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Hospital management autonomy in Chile: the challenges for human resources in health

ABSTRACT

In Latin America, some health sector reforms have included steps to the implementation of autonomous hospitals. In Chile, the health system is implementing a reform that introduces a network of self-managed institutions. These organizations will be high complexity centers that involve greater technical diversity, cost centers and mechanisms to evaluate users' satisfaction. For human resources in health, the implementation of these centers creates challenges in the planning of service provision and a change from the traditional management style of the teams to one based on networks. These challenges include the estimation of gaps in medical specialists and in other professions in the health sector. In order to be successful with self-management, Chile needs to establish universal and local policies that address training and the organization of health service provisioning in these institutions.

DESCRIPTORS: Hospital Administration. Health Care Reform. Personnel Administration, Hospital. Health Management. Chile.

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INTRODUCTION

The health systems reform implemented over recent decades in Latin America included changes to separate the functions of financers and providers, granting of rights to health care services, implementation of health insurance, increasing coverage, changes to human resources policies and implementation of new management models.[16] Moreover, the performance of management duties[20] and the decentralization of services[29] were strengthened. The implementation of the administrative changes was done at a mid- and low-level of the systems.[12] These modifications were translated into restructuring processes and not into greater autonomization in the management of hospital services and institutions.[12]

In regards to human resources in health, the reforms on the continent introduced changes that favored greater productivity, performance evaluations, implementation of incentive systems and new types of contracting.[6] Nonetheless, the inequity in its distribution, the concentration of specialties, the increase of professional migration and the flexibility of employment contracts, continue to constitute areas in need of more regulation.[25]

In Chile the administration of the health sector in the 1990s showed weak institutional integration, a lack of coordination between levels of care and under-utilized human resources.[a] In this regard, the modernization of the public administration during this same decade recognized performance and training as important elements in the career development of human resources for health.[8] However, aspects related to the training and planning of human resources for health continued unresolved.

Currently in Chile health reform is being implemented to optimize the organization of the system, the prioritization of health interventions and the implementation of hospitals with self-management rules. The implementation of the network of self-managed institutions (*Establecimientos de Autogestión en Red)* involves human resource policies utilizing new tools for management and quality in health provisioning.

This article had the objective of introducing some of the policy challenges around human resources for health in regards to the network of self-managed institutions. Conceptual aspects and experiences with hospital autonomy in Latin America are initially addressed, in order to later describe the challenges in managing human resources for health in the administration of these establishments.

HUMAN RESOURCES POLICY AND REFORMS

Human resources for health constitute the central component and largest allocation of resources in health systems[3] and are a crucial support for the successful implementation of health reforms.[15] Nonetheless, the management of human resources for health and its importance to the success or failure of reforms has been a neglected topic.[7] Another typical concern in this respect has been the inability of ministries of health to establish planning processes that satisfy the requirements of the managers, of the population and of the health system as a whole.[24]

In general the effects of health system reforms upon human resources for health have translated into changes in contract types and labor conditions, a duality in relation to public/private employment, new recruitment and retention mechanisms and changes to the skills needed for the reform processes, among others.[26] Due to these issues, some authors[21] recognize the need to discuss aspects such as increasing efficiency, improving performance, greater equity in the distribution of human resources in services, the development of policy and planning capabilities and the development of a new perspective about human resources through identifying priorities in the process of health systems reform.

Aligning health care reforms and human resources for health requires human resource policies that aim to formulate tools which facilitate planning processes, provide support for decision-making and promote guidelines for evaluation of performance.[10] At the same time, considering the efficient use of human resources within the context of institutional capacity should be an essential part of the reform process; this includes the reorientation of education, the training and practice of professionals and the study of ways to retain and strengthen the capacity of human resources for health.[1]

HOSPITAL AUTONOMY

Hospital autonomy involves public hospitals that pass from being part of the public health sector to being institutions that rely on greater freedom in their governance and management.[9] Autonomy seeks to improve efficiency, the acknowledgment of physician responsibilities, accountability and recipient decision-making in the provisioning of services.[22] Likewise, it seeks to improve the quality of care, to reduce costs and to increase institutional surpluses.[28]

In Africa, many experiences of hospital autonomy were implemented through decentralization processes.[5,13] In

[a] Sojo A. Reformas de gestión en la salud pública en Chile. Comisión Económica para América Latina y el Caribe: Santiago;1996. (Series Políticas Sociales, 13).

