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Managing the Transition from Public Hospital to "Social Enterprise:" A Case Study of Three Colombian Hospitals

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Luis Saenz, MD

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ACRONYMS

List acronyms in alphabetical order as needed.

DDM	Data for Decision Making
ESE	Empresas Sociales del Estado
FPMD	Family Planning Management Development
LAC	Latin America and the Caribbean
PAHO	Pan American Health Organization
PHR	Partnerships for Health Reform
USAID	United States Agency for International Development

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1. INTRODUCTION

Hospital reform is a topic of great importance in the modernization of health systems in Latin America and the Caribbean. Because a large proportion of health resources are used for hospitals in all countries of the region, and because there is evidence that in some cases these resources are being used ineffectively and inefficiently, reform of hospital financing and management is essential.

Various countries in the region have begun to address the issue of hospital reform, either as part of the overall modernization and decentralization of the health sector, or through specific hospital modernization projects. In Colombia, some hospitals have made great strides in improving hospital management, as is apparent when the current reality is compared to that of several years ago.

The aim of this document is to highlight some of the Colombian experiences that were analyzed during a series of study tours to Colombia by professionals who are working in the area of hospital reform in various countries of Latin America and the Caribbean. In the course of meetings and visits during the two tours, the professionals were able to learn first-hand about the Colombian experiences and about possible approaches to hospital reforms in their countries. Many of these experiences had not been previously documented. This paper was prepared precisely in order to share information about the processes of change with all professionals in the region. It presents some of the most important experiences and explores the lessons learned from them.

The paper does not seek to synthesize the entire Colombian experience in hospital reform, but only to offer some examples of reforms in hospital management, strategies for transition management used by managers in some of the hospitals visited, and the results that were observed. Specifically, it focuses on three aspects of hospital management: (1) market-oriented hospital management, (2) management of the process of internal transition, and (3) management for interaction with the external environment. These aspects have been key to the implementation of hospital reform in Colombia, and they might prove worthy of consideration in the implementation of hospital reform in other countries.

The document is divided into the following sections: **Section 2:** The context of reform in Colombia; **Section 3:** Framework for hospital reform in Colombia; **Section 4:** Implications of the reform for hospital management; **Section 5:** Selected experiences in the management of hospitals in transition; **Section 6:** Conclusions and lessons learned.

It is hoped that this document and the lessons learned in Colombia will be of use to professionals involved in hospital reform processes, whether at the national, regional, or local level, and help inform the process of hospital reform in their countries.

2. THE CONTEXT OF REFORM IN COLOMBIA

In order to understand the experience of hospital reform in Colombia, it is necessary to place it within the overall context of health sector reform—the comprehensive sector-wide reform process that gave rise to hospital reform. This section presents a general overview of the Colombian reform in order to provide contextual elements that will be useful for analyzing hospital reform. It does not attempt to describe the reform in detail, but only to point out its basic features.

Health sector reform in Colombia began in the 1980s and continued in the 1990s with the enactment of a series of laws and the preparation of a technical platform for change. In these laws it is possible to identify the following goals which health sector reform is intended to achieve:

- universal coverage (equitable access to health services for the entire population);
- more effective use of resources by channeling them toward preventive and primary care and targeting them to rural areas and poor populations; and
- provision of quality services.

To achieve these goals, two main avenues of action were proposed: decentralization of the health sector and creation of a single insurance model for the whole population. These two "avenues" are described below.

2.1 DECENTRALIZATION

National economic authorities were greatly concerned about the inefficiency, poor performance, and lack of accountability that had resulted from centralization. Virtually the entire Colombian public sector was decentralized to the municipal level, and the *municipio*[1] became the basic unit in the organic structure of the Colombian State. Within this framework, health sector reform began formally with a process of geographic decentralization, in which resources were transferred from the Ministry of Health to the departments and *municipios* through the adoption of Law 77 in 1987, Law 10 in 1990, and Law 60 in 1993.

This geographic decentralization of health services gave the mayors and governors responsibility for carrying out the following activities:

- planning, allocating resources, evaluating, and monitoring programs;
- implementing public health programs to provide free services to needy populations;
- promoting the contributory insurance system and guaranteeing the availability of subsidized insurance;

[1] A *municipio* is a political-administrative unit roughly equivalent to a county.

- ensuring the organization of public and private supply of services;
- monitoring the quality of services;
- monitoring health conditions in the population; and
- effecting and encouraging investment in health care infrastructure.

In addition to geographic decentralization, other policies were introduced with a view to bringing about institutional decentralization of the Ministry of Health in terms of the legal status of institutions, hospital autonomy, contracting for services by public hospitals and agencies of the Ministry of Health, human resources, supplies, staffing, etc. Decentralization of the Colombian health system thus gave the departments and *municipios* a great deal of autonomy to make decisions concerning the organization of health services, contracts for public and private services, hiring of new human resources, and the establishment of various payment mechanisms (Bossert, 1998).

2.2 GENERAL HEALTH SOCIAL SECURITY SYSTEM

The second component of health sector reform was the creation of a health services and insurance system, the General Health Social Security System (*Sistema General de Seguridad Social en Salud - SGSSS*). The legal foundation for the SGSSS was provided by Law 100, enacted in 1993. This law unifies the various existing insurance modalities. Among these modalities, the most important was that of the Social Security Institute (*Instituto de Seguridad Social - ISS*), which was established in 1946. Law 100 makes affiliation with the system mandatory, broadens the coverage of comprehensive health services for workers' families, and establishes mechanisms for universal coverage. The social security system is comprised of a contributory system and a subsidized system. Affiliation with one system or the other depends on economic status. Those who can afford to pay are covered under the contributory system. A person is considered able to pay if he/she earns more than two times the minimum wage. Those who cannot afford to pay—i.e., those who earn less than two times the minimum wage—are covered under the subsidized system.

Figure 1 shows the organization of the system graphically.

In the contributory system, contributions are paid to "Health Promoting Entities" (*Entidades Promotoras de Salud - EPS*), which may be private or public. The contribution consists of an amount equivalent to 12% of a worker's salary. The employer contributes two thirds of that amount and the worker contributes one third. In the case of self-employed workers (who have no employer other than themselves), the worker contributes the entire 12%. Out of these contributions, the EPS receives a capitation payment (*Unidad de Pago por Capitación - UPC*) for each insured person. Payment of this premium entitles the affiliates of this system to benefits under the Obligatory Health Plan *(Plan Obligatorio de Salud - POS)*, which includes curative and preventative services at the primary, secondary, and tertiary care levels.

The subsidized system is financed in part by the premiums collected by the contributory system (1% go to the subsidized system) and by national, departmental, and municipal budget allocations, lotteries, and specific taxes. Those enrolled in this system are entitled to a

Subsidized Obligatory Health Plan (POS Subsidiado-POSS), which initially provided 50% of the benefits provided under the POS. That amount has gradually increased, and the benefit level is expected to be equal to the POS by the year 2001. Services not covered under the POSS are provided by public hospitals, which continue to receive direct budget allocations from the State, through supply subsidies, for that purpose. The system is managed by Subsidized System Administrators *(Administradoras del Régimen Subsidiado - ARS)*, which may be public or private entities. The most important of these entities are the Family Health Care Funds *(Cajas de Compensación Familiar)*, which are nonprofit organizations devoted to the financing and/or delivery of health services for poor populations, and the Collective Health Enterprises *(Empresas Solidarias de Salud)*, community-administered organizations created under Law 100 to assist poor populations, which finance and provide health services. The social security system also includes two other forms of insurance—mandatory vehicle insurance and workers' compensation insurance, which are intended to cover the services required in each instance.

This unified insurance model, the goal of which is to achieve universal coverage, provides for participation by the private sector in the financing of health services, which previously had been the sole responsibility of the Social Security Institute (ISS). However, the ISS continues to play its role as an insurer and is considered the largest EPS in terms of number of affiliates and budget. It also continues to play a role in the provision of health services for its affiliates and in the emerging market of public and private providers. As part of the current reforms, the ISS has been divided into several organizations, which have either insurance or service-delivery functions.

Health services are provided by a network of public and private providers under contract with the ARSs and EPSs. To obtain a contract, providers must be certified by the ARSs and EPSs. Once providers have been certified as providers that offer quality services, they are placed on a list of approved providers. The insurance entities supply the list to their affiliates, who are free to select the provider of their choice. The aim in forming such a network of service providers is to establish a competitive market in which both private and public entities compete for contracts with EPSs or ARSs. To that end, the legislation enacted in recent years has encouraged a series of autonomy measures for the public sector with a view to creating a competitive framework that takes advantage of the public infrastructure but allows for private participation. The idea is that public providers can become more efficient and competitive participants if there is legislation in place to support such a process. The possibility of choosing between public and private providers benefits the population, since decisions regarding where to receive health care are no longer governed by socioeconomic status and, as a result, the quality of the care provided is not related to the social background of the health service user.

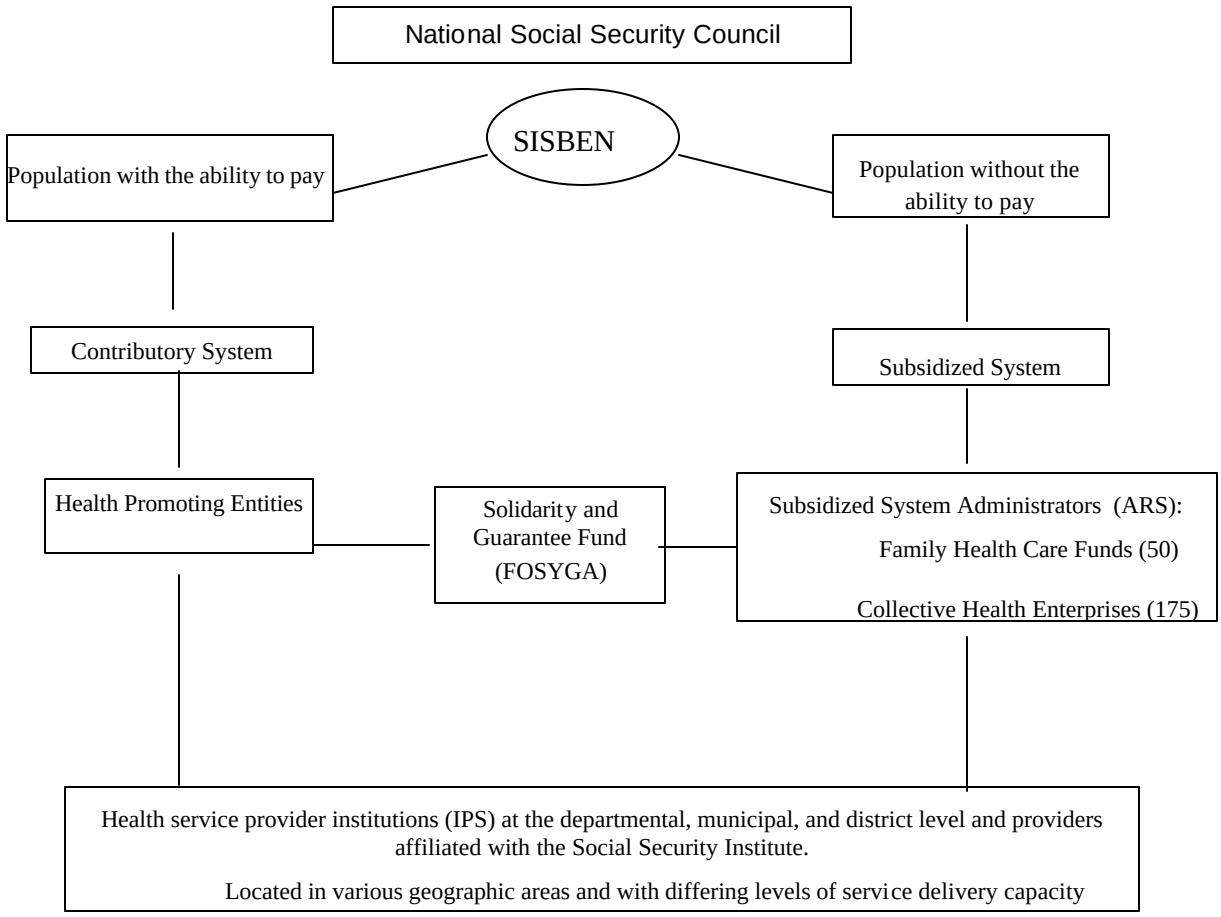
Another component of the health system is the National Social Security Council, which is responsible for formulating policies on health and social security. It is a participatory body that includes representatives of the Ministry of Health, the Health Services Administration, trade organizations, and local units. One role of the Ministry of Health is to prepare proposals for consideration by the National Social Security Council, which converts them into agreements to be executed by the local entities (secretariats, municipal governments, districts, health departments). The Ministry of Health, together with the Ministry of Labor and the Ministry of Social Security, also develops policies, strategies, programs, and projects in accordance with the policy framework established by the Colombian Congress. Other functions of the Ministry include setting quality standards for the administrative and health

care delivery services of the entire system, as well as monitoring risk factors and evaluating managerial efficiency.

Because coverage under the system is based on ability to pay, a system of socioeconomic classification is required to (1) determine which of the two systems individuals will be affiliated with, and (2) for those insured under the subsidized system, determine the amount they can afford to pay in order to partially cover the cost of some of the services they will receive. The Beneficiary Classification System *(Sistema de Clasificación de Beneficiarios - SISBEN*) was designed for this purpose.

The system classifies the population in six socioeconomic categories. The first two comprise the poorest population. As was noted above, the Ministry of Health delegates responsibility to the local entities—departments and *municipios*—for classifying the population. The *municipios* have made significant progress in identifying those who should be covered under the subsidized system. This mechanism has made it possible to identify the poorest strata of the population (strata 1 and 2), who are entitled to receive health services through an ARS. At present, nearly 7 million poor people have been identified by means of this mechanism. This figure represents 60% of the total established as a target. Annex 1 contains a table showing the new functions of each of the institutions and organizations in the Colombian health sector.

FIGURE 1



As in other countries, the health system reform process in Colombia originated as a response to an urgent need to implement changes to address a crisis in the health sector. The country has registered significant success in implementing the reforms, although it has also encountered difficulties, and new problems have arisen. For example, part of the population remains uncovered by either of the two insurance systems. When members of this population seek services, because they have no insurance coverage, it falls to the State to pay for those services. The costs are covered out of national, departmental, or municipal funds. This uninsured population constitutes a source of distortion in the operation of the model, which in turn has negative consequences for the operation of the hospitals, as will be seen below.

