



Modelos de contratación innovadores alineados a incentivos

Fabián Cardona Medina, Vicepresidente de Salud ACEMI

Agenda

1. Conceptos generales
2. ¿En dónde estamos y para dónde vamos?
3. Generación de valor e integralidad
4. Modelos de contratación innovadores



Agenda

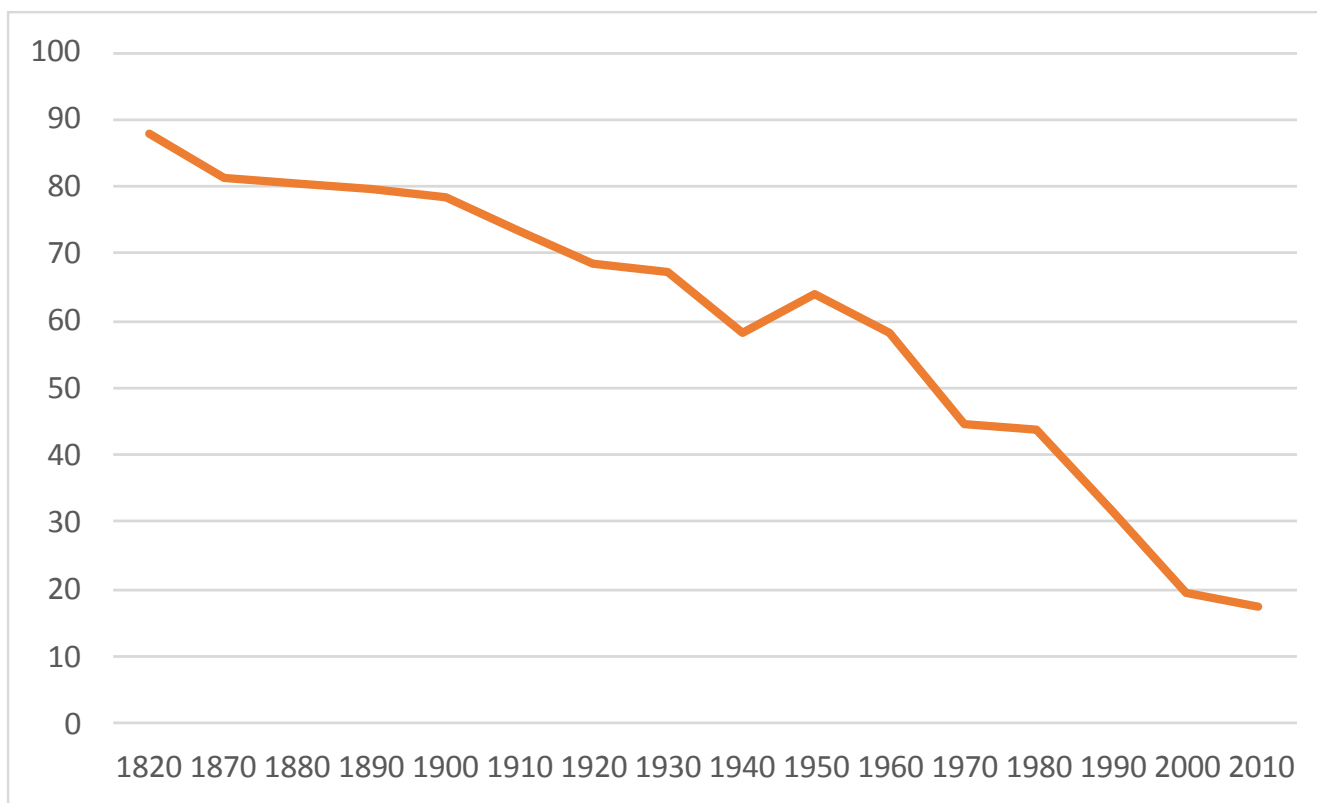
1. Conceptos generales
2. ¿En dónde estamos y para dónde vamos?
3. Generación de valor e integralidad
4. Modelos de contratación innovadores



“Corren malos tiempos y el mundo se está volviendo viejo y malvado. La política es cada vez más corrupta. Los niños ya no son respetuosos con sus padres”

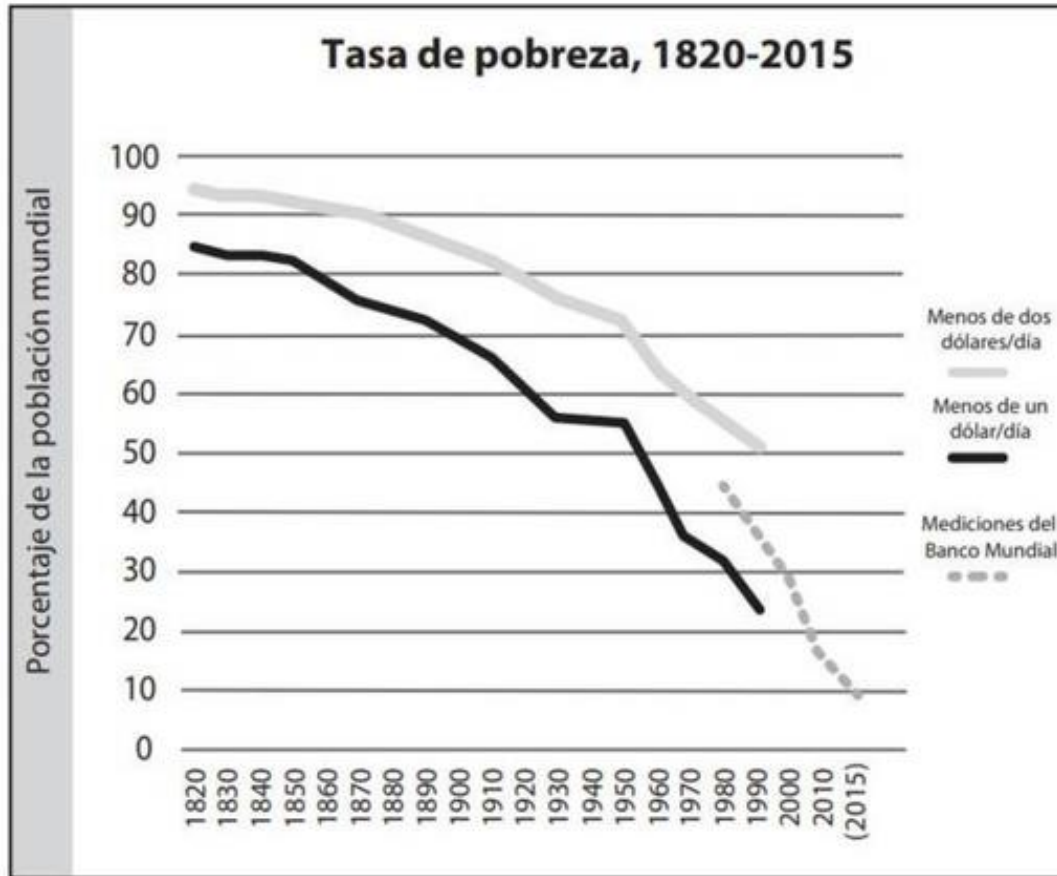
Inscripción en una piedra de Caldea, 3.800 AC.

Tasa analfabetismo a nivel mundial, 1820 - 2010



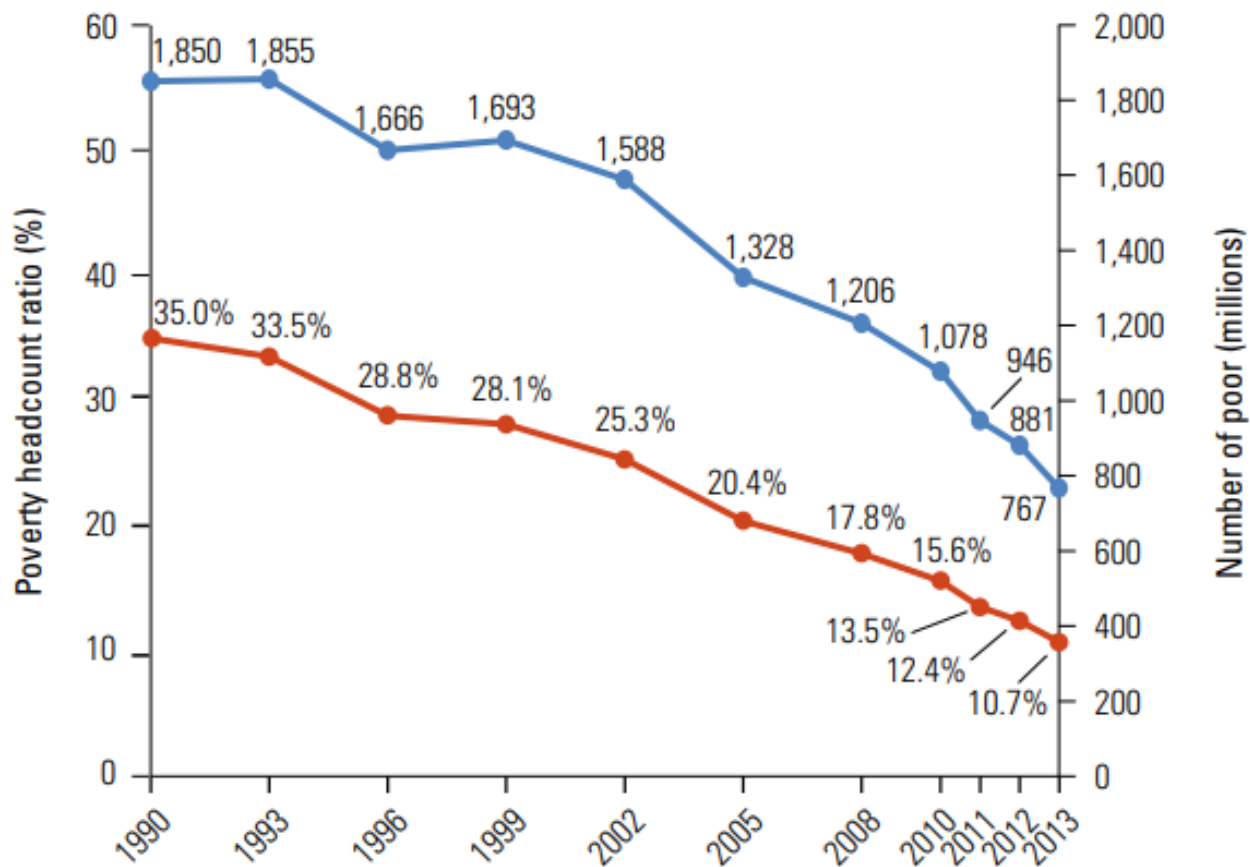
Fuente: OCDE, World development of literacy and attainment of at least basic education.
<http://www.dx.doi.org/10.787/888933095666>.

Tasa de pobreza a nivel mundial, 1820 - 2010



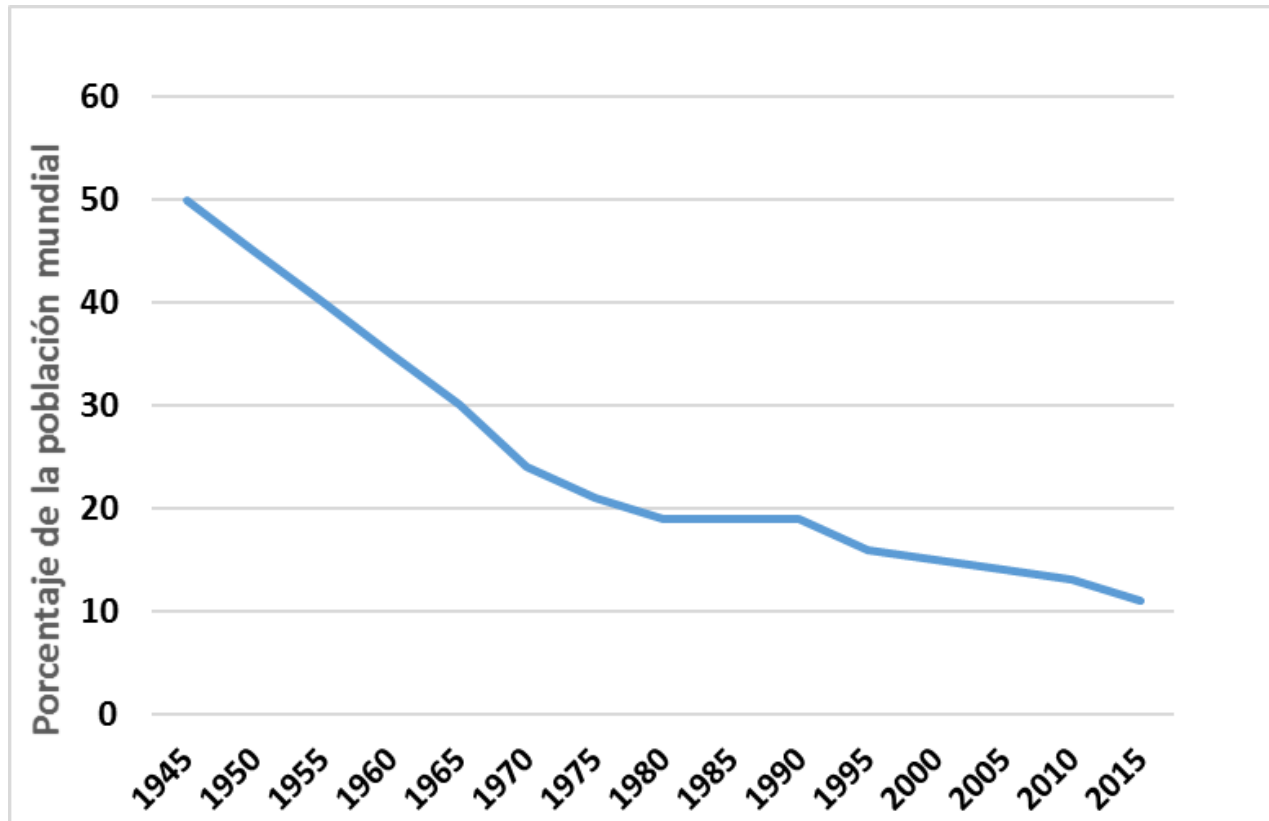
Fuente: Progreso, Johan Norgberg. Bourguignon y Morrison, 2002; Banco Mundial, PovcalNet; Cruz, Foster, Quillin t Schellekens 2015

