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BRAZIL: Enhancing Performance in Brazil's Health Sector: Lessons from Innovations in the State of São Paulo and the City of Curitiba

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Improving Public Sector Performance for Higher Quality Public Spending

The inadequacy of public services in Brazil today constrains the country's economic growth and social development. The volume of government expenditure is not the principal bottleneck: at over 40 percent of GDP, Brazil's total public spending is already much higher than that of comparable middle-income countries. The vital question is how to get greater value for public money. As a federal country, improving service delivery in Brazil calls for strengthening the incentives and institutional capacities at the sub-national level, precisely where the country faces its greatest institutional development challenges. A new report¹ examines how particular managerial innovations have been applied in two locations in Brazil to deliver improved public healthcare services.

The health sector in Brazil absorbs approximately four percent of GDP, and spending levels are likely to rise further given the country's demographic and epidemiological profiles. Improving the efficiency of public health spending is vital to ensuring the country's public finances and macroeconomic stability in the long run.

Current efforts to improve health service delivery in Brazil should be examined against the background of at least two parallel developments that occurred in the early-mid 1990s. At the federal level, Brazil launched a public management reform agenda that subsequently influenced approaches to public sector reform throughout the country. Inspired by that reform discourse, a number of sub-national jurisdictions in Brazil have embarked upon managerial reforms to improve public service delivery. In addition, the health sector itself has been going through important policy

and institutional transformations, driven by implementation of a decentralized health service delivery model.

One of the approaches to service delivery improvement proposed as part of the reforms involves the use of "Social Organizations" to deliver public services via non-government organizations certified to manage public funds for the purposes specified in management contracts. Other changes included measures to make personnel management in the public administration more performance-oriented, through legal reforms to increase managerial flexibility (e.g., managers' ability to fire staff for poor performance) and/or management instruments to enhance public servants' incentives to perform (e.g., performance evaluation and pay).

Since the late 1980s Brazil's health sector has gone through a considerable transformation both in terms of structure (e.g., decentralization, the adoption of the Unified Health System (SUS)), and policy content (e.g., greater emphasis on primary care). The health sector in Brazil now benefits from a reasonably coherent sector-wide policy framework (SUS) – certainly superior to other decentralized sectors such as public security or water supply and sanitation. Nonetheless, the effectiveness of the Brazilian federation in providing public healthcare is still limited, as a majority of the sub-national jurisdictions, particularly at the municipal level, suffer from weak institutional capacity.

Within this broader context, the State of São Paulo and the City of Curitiba offer two examples of innovative healthcare management reforms: "corporatization" of public hospitals in the State of São Paulo, and performance management in the Municipality of Curitiba. On

the surface, these innovations appear to follow the now familiar New Public Management (NPM) prescriptions of “let the managers manage” (managerial flexibility) and “reward performance” (performance-based pay). But the case studies uncover interesting nuances that enrich our understanding of practical, context-specific approaches to performance management within Brazil’s existing institutional constraints. By probing behind the conceptual rhetoric of the reforms, the cases offer insights into “what really matters” in improving public management, particularly with regard to how policy makers can overcome so-called “agency problems.”

The case narratives show how both the State of Sao Paulo and the City of Curitiba have deployed a range of organizational and managerial innovations to diminish policy makers’ informational disadvantage vis-à-vis front-line service providers (doctors, nurses) and achieve greater alignment between the government’s overall policy objectives in the health sector, and the objectives and incentives of the service delivery units and their staff. There is more to management improvement than simply adopting a new organizational model or new managerial slogans. Interestingly, these case studies demonstrate that it is possible to make demonstrable improvements in public service delivery within Brazil’s present legal and organizational context.

Social Organization Hospitals in the State of São Paulo

In the late 1990s the government of São Paulo created Social Organizations in Health (Organizações Sociais em Saúde – OSS) to enable a formal partnership between the state and non-profit, private-sector organizations. Under this OSS model, the government provides budgetary transfers to cover the costs of running the hospital, but responsibility for day-to-day administration is delegated to pre-certified non-profit organizations. The State Secretariat of Health (SES) negotiates and signs a performance contract with each of these hospital managers, granting them greater flexibility than their counterparts in traditional state hospitals to run the hospital in the manner they consider best-suited to meet their performance targets. In 2004, 17 public hospitals in São Paulo operated as OSS.