The successes of the Colombian reform are notable in that they have engendered a new dynamic in the health sector. Insurance coverage has increased, enabling a larger proportion of the population to access health services. There is evidence of increased awareness of the cost of services on the part of the various parties involved, and investment in health in relation to GDP has increased. Various groups have also been formed to undertake evaluations of the reform with a view to planning the next steps to be taken.

3. FRAMEWORK FOR HOSPITAL REFORM IN COLOMBIA

3.1 THE TRADITIONAL COLOMBIAN HOSPITAL

The situation of Colombian public hospitals prior to the reform process was critical in three fundamental respects: (1) efficiency (low productivity and efficiency); (2) quality of care; and (3) limited access to health services for the poor population.

With regard to the problem of hospital output and efficiency, the typical hospital did not have instruments to enable it to estimate costs accurately. It also lacked management and information instruments, and its staffs had little managerial training. There was a high degree of political interference and dependence on the central level for the administration of human resources, that resulted in lack of motivation. In addition, the lack of a direct relationship between financing mechanisms and performance incentives hindered effective hospital management, both in terms of managerial training for hospital directors and information systems and management instruments.

The problem of inadequate quality of care was most apparent in the care received by the poor, who could only be served in hospitals that had some modality for providing charity care. This led to inequalities in treatment and subsequent unwillingness on the part of patients to seek care and follow treatment instructions. Without an officially recognized and technically based quality evaluation system, the delivery of quality services depended solely on the ethics and knowledge of the doctor. Initiatives for the evaluation of technical quality were limited, and the evaluation of quality, as perceived by the user, occurred only in isolated cases. It should be noted, however, that the Social Security Institute did carry out some activities in the area of medical auditing and accreditation.

Jaramillo[2] found that access to health services was limited, especially among the poorest population. The social security covered only 24.1% of the population, of which 22.4% were covered under the contributory system and 1.6% were covered under special systems. As for the rest of the population, 45% received services free or for a token payment, 16% had access to private services, and the remaining 15% had no access to services. At that time (1993), national public investment in health amounted to 3.7% of GDP. The figure had increased to 5.4% of GDP by 1995. Jaramillo also observed inequities in the provision of hospital services and in the use of public subsidies, noting that the wealthiest population received more services than the poorest population. These findings have been attributed to difficulties in targeting public resources and strong political influences in hospital financing. This issue became one of the driving forces behind the effort to reform the health services financing model.

[2] Jaramillo I. El futuro de la salud en Colombia. *Revista SALUTAD* 1999;6: 14-17. [Published by Fundación Universidad de Bogotá Jorge Tadeo Lozano].

3.2 GOALS OF HOSPITAL REFORM

Given this context, the hospital reform movement sought to increase productivity, efficiency, quality of care, coverage, and equity in hospital services. A prerequisite for bringing about the major changes needed in hospitals was general reform of the health sector, and both the components of reform mentioned in Section 3 (decentralization and the creation of the new social security system) had profound implications for the reform of Colombian public hospitals.

First, the laws on decentralization established that hospitals were to be "autonomous" entities, with the idea that they would have permanent control over their governance, financing, and management. Second, Law 100 of 1993 and the new health care model proposed the conversion of hospitals to "social enterprises of the State" (*Empresas Sociales del Estado - ESE).* This transformation required a new structure and a new organization to accommodate the modifications in the hospital financing system.

The guiding principles in the conversion of hospitals to state social enterprises were the following:

- In becoming state enterprises, hospitals would become decentralized public entities at the local level, legally established, with their own assets and administrative autonomy.
- Hospitals would serve as organizations with self-governance and management and with financing mechanisms oriented toward subsidization of demand.
- Hospitals would maintain the social function of contributing to the improvement of quality of life and promoting citizen and community participation.
- Hospitals would develop their business operating capacity through technical and administrative improvements designed to ensure their survival and growth, the quality of their resources, and the organization's ability to compete.

3.3 THE NEW STRUCTURE AND ORGANIZATION OF HOSPITALS

In order to achieve the goals of hospital reform, and so that traditional hospitals could become state social enterprises, each department or *municipio* (depending on the level at which the hospital was administered) had to implement an ordinance or agreement—according to whether the level in question was a department or district—authorizing the conversion of the hospitals in their region. All such ordinances or agreements were to describe the characteristics of the state social enterprises, based on Law 100 and in terms of the aforementioned goals of the reform in order to ensure that the conversion process would be uniform and similar in content.

The reform measures also allowed for the inclusion of private hospitals as additional providers in the network of services that would participate in a context of competition with the public hospitals. The latter would have been transformed into businesses offering services for the users affiliated with the financial entities in the system—the EPSs and the ARSs. The

system would thus be more transparent, since patients' socioeconomic status would not be a consideration in the provision of health services.

As an example of an agreement for the conversion of hospitals, a condensed version of the agreement of the District Council of Bogotá for the conversion of the hospitals of Bogotá to social enterprises of the State (ESE) is presented below (Agreement No. 17 of 1997). That agreement establishes that each hospital will have the following characteristics:

- The hospital is a decentralized public entity, with its own legal status, assets, and administrative autonomy, under the General Secretariat of Health, and is subject to the provisions of Law 100, Chapter III, Articles 194, 195, 197.

- The hospital is entitled to manage its own assets and carry out transactions with the approval of the Secretariat of Health.

- The ESE is governed by a board of directors whose main functions include planning, setting personnel policies, allocating resources, approving investment projects (debt portfolio), establishing internal hospital rules and procedures, and authorizing modifications to the basic organizational structure of the hospital. The board of directors has a minimum of six members, including the following: the mayor and the secretary of health (or their representatives), a representative of the scientific community (a health professional from the hospital) elected through a vote, a representative of the scientific community in the area served by the hospital (scientific associations), two representatives of the community (one from an alliance or association of users and another from a trade union). Board members serve three-year terms.

- The objectives of the ESE are to care for the health and social welfare of the population, provide health services on a contract basis, promote citizen participation, and develop business management capacity.

- Hospitals are to be financed through subsidies, contracts, grants, and contributions.

- Basic structure and functions of the hospital:

    - Management: Maintains unity of objectives and strategies, determines markets, establishes service strategies, allocates resources, sets quality standards, oversees operations and monitors the application of policies internally. The hospital director will be appointed for a three-year term and will serve as the legal representative of the ESE.
    - Patient care: Responsible for the production and provision of services, with their respective procedures and activities, including administrative activities, required for patient care.
    - Logistics: Responsible for planning, supplies, human resources, financial matters, maintenance and procurement of inputs, management of information systems.
    - In addition, there should be one staff position responsible for overseeing scientific activities and another responsible for overseeing administrative matters

- The "acts" of the ESE are governed by public law, while contract-related matters are governed by private law.

- As for the personnel system, there are no modifications for existing employees. Current hospital employees remain public servants with all the rights to which they are entitled by law.

Table 1 summarizes the differences between the traditional hospital and the hospital as a social enterprise of the State (ESE), based on the provisions of the conversion agreements.

TABLE 1. FINANCING AND MANAGEMENT FEATURES OF THE TRADITIONAL HOSPITAL AND THE HOSPITAL AS A SOCIAL ENTERPRISE OF THE STATE

TRADITIONAL HOSPITAL	SOCIAL ENTERPRISE OF THE STATE
▪ Financed by supply subsidy ▪ Historical budgeting ▪ Extremely hierarchical vertical organizational structure ▪ Little quality control ▪ No cost control ▪ Little service management ▪	▪ Financed by demand subsidy ▪ Prospective budgeting based on production of services, not budget items. ▪ Matrix structure organized in business units ▪ Quality management ▪ Cost rationalization ▪ Service management (clinical management)

3.4 NEW SOURCES OF HOSPITAL FINANCING

Many of the changes introduced were prompted by modifications in the sources of financing for hospitals. While traditional hospitals received a historically based budget from the Ministry of Health with no obligation to demonstrate results, the sources of financing in the new framework of the reform were modified in order to gradually move from a supply-based budget to a budget oriented toward the sale of services. The services are sold to the EPSs and the ARSs, which are the entities responsible for providing insurance coverage. The shift from the traditional model of historical budgeting to sale of services was intended to take place gradually, and a transition stage was planned in which the first step would be internal conversion of the hospital.

In accordance with the new legislation enacted in 1993, financing for hospitals comes from the following sources:

- Contracts with EPSs for sale of services;

- Contracts with ARSs for sale of services;

- Supply subsidies or transfers, which persist from the old financing modality that is gradually giving way to the new mechanisms;

- Services covered by the Traffic Accident Insurance Plan (*Seguro de Accidentes de Tránsito – SOAT*);

- Direct payments for services received;
- Contracts with sectional and local funds (with the *municipio* or department) for the provision of care to uninsured persons in proportion to the amount billed; and
- Direct funds from FOSYGA to cover deficits.

These new forms of financing required hospitals to begin applying the concept of social enterprise as defined in the conversion agreements. The logic of the process of change was to modify the rules of the game with regard to financing and enable the hospitals to modify their internal structure and operation and begin to apply business concepts. Mainly, that meant billing for their activities and using production, quality, and costs to adjust to the demands of the services, in addition to developing the capacity to collect for the services billed. The hospitals' future survival would be contingent on their management under these principles.

According to the 1993 legislation, this conversion was to occur over a period of three years. By 1996 all hospitals in the country were to have been converted to state social enterprises and were to be financed through sale of services. However, this deadline was later extended to the year 2001, under law 344 of 1996, owing to difficulties in the implementation of the process.

The new financing modalities depended on the creation of benefits plans in place of the definition of levels of care. As a result, hospitals had an incentive to provide care based more on financial risk than on population or geographic location. One repercussion of this change in the hospital environment was that the capacity to bill for services and adapt to the new rules of the game became crucial. The change also meant that, as part of this new scenario, some hospitals that did not develop the capacity to function in a context of purchase and sale of services would become insolvent and be unable to survive in the future. The situation would be critical in communities where the hospital is too big, or demand is not sufficient to cover hospital expenditures and a subsidy from the State would be required to maintain services. However, the hospital's success as an ESE is not dependent exclusively on improvement of its managerial capacity but also on market characteristics, that determine whether self-financing is sustainable. This in turn will depend on the composition and behavior of demand.

Between 1993 and 1997 the resources allocated to hospitals in relation to GDP increased 2.6 times for hospitals at the primary level of care and 1.5 times for hospitals at the secondary and tertiary levels. A study conducted by Madrid Malo[3] for the Ministry of Health found that for the period 1993–1997, hospital financing derived from the hospital's own revenues (mainly from the sale of services) increased 504% at the primary level, 182% at the secondary level, and 102% at the tertiary level. This increase is attributable to improvements in hospital capacity for billing and collection for services rendered, and to better management. This study also documented an increase, although of lesser proportion, in financing derived from supply subsidies, either from fiscal revenues or from other sources, that reflect the persistence of traditional forms of financing.

[3] Madrid M. Análisis de la evolución de los ingresos de los hospitales públicos a partir de la expedición de la ley 100 y de la situación de los recursos del subsidio a la oferta por recursos de la demanda. [Analysis of the evolution of public hospital revenues following the enactment of Law 100 and the situation of supply subsidy resources vis-à-vis resources derived from demand]. Bogota: Ministerio de Salud de Colombia; 1998.

3.5 PROGRESS AND CHALLENGES IN THE IMPLEMENTATION OF REFORM

By 1997 most hospitals had become social enterprises of the State. In accordance with the proposed new model of hospital financing, supply subsidies would gradually decrease and the hospital's own revenues from the sale of services would increase. In fact, by 1997 tertiary-level hospitals (ESE) had managed to increase their own revenues by 10%, but secondary-level hospitals had not been able to offset the decrease in supply subsidies through an increase in their own earnings.[4] At the same time, however, a significant increase in revenues—close to 40%—was noted for primary-level hospitals.

Various studies have identified the following as the main problems hindering implementation of the reform:

- Public hospitals do not know how to market their products.
- Public hospitals do not know how to contract effectively and in their own best interests.
- Public hospitals have limited capacity to bill for the services they provide.
- The SOAT system used to classify benefits for billing is cumbersome and complicated.[5]
- Within hospitals there is resistance to change, which impedes acceptance of the new business culture.
- Budget transfers under the traditional system persist, which delays adoption of the new system.
- The annual public budget law limits hospital autonomy with regard to the administration of financial resources.
- There is a liquidity problem caused by lack of timely payment by the administrators of the subsidized and contributory systems and the departments, municipios, and districts.

[4] Ibid.

[5] SOAT is a list of benefits and prices for the traffic accident insurance plan, which is used by hospitals as a reference for the payment of benefits by the EPSs and ARSs.

Hence, there are obvious problems related to hospital management and deficiencies in the implementation of the model. The following sections will focus on issues of hospital management.

4. IMPLICATIONS OF THE REFORM FOR HOSPITAL MANAGEMENT

As has been discussed in previous sections, the hospital reform produced a great number of changes within hospitals. It has also been pointed out that the changes in sources of financing that accompanied the hospital conversion process favored new forms of hospital management. By making hospitals autonomous through decentralization and advocating a new approach through the "professionalization of hospital management," the State gave hospitals the support they needed to improve their managerial capacity and thus implement the proposed changes.

With the advent of hospital autonomy and management based on a private legal framework (with a level of risk assumed especially by the hospital manager), the managers of the various services—which were formally organized as cost units (or business units)—became increasingly important figures within the hospital.

In the early 1990s, a law took effect which required that all hospital directors have professional training in hospital management. The university institutions that offered training for human resources in the health field therefore launched programs to train "hospital managers." The need for such training became clear when the hospitals embarked upon the process of conversion to state social enterprises, and each hospital was required to have a hospital manager appointed for a three-year period. This period could be extended if the manager demonstrated good performance.

Under these rules, and with the proper training in management as well as three years to demonstrate results, managers had to create a new reality within their hospitals. To do so, they needed to focus on three main areas: (1) orienting hospital management toward the introduction of improvements in efficiency and productivity, (2) managing the process of internal transition in the hospital, and (3) coordinating external relations with public, private, and community entities. Each of these areas and the main changes required are examined below.

