;
The incorporation of new technologies undergoes increased regulation, based on technical criteria and scientific evidence;
System users seek information to exercise their "choosing power".

In a scenario of higher risk with increase of "fixed price" modality cases (managed procedures or global daily rates), the physician, as the main definer of the quantity of resources and inputs used in the healthcare process, should be aligned and feel he/she is a player in the process. Successful experiences in engaging the healthcare staff to more rational use of resources, as described in international literature, show that the point of convergence is healthcare quality gains in clinical effectiveness. These experiences have shown that it is more difficult to attain alignment with the clinical staff if the objective is only to reduce expenses. In Brazil, there is an additional challenge to overcome: the discrepancy of medical fees practiced by most operators of healthcare plans. A reform of the compensation model of medical service providers should also take place. Without this concurrent initiative, one can reasonably argue that there is a risk concerning the expected gains from the hospital model reform.

Another important challenge is providing information to management. The healthcare information system should be able to generate overall healthcare performance indicators, by procedure, by medical team, and by healthcare unit. However, it does not suffice to have good software. The challenge goes beyond it. We need to build multidisciplinary teams focused on epidemiological analyses, so that we can learn about the mix of procedures, classify risk at different levels, understand eligibility criteria for managed procedures, and evaluate multidisciplinary teams' performance, among other relevant tasks. With the appropriate interaction between management software and healthcare intelligence (specialized human resources), the hospital starts receiving the information necessary to assess its results and to provide support for negotiations/discussions with operators. It is the convergence of healthcare and cost information that will enable appropriate price setting of services rendered in various forms (open account, global daily rates and managed procedures).

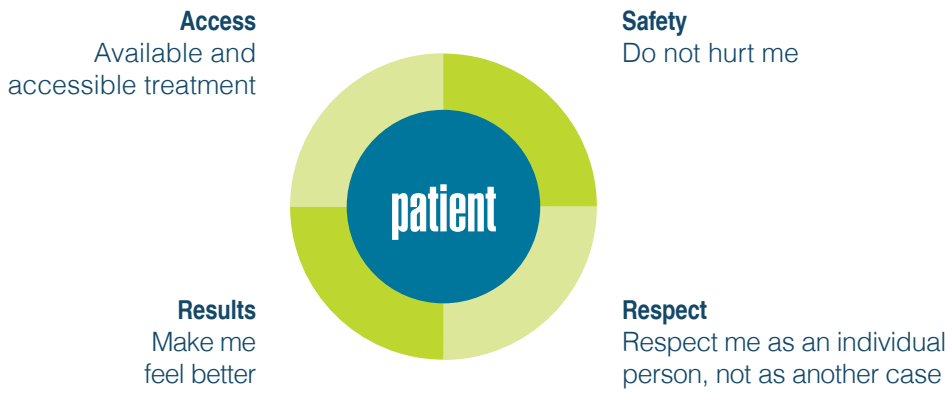
The economic-financial information system should calculate the costs and results by operational area (business unit), procedure/specialty, and contract per healthcare plan operator, along with the monitoring of negotiation results, mainly for the fixed price modalities. Without information on results (profitability), at the appropriate level of detail, the migration process of margins on materials and medical drugs to daily rates and fees will be at higher risk. It should be an attribute of the system to supply the necessary information to the domain of the hospital's economic-financial dimension, identifying where operational gains and losses are incurred. Such information, along with technical/medical protocols/guidelines directs the formation of prices overall and of managed procedures and global daily rates.

In a model with higher predominance of fixed price remuneration it is important to point out that inputs (materials, medical drugs and medicinal gases) shall no longer be considered "revenues", but rather "costs". This poses greater challenges not only to clinical staff management, but also to procurement/purchasing management, and negotiation process with suppliers.

The adoption of technical protocols/guidelines as the basis for the "fixed price" modality defines the need for more integration between input purchasing and technical processes, requiring further standardization.

In changing the remuneration model it is essentially important to be clear about what quality means for the system's users. Figure 4 shows that by placing the patient in the position he/she should occupy – the center, the first quality dimension is access. Once the system is accessed, three other dimensions are fundamental: safety, healthcare output and respect for the individual. The results pursued with the change in remuneration model of the Brazilian supplementary health system should take into account this alignment of principles.

Figure 4 – Patient Preoccupations With Quality



Source: Value in Health Care. Current State and Future Directions. HFMA; June 2011, www.hfma.org/ValueProject

ANAHP hospitals invest in the qualification of their personnel as a competitive advantage

Applied research shows associated hospitals undertaking training and development initiatives.

The more professionals are qualified, the more assertive decisions, processes, and hence, institutions' results will be.

Expanding knowledge in organizations is one of the main strategies to increase service quality in health institutions. The more professionals are qualified, the more assertive decisions, processes, and hence, institutions' results will be. This conclusion was drawn in the study performed in 2011 with National Association of Private Hospitals (ANAHP) associated hospitals to find out how hospitals provided corporate education for their personnel, considering the industry's complex organizational context. The study, conducted as an online survey, involved 21 associated hospitals.

The speed of change in business environments and in technological innovation, in addition to the difficulty traditional universities have in anticipating such market demands, were the main arguments to justify the creation and expansion of Corporate Universities, with the intent of increasing companies' competitiveness to measurable results, optimizing knowledge management and the development of intellectual capital, while decreasing money spent on training programs not focused on business' results or on improvement of processes.

The study showed that all participating associated hospitals offer training and development initiatives, thereby qualifying institutions through the process of acquiring or updating knowledge, skills, and changes in attitude. The analysis of corporate education practices applied in ANAHP hospital organizations was performed comparing results achieved within the principles of corporate education, as described ahead:

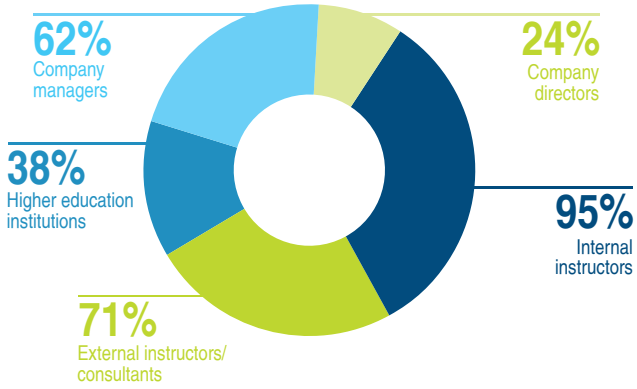
Table 1 – Seven Principles of Success in Corporate Education and its Practices

Principle	Practices
Competitiveness: Increase the level of corporate competitiveness by implementing, developing and consolidating corporate and personal competencies.	Obtain top management's commitment and involvement for the education system.
	Align personnel management strategies, guidelines and practices to the business' strategies.
	Implement a personnel management system by competencies.
	Create educational initiatives and programs aligned to the business' strategies.
Perpetuity:	Be a vehicle to disseminate corporate culture.
	Make leaders and managers take responsibility for the learning process.
Connectivity: The objective is to expand networking of internal and external publics.	Adopt and implement "inclusive" education, encompassing the internal and external publics.
	Implement the knowledge management model that fosters sharing of organizational knowledge and exchange of experiences.
	Integrate the education system with the knowledge management model.
	Create management mechanisms that favor social knowledge building.
Availability: Make activities and resources available so that personnel can learn anytime and anywhere.	Intensively use technology applied to education.
	Implement virtual education projects (learning mediated by technology).
	Implement multiple forms and processes of learning that favor "learning anytime anywhere".
Citizenship: Encourage individual and corporate citizenship, forming social actors characterized by ethical posture and social responsibility.	Obtain synergy between educational programs and social projects.
	Commit to corporate citizenship, fostering: - the constitution of social actors inside and outside the company; - the social construction of organizational knowledge.
Partnership: Continuously constitute internal (with leaders and managers) and external (higher education institutions) partnerships.	Internal partnerships: make leaders and managers responsible for the learning process of their personnel, encouraging participation in educational programs, while creating a workplace favorable to learning.
	External partnerships: establish strategic partnerships with higher education institutions.
Sustainability: Be a result-generating center, as well as to seek self-sustainability by means of alternative resources	Become a center to aggregate results for the business.
	Implement a metric measurement system to assess the achieved results, considering the business' objective.
	Create mechanisms favoring the system's financial self-sustainability.

Source: Éboli (2004, p. 60)

For 95% of the hospitals participating in the study, the facilitators are internal instructors, followed by external consultants for 71%; 62% mentioned companies' managers; 38% elected educational institutions, while only 24% counted on directors in their corporate educational programs. There is an interesting opportunity to expand the facilitation process through partnerships with educational institutions, with the objective of fostering scientific research, as well as more participation of managers and directors of hospital organizations, so as to contribute to the consolidation, strengthening and dissemination of corporate culture.

Training is accomplished through:

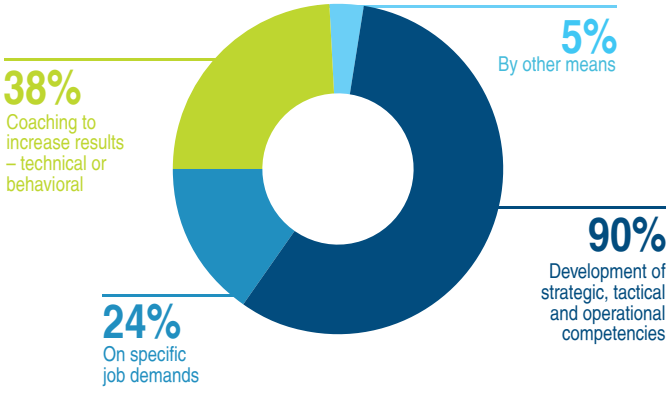


Source: Éboli (2004, p. 60)

Graph 1 – Composition of Instruction Team/Corporate Education Program Facilitation

As related to development of leaders, all participants in the study promoted qualification initiatives for this public. This process is constantly required, given that companies lack sufficient leaders in terms of quality and quantity.

Focus of leadership development programs:

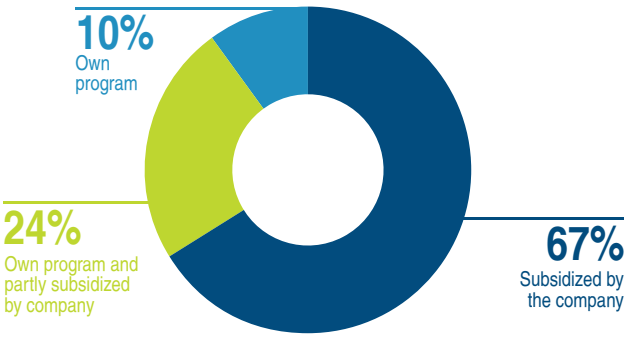


Source: Questionnaire answered by ANAHP associated hospitals.

Graph 2 – Focus of Leadership Development Programs

Most of the hospitals, i.e., 90%, set up their leadership development programs focusing on strategic, tactical and operational competencies; 38% provide coaching to increase technical and behavioral results, while 24% consider job-specific demands. It is important to point out that only one hospital mentioned the development program of future leaders, in addition to offering all other initiatives, characterizing itself as an institution concerned with training successors. The results showed that the concept of essential competencies is more applied to managerial programs than to all other functional groups.

Training and development programs have a budget:

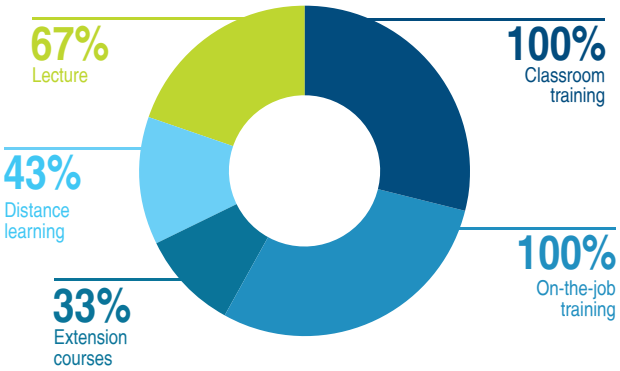


Source: Questionnaire answered by ANAHP associated hospitals.

Graph 3 – Financial Sustainability of the Training and Development Department

The budget for the training and development department to a great extent entails company subsidies in the case of 67% of the hospitals; 24% operate on a shared basis, i.e., with their own program and partial subsidies. Only two hospitals, representing 10% of the institutions surveyed, manage their programs with their own funds, showing that it is feasible and possible to expand the department to become a business unit.

Courses comprising the training and development program for the internal public:

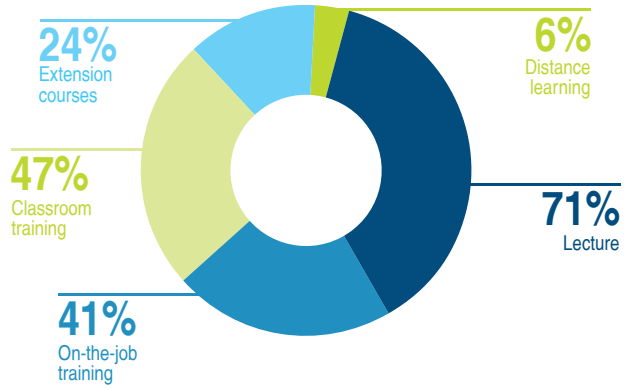


Source: Questionnaire answered by ANAHP associated hospitals.

Graph 4 – Courses Offered the Internal Public.

Classroom training sessions and on-the-job training account for most qualification opportunities for the internal public, with initiatives undertaken by all the hospitals. The next most common are lectures, for 67% of the respondents; distance learning courses in the case of 43% of the participants, and 33% for extension courses.
Based on the learning pyramid presented by Meister (1999) and shared by NTL – Institute for Applied Behavioral Sciences, one observes that the programs offered by the hospitals favor learning and retention of taught contents in 75% to 80% of cases, evidenced by classroom and on-the-job training.

Courses comprising the training and development program for the external public:

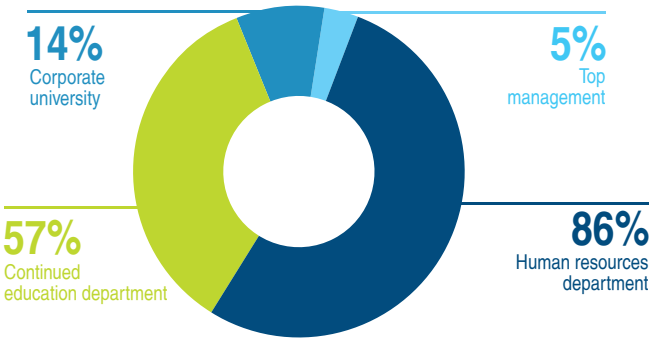


Source: Questionnaire answered by ANAHP associated hospitals.

Graph 5 – Courses Offered the External Public

Most of the offered opportunities consist of lectures, adopted by 71% of the hospitals, followed by classroom training opportunities for 47% of the respondents, and 41% for on-the-job training. Only 24% of the hospitals offer extension courses to the external public, while 6% offer distance learning courses. These results confirm previous answers, showing that training and development initiatives focus on personnel and third party employees, but not on the entire production chain. Lectures may be used to communicate about procedures and advanced technologies in the medical field, promoting the institutions' image.

Training and development programs are the responsibility of:

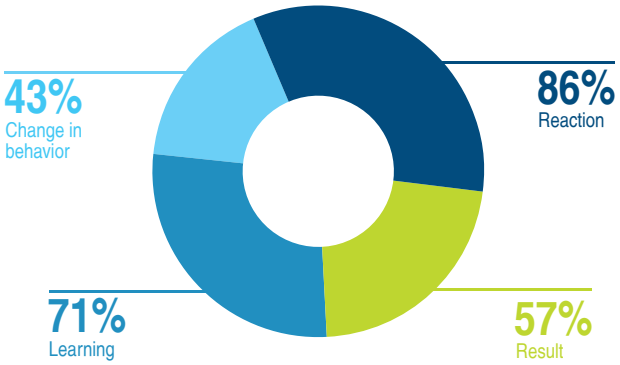


Source: Questionnaire answered by ANAHP associated hospitals.

Graph 6 – Responsibility for Training and Development Programs

The human resources department (HR) is still the most frequently mentioned party responsible for training and development programs. According to some authors, when the continuing education department reports to HR, this means there is a higher expectation concerning executives' commitment and interdepartmental support and requests for budgeted funds. Only one hospital positioned itself as having a top-to-bottom attitude, which, according to some authors, causes greater impact on the organization.

Type of assessment to check learning resulting from training and development activities

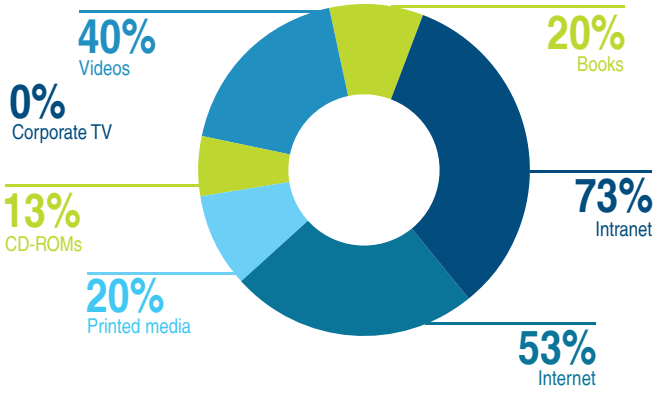


Source: Questionnaire answered by ANAHP associated hospitals.

Graph 7 – Type of assessment to check learning

Concerning the assessments performed by hospitals, 86% of the institutions measured trainees' satisfaction by assessing reaction; learning assessment was mentioned by 71% of the hospitals; assessments based on results ranked second, with 57% of the institutions surveyed, while 43% use the change in behavior assessment. These results confirm that reaction assessment is the easiest and most simple method, however, its focus is on promoting better training and not on trainees' learning.

Technology used in providing distance learning:



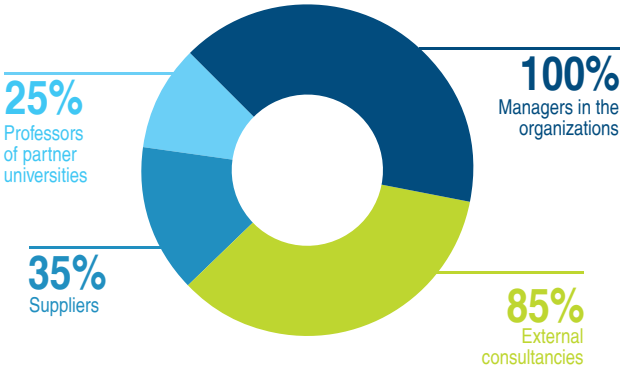
Source: Questionnaire answered by ANAHP associated hospitals.

Graph 8 – Technology Available for Distance Learning Courses

The Intranet is mentioned by 73% of the respondents as the technology used for distance learning courses; 58% of the hospitals participating in the study mentioned they had knowledge management practices and listed the processes of socialization, externalization, combination, and internalization, using the following tools: managerial development programs and qualification initiatives, scientific meetings, meetings for content dissemination after participation in congresses, use of portals to register documents, routines, job descriptions, distance learning training courses, and access to libraries.

Most of the surveyed hospitals (67%) mentioned initiatives to promote social projects through the training of handicapped professionals, courses in governance for needy publics, or the qualification of communities, along with some other programs such as inclusion of handicapped workers in the institution, young apprentice programs, specialized nursing care provided at nursing homes for the elderly, among others, independently of professional qualification.

Partners supporting training and development programs



Source: Questionnaire answered by ANAHP associated hospitals.

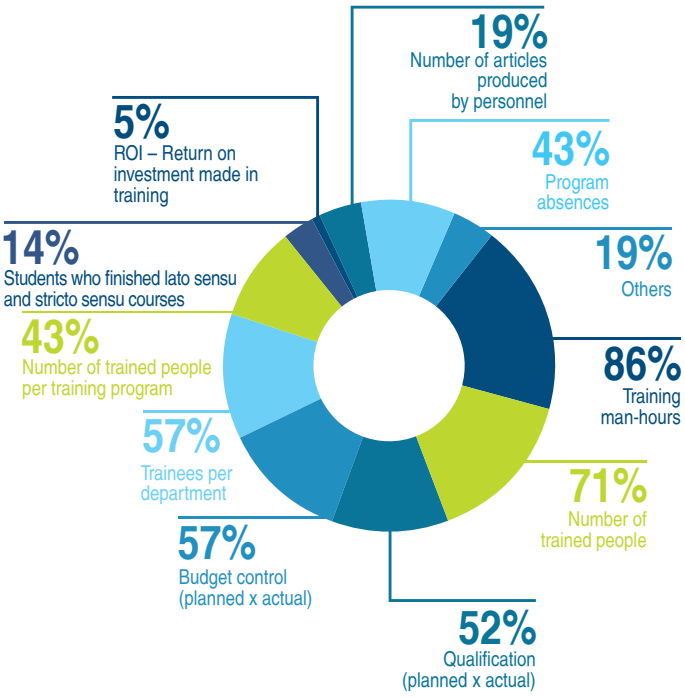
Graph 9 – Partners Supporting Training and Development Programs

Managers are mentioned by 100% of the hospitals as supporters of training and development programs. Other significant data is the participation of external consultancies mentioned by 85% of the surveyed hospitals, while the participation of other suppliers was mentioned by 35% of the participants. Professors of universities were mentioned by 25% of the organizations.

A significant number of the respondents (86%) use the management model by competencies in their human resources processes.

Acting as instructors is the main role of managers in the hospitals' learning process. There has been increase in coaching initiatives by 33%, according to the respondents, in mentoring, by 19%, and in tutoring, by 24%.

Indicators used for assessing efficiency and efficacy of the department responsible for training and development initiatives:

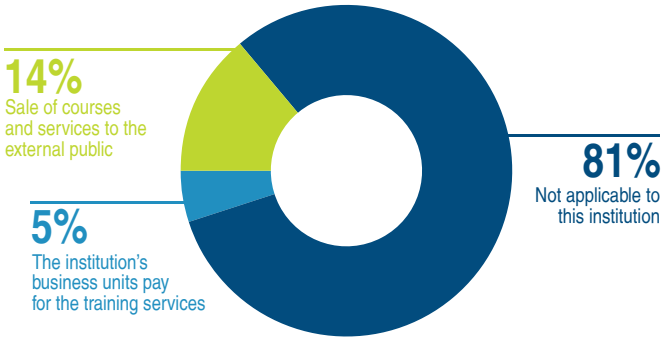


Source: Questionnaire answered by ANAHP associated hospitals.

Graph 10 – Indicators Used for Assessing Efficiency and Efficacy of the Department Responsible for Training and Development Initiatives.

Eighty-sex percent of the hospitals chose the training man-hour as indicator, followed by the number of trained people by 71% of the surveyed institutions; 52% mentioned the percentage of planned versus actual qualification; 57% mentioned planned versus actual budget control; 57% mentioned the control of trained staff per department; 43% of the hospitals mentioned number of trained people per training program and absenteeism per program as indicators. In 19% of the cases, articles published by personnel were the criteria used by the hospitals. Under the category Others, there were 19% of the respondents who reported as indicators knowledge acquisition rate, pre- and post-training healthcare outcomes (for example, hospital infection rate), investment in training/revenue, investment/payroll, hours worked/hours in training, assessment of performance, and competence methodology.

Practices generating revenues for the department responsible for training and development initiatives:



Source: Questionnaire answered by ANAHP associated hospitals.

Graph 11 – Practices Generating Revenues for the Department Responsible for Training and Development Initiatives:

This result shows that hospitals focus on internal development and do not use training initiatives as revenue generators.

Other conclusions:

» All the hospitals informed they have physical infrastructure to conduct training, showing the importance given to the investment in personnel qualification;

» The culture is disseminated by 95% of the surveyed hospitals and in most cases the mentioned practices are focused on the integration programs for new employees;

» The training of leadership focuses on developing strategic, tactical and operational competencies;

» The interest in setting up a corporate university was mentioned by 60% of the surveyed hospitals;

» The hospitals base their corporate education models on the principles of competitiveness, perpetuity, citizenship and internal partnership;

» Some hospitals may also invest in the principles of connectivity, external partnerships, availability and sustainability.

The role of organizational learning lies in assisting organizations in overcoming limits and becoming better in creation, acquisition, interpretation, transference and content retention, in addition to modifying their attitude to reflect new knowledge and insights. With this in mind, the study has shown the principles supporting corporate education models in ANAHP hospitals, as well as the opportunities for performing more strategic activities to encourage competitiveness in the industry.

As a result of this study, it was possible to observe that the hospital industry is constantly developing and the implementation of corporate education models is proof of this intent.

Supplementary healthcare market follows the country's economic growth

Brazilian economy is expected to accelerate growth pace during the year, contributing to the industry's major expansion in 2012.

Between 2009 and 2011, growth in the service industry represented on average 53% of total jobs in the market.

To a major extent, the deceleration of the Brazilian economy in 2011 occurred essentially due to precautionary measures at the macro level (high interest rate cycle and credit restraints to attenuate inflationary pressures), adopted by the federal government in 2010. Following growth of 9% of accumulated Gross Domestic Product - GDP rate in the second quarter of 2010, in comparison with the same period of the previous year, variation in Brazil GDP showed successive retractions until the fourth quarter of 2011, ending the year with 2.7% growth, which compares to 7.5% in 2010.

At the time, according to the assessment of Brazilian Central Bank, the trajectory of price indices pointed to inflationary pressures in relevant economies, including Brazil, in which uncertainty persisted concerning the price trend of financial assets and commodities.

Within this context, macroeconomic policies were tuned to halt growth of inflation and demand for credit, using the base interest rate (SELIC) as the main instrument. In April 2010, increases in the base interest rate began and

were maintained until August 2011, concurrently with the deterioration of the international economic scenario, and a fiscal policy essentially focused on a primary surplus of 3.3% of GDP, among other factors, which culminated in a retraction in Brazil's economic activity.

In 2012, to avoid the continuation of the deceleration, Brazilian Central Bank began reverting said measures, in light of the uncertainties in the international financial economy. The Brazilian economy is expected to accelerate growth during the year, maintaining the inflation rate on a convergent trajectory towards the target. Growth projections of the economy vary from 3% to 3.5%, with an expected investment rate above 20% of GDP in 2012. The government will act to reach a growth rate equivalent to that of the final years of the previous government, of more than 4% on average.

In recent years the labor market has continuously shown good results in Brazil. Between 2003 and 2011, more than 17 million formal jobs were created, representing an annual average increase of 1.9 million jobs (Graph 1). The service sector has concentrated the largest absolute number of jobs created during the period, on average representing 53% of total jobs in the labor market in Brazil between 2009 and 2011. This result has fostered growth of the supplementary health system in the country. In the same period, the number of beneficiaries of health plans in Brazil has increased 48%, approximately 15 million new beneficiaries.

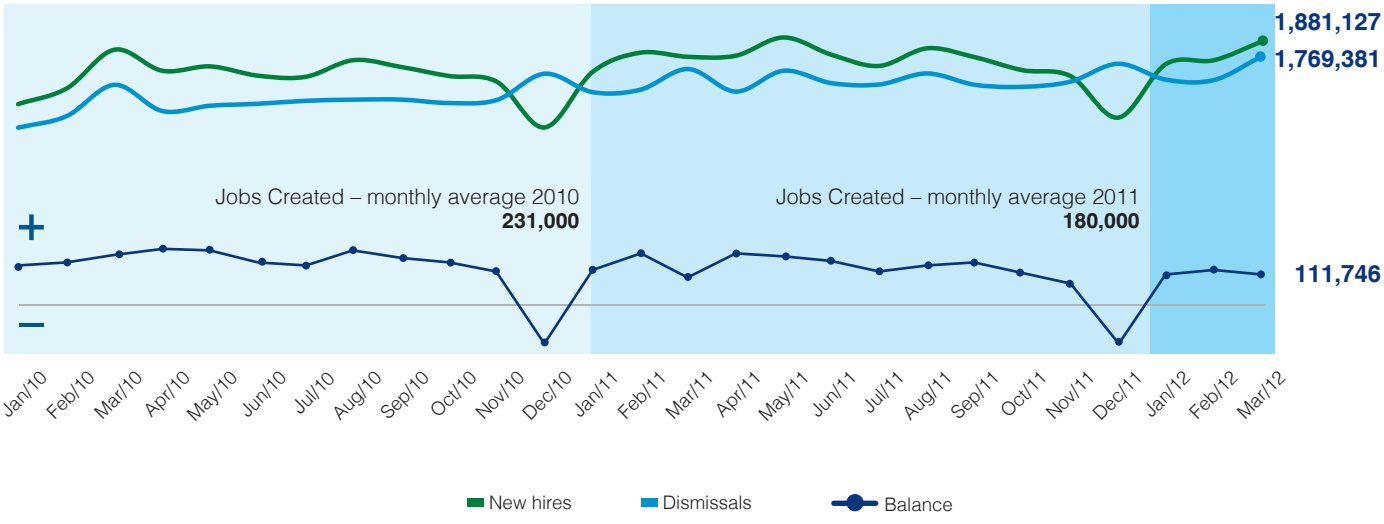
Within this context, the only negative aspect refers to the significant informality of Brazilian labor market, and even though it has declined in recent years, it still shows significant participation in various regions of Brazil. Reasons for this phenomenon are complex, involving a series of social, political and economic factors, and more specifically, are associated with high and growing fiscal burden at different levels of government. The consequence of this fact is that not only are revenues lower, but also the access of this segment of the population to the supplementary healthcare market is compromised.

Merger and acquisition transactions between health plan operators, hospital networks, pharmacies and laboratories that took place at an accelerated pace in the last two years, are expected to occur at a more modest pace in 2012, in view of the international financial instability. As a result of the internationalization of the economy that has taken place in recent decades, the development of business strategies in that direction is essential to achieve a competitive advantage, intensifying market concentration in a number of sectors of the economy.

The world's major central banks have increased global financial liquidity, thus causing important challenges for emerging economies. By means of capital flows, one of the transference mechanisms of the international economy, the prices of commodities and financial assets have increased the stability risks of the financial system, requiring the use of precautionary measures and effective instruments in seeking to attenuate such effects in short-term management of monetary policies.

Although indicators have shown improvement in several countries, the perspective of deceleration of economic growth in 2012 and little growth in coming years is upheld.

Graph 1 – Labor Market Trend



Source: CAGED (Cadastro Geral de Empregados e Desempregados) – Prepared by ANAHP

Beneficiaries

The number of beneficiaries of supplementary healthcare plans totaled R$ 47.6 million in December 2011, the equivalent of little more than 25% of the country's population (Graph 2 – Table 1). In relation to December 2010, there was an increase of 4.2%. In the same period, almost two million formal jobs were created, a fact that suggests a relevant association between economic performance and the development of activities in the supplementary health sector in Brazil. In the last ten years, this sector showed average growth of 4% per year in the number of beneficiaries and kept pace with the annual variation of the GDP (Gross Domestic Product), which, on average, was 3.6%. Exclusive dental plans varied by 14.8% and totaled 16.8 million beneficiaries in the same period, i.e., about 8% of the Brazilian population.

The distribution of beneficiaries by operator modality in the industry concentrates more than 70% of users in Group Medicine and Medical Cooperatives. Considering the regions in the country, the Southeast holds more than 64% of total beneficiaries, followed by the South, 13.8%, Northeast, 12.8%, Midwest, 5.1%, and North, 3.6%. Another important aspect refers to the number of beneficiaries by region and modality. Regions South and North currently concentrate more than 50% of beneficiaries in the Medical Cooperative modality, whereas in the Midwest region this percentage is 47%. In the Southeast and Northeast, about 40% of the beneficiaries have private healthcare plans in Group Medicine modality. This fact shows the growth strategy of operators seeking to strengthen the regional market to expand their activities (Table 2).

Beneficiaries of Private Plans
(by type of contract – millions of beneficiaries)

Graph 2

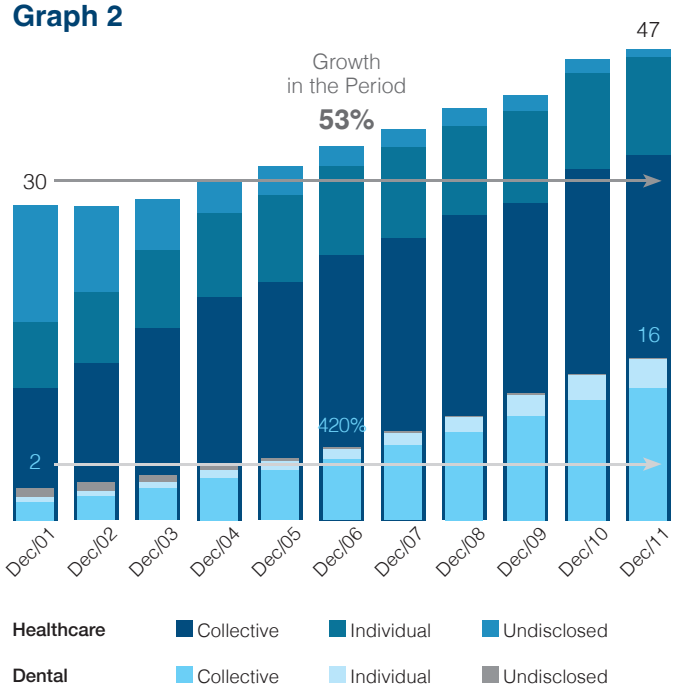


Table 1

Year	Beneficiaries of private healthcare plans, with or without dental care	Beneficiaries of exclusively private dental plans
Dec/01	31,132,361	3,234.364
Dec/02	31,105,254	3,788,701
Dec/03	31,771,197	4,447,374
Dec/04	33,673,600	5,456,603
Dec/05	35,010,992	6,133,143
Dec/06	36,990,397	7,269,601
Dec/07	38,776,559	8,868,752
Dec/08	40,769,647	10,391,758
Dec/09	42,126,562	12,667,111
Dec/10	45,688,689	14,642,659
Dec/11	47,611,636	16,805,450

Source: National Supplementary Health Agency (ANS).

Table 2

Modality	Beneficiaries	%	N	NE	SE	S	MW
Group Medicine	17,835,317	37.5%	19.7%	41.5%	42.4%	22.3%	20.7%
Medical Cooperative	17,102,411	35.9%	52.2%	30.8%	31.1%	55.2%	46.6%
Insurance Co. Specialized in Health	5,832,023	12.2%	11.9%	12.2%	13.9%	5.9%	8.9%
Self-management	5,329,172	11.2%	13.3%	15.0%	9.0%	12.5%	23.2%
Philanthropy	1,512,713	3.2%	2.9%	0.4%	3.8%	4.1%	0.6%
TOTAL	**47,611,636**	**100%**					

Source: National Supplementary Health Agency (ANS).

Revenues

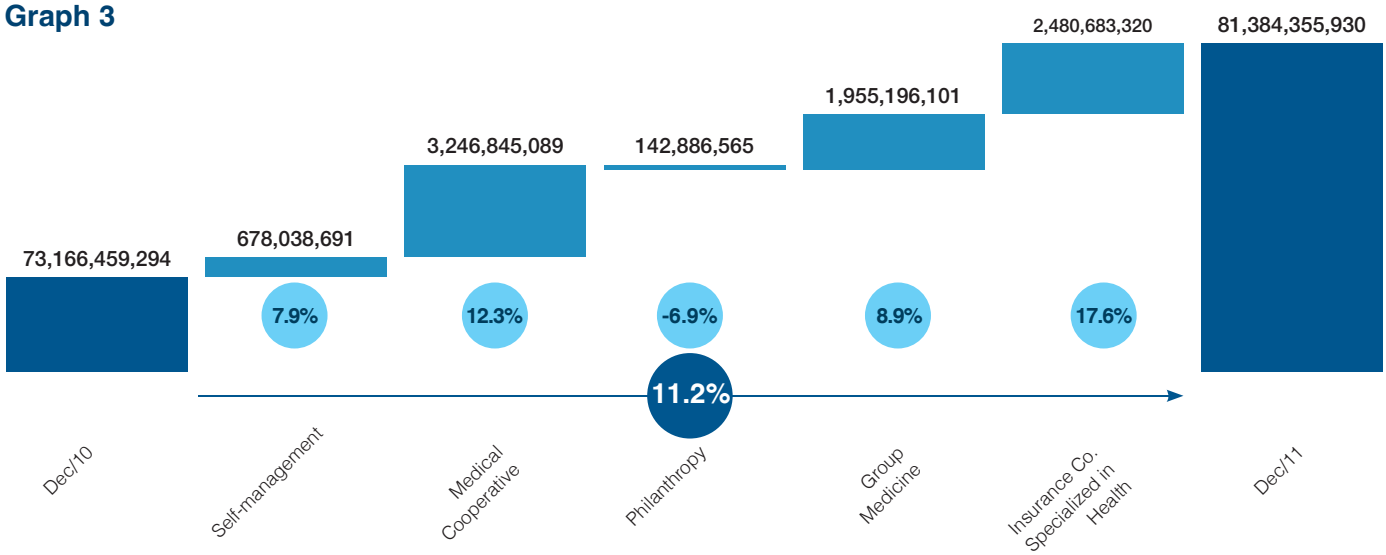
In 2011, revenues from services rendered by private health plan operators increased by 11.2% in comparison with the previous year, from R$ 73 billion to R$ 81 billion (Graph 3). In analyzing such growth one must consider that in the same period, inflation measured by IBGE (Brazilian Institute of Geography and Statistics), according to IPCA index (Broad National Consumer Price Index) was 6.50%, signaling actual growth of approximately 4.7%. In nominal terms, the highest variation occurred in the modality Medical Cooperative, with R$ 3.2 billion in the comparison between December 2011 and December 2010.

As to share of revenues by existing modalities, in 2010, there was significant percentage in Medical Cooperative, with 36.6%, and Group Medicine, with 29.3%, followed by the others: Insurance Co. Specialized in Health, 20.4%; Self-management, 11.4%, and Philanthropy, 2.4%. (Graph 4 – Table 3).

Revenues from Services Rendered

(by modality – 2010/2011)

Graph 3



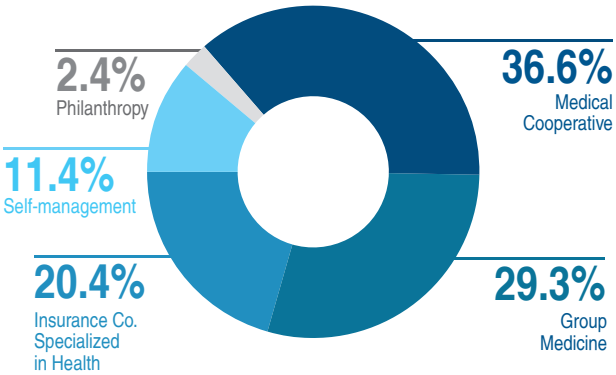
Source: National Supplementary Health Agency (ANS).

Table 3

Modality	Revenues	%
Medical Cooperative	29,749,652,434	36.6%
Group Medicine	23,885,476,164	29.3%
Insurance Co. Specialized in Health	16,576,642,850	20.4%
Self-management	9,245,114,617	11.4%
Philanthropy	1,927,449,865	2.4%
TOTAL	**81,384,335,930**	**100%**

Source: National Supplementary Health Agency (ANS).

Graph 4



Expenses

In 2011, healthcare expenses showed 13.3% increase in relation to 2010. Among modalities, Group Medicine varied the least, with increase of 9.5%, whereas all other modalities showed average increase of 13.4% (Graph 6). In recent years, particularly beginning in 2007, all modalities have shown declining trend in the annual percentage variation of healthcare expenses.

Concerning the share of administrative and operational expenses among the existing modalities, there was percentage distribution similar to the one registered in revenues from rendering services. Medical Cooperatives represent 36.3%; Group Medicine, 28.3%; Insurance Co. Specialized in Health, 20.5%; Self-management 12.6% and Philanthropy, 2.3% (Table 4 – Graph 5)

In analyzing expenses by type and operator modality, the proportion is similar in Medical Cooperative, Self-management and Group Medicine. In these modalities, administrative expenses on average represent 15%, and healthcare expenses, 85%.

This same fact does not occur with the other modalities, mainly with Insurance Co. Specialized in Health, which shares only 8% of administrative expenses (Graph 7).

Considering healthcare expenses by expense item, the highest expenses result from hospital admission, which represent approximately 40.0% of the total; tests amount to 21.6% and medical visits, 19.9% (Graph 8).

Healthcare Expenses

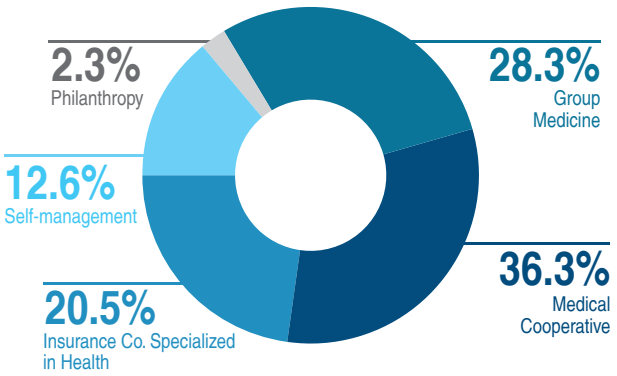
(by modality – 2011)

Table 4

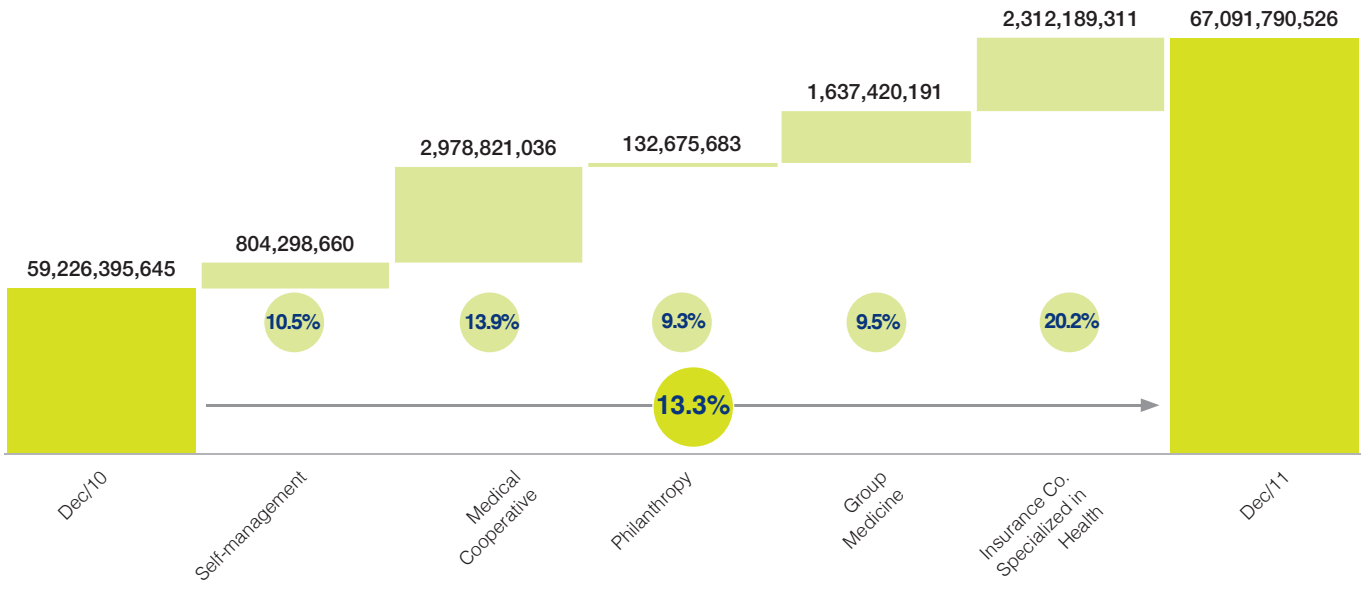
Modality	Revenues	%
Medical Cooperative	24,368,042,883	36.3%
Group Medicine	18,953,844,000	28.3%
Insurance Co. Specialized in Health	13,765,629,214	20.5%
Self-management	8,442,709,133	12.6%
Philanthropy	1,561,565,296	2.3%
TOTAL	67,091,790,526	100%

Source: National Supplementary Health Agency (ANS).

Graph 5

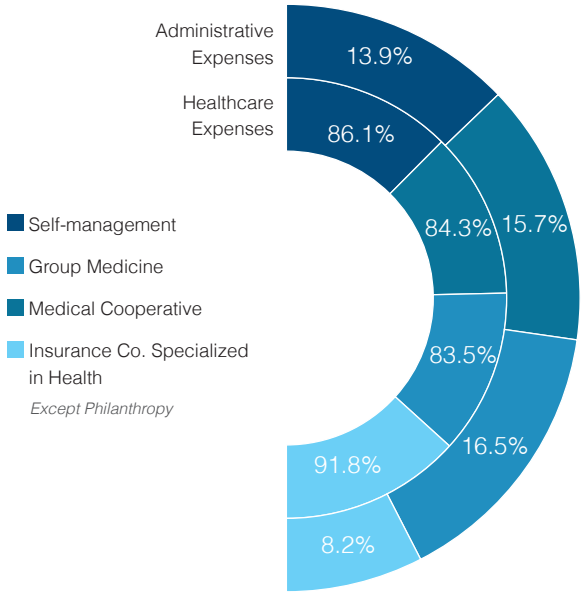


Graph 6



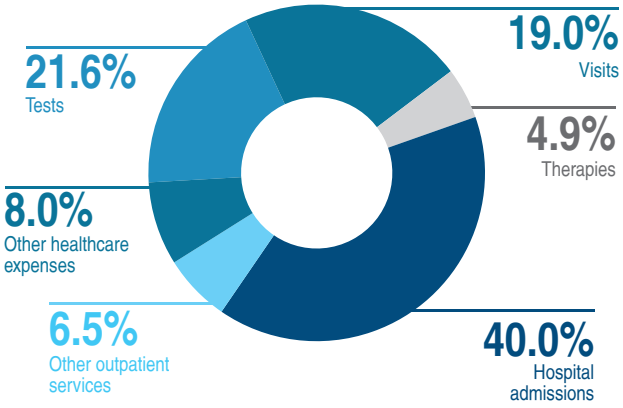
Source: National Supplementary Health Agency (ANS).

Graph 7 – Expenses by Type*
(share of total in %)



Source: National Supplementary Health Agency (ANS).

Graph 8 – Distribution of Medical-Hospital Expenses



Source: National Supplementary Health Agency (ANS).

Coverage

The coverage rate of private healthcare plans in Brazil was 25% in 2011, an increase of 1% in relation to 2010. In the Southeast, the percentage coverage is the highest in comparison with all other regions in the country, amounting to 38.3%. The coverage rate reaches 58.8% in the capital cities f this region, whereas it reaches 31.3% in the countryside (Table 5).

The State of Sao Paulo shows the highest coverage rate in the country – about 44.8%. At the other end, the State of Acre has only 5.9% of healthcare coverage in the supplementary health system. Among the capital cities, Vitoria (ES) has the highest coverage rate, 75.5%, and Boa Vista (RR), the lowest rate, amounting to 9.3%.

Table 5 – Healthcare Coverage

	Region	Capital Cities	Metropolitan Regions of Capital Cities	Countryside
Brazil	**25.0%**	**44.0%**	**37.9%**	**19.0%**
North	10.8%	26.9%	23.2%	4.9%
Midwest	17.4%	27.3%	23.2%	11.5%
Northeast	11.5%	31.5%	25.5%	6.0%
Southeast	38.3%	58.8%	48.2%	31.3%
South	23.9%	51.1%	33.9%	19.9%

Source: National Supplementary Health Agency (ANS).

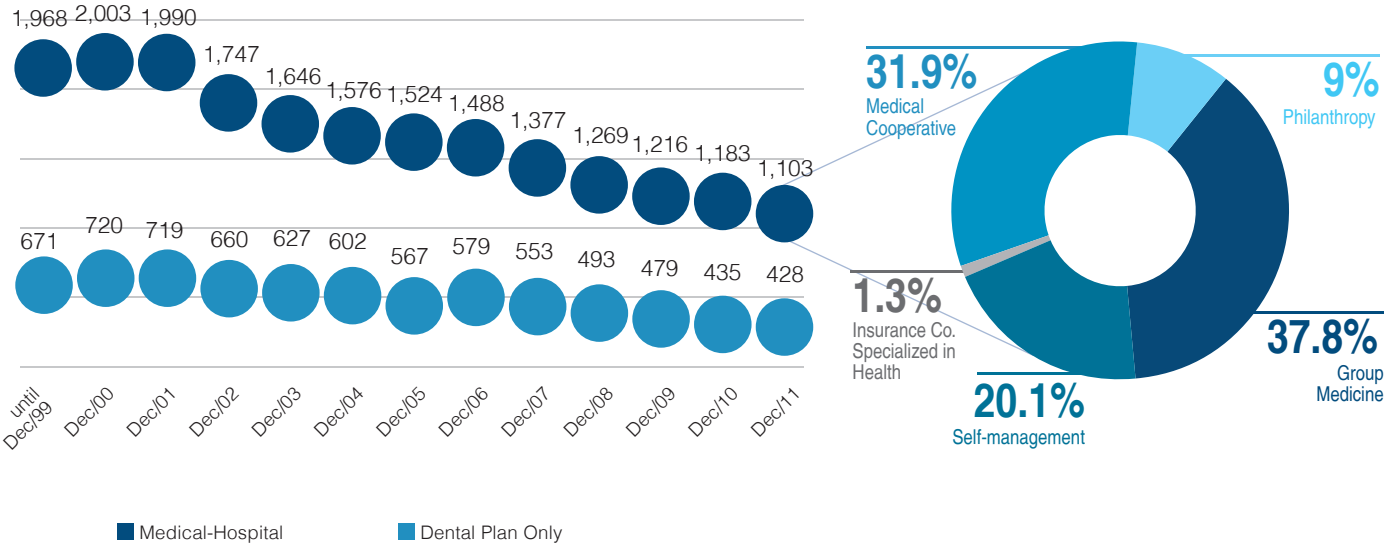
Operators

In December 2011, according to the National Supplementary Health Agency (ANS), there were 1,016 operators with beneficiaries in business in the country, distributed among the modalities Group Medicine, with 37.8% market share, followed by Medical cooperatives, 31.9%; Self-management, 20.1%; Philanthropy, 9% and Insurance Co. Specialized in Health, 1.3% (Graph 9). In relation to the third quarter of 2011, the number of operators with beneficiaries in business decreased 0.8%, in the fourth quarter, decreasing from 1,022 to 1,016.

In order to ensure growth and profitability of businesses, the large operators and hospitals have tried to expand their activities by means of mergers and acquisitions. Since the creation of ANS, almost two thirds of the healthcare operators have disappeared from the market.

In the supplementary healthcare market in Brazil, the regulatory concept requires increasing investment volumes and industry agents' financial stability. Concentration in the industry increases the negotiating power of the institutions, in addition to reducing the risk of insolvency, and in some cases allowing achievement of economies of scale.

Graph 9 – Operators
(by activity and modality)



Source: National Supplementary Health Agency (ANS).

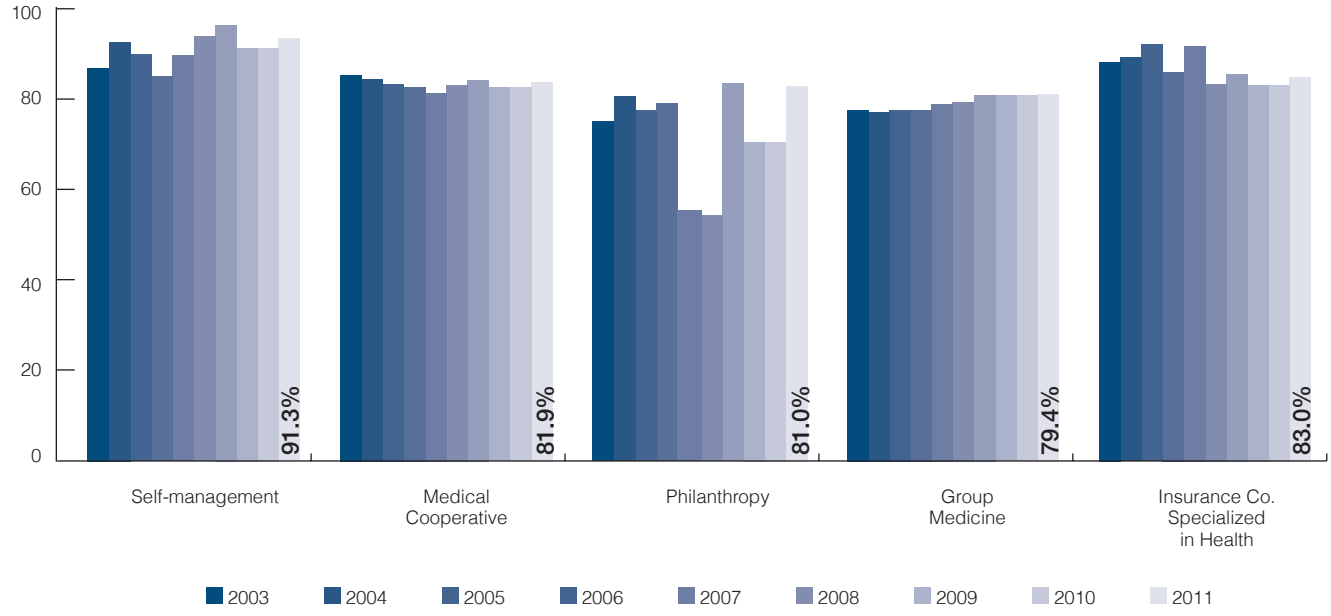
Claims

The claims rate among operators of private medical-hospital health plans increased by 1.4% in 2011, in comparison with the result of 2010. The highlight was the Philanthropy modality, which increased from 69% to 81%, or 12% increase. On the other hand, the Group Medicine modality has been successively increasing its rate, from 75.9% in 2003 to 79.4% in 2011.

In general, the claims rates of the companies that operate in the modalities Self-management and Insurance Co. Specialized in Health are more significant, showing the highest indices in recent years of respectively 91.3% and 83% (Graph 10).

Concerning the old debate about verticalization, the operators that are most verticalized show smaller claims rate, but experience higher administrative rate. In the end, what remains is the recurring debate about the advantages and disadvantages of verticalization.

Graph 10 – Claims
(by modality - %)



Source: National Supplementary Health Agency (ANS).

Economic-financial indicators

Beginning with this edition of Observatório, ANAHP will consolidate relevant information on the supplementary health industry concerning the economic-financial trends of private healthcare plans, through information made available by ANS in the publication "Prisma Econômico-Financeiro da Saúde Suplementar".

Our analysis will focus on the main economic-financial indicators which are extracted from the accounting records of the operators of health plans, setting a qualitative standard that will help analyze the operators' financial health. The data shown refer to the 3rd quarter of 2011 and was statistically adjusted to eliminate possible distortions and classified by modality (Medical Cooperative, Philanthropy, Group Medicine and Insurance Co. Specialized in Health). The analysis encompassed 715 operators, which concentrate 75% of all beneficiaries of private healthcare plans. We have decided to show treated data, excluding observed discrepancies (outliers) and non-aggregated data, so that all operators equally impact the final result of the indicator, irrespective of market share and relevance. Thus, the result of major operators does not distort general results by modality.

Current liquidity

The ratio between Current Assets (Short-term Receivables) and Current Liabilities (Short-term Liabilities) shows the institution's capability to meet its obligations in the short-term. The higher the result, the better, as it shows relative easiness in settling its obligations. If the ratio is equal to one, receivables and obligations match; if it is less than one it means that there would not be enough balance to settle obligations.

In the third quarter of 2011, all analyzed modalities showed favorable results and, on average, had current liquidity index higher than one. Insurance Co. Specialized in Health stood out in this indicator, showing a liquidity rate equal to 2.14, i.e., an increase by 32.1% in relation to the immediately prior quarter. Institutions in the Philanthropy modality showed a rate of 1.01, the lowest among all other modalities. In Group Medicine, the result was 1.17 and for Medical Cooperative, 1.50.

Total Indebtedness

The indebtedness index sets the proportion of total assets supplied by the institution's creditors. Ideally, this indicator should be low and efficiently managed, because the lesser the dependence on third parties to make a profit, the higher the institution's solvency.