A systematic comparison of 12 OSS hospitals and 10 direct administration hospitals in the State of São Paulo (World Bank 2006a) found OSS hospitals were more efficient and provided better quality services. For example, the OSS hospitals offered 35 percent more pa-

tient admissions for each hospital bed and registered lower overall mortality than direct administration hospitals. What accounts for OSS hospitals’ superior performance?

Part of the answer is the accountability relationship between the SES and the OSS hospital. The management contract specifies the volume of different services to be performed each month (e.g., inpatient and outpatient services, medical consultations) in exchange for a specified budget (a prospective payment block contract). Ninety percent of the annual budget agreed between the SES and hospital administrator is delivered in monthly installments. These disbursements will be reduced by 10 percent if the quantity of services delivered falls to 75-84.9 percent of the agreed targets, and by 30 percent if output falls below 75 percent. The remaining ten percent of the budget is delivered quarterly, contingent upon the hospital submitting properly coded data on their patients and the treatments or services provided.

OSS contracts are fine-tuned through regular dialogue between hospital directors and the OSS supervisory staff of the Secretariat of Health. Adjustments are made from one annual contract to the next, but can also be made by consensus within the operational period of a given contract. Since the hospital’s budget depends on meeting the pre-specified performance targets (and submitting well-organized management and performance information to the SES), the hospital managers have a clear incentive to meet the targets. Furthermore, persistent failure to perform could result in non-renewal of the OSS contract.

Once accountability and performance expectations are established, the hospital manager still needs the ability to manage the hospital’s resources, including personnel, to achieve the agreed performance goals. In an analysis of 20 hospitals in São Paulo, there was little or no evidence to suggest that the superior performance of OSS hospitals results from higher salaries, performance pay, superior career development opportunities, or even formal supervision mechanisms. The research did find, however, that OSS hospital managers enjoyed greater freedom in choosing a particular mix of staff/skills and in selecting personnel through less rigid recruitment processes. Rather than being required to follow a rigid process of competitive entry exam (*concurso*), where hospitals are only permitted to recruit those who have passed the exam in the order provided by their test scores, OSS hospital managers are allowed to recruit staff through a more flexible process, determined by referrals, recommendations, and/or face-to-

face interviews. Moreover, contrary to the norm in direct public administration, OSS managers can swiftly fire employees who fail to perform at expected levels.

These findings suggest that under certain circumstances (where accountability relations are clearly defined and credibly enforced), performance improvements can result from granting front-line managers greater flexibility in managing human resources. Looking to the future, one reform option for Brazil's traditional direct administration would be to modify the rules governing concursos to allow hiring managers to interview a short list of pre-qualified candidates instead of forcing them to accept the top qualifiers irrespective of the individuals' likely fit with the organization.

A manager's ability to discipline poor performance is also an important instrument. While a "rapid path" (via rápida) procedure was intended to enable public sector organizations to fire poor-performing employees, applicable rules result in continued delays. Reviewing this rule to allow a speedier process of dismissal could lead to more effective human resource management, although obviously the risk of abuse must be assessed carefully.

Primary Healthcare in Curitiba

Like OSS hospitals in São Paulo, the performance of healthcare management in Curitiba is generally considered superior to that of an average Brazilian municipality.

For three decades Curitiba has constantly innovated in healthcare and managerial practice, in a context of rapidly growing demand for healthcare (thanks to immigration and the devolution of healthcare to local government). Today Curitiba's health management includes several good practices, such as client orientation (e.g., regular use of telephone surveys to measure service quality and detect problems), as well as effective use of management information (e.g., development of a sophisticated integrated information system to manage knowledge about patients and their treatments).

Virtually all of the roughly 5,000 staff of the Municipal Health Secretariat (SMS) are tenured public servants with automatic (rather than merit-based) advancement up the seniority scale. Curitiba has tried a number of bonus schemes to motivate these public servants to become performance-oriented. The first of these schemes (PIQ, 1995), which introduced competition between Health Units, failed as teams were able to cheat on poorly mea-

sured indicators and rivalry between teams also began to undermine the broader unity of staff in the SMS.

A new incentive scheme to improve service quality (IDQ) was introduced in 2000. A quarterly evaluation determines whether individual employees receive a bonus. The result of the evaluation is the weighted outcome of the supervisor's evaluation of the employee, self-evaluation, SMS evaluation of the Unit (based on performance under management contracts), and community evaluation of the Unit. In practice, virtually everybody who does not have a record of excessive lateness or absence gets the bonus. Thus, on the face of it, the scheme operates only to punish extreme cases of poor performance. Nonetheless, staff believe that the IDQ has had an important impact on performance, although this seems to have fallen over time. It may be that, as often happens with workplace innovations, there is a temporary change in behavior until workers readjust to the norm. In this case, however, it also seems that the evaluation process itself (i.e., not the rewards and punishments) has contributed to identifying and solving problems in the Health Units.