Tendencia de la pobreza en número de personas y en %, 1990 - 2013



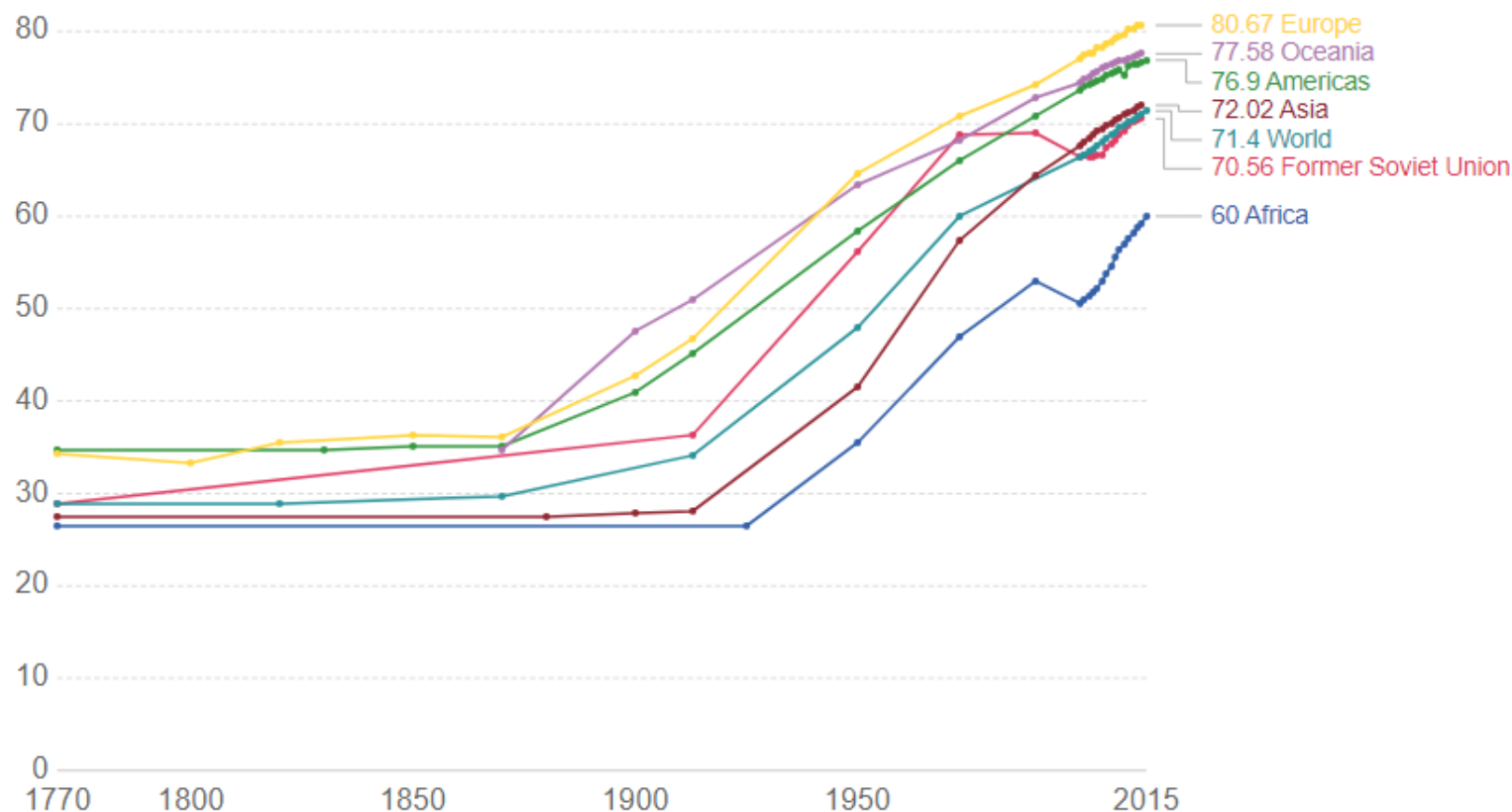
Fuente: Taking on inequality. Poverty and shared prosperity, 2016. WB

Tasa desnutrición 1945 - 2015



Fuente: FAO 1947, 2003, 2015

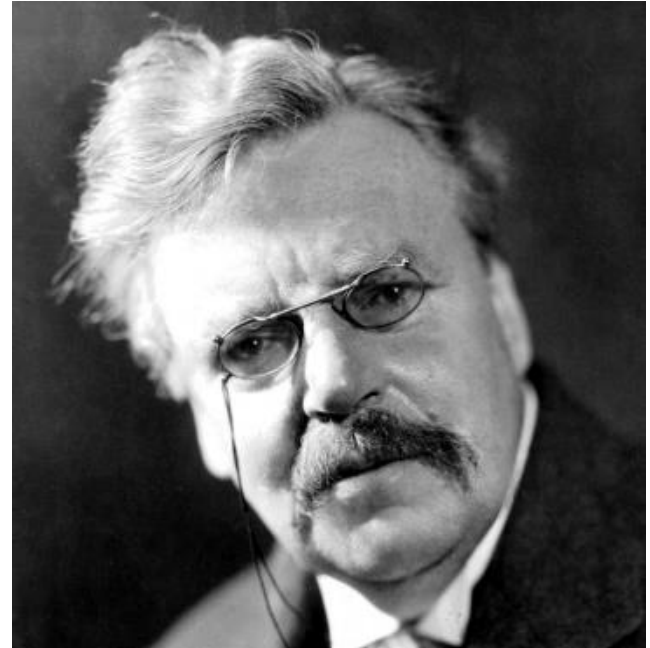
Expectativa de vida a nivel mundial y por regiones, 1770 - 2015



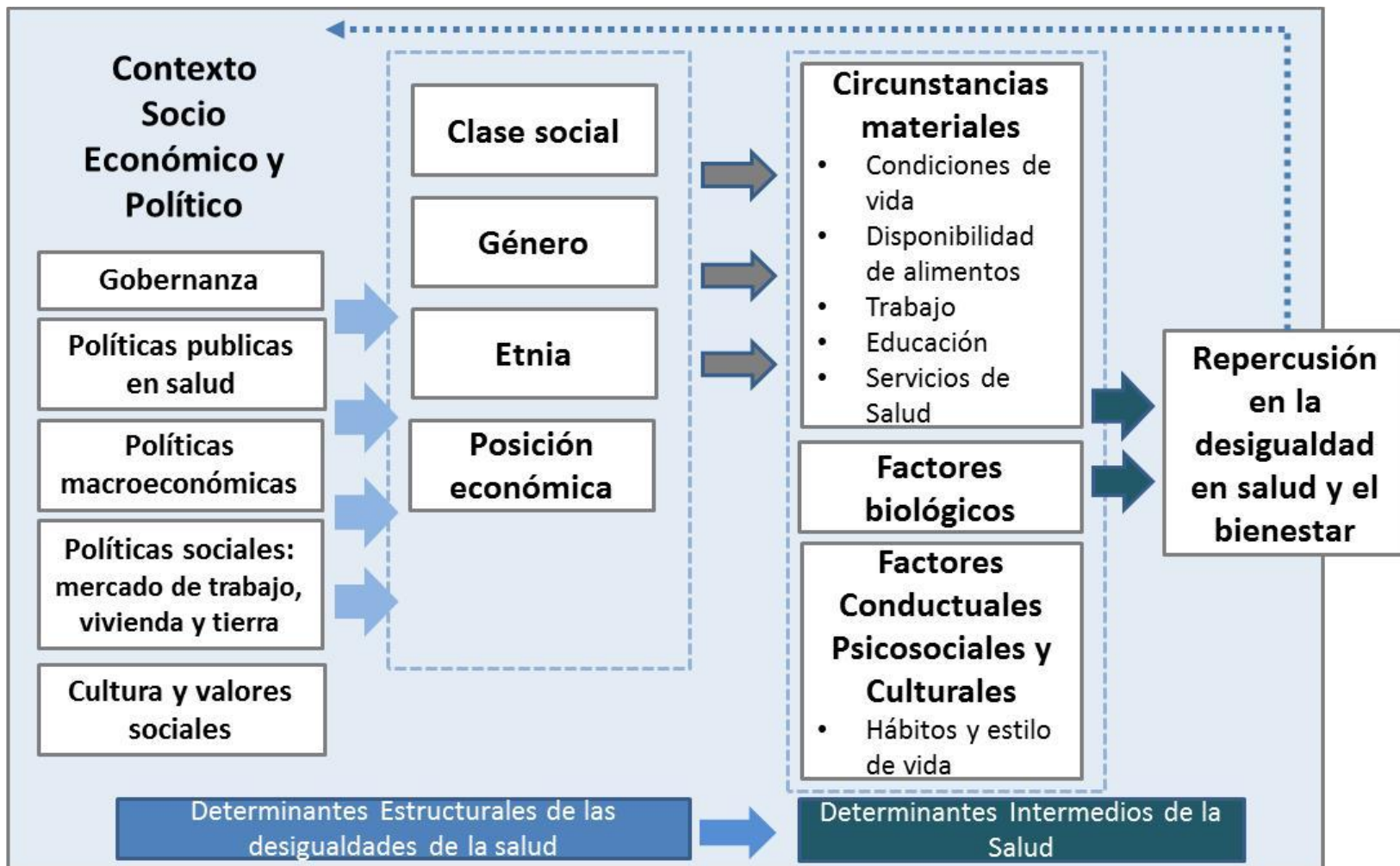
Fuente: Roser, Max, "Life Expectancy" 2016. OurWorldInData.org.
<<https://ourworldindata.org/grapher/life-expectancy-globally-since-1770?time=1770..2015>>

“El pesimista solo cree en si mismo,
el optimista cree en los demás”

Gilbert Keith Chesterton
(1874 – 1936).



¿Cómo se produce salud?

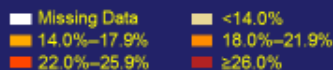


Fuente: marco conceptual de los determinantes sociales de la salud. OMS 2010

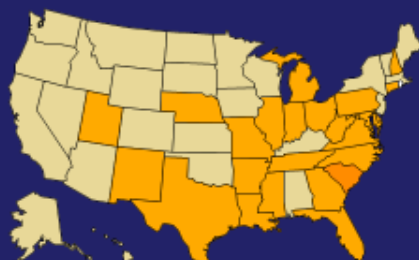
Age-Adjusted Prevalence of Obesity and Diagnosed Diabetes Among US Adults

1994

Obesity (BMI ≥ 30 kg/m²)



Diabetes



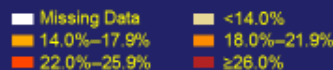
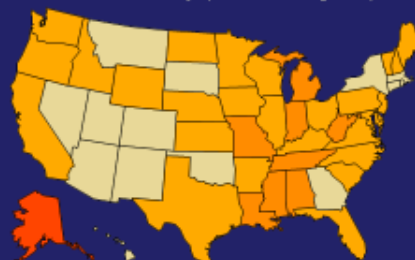
CDC's Division of Diabetes Translation. National Diabetes Surveillance System available at <http://www.cdc.gov/diabetes/statistics>



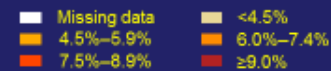
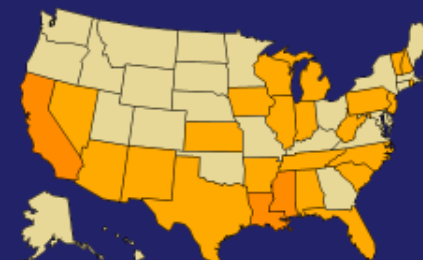
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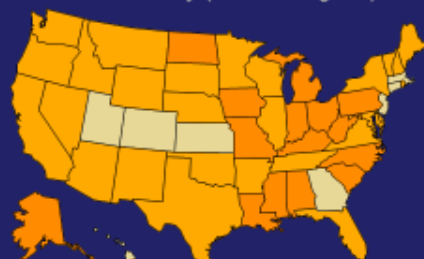
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Age-Adjusted Prevalence of Obesity and Diagnosed Diabetes Among US Adults

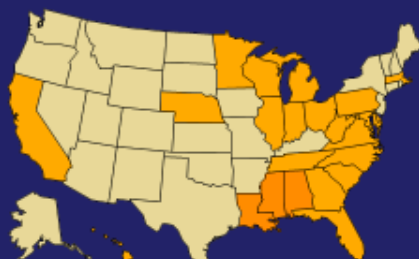
1996

Obesity (BMI ≥ 30 kg/m²)



Missing Data
 14.0%–17.9%
 18.0%–21.9%
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 ≥26.0%

Diabetes



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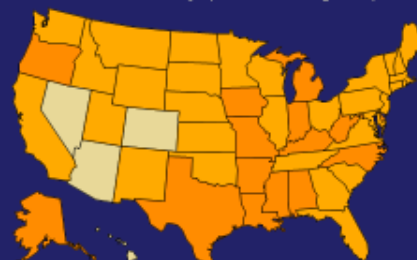
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Age-Adjusted Prevalence of Obesity and Diagnosed Diabetes Among US Adults

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Obesity (BMI ≥ 30 kg/m²)



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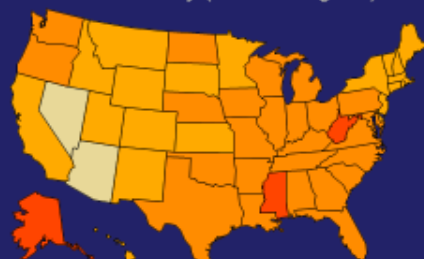
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Age-Adjusted Prevalence of Obesity and Diagnosed Diabetes Among US Adults