According to the published results , the modalities Medical Cooperative and Group Medicine showed the best rates, both at 0.68 in the third quarter of 2011. For Philanthropy the result was 0.58, whereas the lowest index observed was for Insurance Co. Specialized in Health, at 0.48. It is important to emphasize the growing indebtedness level of modalities Philanthropy and Group Medicine, which have shown successive increases since the 4th quarter of 2010.

Return on Net Worth

Return on Net Worth is considered one of the main measures of a company's economic profitability, given that it strongly influences the decision making process of an investor when deciding whether or not to invest capital in a company rather than seek other alternatives of equal risk, and may be compared with the opportunity cost of investments with alternative profitability available in the market. Since it is a purely economic indicator, it does not consider issues related to quality and efficiency of services offered.

In the third quarter of 2011, all modalities showed positive returns, with emphasis to Medical Cooperative modality that achieved the best result, 0.04, remaining practically stable in relation to the previous quarter. Among all other modalities, as was observed in previous quarters, the lowest result was observed in Philanthropy, at 0.01.

Net profit margin

This indicator shows the relation between the net result and total revenues from service rendering. The net margin sets the percentage of each monetary unit from revenues left over after the deduction of all expenses and taxes. Among the modalities analyzed, historically the best performance was achieved by Insurance Co. Specialized in Health, whose result was equal or higher than all others, at 0.05 on average. In the third quarter of 2011, its net profit margin was 0.04, the result equivalent to the one in the Philanthropy modality, whose average in previous quarters was 0.02. In Medical Cooperative the result was 0.02 and in Group Medicine, 0.01.

Total assets turnover

This indicator represents the number of times the Total Assets figure was renewed by revenues from service rendering. In the 3rd quarter of 2011, the modality Group Medicine showed an index of 0.6, maintaining the historical average registered by quarter and the highest result among all other modalities. The modalities Group Medicine and Insurance Co. Specialized in Health showed similar results in the quarter and in the historical series reaching an average of 0.4. The lowest result was achieved in the Philanthropy modality of 0.1 on average.

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ANAHP hospitals consolidate their share in the country healthcare market

Number of installed beds increased 50% in five years.

Ten years have gone by since the creation of ANAHP and various positive changes have taken place in the private health system.

A little more than ten years ago the private health sector experienced a critical phase in our country. Players in the system were faced with increasing relational difficulties, which reflected the unstable environment in the industry at the time.

On account of said scenario, a group of private hospitals with similar problems and challenges facing the industry, met in May 2001 to share experiences and look for solutions. After several rounds of discussions, they reached a conclusion: to establish an entity to defend the interests and needs of the industry and expand the improvements attained by the private institutions beyond the frontiers of supplementary health, benefiting all Brazilians.

Ten years have gone by since the creation of National Association of Private Hospitals (ANAHP) and various positive changes have occurred in the private health system, such as, for example, the creation of the National Supplementary Health Agency (ANS), in order to better regulate and guide the market. In recent years, a major consolidation of the number of operators took place and the operators began to be systematically monitored. Access of users to information

was expanded, gaining in precision and efficiency, and this contributed to the Association's objectives. Another aspect deemed extremely important by ANAHP, which is also one of the criteria for membership in the institution – hospital accreditation – has also gained momentum in the market. Between 2010 and 2011, for example, the number of associated institutions that decided to apply for accreditation programs increased by 17.8%. Among health institutions in Brazil, there has been an increase of only 8.6% in the same period.

In the course of these ten years, ANAHP has undergone major transformations in its management model, increasing its representativeness in the market. In addition, in order to improve further its management model and encourage associated hospitals to follow this path, ANAHP subscribed to corporate governance in 2008. All such events were extremely important and contributed to the objectives of the Association and its associated hospitals, whose membership gradually increased from 23 organizations in 2001 to 45 in 2012.

Among ANAHP associated hospitals, 85% are deemed of high complexity. All have ICU beds and Emergency units, 51% perform some kind of organ transplant, 66% offer minimally invasive surgery, and 14% have already incorporated robotic surgery as an alternative to certain procedures. Offering such services requires constant investments in infrastructure, information technology and medical-hospital equipment with high level of technological sophistication. Another important issue concerns human resources processes, requiring appropriate qualification and specialization of hired staff, according to the institutions' needs.

Through hospital accreditation programs that require monitoring of healthcare processes, standards of excellence, continuous monitoring and assessment, the results achieved by the associated hospitals are comparable to the best hospitals in the world. Such evidence may be checked in the following pages and in the websites of several of the associated hospitals that routinely publish their results.

Beds

Beginning in the 1990's, there has been a progressive declining trend in the number of beds per one thousand inhabitants in Brazil. According to a survey by Assistência Médico-Sanitária – AMS, carried out in 2009 by the Brazilian Institute of Geography and Statistics (IBGE), between 1999 and 2009, the country lost more than 50,000 beds in hospitals. In this period, the number of beds in public hospitals increased by 6.9%, whereas in private hospitals it decreased by 18.4%. Regardless of such reduction, the number of beds in the private sector still represents 64.6% of the total available in the country. However, such reduction is concentrated on small and medium towns, particularly showing the closure of small private hospitals.

In the main metropolitan regions of the country (Salvador, Belo Horizonte, Rio de Janeiro, São Paulo and Porto Alegre) there was growth of 7.4% in the total number of available beds between 2005 and 2009. Beds in private hospitals increased by 6.4% and the public ones by 8.9% in the same period.

The development of the number of beds among ANAHP associates shows significant investments into expanding the offer and the qualification of services, with the objective of meeting the growing demand for high complexity specialized medical services in Brazil.

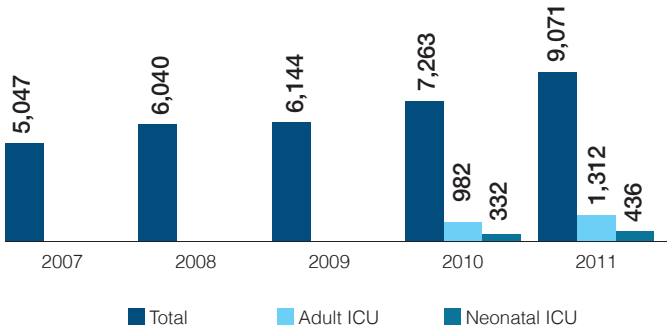
Since 2007, there has been continuous growth in the number of beds installed and in operation in ANAHP hospitals. The number of total beds increased by 79.7%, from 5,047 in 2007 to 9,071 in 2011. Of the total existing beds in 2011, 14.4% were intended for use in Adult ICUs and 4.8% for neonatal ICUs. Between the years 2010 and 2011, the number of ICU beds increased 33% in associated hospitals.

ANAHP Beds
(Absolute numbers)

Table 1

Beds	2007	2008	2009	2010	2011
Total	5,047	6,040	6,144	7,263	9,071
Adult ICU	NI	NI	NI	982	1,312
Neonatal ICU	NI	NI	NI	332	436

Graph 1



Source: SINHA/ANAHP 2011

Rooms

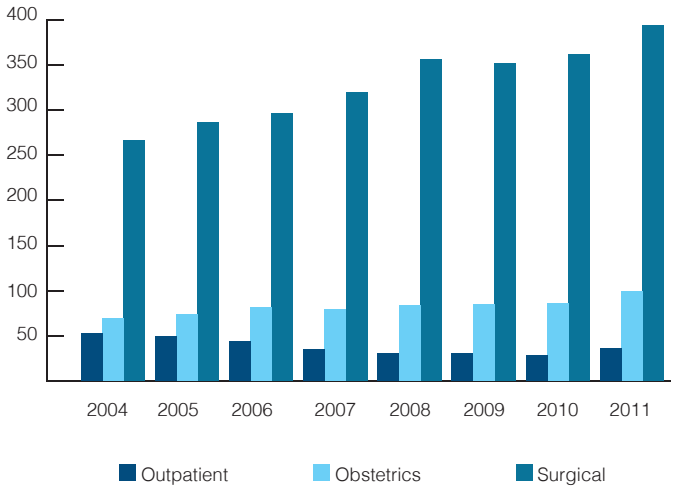
The number of surgery rooms and medical offices follows the growth trend observed in the number of hospital beds in recent years. The number of outpatient surgery rooms has decreased since 2005. Total surgical rooms grouped according to outpatient, obstetric and surgical rooms, increased by 36.1% between 2004 and 2011. Obstetric and surgical rooms increased, respectively, by 43.5% and 47.7%. Emergency medical offices and outpatient rooms have also showed positive results in recent years, with average growth of 2% per year and of 16.7% in 2011, in relation to 2004.

Rooms
(by type – absolute numbers)

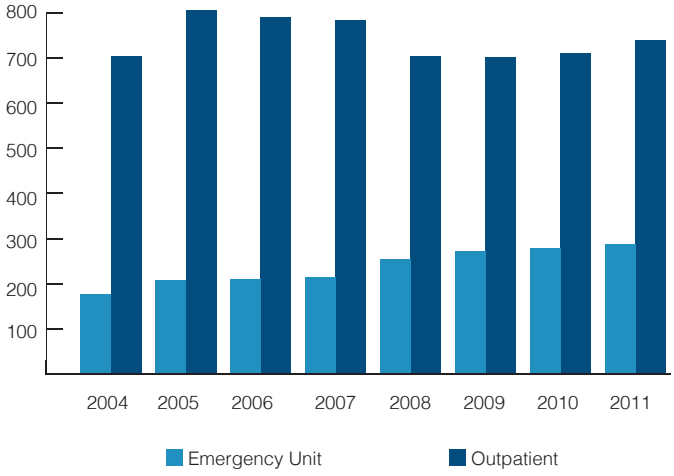
Table 2

	Beds	2004	2005	2006	2007	2008	2009	2010	2011
Surgical	Outpatient	53	49	44	35	30	30	28	36
	Obstetrics	69	74	82	79	83	85	86	99
	Surgical	266	286	295	319	355	351	361	393
Medical Office	Emergency Unit	169	199	202	205	243	260	268	275
	Outpatient	675	772	757	752	675	672	682	710

Graph 2



Graph 3



Source: SINHA/ANAHP 2011

Equipment

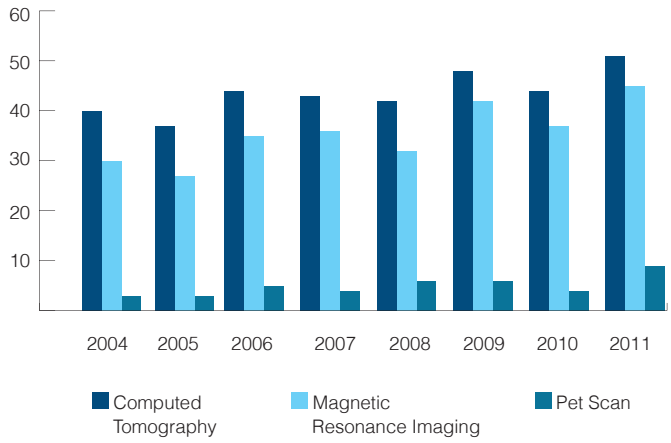
In recent years, investments in hospital and diagnostic equipment have significantly increased among associated hospitals, allowing more precision in test performance and the use of less invasive and more assertive treatments. The number of computed tomography scan, magnetic resonance imaging and Pet Scan equipment used in ANAHP hospitals increased by 43.8% between 2004 and 2011. It is important to emphasize that such devices are not available in all associated institutions, so their number may vary from one associate member to another.

Table 3

Equipment	2004	2005	2006	2007	2008	2009	2010	2011
Computerized Tomography Scan	40	37	44	43	42	48	44	51
Magnetic Resonance Imaging	30	27	35	36	32	42	37	45
PET SCAN	3	3	5	4	6	6	4	9

Equipment
(by type – absolute numbers)

Graph 4



Source: SINHA/ANAHP 2011.

Contracting of services

One of the essential issues concerning contracted services is related to the reduction of costs and improvement of organizational processes.

The need to attain economies of scale with suppliers has strengthened the contracting of outsourced suppliers for non-clinical activities. There is a priority to contract in-house teams for services in which quality and specialization are essential.

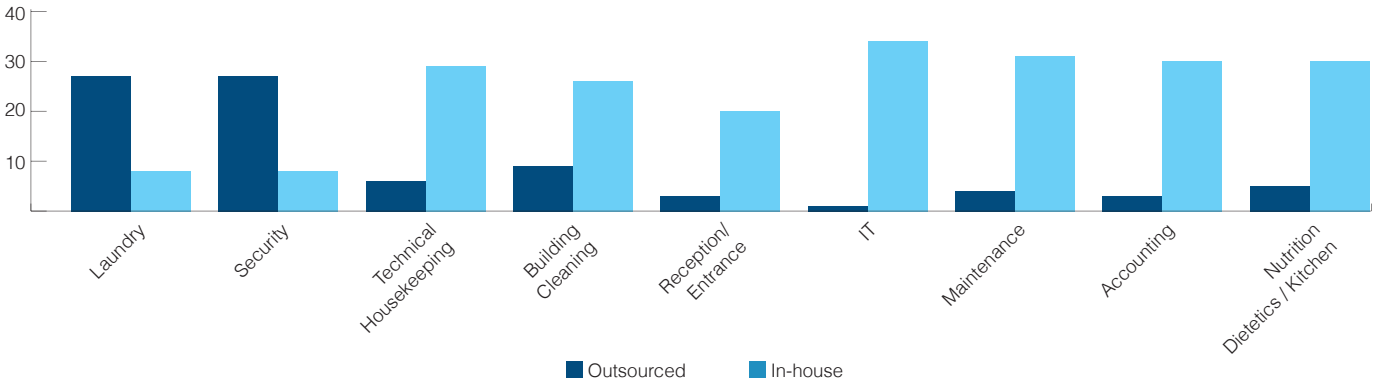
Therefore, there is a clear trend in hiring in-house professionals for services in which quality and specialization are essential. Less complex services, such as laundry and security, are outsourced by 77.1% of ANAHP hospitals.

Contracting
(by type – absolute numbers/2011)

Table 4

Services	Laundry	Security	Technical House-keeping	Building Cleaning	Reception/ Entrance	IT	Maintenance	Accounting	Nutrition Dietetics / Kitchen
Outsourced	27	27	6	9	3	1	4	3	5
In-House	8	8	29	26	30	34	31	30	30

Graph 5



Source: SINHA/ANAHP 2011..

Management Systems

The benefits provided to hospital management by IT are evident on a daily basis and prepares institutions for a market in which information technologies are essential to increase productivity and the quality of processes. Computerized management systems, among other factors, contribute to the reduction of resource waste, help reduce costs, and increase revenues and process efficiency throughout the hospital chain.

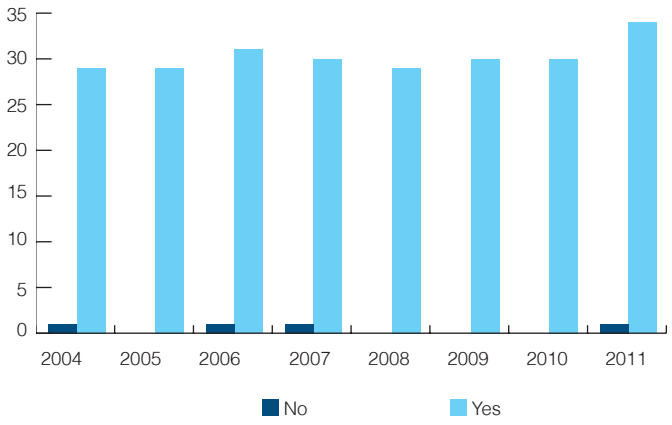
Aware of such benefits, associated hospitals converge towards this trend. With respect to financial management, 98.4% of the hospitals have computer-based systems. Hospital systems (from admission to invoicing) are in use by 100% of the hospitals, and the management systems for costs are used by 87.1% of the institutions. Computer-based systems in healthcare are increasing and electronic medical records are used by 47.8% of the associates.

Hospitals with Computerized Management System

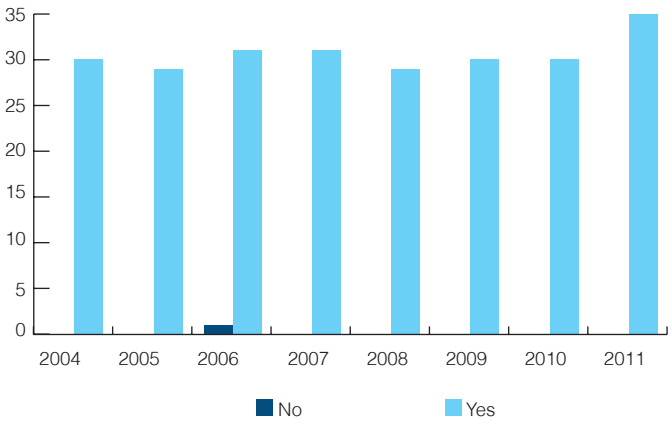
Table 5

	2004		2005		2006		2007		2008		2009		2010		2011	
	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes
Finance	1	29	0	29	1	31	1	30	0	29	0	30	0	30	1	34
Hospital (from admission to invoicing)	0	30	0	29	1	31	0	31	0	29	0	30	0	30	0	35
Electronic Medical Record	22	8	18	11	19	13	16	14	13	16	17	13	19	12	12	23
Costs	9	21	7	22	8	24	6	25	6	23	5	25	5	25	4	31

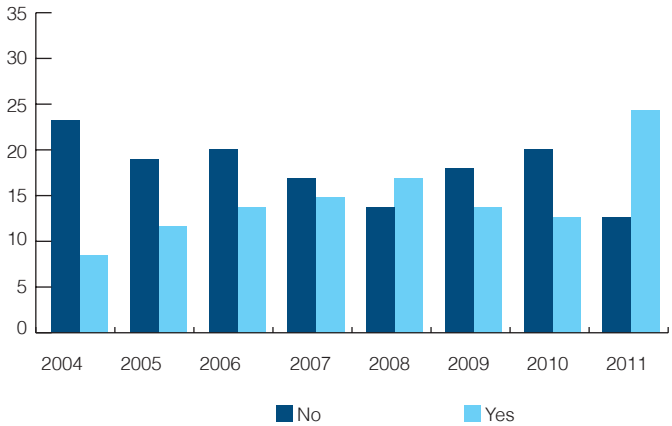
Graph 6 – Financial Department



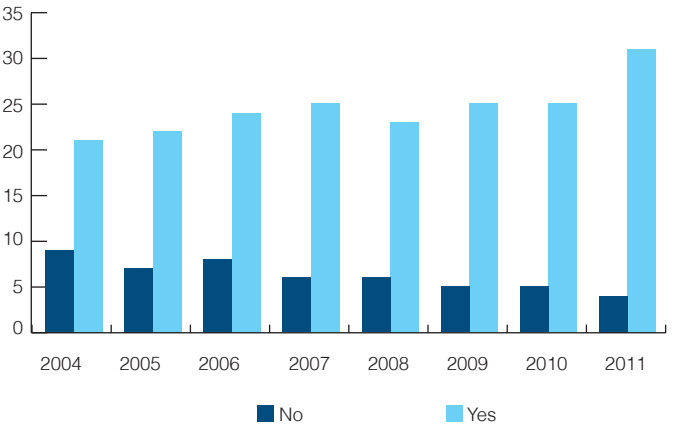
Graph 7 – Hospital Management
(admission to invoicing)



Graph 8 – Electronic Medical Record



Graph 9 – Cost Management



Source: SINHA/ANAHP 2011.

Accreditations

Professional management, and implementation of corporate governance models in the organizations have enabled the adoption of hospital accreditation models with high levels of excellence, such as the National Accreditation Organization and Joint Commission International. Of the associated hospitals, 23.3% hold more than two accreditations, evidencing that in those organizations there is solid institutional commitments for continuous improvement, with focus on quality and safety of patients and better performance of health professionals ANAHP hospitals hold more than 50% of the international accreditations granted to hospitals in Brazil and 21% of the national accreditations.

The contributions of ANAHP associates to hospitals services in the Brazilian health system have driven healthcare and managerial standards to a level comparable to reference hospital networks in the world.

Table 6 – Hospital Accreditation

Type of Accreditation	ANAHP	Brazil	% ANAHP
National Accreditation Organization - ONA	32	153	21%
Joint Commission International (JCI)	11	19	58%
Accreditation Canada	8	15	53%
National Integrated Accreditation for Healthcare Organizations - NIAHO	2	3	67%

*Some hospitals hold more than one accreditation

Source: ANAHP Study of associated hospitals, 2011; ONA at www.ona.org.br; Accreditation Canada at www.iqg.com.br; JCI at www.chacred.org.br; NIAHO at www.drv.com.br

Economic and Financial Analysis

Revenues of ANAHP hospitals sustained growth in 2011.

Revenues of ANAHP associated hospitals amount to approximately 14,1% of healthcare expenses of private health plan operators in the country.

Constant growth of the supplementary health industry in recent years has been strongly influenced by the country's economic development. Even in light of the reduction in the number of formal jobs created in 2011, we have observed the lowest unemployment rates since 2002, in synchronization with the increase in customary average income, positively contributing to the development of the supplementary health industry in Brazil. This growth of income directly reflected in the results obtained by hospitals of the National Association of Private Hospitals (ANAHP), as calculated by the Hospital Indicator System (SINHA).

In 2011, revenues of ANAHP hospitals maintained their growth pace as observed in the previous year, increasing from R$ 7.8 to R$ 9.4 billion, according to data published by SINHA. In 2011, 30 hospitals participated in the survey, down from 31 respondents in 2010.

The main origin of hospital revenues is practically the same throughout Brazil: private health plan operators account for about R$ 8.9 billion of those revenues, which amounts to 94.4% of the total. In comparison with 2010, there was 2.6% increase, a little higher than the results observed in previous years. This result reflects, in addition to other exogenous factors, the increasing number of beneficiaries of private health plans throughout the country.

The main source of revenues is accounted by the modality Insurance Co. Specialized in Health, with about R$ 3.4 billion, followed by Self-management with R$ 2.6 billion, Medical Cooperative with R$ 1.4 billion, and Group Medicine with R$ 1.3 billion. It is important to point out that historically the modality Insurance Co. Specialized in Health has shown the highest claims rates in comparison with all others. By the same token, it is important to observe that, notwithstanding the Medical Cooperatives having absolute predominance in terms of number of lives they represent, together with Group Medicine organizations, the lowest share in service provider revenues, due to the fact that they operate a significant network of own services.

Table 1 – Total Revenues

Year	Total Revenues (In R$ billion)	# of Hospitals
2006	4,923,800	33
2007	5,195,410	33
2008	5,979,304	34
2009	6,473,692	32
2010	7,826,826	31
2011	9,435.777	30

Please note that revenue development depends on sample size, which may vary on a yearly basis.

Source: SINHA/ANAHP 2011.

Revenues of ANAHP associated hospitals correspond to approximately 14.1% of healthcare expenses of private health plan operators in the country. According to the Information Book on Supplementary Health by the National Supplementary Health Agency' from 2011 such expenses reached the amount of R$ 66.8 billion.

Total revenues' distribution by region

Of the regions in Brazil, the Southeast shows the highest healthcare coverage rate of 38.3%. Considering the number of ANAHP associated hospitals in the region, this fact shows their higher share in the distribution of revenues and sales, even though there has been no significant variation in recent years.

Total revenues' distribution by type

Considering revenues distribution by type of ANAHP associated hospitals, it is important to emphasize the decreasing trend in the category Daily Rates and Fees, which has shown consecutive reductions since 2007. In 2011, the share of total revenues in this category decreased by 3.5%, corresponding to 24.5% of the revenues. The revenues resulting from hospital supplies increased 3% in comparison with the previous year, representing 51.5%. Diagnostics and Therapy Unit also increased their percentage share in relation to 2010, from 11.3% to 14.1% of revenues distribution. In the item Other Service Revenues there was 3.4% decrease between 2010 and 2011, from 8.9% to 5.5%.

Table 2 – Distribution of Total Revenues (by type)

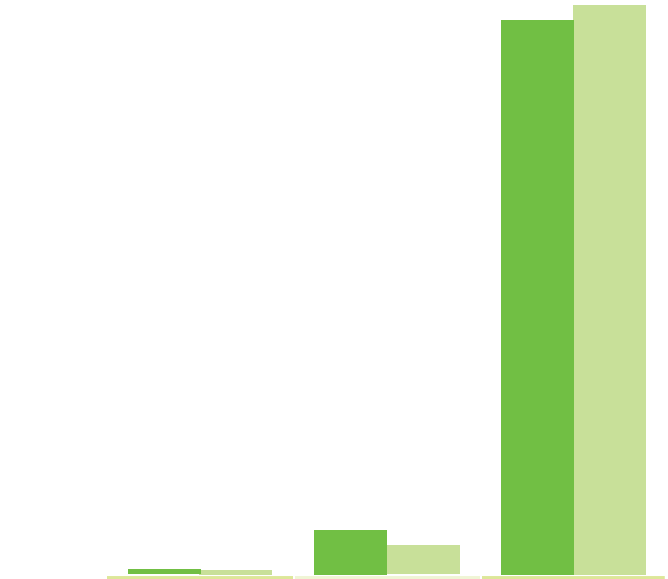
Type of Revenue	2006	2007	2008	2009	2010	2011
Daily Rates and Fees	31.7%	33.1%	30.3%	29.4%	28.0%	24.5%
Hospital Supplies	44.9%	46.4%	48.6%	50.9%	48.5%	51.5%
Diagnostic and Therapy Support	12.0%	11.1%	12.6%	11.6%	11.2%	14.1%
Others / Services	3.0%	2.9%	2.5%	3.2%	3.4%	4.5%
Others / Operational	8.5%	6.6%	6.0%	4.8%	8.9%	5.5%

Source: SINHA/ANAHP 2011.

Total revenues' distribution by source of payment

The total revenues distribution of ANAHP hospitals in 2011 showed similar results to those in previous years. Health plan operators represented 94.4% of total revenues in 2011 - 2.6% increase in comparison with the previous year and the best result since 2004. Revenues from services rendered to private patients decreased by 2.5%, showing the smallest share since the beginning of the series. In 2011, the result was 4.8%, compared with 7.3% in 2010. Revenues from healthcare provided to SUS (Universal Public Healthcare System) patients decreased by 0.1% in relation to 2010, representing 0.7% by source of payment.

Table 3 –Total Revenues' Distribution
(by revenue source)



	SUS	Private	Healthcare Plan
2010	0.8%	7.3%	91.9%
2011	0.7%	4.8%	94.4%

Source: SINHA/ANAHP 2011.

Progression of average prices in ANAHP hospitals

The indicators used by SINHA project to measure average prices practiced by associated hospitals are average net revenue per patient/day and average net revenue per discharge.

In 2011, growth of average net revenue per patient/day was 13.9%, slightly higher than in previous years, in which average growth did not exceed 10%. Of the regions analyzed, the highest variation was in the Northeast, with a considerable increase in relation to the previous year.

The development of average net revenue per discharge also showed a positive result, with growth of 23.6% in 2011. Based on these indicators, the Northeast achieved the highest variation, about 47% in comparison with 2010.

Distribution of expenses in ANAHP hospitals

The distribution of expenses in ANAHP hospitals remained practically stable in 2011. The highest variation was observed in personnel costs, which increased 1.6% and currently represents 40% of associated hospitals' expenses. Expenses with hospital supplies were reduced by 1.7%, corresponding to 27.6% of the total.

Days of sales outstanding and rejection rate

The days of sales outstanding (DSO) of ANAHP associated hospitals increased by 4.3%, from 70 days in 2010 to 73 days in 2011. This is very long term, considering the lag between the rendering of services and receipt of payment, resulting in difficulty in funding and adversely affecting short-term liquidity, in view of the objective of practicing an efficient financial management model.

In the South, similarly to previous years, the days of sales outstanding rate was the longest in comparison to other regions: about 97 days in 2011. On the other hand, in the Northeastern region, DSO did not exceed 71 days. Unlike the situation in the hospitals, in private health plan operators, the DSO relative to services rendered is considerably lower: on average, 16 days, according to ANS data published in its publication Prisma Econômico-Financeiro da Saúde Suplementar.

In the modality Insurance Co. Specialized in Health, the average DSO was seven days, the shortest among all modalities. The longest term was observed in the modality Medical Cooperative: on average, 23 days. The days of sales outstanding for events also stood out: on average, 26 days among all existing modalities, with no significant variations among them.

Such dissatisfactory situation shall attract the attention of Service Providers in order to increase their efficiency in billing processes and to increase payment terms agreed upon with suppliers.

The rejection rate is also an important factor in hospitals' financial cost, with 0.9% increase in relation to the previous year, going from 2.6% to 3.5% in 2011, with no significant variation in relation to previous years. Historically, the Midwest region has always shown the highest rejection rate: on average 5.2%. However, in 2011, this rate showed 1.9% reduction, decreasing from 4.5% in 2010 to 2.6%. The Southeastern region, in turn, has achieved higher results in recent years, increasing from 2.5% in 2010 to 4.0% in 2011.

Table 4 – Total Revenues' Distribution
(by source of payment)

Health Plan Operator	2006	2007	2008	2009	2010	2011
Insurance Co.	46.3%	46.7%	46.0%	44.7%	52.6%	38.5%
Self-management	25.4%	23.1%	21.4%	25.3%	21.2%	29.9%
Group Medicine	17.6%	20.7%	20.2%	18.5%	15.1%	15.5%
Medical Cooperative	10.8%	9.4%	12.5%	11.5%	11.1%	16.1%

Source: SINHA/ANAHP 2011.

Table 5 – Progression of average net revenues
(per patient/day)

Geographic Region	2006	2007	2008	2009	2010	2011
Midwest	982	993	1,127	1,681	1,200	1,255
Northeast	2,234	2,056	2,118	2,476	2,600	2,971
South	1,453	1,546	1,600	1,768	1,801	1,700
Southeast	2,607	2,605	2,714	3,220	2,672	3,373
ANAHP	**2,304**	**2,141**	**2,118**	**2,488**	**2,510**	**2,858**

Source: SINHA/ANAHP 2011.

Table 6 – Progression of Average Net Revenue
(per discharge)

	2006	2007	2008	2009	2010	2011
ANAHP	**8,386**	**8,322**	**9,170**	**10,239**	**10,709**	**13,244**

Source: SINHA/ANAHP 2011.

Table 7 –Total Expenses' Distribution
(by type of expenses)

	2006	2007	2008	2009	2010	2011
Personnel Costs	37.1%	37.5%	36.8%	37.3%	38.3%	40.0%
Hospital Supplies	29.6%	30.5%	30.1%	30.9%	29.3%	27.6%
Other Supplies	4.3%	3.9%	3.6%	3.7%	3.8%	4.4%
Technical and Operational Contracts	7.6%	8.3%	8.3%	7.1%	7.8%	8.3%
Support and Logistics Contracts	3.5%	3.7%	4.2%	4.2%	4.8%	4.9%
Utilities	3.7%	3.3%	3.0%	2.7%	2.3%	2.2%
Maintenance and Technical Support	1.9%	2.2%	2.1%	2.1%	2.1%	1.9%
Depreciation	4.6%	4.7%	5.0%	5.1%	4.6%	4.9%
Other Expenses	7.7%	5.9%	6.8%	6.8%	6.9%	5.7%

Source: SINHA/ANAHP 2011.

Table 8 – Total Expenses' Distribution
(by geographic region and type of expense)

	MW	NE	S	SE	ANAHP
Personnel Costs	28.0%	39.6%	37.9%	39.5%	40.0%
Hospital Supplies	26.9%	30.8%	29.7%	30.4%	27.6%
Other Supplies	1.3%	4.2%	3.4%	3.2%	4.4%
Technical and Operational Contracts	8.8%	5.1%	8.9%	5.7%	8.3%
Support and Logistics Contracts	5.5%	2.4%	4.8%	4.0%	4.9%
Utilities	4.2%	2.8%	3.4%	2.1%	2.2%
Maintenance and Technical Support	2.1%	3.0%	2.8%	2.9%	1.9%
Depreciation	9.4%	3.9%	4.2%	5.3%	4.9%
Other Expenses	14.0%	8.2%	4.9%	6.9%	5.7%

Source: SINHA/ANAHP 2011.

Table 9 – Progression of Days of Sales Outstanding (by region)

Geographic Region	2006	2007	2008	2009	2010	2011
MW	45.1	67.8	66.6	67.9	72.2	68.4
NE	52.4	66.7	61.8	63.8	57.1	58.6
S	103.7	113.4	95.4	93.0	102.3	97.9
SE	67.0	65.3	67.4	69.3	85.8	95.9
ANAHP	**66.8**	**71.8**	**69.2**	**70.7**	**81.8**	**72.4**

Source: SINHA/ANAHP 2011.

Table 10 – Progression of Rejection Rate
(by region)

Geographic Region	2006	2007	2008	2009	2010	2011
MW	4.1%	5.8%	6.3%	5.5%	4.5%	2.6%
NE	3.2%	2.4%	1.3%	1.1%	1.6%	1.4%
S	7.8%	4.2%	5.6%	3.1%	2.8%	3.7%
SE	3.2%	3.2%	2.9%	2.7%	2.5%	3.5%
ANAHP	**3.9%**	**3.4%**	**3.3%**	**2.8%**	**2.6%**	**3.2%**

Source: SINHA/ANAHP 2011.

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Operational Analysis

ANAHP associated hospitals increase hospital services offering.

Among the causes for increase in demand is the change in patients' profile, which is more complex, and a larger hospital structure, resulting from the aging of the population.

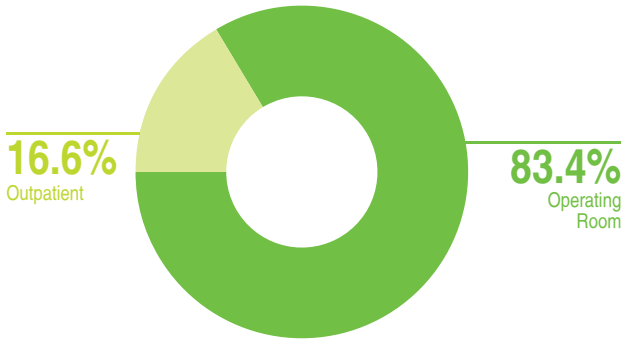
ANAHP hospitals, over the years, have been increasing the services offering in all their fields of activity, thus positively reacting to the heating up of the market.

Hospitals' growth may be observed in the development of the number of Total Available Beds. Said development occurred in practically all regions of the country, with most of the growth taking place in 2010 and 2011, in the Northeastern and Southern regions. Growth was observed mainly in the items Hospital Beds, which showed the same development pattern as Total Beds.

Growth in services offering can also be seen in the development of the item Operating Rooms, which increased at a rate similar to that of Hospital Beds. However, this change was accompanied by decrease in Outpatient Surgery Rooms (Table 1 – 2004 and 2011). These trends were observed in all regions.

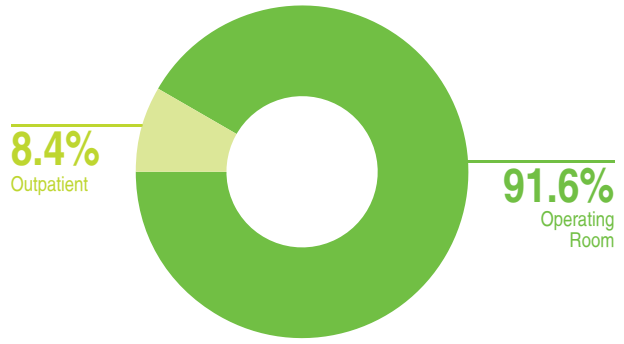
The increase in services offering also took place in the item Obstetric Center, but at a faster pace than that observed in the case of Operating Rooms, in all regions (Table 2). There is an unequivocal predominance in the realization of Cesarean sections, between 85% and 92%, in all regions of Brazil, which has been a constant trend for the last eight years in the Association.

Graph 1 - Operating Rooms
(by type – in 2004)



Source: SINHA/ANAHP 2011.

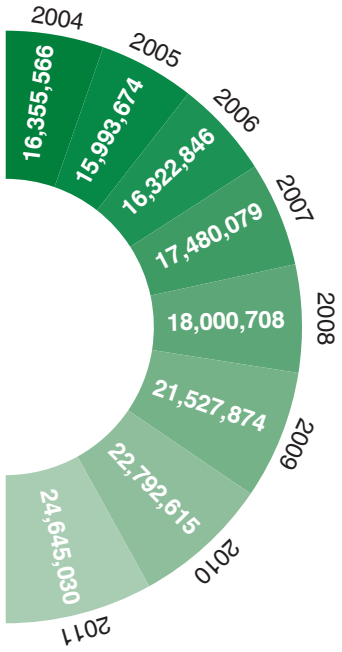
Graph 2 - Operating Room
(by type – in 2011)



Source: SINHA/ANAHP 2011.

Number of Total Performed Tests has also shown constant growth, which occurred in all regions (Table 7). In this aspect, the Southeast region stood out since it showed an increase in volume, as evidenced by growth in the number of tests performed per hospital/year, which increased from 506,889 to 775,804. One should also observe that two thirds of the performed tests are generated by internal demand.

Graph 3 – Total Performed Tests – Laboratory and Imaging



Source: SINHA/ANAHP 2011.

The number of Outpatient Medical Offices has decreased over the years (Table 3), contrarily to the number of Emergency Medical Offices, which has been increasing during the same period (Table 4), a trend observed in almost all regions.

Another observation concerning increased availability of services is the expansion of the item Equipment Existing in Hospitals (Table 5). The number of computed tomography scans and magnetic resonance imaging units increased considerably between 2010 and 2011. Between 2004 and 2011 the number of tomography units per hospital increased from 1.54 to 2.12, whereas the number of magnetic resonance imaging units per hospital increased from 1.30 to 1.96. Such growth in the offering of resources had an impact on the volume of services performed in ANAHP hospitals.

The Total Performed Surgeries, as well as surgeries specifically performed in operating rooms, have shown constant and positive variation over the years in all regions except the South (S) (Table 6).

One can observe that ANAHP hospitals are mainly surgical by nature and there has been no noteworthy variation in surgical admission rates in the last five years.

ICU Admission Rate was maintained stable between 2010 and 2011, having increased in the Northeastern (NE) and Midwestern (MW) regions during this same period; most of the growth occurred between 2005 and 2011 (Table 8).

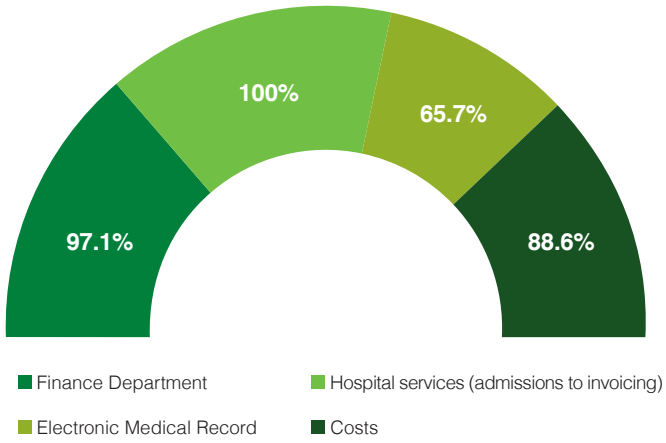
It is interesting to point out that in the South the ICU Admission Rate is significantly lower than ANAHP's average, at the same time it accounts for the highest occupancy rate among associated hospitals.

Hospital Admission through Emergency Department has been growing over the years in a constant manner (Table 9), with slight decrease in the Midwest (MW) and South (S). Further evidence of increased case complexity can be devised from increase in Average Length of Stay (Table 10) which, along with growth in the share of Emergency visits, confirms the trend of increasing number of patients who require more intensive care.

Based on the increase in hospitals' and ICUs' Occupancy Rate and Average Length of stay (LOS), as well as reduction in patient turnover, it seems that the profile of patients receiving care at ANAHP hospitals is more critical. Such increase in LOS is also observed for chronic and resident patients, increasingly more common at ANAHP hospitals.

Notwithstanding the increase in supply and in the capacity to meet the growing demand, the efficiency of operations in terms of level of resources utilization was not adversely affected. This is shown by the increase of Surgeries per Room, that grew by 12% in 2011 compared to 2010 (Table 12 - Median), except for the South region (S). Moreover, the Midwest (MW) should be highlighted for having experienced the best performance in the period 2007 to 2011. A similar fact occurred with the Number of Deliveries per Room (Table 13). Another indicator of improved efficiency was the reduction in Bed Turnover Interval (Table 14), which decreased in all regions in 2011. The Occupancy Rate also showed high degree of resource optimization, while maintaining the growth trend. This fact occurred more markedly in the Midwestern (MW) region in the period 2010 to 2011 (Table 15).

Graph 4 – Level of Computer-Based Management



Source: SINHA/ANAHP 2011.

The gain in efficiency and maintenance of quality rates may be the result of computer-based projects directed to Management, shown by the increased number of hospitals using electronic medical records, and the use of computerized cost and financial systems. It is also important to point out the increase in the number of Accredited Hospitals, showing that services are performed with enhanced safety and quality. Furthermore, we can see the use of methods aimed at improving flows, eliminating waste and providing additional value to patients, such as for example the use of Lean Six Sigma.

All such improvements have occurred without affecting healthcare quality, as shown by the indicators of Overall Mortality (Table 16), which was stable in all regions, and Hospital Infection Rate, which has constantly decreased, mainly in the Southern (S) region, which showed the main decrease in the period 2007 to 2011 apparently as a consequence of improved management of clinical processes and use of protocols and bundles.

It can be noticed that ANAHP hospitals are meeting higher demands for health services while not affecting operational efficiency and healthcare quality. Some potential reasons for the increased demand are the change in patients' profile, which has become more complex, and the need for larger hospital structure, resulting from the aging of the population.

Another driver of massive demand growth is the population's increased financial capacity, enabling the purchase of health plans and resulting from the current economic growth cycle, which has leveraged the total number of people formally hired.

The trend for the future is that such indicators will continue to grow, with increased demand for higher cost services, on account of healthcare high complexity. To present, ANAHP hospitals have proven to be equipped to face such challenge while still maintaining high quality healthcare services.

Table 1 – Variation in the Number of Operating Rooms (by type)

Outpatient	2004	2011	Variation 2011/2004
MW	3	6	100%
NE	9	7	-22.2%
S	4	1	-75.0%
SE	37	22	-40.5%
ANAHP	**53**	**36**	**-32.1%**

Operating Suite	2004	2011	Variation 2011/2004
MW	28	30	7.1%
NE	49	51	4.1%
S	43	56	30.2%
SE	146	256	75.3%
ANAHP	**266**	**393**	**47.7%**

Source: SINHA/ANAHP 2011.

Table 2 – Number of Obstetric Rooms

	2004	2005	2006	2007	2008	2009	2010	2011	Variation 2011/2004
MW	7	9	7	7	7	8	7	8	14.3%
NE	13	13	13	13	13	16	13	16	23.1%
S	11	11	10	10	11	11	11	15	36.4%
SE	38	41	51	49	52	50	55	60	57.9%
ANAHP	**69**	**74**	**81**	**79**	**83**	**85**	**86**	**99**	**43.5%**

Table 3 – Number of Outpatient Medical Offices

	2004	2005	2006	2007	2008	2009	2010	2011	Variation 2011/2004
MW	209	210	217	225	160	184	184	190	-9.1%
NE	126	125	125	143	127	127	127	130	3.2%
S	122	160	123	123	87	91	96	104	-14.8%
SE	218	277	292	261	301	270	275	286	31.2%
ANAHP	**675**	**772**	**757**	**752**	**675**	**672**	**682**	**710**	**5.2%**

Table 4 – Number of Emergency Offices

	2004	2005	2006	2007	2008	2009	2010	2011	Variation 2011/2004
MW	25	25	24	26	16	26	23	19	-24.0%
NE	13	15	15	17	17	17	20	22	69.2%
S	18	18	23	23	23	24	20	23	27.8%
SE	113	141	140	139	187	193	205	221	95.6%
ANAHP	**169**	**199**	**202**	**205**	**243**	**260**	**268**	**275**	**62.7%**

Source: SINHA/ANAHP 2011.

Table 5 – Main Medical Equipment

	2004	2005	2006	2007	2008	2009	2010	2011
	Total							
Computed Tomography Scan	40	37	44	43	42	48	44	51
Magnetic Resonance Imaging	30	27	35	36	32	42	37	45
Pet Scan	3	3	5	4	6	6	5	9

Source: SINHA/ANAHP 2011.

Table 6 – Total Number of Surgeries

	2005	2006	2007	2008	2009	2010	2011	Variation 2011/2005
MW	22,764	12,482	19,855	15,015	28,672	23,954	29,378	29.1%
NE	52,441	52,162	48,441	53,754	57,228	57,009	59,752	13.9%
S	111,565	85,387	71,828	83,117	82,627	NI	NI	NI
SE	223,258	238,097	268,224	329,151	294,201	315,658	406,777	82.2%
ANAHP	**410,028**	**388,128**	**408,348**	**481,037**	**462,728**	**445,146**	**537,856**	**31.2%**

Source: SINHA/ANAHP 2011.

Table 7 - Total Number of Tests

	2004	2005	2006	2007	2008	2009	2010	2011	Variation 2011/2004
MW	1,891,961	1,394,007	1,478,959	1,678,375	1,875,014	1,995,676	1,872.511	1,938,173	2.4%
NE	2,662,015	2,688,635	2,835,534	2,771,717	3,110,911	3,471,773	3,630,459	3,729,838	40.1%
S	2,162,021	2,280,140	2,358,884	2,359,219	965,643	2,556,220	1,886,009	2,757,022	27.5%
SE	9,639,569	9,630,892	9,649,469	10,670,768	12,049,140	13,504,205	15,403,636	16,219,997	68.3%
ANAHP	**16,355,566**	**15,993,674**	**16,322,846**	**17,480,079**	**18,000,708**	**21,527,874**	**22,792,615**	**24,645,030**	**50.7%**

Source: SINHA/ANAHP 2011.

Table 8 – ICU Admission Rate

		2005	2006	2007	2008	2009	2010	2011	Variation 2011/2005*
MW	Average	12.0%	9.8%	9.4%	12.3%	12.9%	24.5%	15.1%	3.1
	Median	8.8%	11.6%	9.1%	11.2%	12.2%	15.9%	15.5%	6.7
NE	Average	16.2%	17.8%	17.6%	15.5%	13.9%	14.2%	15.3%	-1.0
	Median	17.6%	19.4%	15.4%	14.9%	13.3%	13.8%	16.1%	-1.4
S	Average	8.5%	10.0%	8.1%	6.5%	6.8%	8.1%	8.3%	-0.3
	Median	9.7%	11.0%	7.6%	5.9%	5.9%	6.7%	6.3%	-3.4
SE	Average	10.5%	11.3%	12.9%	13.9%	15.5%	18.2%	16.8%	6.3
	Median	10.2%	8.0%	9.2%	9.7%	9.2%	9.7%	10.5%	0.4
ANAHP	**Average**	**11.3%**	**12.0%**	**12.6%**	**13.1%**	**14.0%**	**17.1%**	**15.4%**	**4.0**
	Median	**10.5%**	**11.6%**	**10.1%**	**9.8%**	**9.6%**	**9.8%**	**10.5%**	**0.0**

*In Percent

Source: SINHA/ANAHP 2011.

Table 9 – Hospital Admission Through Emergency

		2004	2005	2006	2007	2008	2009	2010	2011	Variation 2011/2004*
MW	Average	27.2%	24.3%	28.2%	31.8%	35.9%	32.0%	33.7%	29.0%	1.8
	Median	30.2%	23.4%	30.3%	32.5%	35.8%	29.7%	30.1%	25.6%	-4.6
NE	Average	40.2%	35.0%	37.3%	36.3%	34.7%	34.0%	38.4%	35.6%	-4.5
	Median	38.8%	37.6%	37.7%	33.1%	33.0%	32.5%	43.6%	38.5%	-0.3
S	Average	37.0%	24.2%	30.4%	32.1%	30.3%	32.4%	35.7%	29.6%	-7.4
	Median	24.4%	22.9%	28.0%	32.1%	31.0%	31.6%	34.5%	26.5%	2.2
SE	Average	31.5%	32.3%	34.6%	35.2%	36.0%	36.4%	36.1%	36.6%	5.1
	Median	30.7%	28.9%	30.7%	30.2%	34.7%	36.3%	39.1%	39.8%	9.0
ANAHP	**Average**	**33.2%**	**31.1%**	**33.8%**	**34.5%**	**35.1%**	**35.0%**	**36.1%**	**34.8%**	**1.6**
	Median	**30.2%**	**27.8%**	**31.2%**	**31.9%**	**32.8%**	**34.9%**	**36.5%**	**37.3%**	**7.1**

Source: SINHA/ANAHP 2011. *In Percent

Table 10 – Average Length Stay

		2004	2005	2006	2007	2008	2009	2010	2011	Variation 2011/2004
MW	Average	3.54	3.61	4.00	4.50	4.92	4.13	4.08	4.22	19.1%
	Median	3.42	3.58	3.86	4.25	4.85	4.11	4.12	4.32	26.3%
NE	Average	4.67	4.73	4.96	4.78	4.66	4.45	4.84	4.80	2.9%
	Median	5.06	4.12	4.58	4.50	4.32	4.18	5.14	4.78	-5.5%
S	Average	4.92	4.61	4.64	4.46	4.62	4.58	4.97	4.68	-5.0%
	Median	4.87	4.58	4.07	4.22	4.06	3.96	4.70	3.96	-18.7%
SE	Average	3.82	3.68	3.91	4.01	4.38	4.40	4.42	4.86	27.1%
	Median	3.70	3.79	4.11	4.12	4.28	4.36	4.37	4.62	24.8%
ANAHP	**Average**	**4.03**	**3.93**	**4.18**	**4.24**	**4.51**	**4.40**	**4.51**	**4.76**	**18.1%**
	Median	**3.79**	**3.77**	**4.15**	**4.26**	**4.28**	**4.18**	**4.32**	**4.54**	**20.0%**

Source: SINHA/ANAHP 2011.

Table 11 – Emergency Visits

		2004	2005	2006	2007	2008	2009	2010	2011	Variation 2011/2004*
MW	Average	61.0%	61.5%	63.5%	62.1%	64.1%	54.2%	70.4%	72.3%	11.2
	Median	61.0%	61.5%	63.5%	62.1%	64.1%	65.7%	72.6%	82.7%	21.7
NE	Average	49.4%	47.4%	53.1%	57.3%	66.8%	69.2%	95.1%	95.8%	46.4
	Median	49.4%	47.4%	53.1%	57.3%	66.8%	69.2%	100%	100%	50.6
S	Average	67.4%	69.9%	66.2%	53.4%	51.4%	49.6%	56.6%	57.7%	-9.7
	Median	74.4%	70.7%	66.8%	60.2%	58.2%	55.3%	54.6%	57.4%	-17.0
SE	Average	60.7%	62.7%	72.8%	68.7%	70.4%	67.1%	81.7%	79.2%	18.5
	Median	61.2%	56.9%	78.3%	68.8%	71.8%	66.6%	93.9%	79.5%	18.3
ANAHP	**Average**	**60.5%**	**63.0%**	**68.9%**	**63.6%**	**65.0%**	**60.4%**	**78.8%**	**77.9%**	**17.4**
	Median	**55.7%**	**59.7%**	**70.9%**	**63.8%**	**67.4%**	**66.9%**	**81.6%**	**84.0%**	**28.3**

*In Percent

Source: SINHA/ANAHP 2011.

Table 12 – Number of Surgeries
(by room)

		2007	2008	2009	2010	2011	Variation 2011/2007
MW	Average	531	506	741	729	936	76.3%
	Median	519	547	746	758	827	59.4%
NE	Average	637	742	720	572	620	-2.7%
	Median	632	726	610	566	638	1.0%
S	Average	1,252	1,403	1,415	1,796	1,594	27.3%
	Median	1,347	1,228	1,085	1,621	1,235	-8.3%
SE	Average	901	1,001	926	1,036	1,069	18.7%
	Median	893	1,044	957	1,017	1,099	23.0%
ANAHP	**Average**	**856**	**953**	**931**	**1,045**	**1,081**	**26.3%**
	Median	**784**	**897**	**896**	**893**	**1,000**	**27.5%**

Source: SINHA/ANAHP 2011.

Table 13 – Number of Deliveries
(by room)

		2006	2007	2008	2009	2010	2011	Variation 2011/2006
MW	Average	370	411	441	395	623	690	86.5%
	Median	370	411	519	394	623	690	86.5%
NE	Average	290	341	503	550	489	619	113.3%
	Median	286	374	463	441	459	633	121.5%
S	Average	511	562	409	469	517	599	17.2%
	Median	578	583	408	492	529	667	15.4%
SE	Average	590	609	590	610	731	671	13.6%
	Median	557	558	639	555	731	607	9.0%
ANAHP	**Average**	**496**	**529**	**523**	**545**	**624**	**648**	**30.6%**
	Median	**446**	**478**	**517**	**456**	**572**	**643**	**44.4%**

Source: SINHA/ANAHP 2011.

Table 14 – Bed Turnover Interval

		2004	2005	2006	2007	2008	2009	2010	2011	Variation 2011/2004
MW	Average	2.56	2.57	1.66	1.64	2.97	1.65	2.23	1.48	-42.2%
	Median	2.55	1.70	1.33	1.19	1.89	1.63	2.60	1.41	-44.6%
NE	Average	2.26	2.56	2.73	2.27	1.67	1.54	1.73	1.36	-39.7%
	Median	1.63	2.77	2.89	2.21	1.81	1.35	1.19	1.05	-35.5%
S	Average	1.02	1.59	2.51	1.93	2.04	1.73	2.10	2.05	101.3%
	Median	1.24	1.46	2.06	1.87	1.97	1.77	1.63	1.61	29.8%
SE	Average	1.16	1.41	1.29	1.34	1.64	1.25	1.49	1.49	28.5%
	Median	1.19	1.46	1.37	1.38	1.26	1.13	1.60	1.23	3.0%
ANAHP	**Average**	**1.47**	**1.71**	**1.72**	**1.61**	**1.84**	**1.40**	**1.67**	**1.53**	**4.0%**
	Median	**1.39**	**1.61**	**1.55**	**1.57**	**1.61**	**1.39**	**1.60**	**1.36**	**-2.1%**

Source: SINHA/ANAHP 2011.

Table 15 – Hospital Occupancy Rate

		2004	2005	2006	2007	2008	2009	2010	2011	Variation 2011/2004*
MW	Average	59.3%	59.8%	71.5%	74.8%	68.4%	73.8%	66.0%	76.4%	17.17
	Median	57.3%	66.7%	72.1%	79.3%	68.1%	74.4%	61.5%	76.3%	18.98
NE	Average	72.6%	70.2%	64.4%	69.1%	73.8%	74.4%	74.8%	78.3%	5.74
	Median	69.8%	62.6%	66.1%	67.1%	74.6%	74.8%	77.1%	80.8%	10.99
S	Average	82.0%	75.0%	64.5%	68.8%	68.4%	71.4%	69.8%	70.9%	-11.08
	Median	79.2%	69.9%	62.4%	68.9%	66.8%	68.3%	68.8%	71.1%	-8.06
SE	Average	76.9%	73.1%	75.8%	74.6%	70.5%	77.9%	76.0%	77.5%	0.61
	Median	71.3%	72.4%	76.3%	77.0%	75.4%	78.0%	74.6%	80.1%	8.81
ANAHP	**Average**	**74.6%**	**71.2%**	**71.9%**	**72.9%**	**70.6%**	**76.1%**	**74.1%**	**76.9%**	**2.27**
	Median	**69.8%**	**69.5%**	**71.9%**	**75.0%**	**73.7%**	**74.5%**	**73.3%**	**78.5%**	**8.66**

*In Percent

Source: SINHA/ANAHP 2011

Table 16 – Mortality Rate

		2004	2005	2006	2007	2008	2009	2010	2011	Variation 2011/2004*
MW	Average	2.7%	2.8%	2.7%	2.8%	2.6%	2.2%	3.1%	2.5%	-0.21
	Median	2.6%	2.7%	2.4%	2.5%	2.5%	2.2%	3.1%	2.2%	-0.41
NE	Average	2.5%	2.4%	2.6%	2.3%	1.9%	2.2%	2.4%	2.2%	-0.29
	Median	2.4%	2.5%	2.2%	2.2%	1.7%	1.6%	1.9%	1.7%	-0.66
S	Average	2.3%	2.1%	2.3%	2.2%	2.3%	2.0%	2.6%	2.6%	0.34
	Median	2.2%	2.0%	2.4%	2.2%	2.1%	1.9%	2.5%	2.8%	0.60
SE	Average	2.0%	1.9%	2.0%	2.0%	2.1%	8.9%	2.0%	2.2%	0.23
	Median	1.7%	1.7%	1.8%	1.9%	1.9%	2.1%	1.9%	2.1%	0.34
ANAHP	**Average**	**2.2%**	**2.1%**	**2.2%**	**2.1%**	**2.2%**	**6.4%**	**2.3%**	**2.3%**	**0.10**
	Median	**1.9%**	**1.9%**	**2.2%**	**2.1%**	**1.9%**	**1.9%**	**1.9%**	**2.1%**	**0.16**

*In Percent

Source: SINHA/ANAHP 2011.