4.1 MANAGEMENT FOR THE IMPROVEMENT OF EFFICIENCY AND PRODUCTIVITY

The new market orientation required the implementation of a new financial structure within hospitals and led to competition with other hospitals, which entailed three essential changes: (a)implementation of mechanisms to plan and monitor the activities of the hospital using output and cost indicators; (b)orientation of the services toward attracting users or clients; and (c)promotion of contracting for services. Each of these three changes is described briefly below, and in the following section examples are given of how some hospitals implemented them.

4.1.1 Implementation of mechanisms to plan and monitor the activities of the hospital using output and cost indicators

The capacity to estimate costs and bill for services is essential in order to estimate the profitability of the hospital as a whole by determining which services yield profits and which must ultimately be subsidized. The implementation of mechanisms for estimating costs, billing, and contracting to participate in the market of service providers requires information and a capacity for prediction based on the hospital's strengths and weaknesses. First, it is necessary to calculate the costs of the various services and then identify those that are most profitable. Second, it is useful to identify inefficiencies, determine their causes, and propose solutions. To determine costs, the first step is to identify the functional units of the hospital as independent business units, with their own revenues, fixed and variables expenditures, and cost of "sales." This makes it possible to determine the profit margin on the operations carried out by each 'business unit'.

Development of the capacity to bill for services is a key factor in this process. By comparing the price paid for a service by an EPS or ARS with the cost of producing that service it can be determined which services yield the greatest return for the hospital and which are least profitable and, on that basis, measures can be implemented or explanations sought for the differences. The billing process is still not fully functional, having run up against several obstacles, in particular delays in payment by the EPSs and ARSs, which are estimated to average 90 to 120 days at the national level.

It has also been necessary to strengthen managerial capacity. Hospitals are now being run by managers with specific training in the field and ample experience in operation of the system. In addition, the heads of medical departments, nursing, and other key services have been trained in management in order to generate strong capacity for managerial coordination within the hospital and create a critical mass of managers to ensure successful management.

4.1.2 Orientation of services toward attracting users or clients

The orientation of services to attract users is another necessity in the context of competition. Hospitals must focus on publicizing the services they offer and assuring that those services are supplied under the best conditions and with the highest level of quality possible. The hospitals that are most advanced in the reform process have created units to market their services and ensure that the financing entities, especially the EPSs and ARSs, include them when they develop lists of service providers for their members. Hospitals have also had to acquire more detailed knowledge of the profile of demand and the needs of users. As a result, strategic plans are now being developed with an eye to responding to those needs.

At the same time, the voice of the user is being increasingly heard. Users are offered the possibility of making suggestions or expressing their dissatisfaction with the services they receive by means of suggestion boxes placed in the services, opinion surveys, and administrative mechanisms designed to ensure that hospital managers take into account patients' opinions. The orientation of services toward users has also led to changes in hospitals' operational practices as they seek to attract patients, reduce service denial to a minimum, and decrease waiting lines and lists through appropriate management.

4.1.3 Contracting for services

Contracting for professional services as a new mechanism to improve hospital efficiency and quality is beginning to replace the traditional modality of permanent hiring of salaried workers. Although legally it is not possible to modify the contracts of current employees, some hospitals have begun introducing new methods of contracting for services by "purchasing," from a group of professionals organized as a professional corporation, the services provided by certain units of the hospital—for example, intensive care or neonatology. This makes it possible to set quality standards and monitor costs, since the contracting firm's earnings will be linked to its performance. Although use of this modality is not widespread, and its implementation has not been problem-free, it is a contracting method with great potential.

4.2 MANAGEMENT OF THE INTERNAL TRANSITION PROCESS

Hospital reform—which was implemented in a relatively brief period—and the changes in the financing model that accompanied it, required management that was capable of overseeing a major process of internal transition. For the hospital to survive, the director had to develop and implement strategies for persuading the staff to think and act in new ways that were consistent with the purposes of a business concerned with costs, efficiency, marketing, and the quality of care provided to the client. This meant motivating the staff to embrace changes with regard to their image of the hospital, their functions, their capacities, their attitudes, and the way in which they were evaluated and compensated.

The process of transition is defined here as "the process of internal change through which hospital staff let go of the old reality and come to terms with the new situation." Three key phases in the process can be identified: (1) letting go of the past; (2) dealing with the confusion of being between two realities; and (3) making a new beginning.[6] The first phase refers to the fact that the hospital director must help the staff leave behind their old ways of thinking and acting. This requires an internal change in the staff, which can and should be facilitated by the director through various actions. In the second phase of transition, the hospital may enter a period of confusion, when the rules of the past are not being applied, but new rules do not yet exist. During this phase there is often confusion, demotivation, frustration, and internal divisiveness among the staff. The director must continue to provide information, be sure the process remains transparent, and offer support. In the last phase, the director has to guide the staff toward a new beginning. In this phase there are always ambivalent feelings—people are simultaneously fearful and excited about the change. They become nervous anticipating the impact of the changes and wondering how the new situation will play out.

Although, in reality, it is impossible to distinguish exactly where one phase ends and the next begins, this description gives a general idea of the sequence of changes expected and the role that the director must play with the staff. In the case of Colombia, the hospital directors had to take staff through the phases rather quickly in order to assure the survival of their

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[6] Adapted from Bridges, William. *Managing Transitions: Making the Most of Change.* Reading, Massachusetts: Addison-Wesley Publishing Company; 1991.

hospitals. Several examples of successful strategies used by some directors to manage the necessary transition are presented below.

In the Colombian reform, the persistence of career appointments for administrators and collective bargaining agreements allows for little flexibility in contracting practices and hinders the introduction of performance incentive schemes. Given that close to 70% of the resources of hospitals are devoted to payroll, the introduction of new modalities of contracting for services is a priority. The hospitals studied have begun contracting for some services on a per-task or per-product basis as part of the experiment with the new management model.[7]

4.3 MANAGEMENT OF THE EXTERNAL ENVIRONMENT

The third area of importance for the new hospital management is management of the environment in which the hospital operates. In the old centralized model, hospital relations were managed largely by the central level, especially those that had any implications for outlay or commitment of resources. In the new modality, with hospital directors playing the leading role and the hospital is autonomous, the external situation becomes a new priority for management. To obtain sufficient support and reduce risks, the manager needs to focus on three spheres of influence: (a) the public sector, (b) the private sector, and (c) the community.

With regard to the public sector, the hospital director must coordinate with the central level of the Ministry of Health, the *municipios,* and districts as the main decision-makers responsible for public health. At the same time, the director must begin to develop strategies for communicating with the health promoting entities and administrators of the subsidized system in order to ensure the hospital's eligibility to provide services to their affiliates and obtain the corresponding financing.

The director also has to coordinate with the private sector to establish training contracts for hospital personnel and implement external contracting processes (outsourcing) for services in order to increase efficiency. This requires the hospital director to develop negotiating and strategizing skills in order to do business with and obtain the necessary support from private individuals and entities.

Finally, freedom of choice for service users, who select their providers, can have a tremendous impact—either positive or negative—on a hospital. If a hospital acquires a good reputation as a service provider, it is validated and eligible to be certified by the financing entities as a provider for their members. As explained in Section 3 above, when some people in the community are not covered by the system, it creates problems for the hospital when these uninsured individuals seek services. However, if the uninsured person is registered in the system of the *municipio* or district, the services provided to this person can be reimbursed by the public sector. In many cases, hospitals encounter people who cannot afford to pay but have not been classified under the SISBEN. As a result, the hospital must try to collect a large percentage of the cost of the services from the user. Often the uninsured person does not pay, and the hospital has to assume the cost of the services or solicit reimbursement from the

[7] Interview with Dr. José Cifuentes, Director of Human Resources, El Tunal Hospital, Bogotá.

government in the form supply subsidies. For this reason, it is better for the hospital if the entire community is included in some insurance system.

The following section highlights some of the strategies that hospital directors have used to obtain support or establish alliances with organizations in the public sector, private entities, and the community.

5. SELECTED EXPERIENCES IN THE MANAGEMENT OF HOSPITALS IN TRANSITION

To better understand the strategies that might be useful to transform a public hospital into a market-oriented hospital, three Colombian hospitals were studied. Their experiences may provide some valuable insights. The hospitals are El Tunal, La Samaritana, and the Simón Bolívar Hospital. For each hospital, preexisting information was compiled and primary data were collected through in-depth interviews with managers and other hospital personnel. Each case study begins with background information on the hospital, followed by an analysis of the information collected, a summary of the strategies utilized by the managers to transform their hospitals, and the preliminary results of those strategies. The areas of change are those mentioned above: adoption of a market orientation (including mechanisms to reduce costs, increase the sale of services, and improve the productivity and quality of hospital services); management of the transition process ("the process of internal change through which hospital staff let go of the old reality and come to terms with the new situation"), and management of the external environment (coordination with the public sector, the private sector, and the community).

5.1 EL TUNAL HOSPITAL

El Tunal Hospital is located in the District of Santa Fe de Bogotá, although its potential users come from five districts with a total population of 1.5 million. The hospital was built with funding from the mayor's office and a loan from the Inter-American Development Bank as part of a project to promote the overall development of the area. It is considered a tertiary-care hospital. The hospital has emerged from a severe crisis in the areas of management and quality of human resources, which occurred in the years prior to 1997. Its conversion to a social enterprise of the State has afforded the hospital an opportunity to introduce some innovative approaches to management.

5.1.1 Experiences in implementing the new market approach

Strategies

Initially short-term measures were introduced to reduce the hospital's costs, and then longer-term measures were put in place to increase the sale of services and improve productivity and quality.

With respect to the short-term measures, their goal was to address the initial crisis and bring down costs quickly. One of the first strategies was rationalization of the use of resources for general services—phone service, electricity, and water—and elimination of surplus resources such as vehicles, which were reduced from six to one. The second strategy was outsourcing of some services—in particular, contracting externally for medical and nursing personnel to cover night and weekend shifts, which cost less than using regular hospital staff. Laundry services were also outsourced (for one sixth of the hospital's costs), as

were security and food services. The third strategy was joint purchasing of supplies in collaboration with other hospitals, which made it possible to obtain better prices, especially for intravenous solutions and surgical sutures. Finally, checking accounts were replaced by savings accounts in order to avoid payment of the 0.2% tax on bank transactions.

As part of the long-term measures, the management of El Tunal implemented strategies to orient the hospital toward the sale of services. These strategies included strategic planning, creation of a marketing department and a marketing plan, design of a portfolio of services, investment in improving hospital accommodations, and implementation of a system of user opinion surveys.

In the area of financial management, the hospital introduced a cost accounting system, which represented an advance in the use of tools for generating detailed information about the costs of services, allocated by business unit based on the inputs used.

The development of a strategic plan was important in order to identify the hospital's opportunities, taking into account the internal and external reality, including the market. In 1998, with support from a consulting firm, a strategic plan was drawn up, thus introducing the use of strategic planning tools in the hospital. As part of this exercise, the hospital's mission and vision were defined and the business units were identified. The hospital was thus able to determine that its most profitable services were surgery, specialized traumatology, gynecology and high-risk obstetrics, neonatal intensive care, and intermediate intensive care.

The purpose of having a marketing department is to identify, through a systematized process, the needs of users so as to adapt the services to those needs. Hospital resources can then be optimized in order to fulfill the ultimate purpose of offering a benefit to society in the framework of a state social enterprise. Another function of the marketing department in a hospital is to develop materials to publicize its services. In addition, market studies are carried out to obtain input for the strategic plan. Through its marketing department, El Tunal Hospital has put together detailed information on the portfolio of services it offers in the areas of inpatient, emergency, and outpatient care; special programs in the areas of surgery, prevention and promotion, blood bank, and diagnostic and therapeutic support; and administrative and organizational services that facilitate the patient's use of clinical services and expedite administrative procedures.

In addition to its portfolio of services, the hospital has developed marketing plans to attract potential clients. The activities envisaged and implemented under these plans are intended to inform possible users about the hospital's services. Accordingly, the hospital is being promoted at health fairs, where flyers, key rings, and pens bearing the hospital's name are distributed. In addition, as part of this strategy, the hospital has marketed packages of health services to organizations such as teachers' associations and the armed forces.

As another key strategy for selling its services, the hospital has made it a priority to improve its accommodations and has therefore invested in remodeling the physical plant to make the rooms more comfortable, making them single- or double-occupancy, with phone service, private bath, and television.

The hospital's efforts to market its services are directed toward client retention and attracting a larger number of users. Hence, ascertaining users' opinions of the services and offering them the possibility to voice complaints and suggestions is an important strategy. Systematic surveys have been designed to determine how users feel at various times about the

services they are receiving. These surveys evaluate patients' perceptions of the treatment they receive from hospital workers; patients' perceptions of hygiene in the hospital facilities, including the rooms, lavatories, baths, and common areas; and promptness of attention by the services (i.e., Are there delays or are waiting times unreasonably long?). The planning office oversees the administration of general and service-specific surveys, although the surveys are actually administered monthly by an outside agency. The results are disseminated to the public and the hospital staff. In addition, suggestion boxes with complaint and opinion forms have been placed throughout the hospital. Complaint forms are channeled through a committee which, after analyzing them, responds to the patient, and measures are taken internally to solve the problem, whether it is of an administrative or clinical nature.

With regard to improving productivity and quality in the provision of services, strategies have been implemented for the creation of business units, staff training, contracting for professional services, use of cost and production benchmarking, administration of user opinion surveys (as mentioned above), and ISO 9000 certification of key hospital services.[8]

One of the main strategies for improving productivity has been the creation of business units. This has served to level out the hierarchical structure and reinforce the idea of the hospital as a "business." The internal structure of the hospital now comprises only three organizational levels: executive management, business units, and coordinators. The business units are: (1) surgical services, (2) emergency and outpatient services, (3) diagnostic and therapeutic support services; (4) inpatient and critical care services; (5) administration and finance; (6) and human resources.

Each business unit manager (designated "department directors" in the hospital organizational chart) is autonomous and his/her performance is measured by a series of pre-established indicators.