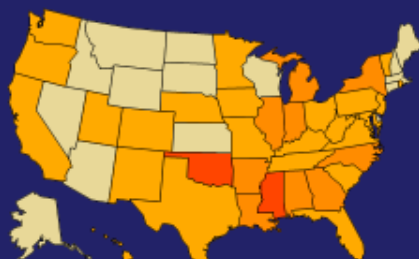
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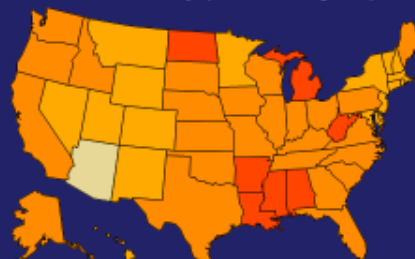
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Age-Adjusted Prevalence of Obesity and Diagnosed Diabetes Among US Adults

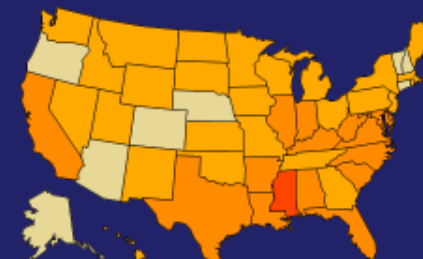
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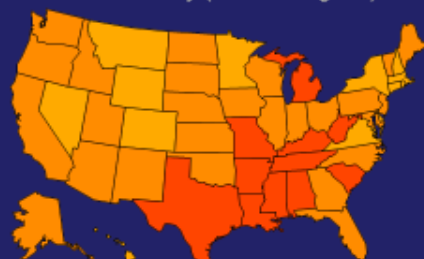
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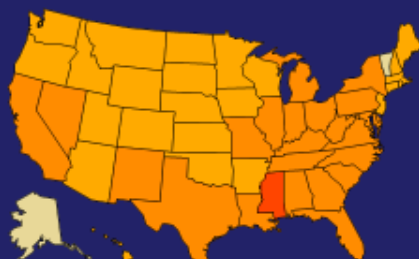
2000

Obesity (BMI ≥ 30 kg/m²)



Missing Data
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Diabetes



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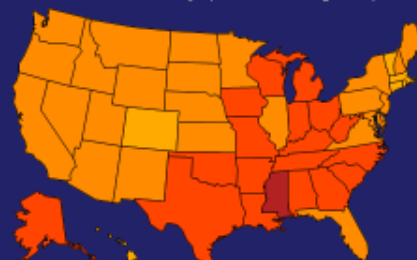
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Age-Adjusted Prevalence of Obesity and Diagnosed Diabetes Among US Adults

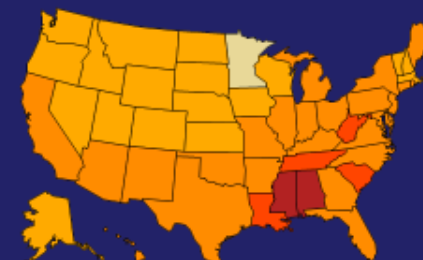
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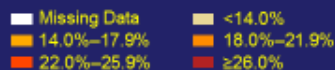
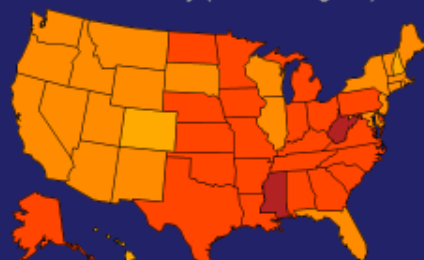
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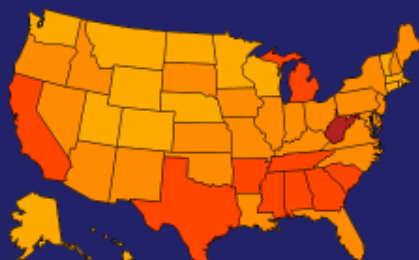
Age-Adjusted Prevalence of Obesity and Diagnosed Diabetes Among US Adults

2002

Obesity (BMI ≥ 30 kg/m²)



Diabetes



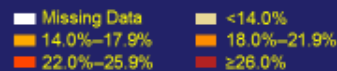
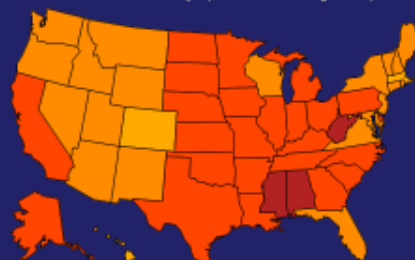
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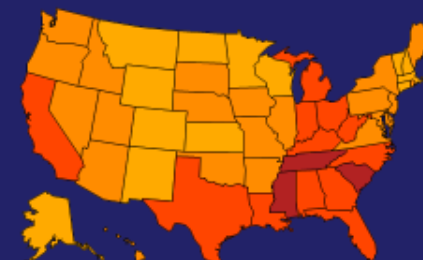
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2003

Obesity (BMI ≥ 30 kg/m²)



Diabetes



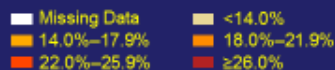
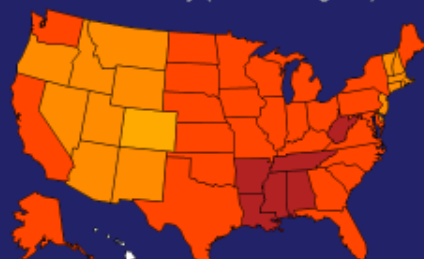
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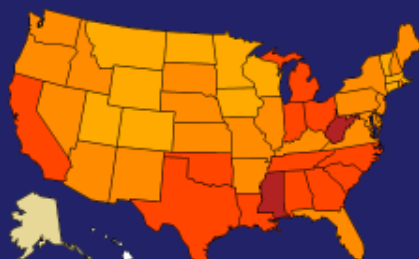
Age-Adjusted Prevalence of Obesity and Diagnosed Diabetes Among US Adults

2004

Obesity (BMI ≥ 30 kg/m²)



Diabetes



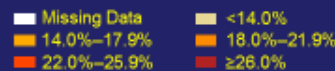
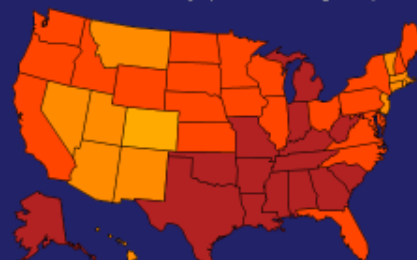
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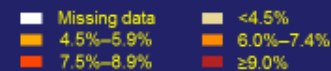
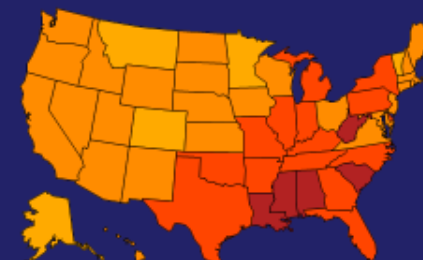
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2005

Obesity (BMI ≥ 30 kg/m²)



Diabetes



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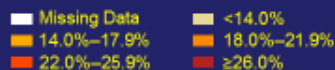
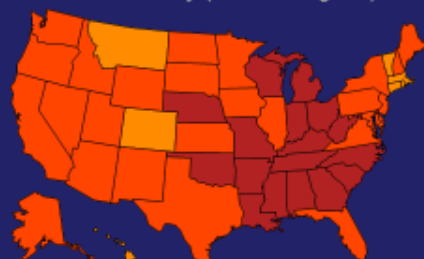
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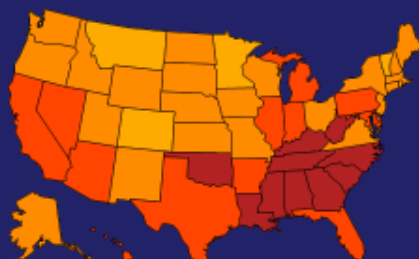
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2006

Obesity (BMI ≥ 30 kg/m²)



Diabetes



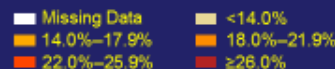
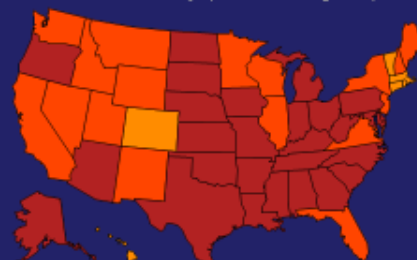
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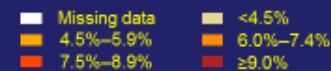
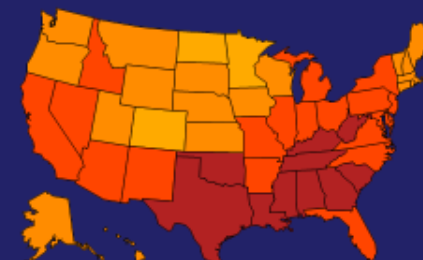
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2007

Obesity (BMI ≥ 30 kg/m²)



Diabetes



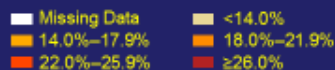
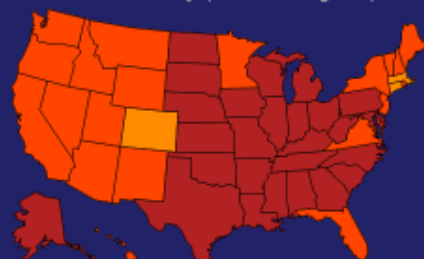
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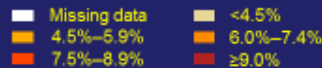
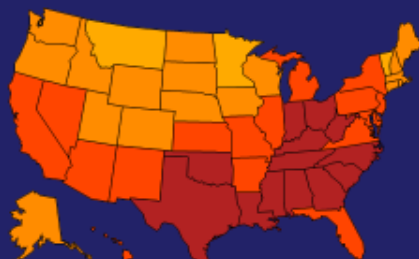
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2008

Obesity (BMI ≥ 30 kg/m²)



Diabetes



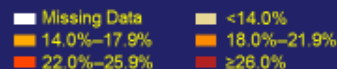
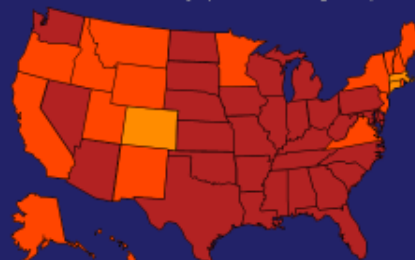
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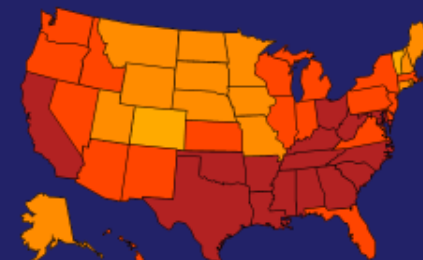
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2009

Obesity (BMI ≥ 30 kg/m²)



Diabetes



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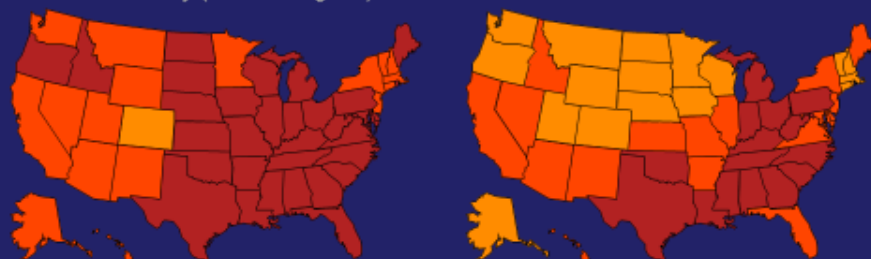
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2010

Obesity (BMI ≥ 30 kg/m²)

Diabetes



Missing Data
 14.0%–17.9%
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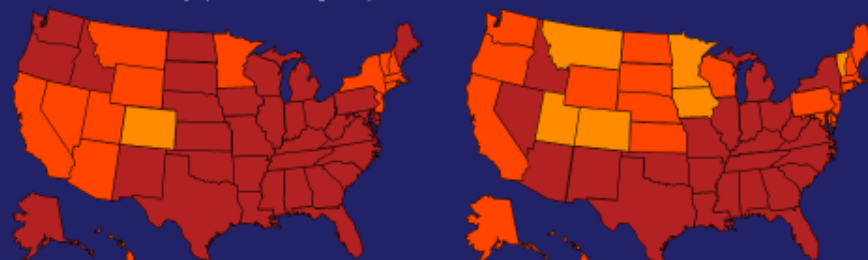


Age-Adjusted Prevalence of Obesity and Diagnosed Diabetes Among US Adults

2011

Obesity (BMI ≥ 30 kg/m²)

Diabetes



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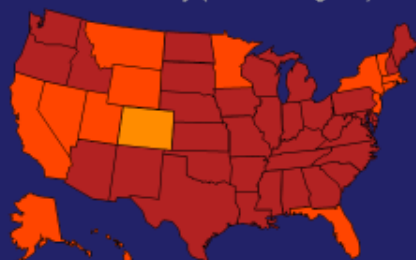
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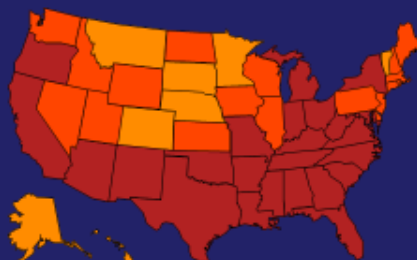
2012

Obesity (BMI \geq 30 kg/m²)



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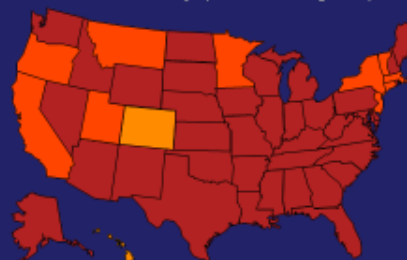
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Age-Adjusted Prevalence of Obesity and Diagnosed Diabetes Among US Adults