People Management

Managers show more concern about human capital.

In 2011, there was a significant increase in the number of institutions interested in sharing data on people management.

Before we begin the analyses, it is important to understand the logic of the diagnosis process of the results in this Section. These are results-oriented indicators, depicting many variables, whose data are not available. Thus, since it is not possible to identify the variables that explain a certain result, the analysis consisted of showing some hypotheses and conditions that may impact these results. This was the way found to support managers in their critical analysis of data within the reality of each hospital.

An initial highlight is the increase in number of hospitals that submitted data on People Management, as shown in Table 1. This increase in participation may have been caused by:

» Increased concern by managers about Human Capital Management;

» Increased interest by hospitals in sharing and comparing data on People Management;

» Increased reliability of results and analyses of data on People Management. Furthermore, there are no doubts concerning data representativeness.

Tabela 1 – Number of Participating Hospitals
(by indicator)

Indicator	Participants in 2010	Participants in 2011	Variation
Staff	33	40	21.2%
Nursing Structure	28	34	21.4%
People Turnover	27	34	25.9%
Absenteeism	25	31	24.0%
Work-related Accidents	22	28	27.3%

Source: SINHA/ANAHP 2011.

Even though new hospitals became associates in 2011 and the average number of respondents for each indicator was 33 institutions, the set of 40 hospitals that informed about their staff totaled 81,219 employees, a figure 42% higher than the one informed in 2010.

The indicators shown below seek to cover the following objectives of Human Capital Management:

» Identify the profile of staff members: composition of staff according to qualification;

» Personnel productivity management: relation of nurses and nursing assistants/technicians per bed;

» Development: hours of training per staff member;

» Retention: personnel turnover;

» Staff member health status: absenteeism.

Profile of staff members

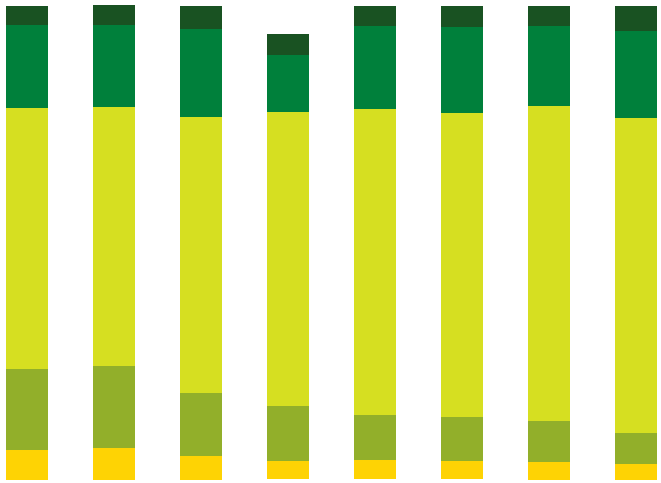
Data relative to education confirms the trend shown in the previous Observatório ANAHP concerning more professionalization of staff, evidenced by:

» Significant increase in the proportion of professionals with complete high school education, which increased from 56% in the triennium 2004/2006 to 65.7% in the triennium 2009/2011;

» Significant decrease in the proportion of staff with only complete elementary education, which started at 15.84% in the triennium 2004/2006 and decreased to 8.16%, on average, in the last triennium;

» Continuous growth in the proportion of graduate level staff, which increased from 4.31% in the triennium 2004-2006, to 4.75% in the triennium 2009/2011, having reached 5.40% in 2011.

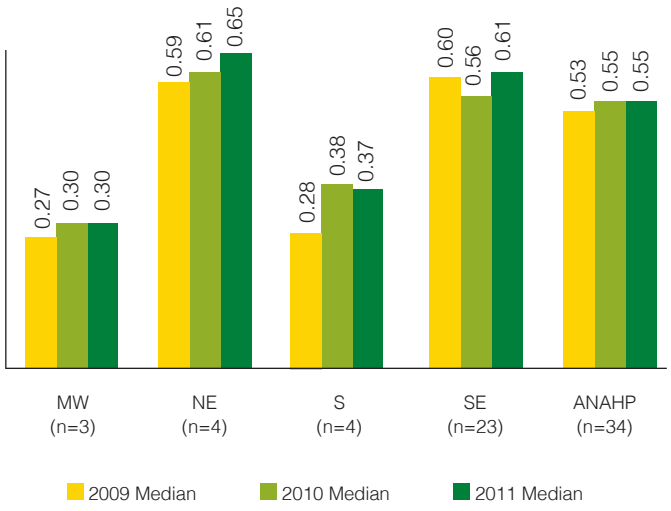
Graph 1 – Staff Members' Education Level



	2004 (n=19)	2005 (n=21)	2006 (n=21)	2007 (n=24)	2008 (n=24)	2009 (n=33)	2010 (n=31)	2011 (n=40)
Total Incomplete Elementary Education	6.23	6.60	4.90	3.79	4.01	3.80	3.65	3.27
Total Complete Elementary Education	16.94	17.25	13.32	11.77	9.60	9.45	8.65	6.40
Total Complete High School Education	55.12	54.71	58.15	62.05	64.54	64.05	66.53	66.70
Total Complete Higher Education	17.52	17.42	18.69	17.97	17.58	18.14	16.89	18.24
Total Complete Graduate Education	3.98	4.02	4.93	4.42	4.26	4.57	4.28	5.40

Source: SINHA/ANAHP 2011.

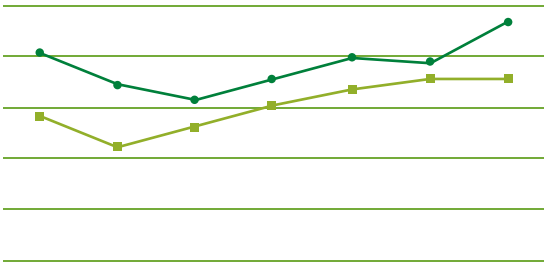
Graph 2 – Number of Nurses
(by beds and regions)



OBS. the sample (n) refers to 2011.

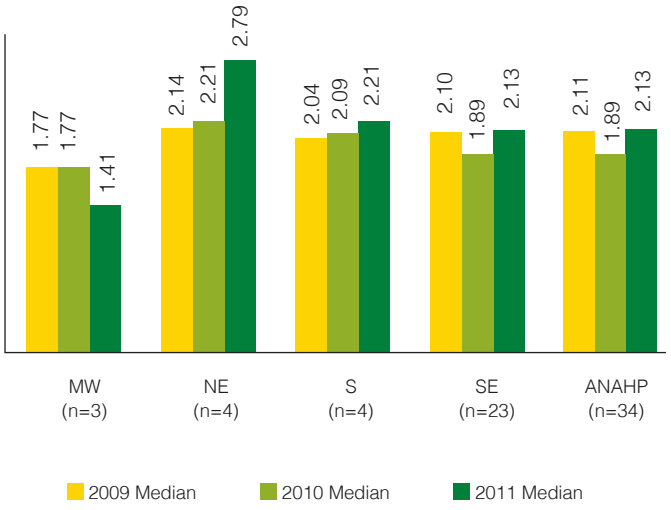
Source: SINHA/ANAHP 2011.

Graph 3 – Number of Nurses
(by beds and regions)



	2005 (n=32)	2006 (n=32)	2007 (n=31)	2008 (n=34)	2009 (n=35)	2010 (n=27)	2011 (n=34)
Average	0.60	0.54	0.51	0.55	0.59	0.58	0.66
Median	0.48	0.42	0.46	0.50	0.53	0.55	0.55

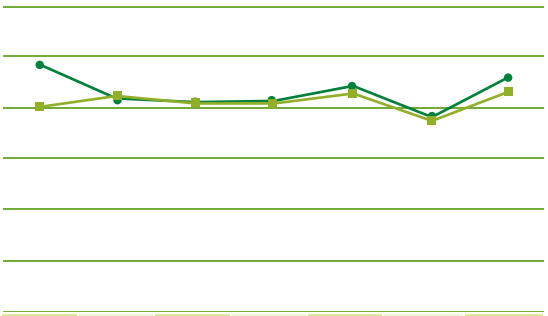
Graph 4 – Number of Nursing Assistants/Technicians
(by beds and regions)



OBS. the sample (n) refers to 2011.

Source: SINHA/ANAHP 2011.

Graph 5 – Number of Nursing Assistants/Technicians
(by beds)



	2005 (n=32)	2006 (n=32)	2007 (n=31)	2008 (n=34)	2009 (n=35)	2010 (n=27)	2011 (n=34)
Average	2.35	2.07	2.04	2.05	2.17	1.92	2.25
Median	2.00	2.09	2.03	2.03	2.11	1.89	2.13

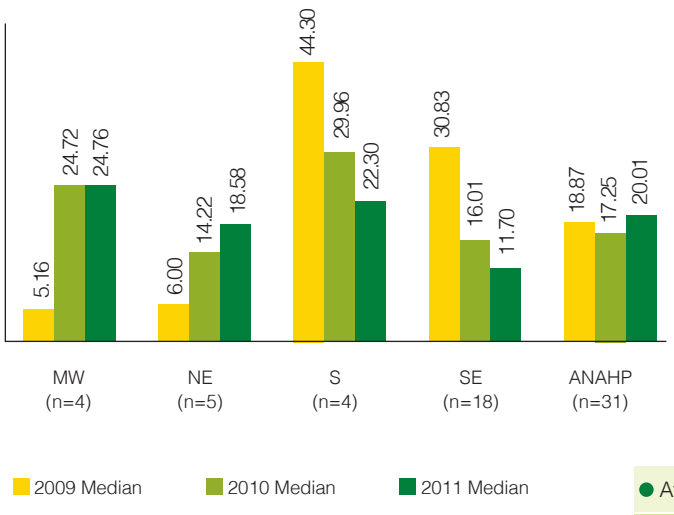
Productivity of personnel: nursing organization

In general, based on the data presented, it can be said that there has not been reduction in the number of registered nurses by operational beds. Except in the Southern region, which showed small reduction (second decimal point), all other regions showed higher or equal Nurses per Bed ratio between 2010 and 2011.

The historical analysis of consolidated data from all hospitals confirms this trend towards the increase in the number of nurses, at least after 2007.

This is not the case with nursing assistants/technicians, whose proportion has remained stable over the years, with small crease observed in 2011, from 1.89 to 2.13 professionals per bed.

Graph 6 – Hours of Training
(average per staff member – by region)



OBS. the sample (n) refers to 2011.

Source: SINHA/ANAHP 2011.

Graph 7 – Hours of Training
(average per staff member)

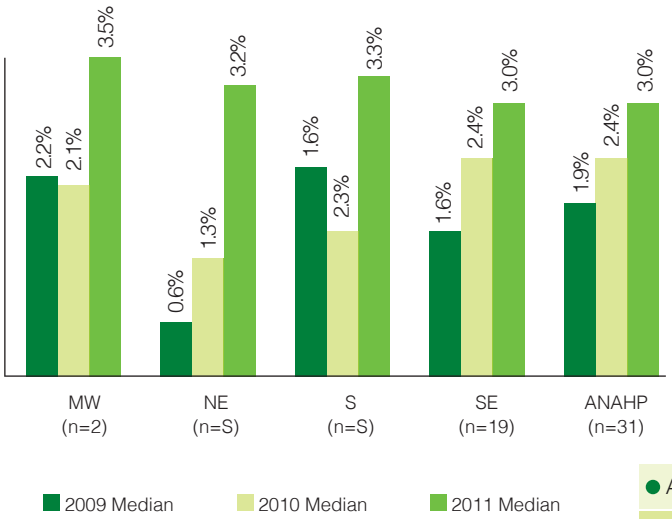
	2004 (n=29)	2005 (n=31)	2006 (n=31)	2007 (n=29)	2008 (n=34)	2009 (n=32)	2010 (n=30)	2011 (n=31)
Average	15.66	22.03	26.04	28.03	23.79	23.39	19.99	21.47
Median	14.00	18.76	27.38	26.43	22.79	18.87	17.25	20.01

Development: hours of training per staff member

The indicator Hours of Training per staff member enables comparison among all participating hospitals, given that it considers the number of staff members in its denominator. However, we believe it should be separated by region due to variations in how data are shown in each region. Regional data show three distinct patterns: growth trend in the Northeast, stability in hospitals of the Midwest, and a trend towards reduction in the South and Southeast. It is interesting to observe that the South, isolated leader in 2009, dropped to second with half the number of hours of the two years before, while the Southeast went from second in the ranking to last, showing almost a third of the figure for 2009. Both trends can be seen in the graph showing the historical development of the whole group of hospitals.

It is important to point out that the indicator measures the number of hours rather than quality or efficacy of qualification processes. Therefore, the reduction in number of hours is not necessarily bad, as for example, they might be using better pedagogical technologies or even alternative tools such as distance learning, which may actually produce better results from learning within shorter duration programs.

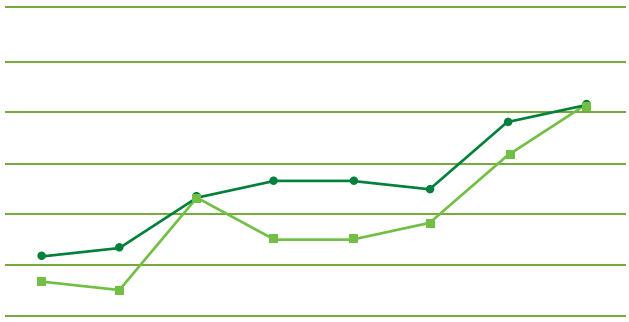
Graph 8 – Annual Absenteeism Rate (by region)



OBS. the sample (n) refers to 2011.

Source: SINHA/ANAHP 2011.

Graph 9 – Absenteeism Rate



	2004 (n=31)	2005 (n=30)	2006 (n=29)	2007 (n=28)	2008 (n=30)	2009 (n=33)	2010 (n=25)	2011 (n=31)
Average	1.2%	1.3%	1.9%	2.1%	2.1%	2.0%	2.8%	3.0%
Median	0.9%	0.8%	1.9%	1.4%	1.4%	1.5%	2.4%	3.0%

Staff members' health: absenteiism

The regional analysis shows that all regions exceeded 3% in absenteeism, meaning that more than 3% of the hired staff is not present. This is certainly reason for concern, mainly if we consider the historical trend of increase among the group of hospitals. Each hospital should try to find out to what extent this rate is related to real absences (justified or unjustified), delays, short or long off-duty periods (more than 15 days) and understand the reasons that may be contributing to more absences at work.

Some potential explanations are:

» Two jobs held by some of the healthcare staff members, bringing about excess of work and more susceptibility to diseases, absences or delays;

» Less commitment of staff members, mainly if the predominant factor is associated with a frequent pattern of absences and delays;

» Overload of work in the institutions and increase in stress, whether due to changes in processes, excessive workload or pressure for better results in healthcare quality, client satisfaction or financial performance.

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Healthcare Services Management

To encorage, disseminate and support the use of best practices in associated hospitals towards achieving excellence in health services.

In 2011, 91% of the associated hospitals sent information on the Best Healthcare Practices Project during the year.

The Best Healthcare Practices Project (Projeto Melhores Praticas Assistenciais - PMPA), implemented in 2003, has been consolidated as a unique basis of clinical indicators for the supplementary healthcare market and has disseminated good healthcare practices and supported the implementation of evidence-based clinical protocols at ANAHP associated hospitals.

The institutional protocols are reviewed each three years, incorporating scientific evidence of clinical guidelines published in national and international literature. Each associated hospital has its own clinical protocol, defining the established processes reviewed by local healthcare teams and including the sequence of services provided and operational routines in order to set the best critical pathway for the said services.

The main recommendations concerning the services standards (Door-to-Electrocardiogram Time; Door-to-Balloon Time; Aspirin at Discharge, among others) are uniform and the indicators have been standardized based on valid criteria set forth in Brazilian and foreign literature (reference). The selection of indicators for the group of hospitals takes into consideration the relevance of the profile on morbidity

and mortality, widely adopted recommendations (clinical guidelines), and the impact on healthcare outcomes from adopting such recommendations.

Beginning in 2007, a healthcare indicator monitoring system has been implemented, encompassing criteria such as performance, quality and safety, as well as those intended to monitor the results of selected clinical protocols.

The project gathers technical directors and representatives of technical healthcare teams every two months. The involvement and contribution of the associated hospitals' technical teams is key to differentiate and qualify work on the Best Healthcare Practices Project PMPA. The efficacy of this work model is proven by its results, given that each hospital is directly associated with achieving the best established practices. This type of involvement plays an essential role in building the monitoring system and implementing improvements resulting from such work.

Under the project, monthly indicators are collected and data are shared with associates on a quarterly basis, along with the definition of targets for the group of hospitals. The hospitals are also required to submit information on annual hospital discharges, which serve to audit monthly data and to complement the analysis of the hospitals' morbidity and mortality profile.

The information database comprises hospital discharges of each associated hospital. Based on such data we can define the clinical and epidemiological profile of the serviced demand, identifying trends related to patterns and the complexity of hospital admissions.

In 2012, we analyzed data on 37 hospitals among the 43 associates. About 85% of the volume comprises information on hospitals that had been submitting data yearly, validating some inferences on historical trends.

To support the analysis and enable comparisons, it is important to characterize the associated hospitals' organization. Most (84%) are large or very large organizations concerning installed available bed capacity. Based on the classification ranking established by the Ministry of Health Ordinance 2224 (Brazil, 2002), which sets healthcare complexity standards – type and number of beds in general; ICU beds; number of surgery rooms; attention to high risk pregnancies – 86% of the hospitals fall into category four (more complex healthcare structure), whereas the other 14% fall into category three. This means there are no low complexity hospitals among the associates. Hospitals with such structure should only be compared to hospitals of similar size (category three or four), given that, upon analyzing the results, we can see that the more complex the organization is, the greater its capacity to service patients with severe conditions and higher risk of complications.

All the hospitals have high volume Emergency Departments. In most cases, they are general hospitals intended for acute cases, but 26 of them have maternity wards. The contribution of mother-child care is relevant, since most of the hospitals cater to high risk pregnant women, being equipped with well organized and complex neonatal units, specialized in care provided to low birth weight newborn babies and those who have severe surgical pathologies.

The organization of Diagnostics and Therapy Services is robust. Hospitals are equipped with computed tomography scan (92%), magnetic resonance imaging (87%), catheter laboratory centers (85%), renal substitutive therapy (82%), chemotherapy (74%), and radiotherapy (36%). In 61% of the hospitals there are day-care units with daily service rate of 192,539 cases in 2011. About 50% of the hospitals have their own outpatient facilities, with service rate of approximately 1.2 million cases in 2011. The basis for such information is a questionnaire sent at the beginning of each year to update data on the overall organization, healthcare services information, classification, quality and safety, clinical staff organization, education and research, and also on philanthropic initiatives. This year, 39 hospitals filled out the questionnaire.

Healthcare Services Management – information from annual databases

In 2011, ANAHP had 43 associates and received databases on discharges from 37 hospitals. Such information is used to audit and consolidate information sent for the Best Healthcare Practices Project, showing strategic and detailed data on the clinical, epidemiological and commercial profile of the hospitals' demand, while also assisting in planning and defining initiatives and goals related to healthcare services management of each of the hospitals and the group as a whole.

In the first quarter of 2012, ANAHP membership increased to 45 service providers.

Over the years, the quality of information on the associated hospitals has improved, particularly concerning diagnoses. The proportion of absent information on associated hospitals registered in the system decreased from 9% in 2007 to 3% in 2011. However, the rate remained at 5% to 6% on non-specified diagnoses, included in the chapter Ill-Defined Symptoms and Affections. Based on this observation and the worsening observed in 2011 (6.5%) in comparison with 2010, a recommendation was made to all hospital managers to change this situation so that in 2012 the statistics may decrease. Another joint effort consists of expanding the documentation of secondary diagnoses. Access to such information helps us qualify the type of patient with co-morbidities, characterizing the mix of patients serviced at the hospitals. Investments in the qualification of personnel to work in Medical Registry Services, the exclusion of doctors from the process of codifying, and expanding the use of clinical data in management may radically change the outcomes. Thus, the organizations' clinical assets are maintained and enhanced patient safety is provided.

The main diagnoses causing hospital admission (except ill-defined affections), in decreasing order, were: Pregnancy, Childbirth and Puerperium, Neoplasm (cancer), Circulatory System Diseases, Genitourinary Diseases, Digestive Tract Diseases, other Factors (reasons for seeking help unrelated to diseases, such as specific procedures – adjustment or removal of orthoses or prostheses, chemotherapy and normal newborn babies), Respiratory System Diseases, Injuries and Poisoning (fractures and injuries resulting from accidents and

external causes), Musculosketal System Diseases, Perinatal Diseases and Infectious Diseases. The group represented 85% of the serviced demand (Graph 1 / Table 1).

For the five main diagnostic groups, there has been considerable growth between 2010 and 2011. Pregnancies and Genitourinary Diseases increased 16%; Neoplasm (Cancer) 15%; Circulatory Diseases 14%, and Digestive Tract Diseases 9%. Such variations require more specialized care for patients with more severe conditions.

Table 1 – Annual Distribution of Hospital Discharges According to Main Diagnosis
(ranked by IDC chapter)

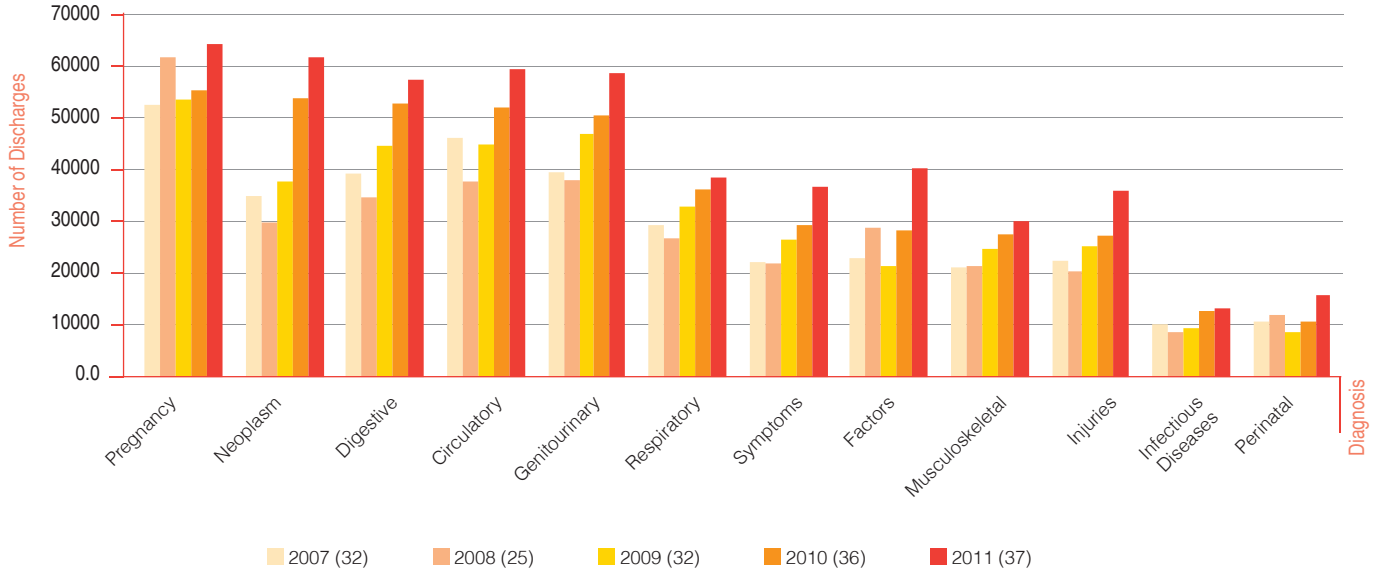
IDC Chapter	Year										
	2007 (32)		2008 (25)		2009 (32)		2010 (36)		2011 (37)		Variation 11/10
	Total	%	Total	%	Total	%	Total	%	Total	%	
Pregnancy	51,983	12.4	61,023	16.6	53,125	12.1	54,771	11.1	63,712	11.3	16,3
Neoplasm	34,718	8.3	29,648	8.1	37,361	8.5	53,256	10.8	61,071	10.8	14,7
Digestive	38,959	9.3	34,317	9.3	44,317	10.1	52,336	10.6	56,778	10.1	8,5
Circulatory	45,644	10.9	37,402	10.2	44,525	10.2	51,534	10.4	58,853	10.4	14,2
Genitourinary	39,122	9.3	37,673	10.2	46,561	10.6	49,989	10.1	58,043	10.3	16,1
Respiratory	28,945	6.9	26,440	7.2	32,687	7.5	35.803	7.2	38,112	6.7	6,4
Symptoms	22,080	5.3	21,713	5.9	26,240	6.0	29,155	5.9	36,442	6.5	25,0
Factors	22,809	5.4	28,461	7.7	21,261	4.9	28,073	5.7	39,960	7.1	42,3
Musculoskeletal	20,884	5.0	21,299	5.8	24,450	5.6	27,315	5.5	29,910	5.3	9,5
Injuries	22,212	5.3	20,226	5.5	25,121	5.7	27,125	5.5	35,612	6.3	31,3
Infectious Diseases	10,081	2.4	8,607	2.3	9,471	2.2	12,627	2.6	13,141	2.3	4,1
Perinatal	10,567	2.5	11,948	3.3	8,549	2.0	10,676	2.2	15,815	2.8	48,1
Endocrine	8.339	2.0	6,656	1.8	8,264	1.9	10,470	2.1	12,011	2.1	14,7
Nervous System	8,663	2.1	6,815	1.9	8,373	1.9	9,909	2.0	10,460	1.9	5,6
Skin	4,548	1.1	4,055	1.1	4,766	1.1	5,109	1.0	6,327	1.1	23,8
Congenital	3,137	0.7	2,943	0.8	3,458	0.8	3,907	0.8	4,185	0.7	7,1
Eyes and Eye-related	3,656	0.9	2,978	0.8	2,943	0.7	2,689	0.5	3,490	0.6	29,8
Blood	2,004	0.5	1,812	0.5	2,005	0.5	2,217	0.4	2,299	0.4	3,7
Hearing	1,704	0.4	1,471	0.4	1,665	0.4	2,096	0.4	2,147	0.4	2,4
Mental	1,282	0.3	1,003	0.3	1,145	0.3	1,307	0.3	1,431	0.3	9,5
No information	38,806	9.2	1,086	0.3	31,189	7.1	24,380	4.9	15,108	2.7	-38,0
Total	420,143	100.0	367,576	100.0	437,476	100.0	494,744	100.0	564,907	100.0	14,2

OBS: Numbers in parentheses represent the number of hospitals that submitted databases.

Source: "PMPA"/ANAHP, 2011.

One can observe the growth in demand by 14% between 2010 and 2011. However, such increase did not result from including information on new associates. Most of the hospitals (70%) expanded between 2010 and 2011, with healthcare service variations amounting to 2% to 25%, with expansion median at 6.5%.

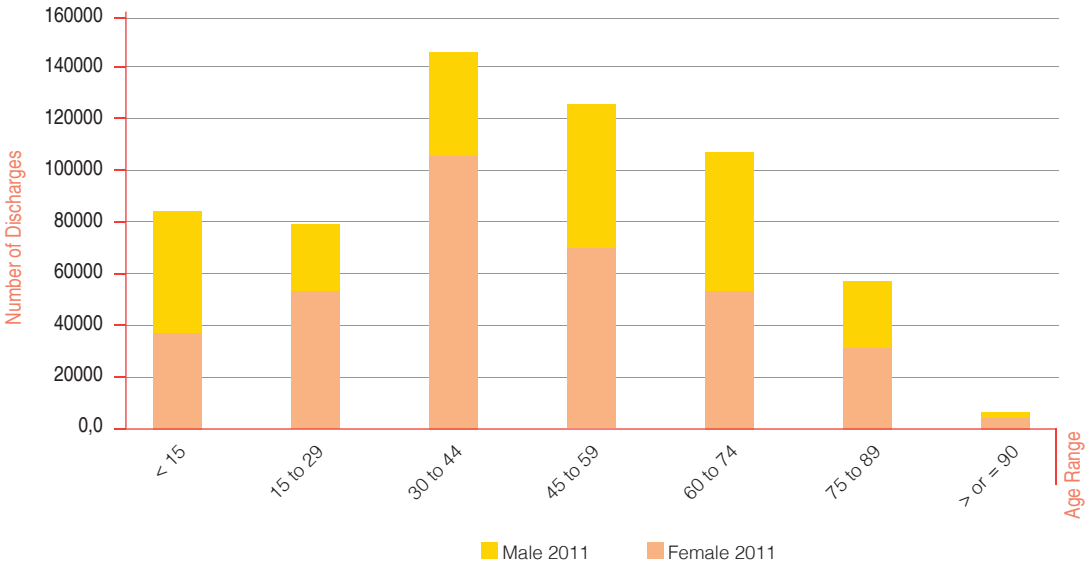
Graph 1 – Annual Distribution of Hospital Discharges According to Main Diagnoses
(IDC chapter – 10th review)



Source: "PMPA"/ANAHP, 2011.

It is interesting to analyze maternity ward trends in the hospitals when looking at hospital admissions included in the chapter Pregnancy, Childbirth and Puerperium, together with the chapter on Perinatal Diseases. The category Factors is interesting because it includes normal newborn babies and other procedures. Some hospitals have information systems on healthcare with separate registry entries for mothers and babies. Since some of the hospitals have changed their information management platform (main software) in the last two years, this may have contributed to the increase in the proportion of children under one year of age in the series, meaning that the analysis could have been misleading.

Graph 2 – Distribution of Hospital Discharges According to Gender and Age Range



Source: PMPA/ANAHP 2011.

As we can observe in Graph 2, in 2011, the age range 30 to 44 years was the most frequently treated group by associated hospitals, followed by age ranges 45 to 59 and 60 to 74 years. Considering gender, the predominance was of females in reproductive age (15 to 44 years), 45 to 59 years, and in the range 60 to 74 years. In children under age 15 and in the age group 60 to 74 years, there was predominance of male gender patients.

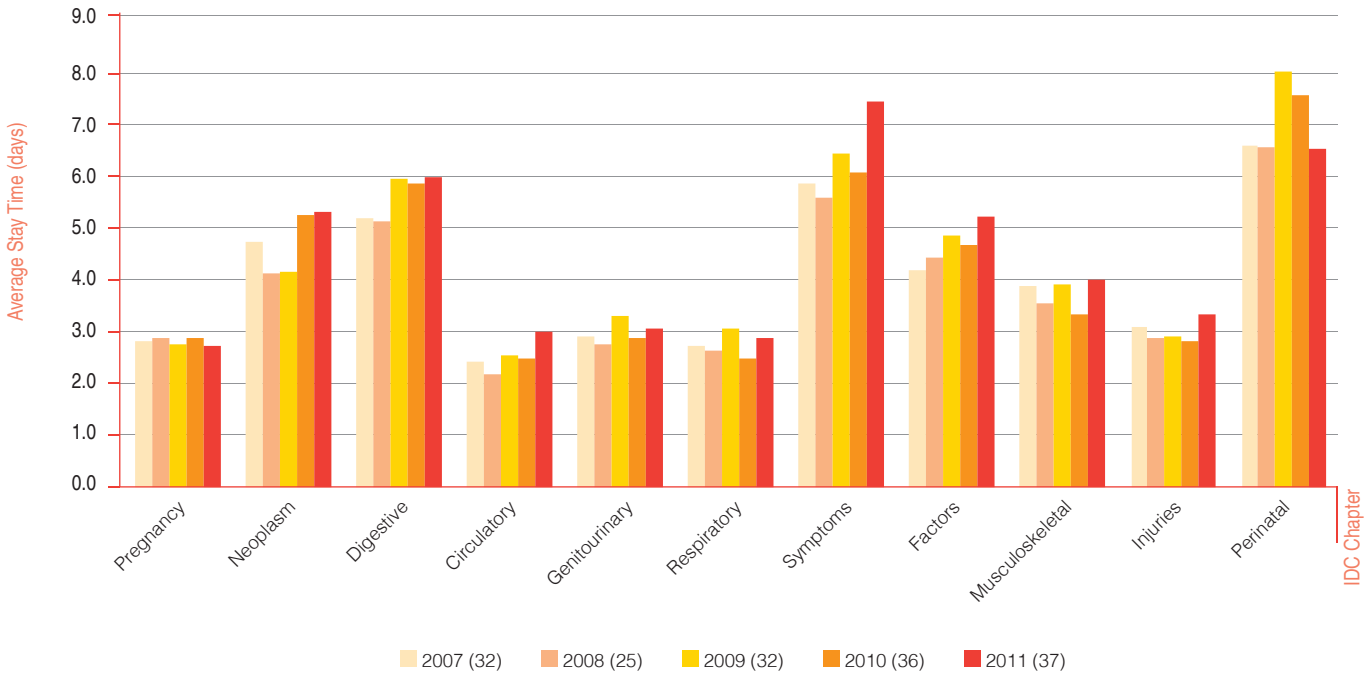
In the historical series, there has been variable increase in demand in all age ranges. Between 2010 and 2011, the number of cases serviced at age 15 and under increased by 19%; in the group 60 to 74, it varied at about 16%; and for people over 74 years of age, the increase was by 14% (Graph 3). The aging of the treated population means high impact on length of stay and on pressure for backup beds.

Graph 3 – Annual Distribution of Hospital Discharges According to Age Range

Source: PMPA/ANAHP 2011.

In Graph 4 we can observe the Average Length of stay (in days), according to the main diagnosis (ICD chapter, 10th review) concerning the last five years of the series.
The Average Length of stay increased from 4.2 days in 2010 to 4.5 days in 2011, whereas the Length of stay for Pregnancy and Perinatal diseases decreased, showing 2.8 days in 2011 for the entire hospital group. The Length of stay increased for Genitourinary, Respiratory, Musculoskeletal Diseases and Injuries.
Upon analyzing the impact of Overall Length of stay in the hospital, particularly of the population above 45 years, Respiratory and Circulatory Systems Diseases show the highest share. Healthcare management based on well-designed institutional clinical protocols plays a determinant role in improving bed management to ensure better healthcare outcomes. The higher the Length of stay is, the lower the bed turnover and the higher the cost of the health system will be. Thus, investing in time management as suggested by the best scientific evidence is one of the most effective strategies to expand hospitals' operational capacity without opening new beds.

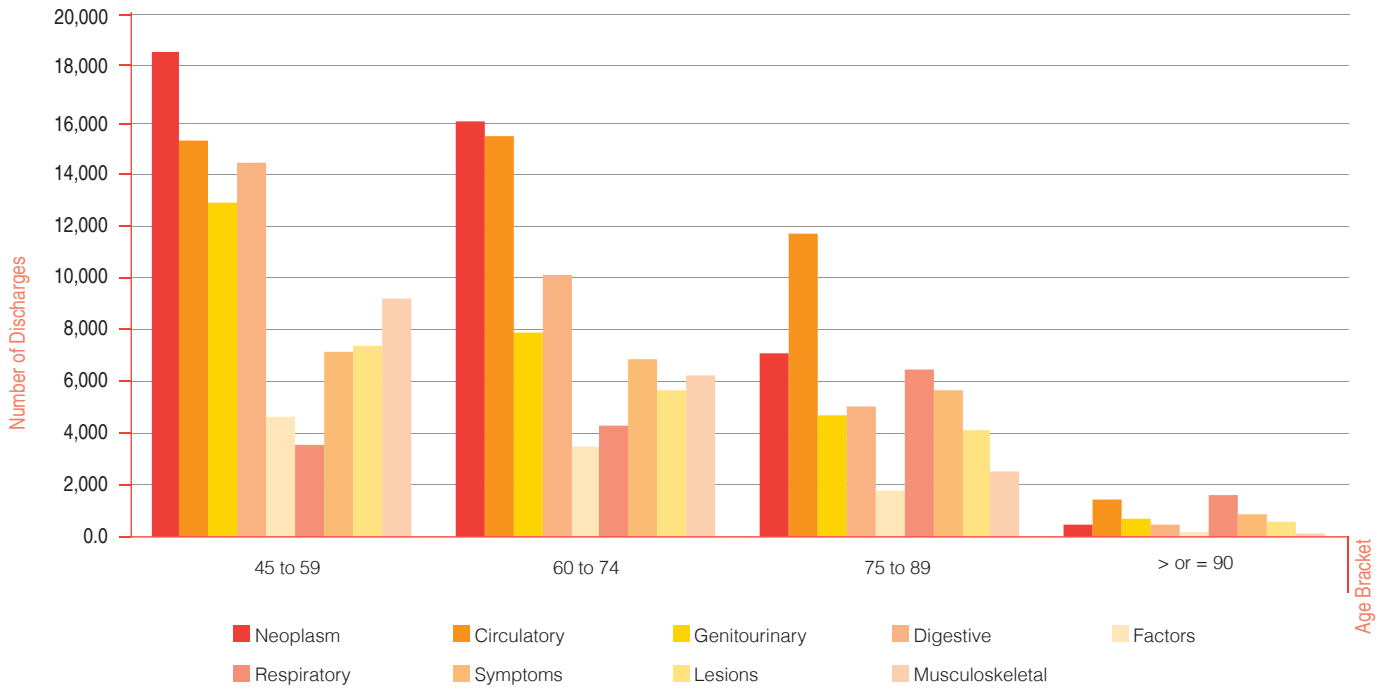
Graph 4 – Annual Distribution of Average Stay Time According to Main Diagnoses
(IDC chapter – 10th review)



Source: PMPA/ANAHP 2011.

The diagnosis groups with Length of stay of more than four days are: Neoplasm (Cancer), Circulatory System Diseases, Respiratory System Diseases, Perinatal Affections and Non-specific Diagnoses (Symptoms). Most cases of these pathologies are predominantly over the age of age range 44 years.
Graph 5 shows the distribution of cases according to age range above 44 years (Graph 5). Neoplasm, Circulatory System Diseases and Genitourinary System Diseases are predominant in patients in 45 to 59 and 60 to 74 age ranges. In older age ranges, the incidence of Respiratory System Diseases increases. Diseases of the Circulatory System are the main reason for hospital admission in the age range 75 to 89 years, followed by Ischemic Heart Diseases, Congestive Heart Failure and Cerebrovascular Diseases wich are the main pathologies affecting this group.

Graph 5 - Distribution of Hospital Discharges According to Age Range Above 44 Years and Main Diagnoses
(2011)

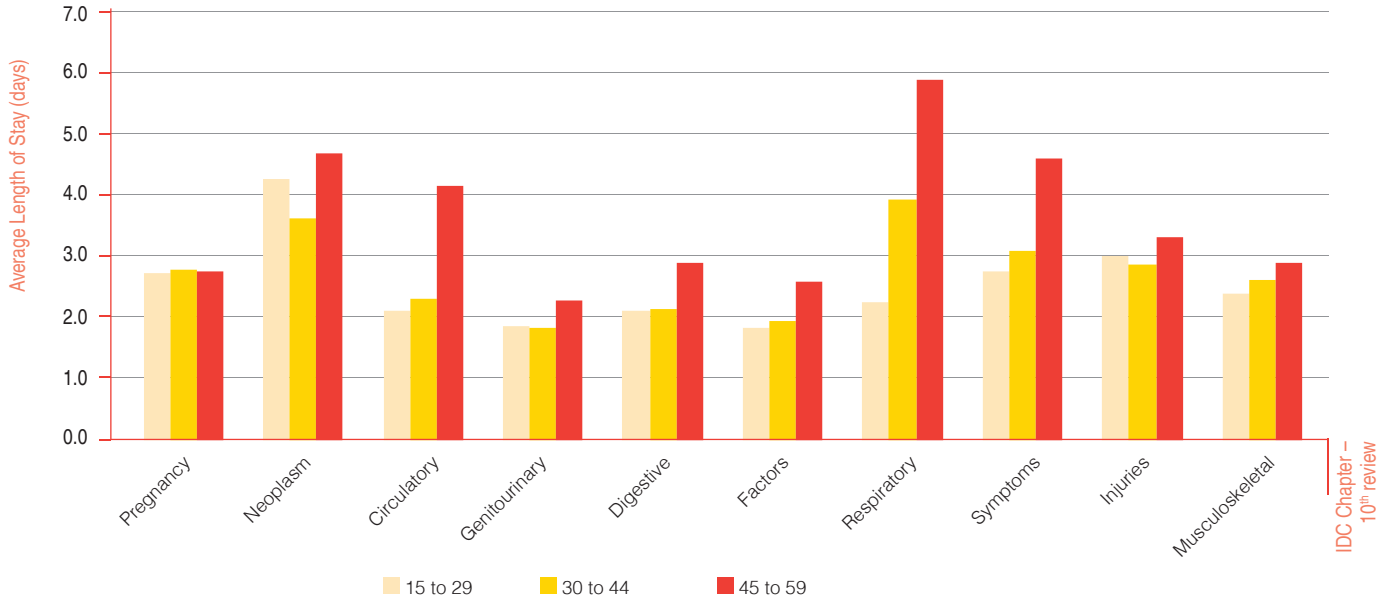


Source: PMPA/ANAHP 2011.

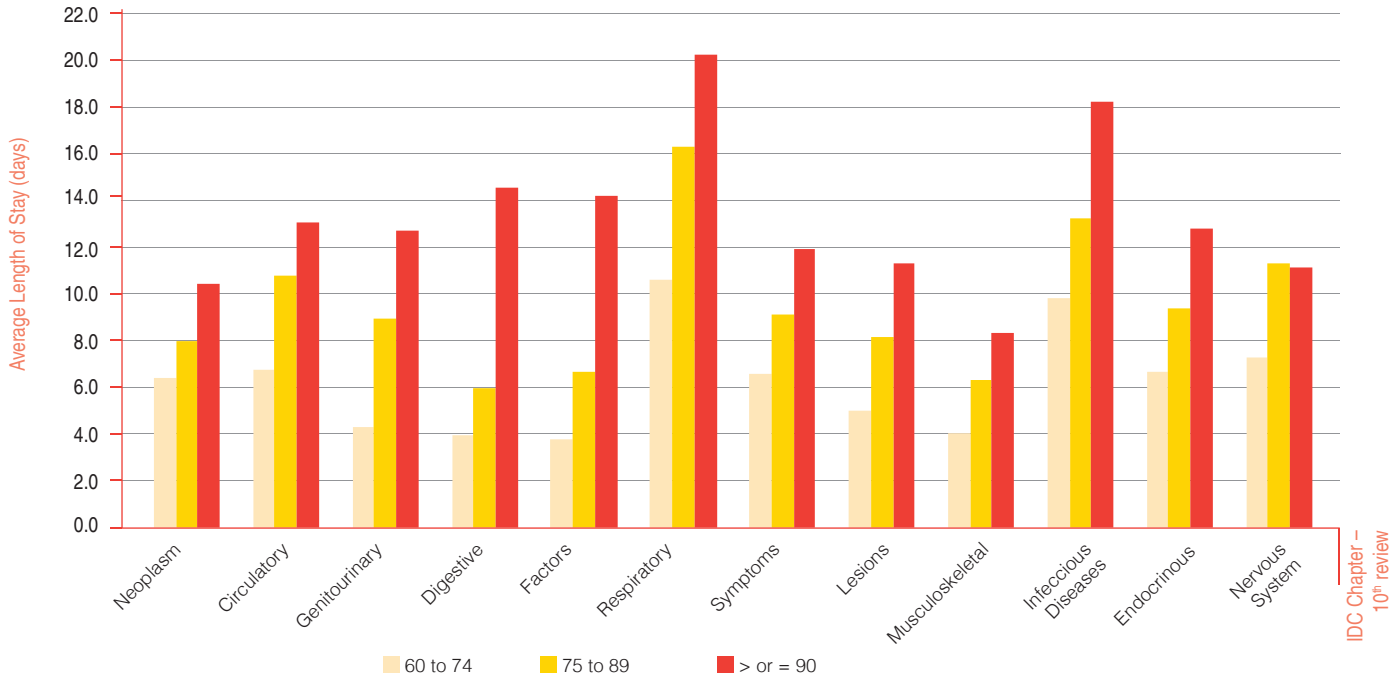
In Graph 6 one can identify the variation in Length of stay according to age range and diagnoses. Length of stay is directly related to the higher age ranges.

The Circulatory and Respiratory Systems Diseases require a higher length of stay, which can reach, respectively, 4 and 6 days, in the bracket 45 to 59 years, but it is in the serviced population over the age of 60 that the Length of stay increases more significantly (Graph 6). The older the group is, the longer the length of stay (Graph 7). Except in the case of Musculoskeletal Diseases in the group above 90 years, the average length of stay was above ten days in 2011 for all other main diagnoses, with Respiratory System Diseases and Infectious Diseases standing out. Monitoring older age cases is essential so that palliative care and backup support for home care may be implemented with better quality, improving results for patients and optimizing the use of beds for acute illness patients.

Graph 6 – Distribution of Average Length of Stay According to Main Diagnoses and Selected Age Range
(2011)



Graph 7 – Distribution of The Average Length of Stay According to Main Chapters and Selected Age Range
(2011)

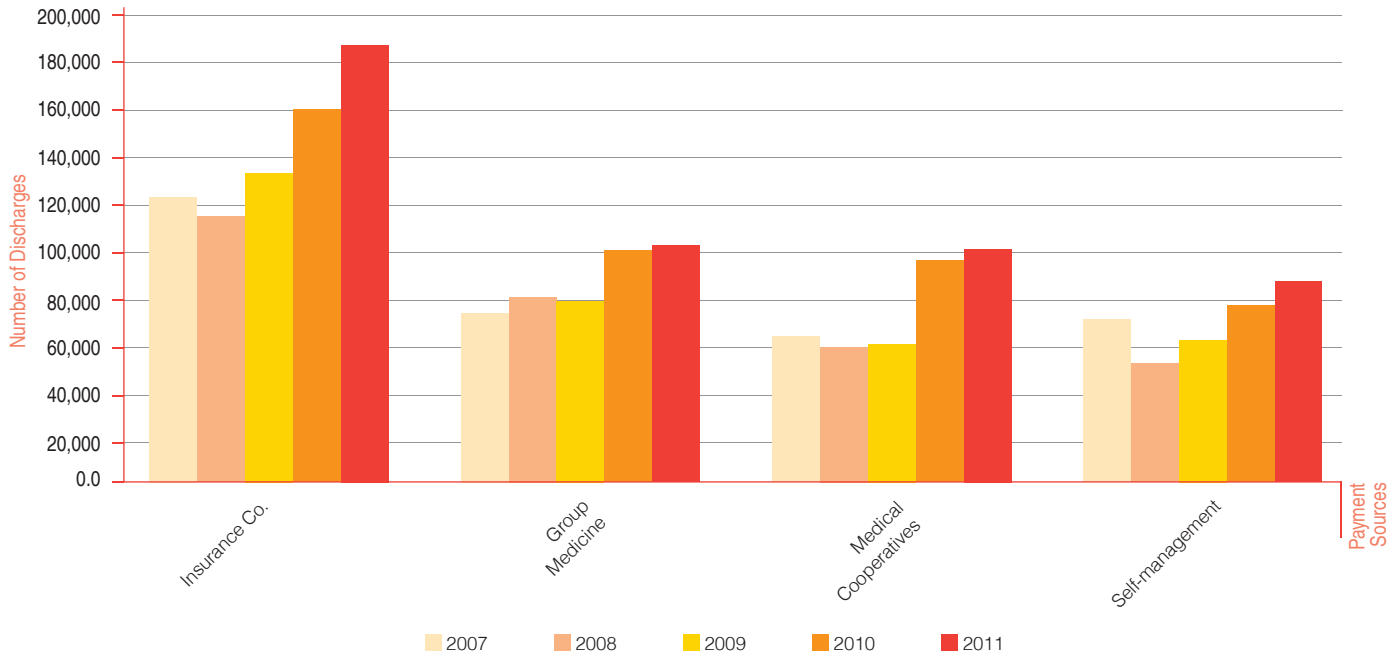


Source: PMPA/ANAHP 2011.

The associated hospitals provide services to patients linked to several payment sources. The historical series (Graphs 8 and 8a) shows the number of cases serviced according to main payment sources - the first graph comprises the most frequent payment sources, and the second graph the less frequent ones. Insurance companies prevail in the studied series, followed by companies in the modalities Group Medicine, Medical Cooperatives and Self-management.

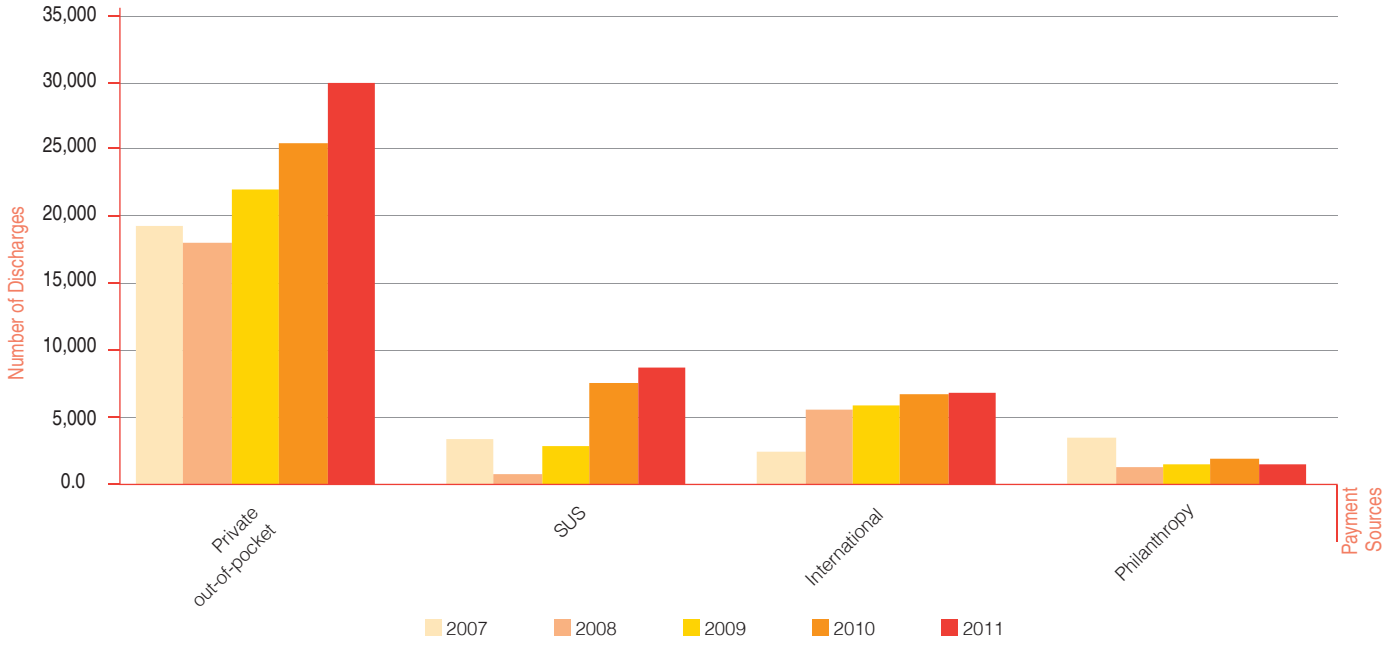
Private out-of-pocket payments, subject or not to reimbursement, service programs exclusively for users of SUS (Universal Public Healthcare System) and patients with international health plans have increased in the last three years.

Graph 8 – Annual Distribution of Main Payment Sources



Source: PMPA/ANAHP 2011.

Graph 8a – Distribution of Discharges According to Less Frequent Payment Sources



Source: PMPA/ANAHP 2011.

Health Services Management – analysis of monthly data

Collecting, consolidation and analysis of data and selected indicators began in January 2007. The monitored indicators attempt to provide support and incentives for best practices and enhanced safety in clinical care services.

The selection of data and indicators reflects key aspects of healthcare, supported by evidence-based clinical criteria and extracted from guidelines that serve as reference for the implemented protocols.

The assessment of provided healthcare services using indicators seeks to evidence the quality of processes and mainly to show the results of managerial work in clinical practice at ANAHP hospitals. Furthermore, it represents a pioneer initiative concerning transparency of information in the private health industry.

In 2011, data and indicators of 39 hospitals were received, corresponding to 91% of the associates. Indicators related to healthcare performance enable the assessment of important dimensions in clinical governance: bed management efficiency; analysis of results of surgical activities, productivity and healthcare efficiency.

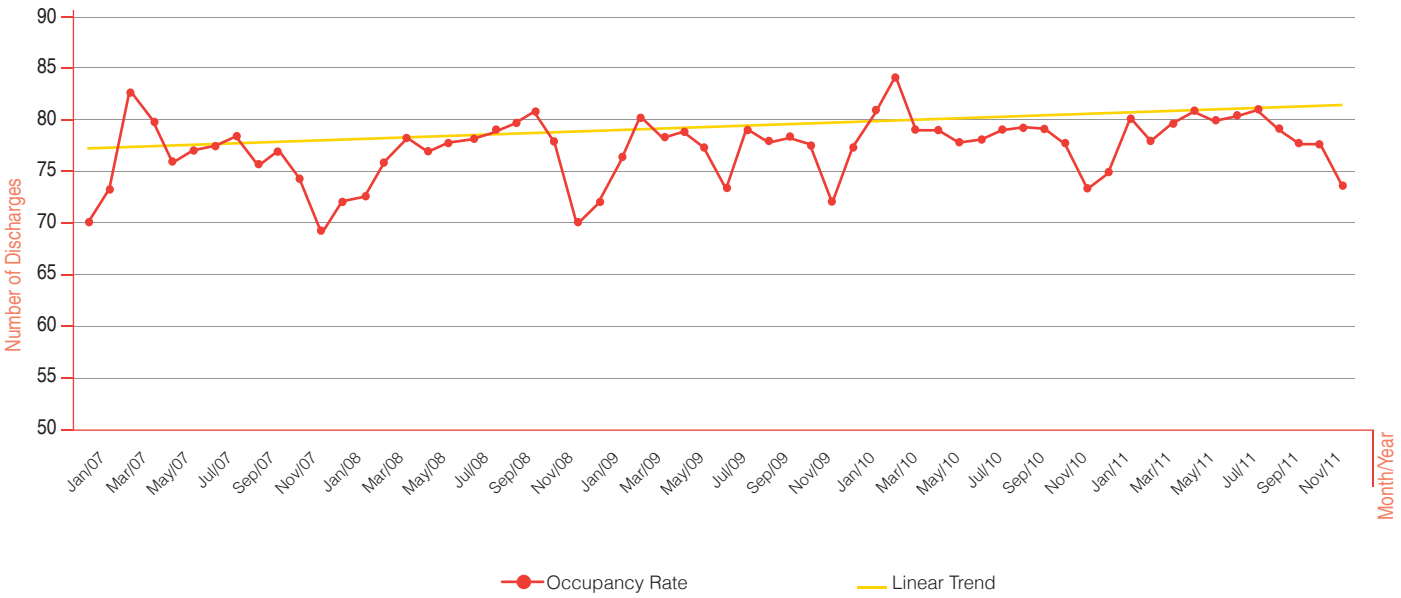
Concerning efficiency of available bed management, the hospitals have shown a linear growth trend of Occupancy rates, at approximately 80% in 2011 (Table 2 / Graph 9). The hospitals operate a considerable number of beds in ICUs for adults (including coronary ICUs), pediatric and neonatal patients. According to data submitted by 39 hospitals in 2011, there are 1,359 adult ICU beds and 446 neonatal ICU beds.

Pediatric beds are not routinely monitored. According to the annual survey, 64% of the hospitals provide pediatric services, with a total of 191 ICU beds for children.