The culture of SMS professional staff is dominated by what might, in shorthand, be called a strategic-planning mindset. The Annual Operating Plans (POAs) – mandated by the Unified Health System (SUS) but often not taken seriously by states and municipalities – are used as real management tools in Curitiba. The POAs are accompanied by simple Management Contracts between the SMS and the Districts and between the Districts and the Health Units. Although these contracts are not formally enforced, they set targets for roughly 60 health outputs and outcomes. The targets are set on the basis of discussions between the parties. The computerized information system and the standardized definitions of procedures coming from the integrated protocols have been vital in minimizing the amount of "gaming" that can go on in the measurement of performance.

The manner in which Curitiba has combined a variety of managerial instruments (e.g., performance review and bonus, management information system, and standardization of basic care according to protocols) seems to be a key ingredient of its relative success. Most commentary ascribes this, at least in part, to the adoption of a strategic-planning approach born of the systematic urban planning that started in Curitiba in the 1960s. This, in turn, was likely facilitated by the remarkable political continuity that the city has enjoyed over the past two decades.

It would not be easy to replicate Curitiba's experience. Curitiba's system is the product of particular historical circumstances; it is complex; and the relatively small size of the SMS helps it to manage this complexity. With these cautions in mind, it would be useful for would-be replicators to understand how Curitiba has applied strategic planning: more as a *modus operandi* (or work habit) than a formal process. That *modus operandi* has pervaded the organization from the top managers to the operational level, and involves a mindset that thinks about the future, looks for and solves problems, understands system complexity (and understands that changes in one place may create problems and opportunities elsewhere). It is empirical, experimental, and risk-taking. The formal tools of performance management seem an adjunct to, not a driver of Curitiba's strategic planning.

Conclusions and Policy Implications

The two cases of public management innovations examined in the report demonstrate two divergent approaches to performance improvement in Brazil's public sector. São Paulo has introduced organizational innovation through contracting out hospital management to qualified NGOs in the form of "Social Organizations." This model involves devolution of managerial responsibilities from the State Secretariat of Health (SES) to each of the OSS hospitals, circumventing the well-known constraints that define human resource management in the state's direct administration. Curitiba, in contrast, managed to strengthen performance of its primary care system within the existing human resource regime. We suggest (but do not prove) that Curitiba's ability to make effective use of the *estatutário* public servants – who are often vilified as complacent in their permanent job tenure – to provide client-oriented healthcare is largely context-dependent (i.e., the product of Curitiba's positive history of public sector development both in the health sector and more broadly).

In both cases, a central challenge is to motivate staff and align their incentives with the government's broader policy objectives. Our case studies do not provide a straightforward blueprint for other sub-national governments in Brazil, but we hope they provide a clearer picture of key elements of the reforms that other governments should consider before embarking on reform processes of their own. The case studies explore two types of management tools: i) those that aim to align the expectations of principal and agent and reduce information asymmetry, and ii) those that provide direct incentives to tie an employee's or manager's behavior to performance outputs. The two types are not intrinsically incompatible, but knowing how to combine these instruments is more an art than a science.

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Instruments for aligning expectations and reducing information asymmetry between principal and agent:

There are a number of things that reform-minded governments can do to better align expectations and incentives between principals and agents. Indeed, our two studies suggest a common list of "good things" to do:

- Invest in strategic planning by clarifying expectations and establishing performance feedback mechanisms. These processes work better when operators – the front-line troops – are directly involved.
- Invest in better strategic management of information by standardizing processes and definitions, ensuring data quality, tapping information from the community, and providing IT systems to manage this information.

Choosing among instruments for direct performance incentives to agents: The instruments that create clearer, direct incentives for staff and managers are generally difficult to apply because they entail complicated policy tradeoffs (including a higher political profile). Our two cases suggest that extrinsic personnel incentives are more compatible with the use of external labor markets, while intrinsic incentives may be more compatible with internal labor markets.

In closing, it should be remembered that the two cases discussed above are drawn from two of Brazil's most sophisticated governments. States or municipalities that lack the particular history and endowments of São Paulo and Curitiba should invest in understanding what strategic planning is, and what alternative incentive systems may be applicable to their setting. Then, they should proceed, where they can, to improve their public sector performance in an experimental but consistent manner.

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