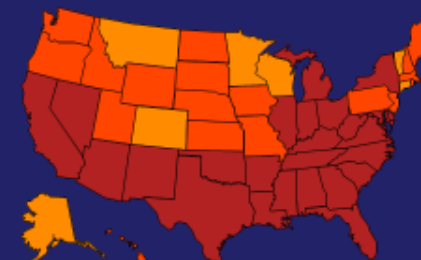
2013

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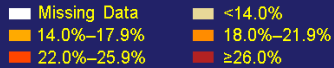
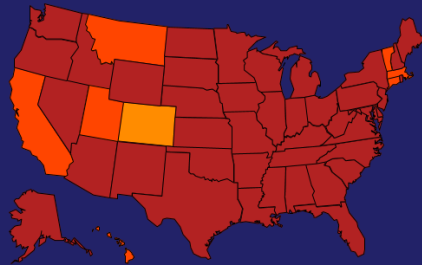
CDC's Division of Diabetes Translation. National Diabetes Surveillance System available at <http://www.cdc.gov/diabetes/statistics>



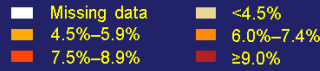
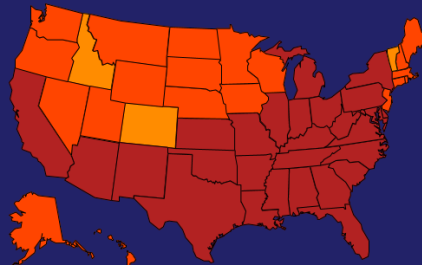
Age-Adjusted Prevalence of Obesity and Diagnosed Diabetes Among US Adults

2014

Obesity (BMI ≥ 30 kg/m²)



Diabetes



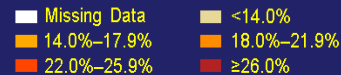
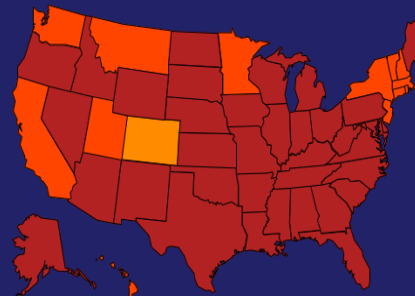
CDC's Division of Diabetes Translation, United States Diabetes Surveillance System available at <http://www.cdc.gov/diabetes/data>



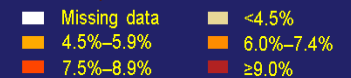
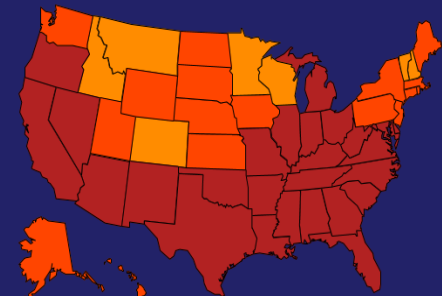
Age-Adjusted Prevalence of Obesity and Diagnosed Diabetes Among US Adults

2015

Obesity (BMI ≥ 30 kg/m²)



Diabetes



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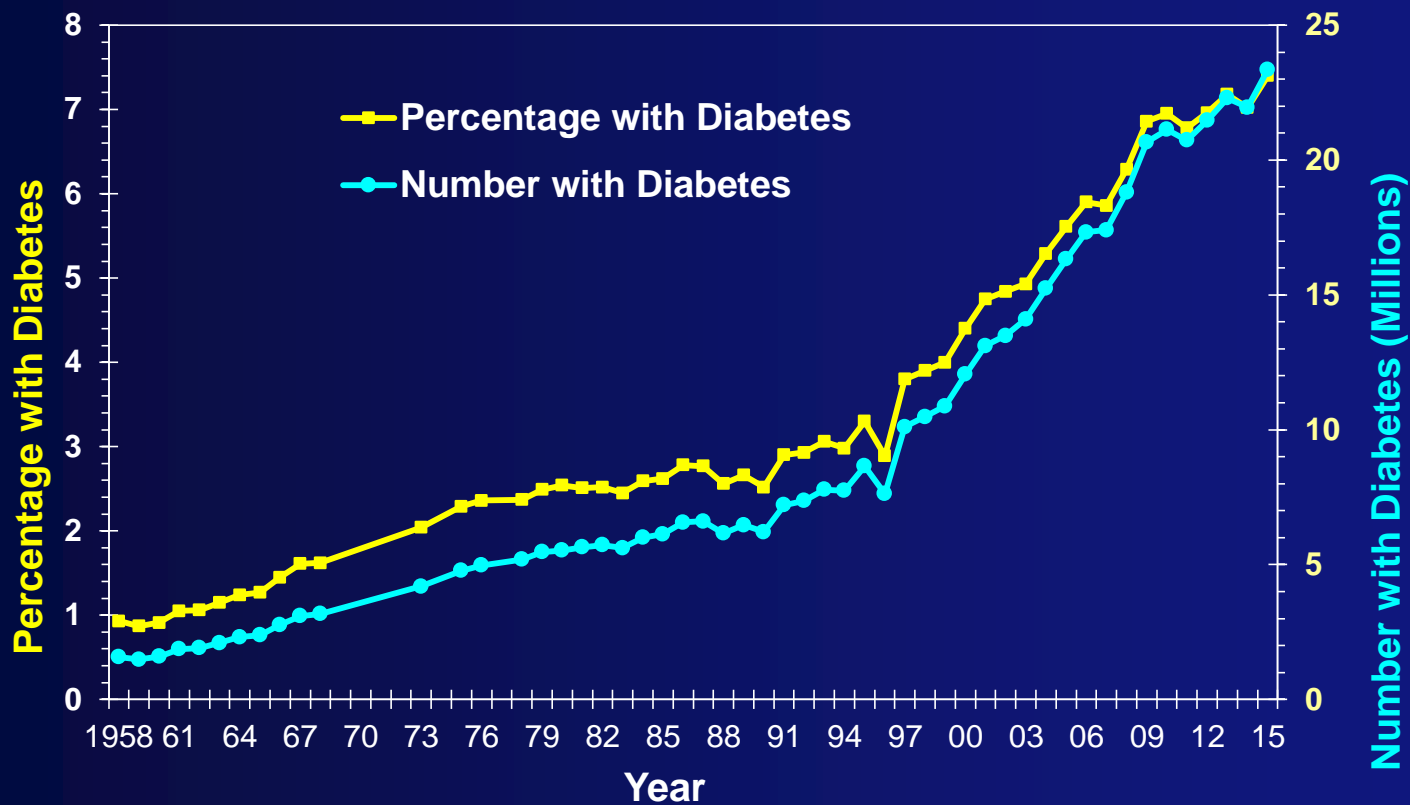
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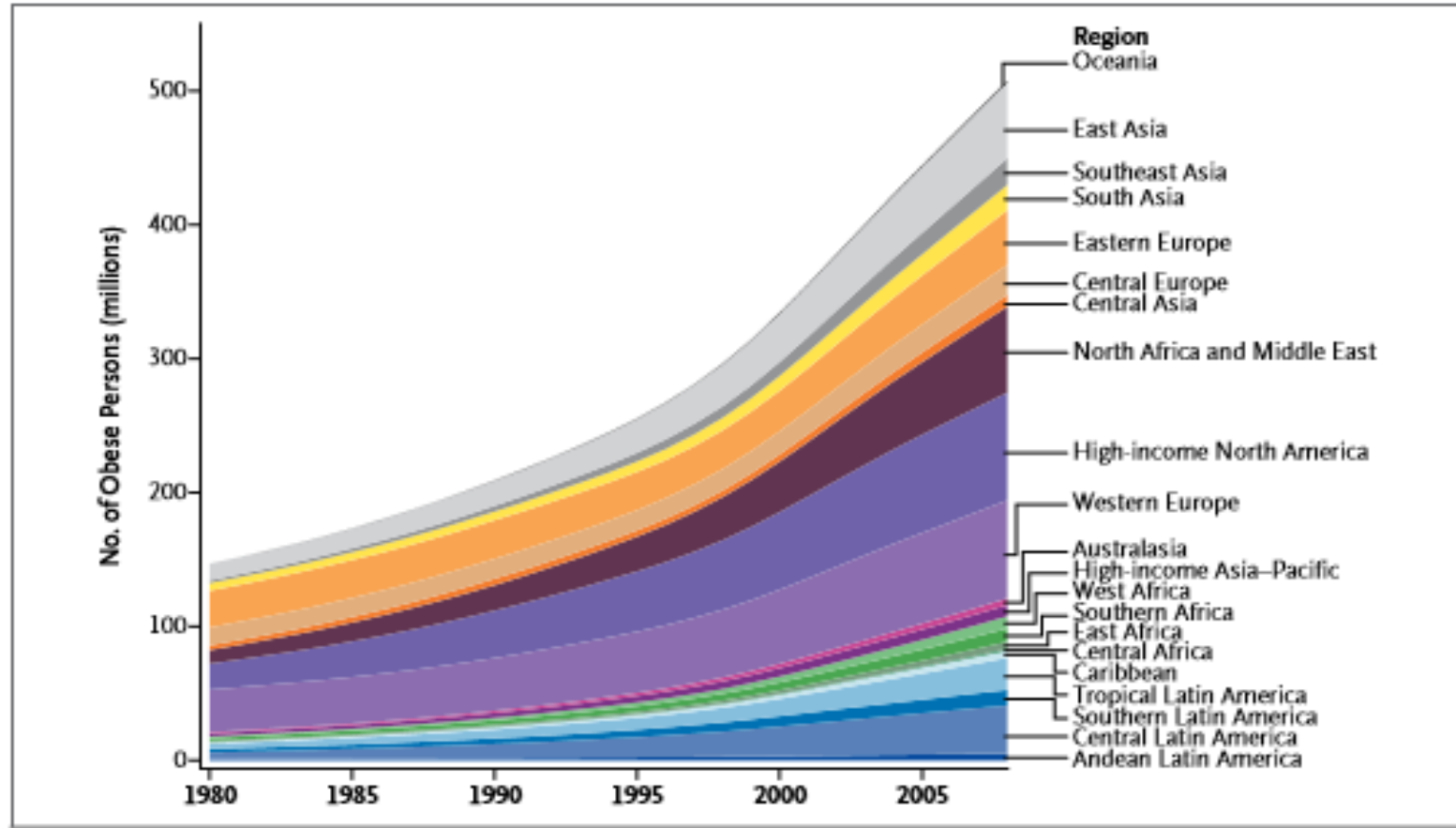
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Number and Percentage of U.S. Population with Diagnosed Diabetes, 1958-2015



CDC's Division of Diabetes Translation. United States Diabetes Surveillance System available at <http://www.cdc.gov/diabetes/data>

La gente esta más enferma



Fuente: New England Journal of Medicine 369;10 nejm.org september 5, 2013



Asociación Profesional Española
de Naturopatía y Bioterapia



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Estas eran nuestras familias



Tomado de Google fotos

- Almorzábamos juntos
- El Stress y la osteoporosis no eran una causa de consulta médica
- Existían clubes de pacientes para Hipertensos, Diabéticos
- Preocupación por el gran tamaño de las familias
- Un paciente hospitalizado era atendido en promedio por dos profesionales
- La alimentación estaba basada en productos perecederos

Esta es nuestra familia actual



Tomado de Google fotos

- Escasamente se almuerza juntos los fines de semana
- Más del 50% de la población tiene algún problema de salud mental
- El principal diagnóstico es la multimorbilidad
- Disminución de la red social de soporte, 18,5% hogares unipersonales
- Un paciente hospitalizado es atendido por siete profesionales
- Se han realizado grandes cambios en los estilos de vida

¿Esta será nuestra familia futura ?



Tomado de Google fotos





**Ninguna enfermedad que pueda
ser tratada con dieta debe
tratarse por ningún otro medio.**

Maimonides

Tomado de Google fotos

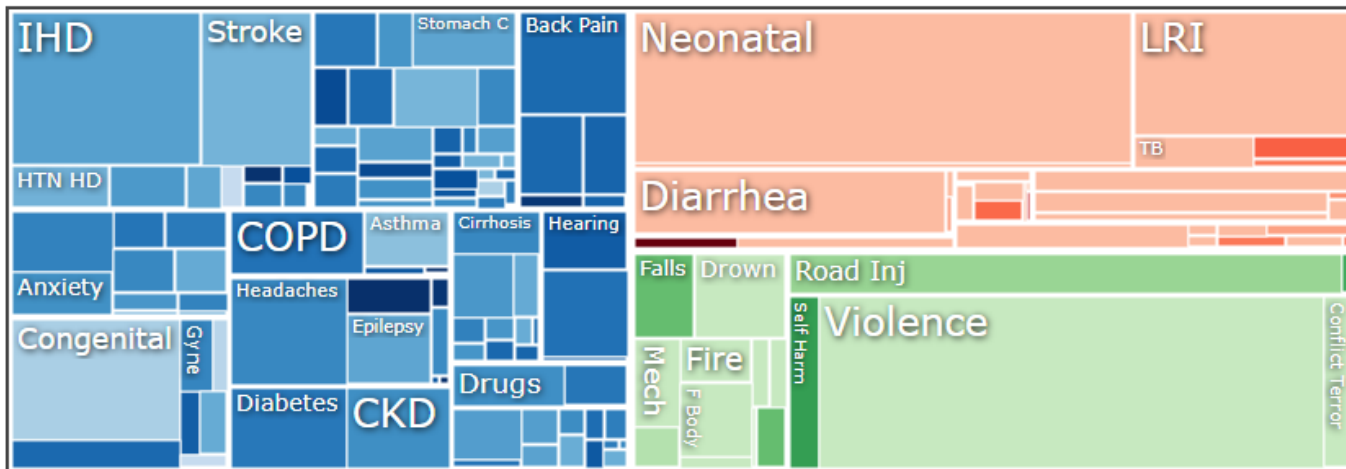
Agenda

1. Conceptos generales
2. ¿En dónde estamos y para dónde vamos?
3. Generación de valor e integralidad
4. Modelos de contratación innovadores