Healthcare Performance Indicators

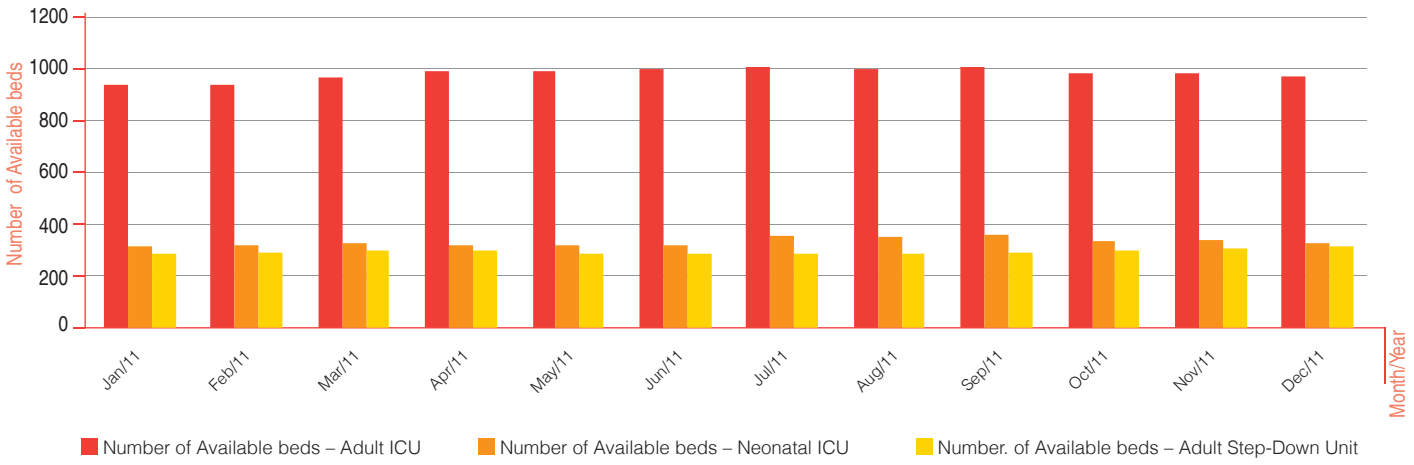
- Operational Occupancy Rate (available patients-day/ available beds-day* 100) – Overall rate of the hospital, adult and neonatal ICU and step-down Unit;
- Average Stay (patients-day/discharges); turnover rate (discharges/available beds);
- Bed Turnover Interval (100-occupancy rate * average length of stay /occupancy rate);
- Rate of patients submitted to surgical procedures (surgery patients/discharges*100);
- Rate of surgeries per patient (number of surgeries/ surgery patients);
- Surgical mortality rate (number of surgical deaths/ surgery patients*100);
- Institutional mortality rate (number of deaths ≥ 24h/ discharges*100);
- Resident patient rate (number of patients with length of stay longer than 90 days/discharges*100).

Graph 9 – Monthly Distribution and Linear Trend of Occupancy Rate



Source: PMPA/ANAHP 2011.

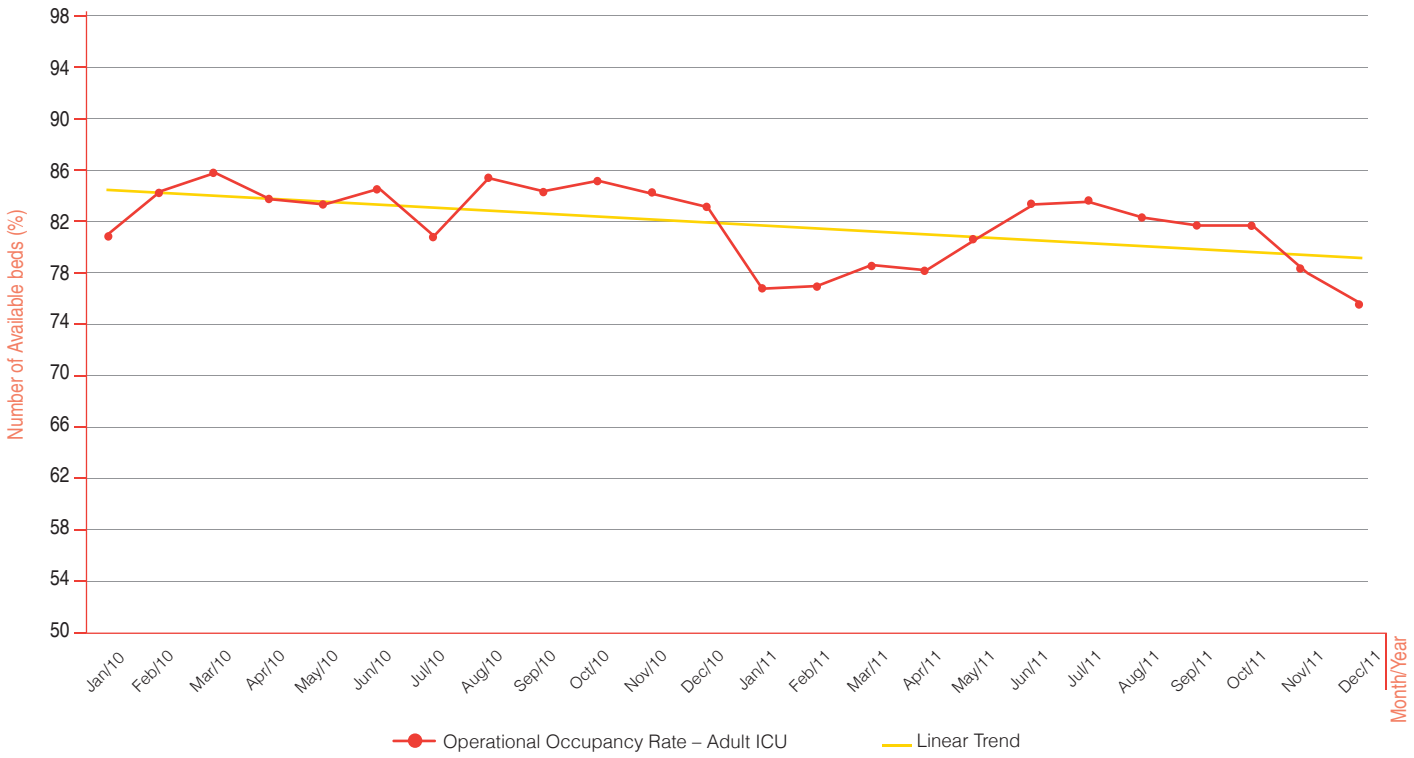
Graph 10 – Monthly Distribution of Number of Available Beds – Step-Down Unit, Adult and Neonatal ICUs



In 2011, nine hospitals informed data and indicators concerning step-down beds. The number of critical beds (ICU beds) monitored by 'type' is shown in Graph 10.

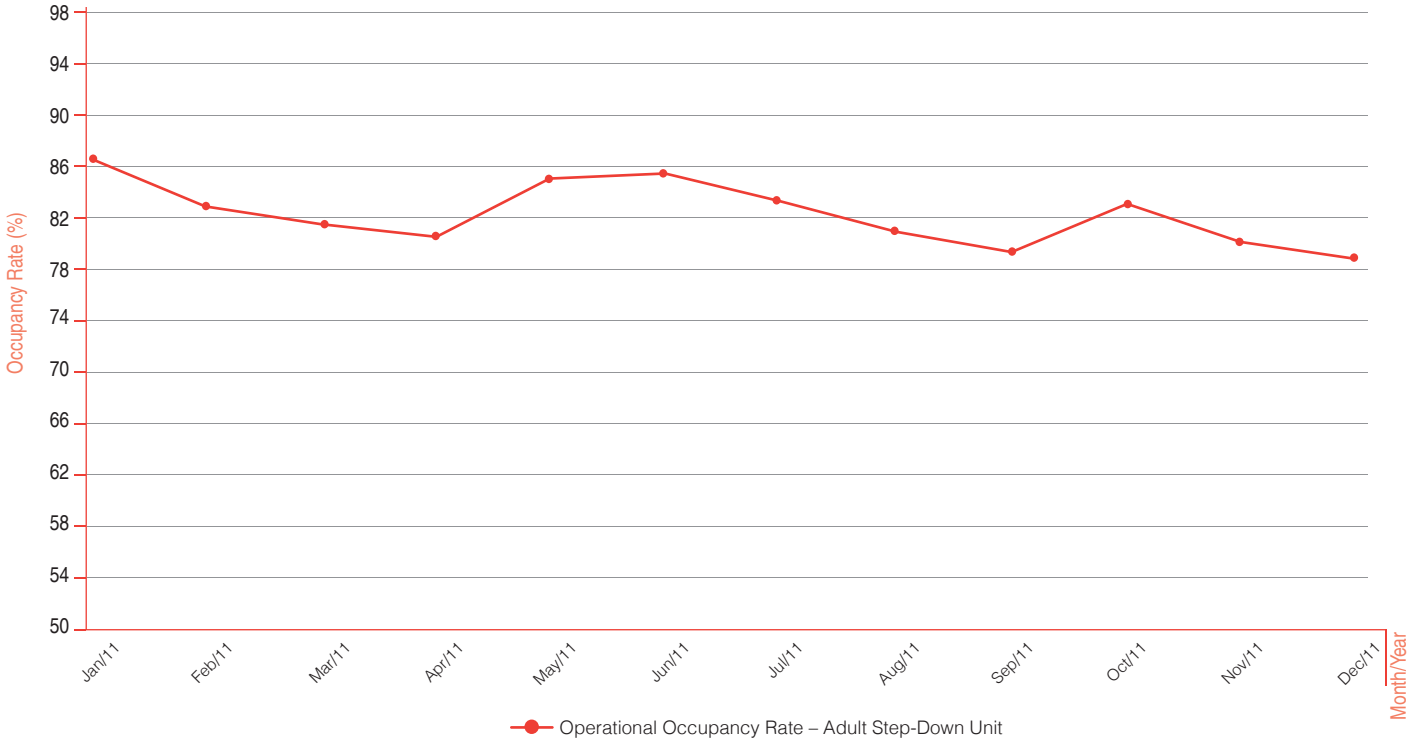
The proportion between intensive care beds and the total hospital beds has been increasing since 2007. In 2011, the sum of critical and semi-critical beds of the group of respondent hospitals (39) was 2,311 beds, which correspond to 22% of total installed beds. The major share (59%) amounts to ICU beds for adults. In some hospitals, the proportion reaches 30% of the total beds. On the one hand, there is an increasing trend in the number of outpatient surgical procedures performed on day-hospital basis and, on the other hand, there is the expansion of intensive care and step-down beds. This healthcare organization model has expanded and resulted in better utilization of critical beds and decrease in length of stay of patients with more severe conditions, who require more complex and intensive clinical care

Graph 11 – Monthly Distribution of Occupancy Rate – Adult ICU



Source: PMPA/ANAHP 2011.

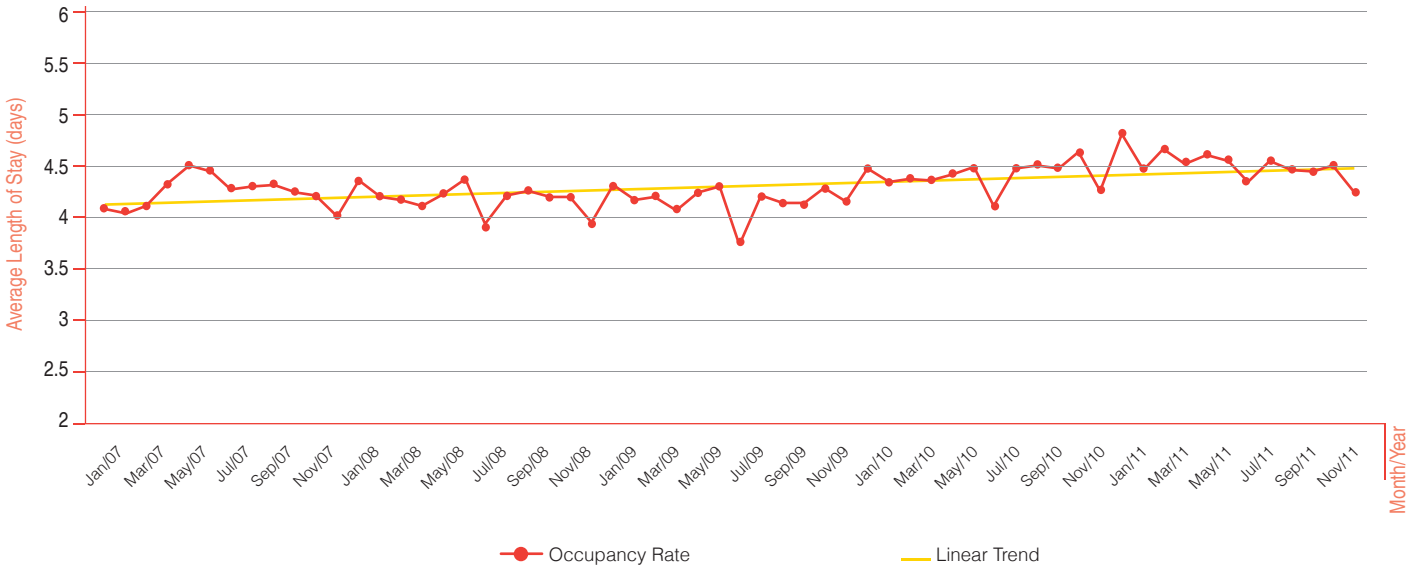
Graph 12 – Monthly Distribution of Occupancy Rate – Step Down Unit



As of 2011, ANAHP started to monitor reasons for observed mortality in comparison with the expected indicator, based on severity scores (generally "APACHE" score and, to a lesser degree, "SAPS") in Adult ICUs. In Table 2, this rate was below 1 during the entire year, with 0.63 average. This is evidence of the quality of care provided in such critical beds.

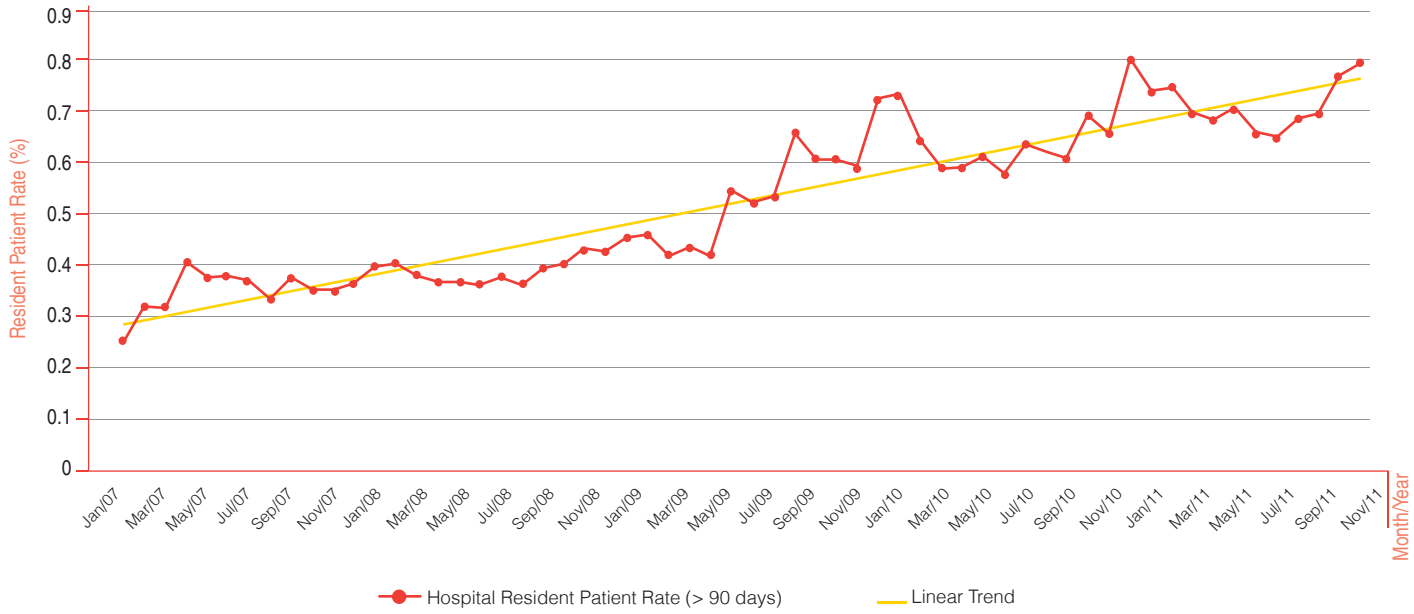
An aspect that has to be carefully analyzed and monitored is adult ICU occupancy rate, since rates above 85% are related to increase in the number of adverse events and less safety for patients and professionals. The Occupancy Rates of Critical and Semi-critical Units for adults have been in the range between 78% and 86% (Graphs 11 and 12). The average length of stay (Graph 13) increased 0.3% caused by population aging, increase in resident (chronic) patients (Graph 14), and as a result of increased severity of cases in the serviced population.

Graph 13 – Monthly Distribution and Linear of Average Length of Stay



Source: PMPA/ANAHP 2011.

Graph 14 – Monthly Distribution and Linear Trend of Hospital Resident Patient Rate (> 90 days)

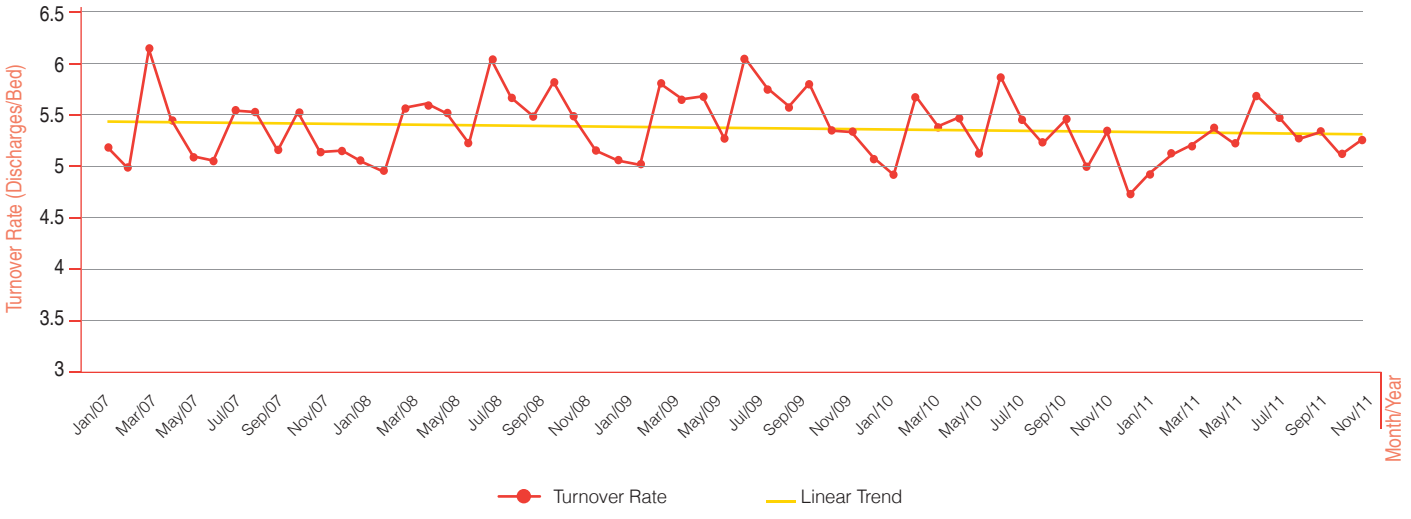


Source: PMPA/ANAHP 2011.

When one analyzes Average Length of Stay and Turnover Rate (Graph 15), the increase of the former indicator is determinant for the decrease of the latter. The increase was only not higher because the Bed Turnover Interval (time the bed stays unoccupied) was reduced (Graph 16) due to investments in management and monitoring of beds by the teams and the involvement of clinical teams in discharging patients before 10 a.m.

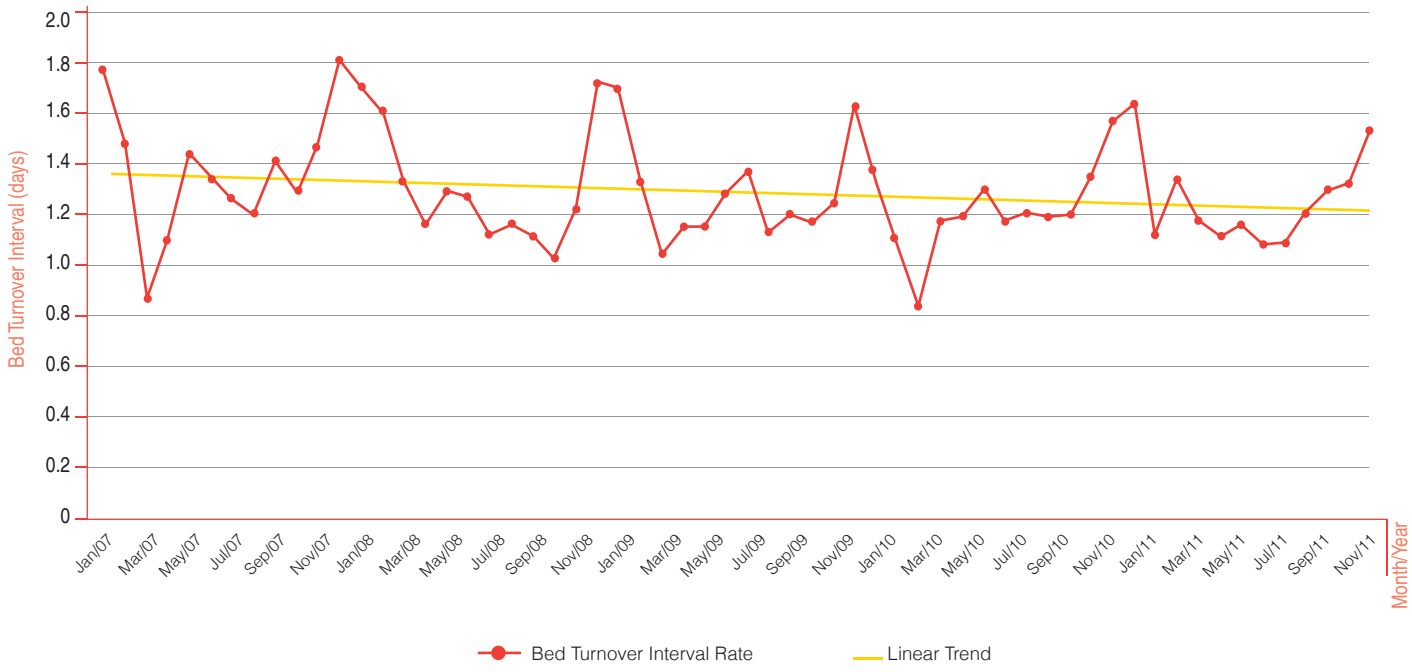
The predominant activity (68%) of hospitals was performance of surgical procedures. In 2011, there was 17% increase in the number of patients submitted to surgical procedures compared to 2010. The number of surgeries per patient is an indication of the surgery mix, in which the proportion of surgeries per patient evidences as the most significant ones plastic surgeries, surgery on children, and less complex digestive tract surgeries, which have also increased, showing

Graph 15 – Monthly Distribution and Linear Trend of The Turnover Rate



Source: PMPA/ANAHP 2011.

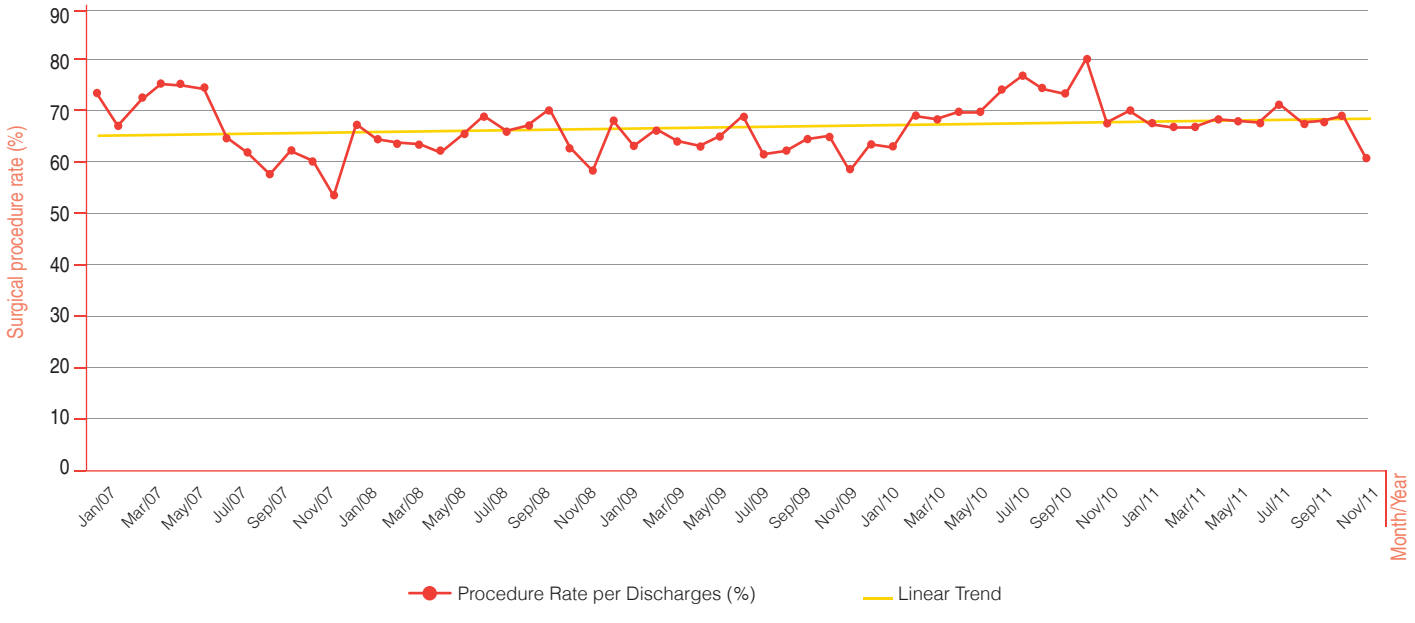
Graph 16 – Monthly Distribution and Linear Trend of Bed Turnover Interval



an upward trend for medium and low complexity procedures. This rate was on average 1.32 and increased 5% in relation to 2010 (Table 2 and 2a – Graph 17).

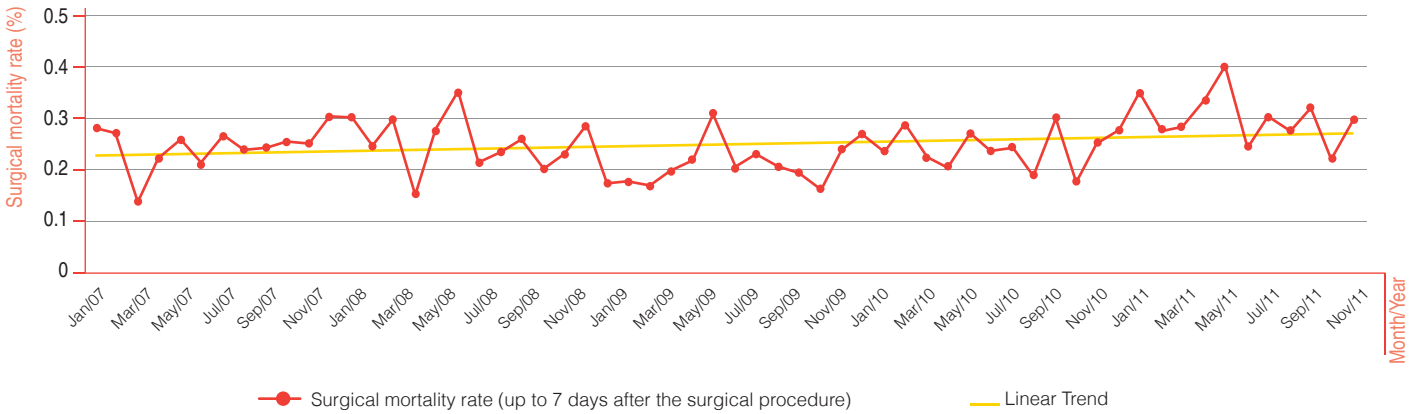
In 2011, the surgical mortality rate had a peak in June 2011, by 0.39%, (Graph 18 – Table 2a). This rate is related to complexity of the procedure and anesthetic risk. Even though there is still no information about Anesthetic Risk, indirect data show an increase in median age and prevalence of co-morbidities, implying higher risk of anesthetic and surgical procedures. There is a slight increase in surgical mortality rates in the linear trend.

Graph 17 – Monthly Distribution and Linear Trend of Surgical Procedure Rate



Source: PMPA/ANAHP 2011.

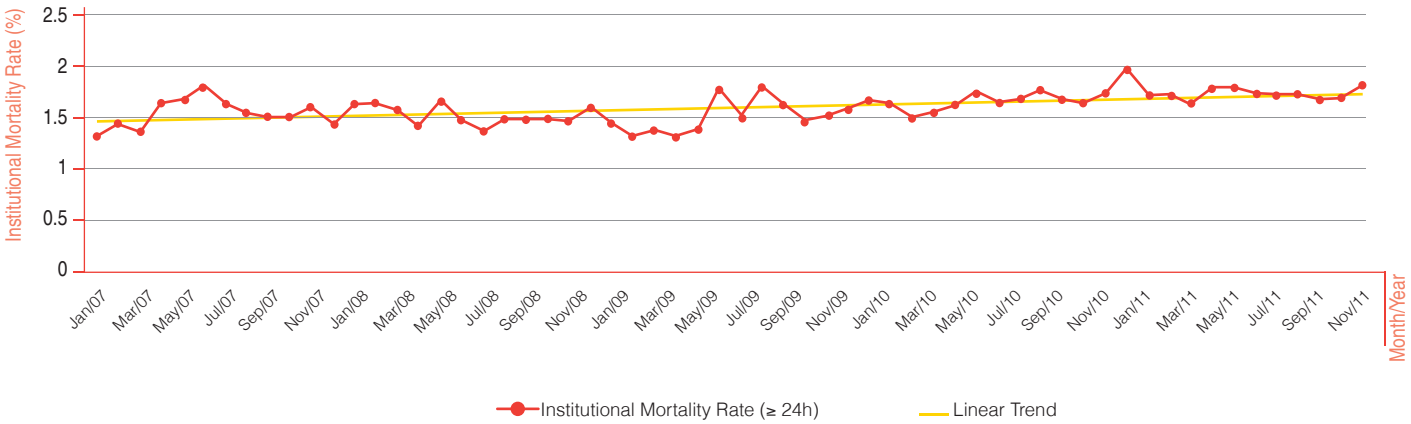
Graph 18 – Monthly Distribution and Linear Trend of Surgical Mortality Rate



Source: PMPA/ANAHP 2011.

The Institutional Mortality Rate is another indicator related to outcomes, but in order to be used for comparison purposes, it has to be adjusted for patient severity and complexity of services. The more complex the hospital is, the higher the number of patients with severe conditions serviced and the higher the risk of life will be. Longevity and the increase in number of oncology patients at all hospitals are indicative of increased severity and complexity. The rate tends to increase, reaching an average of 1.8%. Less variability may be indicative of better management and healthcare process controls. The increase of median age and prevalence of co-morbidities contributed to this raise. Benchmarked against the Institutional Mortality Rates of the monitoring system coordinated by the Hospital Quality Committee (CQH) of Associação Paulista de Medicina, published in PROHASA Indicators No. 63, the rates of ANAHP hospitals are lower than the 2;6% median observed by CQH.

Graph 19 – Monthly Distribution and Linear Trend of Institutional Mortality Rate



Source: PMPA/ANAHP 2011.

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Table 2 – Data and Indicators on Performance and Healthcare Quality

Operational and Healthcare Data	2007	2008	2009	2010	Jan	Feb	Mar
No. of installed beds	5,513	6,272	6,453	7,632	9,478	9,482	9,515
No. of available beds	5,047	6,040	6,144	7,263	8,939	8,982	9,001
Available day-beds	1,824,735	2,187,619	2,234,514	2,635,500	275,433	250,766	278,988
No. of surgical rooms	286	331	334	377	450	450	461
No. of patients-day	1,387,365	1,675,829	1,716,441	2,073,827	206,332	200,835	217,595
No. of hospital discharges (discharges+deaths+external transfers)	323,830	396,564	408,308	466,639	42,628	44,669	46,271
No. of patients staying longer than 90 days	95	129	177	250	345	333	347
No. of deaths ≥ 24 hours	5,054	6,121	6,259	7,818	850	775	807
Total number of deaths	6,426	7,927	7,594	9,226	999	922	971
No. of patients submitted to surgical procedures	215,608	258,941	264,371	331,545	29,997	30,150	30,928
Total number of surgeries	NI	NI	300,105	419,355	39,278	39,269	40,368
No. of surgical deaths	525	657	552	800	83	104	85
No. of clean surgeries	NI	NI	144,891	142,119	13,343	14,365	14,191
No. of surgical site infections	NI	NI	759	851	96	94	107
No. of available beds – adult ICU	NI	NI	NI	982	1,290	1,291	1,292
No. of available beds-day – adult ICU	NI	NI	NI	352,028	39,835	35,993	39,616
No. of hospital infections – adult ICU	3,576	4,296	3,558	3,665	418	335	371
No. of central venus catheter (CVC) associated infections – adult ICU	582	660	590	518	72	60	62
No. of patients-day – adult ICU	174,433	223,795	212,063	294,250	30,730	27,802	31,219
No. of catheters-day – adult ICU	101,223	134,285	125,427	158,612	17,740	16,271	17,734
No. of available beds – neonatal ICU	NI	NI	NI	332	433	433	439
No. of available bed-days – neonatal ICU	NI	NI	NI	115,866	13,313	12,164	13,418
No. of hospital infections – neonatal ICU	NI	NI	909	816	96	74	95
No. of CVC - associated infections – neonatal ICU	NI	NI	NI	NI	22	12	27
No. of patients-day – neonatal ICU	NI	NI	77,869	90,515	8,332	8,138	8,648
No. of catheters-day – neonatal ICU	NI	NI	NI	25,637	2,832	2,399	2,524
No. of available beds – adult step-down unit	NI	NI	NI	NI	288	292	297
No. of available bed-days - adult step-down unit	NI	NI	NI	NI	8,847	8,165	9,201
No. of hospital infections - step-down unit	NI	NI	NI	NI	39	37	42
No. of CVC - associated infections – step-down unit	NI	NI	NI	NI	2	4	4
No. of patients-day – step-down unit	NI	NI	NI	NI	7,660	6,774	7,507
No. of catheters-day – step-down unit	NI	NI	NI	NI	1,837	1,878	1,979

2011										
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Annual
		9,544	9,574	9,622	9,599	9,622	9,634	9,617	9,621	9,609	**9,576**
		9,031	9,069	9,147	9,125	9,085	9,110	9,087	9,159	9,113	**9,071**
		270,793	280,496	274,412	284,363	282,719	274,302	281,465	275,743	279,687	**3,309,167**
		461	461	461	465	468	468	466	466	466	**462**
		215,543	226,292	219,051	228,221	228,680	216,594	218,834	214,029	206,318	**2,598,324**
		47,326	48,795	47,837	52,043	49,935	48,136	48,711	47,058	48,221	**571,630**
		333	336	341	346	327	333	341	365	386	**344**
		779	883	865	914	873	840	828	805	884	**10,103**
		961	1,061	1,046	1,091	1,029	1,029	991	966	1,032	**12,098**
		31,644	33,463	32,627	35,349	35,670	32,706	33,259	32,608	29,449	**387,850**
		40,841	43,649	42,808	48,294	47,665	43,398	43,693	43,032	39,147	**511,442**
		89	111	128	86	107	90	105	73	87	**1,148**
		14,936	16,033	15,570	18,309	17,306	16,065	16,256	16,118	12,925	**185,417**
		117	97	91	125	102	79	92	81	84	**1,165**
		1,300	1,315	1,322	1,327	1,328	1,336	1,298	1,329	1,319	**1,312**
		39,106	40,634	39,592	41,095	40,835	40,041	40,149	39,780	41,061	**477,737**
		348	361	389	404	382	360	337	349	316	**4,370**
		65	55	62	50	60	55	63	66	51	**721**
		30,672	32,859	32,887	34,234	33,555	32,711	32,756	31,116	31,206	**381,747**
		18,078	18,334	18,896	19,623	18,300	18,628	18,140	17,035	17,171	**215,950**
		435	433	435	434	438	423	438	444	446	**436**
		12,888	13,215	12,940	13,249	13,360	12,984	13,442	13,348	13,778	**158,099**
		88	81	82	88	90	80	82	78	84	**1,018**
		17	21	25	21	24	19	18	21	19	**246**
		8,551	8,487	8,484	8,357	8,876	8,702	8,748	9,158	9,669	**104,150**
		2,520	2,240	2,539	2,417	2,877	2,661	3,101	2,819	2,998	**31,927**
		298	287	287	287	286	290	299	307	315	**294**
		8,934	8,841	8,606	8,859	8,859	8,685	9,254	9,197	9,755	**107,203**
		35	38	37	27	23	30	28	35	26	**397**
		5	5	3	2	4	3	4	1	1	**38**
		7,209	7,519	7,352	7,384	7,174	6,915	7,690	7,393	7,710	**88,287**
		1,832	1,884	1,774	1,758	1,842	1,709	1,827	1,974	2,198	**22,492**

Tabela 2a – Indicators on Performance and Healthcare Quality – 2007 to 2011

Operational and Healthcare Data	2007	2008	2009	2010	Jan	Feb	Mar
Occupancy rate	76.0	76.6	76.8	78.7	74.9	80.1	78.0
Average Length of Stay	4.3	4.2	4.2	4.4	4.8	4.5	4.7
Turnover rate	5.3	5.5	5.5	5.4	4.8	5.0	5.1
Replacement interval rate	1.36	1.30	1.28	1.20	1.62	1.12	1.33
Hospital resident patient rate (> 90 days)	0.4	0.4	0.5	0.6	0.8	0.7	0.7
Institutional mortality rate (> 24h)	1.6	1.5	1.5	1.7	2.0	1.7	1.7
Surgery mortality rate (up to 7 days after surgical procedure)	0.2	0.3	0.2	0.2	0.3	0.3	0.3
Operational occupancy rate – adult ICU	NI	NI	NI	83.6	77.1	77.2	78.8
Hospital infection density rate – adult ICU	20.6	19.1	16.7	12.5	13.6	12.0	11.9
CVC utilization rate – adult ICU	58.0	60.1	59.1	53.9	57.7	58.5	56.8
Incidence density rate of CVC - associated infection – adult ICU	5.7	4.9	4.7	3.3	4.1	3.7	3.5
Observed/expected mortality ratio – adult ICU	NI	NI	NI	NI	0.57	0.73	0.64
Operational occupancy rate – neonatal ICU	NI	NI	NI	78.1	62.6	66.9	64.5
Hospital infection density rate – neonatal ICU	NI	NI	11.8	9.0	11.5	9.1	11.0
CVC utilization rate – step-down unit	NI	NI	NI	28.3	34.0	29.5	29.2
Incidence density rate of CVC - associated infection – step-down unit	NI	NI	NI	1.9	7.8	5.0	10.7
Operational occupancy rate – step-down unit	NI	NI	NI	NI	86.6	83.0	81.6
Hospital infection density rate – semi-intensive ICU	NI	NI	NI	NI	5.1	5.5	5.6
CVC utilization rate – semi-intensive ICU	NI	NI	NI	NI	24.0	27.7	26.4
Hospital infection incidence rate associated with central venous catheter – semi-intensive ICU	NI	NI	NI	NI	1.1	2.1	2.0
Surgical site Infection rate	NI	NI	0.5	0.6	0.7	0.7	0.8
Compliance with Prophylactic antibiotic therapy	NI	NI	NI	NI	77.9	83.0	83.5
Surgery rate (per patient)	NI	NI	1.1	1.3	1.3	1.3	1.3
Procedures per discharge rate (%)	66.6	65.2	64.7	71.0	70.4	67.5	66.8

2011										
		Abr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Annual
		79.6	80.7	79.8	80.3	80.9	79.0	77.7	77.6	73.8	**78.5**
		4.6	4.6	4.6	4.4	4.6	4.5	4.5	4.5	4.3	**4.5**
		5.2	5.4	5.2	5.7	5.5	5.3	5.4	5.1	5.3	**5.3**
		1.17	1.11	1.16	1.08	1.08	1.20	1.29	1.31	1.52	**1.24**
		0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.8	0.8	**0.7**
		1.6	1.8	1.8	1.8	1.7	1.7	1.7	1.7	1.8	**1.8**
		0.3	0.3	0.4	0.2	0.3	0.3	0.3	0.2	0.3	**0.3**
		78.4	80.9	83.1	83.3	82.2	81.7	81.6	78.2	76.0	**79.9**
		11.3	11.0	11.8	11.8	11.4	11.0	10.3	11.2	10.1	**11.4**
		58.9	55.8	57.5	57.3	54.5	56.9	55.4	54.7	55.0	**56.6**
		3.6	3.0	3.3	2.5	3.3	3.0	3.5	3.3	3.0	**3.3**
		0.54	0.63	0.68	0.68	0.64	0.62	0.58	0.55	0.67	**0.63**
		66.3	64.2	65.6	63.1	66.4	67.0	65.1	68.6	70.2	**65.9**
		10.3	9.5	9.7	10.5	10.1	9.2	9.4	8.5	8.7	**9.8**
		29.5	26.4	29.9	28.9	32.4	30.6	35.4	30.8	31.0	**30.7**
		6.7	9.4	9.8	8.7	8.3	7.1	5.8	7.4	6.3	**7.7**
		80.7	85.0	85.4	83.4	81.0	79.6	83.1	80.4	79.0	**82.4**
		4.9	5.1	5.0	3.7	3.2	4.3	3.6	4.7	3.4	**4.5**
		25.4	25.1	24.1	23.8	25.7	24.7	23.8	26.7	28.5	**25.5**
		2.7	2.7	1.7	1.1	2.2	1.8	2.2	0.5	0.5	**1.7**
		0.8	0.6	0.6	0.7	0.6	0.5	0.6	0.5	0.6	**0.6**
		81.9	78.9	80.2	77.6	79.0	81.0	79.8	78.0	80.6	**80.1**
		1.3	1.3	1.3	1.4	1.3	1.3	1.3	1.3	1.3	**1.3**
		66.9	68.6	68.2	67.9	71.4	67.9	68.3	69.3	61.1	**67.8**

Healthcare Quality and Safety

Project reduces incidence density rates by 45% in adult Intensive Care Units of associated hospitals.

The implementation of who bundles has contributed to 42% reduction in hospital infection incidence density rates associated with central venous catheters in intensive care units.

The indicators monitored by the Best Healthcare Practices Project are:

Quality and safety indicators

- Hospital Infection (HI) Incidence Density Rate in Adult and Neonatal ICU and Step-down Unit;
- Central Venous Catheter (CVC) associated HI Incidence Density Rate in Adult and Neonatal ICU and Step-do wn Unit;
- CVC Utilization Rate in Adult and Neonatal ICU and Step-down Unit;
- Surgical site Infection Rate;
- Prophylactic Antibiotic Therapy Rate;
- Pressure Ulcer Rate;
- Fall Rate (includes near falls).

The associated hospitals hold accreditation certificates granted by different external evaluation systems and, in recent years, more than one certification model has being used by the institutions, considering their advantages on focusing on the healthcare process and market demands. This applies to a group of hospital service providers with a tradition in assessing and monitoring healthcare quality and safety.

The involvement of healthcare teams, particularly in critical units, has resulted in progress in the prevention of adverse events and in compliance with good practices, leading to decrease in complications and major impacts on patient outcomes.

In 2011, the indicator Prophylactic Antibiotic Therapy Rate was included to measure one of the quality standards of performed surgical procedures. Even though more hospitals have started to report this rate over the year, the number of hospitals reporting it is still lower than that for other indicators.

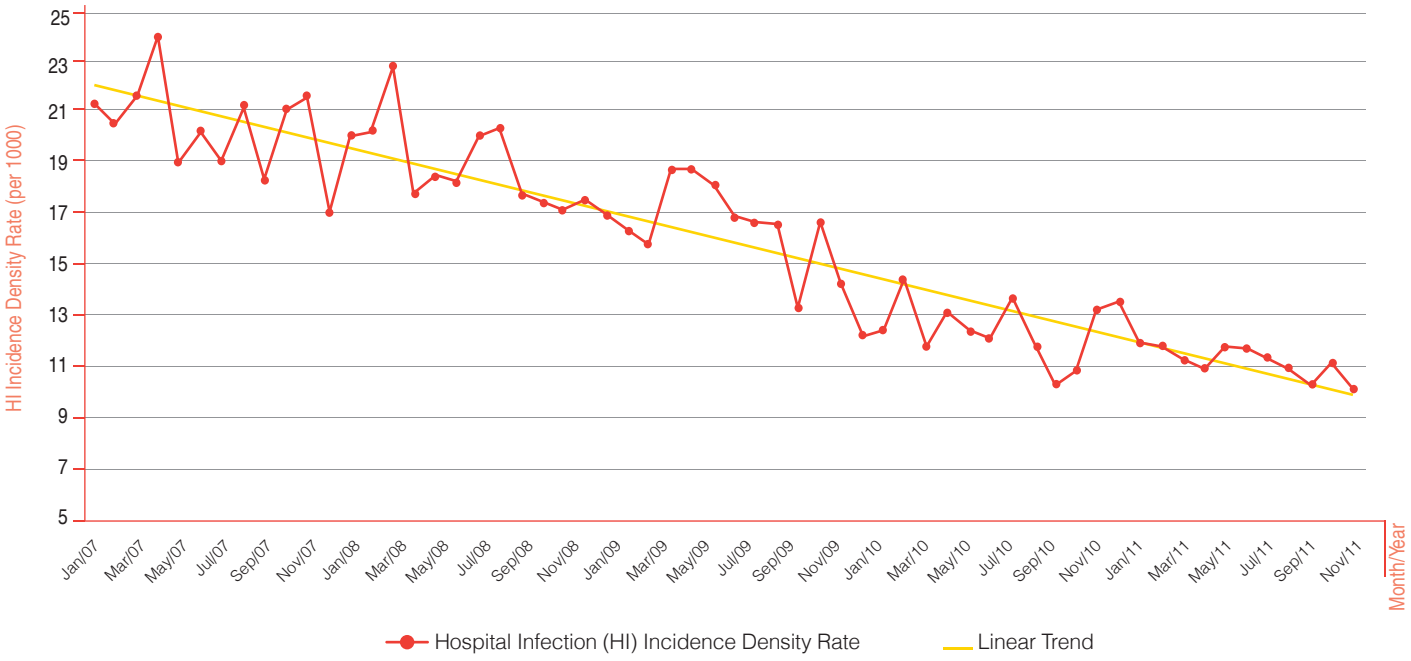
Quality and safety indicators should be interpreted in view of the healthcare organization and the healthcare profile of the hospitals. Therefore, they are comparable to large and highly complex hospitals. The results displaying the data and indicators are shown in Table 2 and 2a.

The Hospital Infection Incidence Density Rate (no. of hospital infections/no. of patients-day X 1000) is directly related to Invasive Procedure Utilization Rate in Intensive Care Units, i.e., the more procedures are applied, the higher the risk of acquiring a hospital infection.

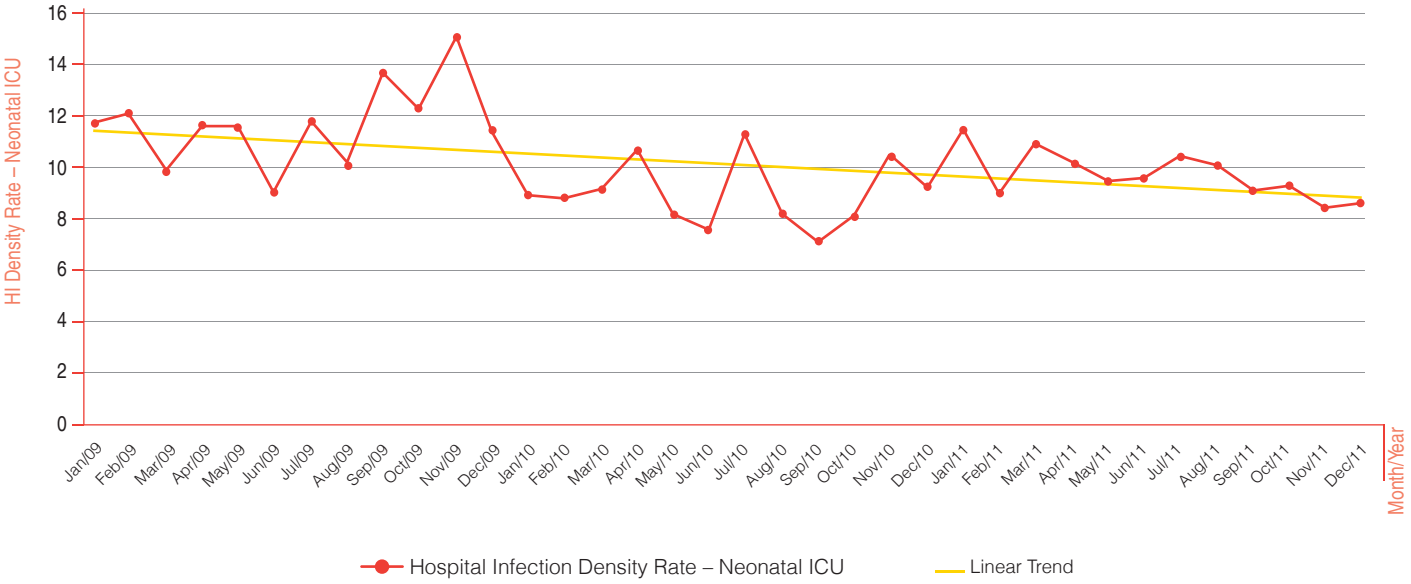
The two main types of infection that occur in critical units are central venous catheter-associated infections and mechanical ventilation-associated infections.

In the Best Healthcare Practices Project, we monitor the Overall Infection Incidence Density Rate in ICUs and CVC-associated infection rate (no. of hospital infections associated with CVC/ no. of catheters-day X 1000).

Graph 20 – Monthly Distribution of HI Incidence Density Rates (per 1000 pd) In Adult ICUs



Graph 21 – Monthly Distribution and Linear Trend of the Hospital Infection Incidence Density Rate (per 1000 pd) – Neonatal ICUs

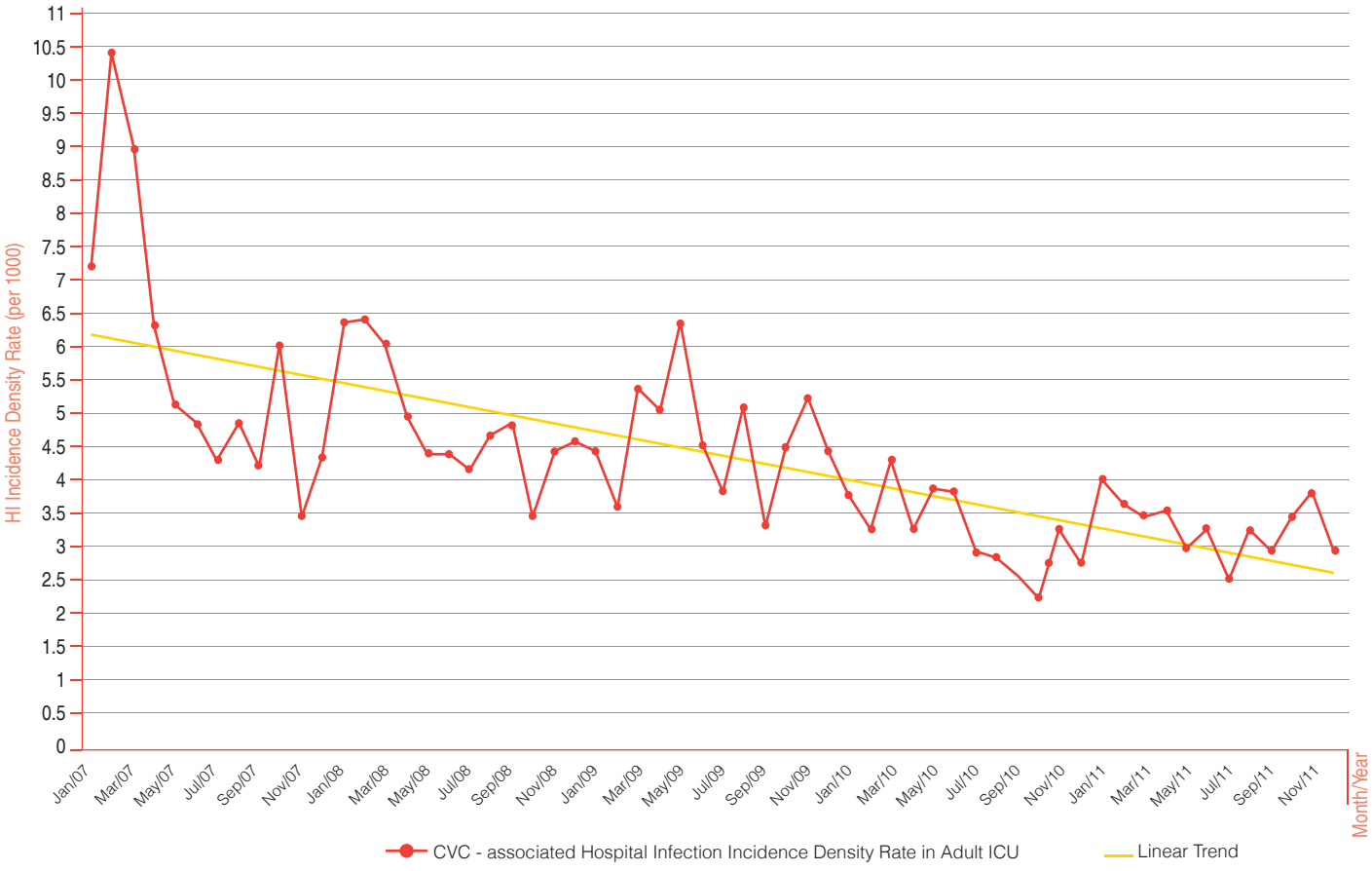


Source: PMPA/ANAHP 2011.

Concerning Hospital Infection Incidence Density Rate in Adult and Neonatal ICUs, we can observe significant decrease in infection rates (Graph 20 and 21). The monitoring of the indicator Incidence Density Rate in Neonatal ICUs was incorporated only in 2009.

In five years, the Hospital Infection Incidence Density Rate in Adult ICUs was reduced by 45%, even considering the increase in aging, patients' increased severity and complexity. This meant an important decrease in healthcare cost for patients and the health system.

Graph 22 – Monthly Distribution and Linear Trend of HI Incidence Density Rates Associated with CVC (per 1000 catheter-days) – Adult ICUs



Graph 23 – Monthly Distribution and Linear Trend of Hi Incidence Density Rates Associated with CVC (per 1000 catheter-days) – Adult ICUs

Source: PMPA/ANAHP 2011.

