Implementing Hospital Self-Management Policy in Chile: Health Professionals' Perceptions*

Implementando la política de autogestión hospitalaria en Chile: percepciones de profesionales de la salud

Implementando a política de autogestão hospitalar no Chile: percepções de profissionais da saúde

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Abstract

Context of the problem: Hospitals have been considered a main component for health systems success. *Objective:* To describe perceptions from hospital staff regarding the implementation of the hospital self-management policy in two highly complex facilities in Chile. *Justification:* A successful policy implementation demands aligned health professionals regarding policy changes. *Methods:* Descriptive and exploratory qualitative study based on semi-structured interviews for health professionals from two hospitals in southern Chile. A convenience sample of nineteen health professionals was selected for interviewing. The interviews' analysis was thought as the content analysis technique in its conventional approach. *Results:* For health professionals, a hospital's self-management policy is conceptualized from financial autonomy. Human resources for health and organizational capabilities still remain as weaknesses of the implementation process. *Conclusions:* Overcoming gaps between design and implementation processes are crucial for success in hospital reform implementation.

Keywords: health Policy; health systems; health Services; health services research; healthcare reform; qualitative research

Resumen

Contexto del problema: los hospitales son considerados claves para el éxito de los sistemas de salud. *Objetivo:* describir las percepciones de profesionales de la salud sobre la implementación de la política de autogestión en red en dos hospitales de alta complejidad en Chile. *Justificación*: una implementación exitosa demanda profesionales alineados con los cambios. *Métodos*: estudio cualitativo descriptivo y exploratorio basado en entrevistas semiestructuradas a profesionales de la salud de dos hospitales complejos del sur de Chile. Se seleccionó una muestra por conveniencia de diecinueve profesionales. Los datos se analizaron mediante análisis de contenido en su aproximación convencional. *Resultados*: para los profesionales, la política es conceptualizada desde la autonomía financiera. Como debilidad de la implementación persiste la ausencia de capacidades organizacionales y competencias de los recursos humanos en salud. *Conclusiones*: superar las brechas entre el diseño y la implementación es crucial para avanzar en la implementación de reformas a los hospitales.

Palabras clave: política de salud; sistemas de salud; servicios de salud; investigación en servicios de salud; reforma de la salud; investigación cualitativa

Resumo

Contexto do problema: os hospitais são considerados chave para o sucesso dos sistemas de saúde. Objetivo: descrever as percepções de profissionais da saúde sobre a implementação da política de *autogestão* em rede em dois hospitais de alta complexidade no Chile. *Justificação*: uma implementação exitosa demanda profissionais alinhados com as mudanças. Métodos: estudo qualitativo descritivo e exploratório baseado em entrevistas semiestruturadas a profissionais da saúde de dois hospitais complexos do sul de Chile. Uma amostra por conveniência de dezenove profissionais foi selecionada. Os dados analisaram-se mediante análise de conteúdo em sua aproximação convencional. *Resultados*: para os profissionais, a política é concebida a partir da autonomia financeira. Como fraqueza da implementação persiste a ausência de capacidades organizacionais e competências dos recursos humanos em saúde. *Conclusões*: superar a fenda entre concepção e implementação é crucial para o progresso na implementação de reformas aos hospitais.

Palavras-chave: política de saúde; sistemas de saúde; serviços de saúde; pesquisa em serviços de saúde; reforma da saúde; pesquisa qualitativa

Introduction

Health systems which have sought to introduce different degrees of autonomy in hospital management, depicts not only common roots but also similar outcomes. Autonomy has been conceptualized as a path in which a hospital, being part of the public provision of health services, has the opportunity for a wider space at fostering their governance and managerial frameworks (1). Therefore, autonomy policy implementation seeks to improve efficiency and accountability as key drivers to fulfill unmet health care for populations (2). Nevertheless, as a policy issue, implementing autonomy has been controversial since it also pursued cost containment throughout contracting out healthcare delivery services (3).

Pursuing hospital autonomy has become a policy quest in low-and middle-income countries. Nonetheless, such experiences for coping hospital performance has not necessarily contributed to the undertaking of gaps in efficiency. On the contrary, their outcomes were related to increasing competition among public hospitals for revenues, quality of care gaps, difficulties in surpassing equity in access to healthcare, and reliability and training for hospital managers (4-7).