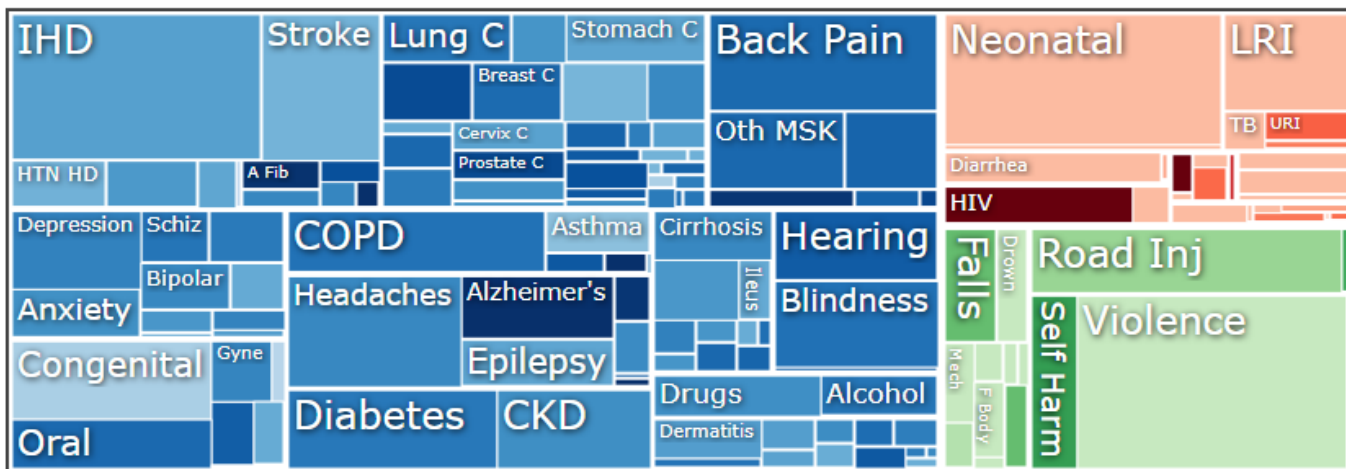


Transición epidemiológica

Colombia
Both sexes, All ages, 1990, DALYs

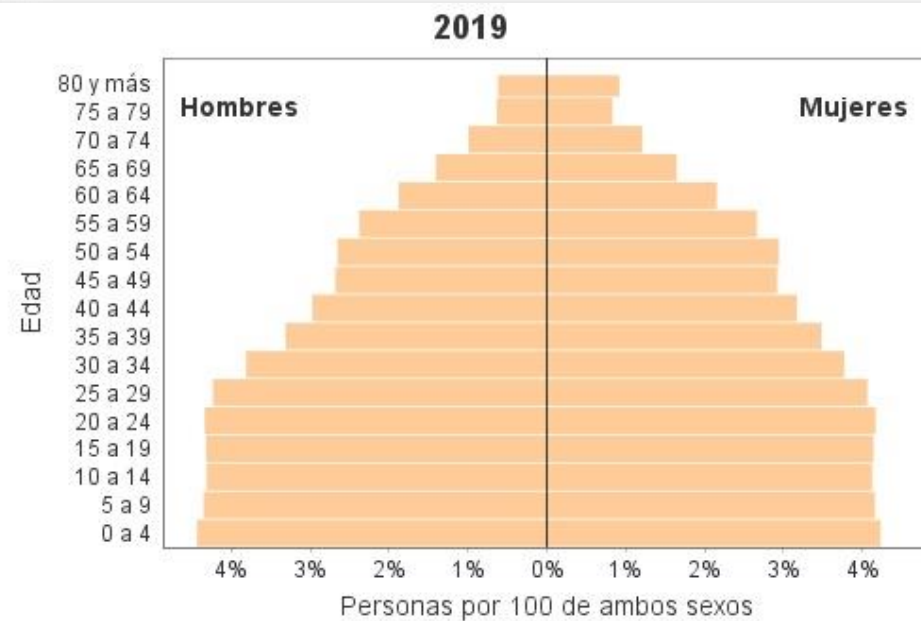
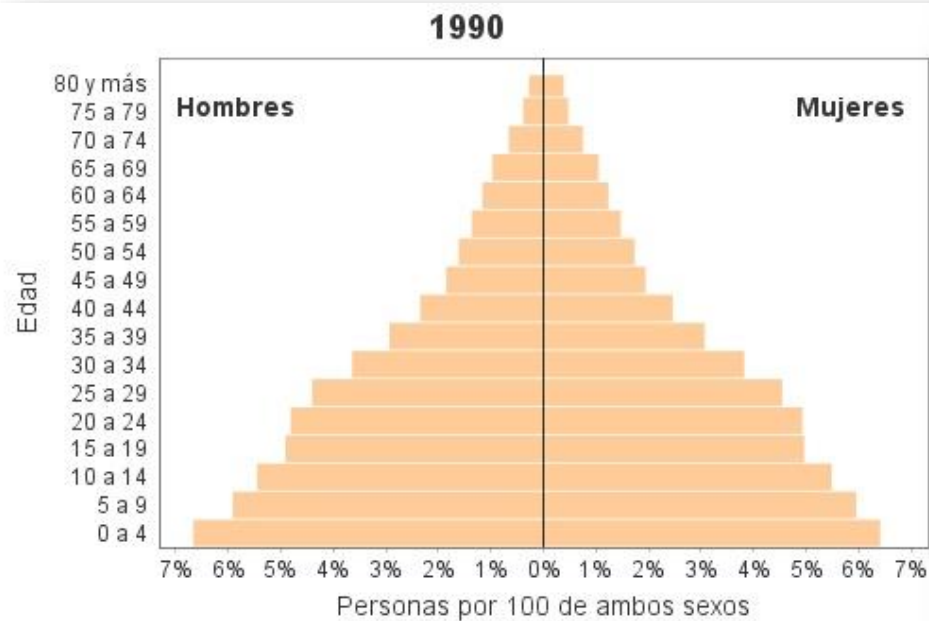


Colombia
Both sexes, All ages, 2017, DALYs



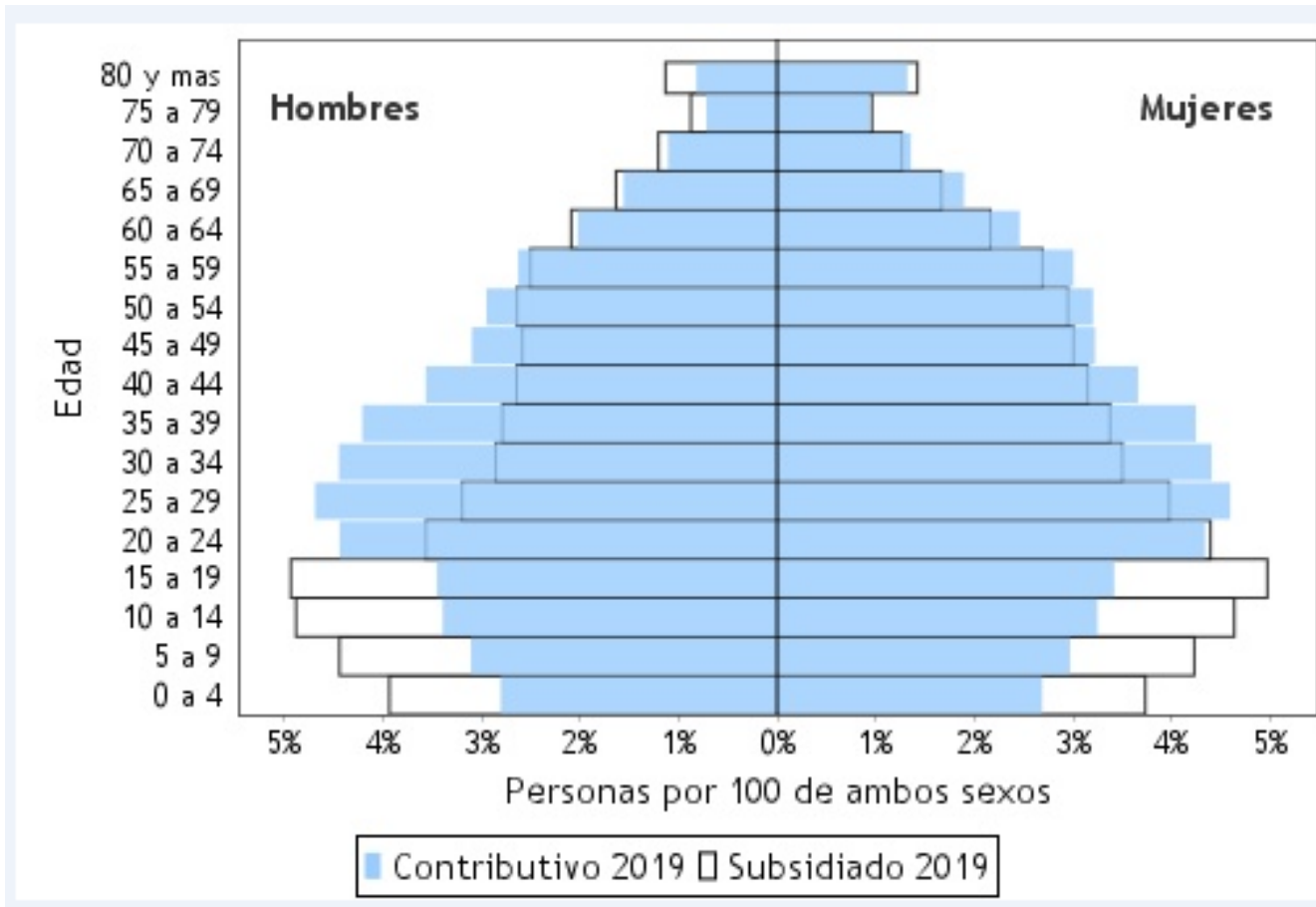
Fuente: <http://www.healthdata.org/gbd>

Transición demográfica



Fuente: Elaboración propia con información DANE

Transición demográfica



Fuente: Elaboración propia con información DANE

Transición financiera

“El costo de la atención en salud en el mundo se duplicará entre el 2010-2030”

Estudio del grupo de ciencias económicas de Harvard, 2011

Estimating future health spending by source in 184 countries, 2013-2040



Tara Tempkin, Nafis Sadat, Abby Chapin, Joseph L. Dieleman

Abstract

Background There is great variation in annual health spending between countries, and differences in how this spending is financed. For example, the average annual spend on health care in low-income countries in sub-Saharan Africa in 2013 was \$135 per person (in 2010 purchasing-power-parity dollars), whereas in high-income countries it is up to 22 times larger. Future health spending estimates and information about the expected source of those funds are hugely important for successful short-term and medium-term planning, maintaining fiscal sustainability, and addressing critical funding gaps. We aimed to forecast government health spending, out-of-pocket health spending, pre-paid health insurance spending, and development assistant for health in 184 countries from 2013 to 2040.

Methods We extracted data from the WHO Health Expenditure Observatory and the Institute for Health Metrics and Evaluation's *Financing Global Health 2015* report. We then adjusted these data by converting to a common, inflation-adjusted currency, and completed the series using multiple imputation. We used a series of ensemble models and observed empirical norms to make our forecast. We aggregated the data to generate a forecast for the total amount of health spending in these 184 countries.

Findings We estimate that global spending on health will increase from \$7.71 trillion in 2013 to \$21.25 trillion in 2040. In per person terms, we expect health spending to increase annually by 4.28% in South Asia, 3.07% in Latin America, 2.98% in high-income countries, and 1.93% in sub-Saharan Africa. The largest portion of health expenditure is expected to be from governments. In 2040, we expect the median government input to health spending will be 60%. We also expect a transition from out-of-pocket spending to pre-paid private spending, with out-of-pocket expenditure reducing by 11% by 2040. Despite remarkable progress, we expect that tremendous inequality in health spending between low-income and high-income countries will persist.

Interpretation Estimates of future spending on health provides planners, funders, and advocates with insight into where more resources are needed to reach important health goals.

Funding Bill & Melinda Gates Foundation.



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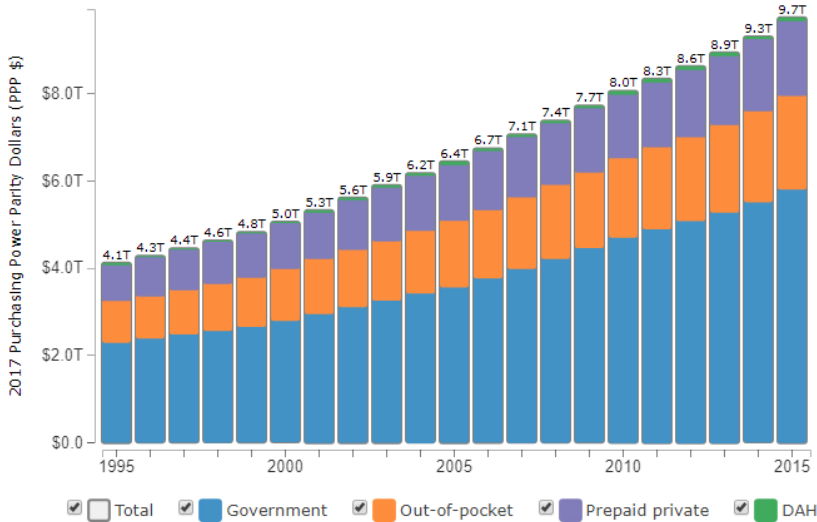
	2010						2030					
	Cancer	Chronic respiratory disease	Cardio-vascular diseases	Diabetes	Mental Illness	Total	Cancer	Chronic respiratory disease	Cardio-vascular diseases	Diabetes	Mental Illness	Total
High Income	1.7	1.5	5.4	0.7	5.5	14.8	2.2	2.0	7.2	1.0	7.3	19.7
Upper Middle Income	0.6	0.5	1.9	0.3	1.9	5.1	1.9	1.8	6.3	0.9	6.5	17.4
Lower Middle Income	0.3	0.2	0.9	0.1	0.9	2.4	0.6	0.5	1.9	0.3	2.0	5.3
Low Income	0.1	0.1	0.2	0.0	0.2	0.5	0.1	0.1	0.4	0.0	0.4	1.0
World	2.5	2.4	8.3	1.2	8.5	22.8	4.9	4.5	15.8	2.2	16.1	43.4

“El costo de la atención en salud se incrementara en 3 veces entre el 2013 y 2040”
Fundación Bill Gates, 2014