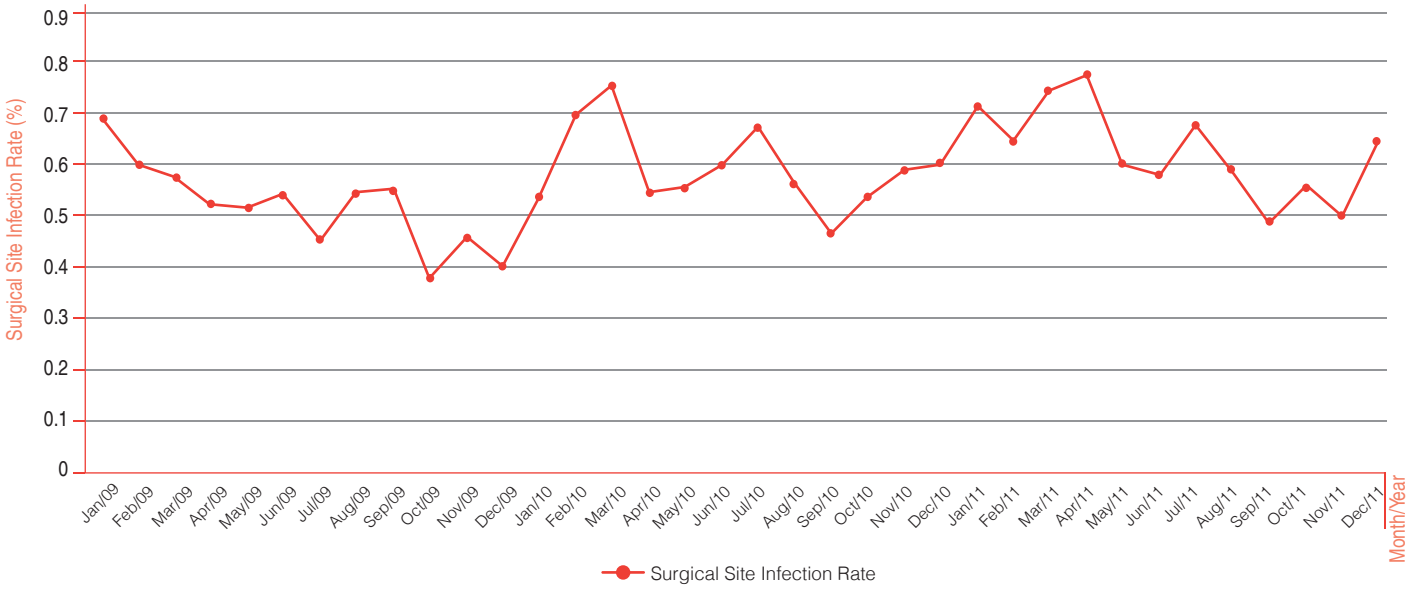
Central Venous Catheter-associated Hospital Infection Incidence Density Rates in Adult Intensive Care Units were also drastically reduced, as can be seen in Graph 22. The decrease, following the first major reduction in 2007, has significant linear reduction trend until December 2011 (Graph 23). In five years there was 42% decrease. Last year, the decrease was smaller, so the teams were mobilized to maintain and reinvigorate the implemented strategies. The results show that care quality at ANAHP hospitals has improved. The goal is to reduce Incidence Density Rates close to zero and some of the hospitals have already achieved it, but it takes greater efforts to fulfill this goal. Decreasing infection, reducing length of stay in the ICU, and preventing patient complications represent continuous efforts for the institutions. Faster return to productive life, lower social cost, and lower disability rate represent significant savings of resources for the health system and the involved families.

Surgical Site Infection Rate (Graph 24) is an indicator that still requires adjustment concerning standardization of active search in the hospitals. Information submitted on this indicator has increased since 2009, and during 36 months of monitoring, we can observe a variation rate between 0.5% and 0.7%. The results are in compliance with literature data.

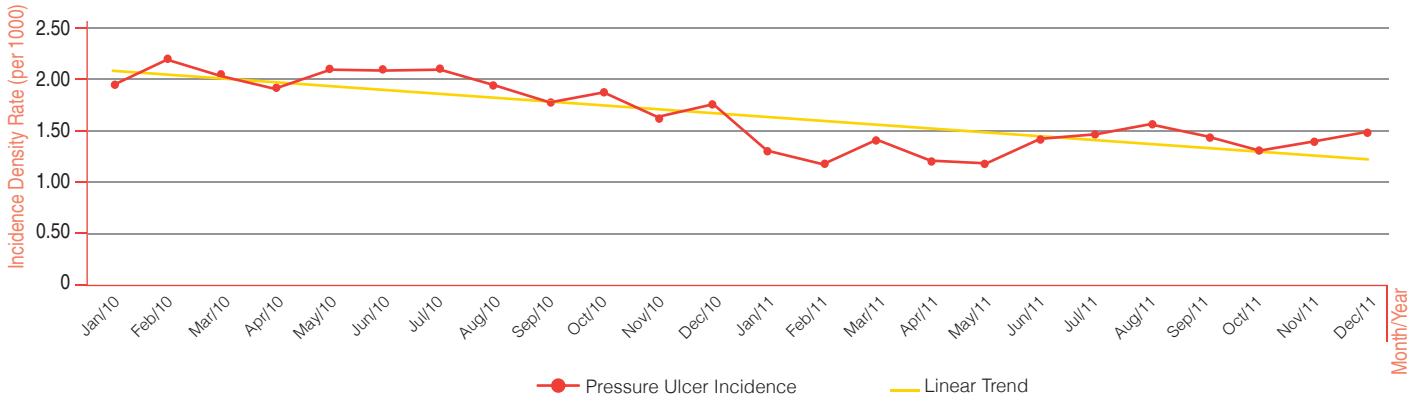
Pressure Ulcer Incidence Density Rate, an indicator incorporated in January 2010, has also shown a decrease in the period (Graph 25).

It means improvement in healthcare safety and quality, particularly relating to nursing care.

Graph 24 – Monthly Distribution of the Surgical Site Infection Rate



Gaph 25 – Monthly Distribution of Pressure Ulcer Incidence Density Rates (per 1000 pd) and Linear Trend



Source: PMPA/ANAHP 2011.

Clinical Protocols

Associated hospitals improve protocol management and set collective goals.

Indicators show a decrease in variability and evidence better healthcare outcomes.

The Best Healthcare Practices Project monitors quality, safety and compliance with selected clinical protocols. Data and indicators were selected based on criteria, standards and recommendations on certain pathologies established in the main guidelines for clinical practice in national and international literature. The following indicators shown in the table are monitored every month by associated hospitals.

Acute Myocardial Infarction (AMI)

The first cause of death in all regions of Brazil is Circulatory System Diseases. Included in this group are Ischemic Heart Diseases, Cerebrovascular Diseases and Congestive Heart Failure. As one can see in Graph 26, the risk of death due to Circulatory System Diseases is higher in the country's Southern and Southeastern regions, according to information extracted from available data on mortality in Datasus system. Neoplasms (cancer) are the second cause of death in the Southern and Southeastern regions, while External Causes take this position in the Midwestern, Northeastern and Northern regions. This different distribution portrays heterogeneous healthcare demands.

Clinical protocol indicators – selected pathologies

Acute Myocardial Infarction (AMI)
- Door-to-Balloon Time (AMI with STEMI)
- Primary Angioplasty Rate (with STEMI)
- Aspirin Rate at Discharge
- Average Length of Stay
- Mortality Rate

Ischemic Stroke
- Door-to-Computed Tomography (CT) Time
- Computed Tomography (CT) Rate
- Average Length of Stay
- Mortality Rate

Community-Acquired Pneumonia (Children, adults, elders)
- Average Length of Stay
- Mortality Rate
- Appropriate Antibiotic Therapy Rate

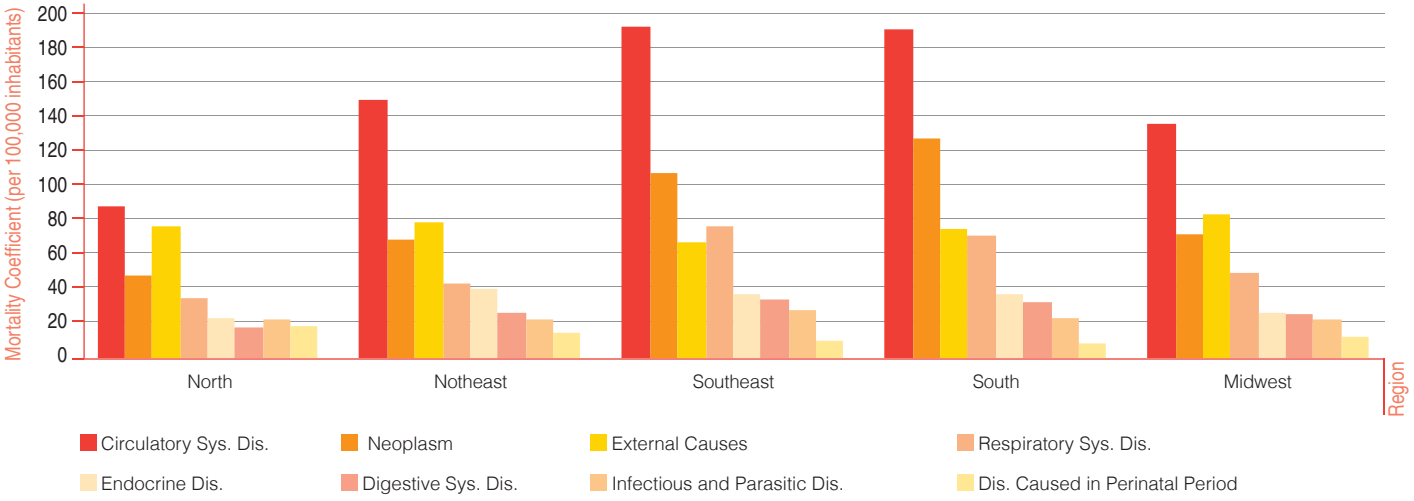
Sepsis
- Average Length of Stay
- Mortality Rate
- Appropriate Antibiotic Therapy Rate

Video-laparoscopic Cholecystectomy and Inguinal Herniorrhaphy
- Average Length of Stay in Hours

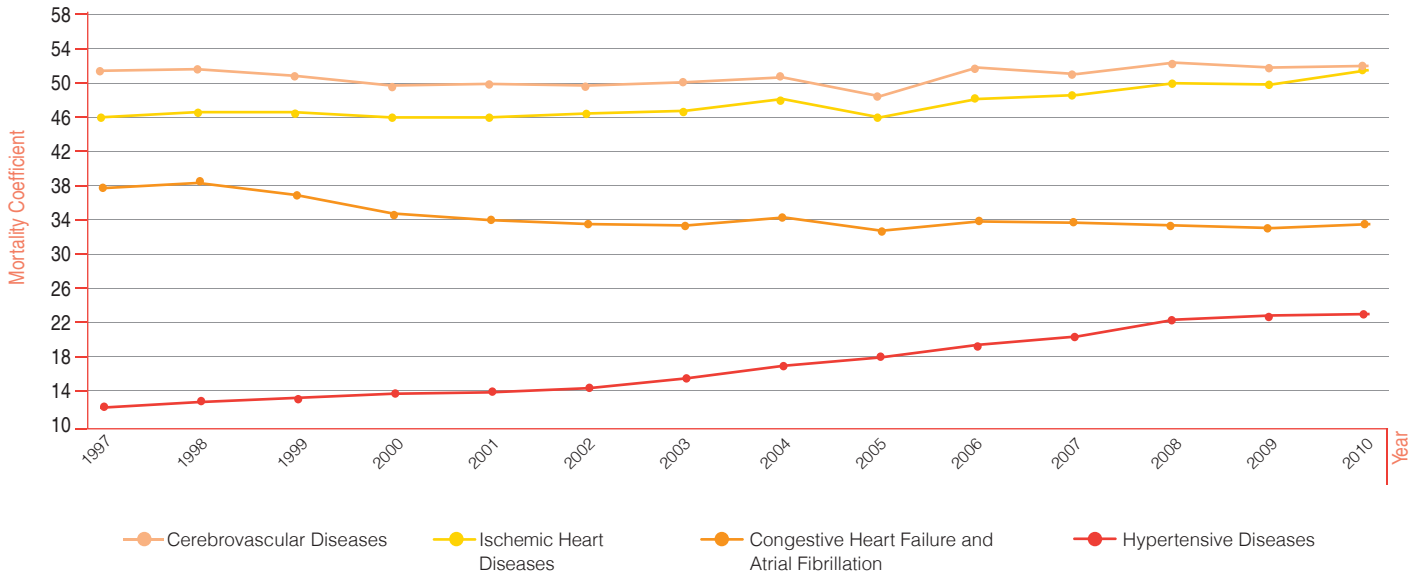
Abdominal Hysterectomy
- Average Length of Stay in Days

The Project follows the three main harm causes of Circulatory System Diseases. As one can see in Graph 27, the diseases with the highest mortality coefficient, the highest incidence and lethality among diseases of the Circulatory System are Ischemic Heart Diseases, in which the Acute Myocardial Infarction is the most diagnosed, and Cerebrovascular Diseases, of which Ischemic Cerebrovascular Accident and Congestive Heart Failure cases are predominant, and which are important causes of death at chronic stage. These diseases are determinant for the use of health services, both for outpatient and hospital services, seeking appropriate treatment. Graph 28 shows the mortality coefficients for the Southeastern region for the main Circulatory System Diseases. This region shows the highest death risk and concentrates most of the population benefitted by supplementary healthcare systems.

Graph 26 – Distribution of Mortality Coefficients of the Main Causes of Death by Regions of the Country
(Brazil – 2010)

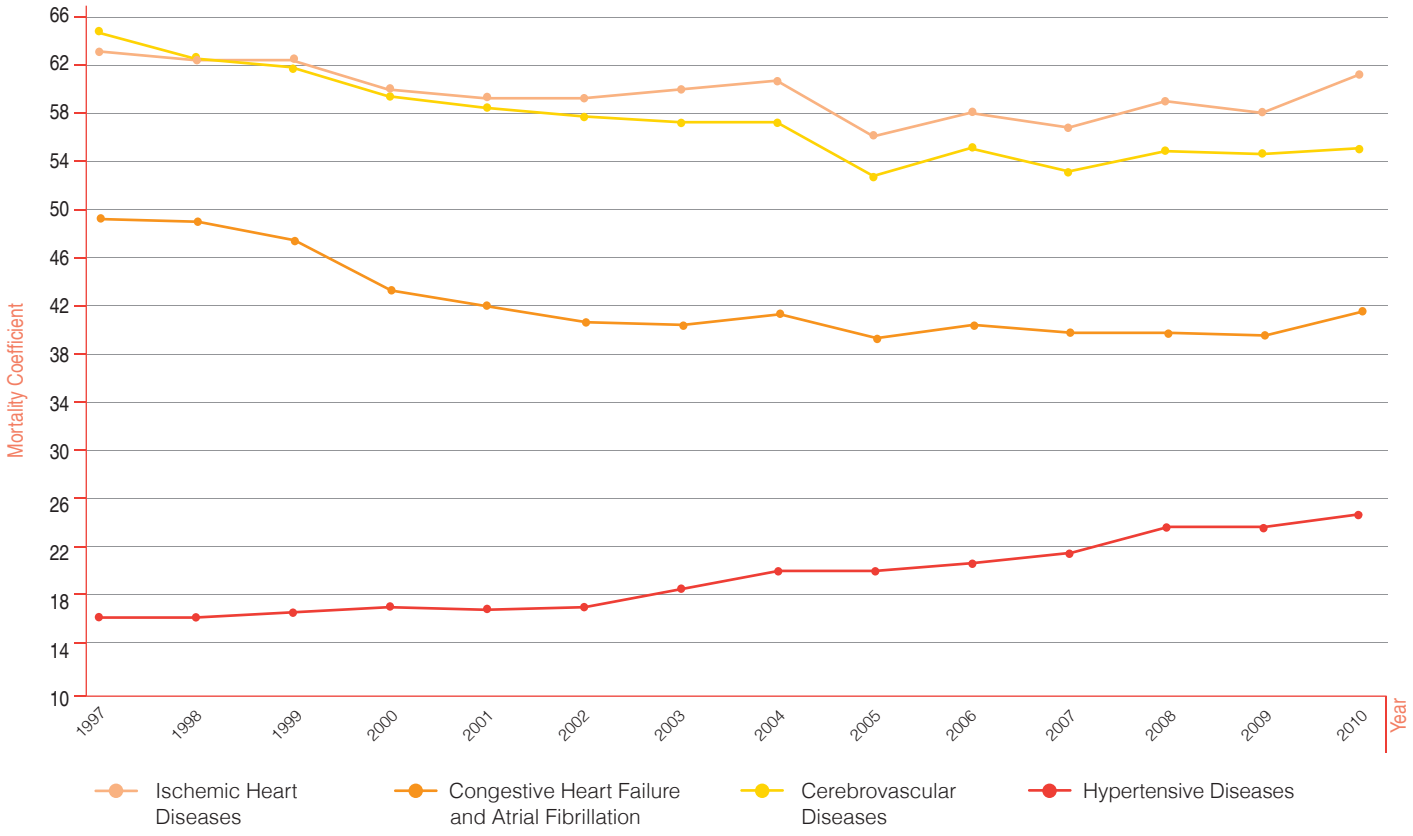


Graph 27 - Annual Distribution of Mortality Coefficients (per 100,000 inhabitants) by Cause – Circulatory System Diseases
(Brazil – 1997 to 2010)



Source: Datasus – Ministry of Health

Graph 28 – Annual Distribution of Mortality Coefficients (per 100,000 inhabitants) by Main Cause – Circulatory System Diseases
(Southeastern Region – 1997 to 2010)



Source: Datasus – Ministry of Health.

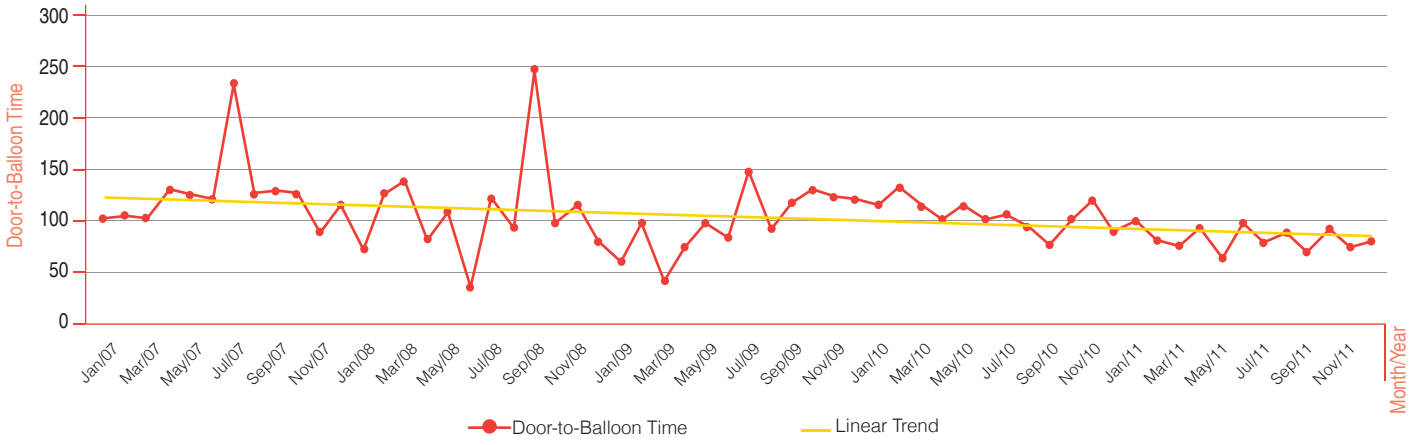
These data reinforce that this selection of conditions was based on health needs, i.e., on the impact they have on health status and quality of life. There is abundant scientific evidence about these diseases in the literature and the main recommendations concerning diagnostics and treatment. It has also been proven that good practices - protocol implementation and monitoring – lead to reduction in length of stay, lethality, and sequelae, particularly of Cerebrovascular Diseases.

As previously shown, based on the analyses of hospitals' databases, Circulatory System Diseases represent 10% to 11% of hospital admission demand, reaching 14% growth between 2010 and 2011. In 2011, 26 hospitals submitted data and indicators on protocols of Acute Myocardial Infarction, 22 hospitals informed data on Congestive Heart Failure and 17 institutions sent data on Cerebrovascular Accidents.

The registry quality was improved and collective goals for some indicators were established, so as to ensure more homogeneity of results.

Door-to-Balloon Time in cases of Acute Myocardial Infarction (AMI) – a critical indicator to watch and related to the prevention of sequelae – shows significant reduction trend, having in 2011 reached an average of 86 minutes (time between arrival at the hospital entrance and the realization of the procedure – primary angioplasty). One also observes the decrease in variability during the year. The gold standard, established by international and national guidelines, is Door-to-Balloon Time of 90 minutes. This was one of the goals established and reached by the group of hospitals, as shown in Graph 29.

Graph 29 – Monthly Distribution and Linear Trend of Door-to-Balloon Time (in minutes)

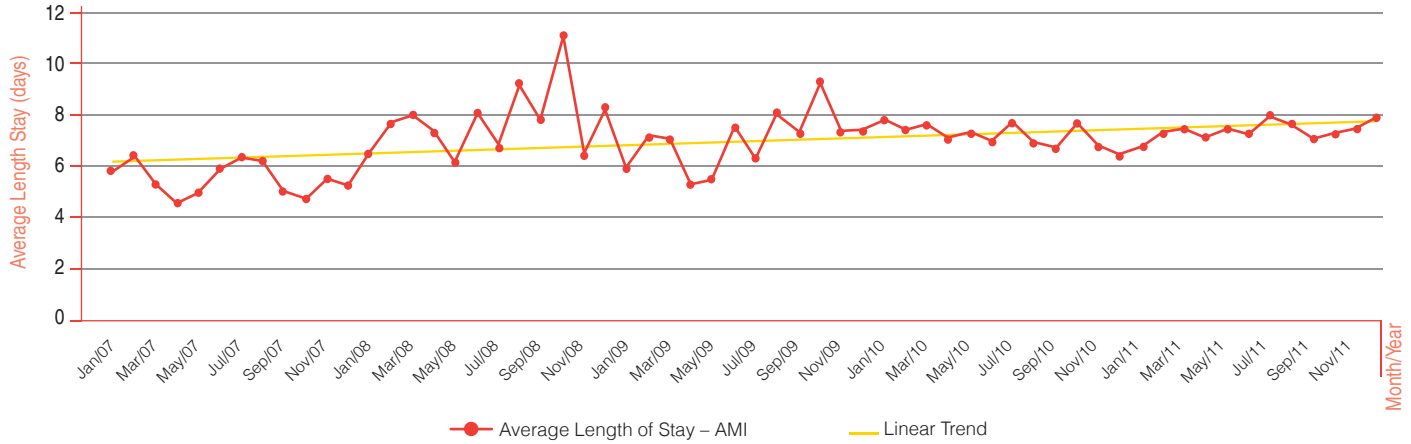


Source: PMPA/ANAPH 2011.

The length of stay recommended by international guidelines is 6 to 8 days in cases of AMI. In the associated hospitals, there has been a linear trend to increase length of stay, but with a reduction in variability, i.e., this process in the hospitals has been under more control since 2010, with length of stays of 6.4 to 8.0 days and an average of 7.4 in the year (Graph 30 – Table 3).

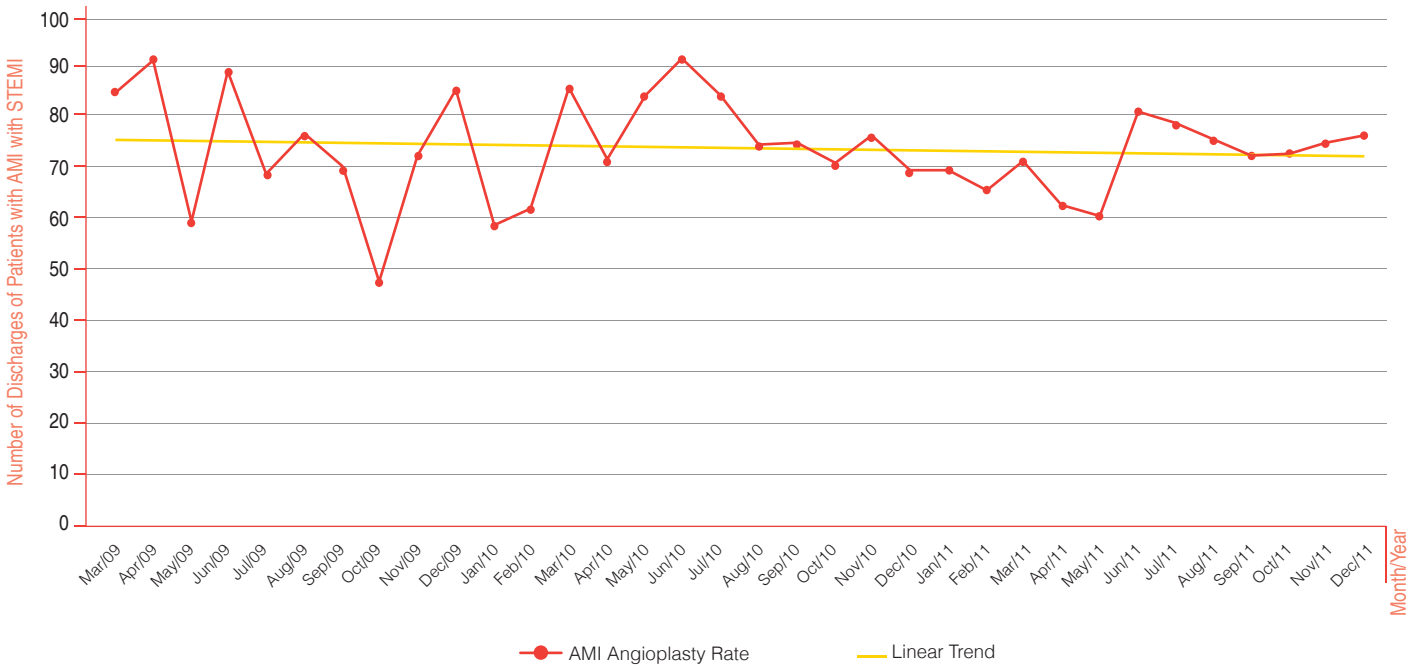
In cases of Acute Myocardial Infarction with STEMI we should follow the Primary Angioplasty Rate. Data started being properly collected in March 2009 and higher variability was observed until mid-2010. International standards for this indicator are between 80% and 85%, but the group of hospitals showed an average of 72% in 2011, which has encouraged the associated institutions to pursue the recommended results. Aspirin Rate at Discharge shows a linear growth trend (Graph 32), but still presents major variability. The rates were between 59% and 80%, with average of 67%. Hospitals have been facing more difficulty to keep up with this indicator. In addition to compliance issues by professionals, there is no formal documentation at discharge, as doctors hand over the prescription to patients but fail to document such information in patient records. These results are compatible with other national studies, but fall short of what is recommended. International literature sets 85% as the goal for Aspirin Rate at Discharge.

Graph 30 – Monthly Distribution and Linear Trend of Average Length of Stay in Patients with AMI



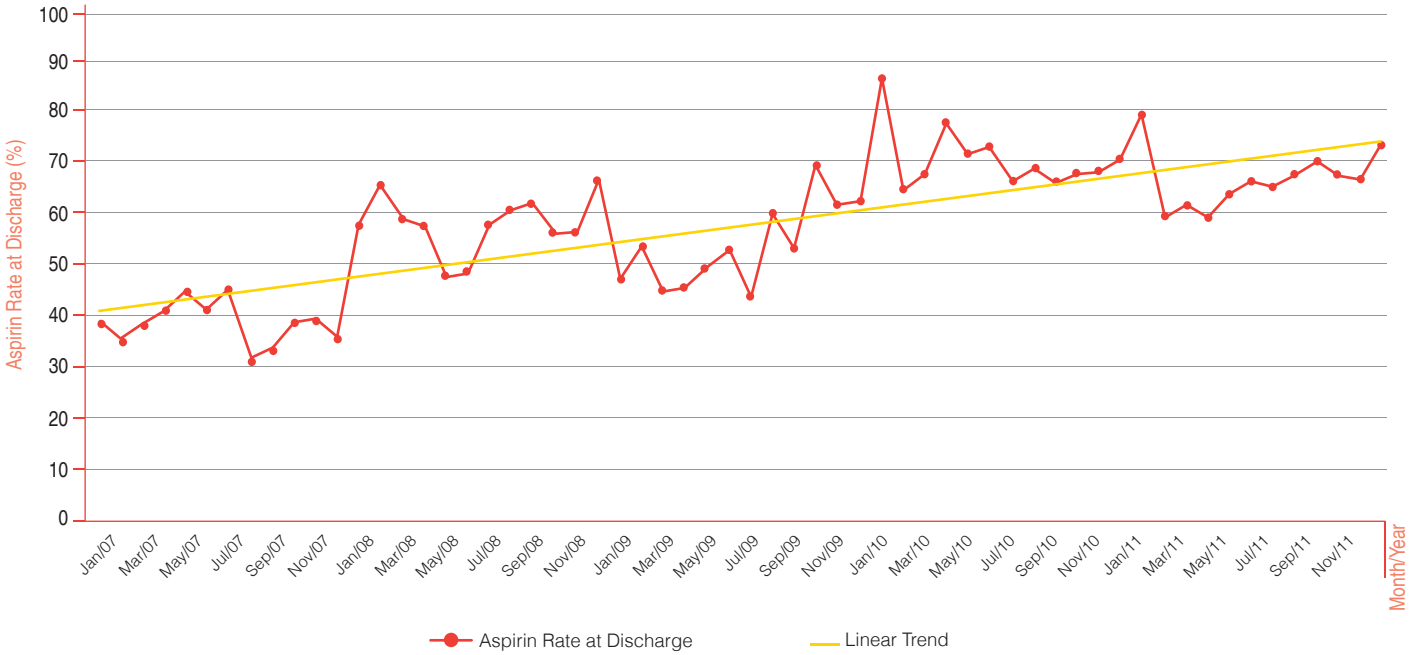
Source: PMPA/ANAPH 2011.

Graph 31 – Monthly distribution And Linear Trend of Angioplasty Rate for AMI Patients with STEMI



Source: "PMPA"/ANAHP, 2011.

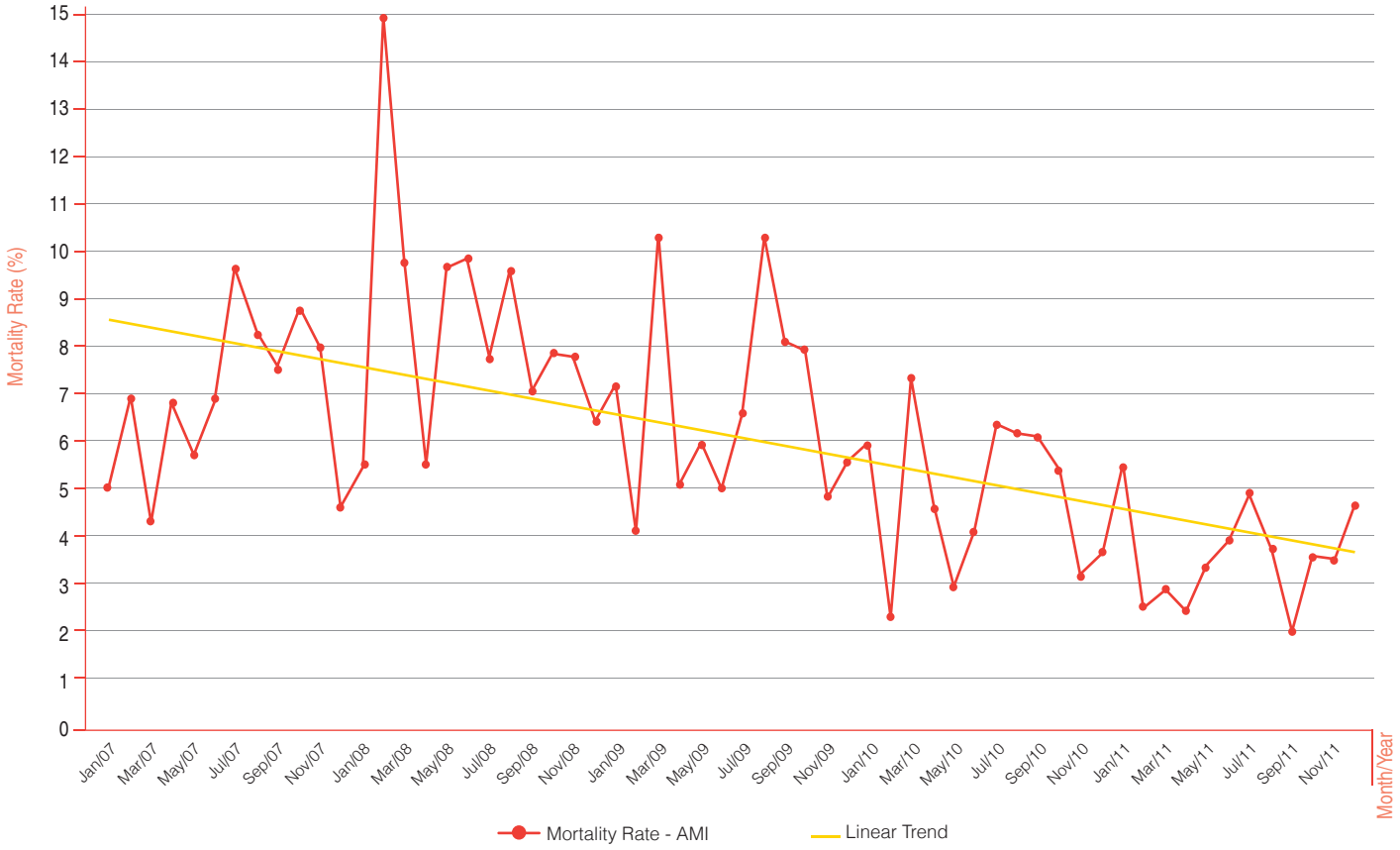
Graph 32 – Monthly Distribution and Linear Trend of the Aspirin Rate at Discharge for AMI Patients



Source: PMPA/ANAHP 2011.

The main indicator that measures healthcare effectiveness is the Mortality Rate of cases in the Acute Myocardial Infarction protocol. Such rates have been decreasing considerably, as can be observed in Graph 33. Considering that there has been increase in the number of cases and in the precision of data collection, one may suppose that clinical cases are being handled better, mainly when we consider the overall information. The population's quicker access to services and to diagnoses and appropriate treatment in emergency units contribute to the reduction of mortality rates, resulting in lower social costs for the health system and the population that uses the services.

Graph 33 – Monthly Distribution and Linear Trend of Mortality Rates of AMI Patients



Source: PMPA/ANAHP 2011.

Ischemic Cerebrovascular Accident (ICVA)

The incidence of Ischemic Cerebrovascular Accidents (ICVA) is related to prevalence of systemic arterial hypertension in the population, level of patients' compliance to hypertension treatment, and exposure to risk factors. Some causes are determinant to the occurrence of Ischemic Cerebrovascular Accidents, such as high incidence of smoking, sedentary lifestyle and obesity. Therefore, initiatives focused on primary prevention that may lead to change of habits, such as smoking cessation, increased physical activities and reduction of body mass are essential to decrease the incidence of cerebrovascular diseases.

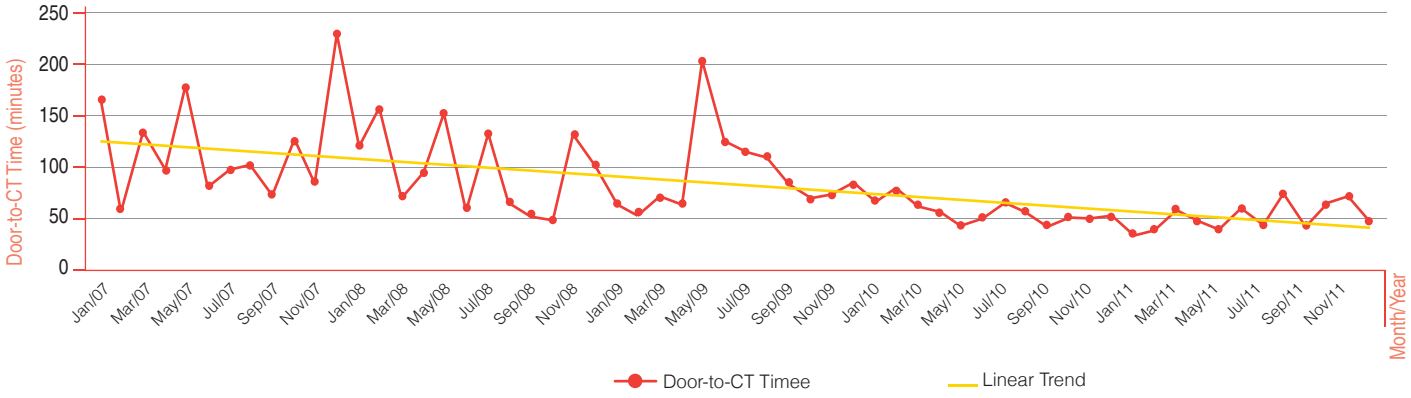
The search for health services at the onset of symptoms and the diagnosis in due time upon arrival at the Emergency unit are secondary prevention initiatives that define the prognosis and the degree of disability resulting from the event. The individual's quality of life and the social impact on families following a patient's discharge are directly affected by such interventions.

Some associated hospitals have implemented protocols for this type of event. ICVA indicators have shown better and more appropriate results in comparison with best practices standards recommended by national and international guidelines. In 2011, 17 hospitals submitted data and indicators on ICVA.

Door-to-CT time shows a linear reduction trend, along with increased effectiveness in healthcare. The reduction, associated with less variability, shows that the protocol has been implemented in these hospitals and that monitoring has produced better health outcomes.

In the historical indicator series, the Tomography Rate increased, but one still can observe major variations over time. On average, the Tomography Rate was 61%. This is a measure that requires investments in the standardization of actions taken and in documenting care.

Graph 34 – Monthly Distribution and Linear Trend of the Door-to-CT Time of ICVA Patients



Source: PMPA/ANAHP 2011.

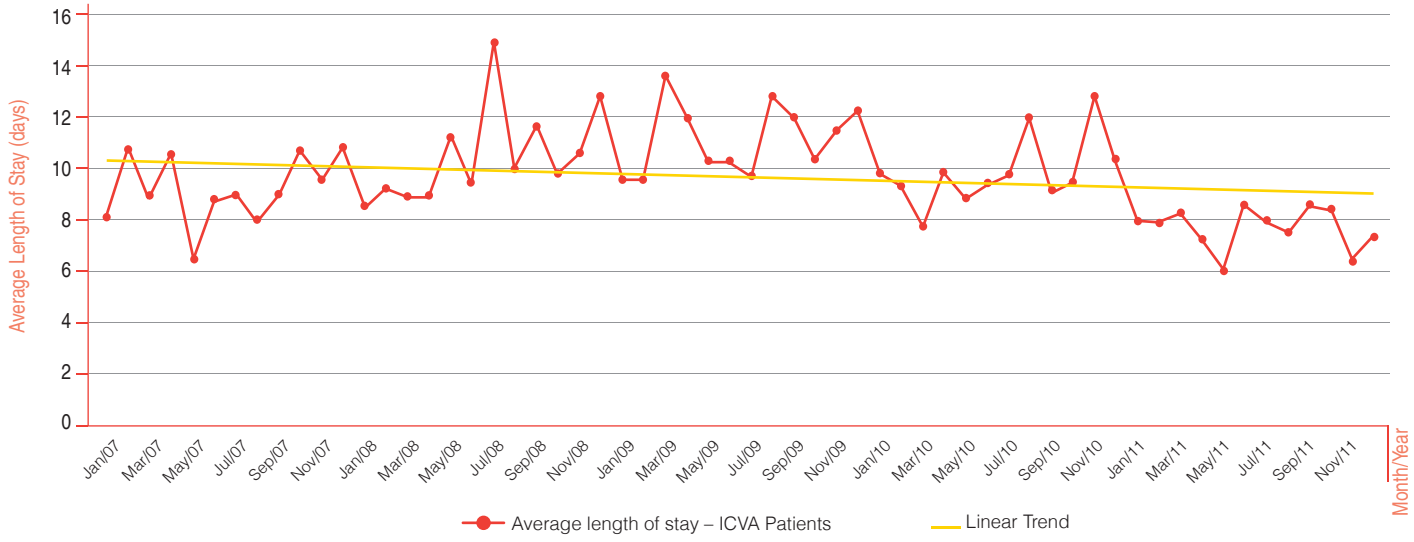
Graph 35 – Monthly Distribution and Linear Trend of the Tomography Rate of ICVA Patients

Source: PMPA/ANAHP 2011.

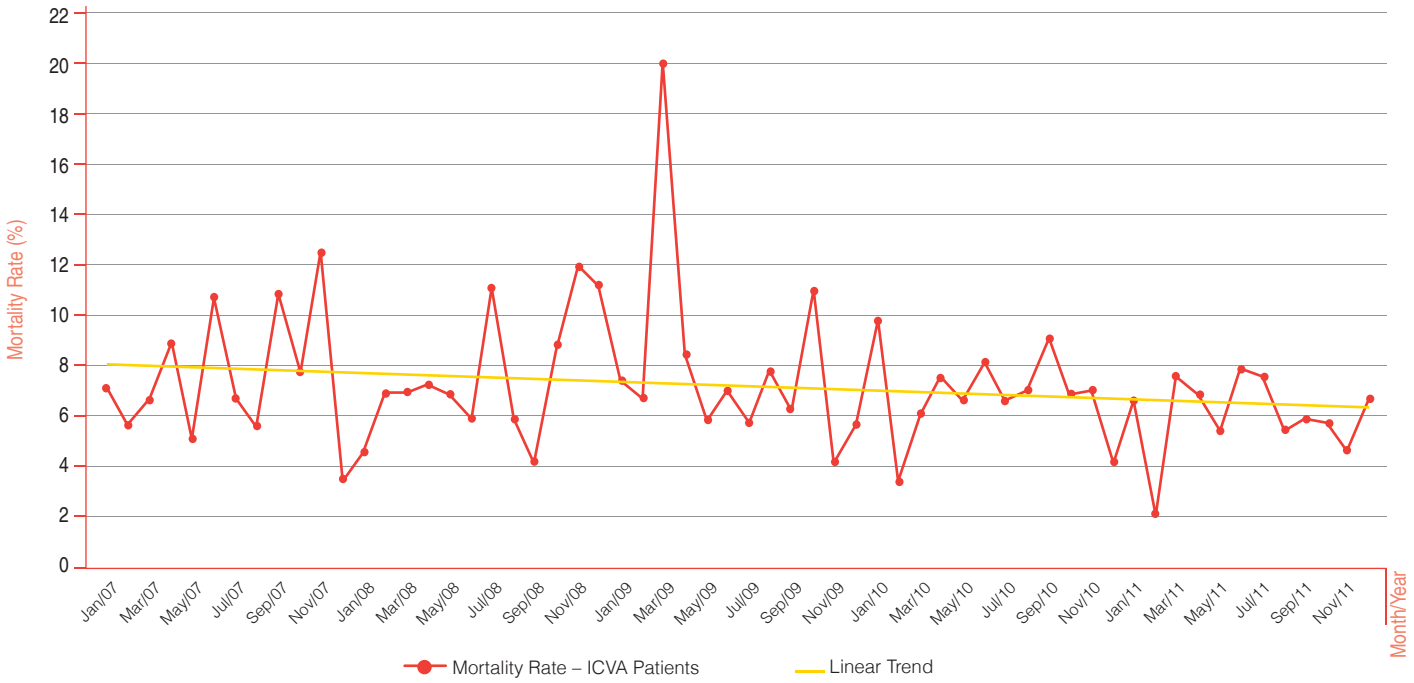
The associated hospitals greatly reduced the Average length of stay in 2011 to 7.6 days on average, ranging from 6.0 to 8.5 days during the year (Graph 36).

The decrease in Door-to-CT Time and the increase in Computed Tomography Rate, along with the decrease in Average length of stay, are elements that show increased standardization among hospitals and better clinical outcomes. Associated with these indicators, the decrease in Mortality Rates due to Ischemic Cerebrovascular Accidents stands out owing to the implementation of said protocols. There was on average 6.0% decrease in Mortality Rates in 2011. During this year, the rate oscillated between 2.0% and 7.9%. The results are compatible with the standards set forth in national and international literature, showing improvement in healthcare management in said cases, with better clinical outcomes.

Graph 36 – Monthly Distribution and Linear Trend of Average Length of Stay of ICVA Patients



Graph 37 – Monthly Distribution and Linear Trend of ICVA Patient's Mortality Rates



Source: PMPA/ANAHP 2011.

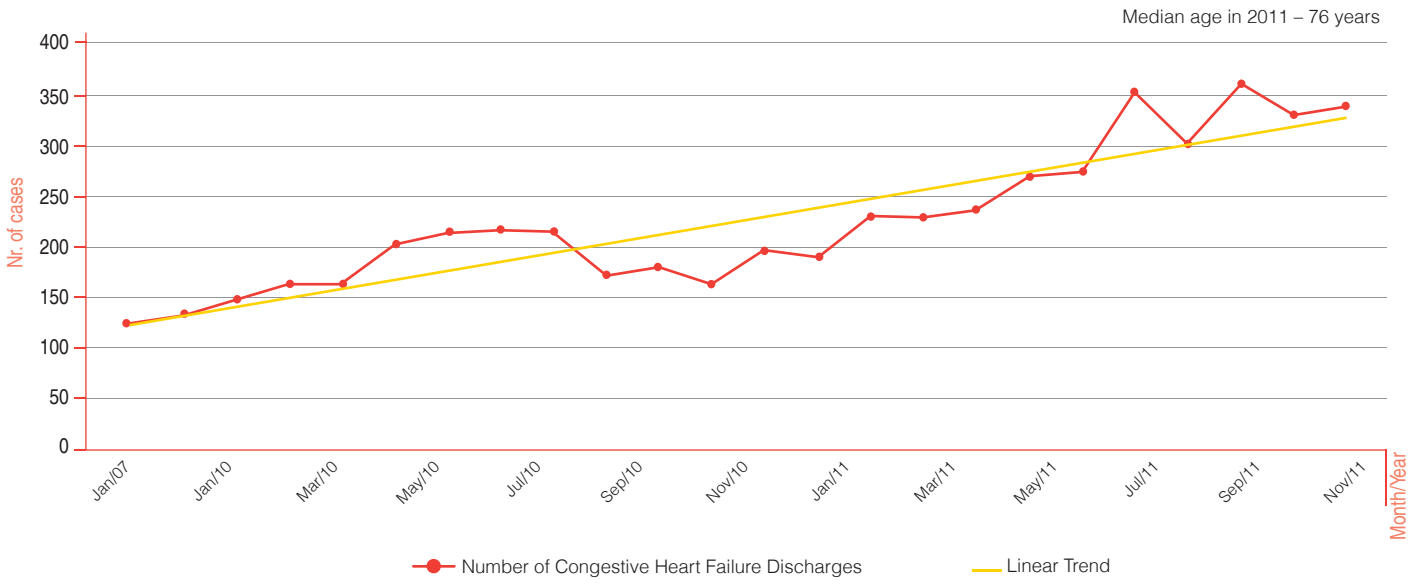
Congestive Heart Failure – (CHF)

Monitoring of Congestive Heart Failure (CHF) began in 2010. One can observe that the number of registered cases has increased during these two years. In 2011, the median age of patients included in the protocol was 76 years (Graph 38). In a 24-month follow-up period, there has been decrease in Average length of stay and Mortality Rate. In 2011, 22 hospitals submitted data on CHF. The Average Length of Stay varied from 8.5 to 12 days.

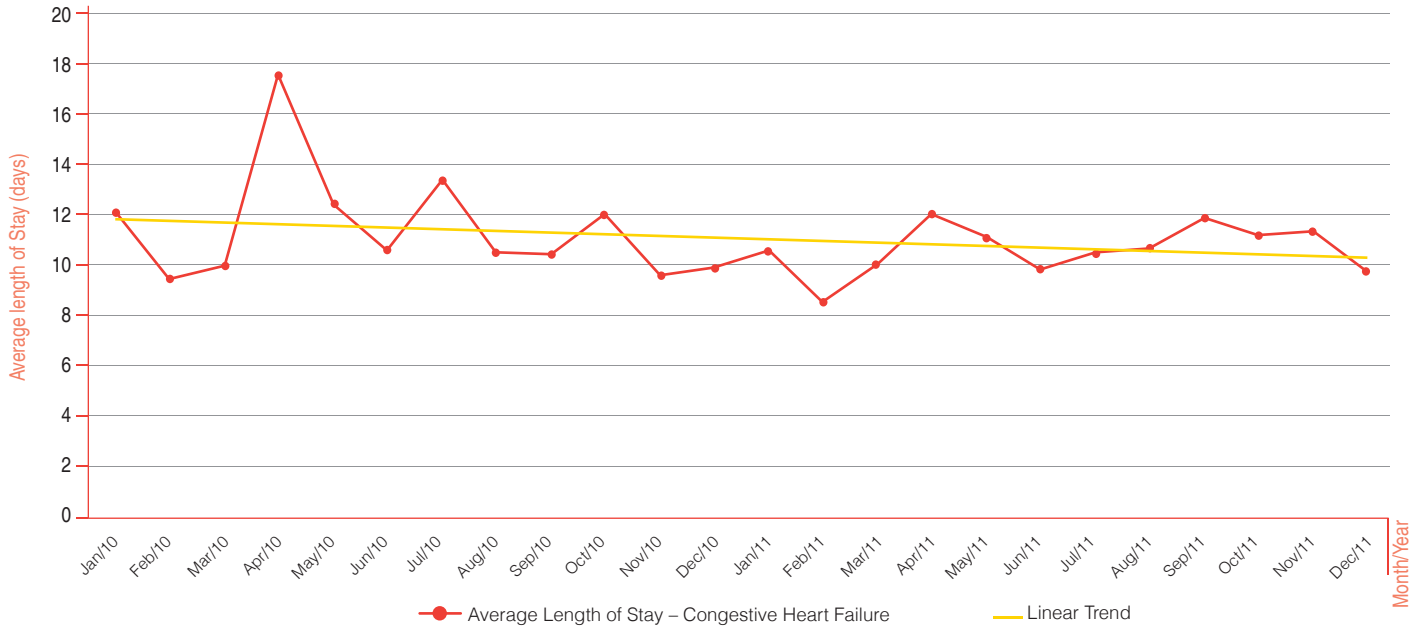
With respect to Mortality Rate, the average in 2011 was 6.8%, ranging from 5.2 to 10.9.

This linear trend shows increasing compliance with healthcare quality and safety standards for provided services.

Graph 38 – Monthly Distribution and Linear Trend of the Number of Congestive Heart Failure Cases

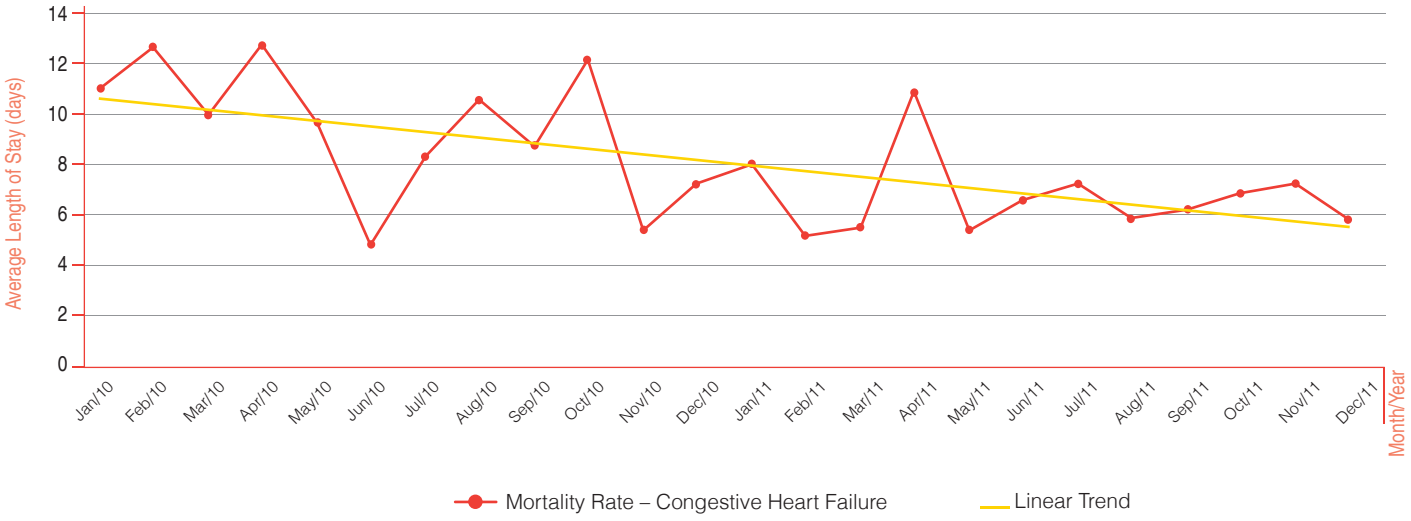


Graph 39 – Monthly Distribution, Linear Trend and Number of Discharges of the Average Length of Stay of Patients with Congestive Heart Failure



Source: PMPA/ANAHP 2011.

Graph 40 – Monthly Distribution and Linear Trend of the Mortality Rate of Patients with Congestive Heart Failure (CHF)



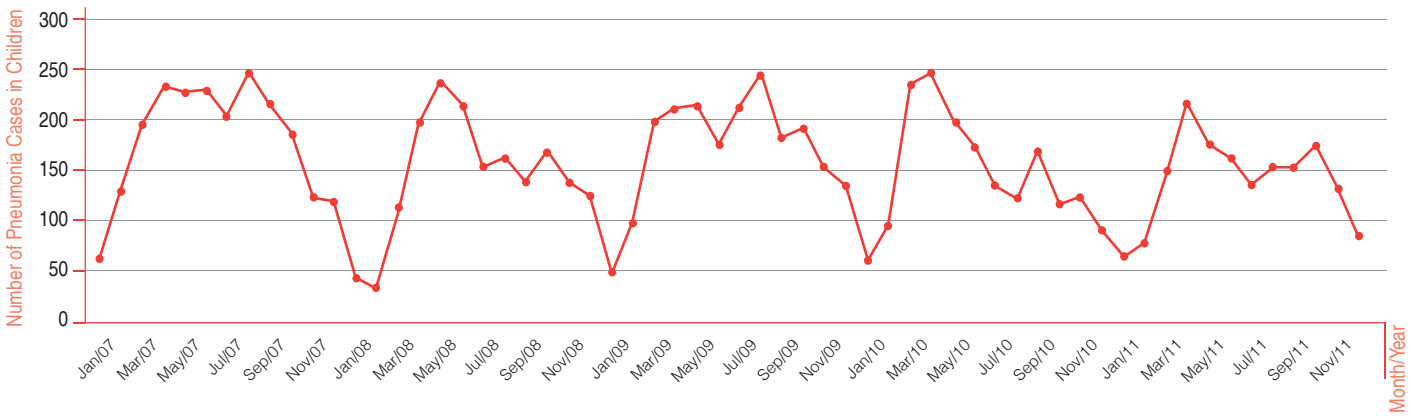
Community-Acquired Pneumonia (CAP)

As we can observe in Graph 26, Respiratory System Diseases represent the third most frequent cause of death in the Southeastern region and the fourth cause in all other regions of Brazil. Community Acquired Pneumonia is one of the main causes of death, presenting increased lethality in recent years in younger age ranges. Inappropriate use of antibiotics, possibly delayed diagnoses and lack of procedure standardization have contributed to increasing lethality in these cases. One should also point out that inappropriate diagnosis and treatment in these cases are determinant for higher risk of developing Sepsis, a severe clinical syndrome with high lethality rates. Children with underlying respiratory diseases (such as asthma and asthmatic bronchitis) and elderly people are risk groups for Community-Acquired Pneumonia.

The project monitors protocols for children and adults, with a distinct focus on people over the age of 60, for whom CAP is a major cause of death.

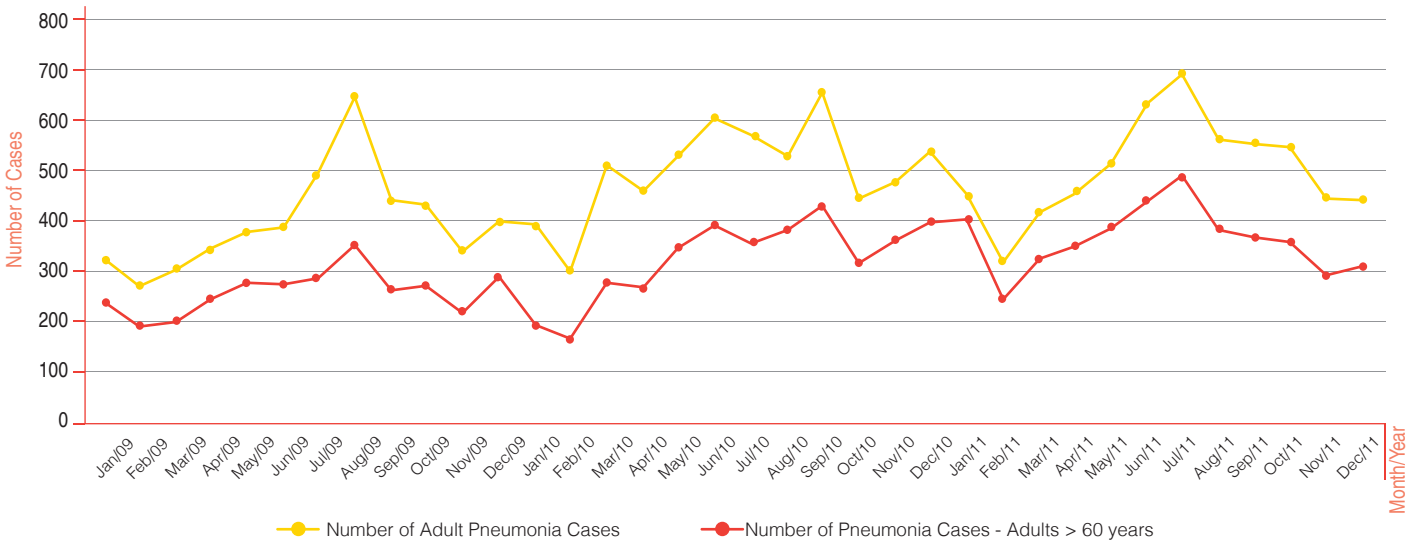
There is seasonal variation in the occurrence of Community Acquired Pneumonia, especially in children. The period of more intensive incidence comprises winter months (Graphs 41 and 42).