Latin America, there have been other experiences. The implementation of autonomous state entities (*Entidades Autónomas del Estado*) in Columbia and of the self-managed hospitals (*Hospitales Autogestionados*) in Argentina are examples of autonomy that pose policy challenges for human resources for health.

In Columbia when Law 100 entered into force, the public hospitals were transformed into autonomous state entities with the power to establish contracts with the health promotion companies (*Empresas Promotoras de Salud, EPS*).[14] The EPS carried out the functions of health insurance providers and of service providers for insured patients,[14] and they provided services to the institutional health service providers (*Instituciones Prestadoras de Salud*, IPS). The IPS were the public or private health service providers responsible for delivering services.[11] This way, the public hospitals could acquire autonomy to establish contracts with the EPS and provide health services.

The establishment of the EPS and the IPS began an uncertain scenario for human resources for health, where fears of hospital privatization, employment instability and the desire for information and guidance to face the changes were the main aspects described in their implementation.[23] Moreover, the contracting of third parties by the IPS generated greater employment flexibility and a reduction in salaries.[8]

The Argentinean reform of the 1990s decentralized the health care system, in regards to insurance providers as well as in the provisioning of services. In the provisioning of services, allowing the self-management of public hospitals stood out.[18] These establishments could negotiate contracts with private insurance and with service providers, sell services, charge co-payments and devote part of their income to incentive structures for human resources.[4] Nonetheless, these changes provoked differences in the budget destined for the management of human resources[18] and the existence of a fearful climate and lack of confidence among health teams.[19]

HEALTH CARE REFORM AND AUTONOMY OF HOSPITAL ADMINISTRATION IN CHILE

The changes to the health system during the military dictatorship of the 1970s and 1980s caused a severe under-financing of hospital services, which impacted on the quality of the service and on the financing of human resources.[17] Therefore, when democracy was reestablished, the health sector sought to recover the investments in health, the infrastructure and the accessibility of the services.[2]

Since the year 2002, the country implemented health reform aiming to define explicit health guaranties available on demand to citizens and to improve the care and management models of the system.[27] Thus, the reform was begun with the promulgation and approval of Law 19,988 which established the necessary financing to meet the priority social objectives of the government.[a] Later, the government promulgated Law 19,937 for the health authority and management,[b] Law 19,966 for a general plan of guaranties in health (GES)[c] and the modification of the ISAPRES law Number 18.433 through Law Number 20,015.[d] The later law was concerned with the obligations and rights of users and continues through the legislative process of the National Congress.

The most important contributions of the approved bodies of law are described in the Table.

The Network of Self-management Institutions

The Law 19,937 on health authority defines the network of self-managed institutions as those hospitals dependent on the health system, which have greater technical complexity, development of specialties, administrative organization and number of services provided. Organizationally, they should comply with procedures for cost measurement, quality of care, user satisfaction and should grant the highest level funding in their budget to personnel.

The directors of the establishments can direct the execution of programs, design future plans and organize the institution internally. Likewise, they will include a consultative council of users, consisting of five representatives from the local community and two representatives of workers from the establishment, which will have a consultative role in the setting of policies and the evaluation of institutional plans.

Initially, the year 2009 was envisioned for the implementation of these institutions in all the country, however this date was postponed in order to optimize aspects of their implementation.