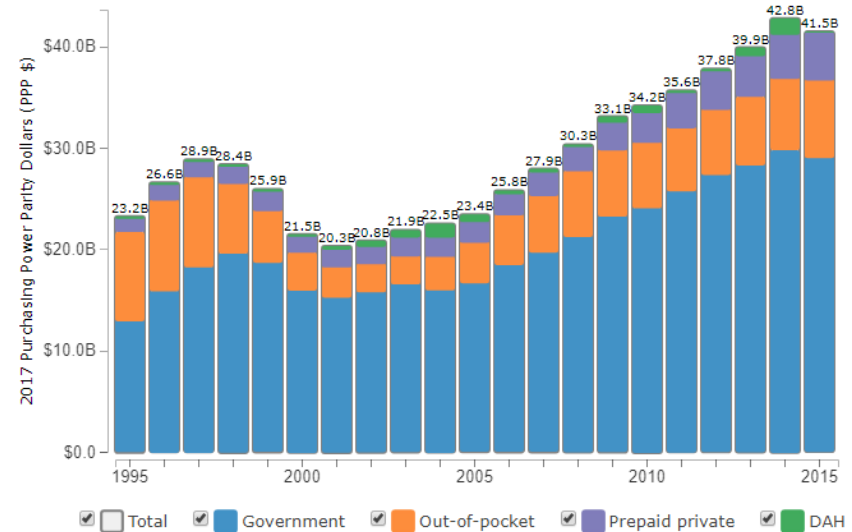


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Gasto de salud Colombia vs Mundo



El gasto en salud en Colombia creció el 79% en los últimos 20 años
El gasto de bolsillo paso del 37% al 14% entre 1995 y 2015



El gasto en salud a nivel mundial creció el 137% en los últimos 20 años
El gasto de bolsillo se ha mantenido en el 23% entre 1995 y 2015

Fuente: Vizhub.healthdata.org

Transición mundial de la financiación

Articles

Past, present, and future of global health financing: a review of development assistance, government, out-of-pocket, and other private spending on health for 195 countries, 1995–2050

Global Burden of Disease Health-Financing Collaborator Network*

Summary

Background Comprehensive and comparable estimates of health spending in each country are a key input for health policy and planning, and are necessary to support the achievement of national and international health goals. Previous studies have tracked past and projected future health spending until 2040 and shown that, with economic development, countries tend to spend more on health per capita, with a decreasing share of spending from development assistance and out-of-pocket sources. We aimed to characterise the past, present, and predicted future of global health spending, with an emphasis on equity in spending across countries.

Methods We estimated domestic health spending for 195 countries and territories from 1995 to 2050, split into three categories—government, out-of-pocket, and prepaid private health spending—and estimated development assistance for health (DAH) from 1990 to 2018. We estimated future scenarios of health spending using an ensemble of linear mixed-effects models with time series specifications to project domestic health spending from 2017 through 2050 and DAH from 2019 through 2050. Data were extracted from a broad set of sources tracking health spending and revenue, and were standardised and converted to inflation-adjusted 2018 US dollars. Incomplete or low-quality data were modelled and uncertainty was estimated, leading to a complete data series of total, government, prepaid private, and out-of-pocket health spending, and DAH. Estimates are reported in 2018 US dollars, 2018 purchasing-power parity-adjusted dollars, and as a percentage of gross domestic product. We used demographic decomposition methods to assess a set of factors associated with changes in government health spending between 1995 and 2016 and to examine evidence to support the theory of the health financing transition. We projected two alternative future scenarios based on higher government health spending to assess the potential ability of governments to generate more resources for health.

Findings Between 1995 and 2016, health spending grew at a rate of 4.60% (95% uncertainty interval 3.80–4.12) annually, although it grew slower in per capita terms (2.72% [2.42–2.94]) and increased by less than \$1 per capita over this period in 22 of 195 countries. The highest annual growth rates in per capita health spending were observed in upper-middle-income countries (5.55% [5.18–5.95]), mainly due to growth in government health spending, and in lower-middle-income countries (3.71% [3.10–4.34]), mainly from DAH. Health spending globally reached \$8.0 trillion (7.8–8.1) in 2016 (comprising 8.0% [8.4–8.7] of the global economy and \$38.3 trillion [30.1–30.6] in purchasing-power parity-adjusted dollars), with a per capita spending of US\$5252 (5184–5319) in high-income countries, \$491 (461–524) in upper-middle-income countries, \$81 (74–89) in lower-middle-income countries, and \$40 (38–43) in low-income countries. In 2016, 0.4% (0.3–0.4) of health spending globally was in low-income countries, despite these countries comprising 10.0% of the global population. In 2018, the largest proportion of DAH targeted HIV/AIDS (\$9.5 billion, 24.3% of total DAH), although spending on other infectious diseases (excluding tuberculosis and malaria) grew fastest from 2010 to 2018 (6.27% per year). The leading sources of DAH were the USA and private philanthropy (including corporate donations and the Bill & Melinda Gates Foundation). For the first time, we included estimates of China's contribution to DAH (\$644.7 million in 2018). Globally, health spending is projected to increase to \$15.0 trillion (14.0–16.0) by 2050 (reaching 9.4% [7.6–11.3] of the global economy and \$21.3 trillion [19.8–23.1] in purchasing-power parity-adjusted dollars), but at a lower growth rate of 1.84% (1.68–2.02) annually, and with continuing disparities in spending between countries. In 2050, we estimate that 0.6% (0.6–0.7) of health spending will occur in currently low-income countries, despite these countries comprising an estimated 15.7% of the global population by 2050. The ratio between per capita health spending in high-income and low-income countries was 130.2 (122.9–136.9) in 2016 and is projected to remain at similar levels in 2050 (125.9 [113.7–138.1]). The decomposition analysis identified governments' increased prioritisation of the health sector and economic development as the strongest factors associated with increases in government health spending globally. Future government health spending scenarios suggest that, with greater prioritisation of the health sector and increased government spending, health spending per capita could more than double, with greater impacts in countries that currently have the lowest levels of government health spending.

www.thelancet.com Vol 393 June 1, 2020 233

- Estudio realizado para 195 países desde 1995 hasta el 2050
- Entre 1995 y 2016 se paso de 3,5 a 8 billones de dólares (MM)
- Se pasará de un crecimiento promedio **del 4,00% al 1,84%**
- Los países de mayor ingreso crecerán a una tasa del 1,38%
- **“Menor costo por uso más eficiente de los recursos”**

The price of excess*

Identifying waste in healthcare spending



*connectedthinking

PRICEWATERHOUSECOOPERS

WHITE PAPER

WHERE CAN \$700 BILLION IN WASTE BE CUT ANNUALLY FROM THE U.S. HEALTHCARE SYSTEM?

ROBERT KELLEY
VICE PRESIDENT,
HEALTHCARE ANALYTICS
THOMSON REUTERS

OCTOBER 2009

RESUMEN
Informe sobre la salud en el mundo



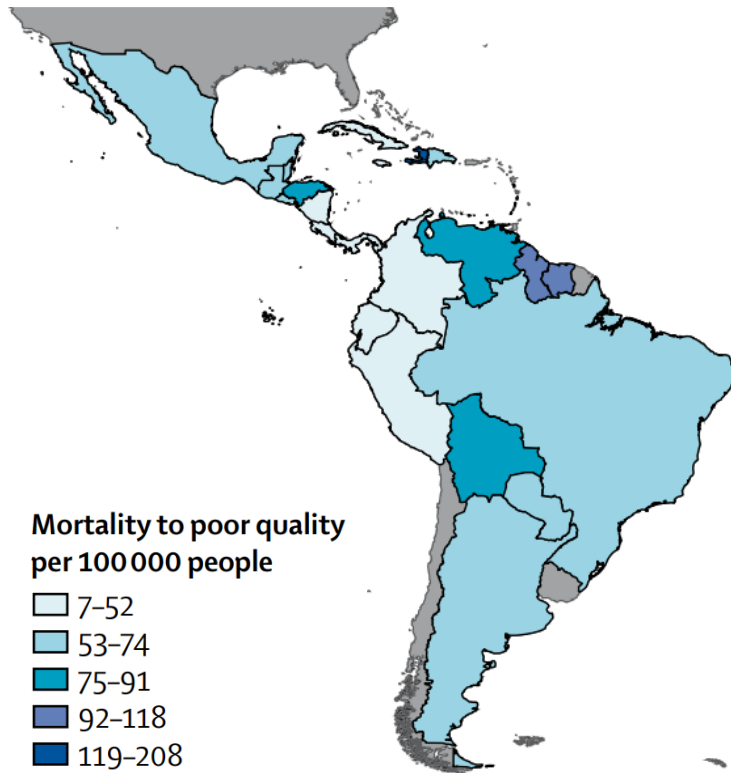
LA FINANCIACIÓN DE LOS SISTEMAS DE SALUD
El camino hacia la cobertura universal

Organización
Mundial de la Salud

Se malgasta el 20-40% de los recursos destinados a la salud, siendo ésta una estimación conservadora. Los países deben desarrollar políticas de salud pragmáticas que aborden diferentes grados de ineficiencia. OMS, 2010.

El monto de los desperdicios oscila entre el 32% y un poco más del 50% de todo el gasto en salud

Muertes evitables en Latam asociadas a mala calidad de los sistemas de salud



Mortality due to low-quality health systems in the universal health coverage era: a systematic analysis of amenable deaths in 137 countries

Margaret E Krav, Arwa D Gage, Naama T Joseph, Gendao Dhanraj, Sebastián García-Galán, Joshua A Salomon

Summary

Background Universal health coverage has been proposed as a strategy to improve health in low-income and middle-income countries (LMICs). However, this is contingent on the provision of good-quality health care. We estimate the excess mortality for conditions targeted in the Sustainable Development Goals (SDG) that are amenable to health care and the portion of this excess mortality due to poor-quality care in 137 LMICs, in which excess mortality refers to deaths that could have been averted in settings with strong health systems.

Methods Using data from the 2016 Global Burden of Disease study, we calculated mortality amenable to personal health care for 61 SDG conditions by comparing case fatality between each LMIC with corresponding numbers from 21 high-income reference countries with strong health systems. We used data on health-care utilization from population surveys to separately estimate the portion of amenable mortality attributable to non-utilisation of health care versus that attributable to receipt of poor-quality care.

Findings 15.4 million excess deaths from 61 conditions occurred in LMICs in 2016. After excluding deaths that could be prevented through public health measures, 8.6 million excess deaths were amenable to health care of which 5.9 million were estimated to be due to receipt of poor-quality care and 2.6 million were due to non-utilisation of health care. Poor quality of health care was a major driver of excess mortality across conditions, from cardiovascular disease and injuries to neonatal and communicable disorders.

Interpretation Universal health coverage for SDG conditions could avert 8.6 million deaths per year but only if expansion of service coverage is accompanied by investments into high-quality health systems.

Funding Bill & Melinda Gates Foundation.

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Introduction

Universal health coverage (UHC) has been embraced by global organisations such as WHO and the World Bank as a means to improve health and reduce the financial burden from receiving care. UHC is a central plank of the Sustainable Development Goals (SDGs), the ambitious new development targets that were signed by 193 UN member states to improve health and development by 2030.¹ Although financing and implementation of UHC will differ by country, the common definition is the ability of all people to obtain good-quality services when they need them without facing financial hardship.²

Supporters of UHC have promoted it as a means for improving population health.³ These supporters theorise that expanding health insurance would promote the utilisation of health services that reduce mortality and morbidity. However, although insurance generally increases use of services, evidence on mortality reductions is mixed. Escobar and colleagues⁴ found that health insurance was associated with improved health status in only three of nine studies in low-income and middle-income countries (LMICs; from Vietnam, China,

and Brazil). In the USA, coverage has been associated with better self-reported health status and in one recent study⁵ with reduced mortality. The lack of consistent evidence on health benefits from insurance coverage might be in part due to methodological challenges because mortality is multifactorial and subject to factors outside of health care; people purchasing insurance are more sicker on average, and deaths are relatively rare and require large studies to measure their prevalence. However, insurance expansion might also be unsuccessful in improving outcomes if no effective treatment is available for a given condition or if quality of care is poor.

In low-income countries, evidence is emerging that expanding health care coverage does not necessarily result in better outcomes, even for conditions highly amenable to medical care. A large programme called Janani Suraksha Yojana, that was set up 15 years ago in India, has provided cash incentives for women to deliver their children in health facilities and has increased coverage of facility births for more than 50 million women, but these incentives have not improved maternal or newborn survival.⁶ Many of the births in this