Graph 41 – Monthly Distribution of the Number of Community-Acquired Pneumonia (CAP) Cases in Children (patients < 13 years)



Source: PMPA/ANAHP 2011.

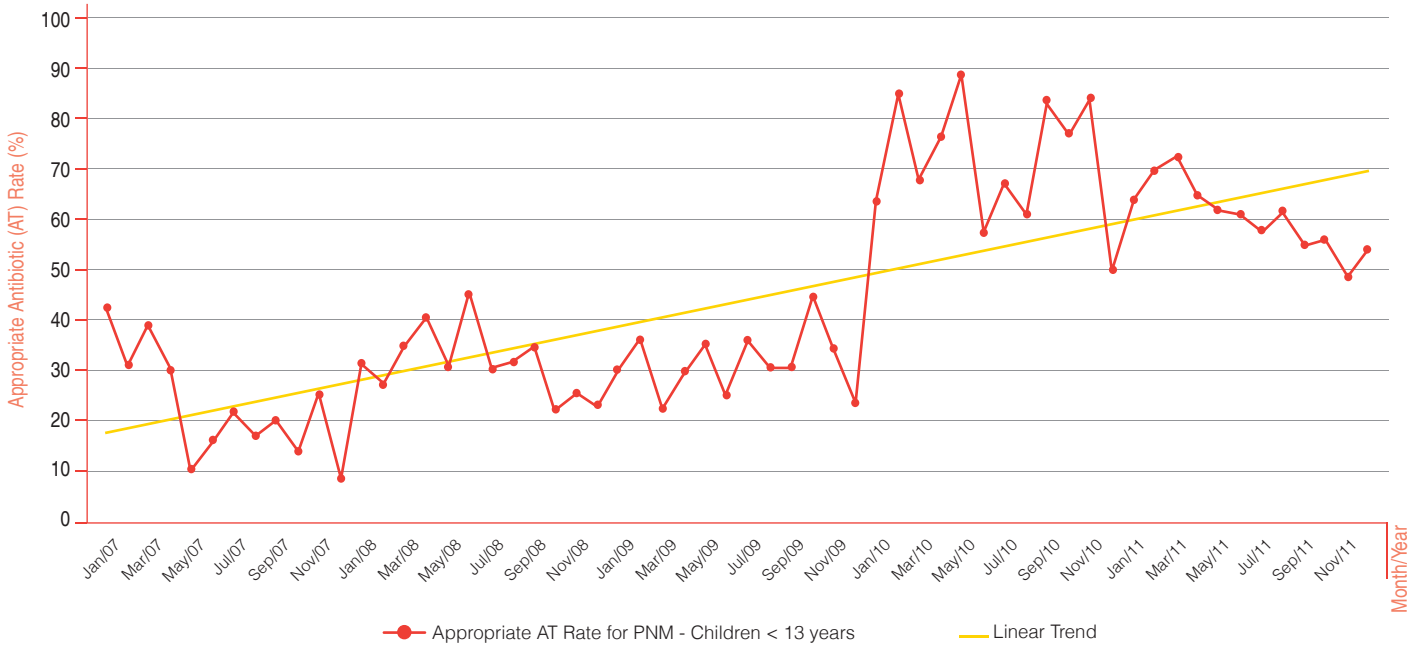
Graph 42 – Monthly Distribution of Number of Adult Patients with Community-Acquired Pneumonia (CAP) and the Number of Patients Older than 60 Years



Source: PMPA/ANAHP 2011.

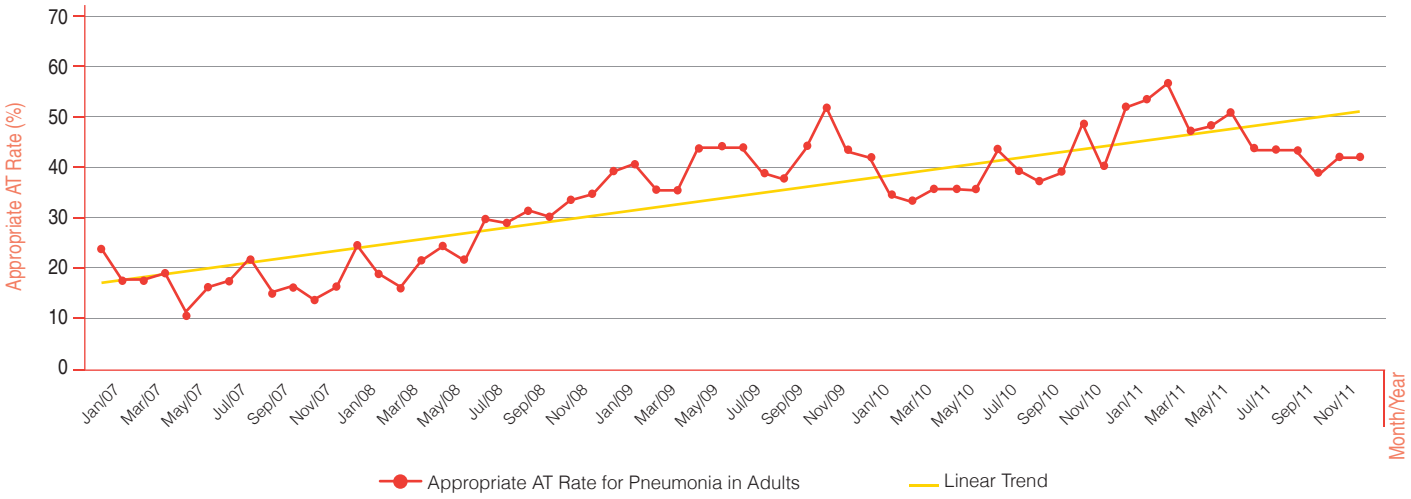
One of the most critical aspects about the implementation of the protocol is Appropriate Antibiotic Therapy Rate (time, strategy and treatment strategy duration). The compliance to such measure has increased for children and adults (Graph 43 and 44). However, overall compliance to such protocols is low in comparison with others previously analyzed. One of the goals for 2012 is to invest in strengthening the implementation of standardization in such cases.

Graph 43 – Monthly Distribution and Linear Trend of Utilization Rates of Appropriate Antibiotic Therapy for CAP in Children (under 13 years)



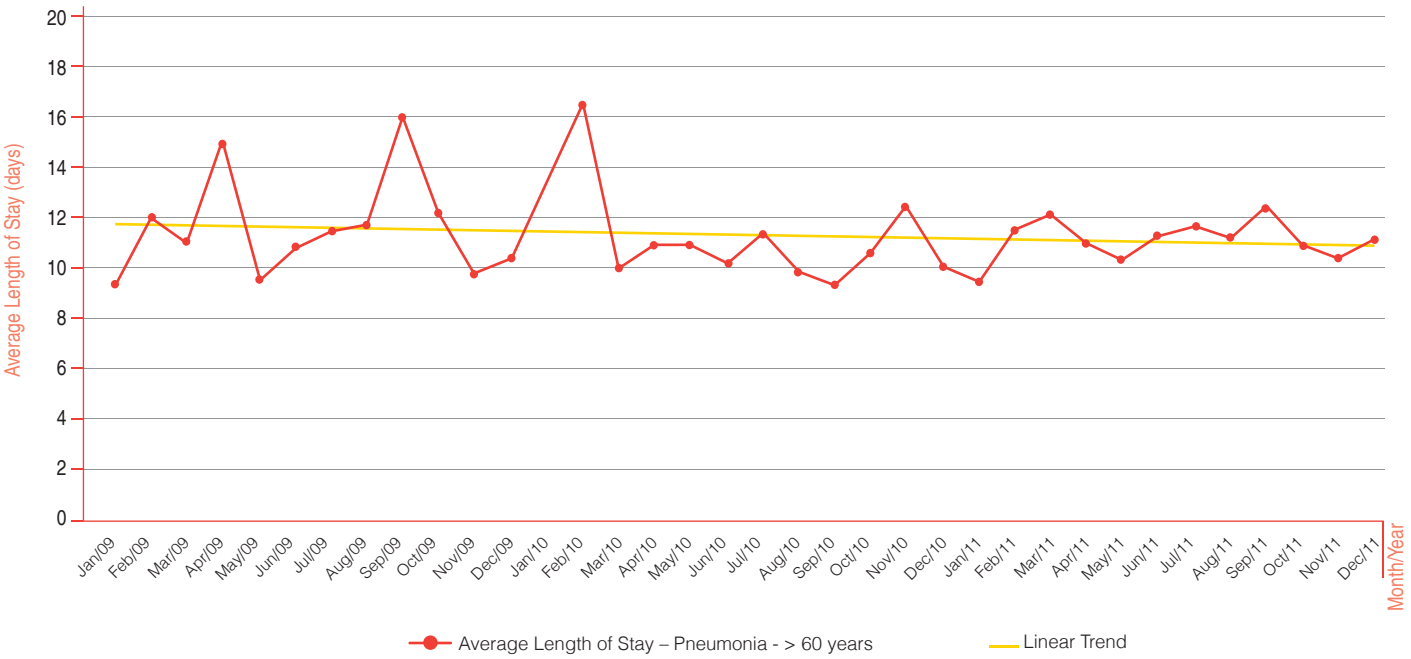
Source: PMPA/ANAHP 2011.

Graph 44 – Monthly Distribution of Utilization Rates of Appropriate Antibiotic Therapy for CAP in Adults and Linear Trend



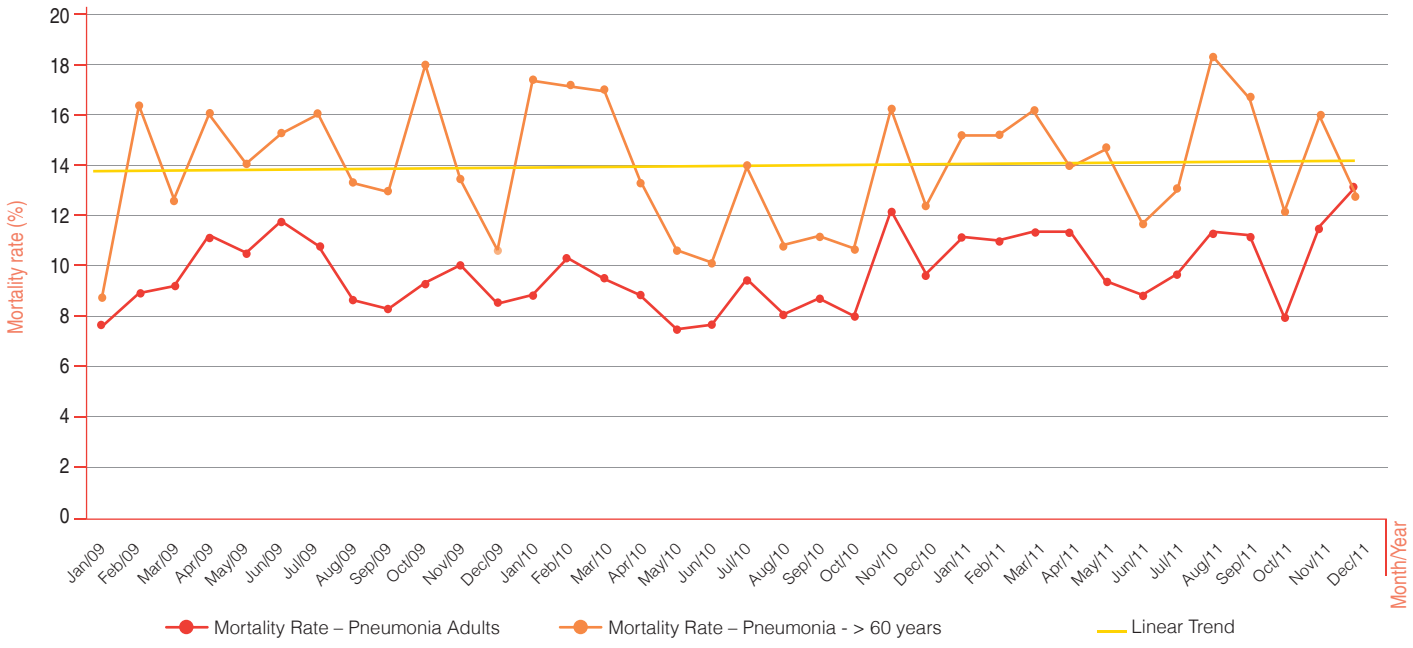
The Average Length of Stay for people older than 60 decreased slightly. The average length of stay for the whole group of hospitals was 11 days. In 2011, 73% of adult patients with community-acquired pneumonia were in the age group over 60 years. The Overall Mortality Rate for Community-Acquired Pneumonia in adults was 11% in 2011 and 15% for people above 60 years of age.

Graph 45 – Monthly Distribution and Linear Trend of Average Length of Stay of Patients with Community-Acquired Pneumonia (CAP) Older than 60 Years



Source: PMPA/ANAHP 2011.

Graph 46 – Monthly Distribution and Linear Trend of the Mortality Rate of Adult Patients and Patients Older than 60 Years with Community-Acquired Pneumonia (CAP)



Sepsis

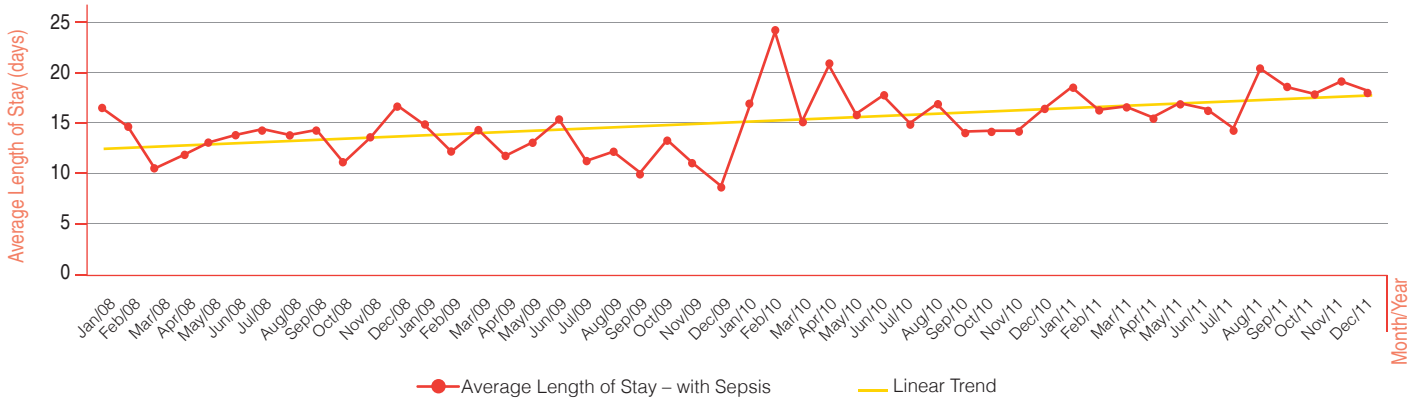
A disease of worldwide relevance and major impact in terms of mortality, Sepsis was the subject of a campaign sponsored by the Institute of Healthcare Improvement (IHI), to enhance awareness of clinical staffs of the importance of early diagnosis of the initial forms of the disease and the power of some initiatives to reduce complications, sequelae and mortality.

In Brazil, the protocol was implemented in a significant number of intensive care and emergency units, correlating the results to those of the international Campaign. The intention was to reduce the number of cases and lethality, which was about 50%.

In 2011, 23 hospitals regularly submitted data on results of the Sepsis protocol. This figure reflects the increase in number of hospitals reporting data, as well as the efficiency of implemented protocols, which is exemplified by the number of detected cases.

One can observe the increase in length of stay in the analyzed series (Graph 47): in 2011, the Average Length of Stay for sepsis cases varied from 16 to 20 days, showing the use of considerable volume of the hospitals' critical resources.

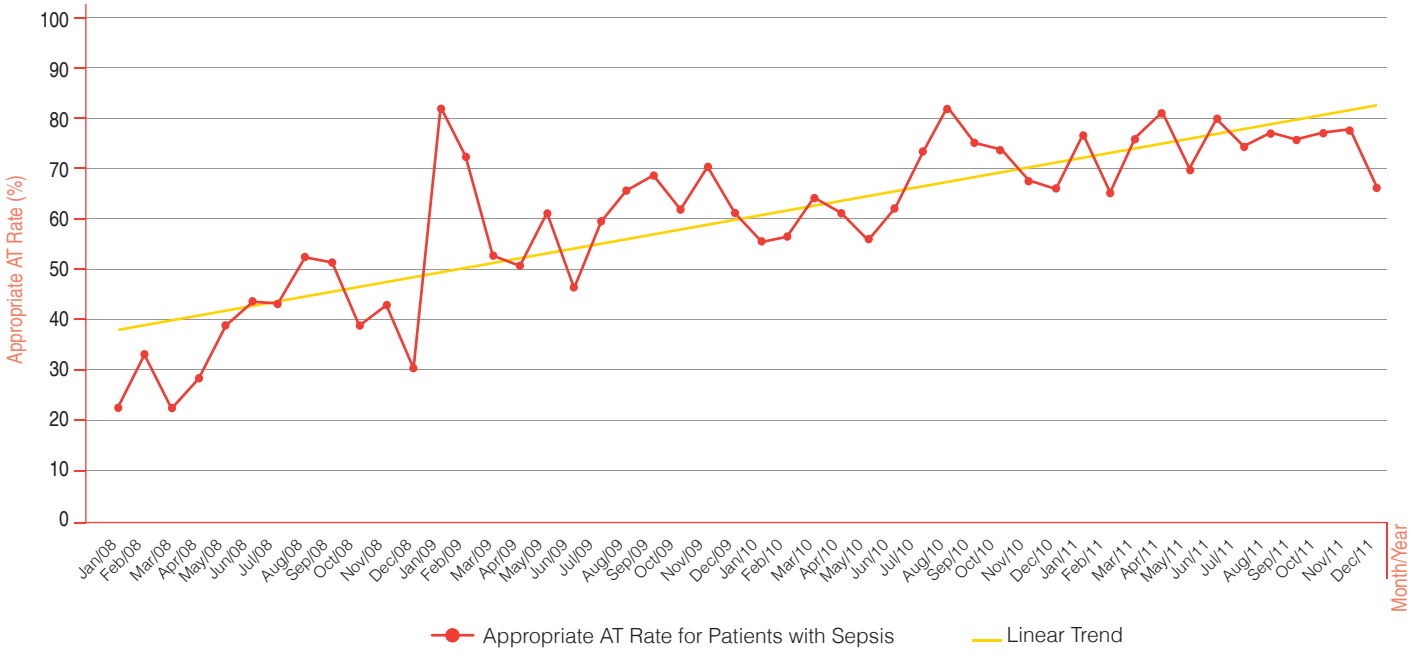
Graph 47 – Monthly Distribution and Linear Trend of the Average Length of Stay of Patients with Sepsis



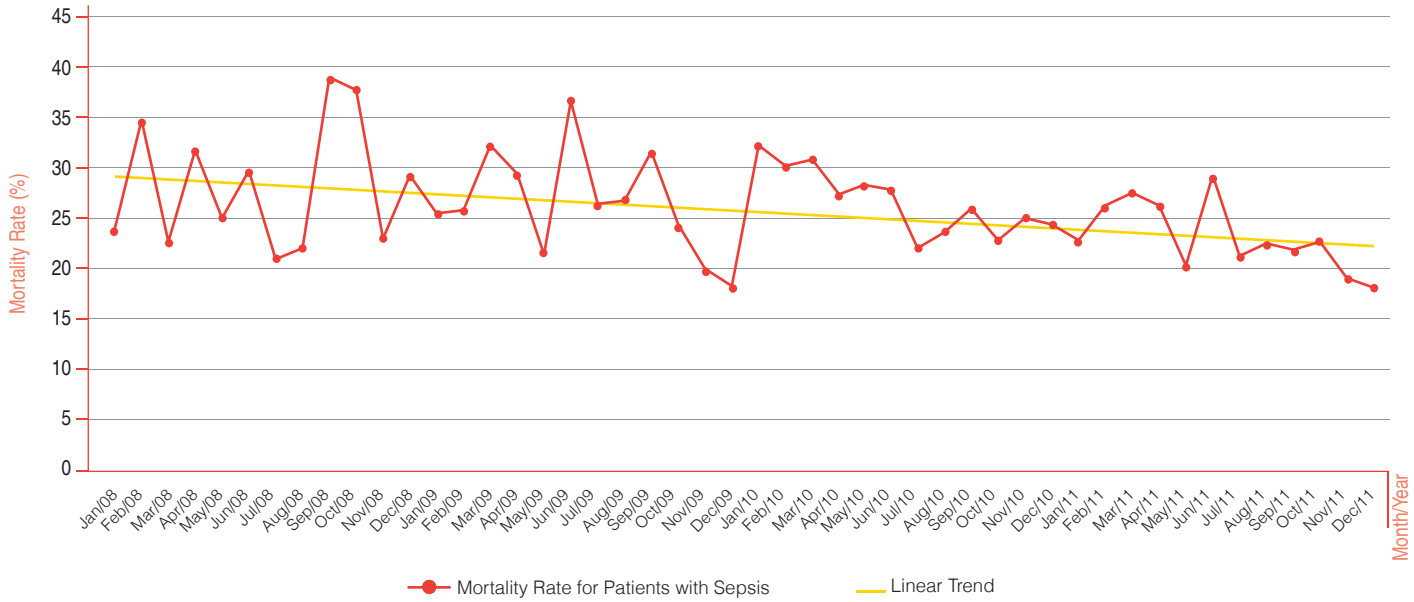
Sourcee: PMPA/ANAHP 2011.

Appropriate Antibiotic Therapy Rate shows a linear growth trend, having reached an average of 75% in 2011, ranging from 66% and 80% in the year (Graph 48). In Graph 49, one can observe the drastic reduction in Mortality Rates, going down from 30% to 35% in 2008 to 23% on average in 2011. These results may be further improved, but are already close to those recommended in international literature.

Graph 48 – Monthly Distribution and Linear Trend of Appropriate Antibiotic Therapy Rate of Patients with Sepsis

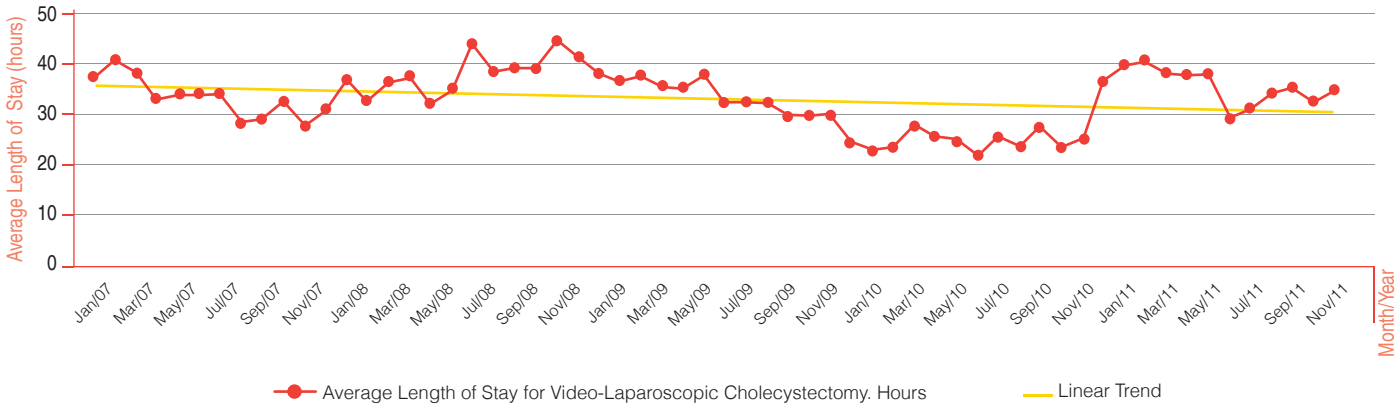


Graph 49 – Monthly Distribution and Linear Trend of Mortality Rate of Patients with Sepsis



Source: PMPA/ANAHP 2011.

Graph 50 – Monthly Distribution of the Average Length of Stay (in hours) for Elective Video-Laparoscopic Cholecystectomy



Source: PMPA/ANAHP 2011.

Video-Laparoscopic Cholecystectomy and Inguinal Herniorrhaphy and Abdominal Hysterectomy

In addition to the indicators Surgical Site Infection Rate and Appropriate Prophylactic Antibiotic Therapy, the following indicators are also monitored: Average Length of Stay in Hours for Video-Laparoscopic Cholecystectomy and Inguinal Herniorrhaphy, and Length of Stay in days for Abdominal Hysterectomy.

There has been linear decreasing trend of Average Length of Stay for Video-Laparoscopic Cholecystectomy in the historical series, although between 2010 and 2011 the indices increased (Graph 50, Table 2).

The decreasing trend can also be observed for Inguinal Herniorrhaphy and Abdominal Hysterectomy (Table 2), however with better results in 2011 than in 2010. This trend inversion is probably related to the incorporation of more complex and severe patients and the use of protocols applicable to such cases. Investments towards improvement of these results are being implemented in 2012.

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Table 03 – Clinical Indicators of Selected Pathologies
(Hospitals ANAHP 2007 to 2011)

Pathologies	Indicators	2007	2008	2009	2010	Jan	Feb	
Acute Myocardial Infarction (AMI)	Door-to-Balloon Time (minutes)	127	111	110	108	102	84	
	Average Length of Stay – AMI (days)	5.4	7.9	7.0	7.2	6.8	7.4	
	Angioplasty Rate – AMI (%)	28.3	42.1	79.9	75.5	69.4	65.6	
	Aspirin Rate at Discharge – AMI (%)	38.3	58.0	53.6	70.6	79.8	59.4	
	Mortality Rate – AMI (%)	7.1	8.6	7.0	5.0	5.7	2.7	
Ischemic Cerebrovascular Accident (ICVA)	Door-to-CT Time (minutes)	122	102	97	61	39	44	
	Door-to-Thrombolysis Time (minutes)	NI	NI	27	96	82	80	
	Average Length of Stay – ICVA (days)	9.1	10.4	11.1	9.7	7.9	7.8	
	CT Rate – ICVA (%)	22.0	36.7	48.4	70.0	66.9	49.3	
	Mortality Rate – ICVA (%)	7.7	7.7	8.1	6.9	6.6	2.1	
Congestive Heart Failure (CHF)	Average Length of Stay – CHF (days)	NI	NI	NI	11.5	10.5	8.5	
	Mortality Rate – CHF (%)	NI	NI	NI	9.1	8.0	5.2	
Pneumonia (CAP) in Children	Average Length of Stay – Pneumonia < 13 years (days)	4.9	5.6	4.9	4.8	5.3	4.4	
	Appropriate Antibiotic Therapy Rate – Pneumonia < 13 years (%)	22.6	33.2	32.3	73.1	64.3	70.2	
	Mortality Rate – Pneumonia < 13 years (%)	0.5	1.0	0.6	0.5	4.3	0.0	
Pneumonia (CAP) in Adults	Average Length of Stay – Pneumonia Adults (days)	7.1	11.1	9.8	8.7	10.2	11.2	
	Appropriate Antibiotic Therapy Rate – Pneumonia Adults (%)	17.2	26.8	41.2	38.4	51.4	53.0	
	Mortality Rate – Pneumonia Adults (%)	8.5	9.4	9.8	9.0	11.2	11.0	
	Average Length of Stay – Pneumonia > 60 (days)	NI	NI	11.6	10.9	9.4	11.5	
	Mortality Rate – Pneumonia > 60 (%)	NI	NI	13.9	12.9	15.2	15.2	
Sepsis	Average Length of Stay – Sepsis (days)	6.9	13.6	12.0	16.5	18.4	16.2	
	Appropriate Antibiotic Therapy Rate – Sepsis (%)	12.2	37.6	62.6	67.1	77.4	65.5	
	Mortality Rate – Sepsis (%)	61.7	27.7	25.8	25.9	22.3	25.8	
Surgical	Average Length of Stay – Hysterectomy (days)	1.5	2.2	1.7	2.6	5.9	5.2	
	Average Length of Stay – Video-laparoscopic Cholecystectomy (hours)	34.0	43.2	34.3	24.8	37.3	40.4	
	Average Length of Stay – Inguinal Herniorrhaphy (hours)	27.0	25.7	17.9	19.8	26.4	26.6	

2011											
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Annual
	79	96	67	100	82	91	73	95	78	83	**86**
	7.5	7.2	7.5	7.3	8.0	7.7	7.1	7.3	7.5	8.0	**7.4**
	71.4	62.7	60.4	81.0	78.8	75.6	72.3	72.7	75.0	76.2	**72.2**
	61.9	59.3	64.1	66.5	65.5	67.8	70.4	67.5	67.0	74.0	**66.9**
	3.0	2.6	3.6	4.1	5.0	3.9	2.2	3.7	3.7	4.9	**3.7**
	63	53	45	65	49	79	48	70	57	52	**53**
	106	74	56	79	47	45	83	57	80	42	**69**
	8.2	7.2	6.0	8.5	7.8	7.5	8.5	8.3	6.5	7.4	**7.6**
	50.9	71.3	41.6	63.9	60.6	58.5	68.0	73.9	61.0	63.3	**60.4**
	7.5	6.9	5.4	7.9	7.6	5.5	5.9	5.7	4.7	6.7	**6.1**
	10.1	12.0	11.1	9.8	10.5	10.6	11.8	11.1	11.3	9.7	**10.7**
	5.6	10.9	5.5	6.6	7.3	5.9	6.3	6.9	7.3	5.9	**6.7**
	5.5	5.4	6.9	6.4	5.6	5.5	5.0	5.1	8.8	4.6	**5.8**
	72.8	65.2	62.2	61.4	57.9	61.8	55.4	56.4	49.3	54.4	**60.9**
	0.0	0.0	0.6	0.6	0.7	0.0	0.6	0.6	0.7	1.1	**0.6**
	11.4	10.6	10.9	10.2	10.8	10.7	10.1	8.9	8.9	9.9	**10.3**
	56.1	46.8	47.8	50.5	43.2	43.2	43.0	38.2	41.7	41.7	**46.0**
	11.4	11.4	9.4	8.9	9.7	11.4	11.3	8.0	11.6	13.2	**10.6**
	12.1	11.0	10.3	11.2	11.6	11.2	12.5	10.9	10.4	11.1	**11.1**
	16.2	13.9	14.6	11.7	13.1	18.3	16.7	12.2	16.0	12.8	**14.6**
	16.6	15.5	16.9	16.3	14.3	20.3	18.5	17.8	19.1	18.1	**17.4**
	76.6	81.7	70.5	80.4	74.9	77.6	76.4	77.8	78.2	66.5	**75.4**
	27.0	25.7	19.8	28.7	20.7	22.1	21.3	22.2	18.5	17.6	**22.6**
	3.9	3.9	2.8	4.0	2.4	2.4	2.5	2.5	4.9	2.5	**3.6**
	41.2	38.8	38.4	38.6	29.7	31.2	34.5	35.7	32.7	35.1	**36.0**
	28.3	34.3	27.9	32.1	27.3	38.4	27.3	38.7	26.3	49.6	**31.7**

- 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 HCor
- Hospital Esperança
- Hospital Israelita Albert Einstein
- Hospital Mãe de Deus
- Hospital Mater Dei
- Hospital e Maternidade Brasil
- Hospital e Maternidade Santa Joana
- Hospital e Maternidade São Luiz
- 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
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- Hospital Santa Luzia
- Hospital Santa Rosa
- Hospital São Camilo Pompeia
- Hospital São José
- Hospital São Lucas
- Hospital São Lucas de Aracaju
- Hospital Sírio-Libanês
- Hospital Vera Cruz
- Hospital VITA Batel
- Hospital VITA Curitiba
- Hospital VITA Volta Redonda
- Hospital viValle
- Real Português Hospital
- Vitória Apart Hospital

Institutional Profile of ANAHP Hospitals

CASA DE SAÚDE SÃO JOSÉ

Brief history of the Institution

Because life is sacred, Casa de Saúde São José is on the eve of completing 90 years of health services in the city of Rio de Janeiro. A member of Associação Congregação de Santa Catarina (ACSC), it is the second largest private and philanthropic foundation in Brazil and a leader in the health sector. It is responsible for generating the revenues needed for ACSC to maintain its 33 social welfare initiatives, which together with Hospital Santa Catarina in São Paulo, treat about 8 million patients a year.

With its mission to serve life through the promotion of health and ready to provide care in 24 medical specialties, ACSC is able to perform 2,500 surgical procedures per month. The hospital has a surgical complex which focuses on invasive and highly complex treatments. This structure is supported by one of the most modern neurological, coronary and neonatal general intensive care centers in the country.

Combining both tradition and state-of-the-art techniques, São José makes ongoing investments in technology and expansion. Its excellence in technology and humane care was confirmed in 2011 by the Canadian International Accreditation Council, certifying that it ranks among the best hospitals in the world.

Highlights in 2011 and 2012

Thanks to a strong master plan for future projects, Casa de Saúde São José intends to expand its capacity to 300 beds by 2015.

In the 2011 balance sheet, an investment of R$ 5.5 million was allocated for renovating the coronary and step-down units. In addition to this extension, the entire technology park was updated, maximizing safety for diagnostics and treatments.

During the first half of 2012, Casa de Saúde São José started operating a Cardiac Center, with a new cath laboratory and cardiac imaging center. Focusing on radiology and interventionist cardiology, intelligent rooms will be inaugurated, with fully automated air conditioning control. This will also enable digital access to patient information, surgeries through international teleconference, and complex procedures performed through imagingguided and minimally invasive techniques. These new features will translate into reduced length of stay and faster patient recovery.

Emergency care - for which the hospital already offers special orthopedic and cardiology services - will also count on emergency urological, neurological, and obstetric care services.

These changes shall also enable the construction of a new surgery complex by 2015, which will concentrate all the surgical rooms in one single building. Casa de Saúde São José is investing in the quality of modern day life, because for our institution, life is sacred.

Characteristics

Philanthropic Hospital	
Founded in	1923
Built up area	30,000 m²
Clinical staff organization	open
Hospital Accreditation	ONA III Accreditation Canada

Hospital Indicators (2011)

Total number of available beds	219
Number of beds in ICUs	55
Number of registered doctors	5,996
Number of active employees	1,128
Number of emergency visits	4,479
Number of outpatient visits	not applicable
Number of hospital admissions	19,788
Number of surgeries per year (except deliveries):	21,673
Number of deliveries per year	3,252
Number of tests performed at the Diagnostics and Therapy Unit	371,141
Gross Revenues (in million R$):	273.4

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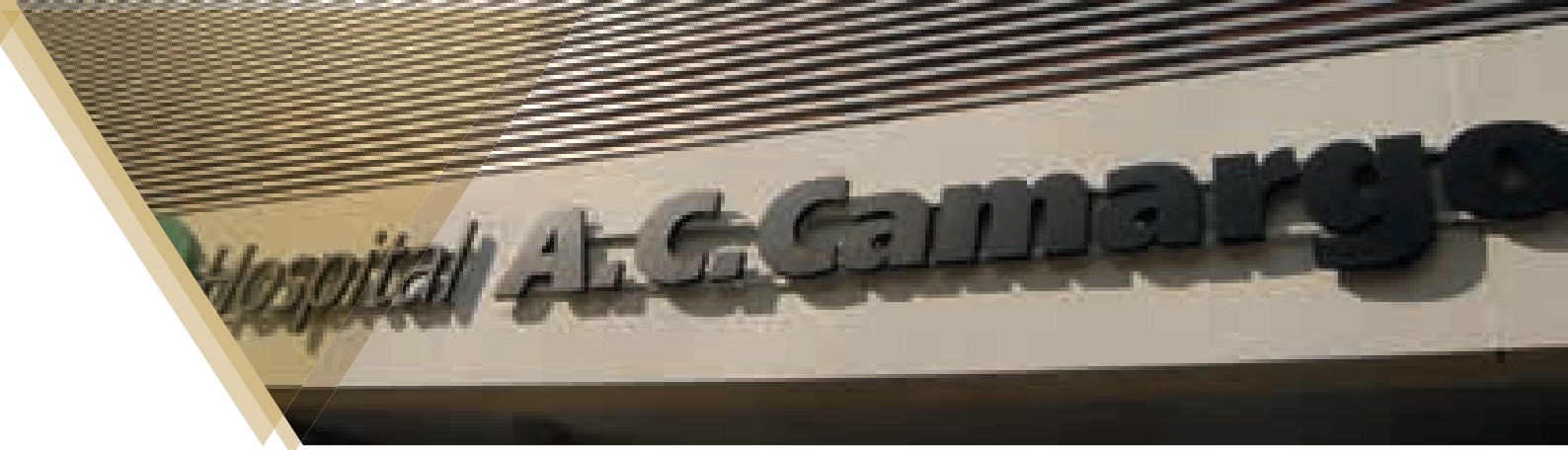

HOSPITAL A.C.CAMARGO

Brief history of the Institution

A philanthropic institution created in 1953 by Antônio and Carmen Prudente, Hospital A.C. Camargo is one of the largest cancer treatment centers in the world. It is an integrated and multidisciplinary hospital which works in prevention, diagnosis, ambulatory care and surgical treatment of more than 800 types of clinically identified cancer, divided into more than 40 specialties. Each year the hospital treats 15,000 new patients from various parts of the country and from abroad. In 2011, more than 1.1 million procedures were performed, and 63.1% of these were dedicated to SUS (Universal Public Healthcare System) patients, all of whom received identical treatment to those patients with private health plans.

The hospital's medical staff consists of a team of over 500 specialists, of whom about 120 are oncologists, the majority having master and doctorate degrees; in turn, they can count on the support of more than 2,400 health professionals. The dedication and interaction of these professionals in interdisciplinary activities result in treatment with excellent success rates, of about 68% for adults - results only comparable to those seen in the world's best cancer centers. Considered as a benchmark for cancer research both in Brazil and abroad, in 2011 the hospital published 188 articles in leading specialized journals. Since its foundation, it has already diagnosed and treated over 700,000 patients, having one of the largest case records in the country for cancer treatment.

Highlights in 2011 and 2012

Following the evaluation process which occurred throughout 2011, Hospital A.C. Camargo received accreditation from Canadian Council of Health Services Accreditation (CCHSA, currently Accreditation Canada): one of the most important seals of approval for global quality management in the provision of health services. A.C. Camargo is the first oncological institution in the country to receive this international recognition. Since its foundation in 1953, half of the oncologists in the country have graduated from this hospital, through its medical residency program; in 2011, its thousandth resident graduated. The hospital is a pioneer in the use of PET-CT scanning; during 2011 the hospital conducted 3,300 of these very high precision tests. In pursuit of further excellence, the institution invested about R$ 9.6 million during 2011 in new technologies. For the treatment of prostate cancer, it has acquired Robotic HIFU Ablatherm equipment: an ultrasound robot designed to hit the smallest of target areas in prostate tumors in a less invasive manner. During 2012, the institution will complete the delivery of further 120 new beds, totaling 421 beds dedicated exclusively for oncology. Such a structure can be compared to the M.D. Anderson Cancer Center, one of the largest cancer centers in the world and one of A.C. Camargo international partners. For 2012, it is planned to hire about 200 new employees and increase the number of beds in the bone marrow transplant department.

Characteristics

Philanthropic Hospital	
Founded in	1953
Built up area	60,000 m²
Clinical staff organization	closed
Hospital Accreditation	National Accreditation Organization (ONA III); Accreditation Canada

Main Indicators (2011)

Total number of available beds	321
Number of beds in ICUs	36
Number of registered doctors	442
Number of active employees	2,444
Number of emergency visits	not applicable
Number of outpatient visits	not disclosed
Number of hospital admissions	not disclosed
Number of surgeries (except deliveries):	8,342
Number of deliveries	not applicable
Number of tests performed at the Diagnostics and Therapy Unit	not disclosed
Gross Revenues (in million R$):	505

Hospital A.C.Camargo
Centro de Tratamento, Ensino e Pesquisa em Câncer

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HOSPITAL ALEMÃO OSWALDO CRUZ

Brief history of the Institution

The vocation of Hospital Alemão Oswaldo Cruz has always been to care for the health of the community ever since 1897, when it was founded by German speaking immigrants. In recent years the hospital has established both its areas of expertise (cardiovascular; digestive; musculoskeletal; oncological and lifelong well-being) and its goals for expansion based on the concept of sustainable growth.

As part of the strategy and thinking relative to the care of its patients, the institution has developed specialty centers, with ongoing investments in technical training and technology, such as: the Institute of Geriatrics and Gerontology; the Prostate Institute; the Center for Excellence in Metabolic and Bariatric Surgery, among others. Initiatives such as these, coupled with a model for quality care earned the hospital accreditation from Joint Commission International (JCI) in 2009.

In 2008, the institution signed an agreement with the Ministry of Health, when it was recognized as a Social Welfare and Charitable Entity, and in 2010, it inaugurated the Outpatients Unit for Social Sustainability in Mooca, in order to service SUS (Universal Public Healthcare System) patients free of charge. In the context of general expansion, the hospital is also opening a new Specialty Center in Campo Belo.

Highlights in 2011 and 2012

In 2011, the focus of Hospital Alemão Oswaldo Cruz was the continuation of its expansion plans with the construction work on the new building in the Paraiso hospital complex, the inauguration of the Nephrology and Dialysis Center, and the new area for Orthopedics. One should also highlight the investments made in technological innovation, in particular acquisitions made for the Diagnostic Imaging Center (DIC), the Clinical Neurophysiology Center and the ICU.

The hospital has also intensified its activities in the area of academic development and scientific research, through its Institute of Education and Science, which accounted for 72 proposals for clinical studies and 20 active international studies during the last year.

In 2012, in addition to the completion of the new building, the institution will celebrate its positive performance with its Social Sustainability initiatives, in partnership with the Ministry of Health, for institutional support of SUS. The hospital has started to manage projects related to management, research, training and technology for the benefit of Brazil's population, including the Integrated Program for Breast Cancer Control.

Characteristics

Philanthropic Hospital	
Founded in	1897
Built up area	96,622 m²
Clinical staff organization	open
Hospital Accreditation	Joint Commission International (JCI)

Main Indicators (2011)

Total number of available beds	221
Number of beds in ICUs	34
Number of registered doctors	5,111
Number of active employees	1,829
Number of emergency visits	55,320
Number of outpatient visits	6,713
Number of hospital admissions	16,255
Number of surgeries per year (except deliveries):	24,616
Number of deliveries per year	not applicable
Number of tests performed at the Diagnostics and Therapy Unit	198,098
Gross Revenues (in million R$):	R$ 421.6

Hospital Alemão OSWALDO CRUZ

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HOSPITAL ALIANÇA

Brief history of the Institution

The creation of Hospital Complex Aliança began in 1982 with an innovative proposal to integrate within the same physical space, the Hospital and the Medical Center. It was inaugurated on October 18, 1990, announcing its arrival on the Bahia medical scene as a new benchmark for the health sector. Besides having an open style clinical staff organization, they maintain their own permanent staff for emergency care, neonatal care, intensive care and for the treatment of complications of those patients hospitalized in the other units. There are 77 medical offices based in the Medical Center: professionals working in various specialties. The hospital also has an auditorium for one hundred people, where both in-house and external scientific meetings are held. In 2000, the infrastructure was extended in order to accommodate pediatric services with the inauguration of Aliança Pediatrics Center, which includes emergency, urgency, and regular care as well as surgical, outpatient and hospital admission. Currently with 203 beds, the hospital has recorded about 250,000 hospital admission over the last 21 years. The institution has 1,552 employees, operating in 60 specialized strategic work teams. The work performed by these teams is based upon the three deeply-rooted values which define the Aliança way: Excellence, Integrity and Improvement.

Highlights in 2011 and 2012

Over the past two years, Hospital Aliança has not limited its efforts for the continuous improvement of its management. Under the auspices of the Dom Cabral Foundation - a benchmark for business schools in Latin America - the Development Plan for Management by Results was implemented, as well as the investment in training hospital leaders. Therefore, Aliança should carry on with its basic guidelines to ensure continuous excellence of its services. It involves prioritizing investments in management, humane treatment and continued training of its personnel. The latest investments are already reflected in the results of a recent survey on customer satisfaction. It was made at the time of patient discharge and indicated a positive index above 90% during all months of 2011. During this same period, there was a decrease in the rate of hospital infections to a minimum level of 1.6%, against the maximum level of 5% recommended by the WHO - World Health Organization. and Aliança's levels of central venous catheter-associated infection reached almost zero (0.31%), reflected in the good results at the ICU. All these factors are translated into local community recognition: for two consecutive years (2010 and 2011) the hospital was awarded the "Top of Mind" - Bahia prize.

Characteristics

For Profit Organization	
Founded in	1990
Built up area	29,216 m²
Clinical staff organization	open
Hospital Accreditation	in progress

Main Indicators (2011)

Total number of available beds	202
Number of beds in ICUs	42
Number of registered doctors	2,760
Number of active employees	1,552
Number of emergency visits	79,189
Number of outpatient visits	not applicable
Number of hospital admissions	12,351
Number of surgeries (except deliveries):	7,347
Number of deliveries	2,056
Number of tests performed at the Diagnostics and Therapy Unit	80,280
Gross Revenues (in million R$):	206

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HOSPITAL ANCHIETA

Brief history of the Institution

A hospital with an architectural design which inspires every human being with a passion for life; brings about a universality of medical knowledge; provides holistic care in their specialized approach; provides comfort and resolution, while also allowing healthcare professionals to fully develop their potential: This is Hospital Anchieta.

As the Institution's sixteenth year comes to an end, it stands out as one of the most modern private health complexes in the country. This is thanks to the comprehensive infrastructure, with outpatient services, diagnostics, and all the hospital back-up services for highly complex healthcare. It is also a benchmark for Quality Management in the area of Health Care. In 2000, Hospital Anchieta received its first ISO accreditation certificate for this service. Since then, the hospital has worked on its Risk Management, and general concern for patient safety has become an Institutional priority, which has led to significant growth and improvement of the organization. In 2002, the hospital received the ONA Certificate of Accreditation Level I. In 2003, it received the level II certificate and by 2006 had already achieved level III. The maintenance of these levels has proven to be the biggest challenge: indeed, even more challenging than receiving these certificates.To reach this current level of excellence, Hospital Anchieta deems it necessary to maintain the level of quality not only in patient treatment, but also in managing its various processes.

"In practice, a hospital that chooses to adopt quality systems has, among its main objectives, the provision of safety and a high standard of care. This is because each of the models - whether ISO, Accreditation or PNQ - determines the customer focus, market vision and provides for the standardization of all processes, the measurement of indicators and the achievement of continuous improvement", says Dr. Delcio Rodrigues, Executive Director.

Highlights in 2011 and 2012

In 2011, Hospital Anchieta recorded the following achievements:

• Implementation of a new organizational model, consolidating its focus on all its efforts dedicated to serving the client – in areas of both management and treatment.

• One of the highlights was the introduction of process management and the restructuring of the areas of logistics and infrastructure, nutrition, storage, clinical engineering, maintenance and supplies - and also the completion of the renovation of the patients' admission area.

• In February the institution's laboratory received a Certificate of Excellence - Gold Category, awarded by the National Quality Assurance (PNCQ) for the Brazilian Society of Clinical Analysis (SBAC) following ten consecutive years of presenting a consistent standard of excellence.

• Hospital Anchieta has invested in Social Responsibility with a view to community development, through events conducted by Anchieta Institute for Teaching and Research – IAEP, through the Best Age Program and lectures for the community. The hospital also provided programs such as Dr. Mirim's, Itinerant Exhibition Stand, and Pre-Natal Courses, the latter having been held for 16 consecutive years, representing a true record in the number of participants.

Characteristics

For Profit Organization	
Founded in	1995
Built up area	60,374 m²
Clinical staff organization	open
Hospital Accreditation	National Accreditation Organization (ONA III)

Main Indicators (2011)

Total number of available beds	153
Number of beds in ICUs	42
Number of registered doctors	519
Number of active employees	791
Number of emergency visits	225,868
Number of outpatient visits	not applicable
Number of hospital admissions	11,944
Number of surgeries (except deliveries):	6,177
Number of deliveries	1,457
Number of tests performed at the Diagnostic and Therapy Unit	587,324
Gross Revenues (in million R$):	107.7

Amor à vida. NCHIETA Hospital Anchieta

Área Especial 8, 9 e 10 - Setor C Norte
Taguatinga Norte
Taguatinga - DF - 72115-700
61 3353-9000 - www.hospitalanchieta.com.br

HOSPITAL BANDEIRANTES

Brief history of the Institution

In 2011, Hospital Bandeirantes, founded in 1975, took an important step towards consolidating the company's new DNA: its Mission, Vision and Values, which can be expressed as follows:

MISSION - To carry out hospital emergency medical care of a highly complex nature, with high- tech excellence and skill;

VISION - To be a national benchmark of high-tech excellence in the hospital sector and to be among the top ten leading medical institution brands;

VALUES - Culture of Safety; Customer Satisfaction; Ethics; Perseverance; Quality; Respect for Life; Environmental Responsibility; Sustainability and Human Skill.

In 2011, a year had passed since the inauguration of the 15,000 m 2 of new buildings, which was a turning point for the institution in the level of hospital care and high-tech medical equipment, which placed the hospital among the country's largest hospitals, with 290 beds, 68 of them in the ICU, and totaling 30,000 m 2, with emphasis on the areas of Cardiovascular and Hemodynamic Care, Oncology, Abdominal Transplants and Specialized Surgery.

Hospital Bandeirantes is accredited by ONA III - National Accreditation Organization's (ONA) Excellence level. The Bandeirantes Health Group, of which the hospital is a part, operates in two areas, with 655 beds and four hospitals:

a) Private network: Hospitals Bandeirantes and Leforte;

b) Network of management contracts with SUS (Universal Public Healthcare System) and the government of the State of São Paulo: Hospital Glória in the capital and Hospital Lacan in São Bernardo do Campo.

Highlights in 2011 and 2012

2011 was a strategic year for the Bandeirantes Health Group (GSB) towards its final consolidation within the premium segment, along with Hospital Leforte in Morumbi, which opened in 2009, and the new Hospital Bandeirantes in Liberdade. It has doubled its treatment capacity and services, such as Nuclear Medicine.

With regard to this, the investments and efforts of GSB leaders have been to strengthen the relationship with two key stakeholders: physicians and health plan operators. This was achieved by improving processes, staging specific initiatives, and implementing measures such as managed surgical procedures.

The target public, i.e., clients/patients, was also the target of specific attention and actions, having promotion of health and quality of life always as the ultimate goal. In 2011, we treated approximately 30,000 people during the year, from businesses and partnering organizations, with various services carried out during the year.

In 2012, the institution will initiate Radiotherapy, Radio-surgery, and IMRT services. In addition, the Oncology Center, already in operation, has two new linear accelerators and a 16 channel PET scanner, placing Hospital Bandeirantes as one of the main centers in Brazil for these specialized services. The Emergency and Cardiovascular Care units, as well as specialized surgeries and transplants, continue to make up the core business of Hospital Bandeirantes.

Characteristics

Philanthropic Hospital	
Founded in	1975
Built up area	30,000 m²
Clinical staff organization	open
Hospital Accreditation	National Accreditation Organization (ONA III)

Main Indicators (2011)

Total number of available beds	255
Number of beds in ICUs	58
Number of registered doctors	4,189
Number of active employees	1,479
Number of emergency visits	78,846
Number of outpatient visits	90,054
Number of hospital admissions	11,878
Number of surgeries (except deliveries):	13,467
Number of deliveries	not applicable
Number of tests performed at the Diagnostics and Therapy Unit	44,081
Gross Revenues (in million R$):	216.2

HOSPITAL BANDEIRANTES

Rua Galvão Bueno, 257 - Liberdade
São Paulo - SP - 01506-000
11 3345-2000
www.gruposaudebandeirantes.com.br

HOSPITAL BARRA D'OR

Brief history of the Institution

Hospital Barra D'Or is considered a benchmark for quality in the city of Rio de Janeiro (RJ). It has just completed 14 years in service this year, establishing itself as a benchmark for healthcare in the region of Barra da Tijuca and adjacent neighborhoods. With the commitment of the entire multidisciplinary staff, the hospital maintains its focus on constant search for quality in healthcare, which is associated with the most humane treatment practices.

Hospital Barra D'Or can be characterized as a hospital with significant experience in the care of critically ill patients, including victims of multiple traumas, and the hospital's expertise can offer several specialized services, such as: general practitioners, surgeons, orthopedic surgeons and ophthalmologists. Barra D'Or Hospital has 46 intensive care beds, distributed between general intensive care, coronary and post-operative units, as well as nine operating rooms. As a result of its expertise, it is able to perform various operations in the area of Catheter Laboratory . One example of this is coronary primary angioplasty bypasses, used to treat cases of acute myocardial infarction.

Highlights in 2011 and 2012

In 2011, Hospital Barra D'Or received re-certification by the National Accreditation Organization (ONA) and Accreditation Canada. The general ICU with 16 beds was renovated to comply with high-tech standards, which included two total isolation beds in its infrastructure, . At the same time, latest generation respirators were purchased, while the entire continuous monitoring system was replaced.

The Surgical Center Technology Park has been updated with the purchase of HD video equipment, new surgical arc equipment, anesthesia machines, surgical tables, including tables specifically for patients suffering from morbid obesity. Every Cath Lab room has been restructured and a new model high-tech angiograph model was installed.

The objective of Hospital Barra D'Or is to seek a balance between modern technology and highly qualified medical staff, from both a technical and human point of view. The hospital works with support groups who assist family members of critically ill patients and also gives lectures for the community, discussing topics of prevention, quality of life and health.

Characteristics

For Profit Organization	
Founded in	1998
Built up area	15,236 m²
Clinical staff organization	mixed
Hospital Accreditation	National Accreditation Organization (ONA III); Accreditation Canada

Main Indicators (2011)

Total number of available beds	166
Number of beds in ICUs	46
Number of registered doctors	17,230
Number of active employees	1,602
Number of emergency visits	89,908
Number of outpatient visits	not applicable
Number of hospital admissions	10,071
Number of surgeries (except deliveries):	6,782
Number of deliveries	not applicable
Number of tests performed at the Diagnostic and Therapy Unit	762,167
Gross Revenues (in million R$):	undisclosed

BARRA D'OR HOSPITAL

Av. Ayrton Senna, 2541 - Barra da Tijuca
Rio de Janeiro - RJ - 22775-002
21 2430-3646 - www.barrador.com.br

HOSPITAL COPA D'OR

Brief history of the Institution

Hospital Copa D'or was founded in May 2000 out of a desire to create a new model for hospital care in Rio de Janeiro: a hospital that could combine cutting edge technology, highly qualified professionals and five star services; a place where people would find safety and comfort while their health is being taken care of.

Situated in the neighborhood of Copacabana, Rio de Janeiro's Southern region, Hospital Copa D'or is recognized for its high standard of quality services and is acknowledged as one of the most important medical centers in the country. Its main features are: excellent services; technical competence; constant investment in technology, and latest-generation treatments performed with human warmth and respect.

Hospital Copa D'or was the first private hospital in Rio de Janeiro to be awarded Joint Commission International (JCI) accreditation and can be compared with any of the best hospitals in the world.