In Latin American countries, as a pathway to achieve better outcomes at a population level, waves of health sector reform have been carried out in the last four decades. Despite a call for action regarding strengthening primary health care, hospital management has taken a significant part in the reform proposals, designed to provide greater opportunities for autonomy in the field of management as a strategy for achieving increased levels of efficiency and quality of its clinical and financial performance (8-13).

Chile was not apart of these changes. Since the return of a democratic government in 1990, one of the first policy efforts was strengthening public hospitals. Subsequent policy initiatives not only coexisted with a strong primary health care expansion but also with a strong political and public focus on hospital performance. The health reform enacted in 2004 introduced the right-based system of Explicit Health Guarantees (GES) which ensures access, timeliness of care, financial protection and quality for 80 health problems. For health care delivery, the reform involved the conversion of highly complex hospitals of the country into self-managed network facilities (EAR) (14). A highly complex hospital is one with the highest level of diagnostic and therapeutic support services, availability and degree of specialization of human resources, equipment and ability to solve (15).

Self-management policy introduced a new model of public management that would give opportunities for greater flexibility and autonomy for the allocation of resources and budget management of hospitals (16). The reform introduced an integrated health care delivery service network model for shaping public provision of health services, and to align hospitals with the process of change of the care model to adjust the provision of health services to the requirements of the GES (17). For high complexity hospitals, accreditation as EAR gave them a status of greater efficiency in management, outsourcing high-cost services, generating development project portfolios and conclude cooperation agreements with other institutions of the healthcare network (17, 18). However, by 2008 only 11 out of the 59 highly complex hospitals had completed the process that would allow them to achieve accreditation as EAR (19).

Although hospital autonomy has been implemented in different country settings,

their outcomes have been measured mainly from a managerial perspective whereas the health team's perceptions have been narrowly explored or even neglected. In Latin America, and Chile, this is a shared policy landscape. Therefore, the EAR implementation is an opportunity to explore how professionals perceived implementation of one of the most controversial market-driven health policys.

As a part of a first stage of this research, perceptions from decision-makers were explored (20). Thus, this research aims to describe perceptions among hospital staff regarding the implementation stage of the hospital self-management policy in two highly complex facilities in Chile.

Materials and methods

Study Design

A qualitative study with descriptive and exploratory purposes was conducted. This type of design allows the description and investigation of poorly understood phenomena, identify or discover meanings units and generate new research hypotheses (21).

Area of Study

The selected hospitals are highly complex hospitals located in the south of the country: Hospital Base in the city of Valdivia (HBV) and Hospital San José in the city of Osorno (HSJO). The hospitals were selected based on the fact that measurements taken in 2008 and 2009 to acquire the EAR status, gave the HBV high scores in relation to HSJO (22). This allowed us to compare the perceptions of professionals who, according to the measurements, work in institutions with different levels of policy implementation.

Qualitative Sample

We selected a convenience sample (23) of nineteen professionals without responsibility in decision making. Professionals with no responsibility in decision making were defined as those who despite engaging in administrative tasks, their contractual liability is imminently clinical. Inclusion criteria was a contractual relationship with the institution for at least two years and the willingness to participate in the research. The criterion of years of contractual relationship sought to ensure that professionals had participated during the implementation stage.

The subjects were contacted personally by the main investigator, prior authorization request submitted to the administrative authorities and approval of the research protocol by the Ethics Committees of the Health Service of Osorno (ORD: N° 2427) and Valdivia (ORD: N° 171), respectively. Eight professionals rejected to participate in the investigation, excusing themselves because of lack of time, apprehensions regarding the confidentiality of information and lack of knowledge of the topic of study.

Data Collection

Fieldwork was conducted from August 2010 to March 2012. The data collection technique used was qualitative in depth semi-structured individual interview (24). The dimension of the interview dealt with the organizational changes introduced in hospital management due to the self-management policy. We searched the overall saturation of the dimensions, which determined the final sample. The interviews lasted from at least 15 minutes to a maximum of 1 hour, they were conducted by two interviewers trained by the research team, with the aim to obtain consistency and reduce the variation of the approximation to the issues presented to the

subjects (25). The interviews were recorded prior signing of the informed consent document, and transcribed verbatim. Later, as a quality criterion in the qualitative research report (26), they were sent to the interviewees for comments and corrections.

Data Analysis

The transcripts were read repeatedly by a group of four researchers and coded according to the content analysis technique in its inductive approach (27, 28). Subsequently, we selected verbatim quotations from the interviews -translated from Spanish into English language- and they were coded according to the interviewee's respective hospital affiliation: [NDM-HBV] and [NDM-HSJO].