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See Comment page 2145

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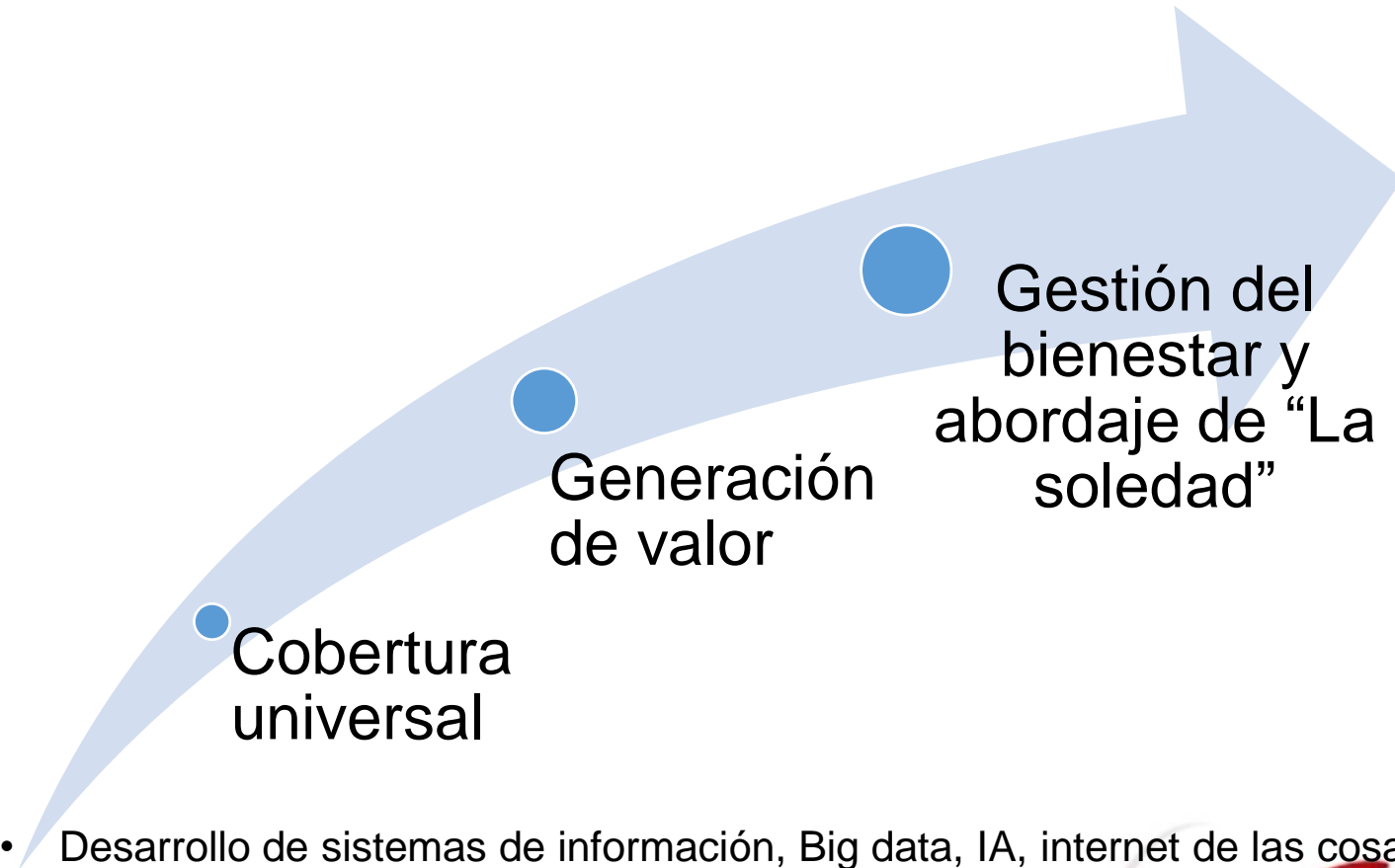
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- Desarrollo de sistemas de información, Big data, IA, internet de las cosas
- La transición financiera y la gestión de ineficiencias
- Volviendo a redefinir los básicos

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BBC Mundo

🕒 28 febrero 2018

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Por **Escarlata Sanchez** • última actualización: 18/01/2018



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Redefiniendo los básicos

“Salud es la habilidad de las personas y comunidades para adaptarse y auto-manejar los desafíos físicos, emocionales y sociales que se presenten en la vida”.

Huber et al. 2011

Medscape martes 8 de octubre de 2019

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Noticias y Perspectivas > XIX Congreso de la Sociedad Argentina de Infectología (SADI) 2019

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Matias A. Loewy
21 de mayo de 2019

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4 September 2019 | News release



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The Lancet Commissions

Dementia prevention, intervention, and care



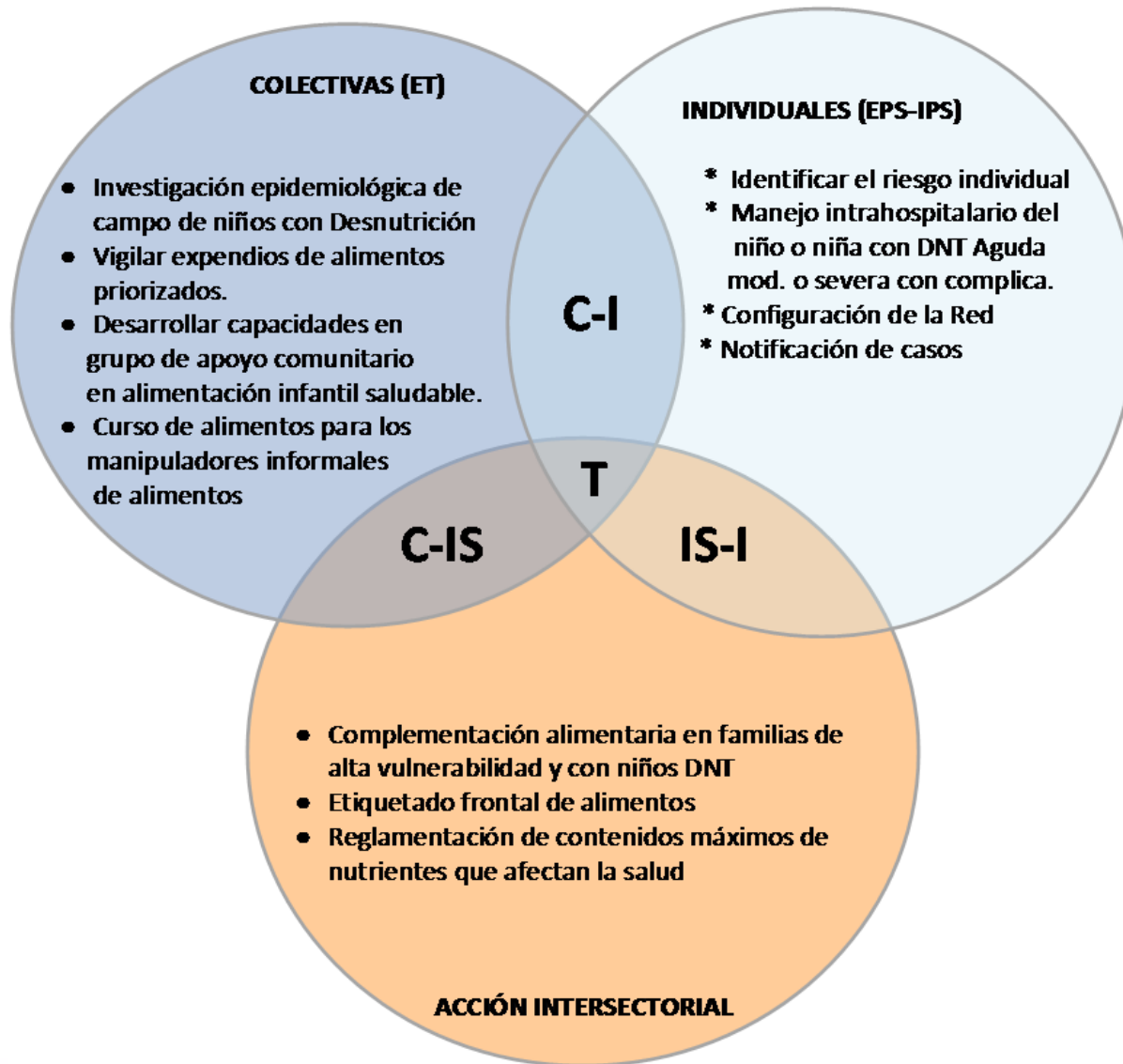
Gill Livingston, Andrew Sommerlad, Vasiliki Orgeta, Sergi G Costafreda, Jonathan Huntley, David Ames, Clive Ballard, Sube Banerjee, Alistair Burns, Jiska Cohen-Mansfield, Claudia Cooper, Nick Fox, Laura N Gittlin, Robert Howard, Helen C Kales, Eric B Larson, Karen Ritchie, Kenneth Rockwood, Elizabeth L Sampson, Quincy Samus, Lon S Schneider, Geir Selbaek, Linda Teri, Naaheed Mukadam



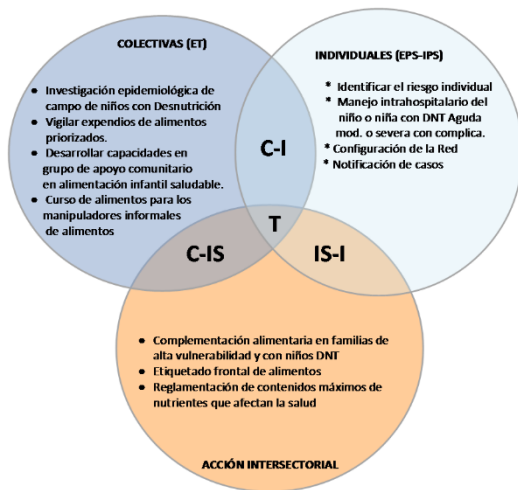
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1. Conceptos generales
2. ¿En dónde estamos y para dónde vamos?
- 3. Generación de valor e integralidad**
4. Modelos de contratación innovadores

Integralidad desde el abordaje regional



Integralidad desde el abordaje regional



C-I ► ET y EPS/IPS

- Vigilancia en Salud Pública (Bajo peso al Nacer/ Desnutrición en menores de 5 años)
- Identificación del riesgo (Entornos de vida: Laboral, educativo, hogar, comunitario e institucional)
- Coordinación para manejo con enfoque comunitario del niño o niña con DNT Aguda moderada o severa sin complicaciones

C-IS ► ET y Otros Sectores

- Mapas de riesgo de la calidad de agua para consumo humano.
- Promoción de la actividad física regular en el espacio público.
- Creación de grupos de apoyo comunitario a la lactancia con los gestores de la red unidos, líderes comunitarios, madres comunitarias, entre otros.
- Acuerdos para la producción y comercialización de comidas saludables con el sector gastronómico y tiendas escolares.

T ► TODOS

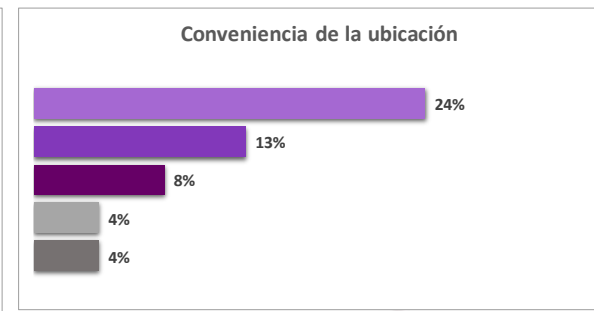
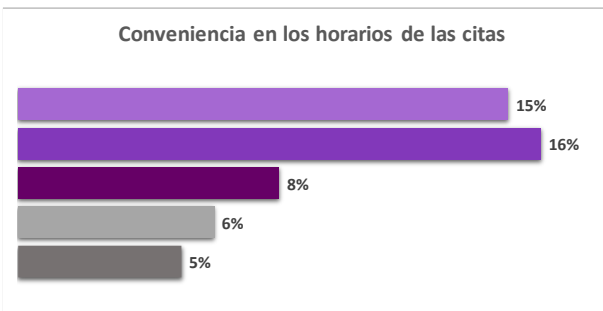
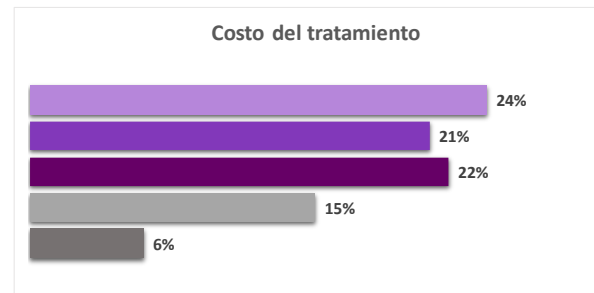
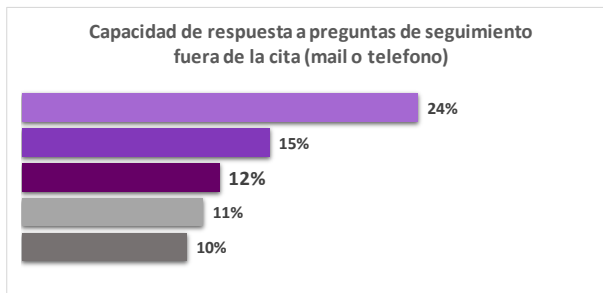
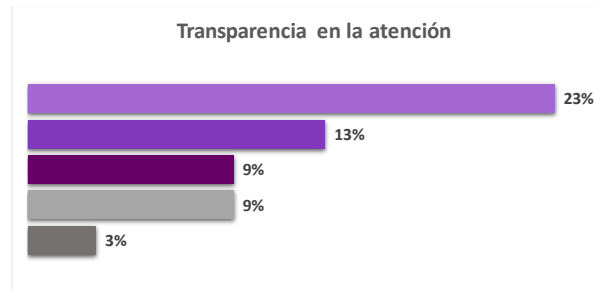
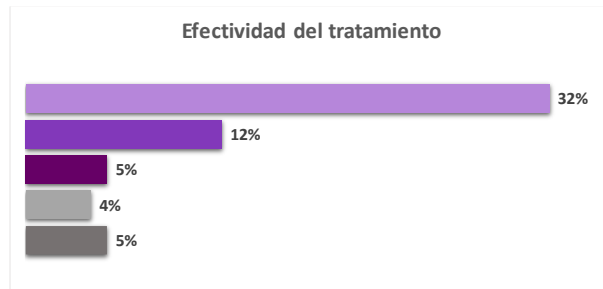
- Definición de Objetivos comunes
- Suscripción de Alianzas estratégicas para la operación coordinada y atención integral
- Observatorio de Seguridad Alimentaria y Nutricional

IS-I ► EPS/IPS y Otros Sectores

- Canalización de niños con riesgo nutricional a EPS/IPS
- Referencia a servicios sociales

Población insatisfecha y muy insatisfecha con la forma tradicional de atención en salud

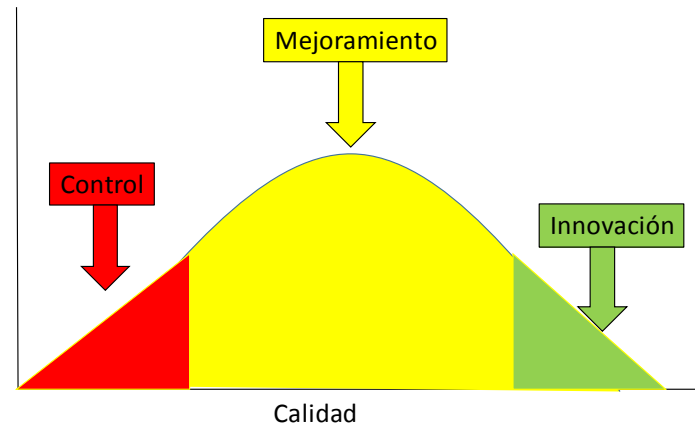
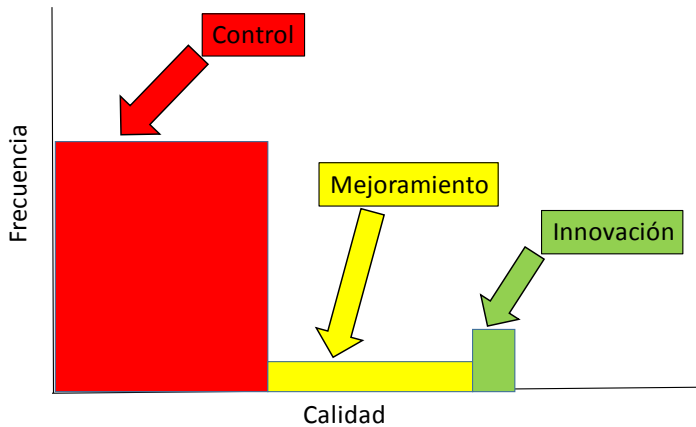
■ Generación Z ■ Millennials ■ Generación Xers ■ Baby Boomers ■ Silent





En donde hacemos los esfuerzos

¿Dónde deberíamos hacer los esfuerzos?