These indicators include the following:

Financial management:

- Account turnover
- Age of accounts receivable (30, 60, 90, 120 days), those more than 120 days overdue are turned over to an external collection agency for a percentage recovery
- Borrowing power
- Leveraging capacity
- Overspending
- Accounts payable to suppliers
- Age of accounts payable
- Substitution of financing sources

[8] The ISO 9000 standards are a frame of reference for business quality control systems designed to assure the quality of products and services. These standards relate to design, development, facilities, and delivery of services. There are three types of standards—ISO9001, ISO9002, and ISO9003—depending on the type of business being evaluated. There are 20 quality assurance standards, which are identified in a manual.

Health services:

- Discharges, consultations, emergencies
- Bed occupancy rate
- Number of surgeries
- Length of stay (number of days)
- Bed turnover

Quality of care:

- In surgery, performance in relation to planned surgical procedures
- Promptness of surgical care
- Analysis of causes of surgery cancellation
- Evaluation of technical quality through audits
- Preparation for ISO 9000 certification
- Nosocomial infection rate
- Hospital mortality rate

Administrative:

- External marketing of hospital services
- Profit and loss statement of each business unit
- Drug waste in hospital pharmacies
- Inventory turnover
- Account turnover

Staff meetings are held every two months to evaluate the results and establish hospital policies. The evaluation is based on the indicators. If the managers (department heads) of the various business units do not register favorable economic performance, they run the risk of losing their contracts.

To improve both productiveness and quality, measures to promote human resources have been implemented. The hospital has established a series of programs for hospital workers in the areas of occupational health and welfare. The aim of these programs is to address key problems of workers with regard to job stress, ergonomics, job fit, performance evaluation and qualification for promotions, encouragement of participation in sports, and certain economic benefits linked to number of children.

In 1999, the equivalent of 93 million dollars was invested in training, which included activities for work groups within the hospital and for groups that traveled outside the country for seminars, congresses, and forums related to topics in their professions. Another strategy for improving productivity has been hiring of human resources, especially physicians, under "productivity agreements"—i.e., contracts in which workload is estimated and payment of a fee based on the attainment of certain productivity goals is stipulated. Currently, 60% of hospital workers are hired to provide professional services on a contract basis, both individually and collectively. These include cardiologists, surgeons, dermatologists,

gastrointestinal specialists, gynecologists and obstetricians, oral health specialists, ophthalmologists, radiologists, urologists, pediatricians, and orthopedists.

To evaluate the level of productivity and quality, and to guide management and provide incentives for staff, the hospital compares itself with other establishments by means of cost and production benchmarking. This methodology is used to make cost comparisons with two private hospitals.

In addition, the hospital has decided to apply for ISO 9000 certification, which is an "objective" quality standard. The process followed for this purpose is similar to that which occurs within a private enterprise in that the most productive processes are standardized. In order to accomplish this, a process of documentation has been initiated in the areas of surgery and diagnosis and treatment. In this process of "dynamic documentation" manuals are continually reevaluated by professionals to determine whether they are satisfactory for meeting the proposed quality standards. The standards are then readjusted based on this evaluation. This is being done with a view to preparing the services for ISO 9000 certification, a process which will begin towards the end of the year 2000. Information about the status of the process is available (in Spanish) at the following Web site: www.galeon.com/tunalq/, which outlines the methodologies, guidelines, and special processes for certification.

Results

El Tunal has achieved good results with the implementation of the aforementioned strategies.

With regard to cost containment, the measures implemented initially were obviously effective in resolving the acute crisis, as the hospital was able to overcome that difficult period and continue operating. The cost accounting system has made it possible to determine the profitability of the various hospital services, 85% of which are currently generating revenues. The cost information system and the use of management information on an ongoing basis have made it possible to monitor productivity and make decisions about the outsourcing of some unprofitable services— for example, support services such as laundry and some clinical services such as internal medicine.

El Tunal Hospital has also experienced an increase in revenues as a result of serving a greater number of patients. Over the last three years, this increase in revenues has reduced its dependence on state subsidies from 95% to 50%. The remaining 50% of financing comes from ARSs, EPSs, ARPs, local entities, and other sources. Clearly, the hospital has moved from a situation of loss and underutilization to one in which it is generating revenues, identifying the products that place it in the best competitive position in relation to other hospitals, and making capital investments in physical plant and equipment. Some of the revenues have been invested in improving working conditions for staff through training programs. The result of the marketing policies has been an increase in services. In 1998 the volume of services provided was one fourth the volume provided in 1999-2000; in the case of

surgery, the volume of services was only 10% of the current level, [9] which reveals the extent to which most hospital services were being underutilized.

Positive results have been obtained from the implementation of strategies to increase the sale of services and improve their quality. By making the user the center of attention, these strategies have achieved patient "loyalty" toward the hospital. Currently, 80%–85% of user opinions toward the hospital are favorable. Patient care practices have also been modified. It has been demonstrated that a satisfied user will recommend the hospital to other patients.

Productivity has been improved by motivating personnel hired under the traditional modality and by increasing the use of contracts for professional services (under "productivity agreements"). The traditional hiring modality does not include any provision for measuring the volume of services produced, whereas the productivity agreement clearly establishes parameters for payment of fees based on the volume of work performed. Nevertheless, productivity has increased among both categories of employees.

5.1.2 Experiences in managing the process of transition

Strategies

The process of internal transition among the hospital staff was crucial to the hospital's success. The staff had to be persuaded to be more concerned about the productivity and quality of services. In order for the hospital to attract more users and survive financially, it had to bring about changes in the staff—a very difficult process.

In 1997, as part of the reform process, a new management team began to introduce measures that altered the status quo in the organization and had an impact on the vested interests of labor unions and some trade groups. This triggered a strike movement. The managers initially took the following actions to address the strike:

- communicated with the staff about the purposes of the modernization process and the new "rules of the game" in the workplace;
- made it known that the hospital was at risk of being closed because of its low productivity;
- drew attention to the existence of practices that were contrary to the principles of the hospital and good quality of care;
- guaranteed hospital workers job security on the condition that they end the strike; and
- established coordination with the hospital unions (currently, periodic coordination meetings are held with six unions within the hospital).

[9] According to an interview with Dr. Carlos Ariel Rodríguez, Director of El Tunal Hospital, Santa Fe de Bogotá.

As objectives for its long-term strategies, the hospital management sought to earn the staff's trust and commitment to work for the future of the hospital, and it encouraged the staff to identify with the new values of the organization, building on the old organizational culture. The values and ways of working that needed to be changed were then identified, as were the new values to be promoted, and strategies were devised to bring about the change in mentality. Through a participatory process of strategic planning, managers and staff together identified the problems in the old culture that needed to be overcome, namely: (1) non-compliance with work schedules, (2) excessive absenteeism due to illness, (3) apathy toward work and toward the hospital, (4) erection of barriers that hindered users' access to services, (5) lack of dedication to work, (6) patronizing attitudes toward patients and co-workers, (7) the concentration of power among staff engaged directly in patient care or among certain groups of professionals, and (8) lack of interest in the hospital's activities.

Bearing in mind these problems, the new values established for the hospital are: honesty in performing one's job, devotion to the work of the hospital, professional confidentiality, institutional commitment, and the human being as the final objective. New approaches to work were also identified, including the following: teamwork, more clinical and practical methods in the use of diagnostic and therapeutic techniques, a focus on patients' problems in order to reduce length of stay and costs, decentralization of hospital management to business units, and coordination with other services.

To help the staff let go of the old culture and embrace and internalize the new values and ways of working, the management used five key strategies: (1) clearly define and ensure that staff know the vision and the mission of the hospital, (2) standardize processes, (3) increase staff involvement, (4) train staff, and (5) keep staff better informed.

The activities began with a process of strategic planning to establish the vision and mission of the hospital, involving all workers. The aim was to devise a mission statement that would reflect the public nature of the organization and its commitment to provide specialized solutions to complex health problems, emphasizing humane treatment of patients.

One of the strategies for improving both the quality of care and the climate within the organization has been to involve workers in the analysis of their work processes and, based on that analysis, propose modifications and improvements. This has been a participatory process that encourages team work and relies on a participatory managerial style. To improve the organizational climate, workers have been encouraged to interact with other workers, irrespective of their status within the organization. For example, it was suggested that workers greet one another in the mornings with a touch on the shoulder—an approach that has yielded positive results.

Strategies have also been developed to provide training in specific areas such as improving interpersonal relationships, forming work teams, marketing of health services, techniques for serving clients, dealing with difficult clients, techniques for improving communication with co-workers and clients, use of free time, ESE formation, stress management, conflict negotiation and resolution, and leadership. This training has enabled workers to gain new knowledge and has also fostered more cohesive teamwork. Greater identification with the hospital has also been promoted—all with the expected result that client loyalty toward the hospital would increase.

To improve internal communications, the staff information office has utilized various audio & visual methods, including 19 notice boards distributed around the hospital,

publication of a monthly newsletter, and a hospital-wide intercom system to transmit news and messages, as well as keep staff informed of progress in the implementation of planned changes.

Results

After several years of transition, it has been possible to persuade the staff to adopt new ways of working and espouse the objective of making El Tunal "the best hospital in the country." This has resulted in greater productivity and user satisfaction, and has made the hospital one of the tertiary-care centers with the best indicators in the country.

During the transition process, workers reacted negatively to the introduction of some aspects of the new culture—for example "the six S's of quality" and the cost accounting system—although the reaction was more one of stress than of upset or aggravation. This reluctance on the part of staff sometimes slowed the pace of reform. Nevertheless, it is now clear to professional and other staff, that it is necessary to produce in order to obtain inputs and ensure that the hospital continues operating. The clinical services have adapted to this way of working and understand that keeping spending to a minimum will reduce costs and help guarantee the hospital's survival.

It has been possible to create a "common language" by means of the notice boards. The information they contain is avidly read and discussed. As a result, workers are less likely to believe gossip. Rather than gossiping, workers now spend more time analyzing the problems that affect the hospital.

The hospital physicians have also been receptive to these new values and ways of working. The doctors have become more competitive, while still retaining their traditional concern for the welfare of the patient. In addition, they have benefited from the opportunities the hospital has afforded them to enhance their knowledge, both through training activities and the availability of protocols and evidence-based tools for the practice of medicine.

The position of the nursing staff vis-à-vis the new values and ways of working has changed, primarily because the traditional hierarchical structure—in which a head nurse coordinated the entire nursing staff—has disappeared. Nurses are now assigned to the various services or business units, and the nurses in each service establish their own procedures, ways of working, and training activities. The nursing staff thus works as part of an interdisciplinary team. Nurses, as those responsible for maintaining the stock of supplies, have also benefited from the improvements in procurement procedures and availability of supplies.

In sum, the strategies implemented at El Tunal have been very effective in helping the personnel to internalize the new culture and new approaches to their work in the hospital. Although some older staff members have been more resistant to the changes than the personnel hired on a contract basis, all staff appear to be equally involved. Moreover, the hospital management is clearly concerned with maintaining cohesiveness among all workers, regardless of which contracting modality they were hired under. It is worth noting that no more strikes have occurred. There has been an obvious change in the attitudes of most staff members, and the majority are clearly committed to improving the care provided to users of the hospital.

5.1.3 Experiences in managing the external environment

Strategies

The manager of a state social enterprise has a sphere of action that is established by law with a view to fulfilling the ultimate purpose of the enterprise, the provision of effective services to the user population. Hospital managers have a presence in the political environment at the national, departmental, and district levels. The hospital remains a public entity, and the manager is responsible for seeing that it runs well. His/her ability to do so depends, in large measure, on the maintenance of good relations with public authorities, be they authorities within the Ministry of Health, the health secretariats, or local entities.

The manager must maintain a relationship of coordination with the Secretariat of Health and the Ministry of Health. Although this is not a relationship of direct subordination, these public institutions do provide support for investment in capital goods and monitoring of technical guidelines and health policies.

In the case of El Tunal Hospital, thanks to the management's maintenance of good relations with public-sector authorities, the Ministry of Health has provided support to enable the hospital to acquire x-ray equipment through a credit agreement with the Government of Spain. Through the Secretariat of Health, financing was obtained for work on the physical plant in order to accommodate the radiology service. In addition, funding is being requested from the National Royalties Fund for the purchase of computerized axial tomography, angiography, and echocardiography equipment.

The management of El Tunal has made an effort to establish relations with several organizations in the private sector, primarily through the sale of its services to groups of insurers under both the subsidized and the contributory systems, in accordance with the systems' rules of operation. In addition, the hospital, as a business, sells services to other businesses that provide services in the areas of incineration, blood bank, pharmacy, laboratory, and parenteral feeding.

The hospital has also entered into agreements with universities, both public and private, to offer practical training for human resources in the health field and to provide opportunities for training of its own staff (the hospital provides practical training for medical residents and interns, and the university reciprocates by offering courses to hospital staff).

As for relations with the community, operating the hospital as a business allows for greater participation by civil society, since, by law, citizen representatives sit on the Board of Directors and thus play a role in administering the hospital.

The community is also involved in quality assessment, especially through the participation of representatives of community organizations in administering the opinion surveys. In addition, the Association of Users participates in following up on complaints in order to ensure that they are addressed promptly and satisfactorily. In this way, the community has been involved in addressing the problem of waiting lists; it has been able to gain a true understanding of the scope of the problem and take part in solving it.

The community also participates on various committees, such as the Surveillance Committee, which verifies that projects are being executed in accordance with specifications

and plays an important role in the infrastructure projects that are being carried out. The community participates on the following committees as well:

- Committee on Community Participation
- Committee on Hospital Ethics (4 members)
- Local committee formed to analyze emergencies

Results

In addition to the normal coordination and that mandated by law, the hospital has derived several advantages from its coordination with the Ministry of Health and the Bogotá Secretariat of Health. It should be noted that the director's performance and administration have made it possible to acquire resources for investment in costly infrastructure and equipment.

The hospital has also developed mechanisms for relating with the external environment, including both private- and public-sector institutions, and obtaining benefits and a transparent interrelationship. This has translated into higher revenues and technology transfer, especially for the clinical laboratory, under agreements with companies from which technology is acquired through a loan-for-use and supply-procurement mechanism. Through specific agreements medical devices and equipment are obtained, including ventilators, electrocardiogram machines, wheelchairs, and other equipment. This has helped the hospital to gain a reputation as a prestigious health care center in which the workers are seen as competitive in the new environment of the health services market.