High complexity medicine is a prominent feature of the hospital and therefore its medical staff maintains the highest academic standards, undergoing training and specializations in the most respected learning institutions for health both in Brazil and overseas.

There are more than 270 available beds spread throughout the various hospital sectors: intensive care, step-down care; pediatrics, emergency - adult and pediatric; coronary unit and day clinic.

Highlights in 2011 and 2012

Hospital Copa D'or inaugurated the new Pediatric Emergency Department in 2011, which offers much more space and comfort for patients. It is a children's unit suitable for receiving children and adolescents with a greater number of beds, clinics and an isolation suite.

In 2012, the Hospital plans to offer greater convenience for its doctors, with the creation of a lounge with conveniences specific to this professional body, in order to facilitate their work whilst on the hospital premises.

Characteristics

For Profit Organization	
Founded in	2000
Built up area	16,800 m²
Clinical staff organization	mixed
Hospital Accreditation	Joint Commission International (JCI)

Main Indicators (2011)

Total number of available beds	228
Number of beds in ICUs	75
Number of registered doctors	1,289
Number of active employees	1,900
Number of emergency visits	109,714
Number of outpatient visits	not applicable
Number of hospital admissions	11,430
Number of surgeries (except deliveries):	7,302
Number of deliveries	not applicable
Number of tests performed at the Diagnostics and Therapy Unit	76,244
Gross Revenues (in million R$):	undisclosed

COPA D'OR HOSPITAL

Rua Figueiredo de Magalhães, 875 - Copacabana
Rio de Janeiro - RJ - 22031-010
21 2545-3600 - www.copador.com.br

HOSPITAL DO CORAÇÃO - HCor

Brief history of the Institution

Recognized nationally and internationally as a center of excellence in prevention, diagnosis and treatment of heart disease, HCor – Hospital do Coração currently also offers other medical specialties such as Orthopedics, Neurology, Neurosurgery, Oncology, Vascular Surgery, Urology, Plastic Surgery, Gastroenterology and Pneumology, among others. These services are performed with the same expertise and dedication as the service currently offered in the Cardiology unit.

HCor is a non-profit charitable organization maintained by the Associação do Sanatorio Sirio, and treated its first patient in 1976. Over the course of the last 35 years it has consolidated itself as the originator and driver for new technologies, new treatments, humane healthcare and the development of national and international research in the field of healthcare. HCor has been accredited since 2006 by Joint Commission International (JCI). Through its philanthropic initiatives, the hospital contributes to SUS (Universal Public Healthcare System) as a member of the Hospital of Excellence Program of the Ministry of Health. Through this service, it is are able to provide cutting-edge resources and excellent treatment to the community, as well as promoting the training of human resources and performing research of significant importance to the population. For the next triennium, 2012-2014, the hospital expects to carry out 36 projects and provide investments over $ 110 million.

Highlights in 2011 and 2012

In 2011, HCor maintained its structural growth process and the creation of new specialized services. During this time the following centers were inaugurated: the Obesity Center – with a modern infrastructure and a multidisciplinary team to care for obese patients through nutritional guidance, diagnostic tests, surgical procedures and rehabilitation programs when needed; the Center for Reproductive Medicine – with the goal of identifying and addressing the problems that give rise to male and female infertility, and the Spine Center - a center of excellence for the diagnosis and treatment of spinal diseases. The Pediatric Cardiac ICU Center underwent expansion and renovation in order to provide a more caring treatment for neonatal and infant patients, as well as children suffering from congenital cardiopathy.

Also in 2012, HCor should consolidate another important move towards organic expansion, with the inauguration of two new units: The HCor Advanced Diagnostic Unit, situated at the corner of Av. Faria Lima and Av. Cidade Jardim, with the inauguration planned for the first half of 2012, and Unit 130, annexed to the current hospital complex, with its inauguration planned for the second half of 2012. Hcor Diagnostics Center can call on a comprehensive infrastructure for diagnostic imaging, clinical analyses, digestive endoscopy examinations and specialized services, such as clinical check-ups, in addition to a women's healthcare center. As a result of its constant search for the expansion of its facilities and technical improvements, Unit 130 is being completed and will feature five underground floors, 13 floors, 45 new suites, and two hybrid rooms planned for cardiac and neurosurgical procedures. In addition, this unit will be connected with the main building by an overhead walkway and an underground passageway. The construction of a new building in the vicinity of HCor hospital complex should commence in 2012, where Hcor Onco-Center will be located.

Characteristics

Philanthropic Hospital	
Founded in	1976
Built up area	44,000 m²
Clinical staff organization	open
Hospital Accreditation	Joint Commission international (JCI)

Main Indicators (2011)

Total number of available beds	237
Number of beds in ICUs	53
Number of registered doctors	1,119
Number of active employees	1,977
Number of emergency visits	34,660
Number of outpatient visits	147,809
Number of hospital admissions	9,217
Number of surgeries (except deliveries):	5,444
Number of deliveries	not applicable
Number of tests performed at the Diagnostics and Therapy Unit	1,469,848
Gross Revenues (in million R$):	298

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Paraíso - São Paulo - SP - 04004-030
11 3053-6611 - www.hcor.com.br

HOSPITAL ESPERANÇA

Brief history of the Institution

As a result of investments in modern architecture and up-to-date technological infrastructure, Hospital Esperança was inaugurated in August 2000 on the banks of Rio Capibaribe, in the capital city of Pernambuco. Currently, the hospital is nationally recognized as the second medical complex of its type in Brazil.

There were many reasons why Hospital Esperança consolidated itself into one of the most advanced hospital complexes in the country. One of the main reasons is its humane and caring treatment, demonstrated through the panoramic views seen from all apartments, suites, ICUs and surgical centers. In addition, there are other factors involved, which leave no doubt as to the conceptual pillars advocated by this complex: innovation; precision; respect and advancement.

From the joint initiatives performed with Rede D´Or São Luiz, Hospital Esperança has made investments in the renovation of its installations and has also expanded and purchased equipment, which leads to even more efficient and humane care.

The entire work philosophy and policies are focused on quality care and patient safety. Hospital Esperança is currently accredited at level II (full) by National Accreditation Organization (ONA) and is preparing to be accredited by the Canadian Council on Health Service Accreditation – CCHSA, currently Accreditation Canada, which grants international recognition for the provision of health services.

Highlights in 2011 and 2012

In 2011, Hospital Esperanca provided the community a new emergency department, with modernized facilities, which will improve the hospital's ability to serve the region. It has transformed the Center into one of the largest private hospitals in the North and Northeast regions of the country.

With investments of about R$ 30 million and giving continuity to its expansion plan, 40 new beds were opened. This was the first phase of the project, which will possibly feature additional 60 beds to be delivered and two new surgical rooms up to June 2012. All in all, there will be one hundred new beds for the apartments, the adult intensive care rooms and the cardiology and infants units.

As a result, the hospital capacity will increase by 60%, providing greater comfort and expanding the options of beds. The vertical structure project will also feature four new elevators, which will improve the flow of customer services and ensure more agility in hospital procedures. The hospital will have an Oncology Center and over 320 parking spaces.

In order to offer better quality treatment, many clinical protocols were implemented in accordance with those used in the best hospitals throughout the world, in addition to continuous investments in human care management.

Characteristics

For Profit Organization	
Founded in	2000
Built up area	25,000 m²
Clinical staff organization	mixed
Hospital Accreditation	National Accreditation Organization (ONA II)

Main Indicators (2011)

Total number of available beds	160
Number of beds in ICUs	43
Number of registered doctors	450
Number of active employees	1,269
Number of emergency visits	91,223
Number of outpatient visits	not applicable
Number of hospital admissions	13,437
Number of surgeries (except deliveries):	9,820
Number of deliveries	2,540
Number of tests performed at the Diagnostics and Therapy Unit	400,886
Gross Revenues (in million R$):	undisclosed

HOSPITAL ESPERANÇA

Rua Antônio Gomes de Freitas, 265 - Ilha do Leite
Recife - PE - 50070-480
81 3131-7878 - www.hospitalesperanca.com.br

HOSPITAL ISRAELITA ALBERT EINSTEIN

Brief history of the Institution

Sociedade Beneficente Israelita Brasileira Albert Einstein was founded on June 4, 1955 by members of the Jewish community in the city of São Paulo. Throughout the last 50 plus years, Hospital Einstein has been a benchmark for both physicians and patients, offering services covering the entire health spectrum, from prevention and diagnosis to treatment and rehabilitation. The healthcare activities are distributed among Albert Einstein Hospital, which has just completed 40 years; the Diagnostic and Preventive Medicine Unit, which is present in four different locations in the state capital, and also in Alphaville, in the Greater São Paulo area; Instituto Israelita de Ensino e Pesquisa, responsible for developing cutting-edge research and providing undergraduate and graduate technical and advanced courses in various health areas; Instituto Israelita de Consultoria e Gestão, responsible for providing consulting on Einstein expertise in hospital management and care that has made it a benchmark in the Brazilian healthcare market, and finally Instituto Israelita de Responsabilidade Social (IIRS), which accounts for about 3 million visits in Primary Healthcare Units administered for the City of São Paulo in the districts of Campo Limpo and Vila Andrade, and more than 300,000 people treated free of charge in the community of Paraisópolis. Furthermore, IIRS is responsible for managing Hospital Dr. Moses Deutsch, which serves about 600,000 residents in the districts of Jardim Angela and Jardim São Luiz, in the region of subdistrict M'Boi Mirim.

Highlights in 2011 and 2012

For Hospital Einstein, the year 2011 was marked by significant increase in its activities. At the hospital, the number of treated patients increased by 8%, totaling 188,000 cases. It also created 44 new operational beds and 30 new long-stay beds. The Diagnostic and Preventive Medicine unit showed 27% increase in the number of tests and now accounts for 40% of the Society's revenues. Other highlights were the beginning of the construction of the new Alphaville unit, which after October 2012 will offer a built area of 6,000 m²; the inauguration of the administrative block and support services in Morumbi Unit; and the inauguration of Paraisópolis Health Complex, which includes an Outpatient Medical Care unit, a Primary Healthcare Unit and a Psychosocial Care Center, thus allowing the expansion of its social initiatives in that community.

We also highlight the Planetree award, which recognizes healthcare organizations that provide outstandingly humane care for its patients and families - Einstein is the only institution in Latin America to have received such recognition. In addition, Einstein's scientific research unit has achieved the indexation of its journal - Einstein - in the database of Scientific Electronic Library Online (SciELO). Moreover, the Center for Experimental Surgery and Training was accredited by the Association for Assessment and Accreditation of Laboratory Animal Care (AAALAC).

Characteristics

Philanthropic Hospital	
Founded in	1971
Built up area	218,550 m²
Clinical staff organization	open
Hospital Accreditation	Joint Commission International (JCI)

Main Indicators (2011)

Total number of available beds	644
Number of beds in ICUs	41
Number of registered doctors	5,467
Number of active employees	9,550
Number of emergency visits	227,005
Number of outpatient visits	216,275
Number of admissions	46,417
Number of surgeries (except deliveries):	35,420
Number of deliveries	3,531
Number of tests performed at the Diagnostics and Therapy Unit	3,786,065
Gross Revenues (in million R$):	1,380

Av. Albert Einstein, 627 - Jardim Leonor
São Paulo – SP - 05652-900
11 2151-1233 - www.einstein.br

HOSPITAL MÃE DE DEUS

Brief history of the Institution

Hospital Mae de Deus, maintained by Associação Educadora São Carlos (AESC), a branch of the Congregation of the Missionary Sisters of São Carlos Borromeo – Scalabrinianas, has been operating in the "Gaúcho" society for 32 years, ensuring complete and integrated solutions for healthcare, promoting the development of science, technology and humane care.

Throughout its history, focusing on technical and technological developments, in constant pursuit of excellence in its services and always seeking innovation in its medical-care management model, the hospital became a benchmark at both regional and national levels.

For more than ten years the hospital has intensified its role relative to social responsibility through partnerships with government entities in the area of Public Health, leading to the implementation of Mãe de Deus management model in other hospitals, for the benefit of SUS (Universal Public Healthcare System). Nowadays, Mãe de Deus Health System consists of eight hospitals, distributed over seven municipalities in the State of Rio Grande do Sul, accounting for more than 1.2 million visits and procedures, with a structure of 1,600 beds.

The Congregational values based on humane care, knowledge and selfsustainability are Hospital Mãe de Deus' pillars. It also follows the principles of quality and safe care, as determined by the criteria used by Joint Commission International (JCI) (currently under certification) and by National Accreditation Organization-ONA-level III (Excellence).

It is important to highlight the managerial and technical skills in the implementation of strategic planning. There was also flexibility and speed of adaptation of our teams to the proposals for restructuring and developing the Institution model. The result is not due to miraculous formulas or chance, but rather due to the collective efforts in pursuit of a common goal to be overcome each day.

Highlights in 2011 and 2012

In 2011, Hospital Mãe de Deus was noteworthy for its caring treatment and hospital manner when dealing with patients, family members and employees.

The people management model adopted by the hospital was recognized by the Brazilian Association for Human Resources-ABRH-RS, awarded "Personalidade Top Ser Humano" - Corporate category, relative to the initiative "INCUBADORA"- referring to the training of all clinical employees when they are hired. The hospital was also honored with the award "Top Ser Humano" - Citizenship category- for its initiatives, ''Centers for Psychosocial Treatment for alcohol and other drugs: another life is possible, health in the process of change" - a partnership developed between Hospital Mãe de Deus and the Municipality of Porto Alegre, which enabled the implementation in 2009 of CAPS AD Vila Nova and CAPS AD IAPI, in which initiatives for care and rehabilitation of alcohol and other drugs users are developed.

In 2011, the hospital invested R$ 16 million, and for 2012 the forecast is to invest R$ 32 million more for renovation of the technological park, expansion of the intensive care area, including pediatrics, the recovery wing and the surgical center.

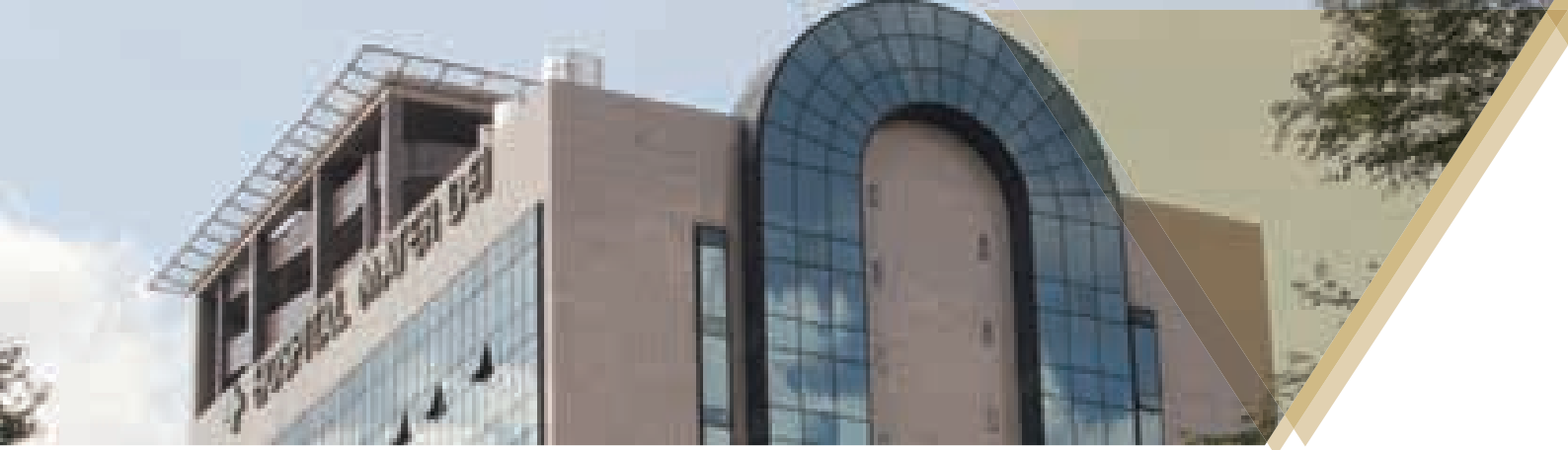
Characteristics

Philanthropic Hospital	
Founded in	1979
Built up area	58,000 m²
Clinical staff organization	open
Hospital Accreditation	National Accreditation Organization (ONA III)

Main Indicators (2011)

Total number of available beds	380
Number of beds in ICUs	54
Number of registered doctors	4,193
Number of active employees	2,372
Number of emergency visits	51,540
Number of outpatient visits	82,720
Number of hospital admissions	15,444
Number of surgeries (except deliveries):	30,160
Number of deliveries	1,761
Number of tests performed at the Diagnostics and Therapy Unit	1,508,032
Gross Revenues (in million R$):	257

Avenida José de Alencar, 286 - Menino Deus
Porto Alegre - RS - 90880-480
51 3230.6000 - www.maededeus.com.br



HOSPITAL MATER DEI

Brief history of the Institution

Since its foundation on June 1, 1980, Hospital Mater Dei has promoted constant improvement in its care and administrative processes in order to provide quality medical hospital services, maintaining its philosophy to always offer an unequalled, personalized and caring treatment for all patients. During the 1980's, the hospital occupied an area of approximately 11,000 m², currently occupied by Block I. Already in 2000, Block II, with approximately 26 000 m², began its operations, enabling increased capacity for care and treatment compared to the previous structure.

For the past 32 years, the institution has made regular investments in therapeutic and diagnostic equipment, infrastructure, managerial initiatives, strategic planning of medical staff and training of its employees in order to offer a safe environment, improve processes and meet its own high standard of quality.

Hospital Mater Dei was the first hospital in a Brazilian capital to be awarded the National Accreditation Organization's (ONA) accreditation level III, in 2004. In 2008, the hospital was awarded ISO 9001/2008 certification, and in 2009, the international National Integrated Accreditation for Healthcare Organizations - NIAHO certification (adopted as the American health model and recognized by the Centers for Medicare and Medicaid Services), being the first hospital outside the United States to achieve this award.

Highlights in 2011 and 2012

In 2011, the hospital began its construction work of the Mater Dei Contorno unit, which will have a built up area of 65,000 m². The new facility will be a high complexity hospital with 320 beds, suitable for various treatments: highly complex surgery; treatment of chronic degenerative diseases, oncology, urgent and emergency treatment, among others. With increasing occupancy rate and, in many cases, surpassing the amount of beds available, the above mentioned acquisition was made to enable the expansion of the current institution, which has two interconnected blocks totaling 309 beds.

Next to the current headquarters, the new hospital unit is situated on Avenida do Contorno, No. 9,000, strategically placed, as it will link important thoroughfares and avenues, facilitating both access and movement. The construction area of Mater Dei Contorno will be 65,000 m², with 889 parking places.

The project was designed by architect Zanettini, a specialist in hospital construction, and it is meant to provide customers innovative architectural solutions, respecting the advanced concepts of modernity, sustainability and environmental preservation. It is estimated that further R$ 250 million will be invested in the construction of the new unit, with 50% of this amount to be financed by Banco Nacional de Desenvolvimento Econômico e Social (BNDES), and the remainder coming from the hospital's own resources. Mater Dei Contorno is expected to be inaugurated in 2014.

Characteristics

For Profit Organization	
Founded in	1980
Built up area Approximately	36,000 m²
Clinical staff organization	mixed
Hospital Accreditation	National Accreditation Organization (ONA III); National Integrated Accreditation for Healthcare Organizations (NIAHO)

Main Indicators (2011)

Total number of available beds	304
Number of beds in ICUs	76
Number of registered doctors	2,601
Number of active employees	1,653
Number of emergency visits	274,613
Number of outpatient visits	1,537
Number of hospital admissions	21,608
Number of surgeries (except deliveries):	26,721
Number of deliveries	2,495
Number of tests performed at the Diagnostics and Therapy Unit	1,187,179
Gross Revenues (in million R$):	250

MATER DEI HOSPITAL

Rua Mato Grosso, 1.100 - Santo Agostinho
Belo Horizonte - MG - 30190-081
31 3339-9000 - www.materdei.com.br

HOSPITAL E MATERNIDADE BRASIL

Brief history of the Institution

Hospital e Maternidade Brasil is the result of a dream that came true by a group of young doctors who, in 1966, believed it was possible to offer the community in the region of Santo André hospital treatment with the same standard of quality found in the best hospitals within the capital.

The hospital opened in 1970 with 30 rooms, two suites, two surgical rooms, two maternity rooms, a nursery and a recovery center. Nowadays, Hospital e Maternidade Brasil is a hospital complex with 260 beds, performing 1,200 surgeries, 270 deliveries, attending 21,000 emergency visits, and receiving 20,000 laboratory tests a month.

The hospital remains in a state of constant evolution and provides its clinical staff and patients with the most advanced facilities in the field of medicine. All sectors are computerized, ranging from the administrative sector to the hospital's various public services: reception, outpatient clinics and internal service sectors. Viewed as a model system, the computerized processes are reason for requests and questions by other institutions within the region.

As a result of its constant search for excellence in promoting patient's healthcare, Hospital e Maternidade Brasil nowadays is a benchmark center for healthcare in Santo André and the entire ABC Paulista region.

Highlights in 2011 and 2012

In 2011, the hospital was awarded ONA level III by National Accreditation Organization, making it the only hospital in the ABC region to obtain the highest level from this institution. It means that the company has constantly improved its services, with standardization of its processes and an offering infrastructure suitable for promoting safety and quality in healthcare.

The hospital opened a care facility with a pediatric emergency center, orthopedics rooms, clinical analysis collection unit, and outpatient psychiatry and plastic surgery facilities. R$ 10 million were invested in the construction of these facilities.

In 2011, 14 more beds were opened in the ICU, together with new mechanical ventilators, monitors, and beds for the unit. In addition, the diagnostic area received two magnetic resonance imaging devices and one CAT scanner and the cath lab was also renewed. The Surgical Center, besides modernizing the technological apparatus, had undergone a complete renovation.

In January 2012, Clínica Médica Porta Aberta was inaugurated to ease congestion and reduce the waiting time at the emergency unit, separating less serious cases from more complex ones, in accordance with the patients' criteria and symptoms. With the initial capacity to receive 200 patients per day, the center has expanded its capacity for patient care within the unit to meet the growing demand of the region.

Characteristics

For Profit Organization	
Founded in	1970
Built up area	31,536 m²
Clinical staff organization	open
Hospital Accreditation	National Accreditation Organization (ONA III)

Main Indicators (2011)

Total number of available beds	204
Number of beds in ICUs	56
Number of registered doctors	411
Number of active employees	2,017
Number of emergency visits	262,326
Number of outpatient visits	249,072
Number of hospital admissions	21,640
Number of surgeries (except deliveries):	14,476
Number of deliveries	3,279
Number of tests performed at the Diagnostics and Therapy Unit	1,318,266
Gross Revenues (in million R$):	undisclosed

Hospital e Maternidade Brasil

Rua Cel. Fernando Prestes, 1.177 - Vila Dora
Santo André - SP - 09020-110
11 2127-6666 - www.hospitalbrasil.com.br

HOSPITAL E MATERNIDADE SANTA JOANA

Brief history of the Institution

In the late 1940's, the access to hospital care for expectant women was still very limited in the city of São Paulo. These were times in which the majority of babies were still born at home. It was during this period, in 1948, that a group of young graduate doctors from Santa Casa School of Medicine founded Casa de Saúde Santa Joana, offering safety and specialization for expectant mothers and babies. Among these doctors was Dr. Eduardo Amaro. The small health center evolved and became Hospital e Maternidade Santa Joana. Its vocation for pioneering has remained over the past six decades. After developing the maternity segment with a new concept in architecture and hospitality administration, in the beginning of 1990, the institution became a benchmark for the treatment of premature babies with low birth-weight. Nowadays, the hospital has a neonatal ICU with 90 beds, with highly skilled clinical staff using cutting-edge technology.

The hospital has partnerships with both national and overseas universities. Hospital e Maternidade Santa Joana is also a benchmark in obstetric anesthesia, in high-risk pregnancy care and in hospital infection control, and has the largest private human milk bank in the country. In 2005, it was the first maternity unit in Brazil to be accredited level III – Excellence, the highest level in the National Accreditation Organization (ONA).

In 2000, the hospital acquired Maternidade Pro-Matre Paulista and in 2009 acquired Perinatal Unidade Barra e Laranjeiras, which became parts of the Santa Joana Group.

Highlights in 2011 and 2012

The expansion of its facilities was a milestone for the Hospital and Maternity unit in November 2011. A modern Center for highly complex medicine was developed and dedicated entirely to the health of both mother and baby, in order to meet patients' needs by concentrating all the most modern concepts in one single place.

Over the past 15 years, Hospital e Maternidade Santa Joana has increased its built up area from 14,000 m² to 40,000 m².

The surgical and obstetric centers are fully computerized and integrated, with three smart rooms, designed for highly complex procedures and with identical configuration to that of the transplant rooms. There are also facilities for video transmission, laminar flow, monitors with flexible arms for video-surgery and digital PACS (Picture Archiving and Communication System) radiology, with a supplies sterilization center allocated within the same sector. This has provided a basis for innovative surgical techniques to be carried out, highlighting the pioneering spirit of the maternity unit. The hospital maintains partnerships with highly respected medical schools in the country and abroad, for the purpose of scientific exchange. Healthcare, diagnostic imaging tests, and human respect and care in the hospital processes are also characteristics of the Institution.

Characteristics

For Profit Organization	
Founded in	1948
Built up area	40,000 m²
Clinical staff organization	open
Hospital Accreditation	National Accreditation Organization (ONA III)

Main Indicators (2011)

Total number of available beds	300
Number of beds in ICUs	70
Number of registered doctors	4,000
Number of active employees	2,200
Number of emergency visits	41,000
Number of outpatient visits	not applicable
Number of hospital admissions	22,934
Number of surgeries (except deliveries):	7,700
Number of deliveries	14,700
Number of tests performed at the Diagnostics and Therapy Unit	5,200
Gross Revenues (in million R$):	undisclosed

Rua do Paraíso, 432 - Paraíso
São Paulo - SP - 04103-000
11 5080-6000 - www.hmsj.com.br

HOSPITAL E MATERNIDADE SÃO LUIZ

Brief history of the Institution

Considered one of the largest private hospitals in the country, Hospital São Luiz was opened in 1938 as a polyclinic with 12 beds in the neighborhood of Itaim Bibi. Two years later it became the first private Emergency unit in the region, and it was only a matter of time before commencing the construction of the hospital building, opened in 1963 with 80 beds. In 1983, the maternity unit was inaugurated and with it came the innovative concept of hospitality in the field of healthcare in Brazil. In addition to this, there was a genuine concern to offer comfort and humane care, practices which are considered a benchmark in the areas of maternity and neonatal ICU within the network. In 1994, a modern diagnostic center was added to the hospital complex, equipped to carry out latest generation type tests with the support of specialized teams.

Currently, São Luiz brings together highly trained medical teams, service excellence and high-tech equipment, serving more than 40 medical specialties. The hospital is a benchmark in urology, gynecology, neurology, orthopedics and cardiology. Its technological center was opened in 2005, offering the community innovation and safety within the surgical center, the obstetrics center and the intensive care unit (neonatal and adult). As a result of its tradition in excellence and constantly evolving improved practices, Hospital e Maternidade São Luiz has been the official hospital for Brazilian Fórmula 1 Grand Prix for the past 12 years.

Highlights in 2011 and 2012

The most significant project for Itaim unit between 2011 and 2012 was its expansion, which is accompanied by the modernization of the Emergency unit, located on Avenida Santo Amaro. Since the construction works started, 39 new suites have been built to the highest standard of finishing and equipped with state-of-the-art infrastructure on the 1st, 2nd and 3rd floors.

On the ground floor, the Emergency facilities are being duplicated, which will enable the expansion of its capacity. Sophistication and modernity convey to the new Emergency unit a comfortable environment.

In addition to the expansion and redesigning of the interior architecture, the Emergency unit will work under a new care concept: the Smart Track model, which will add value to both the technical quality and to the perceived quality, two strategic points of great relevance to the work philosophy of D'Or São Luiz network.

With the expansion, it is intended to surpass the mark of 400 beds in the coming years. In the first half of 2012, the unit will feature over 11 ICU adult beds.

Another important milestone is the quest for accreditation: certification by Joint Commission International (JCI). Since the beginning of 2011, the entire hospital management has been engaged in improving processes, policies, routines and infrastructure, aiming to meet the recommended JCI standards. The key to this project is to offer customers, doctors and employees technical quality, perceived quality and safety.

Characteristics

For Profit Organization	
Founded in	1938
Built up area	35,745 m²
Clinical staff organization	open
Hospital Accreditation	National Accreditation Organization (ONA III)

Main Indicators (2011)

Total number of available beds	371
Number of beds in ICUs	85
Number of registered doctors	12,100
Number of active employees	1,922
Number of emergency visits	133,690
Number of outpatient visits	not applicable
Number of hospital admissions	19,532
Number of surgeries (except deliveries):	15,797
Number of deliveries	8,181
Number of tests performed at the Diagnostics and Therapy Unit	213,877
Gross Revenues (in million R$):	undisclosed

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Vila Nova Conceição
São Paulo - SP- 04544-000
11 3040-1100 - www.saoluiz.com.br

HOSPITAL MEMORIAL SÃO JOSÉ

Brief history of the Institution

Founded on June 2, 1989, Hospital Memorial São José (HMSJ) complex was opened in Recife to excel in service quality and offer the State of Pernambuco and the Northeast region access to technological innovations and high-complexity procedures – which used to be performed only abroad.

The hospital has its own physical infrastructure in a complex which comprises six buildings, together with one of the most complete diagnostic centers in Brazil, consisting of Maximagem, Unigastro, Unicardio, Mediax, MCor, among others. The hospital offers its patients and the local population five MRIs, two CAT scanners, two angiography devices, among other advanced technology equipment.

Hospital Memorial São José has 155 beds designed to offer maximum comfort and safety to its patients. In addition to the emergency pediatric and multidisciplinary centers recently expanded for greater patient comfort, the adult ICU, neonatal, pediatrics and coronary centers within the complex have three surgical units, one of which is intended for procedures that do not require more than 12 hours of hospital stay. All investments in the physical area and in cutting-edge technology are accompanied by continued professional advanced training of its medical and managerial staff.

Highlights in 2011 and 2012

HMSJ continued the development of its facilities with the expansion of its emergency Cardiology and Orthopedics units and its specialized clinics. An important focus during the year of 2011 was the implementation of the BMT (bone marrow transplant) center in an environment built and meticulously designed specifically for this purpose. For almost a year now, autologous and allogenic transplants have been performed with great success.

Hospital Memorial São José has made some profound structural reforms and significant investments in training of staff and hiring of new professionals over the past three years. This consolidated the process of International Accreditation by Joint Commission International (JCI), which led to the Accreditation Award in February 2012, making HMSJ the first hospital to be accredited by JCI in Northeastern Brazil.

HMSJ continues to invest in human resources, infrastructure, and acquisition of new cutting-edge medical equipment in order to meet its commitment to quality and reliability of its services.

Characteristics

For Profit Organization	
Founded in	1989
Built up area	25,000 m²
Clinical staff organization	open
Hospital Accreditation	Joint Commission International (JCI)

Main Indicators (2011)

Total number of available beds	155
Number of beds in ICUs	44
Number of registered doctors	674
Number of active employees	835
Number of emergency visits	69,308
Number of outpatient visits	not applicable
Number of hospital admissions	12,099
Number of surgeries (except deliveries):	7,704
Number of deliveries	1,753
Number of tests performed at the Diagnostics and Therapy Unit	302,985
Gross Revenues (in million R$):	94

MEMORIAL SÃO JOSÉ
HOSPITAL E CLÍNICAS

HUMANO COMO VOCÊ.

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Recife - PE - 50070-160
81 3216-2222 - www.hospitalmemorial.com.br

HOSPITAL MERIDIONAL

Brief history of the Institution

Within just ten years, Hospital Meridional went from a 50-bed institution to a high quality, resolutely spirited hospital complex, with over 160 beds. Located in the State of Espírito Santo, the hospital's quality and safety in healthcare is recognized both nationally and internationally. During a recent survey carried out by Instituto de Pesquisa Futura, an affiliated company to Rede Globo, it was elected as the main choice of physicians in Espírito Santo for the treatment of complex pathologies.

During these past ten years, the hospital has become a benchmark in highcomplexity procedures and has achieved many scientific breakthroughs. Furthermore, Hospital Meridional has also grown through the purchase of other hospitals in the State: two in the city of Vila Velha and one in the city of Cariacica - all of which are in the Metropolitan Vitoria region. This corresponds to the acquisition of 167 additional beds (nearly 230 beds when combined with those of Meridional).

Hospital Meridional has a completely integrated system for treating Neurology patients and is renowned for its work with heart, liver and kidney transplants. In addition to a team of highly qualified professionals, it also offers a transplant center devoted exclusively to the preparation and follow-up of donor candidates, transplanted patients and their families. The entire success achieved by Hospital Meridional is mainly due to the pioneering spirit and expertise of its senior management which, regardless of the size of each challenge, never deviated from its focus on investing in quality and safety for every service offered.

Highlights in 2011 and 2012

The year 2011, in which the hospital completed ten years, was a year of many conquests for Hospital Meridional. Last year, the hospital achieved accreditation by the Canadian model of international accreditation, consolidating one of its main values, which is focus on quality treatment and safety for the client.

In 2011, Hospital Meridional also realized a significant and daring dream: the first Quality Healthcare Congress, which featured more than 50 speakers, of which 20 were from outside the State of Espírito Santo. The Congress received over 300 participants and also some associated ANAHP partners, and was considered a great success by all. Last year, the hospital was re-certificated with National Accreditation Organization (ONA) level III accreditation, confirming the maturity of the hospital's quality system and its talent for always being a pioneer in quality healthcare for the State of Espirito Santo, by seeking to implement ONA in 2005, and by gaining the Canadian model of international accreditation in 2011 - the first in the State. During this period, Hospital Meridional acquired yet another hospital in the best neighborhood of the city, with an area of about 8,000 m², where Meridional Vitoria will be built.

Characteristics

For Profit Organization	
Founded in	2001
Built up area	14,783 m²
Clinical staff organization	open
Hospital Accreditation	National Accreditation Organization(ONA III); Accreditation Canada

Main Indicators (2011)

Total number of available beds	161
Number of beds in ICUs	52
Number of registered doctors	560
Number of active employees	622
Number of accident and emergency consultations	99,392
Number of outpatient visits	64,161
Number of hospital admissions	7,126
Number of surgeries (except deliveries):	8,445
Number of deliveries	16
Number of tests performed at the Diagnostics and Therapy Unit	29,341
Gross Revenues (in million R$):	75

HOSPITAL MERIDIONAL
Gente de bem com a vida

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27 3346-2000 - 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 building of a German hospital in Porto Alegre, which was eventually inaugurated on October 2, 1927. The hospital was designed to cater for all illnesses and patients regardless of race, belief or nationality, preserving German values, language and culture in the State of Rio Grande do Sul. Initially, the hospital was administered by the German deaconesses, who, during that same year, founded the School of Nursing, which still exists today.

In the beginning of the 1970's, the hospital administration was professionalized. In 2004, the hospital doubled the size of its installations and currently consists of a Hospital Block, two Clinical Centers and an Education and Research Institute. In addition, in 2004 a unit next to Iguatemi Shopping Center was inaugurated (Hospital Moinhos de Vento Iguatemi), which provides prevention, medical visits, diagnostic services and treatments. AHMV support units, where social support initiatives for the community are developed, were also inaugurated. In addition to being the first hospital in the Southern region of Brazil to receive accreditation by Joint Commission International (JCI) in 2002, in this same year it was recognized by the Ministry of Health as one of the hospitals of excellence serving SUS (Universal Public Healthcare System). Furthermore, Restinga e Extremo Sul Project was initiated. With the beginning of the construction of Restinga Hospital in the extreme south, this project proposes the establishment of a regional system for healthcare. This is intended to provide primary care coupled with specialized care, emergency and hospital services of medium complexity, together with the structure called School of Health Management, responsible for training of human resources.

Highlights in 2011 and 2012

The year 2011 was one of significant investments and achievements for Hospital Moinhos de Vento. Maternidade Helda Gerdau Johannpeter was inaugurated, offering customers a new concept in maternity services, spearheading the Institution's focus on excellence.

The project, which was based on four pillars - humane care, safety/technology, privacy and hospitality - was awarded Top MKT ADVB/RS 2011, Health category.

This standard of excellence has been recognized both nationally and internationally with the accreditation award for the fourth consecutive year (since 2002) given by Joint Commission International (JCI), ranked 3rd place in the best Latin American hospitals and clinics award (published by the journal Americaeconomia). With respect to its own clients, the hospital was awarded TOP citizenship award and was among the 30 best companies to work for in Rio Grande do Sul. References such as these reflect the investments made in personnel management and in the refinement of its socio-medical care practices.

The recognition of Hospital Moinhos de Vento's management system using the BSC methodology, as well as the concept of co-creation for the definition of strategies, with the alignment of units working as contributing panels for the strategy to be followed in 42 units, won a deserved publication in Harvard Business Review in October 2011.

The inauguration of the orthopedics and neurology centers and the implementation of the Datamatrix code used for the identification of pharmaceutical products are also reasons for pride in the institution.The social responsibility initiatives, such as Projeto Social Restinga Extremo Sul, also received community recognition, through TOP Citizenship award, further proving our commitment to meet community demands with the same expertise which is characterized in the hospital's core activity.

Characteristics

Philanthropic Hospital	
Founded in	1927
Built up area	86,000 m²
Clinical staff organization	open
Hospital Accreditation	Joint Commission International (JCI)

Main Indicators (2011)

Total number of available beds	464
Number of beds in ICUs	72
Number of registered doctors	2,572
Number of active employees	2,516
Number of emergency visits	40,216
Number of outpatient visits	242,391
Number of hospital admissions	23,480
Number of surgeries (except deliveries):	16,912
Number of deliveries	4,089
Number of tests performed at the Diagnostics and Therapy Unit	652,997
Gross Revenues (in million R$):	314.2

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Porto Alegre - RS - 90035-001
51 3314-3434 - www.hospitalmoinhos.org.br

HOSPITAL MONTE SINAI

Brief history of the Institution

Pioneering, quality and excellence in health services have set the journey of Hospital Monte Sinai (HMS) in its 18-year history. Since its foundation, in 1994, the hospital has been a reference for 150 municipalities in the so-called Zona da Mata Mineira, and even for some in other States, comprising a population of almost two million inhabitants. The Hospital has a highly qualified staff, while employing state of-the-art technology for all sorts of treatments, emergency services, and medical hospital procedures, in the most modern and respected organization in the region. Management efficiency and infrastructure quality have been recognized by renowned health centers and organizations. With its management policy anchored on the principles of the National Foundation for Quality since 2002, Monte Sinai was the first hospital in the State of Minas Gerais to be accredited by National Accreditation Organization (ONA), in 2003.

In 2006, HMS became the first Gold class hospital in Mineiro Quality Prize, having been the pioneer in the region, upon confirmation of its international accreditation by the National Integrated Accreditation for Healthcare Organizations (NIAHO).

The method, by which hospital excellence is certified and confirmed to include qualified hospitals in the American health system, is suited for Monte Sinai's objectives: risk management, with focus on safety and care provided to patients.

In order to become a reference in the country, the hospital invests in resources, hospitality and the qualification of its clinical staff. Always betting on its modern organizational structure, this year will consolidate its plan as the Monte Sinai Hospital Complex.

Highlights in 2011 and 2012

In 2012, the Monte Sinai entered the final construction phase of its Medical Center, an innovative and bold project, which brings the national health action to Juiz de Fora. This audacious undertaking positions Hospital Monte Sinai as one of the largest hospital complexes in the country. The new structure will encompass only health clinics and specialists, in a reference center that will combine services, products and professionals in two buildings, with a built up area of about 40,000 m².

The two buildings complete the hospital complex, planned with the main objective of allowing for more integration among patients, professionals and the hospital. The medical center has 315 medical offices, organized in 218 suites of medical offices and specialty clinics, in addition to 24 stores in the convenience area, a complete fitness center, swimming pool, 565 parking spaces, and an auditorium with 250 seats, two conference rooms, and a foyer for scientific events, which comprise the Monte Sinai Study Area. Each tower has independent entrances, central air conditioning, sophisticated acoustic isolation, a food courtyard and a drop-off area that is not on the public road. Linked to the hospital by an overhead walkway, the Medical Center will bring about unprecedented integration in the region, offering both to clients and professionals all-in-one-single-place, all health conveniences and full hospital services support, along with a modern diagnostics and therapy center, and the most advanced highly complex organizational structure in the region.

Characteristics

For Profit Organization	
Founded in	1994
Built up area	28,301 m²
Clinical staff organization	open
Hospital Accreditation	National Accreditation Organization (ONA III); National Integrated Accreditation for Healthcare Organizations (NIAHO)

Main Indicators (2011)

Total number of available beds	216
Number of beds in ICUs	52
Number of registered doctors	1,263
Number of active employees	848
Number of emergency visits	24,431
Number of outpatient visits	25,250
Number of hospital admissions	11,357
Number of surgeries (except deliveries):	11,708
Number of deliveries	897
Number of tests performed at the Diagnostics and Therapy Unit	415,004
Gross Revenues (in million R$):	90.3

MONTE SINAI
HOSPITAL E MATERNIDADE

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Juiz De Fora - MG - 36025-60
32 3239 - 4555
www.hospitalmontesinai.com.br

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. The plot of land was donated by JAMIC, an entity of the Japanese government. The total cost for the construction of the hospital was US$ 5.5 million. Out of the total, US$ 3.5 million were subsidized by the Japanese Government, while the rest was covered by funds collected in Brazil thanks to the contributions of the Nikkei community members, the donations of corporate entities, and Enkyo's own funds. Hospital Nipo-Brasileiro was inaugurated on June 18, 1988, the day of the 80th anniversary of Japanese immigration to Brazil. The institution started its activities on September 19, with 30 installed beds. In 1995, the second construction phase was completed, with the opening of R. Jinnai Pavilion. On August 1, 2004, the Diagnostics Center was inaugurated, integrating areas of endoscopy, chemotherapy, spirometry, among others. Hospital Nipo-Brasileiro currently has more than 220 beds and is renowned as a reference center for minimally invasive procedures, adopting video and advanced angioplasty techniques. The institution seeks to continuously improve, the hospital receives doctors from other countries and sends abroad members of its staff for training, to take courses and internships in Brazil and abroad.

Highlights in 2011 and 2012

In 2011, Hospital Nipo-Brasileiro inaugurated a new pediatric emergency facility, which, on average, sees 8,000 patients per month. Other improvements are unification of the waiting rooms, increase in the number of medical offices, beds for rest, isolation rooms with showers and inhalation connection points. In addition, more space in internal circulation corridors, with passage areas as specified by ANVISA norms, a public restroom for handicapped persons, unified triage center at the nursing station, puncture room and an independent entrance.

In the adult Emergency unit which sees on average 25,000 people per month, the waiting room was expanded and the service center isolated, thus providing more comfort to patients, accompanying persons, and the professionals who work there. The hospital administrative departments are now set up in a three-story building, designed for each sector. In total, there are 120 people working in a room equipped with standardized furnishings, air-conditioning, stairs, lighting, and safety installations in general, all carefully planned to provide ergonomic comfort and well-being for the staff. The Hospital's unoccupied area will be used to set up a new cath lab, comprising 400 m^2 area on the 6th floor of the main building. The service, apart from being among the most modern in the country, is prepared for the performance of the most advanced diagnostic and therapeutic procedures.

In 2011, the hospital joined the Sepsis Survival Campaign, an initiative of Instituto Latino Americano de Sepse (ILAS), with the implementation of managed Clinical Protocols that cause impact on clients and reduce the number of deaths.

Characteristics

Philanthropic Hospital	
Founded in	1988
Built up area	22,071 m^2
Clinical staff organization	open
Hospital Accreditation	National Accreditation Organization (ONA II)

Main Indicators (2011)

Total number of available beds	259
Number of beds in ICUs	60
Number of registered doctors	430
Number of active employees	1,496
Number of emergency visits	318,831
Number of outpatient visits	247,197
Number of hospital admissions	15,831
Number of surgeries (except deliveries):	11,455
Number of deliveries	2,991
Number of tests performed at the Diagnostics and Therapy Unit	1,145,057
Gross Revenues (in million R$):	not informed

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11 2633-2200 - www.hospitalnipo.org.br

HOSPITAL NOSSA SENHORA DAS GRAÇAS

Brief history of the Institution

The history of Hospital Nossa Senhora das Graças (HNSG) began in 1953, with the construction of a dream, idealized by Sisters of Companhia Filhas da Caridade de São Vicente de Paulo, under the leadership of Sister Estanislava Perz. The work was initially focused on the poor, on sick sisters, and also served as a learning nursing internship for Catarina Laboure Nursing School. Nowadays, the hospital is a national and international reference in highly complex clinical and surgical treatments, such as bone marrow and hepatic transplants.

With a 59-year-old history, HNSG is accredited for excellence by the National Accreditation Organization, the result of constant dedication to quality management, while seeking to offer a standard of excellence to its clients. Its vocation is centered on the commitment to offer increasingly better services to its clients, by means of investments in the advanced diagnostics and treatment center, in hospitality and in specialized units for intensive therapy and surgery, in addition to the adoption of policies to humanize treatment.

The institution invests a part of its profits into maintaining and financially supporting units that cater to SUS (Universal Public Health System), by means of the subsidiary organization Maternidade Mater Dei, in the city of Curitiba, incorporated in 2007, which performs more than 600 obstetric procedures per month, and into the management of Hospital Materno Infantil Dr. Jeser Amarante Faria (HNSG), in partnership with the government of the State of Santa Catarina, in the city of Joinville.

Highlights in 2011 and 2012

Hospital Nossa Senhora das Graças last year developed multidisciplinary healthcare projects and protocols essentially aimed at the improvement of management, so as to ensure quality, safety, and humane treatment of patients. Such initiatives resulted in prestige for HNSG and allowed for important improvements in the services provided.

As recognition of its safe healthcare practices, in particular some actions developed for the prevention of skin lesion risks, in the beginning of 2012, HNSG received the Diamond category award – 3M's maximum certification. HNSG had already been distinguished with this award in 2011, in the Gold category. Among the main assessment criteria are: skin care and protection, the protocol on prevention of pressure ulcer, care in the preparation and selection of bandages, application and removal of adhesive material, and the protocol on prevention of dermatitis associated with incontinence, including: hygiene, hydration and protection.

In 2012, HNSG has also consolidated projects with the creation of the Patient Healthcare Safety Service, further building on the healthcare safety culture within the institution. This project will bring together the departments of Hospital Infection Control Service and Hospital Epidemiology Service, along with Risk Management. This new service seeks to improve the management of multidisciplinary Clinical Protocols, both in the intensive care units (ICUs) and in other hospital sectors.

Characteristics

Philanthropic Hospital	
Founded in	1950
Built up area	39,756 m²
Clinical staff organization	open
Hospital Accreditation	National Accreditation Organization (ONA III)

Main Indicators (2011)

Total number of available beds	201
Number of beds in ICUs	37
Number of registered doctors	1,158
Number of active employees	1,113
Number of emergency visits	70,167
Number of outpatient visits	51,610
Number of hospital admissions	13,790
Number of surgeries (except deliveries):	8,078
Number of deliveries	2,667
Number of tests performed at the Diagnostics and Therapy Unit	626,428
Gross Revenues (in million R$):	80.5

HOSPITAL NS DAS GRAÇAS

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Curitiba - PR - 80810-040
41 3240-6060 - www.hnsg.org.br

HOSPITAL NOSSA SENHORA DE LOURDES

Brief history of the Institution

Located in the Jabaquara district, South of the city of São Paulo, Hospital Nossa Senhora de Lourdes was founded in 1958, having in subsequent years become a reference in health services in its region. Already in 1998, Hospital da Criança (children's hospital) was inaugurated, a center specialized in pediatric treatment, capable of providing complete services with comfort, care and safety.

In April 2012, Hospital Nossa Senhora de Lourdes and Hospital da Crianca were acquired by Rede D'Or São Luiz, that intends to invest about R$ 50 million in the institution and manage the two hospitals by 2013.

Highlights in 2011 and 2012

Having completely finished the expansion and modernization project of its physical and technological structure in 2011, Hospital Nossa Senhora de Lourdes took yet another step in its project to grow and consolidate. This project to invest in construction works, equipment and furnishings started in 2007, totaling R$ 92 million in 2011.

One of the project's highlights is the new Surgery Center that received investments totaling R$ 16 million and is considered one of the most modern in the country. This sector occupies two floors of the hospital complex and has 15 rooms, two of which are intelligent rooms. They are all integrated with a surgery supply center and were built according to a pioneer, modern and functional architectural project.

Characteristics

For Profit Organization	
Founded in	1958
Built up area	32,800 m²
Clinical staff organization	open
Hospital Accreditation	in progress

Main Indicators (2011)

Total number of available beds	282
Number of beds in ICUs	63
Number of registered doctors	2,300
Number of active employees	1,544
Number of emergency visits	250,000
Number of outpatient visits	185,000
Number of hospital admissions	14,500
Number of surgeries (except deliveries):	11,800
Number of deliveries	not informed
Number of tests performed at the Diagnostics and Therapy Unit	173,000
Gross Revenues (in million R$):	undisclosed

GRUPO NOSSA SENHORA DE LOURDES
ATENDIMENTO GLOBAL À SAÚDE

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11 5018-4000 - www.nsl.com.br

HOSPITAL NOVE DE JULHO

Brief history of the Institution

Founded in 1955, Hospital Nove de Julho is one of the most important private health Institutions in Brazil. A benchmark for highly complex medicine, the hospital concentrates its investments on emergency care and the development of specialized centers.

In 2011, the Emergency Department was renovated, with the inauguration of ten ICU beds in the department. The unit is designed so that there are always available beds for any patient requiring intensive care treatment, in addition to those in the other ICUs of the hospital. The goal is to provide faster treatment, especially for patients in the emergency department who require specialized care that can only be found in the Intensive Care Unit. This concept reinforces the pioneering spirit of Hospital Nove de Julho in caring for trauma victims, and involves patients' requiring highly complex clinical and surgical treatments.

The Center for Specialized Medicine - CME 9 - focuses on a wide range of services and combines all the expertise of the hospital on 13 floors under one roof: outpatient treatments; specialized centers; women's clinic, oncology, dialysis, physiotherapy and the diagnostic center.

Highlights in 2011 and 2012

Among the most recent and significant events relative to expansion and modernization of Hospital Nove de Julho were:

» International accreditation by the Joint Commission International (JCI);
» Operational start-up of the Center for Specialized Medicine (CME 9);
» Addition of 24 inpatient beds;
» Expansion and modernization of the technological park of the Surgical Center;
» Construction of the new tower (120 rooms, six surgery rooms, seven-story basement parking lot and a heliport).

Characteristics

For Profit Organization	
Founded in	1995
Built up area	27,432 m²
Clinical staff organization	open
Hospital Accreditation	National Accreditation Organization (ONA III); Joint Commission International (JCI); Accreditation Canada

Main Indicators (2011)

Total number of available beds	294
Number of beds in ICUs	70
Number of registered doctors	4,306
Number of active employees	1,593
Number of emergency visits	101,160
Number of outpatient visits	43,365
Number of hospital admissions	17,723
Number of surgeries (except deliveries):	12,944
Number of deliveries	not applicable
Number of tests performed at the Diagnostics and Therapy Unit	1,203,612
Gross Revenues (in million R$):	343.8

Rua Peixoto Gomide, 625 - Cerqueira César
São Paulo - SP - 01409-902
11 3147-9999 - www.hospital9dejulho.com.br

HOSPITAL PORTUGUÊS

Brief history of the Institution

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

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

On September, 16, 1866, the Institution founded Hospital Português in Alto do Bonfim. In 1927, its management started accepting registered partners of any nationality, as well as the spouses and children of Portuguese. This is why, on May 24, 1929, the Society was recognized as an institute of public utility. In 1931, a new more modern hospital was opened on Avenida Princesa Isabel, with the capacity to provide care to the population in general. Since then, Hospital Português has undergone a series of expansions, which translate into the high complexity medical care provided, without losing its philanthropic profile.

Highlights in 2011 and 2012

Hospital Português, thanks to its integrated medical staff management policy that has reallocated the availability of beds and allowed for more integration of services and hospital departments, along with other initiatives to optimize processes, has been able to substantially improve its healthcare capacity and successful outcomes.

With the availability of new emergency sectors in specialty fields such as orthopedics, otorhinolaryngology and ophthalmology, the offer of care services has been positive in all aspects.

As a natural consequence, Hospital Português was awarded the Bahia Health Benchmarking Trophy award, an initiative of Revista Diagnóstico. Competing with four other large philanthropic hospitals, it achieved the best marks.

Receiving this award reflects the recognition of the initiatives and actions of Hospital Português, making it stand out in terms of innovation, credibility, new investments, and market visibility.

Thus, the institution is headed in the right direction to reach new objectives in terms of excellence, fulfilling its mission to offer the best to its clients and guaranteeing financial returns.

Characteristics

Philanthropic Hospital	
Founded in	1857
Built up area	28,800 m²
Clinical staff organization	mixed
Hospital Accreditation	National Accreditation Organization (ONA I)

Main Indicators (2011)

Total number of available beds	471
Number of beds in ICUs	124
Number of registered doctors	1,694
Number of active employees	2,368
Number of emergency visits	25,970
Number of outpatient visits	not applicable
Number of hospital admissions	13,309
Number of surgeries (except deliveries):	7,227
Number of deliveries	2,591
Number of tests performed at the Diagnostics and Therapy Unit	889,346
Gross Revenues (in million R$):	237.4

Hospital Português

Av. Princesa Isabel, 914 - Barra Avenida
Salvador - BA - 40140-901
71 3203-5555 - www.hportugues.com.br

HOSPITAL PRÓ-CARDÍACO

Brief history of the Institution

Hospital Pró-Cardíaco was founded on November 9, 1959, based on the model concept of a cardiology emergency unit.

It currently has 110 beds for clinical and surgical inpatients and its activities have always focused on high-complexity proceedings. The hospital has always sought to benchmark against institutional breakthroughs in Brazil and abroad, in combination with quality care and innovation. It gained its outstanding ranking on the national scene as a Premium Hospital. Its emergency, intensive and coronary therapy units have contributed to achieving these results.

It passed important landmarks along the way: first coronary unit in 1968; first cath laboratory in a private hospital, in 1980; intensive care unit using modern technology and transdisciplinary healthcare and a surgical center in 1988, as well as the first chest pain unit in Brazil in 1995.

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

Highlights in 2011 and 2012

In 2011, the hospital began a physical and structural transformation process: a general reformulation of its hospitality concept, along with a three-phase expansion plan, aimed at duplicating the institution's installed capacity. The first phase was finished in February 2012. Still in this year the inauguration of the annex building is planned, comprising a test center and new beds.

In addition, investments were made in the modernization of the technological and diagnostic park, which nowadays is equipped with the best equipment for nuclear, catheter and arrhythmology medicine. In 2012, the new hybrid room will start its operation, equipped with differentiated technology, to increase the number of treatments offered by the hospital.

In March 2012, Hospital Pró-Cardíaco was certified by Accreditation Canada. In addition, it became the first center outside Canada to earn Stroke Services Distinction from Accreditation Canada CVA patient program, a benchmark for the institution.

Characteristics

For Profit Organization	
Founded in	1959
Built up area	10,050 m²
Clinical staff organization	mixed
Hospital Accreditation	National Accreditation Organization (ONA III): Accreditation Canada

Main Indicators (2011)

Total number of available beds	110
Number of beds in ICUs	34
Number of registered doctors	1,500
Number of active employees	912
Number of emergency visits	8,959
Number of outpatient visits	not applicable
Number of hospital admissions	2,999
Number of surgeries (except deliveries):	1,616
Number of deliveries	not applicable
Number of tests performed at the Diagnostics and Therapy Unit	28,649
Gross Revenues (in million R$):	171

Rua Dona Mariana, 219 - Botafogo
Rio de Janeiro - RJ - 22280-020
21 2131-1449 - www.procardiaco.com.br

HOSPITAL QUINTA D'OR

Brief history of the Institution

Founded in September 2001, Quinta D'Or resulted from the renovation of the old Hospital São Francisco de Paula. Spaces of the historical building were completely restored and the entire structure modernized, while preserving the spacious suites with a view to Quinta da Boa Vista, one of the largest and most beautiful municipal parks in Rio de Janeiro, and the natural illumination of its corridors, conveying a cozy and humane environment.