Quality and rigor in qualitative research

The quality of the research was supervised through rigorous scientific criteria of credibility, reliance, confirmability and transferability (29-31). The credibility through triangulation of researchers and sending transcripts to the interviewees. The dependability and confirmability through systematic description of the methodological approach used and reflexivity in conducting the analysis. Finally, organizational and structural homogeneity of the function of public provision of the Chilean Health System allows transferability of findings to other similar hospitals in the country.

Results

In Table 1, qualitative sample features are exhibited. Table 2 presents the subject categories and subcategories that emerged from the analysis of the interviews. The results are developed according to each subject category, their respective subcategories and verbatim quotes.

TABLE 1. Socio-demographics features of a qualitative sample of health professionals from Hospitales Base from Valdivia and San José from Osorno, August 2010 - March of 2012

Variable	HBV [a]	HSJO [b]	Total
	n	n	n
Sex			
Men	2	2	4
Women	11	4	15
Total	13	6	19
Age			
20 - 30	1	1	2
31 - 40	2	2	4
41 - 50	2	2	4
51 - 60	8	1	9
61 - 70	0	0	0
Total	13	6	19
Profession			
Registered Nurse	11	1	12
Medical Technician	1	0	1
Kinesic Theraphist	0	1	1

Registered Widwife	1	1	2
Pharmacist	0	2	2
Lawyer	0	1	1
Total	13	6	19
Years on active duty			
01 - 10	2	4	6
11 - 20	2	0	2
21 - 30	4	0	4
31 - 40	5	2	7
Total	13	6	19

[a] Hospital Base Valdivia. [b] Hospital San José from Osorno.
Source: author's own work

TABLE 2. Categories and thematic sub-categories which emerged from discourses of a qualitative sample of health professionals from Hospitales Base from Valdivia and San José from Osorno, August 2010 - March of 2012

Thematic Categories	Thematic Sub-categories
Policy design	Meaning
	Aims
	Process
	Participation
Policy implementation	Organizational obstacles
	Leadership
Policy strengthening	Human resources
	Infrastructure
	Participation
	Evaluation

Source: author's own work

Policy design category

For interviewees the meaning of the policy of self-management network is determined by the autonomy in decision making regarding the allocation and efficiency of financial resources. It also relates to the autonomy for organizational decision making to improve the provision of health services. Both of these perceptions were strongly associated since autonomy for resource allocation need new hospital governance frameworks where decision-making exhibit the same degree of autonomy for health teams.

> [NDM-HBV] […] Its purpose is to save money, reduce costs and expenses they have for the country in health, I think that is the purpose, if it works, I doubt it, but I do think that is the purpose […]

The policy aims were based on perceptions of meaning since they also understood policy changes oriented toward efficiency in resource allocation and managerial processes. Thus, the policy process was perceived as an opportunity for reforming the strong path dependence in hospital´s organizational culture which also was perceived as a barrier

for achieving greater levels of managerial and financial efficiency. Despite the fact that professionals were from two different hospitals, these aims were shared.

> [NDM-HSJO] […] To make more profitable the very scarce resources there are in health, in this case mostly financial and to make management more efficient […]

Professional's perceptions on policy process were based on a financial orientation approach. The latter was determined by the cost containment of public spending on health, specific to high complexity hospitals. Nevertheless, for professionals from both hospitals, there was a lack of participation in the policy process which undermined the policy implementation.

The concepts that the respondents perceive, regarding the design of the policy, link the financial dimensions as determinants of self-management. This concept is built independently from the hospital where they work.

Policy implementation category

The implementation of the policy of hospital self-management involved to adapt health teams to new organizational and administrative bodies. Professionals perceived as an obstacle shifting managerial paradigms since they don´t know if the information regarding policy changes was sent for all managerial levels. Moreover, for health professionals, policy implementation carried out in a new hospital governance which was not necessarily shared at providing healthcare services.

> [NDM-HBV] […] I think it's a bit of that, eh, the paradigm shift that comes with, with new management models brought by the reform, it kind of proposed many challenges. Now, I do not know whether the information soared to all levels […]

On the other hand, health professionals perceived a lack of leadership that resulted in low management skills, team training, and availability of professionals. They also identified misinformation of health teams on policy changes. For professionals from both hospitals, it is difficult to move a successful policy implementation forward without overcoming the human resources and training gap. This perception is quite relevant since professionals perceived the policy as an opportunity for having autonomy from centralized decision-making on resource allocation and human resources development.