5.2 LA SAMARITANA UNIVERSITY HOSPITAL

La Samaritana University Hospital is located in the Department of Cundinamarca and is affiliated with the Secretariat of Health in that department. It is the only tertiary-care hospital in the area. Although it forms part of the network of services in Cundinamarca, it is located on the fringes of the city of Bogotá and many of its users therefore come from the District of Santa Fe de Bogotá.

In 1995, the hospital was on the verge of being closed owing to underutilization, coupled with deterioration of its physical plant and obsolescence of it equipment. It was even proposed that it be sold to the private sector. In response to this situation, a new management team took over administration of the hospital with an eye to salvaging it and converting it to a social enterprise of the State, which occurred in December of that same year.

With the support of the government of the Department of Cundinamarca, a plan was implemented to revitalize the hospital, revive services that had been closed, restart surgical activity and reopen closed floors, and give special emphasis to the emergency room, which was the gateway for more than half the hospital's patients.

5.2.1 Experiences in implementing the new market approach

Strategies

The new managerial team realized that, in the context of hospital reform, focusing on "the market" and competing effectively would be very important for the survival of La Samaritana Hospital. The team launched a plan to introduce a series of shock measures to contain costs as one of the short-term strategies for improving the hospital's efficiency. The short-term strategies were aimed at regulating the use of inputs by modifying the basic supply of drugs, reducing the amount of drugs, and curbing waste. A plan was also drawn up to reduce the use of paper and rationalize use of utilities such as water, electricity, and telephone (especially cellular telephones). In the area of human resources, measures were proposed to decrease staff overtime, reduce the number of supernumerary workers, eliminate duplication of staff functions, increase the number of productivity agreements, and outsource billing and some clinical services, such as renal dialysis.

At the same time, to prepare for the long term, a process of strategic planning was carried out to identify strategies for increasing hospital revenues. The key strategies on which this plan was based were: (1) enhanced productivity, (2) improved billing and financial control, (3) promotion of the hospital's services, (4) diversification of financing sources, and (5) improved quality of services.

To improve productivity, the hospital management team implemented a gradual conversion of hospital services to productivity agreements. Under these agreements, the professionals involved, individually or collectively through the formation of professional corporations, would sell their professional services to the hospital. The services included were anesthesia, plastic surgery, gastrointestinal medicine, diagnostic imaging, endocrinology, neurology, urology, otorhinolaryngology, neonatology, pediatrics, gynecology/obstetrics, social work, and physiotherapy. The advantage of this type of contracting is that improvements in productivity are achieved by making better use of the hospital's infrastructure and equipment; in addition, it is associated with gains in the time and dedication of medical staff. It also affords the possibility of higher earnings for the professionals because a direct relationship is established between volume of work performed and income. Another measure implemented was the establishment of minimum production levels for each service, with close monitoring under management commitments between the manager of the hospital and the heads of the various departments (these commitments are described in greater detail below).

To improve billing and provide sales and post-sales follow-up on services rendered, a unit was created to handle billing, manage the portfolio of services, and deal with billing problems (invoices not paid owing to inconsistencies and errors in their preparation). In order to improve billing and cost recovery, it was necessary to establish the principle that all services are billable, which meant raising awareness among the doctors of the need to collect the information required to achieve an accurate billing process.

The hospital also developed strategies for marketing its services, including studies of demand and formulation of plans for the promotion of services among the EPSs, ARSs, and ARPs. As in other hospitals, a marketing unit was created to determine demand and promote the hospital's services more efficiently, in particular the portfolio of services already developed.

In addition, business units were created, establishing potential supply by means of a package of services for each unit. The hospital is making an obvious effort to respond to demand by analyzing the affiliations of the inhabitants of the *municipios* of Cundinamarca in order to determine their health needs and draw up a proposal—to be presented to the EPSs, ARSs, and ARPs—to tailor the hospital's supply of services accordingly. These measures are aimed at diversifying the sources of financing in order to reduce the income obtained from the Cundinamarca Secretariat of Health in the form of supply subsidies. The aforementioned study analyzed which ARSs and which EPSs cover the population of the 117 *municipios* in the Department of Cundinamarca. It showed that the largest EPS is the ISS, which covers 66% of the population enrolled in the contributory system and that 6 ARSs cover 71% of the population enrolled in the subsidized system. This knowledge will make it possible to carry out a more informed marketing effort and present to these ARSs and EPSs packages of services that the hospital would be willing to supply at competitive prices.

Activities were also carried out with ARSs and EPSs to ascertain their perceptions of the hospital and then address the weaknesses and limitations they pointed out.

Shifting the hospital's orientation toward sale of services also required changes in patient accommodations in order to make the rooms more comfortable, for example by converting them to one- or two-person rooms and offering special services such as private baths and television.

Assuring the quality of the services provided was considered crucial to increasing the hospital's revenues, given that the Colombian health system allows freedom of choice by users. To that end, the hospital has implemented several strategies. To enhance technical quality, quality assurance programs are being implemented, as are the essential requirements established by the Ministry of Health. Guidelines for the management of health problems and audit procedures are also being developed.

An innovative strategy that has been used in this hospital to improve the treatment of patients—as part of the effort to enhance quality—is the evaluation of "moments of truth," which are the times when the patient comes into contact with the various hospital services. The evaluation yields detailed information about the weaknesses and problems in the patient's contact with hospital services and staff, which can be used as a basis for designing improvements in work processes. This experience is discussed in greater detail below.

Daily monitoring of the clinical, administrative, and operational activities of the hospital through end-of-shift meetings makes it possible to take the pulse of the hospital on a daily basis and is an example of the day-to-day management that has been implemented in this establishment. The end-of-shift meetings are held daily and are attended by the hospital director, the heads of the various departments and services, and key personnel in the area of supplies. During these meetings, the night shift managers, using a standardized format, report on what has happened during the night, and the heads of service make decisions about how to address the problems that have arisen. This practice yields immediate results, since it serves to rapidly identify the highest-impact problems and enables the hospital's upper management to analyze them and take appropriate action.

The hospital management has made user satisfaction a priority, creating a Department of User Care to analyze users' opinions, complaints, and suggestions at the highest level of the organization. This department was responsible for designing the User Information and Care System (*Sistema de Información y Atención al Usuario – SIAU*) to process complaints and

opinions. Patients receive a form for submitting complaints. The complaints are then analyzed and followed up, and a written response is sent to the user. In addition, the measures taken in response to complaints are subsequently incorporated into the hospital's strategic plans. This department is also responsible for conducting surveys in the area of outpatient care in order to analyze the "moments of truth" mentioned above. These surveys are carried out on the floors, evaluating the opinions deposited in the four suggestion boxes placed at key points in the hospital: the radiology department, the main entrance, the second floor, and the fourth floor. General user satisfaction surveys are also conducted periodically.

Other measures implemented include making available an 800 number to patients so that they can call or receive calls from their families and monitoring of indicators such as wait time, timeliness of care, length of hospital stay, and services denied (i.e., the patient leaves the hospital without receiving services). Another initiative is a program in which the attending physicians meet with patients' family members to inform them of the patient's status and course of treatment; these meetings are held every day from 3:00 p.m. to 4:00 p.m. in each of the services.

Results

The results in terms of cost containment have been limited owing to the hospital's high benefit liability. With the policies implemented, there is a point at which costs cannot be reduced any further unless contracting modalities are changed, not only for professional staff, but for hospital workers in general. This is the challenge the hospital faces at present. Its financial statements have shown negative net revenues for the past two years, although for 1997 it did register a profit, which was invested in infrastructure improvements, training, and equipment. One of the reasons for this unfavorable result is the increase in uninsured patients whose care generates expenses that are very difficult to recover.

As for the measures to improve productivity, indicators of length of hospital stay, cancellation of surgeries, and rate of unnecessary tests have been designed. A gradual improvement in the evolution of these indicators has been noted. Bed use has become more versatile. Beds are no longer assigned to specific services; instead, they are assigned according to demand. An increase in productivity among both regular staff and contract workers has also been observed. The motivation of the hospital staff has made it possible to respond to demand, adhere to schedules, and analyze the output of each service in the hospital in order to have the best information possible for decision-making.

The success of the strategies aimed at boosting the sale of services has resulted in an increase in the number of contracts with some EPSs and a decrease in contracts with others, which has prompted efforts to put together a case mix that will make the hospital more attractive to the EPSs and ARSs. The net result has been an increase in the number of patients, which is also linked to the efforts to promote the hospital.

The efforts to increase user satisfaction have also produced positive results. There has been a decrease in the number of complaints and an increase in satisfaction rates, which currently stand at over 90% in all areas of the hospital. The surveys that are periodically conducted among patients who visit the hospital evaluate patients' perceptions of how they were treated, clarity of the information supplied, and promptness of care for several points of contact between patient and hospital. Staff-patient interaction is also more closely monitored

and has improved. Staff members recognize that if a patient complains about them, there will be a response, and they may be subject to sanctions.

5.2.2 Experiences in managing the process of transition

When the new executive management team took over, the atmosphere at La Samaritana was marked by pessimism and an inability to think and work in innovative and creative ways. There was also a lack of communication and participation on the part of staff, and internal information did not flow down to all personnel strata within the hospital. Various strategies were implemented to encourage staff to let go of the previous culture and assimilate the new values of honesty, commitment, tolerance, professionalism, and punctuality.

One strategy was to improve communication and participation by workers within the hospital, making use of several means such as notice boards distributed around the hospital, regular news bulletins, and videos explaining the conversion process. For example, each service has indicators, established by the service staff themselves in collaboration with the hospital management, which are posted on notice boards located in clearly visible places within the service. This gives everyone the opportunity to see performance indicators and share the success from the results of their work. Moreover, the staff are motivated to try to improve in areas where indicators reveal deficiencies.

The staff's participation in developing the strategic plan and the new vision and mission for the hospital enabled them to identify with the process of change and also feel involved in solving the problems associated with the process. Based on an internal strategic analysis, which pinpointed strengths and weakness, and an external analysis, which identified opportunities and threats, it was possible to formulate a diagnosis and develop some objectives for the hospital, as well as a detailed plan for overcoming the key weaknesses identified. Those weaknesses were the low scientific and technological capacity of the hospital, deficiencies in financial management systems, limitations in patient care and quality of the services provided, lack of adequate information systems, ineffective operation of the network of services, poor performance of workers, and inadequate availability of supplies.

The plans proposed to address these problems were developed by the hospital authorities, who also closely monitored their implementation. They created programs that enabled them to develop human resources and improve processes—especially those related to the provision of emergency services, and non-urgent inpatient and outpatient care. The hospital's financial management and its teaching and research capacity were also strengthened. This exercise clearly revealed the future challenges for the hospital with regard to the improvement of quality, operation of the network of services, and need to formulate an incentives policy to enhance productivity. The new management team used priority-setting by means of the Pareto method during the initial stage of its work. With this quantitative approach it was possible to identify 20% of the causes responsible for 80% of the problems in a given situation or department, which served to focus efforts on priority problems.

Another strategy implemented was the signing of management commitment agreements between the director of the hospital and the department heads. These agreements establish the responsibility of the department heads for meeting the objectives set out in the strategic plan and adhering to the policies and procedures concerning programming, coordination, supervision of programs that ensure the provision of health services, as well as coordination of academic, patient care, administrative, research, and managerial activities, in order to

achieve the productivity goals of their respective departments. The management commitment agreements contain specific objectives which clearly point out the importance of participating in the evaluation of services and promoting interdisciplinary work within the hospital and interinstitutional coordination with regard to educational, research, and community activities.

The agreements also establish the obligation to promote timely acquisition of resources and ensure updating and dissemination of processes, standards, and procedures manuals. The department heads are responsible for explaining the scope of the management commitment to their staff and informing them of the expected results, making the workers understand that their remuneration is linked to the achievement of results and thus creating an awareness that if the staff does not produce, the hospital will not be able to survive in the medium term.

Each service establishes the targets for each of the indicators, which are monitored and evaluated at the end of the period. The indicators used are listed below:[10]

Number of discharges per service	Proportion of canceled surgeries
Average length of stay per service	Prolongation of prior surgery
Number of outpatient consultations per service.	Surgeon not on time
	Change of diagnosis
Number of interservice consultations per service.	Inadequate preparation of patient for surgery
Number of elective surgeries scheduled	Prolongation of surgical time
	Rate of nosocomial infections
Number of outpatient surgeries	Number of complaints resolved
Number of emergency surgeries	Evaluation of quality of clinical records
Waiting time for first outpatient appointment	Effectiveness of response in assessment of emergencies
Waiting time for elective surgery	Effectiveness of response in interservice consultations
Mortality rate of the service	
	Number of iatrogenic problems resolved

A cost accounting system for services rendered is just being introduced in the hospital. As of the date of this study, tests and exercises were underway with the different parties involved for the purpose of establishing comparisons between departments, determining the consistency of information, and formulating the ground rules for introducing a culture of costs. Once specific information is available about each department and its position with regard to its production break-even point, the necessary adjustments will be made and the cost information will become useful for decision-making and for benchmarking with other services in other establishments.

The hospital has encouraged management training for the entire executive management team and the department heads. To that end, facilities have provided executives with university training through courses that are suited to the needs of the hospital and, in some cases, through established scholarship programs. This training has led to improvement in

[10] Management commitment agreements with department heads of La Samaritana Hospital, 1998.

managerial capacity within the hospital, since with larger numbers of trained managers, a group of professionals who understand the language of business management has been created, and it is easier to introduce the new culture among this group. An example of this is the implementation of several management committees, which serve as the forums within which decisions are made and the hospital is actually managed. The Steering Committee meets every Monday and includes the heads of all departments and services and representatives of workers hired under productivity agreements. In this committee, the hospital's most important problems are reviewed and educational activities are carried out in the areas of managerial techniques, information systems, quality, costs, and leadership, among others. The problems are thus analyzed by each department manager and the tasks to be undertaken during the week are planned.

Management committee meetings are also held at the level of each department and service. These meetings are devoted to seeking solutions to problems and monitoring implementation of the proposed solutions, for which each manager is accountable. These meetings also serve as a means of reinforcing the hospital's values, especially when any difficulty arises, such as an increase in tardiness or other employee conduct problems. Managers are continually encouraged to model the desired values. There has been a gradual shift from a culture of "emergency management," in which managers spent their days "putting out fires" and in which problems were addressed only when they were urgent or had reached crisis proportions. Instead, in the management meetings, the managers now address substantive issues of long-term significance for the hospital, which previously were put off for lack of time.