In the course of its ten years of existence, the institution solidified its vocation to care for patients with complex diseases, in a working environment that stands out for harmony and cooperation, with multi-professional high-performance staff acting in a transdisciplinary manner. This structure has led to achieving level III accreditation by National Accreditation Organization (ONA), as well as international accreditation by Accreditation Canada.

Hospital Quinta D'Or has become a reference in the region, which is densely populated, for clinical and surgical emergencies, with the capacity to provide solutions and technological means widely recognized by the medical community of Rio de Janeiro.

This hospital complex currently has over 300 beds for inpatients, intensive and step-down therapy units, pediatrics, national ICU, neonatal, and respiratory and liver units. The plot adjacent to the hospital, with 16,000 m^2, has a large parking lot and provides the possibility of expanding the hospital's buildings complex.

Highlights in 2011 and 2012

In 2011, its 10th anniversary, the hospital added a new unit: D'Or Oncology Center, with built up area of 700 m^2, staffed with a multidisciplinary team of recognized competence in the field and equipped with state-of-the-art technology equipment for radiotherapy, including Novalis™, a very modern radiosurgery device, the only of its kind in the State of Rio de Janeiro and the second to be installed in the country.

In 2011, Hospital Quinta D'Or consolidated its entry in the field of transplants, having set up the liver unit in the second half of the year, entirely equipped to assist liver patients in all phases of the disease, providing post-surgery support in monitoring transplanted patients. The clinical and surgical teams are widely experienced in the field of transplants and characterized by outstanding academic credentials. In the end of 2011, the institution was re-certified by Accreditation Canada and by ONA at level III excellence, reassuring the quality standards of its processes and the degree of safety provided to patients.

In 2012, the hospital continues to benefit from initiatives to expand its installations and to install new points of interconnection between its two buildings. Expansion works of the hospital complex are planned for the end of the year, with the construction of another building with a capacity of approximately 600 new hospital beds.

Characteristics

For Profit Organization	
Founded in	2001
Built up area	26,587 m^2
Clinical staff organization	open
Hospital Accreditation	National Accreditation Organization (ONA III); Accreditation Canada

Main Indicators (2011)

Total number of available beds	323
Number of beds in ICUs	115
Number of registered doctors	
Number of active employees	2,328
Number of emergency visits	98,415
Number of outpatient visits	not informed
Number of hospital admissions	12,683
Number of surgeries (except deliveries):	7,870
Number of deliveries	260
Number of tests performed at the Diagnostics and Therapy Unit	not informed
Gross Revenues (in million R$):	not informed

QUINTA D'OR HOSPITAL

Rua Almirante Baltazar, 383 /435/ 467
São Cristóvão
Rio de Janeiro - RJ - 20941-150
21 3461-3600 - www.rededor.com.br/quintador

HOSPITAL SAMARITANO

Brief history of the Institution

Hospital Samaritano, located in the city of São Paulo, the largest city in Brazil, is one of the most important centers of excellence in health in the country, recognized by the Ministry of Health for the quality of assistance and services it renders in the field of social responsibility, and more specifically, in the implementation of programs for the development of SUS (Universal Public Healthcare System).

With a history of 118 years, it has a superb infrastructure, state-of-the-art technology, and highly specialized clinical staff in the clinical and general surgery fields, such as in cardiology, neurology, orthopedics, oncology, and diagnostic, therapeutic and emergency medicine, in addition to differentiated services provided by the nursing staff.

In 2004, the permanent quest for healthcare quality led the hospital to receive the International Accreditation Certificate from Joint Commission International (JCI) . an important U.S. certification entity of hospital quality standards in the world. This international achievement has consolidated its position as a hospital of excellence. In 2007 and 2011, the hospital was reaccredited by the JCI.

Highlights in 2011 and 2012

In 2011, Hospital Samaritano inaugurated a building comprising the new hospital complex. It has 19 floors and a heliport, ten surgical rooms for the performance of highly complex procedures, five floors for hospitalizations, with 80 new suites of 37.33 m^2 in size, all with a balcony, and four VIP suites measuring 53.10 m^2, with a foyer. It also has an ICU with private suites that enable families to closely monitor the care provided to patients, providing humane treatment. Furthermore, there is a parking lot with 300 spaces, gastronomy and nutrition service, an atrium with a convenience store, in addition to other amenities.

The diagnostic and therapeutic medical center is also in this new building, encompassing the Women's' Unit, the Cardiology and Neurophysiology Unit, and is equipped with state-of-the-art equipment for image diagnostics, such as a PET/CT scanner, computed tomography scan and magnetic resonance imaging (Tesla 3.0 with multimedia capability) equipment, x-ray devices, ultrasonography, nuclear medicine and endoscopic equipment with full HD capability.

Another important highlight was the acquisition of more than 1,700 digital certificates, enabling more safety in inputting information into electronic files by the medical and healthcare staff, along with the bedside use of mobile devices such as tablets and notebooks, allowing for faster service by the nursing staff.

Characteristics

Philanthropic Hospital	
Founded in	1894
Built up area	60,000 m²
Clinical staff organization	open
Hospital Accreditation	Joint Commission International (JCI)

Main Indicators (2011)

Total number of available beds	261
Number of beds in ICUs	59
Number of registered doctors	2,078
Number of active employees	1,925
Number of emergency visits	146,922
Number of outpatient visits	not applicable
Number of hospital admissions	15,990
Number of surgeries (except deliveries):	11,160
Number of deliveries	319
Number of tests performed at the Diagnostics and Therapy Unit	1,351,638
Gross Revenues (in million R$):	305.7

Rua Conselheiro Brotero, 1489 - Higienópolis
São Paulo - SP - 01232-010
11 3821-5300 - www.samaritano.org.br

HOSPITAL SANTA CATARINA

Brief history of the Institution

On June 16, 1897, at the request of Friar Ciriaco, the first Saint Catherine nuns coming from Braunsberg arrived in Petrópolis, in the state of Rio de Janeiro, entrusted with the mission of organizing and installing a hospital in São Paulo. After facing a series of difficulties, moving with their patients from one house to another, Associação Congregação de Santa Catarina was capable to purchase a plot of land on what is today Avenida Paulista. With the support of Dr. Walter Seng, the first medical director of Hospital Santa Catarina, and encouragement and guidance of the prior of the São Bento monastery, Father Miguel Kruse, and financial support from Germany and generous donors, the first building was constructed, called Sanatório Santa Catarina. Its inauguration took place on February 6, 1906, under the leadership of Sister Beate Heinrich.

For over 100 years, Hospital Santa Catarina (HSC) has excelled in offering safe and humane healthcare. A reference in Brazil in quality healthcare, 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. With its modern infrastructure, offering state-of-the-art equipment and complete ICUs, and thanks to its specialized staff, Hospital Santa Catarina is able to continuously enhance its processes.

Highlights in 2011 and 2012

The year 2011 was a landmark in the history of HSC. Among other major initiatives, the institution heavily invested in clinical governance, improving infrastructure and services for doctors. One of the most important initiatives was the construction of a service area, called “Service for Doctors”. The institution’s intent in constructing this area was to create a comfortable and complete lounge so that doctors’ could rest between procedures, and yet have administrative support in one single area.

Another highlight in 2011 was the consistent work to position the brand, involving the dedication of the teams, the review of processes, and investment in advertising.

In 2012, Hospital Santa Catarina concluded the first renewal phase of its adult first-aid service. Two important areas were incorporated to it: The Chest Pain Unit and the Encephalic Vascular Accident Unit. Both have their own independent nursing staffs and are integrated with the cardiac and neurological ICUs and with cardiac and respiratory monitoring technologies, a unique form of organization among hospitals in the Avenida Paulista region. The structure has been expanded: in an area of 1,000 square meters, there are six new medical offices, two triage stations, a post-visit rest room, an emergency and a suture room, and a new reception.

Characteristics

Philanthropic Hospital	
Founded in	1906
Built up area	59,516 m²
Clinical staff organization	open
Hospital Accreditation	National Accreditation Organization (ONA III); Accreditation Canada

Main Indicators (2011)

Total number of available beds	337
Number of beds in ICUs	94
Number of registered doctors	5,000
Number of active employees	2,300
Number of emergency visits	151,833
Number of outpatient visits	76,084
Number of hospital admissions	18,097
Number of surgeries (except deliveries):	28,558
Number of deliveries	4,288
Number of tests performed at the Diagnostics and Therapy Unit	1,046,685
Gross Revenues (in million R$):	396.8

Hospital Santa Catarina

Avenida Paulista, 200 - Bela Vista
São Paulo - SP - 01310-000
11 3016-4133 - www.hsc.org.br

HOSPITAL SANTA GENOVEVA

Brief history of the Institution

Founded in 1964, with a built up area of 11,300 m², located in an environmentally protected forest area with original vegetation, Hospital Santa Genoveva has 133 beds in suites, wards, ICUs, day clinic and 24-hour emergency unit. Its surgical center has six rooms, a self-operated diagnostic cath lab center, hemodynamic, radiology, tomography, ultrasonography, endoscopy, colonoscopy, ergometrics, echography, holter monitoring, and mapping units, as well as a clinical analysis laboratory. The parking lot holds up to 250 cars.

The hospital is one of the most traditional private health services in the State of Goiás, classified as a general hospital. It is a reference in cardiac surgery, bariatric surgery, general surgery, neurology, orthopedics, and heart, kidney, and kidney pancreas transplants (the only private hospital in Goiás to perform transplants). Its founder, Dr. Francisco Ludovico, also founded the Medical School at Federal University of Goiás. Accredited by the National Accreditation Organization (ONA), the only one in Goiás, Hospital Santa Genoveva offers medical internships in cardiology, general surgery, internal medicine, and anesthesiology, with funds provided by the institution itself, and with authorization from the Ministry of Education (MEC). The promotion of life in all its values, based on knowledge, technology, and a self-sustaining management model, with social and environmental responsibility – is the raison d'être of the hospital for both internal and external clients.

Highlights in 2011 and 2012

In 2011, Hospital Santa Genoveva consolidated its decision-making management model, seeking the commitment and involvement of the entire transdisciplinary team, in addition to the alignment of its strategies to integrated management, pursuant to risk management. Aimed at better serving its clients, a hospitality revitalization program was conceived, and in 2011 66% of the buildup area originally planned for the first half of 2012 was prematurely completed (units and room). The institution continues to invest in human capital, by continuing its educational program through graduate courses (Getúlio Vargas Foundation), offered for qualifying administrative managers and nursing supervisors in the specialty areas of ICU, emergency unit, and infection control. In addition, the first graduate class in Emergency Medicine was formed by ABRAMURGEM.

Characteristics

For Profit Organization	
Founded in	1970
Built up area	11,300 m²
Clinical staff organization	open
Hospital Accreditation	National Accreditation Organization (ONA I)

Main Indicators (2011)

Total number of available beds	122
Number of beds in ICUs	19
Number of registered doctors	115
Number of active employees	310
Number of emergency visits	18,295
Number of outpatient visits	49,800
Number of hospital admissions	8,032
Number of surgeries (except deliveries):	1,994
Number of deliveries	22
Number of tests performed at the Diagnostics and Therapy Unit	25,186
Gross Revenues (in million R$):	32.4

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Setor Santa Genoveva
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62 3264-9000 - 62 3264-9032
www.santagenoveva.com.br

HOSPITAL SANTA JOANA

Brief history of the Institution

In the late 1970's, a modern and elegant architectural and decoration project was designed, using the latest hospitality concepts, to inaugurate Hospital Santa Joana, whose proposal was to offer excellence in quality in patient care, in addition to safety and comfort.

Three decades later, recognition and the prestige enjoyed with clients and the medical class show that the courage and determination to change paradigms, implementing new concepts in private healthcare management, were initiatives that enriched hospital care in Brazil. Innovations, technological advancements and also new concepts in hospital management were constantly incorporated in our institution. The surgery center, already in those days, was inaugurated with a positive pressure system equipped with special filters. The hospital also stood out as the first in Latin America to have tridimensional two-plane angiography equipment for the realization of neurological and cardiological interventions. Santa Joana's maternity was the first in Recife region with round-the-clock pediatric care, in addition to other pioneer initiatives such as the implementation of the first intensive care and radiological units in a 24-hour regimen in a private hospital in Pernambuco. The hospital was also the first of the private network to implement a hospital infection control commission in Pernambuco.

In the course of its history, Hospital Santa Joana developed a permanent investment policy for state-of-the art technology and for developing its human resources, always seeking to offer doctors and patients the most modern features available in all segments. Therefore, Hospital Santa Joana is nowadays a reference in various specialties and high complexity services, such as Oncology, Neurology, Neurosurgery, Trauma Orthopedics, Clinical and Surgical Cardiology, Urology, Neonatology, Angiography and Catheter Laboratory, Preventive Diagnostic Medicine, among others.

Highlights in 2011 and 2012

Since its foundation, Hospital Santa Joana has undertaken actions focused on constant improvement of its services, with a permanent policy to invest in state-of-the-art technology and in the development of its human resources, always seeking to offer doctors and patients the most modern items available in all segments. Currently in the final stage to be accredited by Joint Commission International (JCI), several innovations relative to its physical infrastructure and human and technological resources are on the institution's radar. In 2011, some of the main actions were: expansion of the Multi-emergency Unit, which doubled the number of beds available for adult care, the inauguration of specialized clinics for Urology and Orthopedics care, and renovation of the Old Building (Casarão), whose construction dates back to the beginning of the 20th century, offering exclusive services to clients, such as restaurant and cyber café and a gala room for events. In 2012, there was expansion of the hospital complex, with 20% increase in the number of beds, the new Clinical and Surgical Unit in a recently raised new building, and the inauguration of the newest ICU in the State of Pernambuco, which occupies an entire floor in the main building, with twice more hospital beds and the most modern technological resources. Concerning improvement of healthcare processes and risk management, emphasis should be laid on electronic medical prescriptions and medical drug tracing right up to bedside delivery, by using hand-held computers. By 2015, such modifications will also allow the construction of a new surgical complex, concentrating all rooms in a single building.

Characteristics

For Profit Organization	
Founded in	1979
Built up area	16,680 m²
Clinical staff organization	open
Hospital Accreditation	in progress

Main Indicators (2011)

Total number of available beds	149
Number of beds in ICUs	48
Number of registered doctors	1,003
Number of active employees	1,266
Number of emergency visits	not applicable
Number of outpatient visits	80,555
Number of hospital admissions	10,860
Number of surgeries (except deliveries):	7,355
Number of deliveries	1,500
Number of tests performed at the Diagnostics and Therapy Unit	89,350
Gross Revenues (in million R$):	106.8

HOSPITAL SANTA JOANA

Rua Joaquim Nabuco, 200 - Graças
Recife - PE - 52011-000
81 3216.6666 - www.santajoana.com.br

HOSPITAL SANTA LUZIA

Brief history of the Institution

In its 43 years of existence, safety has been one of the main attributes clients recognize when defining Hospital Santa Luzia. Founded in 1969, it became a high complexity general hospital and over the years it has consolidated as a reference in medical and hospital services in the Federal District and surrounding regions.

Its constant concern about the technical qualification of its professionals, the continuous improvement of quality in medical-hospital procedures, and constant investment in technology, are factors that place Hospital Santa Luzia in a select group of hospitals in the country, which transformed the trade of looking after people into the art of doing good, minimizing damage and promoting cure.

Located in Setor Hospitalar Local Sul, a reference sector for medical-hospital services in Brasília, Hospital Santa Luzia offers an infrastructure with all human and technological resources required for such services and even offers an additional differential: an overhead walkway that links it to another institution of Grupo Santa Luzia – Hospital do Coração do Brasil, a large center specialized in cardiovascular diseases.

It currently occupies a 6,685 m² plot of land and has a built up area of 14,221 m².

Highlights in 2011 and 2012

In January 2011, in order to strength management, Grupo Santa Luzia consolidated the full professionalization of its Executive Board, which, for more than 20 years, had included executives who were members of the shareholder family. This initiative essentially focused on strengthening management. Following recommendations of IBGC (Brazilian Institute of Corporate Governance), which represents the best practices to be adopted by organizations, a Board of Directors was set up, whose mission is to protect the interests of the group, making sure that decisions made and actions undertaken in the quest for attaining such objectives are in line with its vision, mission, and values. The Board comprises shareholders and two independent members: Alceu Alves da Silva, executive director of Hospital Mãe de Deus and of Sistema de Saúde Mãe de Deus, of the City of Porto Alegre, and José Gilberto Jaloretto, who holds a doctor's degree in Accounting and is a member of the Audit Committee of Banco do Brasil conglomerate.

In March 2012, as part of Hospital Santa Luzia's installed capacity expansion plan, 14 new inpatient beds were installed, in tune with the most modern guidelines for quality services, along with the humanization of the system.

Concerning incorporation of technology, in February there was the inauguration of two intelligent surgery rooms, equipped with state-of-the-art equipment, enabling the performance of complex procedures with enhanced safety, both for patients and the clinical staff.

Characteristics

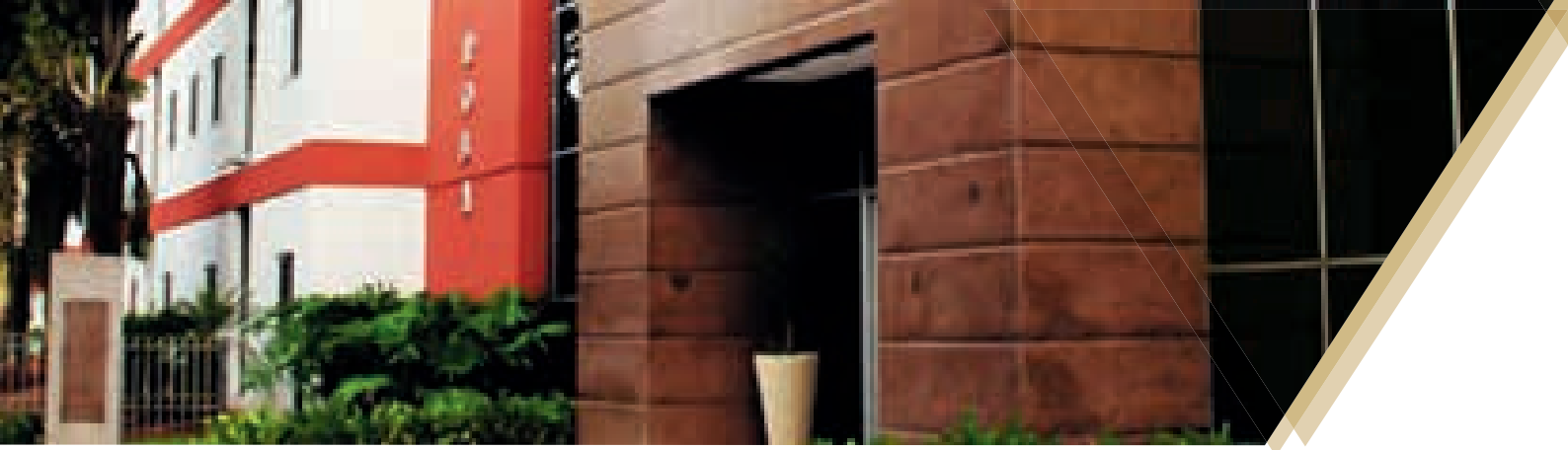
For Profit Organization	
Founded in	1969
Built up area	14,221 m²
Clinical staff organization	open
Hospital Accreditation	National Accreditation Organization (ONA II)

Main Indicators (2011)

Total number of available beds	158
Number of beds in ICUs	49
Number of registered doctors	387
Number of active employees	1,238
Number of emergency visits	136,462
Number of outpatient visits	72,534
Number of hospital admissions	6,507
Number of surgeries (except deliveries):	7,937
Number of deliveries	1,984
Number of tests performed at the Diagnostics and Therapy Unit	819,132
Gross Revenues (in million R$):	157.3

Hospital Santa Luzia

SHLS 716 - Conjunto E - Asa Sul
Brasília - DF - 70390-903
61 3445-6000 - www.hsl.com.br



HOSPITAL SANTA ROSA

Brief history of the Institution

Based on a modern and bold concept, in line with the world trend towards humanization of hospital environments, Hospital Santa Rosa, located in the city of Cuiabá, in the State of Mato Grosso, will celebrate its 15th anniversary in 2012, recognized as a reference hospital in the State.

Hospital Santa Rosa has the mission of offering innovative, sustainable, and quality hospital care. It increasingly invests in technology, specialized medicine, people qualification, comfort and safety for patients and staff. Even though it has been in Mato Grosso market for only a short period, it has broad experience, showing that it is an institution to be taken seriously, which has a vision and is committed to society and to providing quality services.

It is the only hospital in the State to have achieved Hospital Accreditation. In 2011, it was re-certified by Instituto Qualisa de Gestão (IQG), associated with ONA - National Accreditation Organization, at level II (full accreditation).

With an outlook set until 2014, Hospital Santa Rosa wants to be an institution recognized as a reference hospital for high complexity procedures, quality care, production of knowledge, humanization, and social responsibility.

Highlights in 2011 and 2012

In 2012, through the support of Dr. Cervantes Caporossi Study Center, Hospital Santa Rosa set up a new medical residency modality, which now entails residency in the fields of General Surgery, Physiotherapy, Intensive Therapy, and Nursing in Intensive Therapy. At the graduate course level, courses are offered in Physiotherapy and Nursing in Intensive Therapy.

The hospital inaugurated a new inpatient ward on a floor denominated “Viola de Cocho” [literally, “trough guitar”], in honor of the local city culture and, similarly to the strings instrument, wood was the theme adopted in developing the new area.

Hospital Santa Rosa Cath Laboratory Center has been equipped with more technological devices, modern environment and equipment, thus enabling the performance of high complexity exams and surgeries.

The Intensive Care Unit (ICU) received seven additional beds, totaling 31. For the sixth time, the hospital was awarded Top of Mind award by Revista RDM, as the most remembered health institution in Mato Grosso and, for the second consecutive time, the Social Responsibility award, instituted by the State’s Legislative Assembly.

Characteristics

For Profit Organization	
Founded in	1997
Built up area	13,937 m²
Clinical staff organization	open
Hospital Accreditation	National Accreditation Organization (ONA II)

Main Indicators (2011)

Total number of available beds	152
Number of beds in ICUs	41
Number of registered doctors	663
Number of active employees	602
Number of emergency visits	65,369
Number of outpatient visits	not applicable
Number of hospital admissions	7,737
Number of surgeries (except deliveries):	7,602
Number of deliveries	380
Number of tests performed at the Diagnostics and Therapy Unit	441,736
Gross Revenues (in million R$):	40

HOSPITAL SANTA ROSA

Rua Adel Maluf, 119 - Jardim Mariana
Cuiabá - MT - 78040-360
65 3618-8000 - www.hospitalsantarosa.com.br

HOSPITAL SÃO CAMILO POMPEIA

Brief history of the Institution

Hospital Sao Camilo Pompeia is a philanthropic institution belonging to São Camilo hospital chain of São Paulo, whose main purpose is to contribute to the maintenance of 50 other hospitals of Sociedade Beneficente São Camilo (SBSC) spread all over Brazil, which serve needy communities through SUS (Universal Public Healthcare System) in areas where they are located.

Located in the Western part of Sao 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 registered clinical staff of roughly 3,000 highly qualified doctors, who serve about one million people per year.

The history of the hospital marks the entry of Província Camiliana in Brazil. Conceived by Father Inocente Radrizzani, Policlínica São Camilo hospital opened in 1928 was the construction cornerstone of what was to become a spacious modern hospital complex. On January 23, 1960, following a series of reforms and expansions over the years, Policlínica was transformed into Hospital São Camilo Pompeia on January 23, 1960.

Apart from the Pompeia Unit, São Camilo Hospital Network of São Paulo also comprises units Santana (234 beds) and Ipiranga (124 beds).

Highlights in 2011 and 2012

Hospital São Camilo Pompeia started the year 2012 with achievements, big projects, and novelties. After opening a Reference Center in 2011 for bone marrow transplants and onco-hematology patients, the unit continues to perform aligned with innovative management concepts, while progressing in the expansion and modernization of its installations.

The new Emergency Unit, inaugurated in February of this year, was expanded to serve patients more quickly and more comfortably. This is just the first novelty. Pompeia Unit will also begin the construction of a new building in 2012. The current building, which nowadays comprises the administrative department, will be adapted to additionally receive approximately 90 beds and new surgery rooms. With this expansion, the unit will have a total of 400 beds. Furthermore, the facade will be modernized, providing the building a new look.

In synchronization with this growth rate, Pompeia Unit has accumulated yet another victory: Joint Commission International (JCI) Certification. Having achieved ONA III and Canadian International Accreditation, the institution, now in April of this year, received yet another seal attesting the quality of processes and the safety of procedures.

Characteristics

Philanthropic Hospital	
Founded in	1960
Built up area	38,772 m²
Clinical staff organization	open
Hospital Accreditation	Joint Commission International; National Accreditation Organization (ONA III); Accreditation Canada

Main Indicators (2011)

Total number of available beds	300
Number of beds in ICUs	80
Number of registered doctors	2,605
Number of active employees	1,628
Number of emergency visits	278,220
Number of outpatient visits	105,877
Number of hospital admissions	18,331
Number of surgeries (except deliveries):	11,175
Number of deliveries	1,126
Number of tests performed at the Diagnostics and Therapy Unit	1,299,863
Gross Revenues (in million R$):	355

Avenida Pompeia, 1178 - Pompeia
São Paulo - SP - 05024-000
11 3677-4444 - www.saocamilo.com

HOSPITAL SÃO JOSÉ

Brief history of the Institution

Designed to off er humane and personalized services by means of a complete care and technology structure, Hospital São José was inaugurated on November 27, 2007 by Beneficência Portuguesa of São Paulo, one of the biggest hospital complexes in Latin America.

The hospital is a reference in Oncology in Brazil. Its clinical staff comprises renowned specialists who, together with other health professionals, offer multidisciplinary services of international standard to its patients. With more than 23,000 m², the institution also operates an Education and Research Center recognized for the technical and scientific output continuously produced by its professionals.

In December 2010, Hospital São José was accredited with the seal of Joint Commission International (JCI) following the implementation of a project aimed at improving service quality and the safety of its patients, while continuing to undertake periodic improvements, always seeking to attain increasingly satisfactory medical and care results.

Highlights in 2011 and 2012

In 2011, Hospital São José inaugurated the Advanced Oncology Center. This project received a R$ 3 million investment, placing the institution among the major references for cancer treatment in Brazil.

Apart from the modern hospital infrastructure, the Oncology Center has a highly qualified clinical staff, led by oncologist Antonio Carlos Buzaid. The Center's coordination team also comprises doctors Fernando Cotait Maluf, head of the Oncology Clinic, Riad Younes, head of Oncology Surgery, and Phillip Scheinberg, head of Hematology Service. The staff also comprises distinguished professionals in specific fields, including Rafael Schmerling, specialist in melanoma and sarcoma, Roberto Buessio, hematologist and bone marrow transplant surgeon, Marcelo Cruz, specialist in breast, lung and gastrointestinal tumors, Fabio Schutz, specialist in urinary tract tumors, and Simone Noronha, coordinator of Genetic Counseling.

In order to provide total care, particularly during chemotherapy procedures, one of the professionals comprising the multidisciplinary oncology team is dentist Marcelo Seneda, specialist in Oral Medicine focused on Oncology. For all these reasons, combining care and technological quality, medical expertise and outstanding hospital infrastructure, Hospital São José provides customized and humane individual treatment to all patients with cancer who undergo treatment in the institution.

Characteristics

For Profit Organization	
Founded in	2007
Built up area	29,761 m²
Clinical staff organization	open
Hospital Accreditation	Joint Commission International (JCI)

Main Indicators (2011)

Total number of available beds	65
Number of beds in ICUs	14
Number of registered doctors	1,660
Number of active employees	588
Number of emergency visits	not applicable
Number of outpatient visits	7,282
Number of hospital admissions	2,853
Number of surgeries (except deliveries):	2,853
Number of deliveries	not applicable
Number of tests performed at the Diagnostics and Therapy Unit	173,589
Gross Revenues (in million R$):	104.4

HOSPITAL SÃO JOSÉ

Rua Martiniano de Carvalho, 965 - Bela Vista
São Paulo - SP - 01321-001
11 3505-6000 - www.bpsp.org.br

HOSPITAL SÃO LUCAS

Brief history of the Institution

Founded in January 1969, in the city of Ribeirão Preto, in the countryside of the State of São Paulo, through the Association of Professors and Doctors of the School of Medicine of USP – Universidade de São Paulo, Hospital São Lucas S/A is recognized as one of the main medical-hospital service providers, delivering quality and safety for medical excellence in Neurology, Cardiology and Gastroenterology, and also for its pioneer role in bone marrow transplants (in the private network) in and around Ribeirão Preto.

São Lucas was the first hospital in the countryside and the seventh in Brazil to be certified by the National Accreditation Organization (ONA).

The success of Grupo São Lucas, which also operates Hospital Ribeirania, RD Diagnósticos, Multilav Lavanderia Industrial and Multilav Esterilizações, is the result of many years of quality services and safety, focusing on client satisfaction, based on the main concept of "people looking after people". This value has always paved the way for its actions and guaranteed its commitments.

Highlights in 2011 and 2012

Excellence – this is the major objective of Hospital São Lucas for the year 2012. The implementation of CVA and AMI Protocols consolidated the outstanding quality and safety, with specialists on duty around-the-clock. Hospitalists have also joined the team, whose knowledge and care quality guides the hospital conduct. Large investments were made to purchase modern equipment, making Hospital São Lucas a complete private center for video surgery in the region. The surgery center was renovated and a new modern and comfortable medical facility built.

In 2010, the Bone Marrow Transplant Service performed the first transplant in a private hospital of Ribeirão Preto and surrounding area, and in 2011 the number of transplants increased significantly.

Characteristics

For Profit Organization	
Founded in	1969
Built up area	6,333 m²
Clinical staff organization	open
Hospital Accreditation	National Accreditation Organization (ONA II)

Main Indicators (2011)

Total number of available beds	84
Number of beds in ICUs	22
Number of registered doctors	1,438
Number of active employees	416
Number of emergency visits	53,730
Number of outpatient visits	undisclosed
Number of hospital admissions	5,174
Number of surgeries (except deliveries):	6,611
Number of deliveries	not applicable
Number of tests performed at the Diagnostics and Therapy Unit	163,258
Gross Revenues (in million R$):	55.1

SAO LUCAS HOSPITAL

Rua Bernardino de Campos,1426 - Vila Seixas
Ribeirão Preto - SP - 14015-130
11 4009 0020 - www.gruposaolucas.com.br

HOSPITAL SÃO LUCAS DE ARACAJU

Brief history of the Institution

Clínica e Hospital São Lucas was founded on October 18, 1969, on Physician's Day, by a cardiologist and a lung specialist – brothers-in-law and companions, both professors at the School of Medicine at Universidade Federal de Sergipe.

Since the beginning, the institution stood out for its differentiated concern about care quality, seeking to attract good doctors, qualified nursing staff, and quality supplies and equipment. For more than 40 years it has been a reference for hospital services in the State of Sergipe and in the Northern and Northeastern regions, with emphasis on the fields of Cardiology, Neurology, Geriatrics and Complex Surgeries, among others. The institution also performs kidney transplants, cardiac surgery, endovascular hemodynamic procedures, in combination with broad range of diagnostic exams, while serving inpatients and outpatients.

To fulfill its mission, which apart from care providing, also includes education and research, the hospital established Fundação São Lucas (FSL) on October 2, 1986, which independently manages a child care center open to the community and a school that offers technical courses in health, recognized as the best in the area. The hospital has also actively participated in several multicenter studies, both national and international, through its Centro de Ensino e Pesquisa (CEPFSL).

Highlights in 2011 and 2012

In the end of 2011, the hospital was invited to participate in the Accreditation Canada process. The institution intends to be one of the first hospitals of the Northern region to undergo an international certification process. This will be a major challenge for the institution's staff and a major issue for the hospital Administration in 2012.

Characteristics

For Profit Organization	
Founded in	1969
Built up area	undisclosed
Clinical staff organization	open
Hospital Accreditation	National Accreditation Organization (ONA III)

Main Indicators (2011)

Total number of available beds	150
Number of beds in ICUs	30
Number of registered doctors	500
Number of active employees	1,100
Number of emergency visits	72,000
Number of outpatient visits	not applicable
Number of hospital admissions	8,500
Number of surgeries (except deliveries):	9,000
Number of deliveries	not applicable
Number of tests performed at the Diagnostics and Therapy Unit	840,000
Gross Revenues (in million R$):	undisclosed

São Lucas

Av. Coronel Stanley Silveira, 33 - São José
Aracaju - SE - 40015-400
79 2107-1017 - www.saolucas-se.com.br

HOSPITAL SÍRIO-LIBANÊS

Brief history of the Institution

SBSHSL - Sociedade Beneficente de Senhoras - Hospital Sírio-Libanês – is a Brazilian institution whose reason for existing is philanthropy. The concept arose in 1921, from an initiative of a first-generation immigrant group of women of Syrian and Lebanese ancestry, which wanted to offer quality medical care that would suit the importance of the city of São Paulo. SBSHSL is the supporting institution of Hospital Sírio-Libanês (HSL), an international reference in health, whose main characteristic is the union of the clinical staff's excellence with pioneer initiatives, along with the most up-to-date technologies and humane treatment offered to all patients from Brazil and abroad, in more than 60 medical specialties.

In order to support HSL with education and research activities, the hospital maintains Instituto Sirio-Libanes de Ensino e Pesquisa (IEP), whose mission is to generate and communicate knowledge, as well as to qualify health professionals, thereby contributing to the hospital's excellence and to health in Brazil. SBSHSL philanthropy department works in partnership with the Ministry of Health, developing projects for SUS (Universal Public Healthcare System) taking good management practices and quality medicine to an increasing number of doctors throughout Brazil. Through Instituto de Responsabilidade Social Sírio-Libanês the institution manages nine teams in the family health program within Primary Healthcare Units Nossa Senhora do Brasil, in Humaitá and Cambuci, in three municipal administrative health institutions, and in Hospital Menino Jesus, acting as a social organization for the municipal government of the city of São Paulo, in Hospital Geral do Grajaú and in a municipal administrative health institution in Interlagos, acting as a social organization for the State of São Paulo.

Highlights in 2011 and 2012

The year 2011 is a landmark in the continuity of Hospital Sírio-Libanês expansion, with the start-up of works that will double the capacity at headquarters in Bela Vista district in São Paulo, beginning in 2013. Last year, two units were inaugurated: the unit in Jardins district, in Sao Paulo – the Women's Clinic, and the Oncology Center of Sírio-Libanês Brasília, in the Federal District.

Among the new services offered, the following should be highlighted: the Human Reproduction Center, the Bone Marrow Transplantation Unit, the Otorhinolaryngology Service Unit, the Video Urodynamic Service Unit, the Diabetes Center, the Neuroscience Center and as a pioneer initiative, the nighttime Hemodialysis Center. The hospital has also become one of five institutions in the world to have a state-of-the-art Novalis TX linear accelerator, providing more precision in radiotherapy and radio-surgery procedures. It also incorporated the Fibroscan technology for improved diagnosis of hepatic diseases and tomosynthesis mammography, enabling higher precision in breast pathologies. The partnership with Memorial Sloan Kettering Cancer Center (MSKCC) provides opportunities in education and scientific cooperation with Sirio-Libanes Oncology Center. On the other hand, the partnership set up with Ludwig Cancer Research Institute enabled the creation of the Molecular Oncology Center, whose objective is to promote basic and translational research in the quest for new diagnoses and treatments. The highlight in educational activities in 2011 was the approval by CAPES of a Professional Master's Certificate in Technology Management and Innovation in Health, set to start its activities in 2012. The Philanthropy department closed the first triennium involving 21 SUS development projects in partnership with Ministry of Health, which received funds amounting to R$ 180 million. More than half of these programs focused on training and qualification of almost 50,000 doctors, managers and other SUS professionals from around the country.

Characteristics

Philanthropic Hospital	
Founded in	1921
Built up area	99,989 m²
Clinical staff organization	mixed
Hospital Accreditation	Joint Commission International (JCI)

Main Indicators (2011)

Total number of available beds	350
Number of beds in ICUs	44
Number of registered doctors	3,356
Number of active employees	4,279
Number of emergency visits	77,514
Number of outpatient visits	70,609
Number of hospital admissions	17,502
Number of surgeries (except deliveries):	16,471
Number of deliveries	not applicable
Number of tests performed at the Diagnostics and Therapy Unit	3,040,167
Gross Revenues (in million R$):	865.4

HOSPITAL SÍRIO-LIBANÊS

Rua Dona Adma Jafet, 91 - Bela Vista
São Paulo - SP - 01308-000
11 3155-0200- www.hospitalsiriolibanes.org.br

HOSPITAL VERA CRUZ

Brief history of the Institution

Designed and built by Dr. Sylvio Miraglia and Dr. Antonio Figueiredo Starling and by engineer Dr. Ajax Rabello, Hospital Vera Cruz was inaugurated on April 9, 1949 as the most modern hospital in the State of Minas Gerais. Its mission is to provide resolute and humane medical and hospital care, of high value to clients, developed by highly driven and motivated employees. Hospital Vera Cruz is a pioneer in performing cardiovascular surgery in Minas Gerais and is a nationwide reference in hospital infection control. The hospital focuses on performing high complexity medicine. Its clinical staff has comprised highly renowned professionals in the medical circles of Minas Gerais and Brazil, many of whom are university professors who actively participate in representative hospital and medical organizations.

As a result of corporate governance and professional management started in 1995, the use of the Tasy information system since 2000, strategic planning implemented in 2002, sectorial budgeting since 2005, and quality management system put in place in 2006, Hospital Vera Cruz has been assessed by DNV and fully accredited by ONA in 2008 and accredited for Excellence in 2010, with distinguished performance in Anesthetics and Catheter Laboratory. In 2009, Hospital Vera Cruz was distinguished for its People Management in a study on "Reference Hospitals" conducted by ITMidia. In 2010, it was again distinguished for Sustainability in that year's study.

Highlights in 2011 and 2012

In 2011, Hospital Vera Cruz established a new Corporate Governance model, which made it possible to move the entity's partners to control bodies, enabling of the inclusion of market professionals in the executive bodies. With this approach, the hospital restructured its corporate composition, implementing an internal body to conduct its Strategic Management and review its Strategic Planning.

In 2011, Hospital Vera Cruz made important investments in the Information Technology field, having acquired a new server, to support Tasy information system database. It also acquired the System Adviser information system from Interact, to facilitate monitoring of the hospital's strategy and quality. Furthermore, it associated with Bionexo portal to optimize its procurement process. Finally, the hospital made improvements to its infrastructure and technological facilities, focusing on high complexity.

The hospital consolidated its ranking as a national reference in the treatment of CVA and was the only private hospital in Brazil with its own Vascular Unit, to be invited to take part in an international project by Boehringer to validate a CVA protocol.

Characteristics

For Profit Organization	
Founded in	1949
Built up area	8,370 m²
Clinical staff organization	mixed
Hospital Accreditation	National Accreditation Organization (ONA III)

Main Indicators (2011)

Total number of available beds	157
Number of beds in ICUs	24
Number of registered doctors	1,371
Number of active employees	696
Number of emergency visits	122,147
Number of outpatient visits	84,554
Number of hospital admissions	9,188
Number of surgeries (except deliveries):	7,258
Number of deliveries	not applicable
Number of tests performed at the Diagnostics and Therapy Unit	628,268
Gross Revenues (in million R$):	69.4

Hospital Vera Cruz
Cuidando da vida a vida toda

Avenida Barbacena, 653 - Barro Preto
Belo Horizonte - MG - 30190-130
31 3290-1000 - www.hvc.com.br

HOSPITAL VITA BATEL

Brief history of the Institution

Hospital VITA Batel was inaugurated in December 2004, in one of the most elegant districts of the city of Curitiba, to offer differentiated, high-quality and safe services to the population.

In its seven years of existence and dedication to its patients, it obtained the certificate of excellence awarded by the National Accreditation Organization at the level of excellence (ONA III). It recently began the process to obtain its international certification from Accreditation Canada, as well as from the Surgical Review Corporation in Bariatric Surgery.

It has an open clinical staff and large demand for services of medium to high complexity, particularly in the specialties of Cardiology, Neurology, Orthopedics, General Surgery and Urology. Nowadays, it is a national and international reference in bariatric surgery. Currently it has 80 beds, of which 57 are suites, 23 ICU beds (General Surgery and Cardiology) and seven surgical rooms.

The institution developed programs to promote health and the prevention of diseases, through the Viver Mais Vita, aimed at the elderly patients and in partnership with health plan operators.

Since 2009, the alliance with Hospital do Coracao of Curitiba has transformed Hospital VITA Batel into a reference for cardiac care as well.

Highlights in 2011 and 2012

In 2011, Hospital VITA Batel initiated an international accreditation process at Accreditation Canada and, in October 2012, it will be inspected by the organization for the accreditation survey.

Other highlights:

» Creation of the Hospitality Management Office;
» Restructuring of the People Management Model;
» Accreditation in Bariatric Surgery by the Surgical Review Corporation;
» Diamond certification from 3M for the Prevention of Skin Lesions.

Characteristics

For Profit Organization	
Founded in	2004
Built up area	6,700 m²
Clinical staff organization	open
Hospital Accreditation	National Accreditation Organization (ONA III)

Main Indicators (2011)

Total number of available beds	80
Number of beds in ICUs	23
Number of registered doctors	925
Number of active employees	354
Number of emergency visits	64,589
Number of outpatient visits	not applicable
Number of hospital admissions	8,358
Number of surgeries (except deliveries):	8,641
Number of deliveries	not applicable
Number of tests performed at the Diagnostics and Therapy Unit	53,544
Gross Revenues (in million R$):	49.9

Rua Alferes Ângelo Sampaio, 1896 - Batel
Curitiba - PR- 80420-160
41 3883-8482 - www.hospitalvita.com.br

HOSPITAL VITA CURITIBA

Brief history of the Institution

Hospital VITA Curitiba, inaugurated in March 1996, was acquired by VITA Participações in June 2000. It has a built area of 18,000 m² on a plot of approximately 102,000 m². It currently has 155 beds and about 560 employees. Each month it provides about 11,000 emergency visits, 850 hospital admissions and 750 surgeries. It is characterized as a general hospital with an open clinical staff, which provides service in several medical specialties.

VITA Curitiba is one of the most modern hospital complexes in the country and the most important in the State of Paraná, focusing on medium to high complexity care. The hospital operates in five clearly structured vocational areas: Cardiology, Neurology, Orthopedics, Pediatrics and Emergency Medical Services. Its structure comprises the following services: Inpatient Unit, General Purpose ICU, Coronary ICU, Pediatric ICU, Neurological ICU, Day-Hospital, Surgical Unit, 24-Hour Emergency Unit, Medical Offices Center, and Diagnostics and Treatment Unit.

Highlights in 2011 and 2012

» Implementation of "CERO"- Center of Excellence in Bone Reconstruction;
» Creation of the Exclusive Pediatric Emergency Center;
» Participation as a Multiplier Hospital in the Brazilian Patient Safety Program;
» Creation of the Office of Hospitality Management;
» Restructuring of the People Management Model;
» Technological Updating of the Imaging Service.

Characteristics

For Profit Organization	
Founded in	1996
Built up area	18,000 m²
Clinical staff organization	open
Hospital Accreditation	National Accreditation Organization (ONA III); Accreditation Canada

Main Indicators (2011)

Total number of available beds	155
Number of beds in ICUs	44
Number of registered doctors	2,105
Number of active employees	560
Number of emergency visits	127,615
Number of outpatient visits	24,379
Number of hospital admissions	10,230
Number of surgeries (except deliveries):	8,987
Number of deliveries	not applicable
Number of tests performed at the Diagnostics and Therapy Unit	80,946
Gross Revenues (in million R$):	76.6

HOSPITAL VITA CURITIBA

Rodovia BR 116, Km 396, 4021 - Bairro Alto
Curitiba - PR - 82590-100
41 3315-1900 - www.hospitalvita.com.br

HOSPITAL VITA VOLTA REDONDA

Brief history of the Institution

Since its foundation in 1953, as the hospital of CSN – Companhia Siderúrgica Nacional, and nowadays as Hospital VITA Volta Redonda, the institution is the city's pride, given its tradition in offering high-quality services to the Southern region of the State of Rio de Janeiro.

Hospital VITA Volta Redonda is a general hospital, with built area of approximately 11,000 m², distributed on four floors, and located in the most upscale part of the city of Volta Redonda.

Currently, the hospital has 104 inpatient beds, receiving 5,000 admissions and 90,000 emergency cases per year. It has a Specialty Medical Center, an Imaging Diagnostic Center, a Surgical Center with eight operating rooms, a General Adult ICU, a Cardiac Intensive Care Unit, a Cath Laboratory and a complete Diagnostics and Therapy Unit.

Hospital VITA Volta Redonda was the first hospital in the State of Rio de Janeiro to obtain accreditation at the excellence level from the National Accreditation Organization (ONA). It was also the fifth to obtain the seal certifying quality in care provided by Brazilian hospitals. Currently, it is a member of the Canadian Council on Health Services Accreditation (CCHSA, currently Accreditation Canada) and is in the final phase to obtain this important seal for international quality. Hospital VITA is a founding member of ANAHP.

Highlights in 2011 and 2012

In 2011, Hospital VITA Volta Redonda supported the implementation of Zero Risk Program, which promotes management of clinical and non-clinical risks. It thereby fulfills one of the targets of its mission "…to achieve excellence in quality of services provided to all its clients." Also in 2011, it improved its protocol management system and set up a clinical auditing service, staffed with individuals dedicated to this activity. In November 2011, the Cardiac ICU was inaugurated with 11 beds divided into post-cardiac surgery beds and acute heart disease beds. Each bed type has specific design and technological specifications, appropriate for the required level of care and clients' clinical conditions.

In 2012, the Specialty Medical Center, apart from its already renowned excellence in medical care, will receive investments of about R$ 1.5 million, which will enable the renovation of the building and technological updating. It will then have a threefloor structure, a panoramic elevator and medical offices that will provide clients with more comfort.

The hospital also maintains its commitment to achieving excellence in the quality of services rendered to all clients by using top quality tools from the domestic and international markets. Furthermore, it participates in several local and international certification programs, thereby consolidating its commitment to continuous improvement.

Characteristics

For Profit Organization	
Founded in	1953
Built up area	11,000 m²
Clinical staff organization	open
Hospital Accreditation	National Accreditation Organization (ONA III)

Main Indicators (2011)

Total number of available beds	102
Number of beds in ICUs	26
Number of registered doctors	343
Number of active employees	334
Number of emergency visits	85,243
Number of outpatient visits	not applicable
Number of hospital admissions	6,798
Number of surgeries (except deliveries):	3,567
Number of deliveries	not applicable
Number of tests performed at the Diagnostics and Therapy Unit	472,865
Gross Revenues (in million R$):	53.6

Rua Lions Club, 160 - Vila Santa Cecília
Volta Redonda - RJ - 27255-430
24 2102-0001 - www.hospitalvita.com.br

HOSPITAL VIVALLE

Brief history of the Institution

Hospital viValle started its activities in 1980 as Clinica GastroClinica and in 2000 began operations as a hospital unit. In 2006, its name changed to Hospital viValle, a strong brand that is gaining increasing recognition throughout Vale do Paraíba region.

Nowadays, viValle facilities hold a round-the-clock clinical and orthopedic emergency care unit, an Oncology center, and a highly equipped surgical center to carry out all types of operations in a variety of specialties. It has a humanized ICU, with eight beds, and the only sterile supply center in the region to hold high-technology equipment for the control of hospital infection.

To ensure first-class treatment, Hospital viValle provides its patients all the comfort and convenience of a hotel, offering top quality facilities and excellent food, operating within a hospital cuisine concept.

The same professional and humanized service offered at Hospital viValle can be seen at viValle Medical Center, renowned for its medical and health professional staff that delivers differentiated healthcare services in a wide range of specialties and treatments. The unit also has viValle check-up service, dedicated to the promotion of health through prevention.

Highlights in 2011 and 2012

In 2011, Hospital viValle began the second phase of its master plan, by expanding its emergency unit by 40% and building the Cath Lab Unit in a new 220 m² area.

The Cath Lab, to be inaugurated in the first half of 2012, will encompass imaging diagnostic technology and therapy in the areas of Interventional Cardiology and Interventional Neuroradiology, Interventional Vascular Radiology, and Invasive Electrophysiology.

In 2011, company URC Diagnósticos became part of Imaging Diagnostics Center of Hospital viValle, in order to reduce the turnaround time of exams and improve services offered to patients. At the end of 2011, the hospital joined D'Or São Luiz network, one of the biggest health service groups in Brazil.

Hospital viValle has taken part in the certification processes since 2006, when it was certified by ONA II, and in 2012 it was awarded ONA III certification, the seal of the National Accreditation Organization, issued by Instituto Qualisa de Gestão, confirming the excellence of hospital services.

During 2012, new projects and partnerships are in progress to maintain and improve service and healthcare quality.

Characteristics

For Profit Organization	
Founded in	2000
Built up area	4,625 m²
Clinical staff organization	mixed
Hospital Accreditation	National Accreditation Organization (ONA III)

Main Indicators (2011)

Total number of available beds	53
Number of beds in ICUs	8
Number of registered doctors	1,078
Number of active employees	330
Number of emergency visits	58,951
Number of outpatient visits	15,212
Number of hospital admissions	3,808
Number of surgeries (except deliveries):	3,536
Number of deliveries	not applicable
Number of tests performed at the Diagnostics and Therapy Unit	97,591
Gross Revenues (in million R$):	undisclosed

hospitalviValle
Você sente a diferença

Av. Lineu de Moura, 995 - Jd. Urbanova
São José dos Campos - SP - 12244-380
12 3924-4900 - www.vivalle.com.br

REAL HOSPITAL PORTUGUÊS

Brief history of the Institution

Real Hospital Português de Beneficência (RHP), in the State of Pernambuco, was founded in 1855 by Portuguese doctor Jose D'Almeida Soares Lima Bastos, at the time president of Portuguese Readers' Group, in the city of Recife, a resistance center for the treatment of victims of the cholera epidemics that ravaged the country.

With a permit dated July 2, 1856, which sought to manifest the Portuguese nation's support for the institution, King of Portugal placed the hospital in Recife under his royal protection, an honor ratified in 1862. Subsequently, a permit issue on November 7, 1907, granted by King Carlos I of Portugal, awarded to Hospital Português de Beneficência, in Pernambuco, the title of Royal [Real].

RHP is considered the most complete center of medical excellence in the North and Northeast of Brazil, the most complex and best equipped in these regions. The hospital facilities comprise São João de Deus building (Oncology), Real Hospital do Coração (RHC), Egas Moniz building (Real Vida general emergency services and inpatient beds), Real Mater (maternity), Infante (Pediatrics unit), Arnóbio Marques building (medical offices), José Maria Matos building (parking lot and medical and administrative offices), Ambulatório de Beneficência Maria Fernanda (outpatient clinic), and Boa Viagem advanced unit. In addition, more than 50 specialized clinics and three laboratories operate on the premises of RHP.

Real Hospital Português is managed by an administrative committee made up of members of Associação RHP. Every two years the members of this committee elect the administrator, who holds the decision-making power in the hospital and sets the direction in which the institution is to head.

Highlights in 2011 and 2012

In the beginning of 2011, Real Hospital Português inaugurated a new clinical testing laboratory – Real Lab – with an expanded and modern structure, aiming at doubling the service capacity with very high quality tests and higher precision and speed in delivering results. The Siemens Advia Workcell system was put in place, consisting of a 9-meter long platform, with a capacity to process 400 sample tubes per hour.

Another highlight in the technological area was the construction of Hospital Português new surgery center, which was installed in the São João de Deus building. It comprises seven integrated and intelligent rooms, i.e., it has high level technology to integrate audio and video, medical equipment, the surgery room, and information and telecommunication systems. One of them is equipped with exclusive Variop System that ensures lower infection risk, easy cleaning, and optimization of work flows.

RHP was also awarded Pernambuco Pride Award, which is granted by Diário de Pernambuco newspaper to institutions that stand out in the State. For the eighth consecutive year, the hospital was honored with the "Brands that I like" trophy, an award that distinguishes the companies of choice of consumers in Recife.

For the 14th consecutive year, Real Hospital Portugues was elected the most remembered private hospital by the inhabitants of Pernambuco, in the brand recall survey conducted by Jornal do Commercio.

Characteristics

Philanthropic Hospital	
Founded in	1855
Built up area	117,736 m²
Clinical staff organization	mixed
Hospital Accreditation	National Accreditation Organization (ONA I)

Main Indicators (2011)

Total number of available beds	594
Number of beds in ICUs	148
Number of registered doctors	11,587
Number of active employees	3,761
Number of emergency visits	213,859
Number of outpatient visits	53,308
Number of hospital admissions	25,130
Number of surgeries (except deliveries):	21,015
Number of deliveries	2,174
Number of tests performed at the Diagnostics and Therapy Unit	1,344,911
Gross Revenues (in million R$):	351.9

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Recife - PE - 52050-910
81 3416.1122 - www.rhp.com.br

VITÓRIA APART HOSPITAL

Brief history of the Institution

Inaugurated in 2001, Vitória Apart Hospital was conceived with the objective of being a complete hospital, offering maximum safety and comfort to its patients and staff. In 2005, only four years after its creation, it had already obtained ONA certification – National Accreditation Organization and in 2011 it was re-certified at the organization's maximum level of excellence. The group of doctors that conceived the project did all it took to transform it into a health reference in the State of Espírito Santo, and nowadays Vitória Apart is considered one of the biggest and best hospitals in the State.

With the mission of offering solutions in health, combining technology and humane care, Vitória Apart uses modern management tools to achieve its strategic objectives. The institution applies values such as innovation, friendliness, ethics and sustainability to provide excellence in care as the basis for all its actions. The proposition is to offer emergency outpatient care and hospital care at different levels, without the need to transfer patients to perform services and tests in other hospital units. In the near future, the hospital will take another step forward to reinforce its importance for the medical community and the State population, by finishing its expansion works. The new Vitoria Apart is getting ready to offer differentiated emergency services in a 2,000 m² area, having the capacity to perform 20,000 treatments per month, expand the number of medical specialties, and offer 140 additional beds.

Highlights in 2011 and 2012

The year 2011 was important for Vitória Apart Hospital to consolidate a number of projects, with the objective of being recognized as one of the best and largest private hospitals in the country. One of those initiatives was the implementation of 2011/2015 Strategic Plan, with the definition of the lines of activity for the next five years. The differential of the applied method, apart from its widespread communication and the direct involvement of top management, was setting up the Strategy Office, responsible for monthly monitoring of plans, and of the Orientation Committee, comprising members of the Board and directors, who validate the monthly progress of the entire plan in accordance with the schedule, budget and achieved objectives.

Another activity that should be pointed out was the creation of the Medical Quality Committee, which comprises representatives of different specialties in a formal discussion and doctor-hospital interaction forum. This is the first step to elaborate a clinical staff management program to start activities still in 2012.

Vitória Apart Hospital operates focused on safety of patients, professionals and their visitors. To that end, it develops the Risk Management Program, whose objective is to improve healthcare efficiency, fostering the safety culture within the organization, while also identifying, handling and monitoring the risks of each sector.

The creation of Vitória Apart Hospital Health and Citizenship Institute is also reason for pride in the institution. Its objective is to develop, together with the neighboring communities, a supplementary program in health services, intended as an instrument to foster local sustainability, based on public-private partnerships.

Characteristics

For Profit Organization	
Founded in	2001
Built up area	47,845 m²
Clinical staff organization	mixed
Hospital Accreditation	Hospital Accreditation: National Accreditation Organization (ONA III)

Main Indicators (2011)

Total number of available beds	225
Number of beds in ICUs	71
Number of registered doctors	726
Number of active employees	1,019
Number of emergency visits	81,349
Number of outpatient visits	not applicable
Number of hospital admissions	10,359
Number of surgeries (except deliveries):	12,756
Number of deliveries	699
Number of tests performed at the Diagnostics and Therapy Unit	not applicable
Gross Revenues (in million R$):	77.5

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