> [NDM-HSJO] […] Mainly the lack of professionals there is in the service and at country level, and when having separate units and centers of different costs one can not share the personnel, because it means saying I will give you this if you give me that […]

The perceptions of professionals regarding the implementation of the policy, help establish the relevance of policies and strategies for health and human resources as a gap between design and implementation.

Policy strengthening category

For the interviewees, health human resources, infrastructure, participation and evaluation are established as the main policy options for strengthening the network hospital self-management policy.

At the human resources for health policies, for health professionals it is necessary to improve the system for the designation of managers, performance measurement and participation in order to strengthen the policy. Also, better strategies for attraction and human resources for health retention. It is also important for health professionals improving participation in policy changes. This participation is conceived from strengthening

teamwork and improving communication within organizations.

> [NDM-HBV] […] Changes in improving communication, strengthen teamwork, strengthen the skills of the management teams and working groups that are necessary to carry out self-management […]

Health professionals also recommend moving toward evaluation processes which allow measureable policy changes, and also generate new guidelines to overcome training gaps. They perceived a lack of previous organizational diagnosis which undermined policy implementation. Therefore, improving evaluation processes would help to surpass this gap as well.

> [NDM-HSJO] […] To make a good diagnostic process, see what do we lack, clinical or administrative, and then supervising, setting up monitoring guidelines to see the results […]

The policy options perceived as necessary to strengthen the policy implementation and evaluation are related to gaps between the design and the implementation of organizational changes.

Discussion

The study results are the first qualitative evidence that address the implementation of the self-management hospital policy among health professionals from two different hospitals. Also, they allow to establish the main gaps that professionals perceive regarding the elements of design and implementation of the policy.

The meaning of both respondent categories regarding self-management is consistent with the objectives that different authors have raised regarding hospital autonomy as a policy for cost containment and hospital efficiency (3, 32). It is also important to address that professionals conceptualization is aligned with health decision-makers perceptions on it (20). This meaning can be explained by initial elements of the design process of the policy oriented to position within the hospitals the financial efficiency as main objective of self-management and a determining factor for the efficiency and quality in the provision of health services.

As in other experiences of implementing hospital autonomy in Latin America (33, 34), the high degree of organizational uncertainty in health teams has been an obstacle to implementation. In both studied hospitals, regardless of the results achieved by the institutions during the accreditation as EAR (22), misinformation in the implementation stage has not allowed a better coordination of the service. In this regard, misinformation has been highlighted as an obstacle for the achievement of better coordination of service (35). In the case of Chile, misinformation as a barrier to service coordination also affects the performance of healthcare networks introduced by the health reform. The latter is even supported by the absence of a network perspective in the conceptualization of self-management by professionals.

Moreover, although the high turnover of hospital executives was noted as one of the greatest difficulties of the facilities to access the EAR category (36), an important finding was the perception of the need to improve the selection of the management team by health professionals. As a contribution to this phenomenon it has been highlighted the lack of recognition and commitment, rather than pecuniary aspects, as demotivational factors on hospital managers in Chile (37).

The lack of a human resources policy to accompany changes in hospital organizations

was noted as a crucial gap between design and implementation (22, 38, 39). However, the results show that nine years after the promulgation of the reform laws, this continues to be one of the determining factors for the performance of the teams and health institutions. Thus, for the implementation of the policy is relevant in order to make progress in the alignment of the professional profiles required, selection process, induction and evaluation. Also, there must be progress in the definition of strategies aimed at better retention and distribution of key professionals for hospital functioning.

Despite the design of the hospital self-management policy sought to improve administrative processes in the provision of health services, the lack of organizational skills and effective training for health teams has prevented to reach the standards needed for the self-management of institutions. It will be crucial to move forward in overcoming these obstacles to deliver a better health service provision.

Conclusions

The meaning o self-management hospital policy is strongly related with financial cost containment and resource allocation efficiency over a public health perspective of change. Thus, there is financing and not and explicit provision of health services the root of policy understanding among hospitals professionals.

The self-management hospital policy implementation has shown greater gaps between design and implementation. These gaps are undermining policy changes within high complexity hospitals. Even more, surpassing the policy gaps will allow hospital teams to manage policy change and improve provision of health services.

Improving policy implementation will demand moving toward better strategies for overcome policy gaps. Designing policies for human resources attraction and retention will be crucial for policy success. Moreover, conducting research to identify hospital performance on access and quality in health care delivery will also be necessary for a comprehensive policy evaluation.

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