In the area of quality, various measures are being taken to improve the treatment of patients, the timeliness of care, and the technical quality of the services provided. Workers are increasingly aware that the future of the hospital depends on the number of users who seek its services. Obviously, a user who feels he/she has been badly treated will not return or recommend the hospital to others. In the sphere of quality assurance related to the timeliness of care, a system has been put in place to streamline clinical appointment and record-keeping processes. As for technical quality, the essential requirements formulated by the Ministry of Health are currently being implemented, although considerable resources—which the hospital does not presently have—will be required in order to achieve full implementation. In addition, the management commitment agreements set certain quality parameters, especially in relation to nosocomial infections, hospital mortality, complications, and timeliness of surgical procedures. Thanks to the efforts to promote a culture of quality, hospital personnel are more conscious of the fact that the hospital's primary responsibility is to the patient, and this has given rise to a greater sense of devotion to the hospital.

Results

La Samaritana Hospital did not develop any specific plan to guide workers in the hospital's conversion to a state social enterprise, but initiatives were implemented during the process that were useful for addressing the priority needs associated with the change. Although the hospital's values have been set down in writing and are enshrined in the corporate principles of the hospital, it will still take some time before they become part of the daily routine. More concrete and explicit incentive mechanisms are needed for that purpose. Nevertheless, it is clear that the workers have understood the threat of insolvency and are working on improving billing, treatment of patients, and encouraging a culture of quality in the treatment of patients and their fellow workers.

The strategies for boosting productivity have created a culture oriented toward the use of indicators for management. The most widely used indicators are length of stay (days), timeliness of care, staff per bed, bed turnover, hospital mortality rate, and occupancy rate. This makes it possible to draw comparisons between departments, seek explanations for differences, and follow through on corrective measures. Work processes within the hospital have also been enhanced through the introduction of standardized processes and the establishment of clinical protocols that help personnel to be more productive.

The strategies for creating a culture of cost recovery have also yielded results by encouraging staff to focus more on billing, avoiding collection problems due to faulty invoices, and making it clear that the hospital's survival depends on the sale of services. Each worker is aware of the need to keep track of billing information, without forgetting that the patient comes first. In the case of management, there is awareness that the source of payment for each patient should be identified.

La Samaritana's situation has improved since 1997. While labor unions are active in the hospital, no strike movements involving the whole hospital have occurred, although there have been targeted strikes with very concrete demands or, occasionally, strikes to support causes outside the hospital. In general, hospital staff feel comfortable working in the hospital with the prospects offered them. Given the critical labor situation in the country, there is little job mobility and staff turnover due to dismissals is very low. In 1999, according to official data from the *Boletín de Indicadores de Gestión* [Bulletin of Management Indicators],[11] the number of discharges from the hospital increased by 10% compared to 1997. During the same period, outpatient visits increased 16% and surgeries increased 23%, while emergency visits decreased 13%. Some indicators of use of hospital beds have also risen. For example, bed turnover increased 18% and occupancy rate rose 1.4%. At the same time, average length of stay decreased by 18%.

5.2.3 Experiences in managing the external environment

Strategies

The La Samaritana Hospital has made an effort to coordinate with the public sector, the private sector, and the community. With the public sector, it collaborates first with the Secretariat of Health of the Department of Cundinamarca. This support basically takes the form of financing for the care of uninsured patients with limited resources. The second level of coordination with the public sector is with the Ministry of Health, which serves as the regulatory and policy-making entity for the sector and is responsible for setting policies and standards for the treatment of patients. For example, based on the epidemiological situation, guidelines are established for the diagnosis and treatment of certain pathologies that are important for public health. The Ministry of Health also sets general policies for the regulation of the sector, especially with regard to the operation and accreditation of establishments, both public and private. With the Ministry of Energy the hospital is collaborating on the implementation of a project aimed at conserving energy in the hospital.

[11] Ministerio de Salud de Colombia. Programa de Mejoramiento de los Servicios de Salud, Indicadores de Gestión 1997–1999. Hospitales de Tercer Nivel. [Ministry of Health of Colombia. Health Services Improvement Program, Management Indicators 1997–1999. Tertiary-care hospitals.]

This pilot program is being carried out with technical assistance from the Ministry and is expected to yield positive results in terms of greater efficiency in energy use.

The hospital is coordinating with the private sector in two areas. In addition to its relationship with private entities through the sale of services under the contributory system, a program for the sale of health services to private companies is being implemented. In this program, a company contracts with the hospital to provide health services to its employees. This type of program, which might be termed "company medicine," has been implemented thus far in three companies in the Cundinamarca area with positive results.

The other area of external coordination is with universities, both public and private, which takes place through the hospital's Education Department. The hospital has signed agreements for training of health professionals at both the graduate and post-graduate levels in medicine, nursing, nutrition, administration, and management. In fact, the hospital is considered a pillar of medical training in the Colombian community, both for its educational tradition and for its level of research and the academic caliber of many of its specialists. In the coordination with universities, the aim is for the hospital to provide practical training, while at least recovering the costs incurred.

A project known as "City of Health" is currently being designed. This project takes advantage of the existence of eight hospitals in the vicinity of Avenida Primera in the city of Bogotá. In addition to Hospital Universitario La Samaritana, the hospitals include the Cancer Hospital and the Dermatology Hospital. These hospitals have deep roots in the Colombian community and are also known internationally. The main idea of the project is to put together a combined portfolio of services to be offered both at the national and international levels. Some examples of the services are treatment of cancers such as bone cancer and minimally invasive surgery. This project also includes an urban renewal component, which calls for improvement and rerouting of streets, creation of green spaces, restoration of historic sites, and construction of new housing.

Coordination between La Samaritana and the community occurs through the Cundinamarca Users Association. This association is represented on the Board of Directors of the hospital and carries out the functions established by law for social enterprises of the State. The association is active in nine hospitals located in the Department of Cundinamarca. Through an information system, opinions, complaints, suggestions, and other information on patients is collected from the entire network of services, and it is then analyzed at the regular meetings of the association. Every three months a meeting of association and hospital representatives is held. At this meeting matters of concern to La Samaritana are discussed and decisions are made through the Department of User Care. The Users Association is also consulted with regard to major issues affecting the hospital; for example, it was actively involved in 1995 when a proposal was put forward to sell the hospital.

Two volunteer women's organizations are also involved in hospital activities. A women's auxiliary group provides support to patients who require special assistance for their diagnosis, treatment, and care, and a Chilean women's organization has taken responsibility for remodeling and maintaining one of the hospital's surgical wards.

Results

Although the hospital does coordinate with the Secretariat of Health of Cundinamarca and with the Ministry of Health, it is an autonomous and decentralized entity of the State. According to hospital authorities, this has enabled it to ensure that decision-making is guided by technical considerations, not political considerations as was the case before. This has enhanced the hospital's operation significantly.

It is clear that the hospital benefits from being an academic center for the training of professionals in the health sector. This serves as a stimulus for research and an incentive for the professionals involved, and provides a center of excellence for the trainees. However, the strategies proposed to cover the costs of this activity are still being worked out through a long process of negotiation and implementation, and thus far the only concrete benefit obtained has been an exchange of scholarships for hospital personnel.

The involvement of the community benefits the hospital by enabling it to respond to needs expressed by the community with regard to its services. The oversight function of the Cundinamarca Users Association has led to improvements in the quality of services and effective community participation in the management of the hospital.

5.3 SIMÓN BOLÍVAR HOSPITAL

Simón Bolívar Hospital is a tertiary-care hospital of high complexity, located in the northeastern zone of the city of Bogotá. It is near several poor and heavily populated districts, and a large proportion of its user population is uninsured. Because it is also located close to several major highways, the hospital is frequently called on to treat accident victims.

This center can be seen as the prototype of a large public institution that is entering the conversion process with a series of fixed financial charges, since most of its expenses are for payroll and most of its workers are public servants. This hospital has undergone a process of gradual conversion, with no abrupt changes.

The cornerstone of the hospital's strategy for its conversion to a social enterprise of the State has been promotion of the development of human resources and reinforcement of its scientific, technological, and infrastructure bases. The conversion process began in 1998 under the leadership of a new management team and with an orientation toward excellence.

The incoming management team began by implementing a series of measures aimed at adapting to the new rules of the game imposed by the reform, and it also took action to prepare for the long term. A process of strategic planning was undertaken to establish institutional policies.[12] This process led to the adoption of management policies that emphasize excellence as the essential motor for enhancing quality and establish an organizational culture in which it is clear that the hospital's raison d'être is the patient.

Policies on patient care were formulated taking into account the health problems most frequently treated in the hospital, i.e., problems associated with violence (owing to the

[12] Redimensionamiento Estratégico, Plan de desarrollo 1988–2001. [Strategic Reorientation, Development Plan 1988–2001]. Hospital Simón Bolívar. Santa Fe de Bogotá; 1988.

hospital's location in a high-risk area), cardiovascular problems, and maternal and child health problems. This treatment focus earned the hospital a reputation as a specialized center offering highly skilled care.

The hospital's educational policies emphasize training of its own human resources and provision of practical training for health professionals.

Its management policies are oriented toward promoting self-direction and a sense of ownership among hospital workers.

The policies on quality are aimed at monitoring compliance with the essential requirements proposed by the Ministry of Health, development of a system for responding to complaints and suggestions from users, and enhancing the quality of medical documentation.

The hospital's policies on management of human resources are aimed at motivating and training hospital personnel.

Its policies on occupational health seek to ensure the quality of the work place, and prevention of occupational accidents and illnesses.

5.3.1 Experiences in implementing the new market approach

Strategies

In order to address the new challenges that the shift to a market orientation entailed, strategies were promoted to reduce costs, increase revenues, and offer services of better quality. These strategies have been implemented gradually and have served as a motivating force for the hospital's management team. The policies implemented are described in greater detail below.

With a view to optimizing the length of hospital stays and reducing unnecessary days—and consequently costs—of hospitalization, a medical audit program has been implemented. The program focuses on the evaluation of clinical records, orders for laboratory tests and imaging studies, and length of stay. It seeks to ensure that patients' stays are not prolonged due to administrative problems. Another aspect of this program is the formation of ad hoc commissions to examine cases in which there may be problems of technical quality that may have legal repercussions. Quality in clinical practice is also promoted through the use of protocols for the management of the most frequent and/or costly problems.

Another strategy has been a staff review aimed at evaluating performance and setting objectives, with professional staff and their respective supervisors agreeing on work load and working hours. This has made it possible to determine the potential capacity of the services. Monitoring is carried out on the basis of this potential capacity in order to identify and determine the cause of shortcomings, and gradually approach optimum output levels. These measures have prevented duplications in hiring of professional staff and have had a positive impact on the hospital's costs.

As in the other two hospitals studied, a series of initial measures were taken with regard to the management of general services, that helped bring down costs. In the case of Simón

Bolívar Hospital, efforts to promote savings of electricity, water, and telephone services yielded positive results, as evidenced by decreases in the consumption of these services. The vehicle fleet was renovated through the addition of more efficient vehicles, the hours of boiler operation were restricted, and rational use of ambulances was promoted. Another successful measure was the diversification of packages of surgical instruments, with the inclusion of only the instruments necessary for specific procedures.

A major challenge facing the hospital was that of increasing revenues. Several key strategies were implemented with the aim of: (1) improving productivity, (2) promoting the hospital's services among EPSs and ARSs in order to diversify sources of financing, (3) improving billing and financial control, and (4) enhancing the quality of services. To improve the productivity of services, operational plans have been prepared for each service, identifying the inputs and human resources needed. These plans have been evaluated by the professional staff and their respective supervisors, who will be responsible for achieving the targets set and identifying the constraints that will limit execution of the plans. Decentralizing responsibility for evaluation to those directly involved enables the services to function as independent budget execution centers or "business centers." As a result, "work commitments" are now established between each professional and the head of the service, based on the number of hours that the professional has been hired to work for the hospital. Satisfactory performance under these agreements is rewarded with credits for training activities and possible promotions. The decentralization of professional staff has also involved nurses, whose position has changed within the organizational structure of the hospital; rather than coming under a central nursing department, they are now part of each service, which functions as a business unit. To motivate staff to improve productivity, the hospital management promotes the practice of comparing indicators with those of other establishments, which has enabled the hospital to engage in processes of benchmarking with hospitals having high standards and thus improve its own practices. A combination of indicators is used to evaluate the services in terms of quality, use of services, and administration of contracts. The most important ones are mortality rate, nosocomial infection rate, surgery cancellation rate and reason for cancellation, average length of patient stay, bed turnover rate, number of procedures performed, number of outpatient visits, number of discharges and readmissions, and financial indicators such as unbilled charges and number of faulty bills each month. As in the two previous hospitals, priority has been given to using strategies to raise awareness of costs among employees.

The other key strategy for increasing revenues has been promotion of a new relationship with financing entities in order to reduce dependence on the budgetary funds traditionally contributed by the Secretariat of Health. Measures have been introduced to increase contracting with the EPSs and ARSs. As a result, the number of contracts has risen from three to forty; contracting with ARSs, in particular, has increased. The measures taken include improvement of contractual mechanisms in order to more clearly specify the obligations of each party. Rather than attempting to increase the volume of patients, the hospital has focused on improving the capacity for billing the local entities and the ARSs, especially by reducing the number of faulty and uncollectible invoices, establishing contracts to cover the uninsured, and identifying the source of financing for each patient who enters the hospital. To speed up payment from the ARSs, an agreement has been reached to maintain two auditors in the hospital to review all invoices and avoid the return of invoices due to administrative errors.

Another strategy for boosting revenues has been marketing of services in the areas in which the hospital is most competitive, including burn care, care of patients with HIV/AIDS, and intensive care. Promotional activities are carried out by each of the services and

departments. In HIV/ AIDS and burn care units, hospital personnel work with the family to explain the care that the patient requires and the possible complications.

To make the hospital more appealing, strategies have been implemented to improve the basic accommodations, including repairs to the roof, walls, and floors, although financing constraints have prevented the hospital from making large capital investments.