[a] Ministerio de Hacienda. Ley Nº 19.988, de 14 de julio de 2003. Establece financiamiento necesario para asegurar los objetivos sociales prioritarios del gobierno. *Diario Oficial*. 13 ago 2003[citado 02 feb 09].Disponible en: http://www.bcn.cl/leyes/pdf/actualizado/213493.pdf
[b] Ministerio de Salud de Chile. Ley Nº 19.937, de 30 de enero de 2004. Modifica el D.L. nº 2.763, de 1979, con la finalidad de establecer una nueva concepción de la autoridad sanitaria, distintas modalidades de gestión y fortalecer la participación ciudadana. *Diario Oficial*. 24 feb 2004[citado 06 ene 09].Disponible en: http://www.bcn.cl/leyes/pdf/actualizado/221629.pdf
[c] Ministerio de Salud de Chile. Ley Nº 19.966, de 25 de agosto de 2004. Establece un régimen de garantías en salud. *Diario Oficial*. 03 sep 2004[citado 06 ene 09]. Disponible en: http://www.bcn.cl/leyes/pdf/actualizado/229834.pdf
[d] Ministerio de Salud de Chile. Ley Nº 20.015, de 03 de mayo de 2005. Modifica la ley 18.433 , sobre instituciones de salud previsional. *Diario Oficial*. 17 mayo 2005[citado 06 ene 09]. Disponible en: http://www.bcn.cl/leyes/pdf/actualizado/238102.pdf

Table. Main contributions of the bodies of law approved for health system reform in Chile.

Body of law	Contributions
Law 19,937 of health authority and management	Defines the new structure of the Ministry of Health. Creates the Sub-Secretary of Care Networks, which coordinates the entire care network in the country. Creates the Sub-Secretary of Public Health tasked with health standards and epidemiological monitoring. Creates the Network of Self-management Establishments. Creates the Superintendent of Health, whose purpose is to monitor the National Fund for Health and the Health Insurance Institutions.
Law 19,966, which establishes the plan of guaranties in health	Establishes a framework of explicit guaranties in health regarding access, quality, financial protection and opportunity, for the services associated with all the combination of priority programs, illnesses and health conditions. Establishes the reliance on studies to determine a list of priorities in health and of interventions that consider the health situation of the population and when possible their cost-effectiveness. Considers the performance of studies about epidemiology, illness rates, economic evaluations and potential demand.
Law 20,015, which modifies the Health Insurance Institutions Law	Establishes changes in regards to the functioning of the Health Budget Institutions and the role of the Superintendent in its oversight.

THE CHALLENGES OF SELF-MANAGEMENT

At first, reform proposed the development and the strengthening of human resources through the redefinition of the medical professions, continuing education, accreditation and the study of career mechanisms and incentives.[27] However, these proposals were not included, when implementing the organizational and structural changes to the system. Therefore, among the network of self-managed institutions, the challenges for human resource policies are rooted in working in a network model and in the provisioning of services for the GES pathologies.

The business model centered on the production process begins to not work when used in a network. The innkeepers style, "each one tightens their screw" without being involved in the final result, should be changed to a strategic focus centered on meeting user demand for health services through the supply of institutional services adjusted to the actual and the projected demand. Also, it is necessary to change from making decisions grounded on the existing record to decision-making based on anticipation, changing from mass coverage of care for focusing on diverse priority groups. Even then the strategic focus requires an understanding of different settings to guarantee intra- and inter-institutional synergies.

Thus, meeting the demand for the GES in the network of self-managed institutions can allow for an understanding of human resource requirements and planning; with greater clarity in the identification of gaps in medical specialties and gaps in other health professionals, which are a bottleneck to resolving and managing demand. In turn, planning should identify the general competencies that are expected of human resources under self-management.

Finally, the perception of health teams in regards to changes and the decision-making that autonomy grants them should be considered in order to reduce uncertainty regarding issues such as labor flexibility and privatization of services, which were described in other processes of hospital autonomy on the continent.

FINAL COMMENTS

The implementation of the network of self-managed institutions constitutes an experience that is not exempt from the difficulties of other processes implemented on the continent. Because of this, success depends on the tasks carried out by the health institutions and on the regulatory frameworks and incentive structures of public policies for health in Chile.

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