Design thinking
Circular economy

Six Sigma

Lean

Restricciones en salud

Fuente: Trilogía de Juran, modificado y presentado por Dr. Donald Berwick 02/04/2019

“Un sistema esta perfectamente diseñado para lograr exactamente los resultados que obtiene”

Paul Batalden



Integralidad en la atención

- Carga de enfermedad
- Expectativas y nivel de confianza
- Recursos: TH, red, SI, financieros, etc.



- Mejora continua de los resultados en salud
- Mejora de la experiencia del paciente
- Optimizar los recursos del paciente

Sistema de salud y Determinantes sociales de la salud

“LAS GRANDES OBRAS LAS SUEÑAN LOS
GENIOS LOCOS,
LAS EJECUTAN LOS LUCHADORES NATOS,
LAS DISFRUTAN LOS FELICES CUERDOS Y
LAS CRITICAN LOS INÚTILES CRÓNICOS”

SANTIAGO RAMÓN Y CAJAL

Earth

Tomado de Google fotos

Agenda

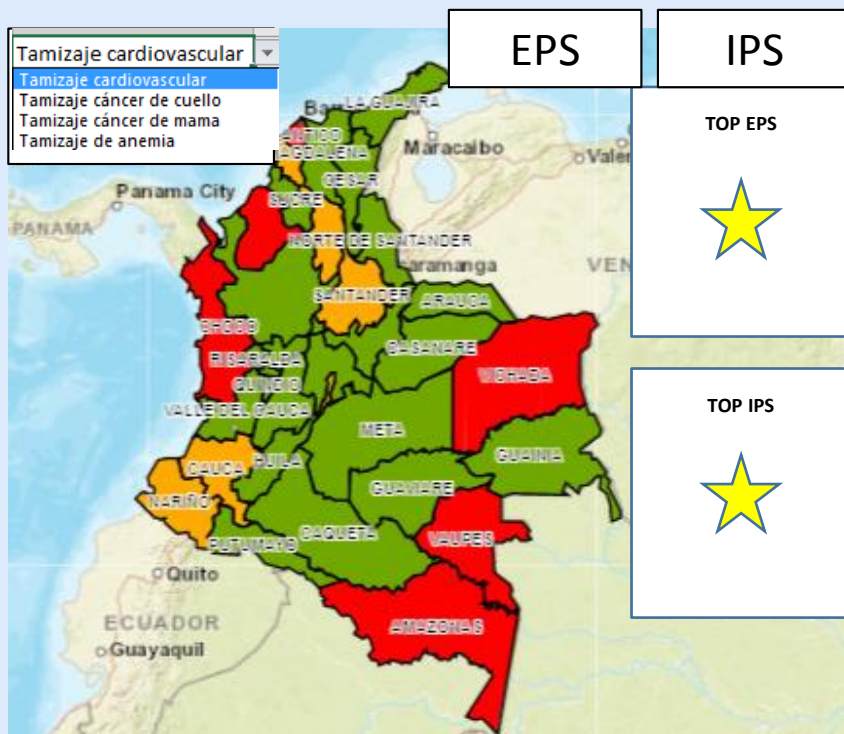
1. Conceptos generales
2. ¿En dónde estamos y para dónde vamos?
3. Generación de valor e integralidad
4. Modelos de contratación innovadores



Estrategia 1. Uso de tecnologías de la información y la comunicación Sistematización de la herramienta para el seguimiento nominal de acciones



Red pública



Ciudadano

Sus acciones promocionales y preventivas

Tamizaje de cáncer de cuello uterino		
Procedimiento	Fecha de realización	Días para próxima intervención
ADN VPH	12/10/2015	400

El tamizaje de cáncer de cuello uterino se debe realizar en todas las mujeres entre los 25 y 65 años

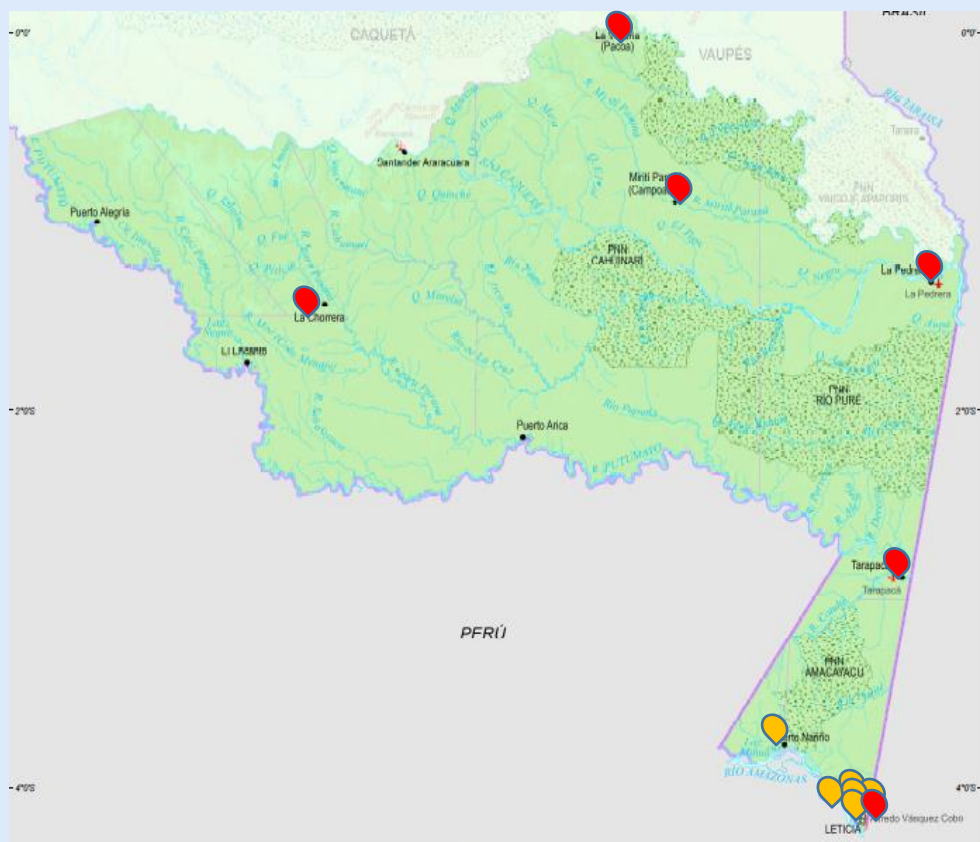
Información en salud

Actor (EPS, IPS, DTS)

Tamizaje de cáncer de cuello uterino		
Usuarios con actividad realizada	50%	Consultar listado
Usuarios a programar el próximo mes	10%	Consultar listado
Usuarios a programar el próximo trimestre	5%	Consultar listado
Usuarios nunca contactados	50%	Consultar listado

Fuente: Viceministerio de salud pública y prestación de servicios, MSPS

Estrategia 1. Uso de tecnologías de la información y la comunicación Sistematización de la herramienta para el seguimiento nominal de acciones



IPS	Control de placa dental
910010011101	17,87%
910010012601	13,24%
910010016801	13,06%
Sin asignar	8,69%
910010006901	6,83%

EPS	Control de placa dental
E.P.S. 1	50,00%
E.P.S. 2	9,88%
E.P.S. 3	8,49%
E.P.S. 4	1,86%
E.P.S. 5	0,00%

Fuente: Viceministerio de salud pública y prestación de servicios, MSPS

Del pago por volumen al pago por valor

Riesgo Modalidad	Sin transferencia de riesgo primario de incidencia (Pago fijo por paciente)	Con transferencia de riesgo primario de incidencia (Pago fijo todos pacientes)
Episodio (ciclo de atención con inicio y final)	Pago por episodio	Pago global prospectivo por episodio
Grupo de riesgo o condición médica (ciclo de atención con inicio y sin final)	Pago integral por grupo de riesgo	Pago global prospectivo por grupo de riesgo
Otras modalidades	Pago por contacto por especialidades, pago por escenario de atención, pago por tipo de servicio	Pago global prospectivo por especialidad, por nivel de complejidad, por escenario de atención, por tipo de servicio

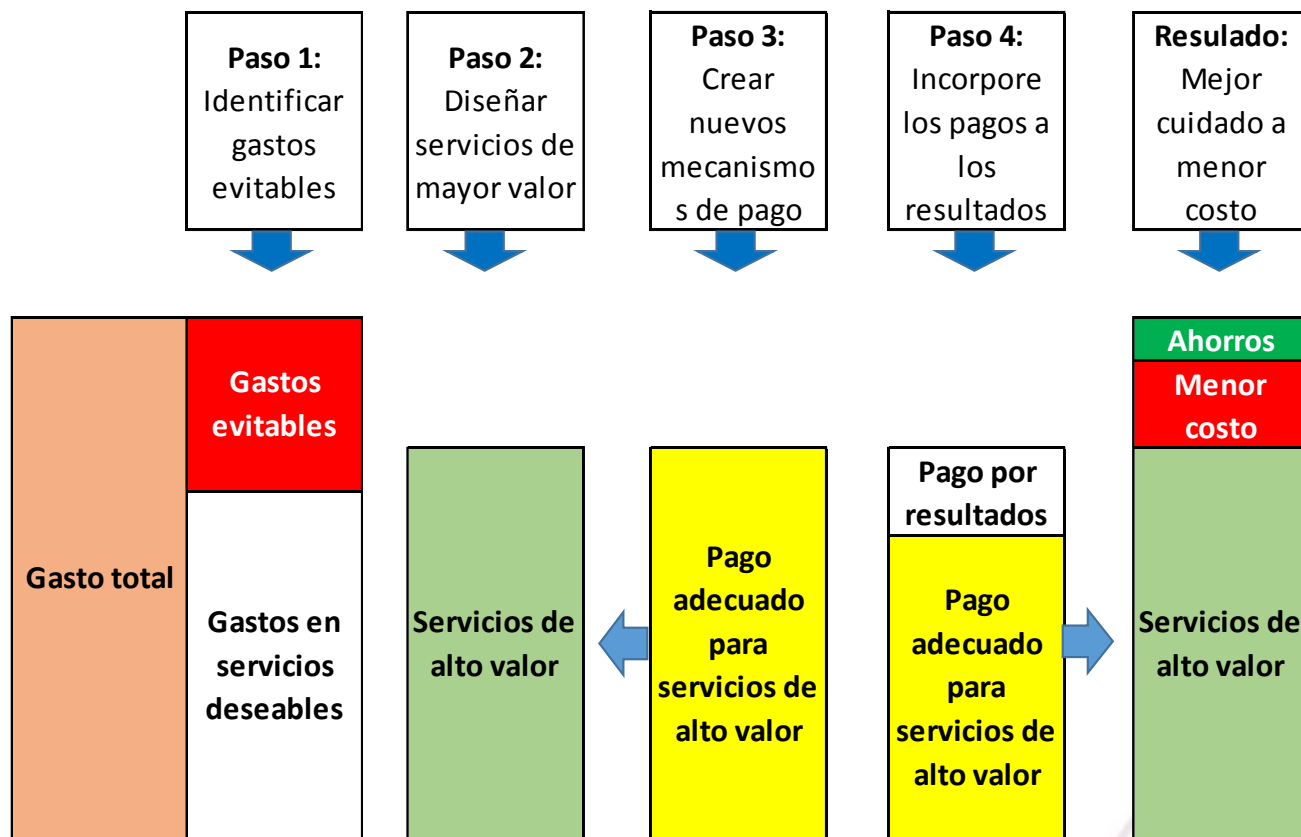
Fuente: Documentos PROESA # 18, 2018

¿Qué es lo que hace innovador y que genere valor?

- Los deseos del paciente son un requisito y no un objetivo
- Generación de valor:
 - Obtener mejores desenlaces en salud
 - Satisfacción del paciente y familia
 - Sostenibilidad en el tiempo
- Asegurar la integralidad, coordinación y la continuidad en la atención
- Todos deben gestionar riesgos en salud
- Las IPS deben construir modelos de atención que minimicen las ineficiencias y mejoren desenlaces
- Las EPS deben fortalecer la caracterización poblacional y predictiva, adicional a pagar por lo que se evita



Pasos para construir modelos con mayor valor



Fuente: Con permiso del Dr. Harold Miller, modificado

Lecciones aprendidas EPS - IPS

1. Empresas con experticia en atención integral, no fraccionamiento y estar dispuestas a realizar las cosas de manera diferente
2. Generación de confianza como principal factor de éxito
3. La información no es un requisito, es un objetivo
4. Talento humano multidisciplinario y trabaja en equipo
5. Cuentan con ciclos de mejora continua
6. Migración de pago por actividad y servicios empaquetados a pagos globales prospectivos, con medición de resultados
7. Gestión conjunta de indicadores de proceso y resultado
8. Se involucran a los pacientes y familias en el ciclo de atención
9. Hay esfuerzos para el empoderamiento del PF
10. La puesta en marcha requiere de varios años, mínimo tres

"Nunca dudes que un pequeño grupo de ciudadanos pensantes y comprometidos pueden cambiar el mundo. De hecho, son los únicos que lo han logrado"

Margaret Mead



GRACIAS !!!!