To improve the quality of care, the hospital management team has employed a series of strategies to address both the human factor in the quality of patient treatment and the technical dimension of quality. A bioethics committee has been formed to promote humane treatment in the hospital. This committee carries out activities and programs to help staff treat patients well, and understand the stresses that patients and their families undergo during an illness. Programs have also been designed in which staff "adopt" patients, whom they visit while the patient is hospitalized. This program, which is called "Adopt a patient: Open your heart and put yourself in the patient's place," gives patients the opportunity to converse with a hospital staff member and receive comfort and encouragement regarding their condition.

To improve the timeliness of care, in the administrative area special patient service windows have been opened for specific groups such as senior citizens, pregnant women, and women with children. The management team and the departments and services, functioning as business units, monitor a series of quality indicators, which include length of hospital stay, nosocomial infections and complications, and cancellation of surgeries and causes of those cancellations. The hospital has also applied for accreditation from the Secretariat of Health so that it will have a license to present to the EPSs and ARSs and thus obtain more contracts to provide services to patients from the district of Santa Fe de Bogotá. As another of the measures taken to promote excellence, the hospital is working on meeting the requirements for authorization by the Secretariat of Health to sell its services to that entity under more favorable terms and become a member of the Secretariat's network of service providers.

To improve relations with users, the hospital decided to open an Office of User Care, overseen by professionals in social work. Its function is to process complaints and opinions received by telephone, in writing, or in person. Forms are available near suggestion boxes for patients to submit their opinions and complaints, which are followed up. There are eight boxes for the collection of suggestions and complaints, 95% of which are submitted anonymously. Experience has shown that the comments received are both positive and negative. Bimonthly meetings are held with representatives of the community (through the Users Association) to analyze complaints submitted by users who identify themselves. These are studied and the patient receives a written response signed by the director of the user care unit.

Results

Administrative, financial, and technical functions have been separated within the hospital in order to emphasize billing and marketing, avoid faulty invoices, and separate these processes from the provision of health services. An administrative department is responsible for management of human and technology resources, the physical plant, and information. The commercial-financial department is responsible for relations with health care financing entities and for the effectiveness of efforts to attract additional resources.

Since the cost accounting system is still being adjusted and has not been fully implemented, information on costs is not utilized very extensively for decision-making. The main achievement in the area of costs is that the staff are now talking about costs, are aware of the need to reduce waste, and are actively involved in billing activities.

The hospital has reduced its dependence on funding from the Secretariat of Health from 80% to 65%,[13] and it intends to continue this trend in order to decrease the proportion of financing it receives from the public budget. The 10% increase in new patients is mainly the result of an improvement in systems for identifying the sources of payment for services. The function of the commercial-financial department is to monitor what the services have committed themselves to sell and ensure collection of the corresponding invoices. Positive results have been obtained, as evidenced by the fact that invoicing times and the number of faulty invoices have been reduced, and personnel have become conscious of the need to accurately record the services provided in order to be able to bill for them.

Owing to limitations in the availability of data, it has not been possible to fully asses the progress made toward the proposed goals for sale of services. Nevertheless, based on estimates of the potential capacity of the services and departments, staff productivity has increased.

The management holds meetings with each service to analyze the evolution of the indicators, audit reports, and monitor the operational plans. If it is found that the expected productivity levels are not being achieved, the indicators are assessed and the reasons for the problems encountered are analyzed. Problems are not left up in the air; the causes are sought and the individuals concerned are encouraged to participate in solving them. It is in this way that a decrease in length of stay was achieved and the bed turnover rate was increased. In 1999, the hospital, which has 314 beds, registered 15,080 discharges, which represented an increase of 23% with respect to 1997.[14] Outpatient consultations have increased 64%, emergency visits are up 28%, the number of surgeries has grown 40%, and the bed turnover rate has risen 18%, while the average stay has become 8% shorter.

It has been possible to make some infrastructure improvements with the resources available—for example, increases in the numbers of baths and repairs to damages in the walls and roof. In the organization of the hospital, selective patient service windows have been established and a take-a-number queuing system has been installed. These measures are aimed at reducing the patient's wait time as much as possible. Administrative procedures have also been simplified, both for inpatients and outpatients. Medical appointment schedules have been modified, and users' opinions have been incorporated into the hospital's plans and day-to-day management. Positive results have been obtained, since the number of complaints has declined, as has the number of lawsuits filed against the hospital for poor treatment of patients. Currently, the greatest source of dissatisfaction with the hospital has to do with the amounts charged to uninsured patients.

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[13] According to an interview with Dr. Carlos Rada, Director of Hospital Simón Bolívar.

[14] Ministerio de Salud de Colombia. Programa de Mejoramiento de los Servicios de Salud, Indicadores de Gestión 1997–1999. Hospitales de Tercer Nivel. [Ministry of Health of Colombia. Health Services Improvement Program, Management Indicators 1997–1999. Tertiary-care hospitals.]

5.3.2 Experiences in managing the process of transition

Strategies

The hospital has clearly established the new values to be promoted among workers, namely: commitment, discipline, service, quality, and responsibility, as well as the principles of loyalty, ethics, honesty, justice, solidarity, humaneness, and excellence. It has also identified the main undesirable aspects of the prior culture to be overcome: confusion of the worker's own values with those of the hospital and failure to recognize that a supervisor and co-workers are necessary to achieve the proposed goals.

The hospital is promoting new ways of working oriented toward ensuring its long-term survival. It has been emphasized that workers should not think solely in terms of immediate issues, such as the possibility of losing their jobs, but of the need to sustain the hospital as part of the community in the future. This means understanding and becoming conscious of the fact that the hospital must survive on what it produces. Using the hospital's problems as a means of motivating the entire staff to join in the search for solutions has been one of the objectives proposed by the management. This has been achieved through creation of business units, which afford the staff of each unit the possibility of devising solutions to their own problems. Staff have been encouraged to think of the cost of not providing quality services and bear that in mind as they perform their daily tasks.

Strategies for letting go of the past have been implemented through the use of monitoring indicators by all hospital managers. These indicators are disseminated so that people know what is happening in the hospital.

Prestigious leaders have been enlisted to serve as agents of change and talk with staff in their daily work about issues relating to the hospital's conversion. These leaders are persons of national renown in the clinical domain.

Workers have been encouraged to use methodologies to analyze causes of problems and identify solutions through their work teams. In addition, supervisors have been urged to listen to and support their workers when they voice complaints and concerns.

A strategy of great importance is the timely payment of workers' wages, especially in the current context of economic crisis in which workers frequently experience cash flow problems.

The need to put the patient first has been stressed. Workers understand that patients are free to choose to come to the hospital or not. Therefore, everything possible should be done to ensure that patients are satisfied with the services and the treatment they receive in the hospital.

The manager or department heads take advantage of each contact with the staff to provide information and foster transparency. The manager holds a question-and-answer session every month so that the employees can inquire about matters that concern them. At these sessions, the participants also discuss the progress achieved, the problems confronting the hospital, and measures being taken to solve them.

Results

There have been obvious changes in the climate within the organization. Fewer and fewer workers appear troubled by these changes and the mechanisms for measuring the activity of both professional and non-professional staff. Hospital workers have come together to look for solutions to the hospital's problems. The labor unions have acknowledged that some of the measures have had a positive impact. The work stoppages that have occurred have been in solidarity with other unions outside the hospital, not for internal reasons. Unlike the situation that prevailed several years ago, in which work stoppages in the hospital were frequent, there is now evidence of a culture of respect and appreciation among workers.

The workers also understand the consequences of failing to perform their duties as expected; they know that they may be subject to disciplinary action and that the sanctions may include dismissal. This occurs especially when there are deficiencies or problems in the direct care of patients. However, it has been observed that staff turnover is not high and, owing to the scarcity of employment opportunities, there is a tendency among employees to perform well in order to keep their jobs.

The doctors have expressed positive opinions toward the changes and toward the measures implemented in the organization of services to make them accountable to management and to the work teams. However, they consider the bureaucratic procedures excessive and believe that they require professionals to spend too much time filling out forms, which takes away time that they should be spending on patient care.

The nurses say that the changes have been positive for patients, especially the emphasis on humane treatment. It is recognized that the hospital is now bringing in more resources. The nurses play a very important role in the billing process since they are responsible for quality controls.

Decentralization of the Nursing Department has resulted in differences in the organization of shifts, training, and work procedures. There are now no nursing supervisors per se; rather, a team leader is designated for each work team in each business unit.

5.3.3 Experiences in managing the external environment

Strategies

The hospital has established agreements with the private sector to provide practical training for students who are at various stages of their medical education at several universities.

Another area of coordination with the private sector has been meetings with the hospital's suppliers to analyze the purchasing and payment process with a view to streamlining the delivery of supplies and payment of invoices. The aim of these efforts has been to create a "win-win" situation and demonstrate the advantages of establishing a private-public collaboration based on mutual trust and knowledge.

The mechanisms of coordination with the public sector are based on the hospital's normal interrelationship with the Secretariat of Health and the Ministry of Health, which are

established by law, as well as its dealings with the local entities for the treatment of uninsured patients. It has also coordinated with foundations for the care of abused children and accident victims and, similar to its collaboration with private universities, it has entered into arrangements with public universities to provide practical training for health professionals. In addition, the hospital has joined with other providers in forming a network and designing an innovative and comprehensive portfolio of services.

As for mechanisms of coordination with the community, by law, representatives of the community sit on the hospital's Board of Directors. One of the priorities of the Users Association has been to channel patients' complaints and try to reduce long wait times in some of the hospital services.

Additionally, volunteer women's groups take responsibility for procuring medications for some patients and organizing fund-raising activities for the hospital.

Results

The hospital has been able to find new ways of relating to suppliers of inputs. In a context of economic crisis, this has enabled the hospital to create favorable conditions so that the it is assured of having the inputs it needs when it needs them. Moreover, suppliers receive payment more promptly.

As for relations with the Ministry of Health and the Secretariat of Health of Bogotá, positive results have been obtained with regard to technical support. The greatest concern of the regulatory entities is that the hospital maintain a balanced financial position and not generate instability as a result of conflicts or poor relations with the community and between the various political forces.

Positive relations have been fostered with several community groups that coordinate with the hospital, for example through active involvement in problems and matters affecting users, including waiting lists, problems with the availability of pharmaceuticals, and support for the introduction of programs to promote humane treatment.

6. CONCLUSIONS AND LESSONS LEARNED

The conversion of Colombian public hospitals into social enterprises of the State is an ongoing process. This study presents and describes some of the strategies that have been used to improve hospital management, exploring how a state social enterprise transforms itself and survives by attracting patients. It is a study that looks at hospitals from the inside, assessing and analyzing the changes made in their organization to achieve the goals of hospital reform. The findings make it possible to affirm that the hospitals studied have distanced themselves from the prior reality of traditional public hospitals. Their experience furnishes some lessons that may be useful to decision-makers and directors and managers of other Latin American hospitals engaged in hospital modernization.

Although, the three hospitals studied do not constitute a representative sample of all Colombian hospitals, they are valid examples of health establishments that have effected major changes as part of the overall reform of the health system spawned by the enactment of Law 100 in 1993. This study was not intended to present experiences with change in all of the country's almost 1000 hospitals; rather, it sought to describe the experiences of three establishments that are taking innovative approaches to hospital management and that are doing so in the context of the new rules introduced under the health system reform process.

6.1 KEY STRATEGIES USED IN THE CONVERSION TO SOCIAL ENTERPRISES OF THE STATE

Table 2 summarizes the key strategies used by the three hospitals to bring about the conversion and acquire the features of a social enterprise of the State operating in a framework of decentralization and utilizing the sale of services as its principal modality of financing.

TABLE 2: SUMMARY OF THE STRATEGIES USED BY THE THREE HOSPITALS STUDIED TO ACCOMPLISH THE CONVERSION TO STATE SOCIAL ENTERPRISE

FEATURE	CHANGES REQUIRED	STRATEGIES EMPLOYED BY THE HOSPITALS STUDIED	EL TUNAL	SIMÓN BOLÍVAR	LA SAMARITANA
▪ Market-oriented management	▪ Implement mechanisms for management and financing by sale of services	▪ Design and implement strategic plans, identifying niche markets and services in which the hospital has competitive advantages.	▪	▪	▪
		▪ Professionalize hospital management through training for executive management, heads of services, and other key personnel in hospital management.	▪	▪	▪
		▪ Create business units to serve as cost centers for financial evaluation within a two-tiered, results-oriented organizational chart	▪	▪	▪

FEATURE	CHANGES REQUIRED	STRATEGIES EMPLOYED BY THE HOSPITALS STUDIED	EL TUNAL	SIMÓN BOLÍVAR	LA SAMARITANA
		▪ Make effective use of financial, service output, and quality indicators for decision-making.	▪	▪	▪
	▪ Reduce costs	▪ Carry out joint purchasing of drugs and other inputs in collaboration with other hospitals, creating economies of scale.	▪	▪	▪
		▪ Contain costs through rationalization of the use of general services.	▪	▪	▪
	▪	▪ Outsource laundry, patient and employee food services, security, billing, and some clinical services.	▪	▪	▪
	▪	▪ Improve the process of procurement and payment for hospital supplies.	▪	▪	▪
	▪	▪ Contract for packages of services from physicians and nurses to cover night and weekend shifts as a shock measure to reduce costs during a financial crisis*	▪	▪	▪
	▪ Enhance productivity and quality	▪ Utilize benchmarking techniques to compare the hospital with other hospitals.	▪	▪	▪
		▪ Improve clinical quality through the application of protocols and audits of clinical services.	▪	▪	▪
		▪ Hire professionals in medicine, nursing, and other health care fields through the modality of professional fees linked to productivity and results in terms of timeliness and quality.	▪	▪	▪
		▪ Obtain certification for key hospital services in accordance with international quality standards such as the ISO 9000 standards.	▪	▪	▪
		▪ Invest in the hospital's human talent through training programs, improvements in the work environment, participation by workers in work teams with responsibility for their respective services, and incentives.	▪	▪	▪
		▪ Utilize the modality of management commitments between the hospital director, the heads of services, and workers to guide the expectations and results of work and time management in the hospital.	▪	▪	▪
	▪ Orient services toward attracting users or patients	▪ Create marketing units to promote the hospital's portfolio of services among users and purchasing agents.	▪	▪	▪
		▪ Upgrade accommodations, creating different types of rooms to improve patient comfort.	▪	▪	▪

* This measure was adopted at El Tunal Hospital after it was discovered that contracting staff in this manner would be less expensive. In some cases, however, the cost of using contract workers might be higher than the cost of using regular salaried staff.

FEATURE	CHANGES REQUIRED	STRATEGIES EMPLOYED BY THE HOSPITALS STUDIED	EL TUNAL	SIMÓN BOLÍVAR	LA SAMARITANA
		▪ Create and implement mechanisms to evaluate user satisfaction and respond in a timely and effective manner to complaints and suggestions in both the clinical and administrative areas.	▪	▪	▪
		▪ Create a department of user care to conduct periodic evaluations and systematically address complaints and suggestions.	▪	▪	▪
▪ Management of the internal transition	▪ Let go of the past and the prior organizational culture	▪ Communicate the reasons for the change in an ongoing and understandable manner.	▪	▪	▪
	▪	▪ Establish clear rules for staff so that staff understand that (a) there are consequences for poor treatment of patients, and (b) the hospital's survival depends on workers' good performance to assure the sale of services.	▪	▪	▪
		▪ Continuously disseminate the hospital's values, principles, and approaches to its work in the framework of the conversion.	▪	▪	▪
	▪ Manage the confusion of being between two realities	▪ Utilize multiple media (print, video, audio) to keep staff continuously informed of changes and of the hospital's performance.	▪	▪	▪
		▪ Offer opportunities for dialogue between the hospital manager and workers by practicing "open-door management" and holding periodic meetings for the exchange of views about the hospital's situation.	▪	▪	▪
	▪ Foster a new organizational culture	▪ Publish the performance indicators of each service so that all workers feel ownership of the achievements and of the effort required to improve performance.	▪	▪	▪
▪ Management of the external environment	▪ New relations with the public sector	▪ Establish clear rules delineating the role of the director—as the individual responsible for running the hospital—from that of the authorities of the Ministry and the Secretariat—as those responsible for policy-setting, evaluation, and financing.	▪	▪	▪
		▪ Participate as a member of the public network of health services together with other hospitals and primary care facilities.	▪	▪	▪
		▪ Seek external financing for costly infrastructure and equipment investment projects.	▪	▪	▪

FEATURE	CHANGES REQUIRED	STRATEGIES EMPLOYED BY THE HOSPITALS STUDIED	EL TUNAL	SIMÓN BOLÍVAR	LA SAMARITANA
	▪ New relations with the private sector	▪ Establish ties with businesses for joint projects to enable the use of high-technology equipment through loan-for-use and leasing agreements.	▪	▪	▪
		▪ Establish agreements with private universities for the hospital to provide practical training for health personnel.	▪	▪	▪
	▪ Collaboration between the community and the hospital	▪ Involve community organizations in hospital management through the board of directors, the ethics committee, and the oversight committee, and in monitoring the timeliness of care and evaluation of user opinions.	▪	▪	▪
		▪ Seek the support of women's volunteer organizations to obtain treatment and provide support to patients who need it.	▪	▪	▪
		▪ Invest or participate in community improvement projects.	▪	▪	▪

6.2 LESSONS LEARNED FROM HOSPITAL REFORM

These three case studies yield several lessons regarding the strategies used to convert the hospitals to social enterprises of the State. Rather than comparing the performance of the three hospitals, the purpose of this study was to extract lessons from their varied experiences. It is clear that a transformation has occurred. The hospitals have become user-centered establishments whose survival depends on attracting patients and providing them quality services. Gradually, their revenues are being derived more from the sale of services and less from publicly funded supply subsidies.

The implementation of cost accounting systems and business units such as those at El Tunal Hospital are clear evidence of the shift toward managing hospitals like businesses. Decisions are made on the basis of reliable, up-to-date information, in a flat hierarchical structure and the hospital manager is a strategist and evaluator of the hospital's overall performance. Another initiative has been the professionalization of executive management, departmental and service management, and other key managerial positions by hiring individuals with training in hospital management. All three hospitals have implemented strategic plans to guide the sale of services, emphasizing the areas in which they have comparative advantages.

A noteworthy experience is that of La Samaritana Hospital, which has opened a user care department with an effective information system to evaluate what occurs in the "moments of truth" when patients come into contact with hospital services.

El Tunal Hospital, meanwhile, has put in place a marketing unit that promotes the hospital's services among potential purchasers of those services, which will soon gain ISO 9000 certification.

Simón Bolívar Hospital has developed strategies for identifying its potential capacity and thus—in a context of more limited change than the other two hospitals—establishing a commitment with its professional staff to achieve production goals and enable the hospital to offer services of higher quality in its areas of specialization: treatment of multitrauma victims, burn victims, patients with HIV/AIDS, and critical patients, including both adults and children, who require intensive care. This hospital also has a service audit program with two purposes—to encourage better use of resources and to foster quality in clinical practices.

The three hospitals have developed tools for assessing user opinion and channeling complaints and suggestions. This is fundamental in a hospital run as a business, since users are the lifeblood of the hospital, which depends on patients' choosing it to fulfill their needs and recommending it to other potential users.

The participation of the community has been legitimated in the three hospitals studied. On one hand, by law, the community must be represented on the board of directors, and on various committees that oversee quality and effective use of resources. However, the community has also been involved in solving critical problems within the hospitals, such as waiting lists. This has made it possible for the hospital to gain an in-depth understanding of the situation and seek solutions that will represent a commitment for the professionals involved and make the process more transparent.

The experience of contracting with private suppliers establishes new rules and references, in which there is mutual agreement to do "good business" in order to create a "win-win" situation. The management of Simón Bolívar Hospital, for example, has worked with suppliers to develop mechanisms for ensuring prompt payment of invoices by the hospital and timely delivery of supplies by the suppliers. In the case of El Tunal, loan-for-use agreements have been established with several suppliers, while clinical laboratory and blood bank services are leased.

In the new culture of survival and sustainability of the hospital through the sale of services, hospital staff have adopted new practices, focusing on patients and on ensuring good technical quality of services and proper treatment of patients as a means of keeping the hospital alive. At the same time, management is focusing on its "internal clients," instituting measures to improve communication and opportunities for dialogue between staff and management, as well as communication to keep staff informed of the status of the conversion process and ongoing evaluation of staff performance. In general, to date, there have been no mass dismissals of personnel; instead, hospital workers have adapted to the new culture, albeit partly as a result of a tight labor market and the difficulties of finding a new job. In the three hospitals studied, staff turnover is low, except among business unit managers (department directors) at El Tunal Hospital and in cases where professionals have voluntarily switched over to the modality of contracts for professional services.

In summary, the following are the fundamental changes that have aided the process of conversion of traditional hospitals to social enterprises of the State:

- The enactment of Law 100, which defined the conceptual framework for the conversion within a decentralized environment, coupled with the district council agreements, which operationalized the changes, creating boards of directors and establishing the powers of managers and the internal organization of hospitals.

- The existence in the country of a corps of human resources trained in the management of health services and hospital administration. This made it possible to form hospital management teams that understood the scope of the changes and could implement the new policies in the hospital.

- Structuring of hospitals in business units and the design of medium- and long-term strategic plans. This provided a long-range vision for the hospital and made it possible to establish strategies to gradually overcome the constraints encountered. The existence of business units has contributed to greater accountability and has motivated staff to feel ownership of the services they provide and be more aware of the costs that they entail.

- Centering of hospital organization around the needs of patients and service users. This has enabled the hospital managers to gain more knowledge of patients' needs through the mechanisms for evaluating user satisfaction and opinions. It has also made it possible to propose preventive measures before problems turn into crises. The result has been that workers are more motivated to perform better in their jobs because they understand that the way in which patients are treated and the quality of care they receive will determine whether they remain "clients" of the hospital. This has fostered the emergence of a new organizational culture.

- Systems of information that make if possible to quantify the hospital's performance over time, measure and compare its activities, and determine the costs of the services provided.

- Political support for hospital management teams, which has enabled them to carry out their functions so that the hospital can serve as a politically positive point of reference and not a source of dissatisfaction in the community.

- Managerial capacity for participatory leadership, which has allowed the formulation of clear goals and has empowered hospital workers to attain the expected outcomes.

Other more specific and innovative experiences that are worthy of note and that place the hospitals studied in the vanguard of experimentation in hospital administration include:

- The implementation of service audit systems at the Simón Bolívar Hospital in order to assess length of hospital stay and quality of care. With the implementation of this audit system, it has been possible to persuade doctors, nurses, and allied health care personnel to embrace a logic of quality. In addition, the audit group, working in conjunction with the Universidad del Bosque, has developed evaluation instruments of high technical quality.

- La Samaritana University Hospital has implemented a system of telemedicine in order to establish a network of communications with primary- and secondary-level hospitals in the Department of Cundinamarca, for which La Samaritana serves as the tertiary-level referral center. This has enabled doctors in these lower-level hospitals to receive support in diagnostic imaging and treatment at the local level or through transfer of patients to the referral hospital. The operation of the system is coordinated by the hospitals' radiology services, which have computer equipment capable of receiving by the telephone imaging studies carried out in referral

hospital. After receiving the studies, specialists analyze them and communicate instructions for patient care. This has improved efficiency in patient referrals and reduced unnecessary referrals. It has also enhanced the diagnostic capacity of the system and improved the quality of care for seriously ill patients located far from the specialized center.

- The use of management commitments and performance agreements between the Secretariat of Health and the hospitals, especially those in the District of Santa Fe de Bogotá, are a means of assuring the fulfillment of consistent and harmonious objectives by all the health services in the Bogotá community. Based on an analysis of the economic and political situation, a policy document was prepared and published in November 1999.[15] This document provides guidelines for organization, financing, and management of the expected changes in the social enterprises during the year 2000.

6.3 CHALLENGES FOR COLOMBIAN HOSPITAL MANAGEMENT

The reform of the Colombian health system, like other similar processes, is a process of ongoing change, in which adjustments and modifications are being introduced gradually and incrementally by means of legislation, regulations, and new practices. Over time, a new culture—distinct from the one that prevailed several years ago when the changes began—has emerged. Nevertheless, the interviews conducted for this study revealed several concerns about the direction the reforms have taken. These concerns are linked to the social, political, and economic environment in the country, as well as the situation of the health services themselves. Some of them are summarized below as a corollary to the study findings:

- Under the legislation currently in force it is not possible to offer economic incentives for good performance to workers who are classified as public servants and or public officials. As performance incentives for these employees, hospitals are therefore using training programs or awarding points toward a higher position on the promotion ladder. The introduction of more flexible forms of contracting, such as contracting for services based on professional fees, has created different categories of staff, which could have repercussions on personnel performance and motivation in the future.

- Although efforts have been made to introduce a culture of quality in the hospitals studied, the number of patients served and the volume of services provided continue to be overriding concerns because the financing model is based on billing by activity. Consequently, the hospital's survival is linked to the volume of activities produced within a system in which professionals are obliged to devote a considerable portion of their time to the administrative process of obtaining and filling out forms.

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[15] Secretaría de Salud de Santa Fe de Bogotá. Hacia la eficiencia social en la inversión de recursos, la gestión transparente y la rendición de cuentas en su manejo en el sistema público de salud de Santa Fe de Bogotá: Lineamientos de política para el año 2000. [Toward Social Efficiency in the Investment of Resources, Transparency, and Accountability in the Management of the Public Health System of Santa Fe de Bogotá: Policy Guidelines for the Year 2000]. Bogotá; 1999.

- The environment in which the hospitals are operating one year after the study visits has changed. There has been tremendous pressure to introduce new hospital financing schemes based on "finished" cases rather than on payment by activity. There has also been great pressure to diminish fixed costs, especially payroll costs. As a result, managers are looking for new strategies to address these new challenges in what appears to be a second wave of hospital reform, which will make it necessary to come up with new approaches to gain the support of workers and once again leave behind a previous culture.

Although the experiences presented here were extracted from the Colombian reality and occurred as a result of measures taken in that context, the strategies examined may be applicable to hospital reform in other Latin American contexts in which the aim is to decentralize, enhance productivity and quality, and involve workers and the community in participatory management of the hospital.

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ANNEX 1: NEW FUNCTIONS OF HEALTH SECTOR ENTITIES

NAME	ROLE
▪ Consejo Nacional de Seguridad Social [National Social Security Council] (CNSSS)	▪ Formulation of health policies at the national level.
▪ Fondo de Solidaridad y Garantía [Solidarity and Guarantee Fund] (FOSYGA)	▪ Administration and distribution of the resources of the system through subaccounts for the contributory system, the subsidized system, prevention and health promotion, and insurance against catastrophic risks and traffic accidents.
▪ Ministerio de Salud [Ministry of Health]	▪ Execution of policies, regulations, technical support, supervision of public financing.
▪ Superintendencia de Servicios de Salud [Superintendency of Health Services]	▪ Supervision of insurers and providers.
▪ Unidades Territoriales: Departamentos y Municipios [Local units: departments and *municipios*]	▪ Local administration of health care, monitoring of health conditions and insurance, attention to public health.
▪ Régimen Contributivo [Contributory System]	▪ Insurance system for the population with the ability to pay (i.e., those who earn more than two times the minimum wage).
▪ Régimen Subsidiado [Subsidized System]	▪ Insurance system for the poor population.
▪ Instituto de Seguro Social [Social Security Institute] (ISS)	▪ The largest EPS, which in turn has a network of providers offering services to members of both the contributory system and the subsidized system. The ISS network also comprises hospitals/social enterprises of the State (which provide services under contract with the ISS).
▪ Entidades Promotoras de Salud [Health Promoting Entities] (EPS)	▪ Insurers that participate in the contributory system under contract with private companies. They take responsibility for affiliating the population and offer health services through a network of their own or contract providers.
▪ Administradores del Régimen Subsidiado [Administrators of the Subsidized System] (ARS)	▪ Insurers under contract with the State to cover those who are insured by the Subsidized System. The principal ARSs are the family health care funds, which design programs specifically for that purpose, and the hospitals/social enterprises of the State.
▪ Empresa Social del Estado [Social Enterprise of the State] (ESE)	▪ Autonomous public hospital that contracts with insurers to provide services to their members under both the contributory and subsidized systems. Also provides services to the uninsured population through supply subsidies.

PUBLICATIONS OF THE REGIONAL INITIATIVE OF HEALTH SECTOR REFORM FOR LATIN AMERICA AND THE CARIBBEAN

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2. BASE LINE FOR MONITORING AND EVALUATION OF HEALTH SECTOR REFORM IN LATIN AMERICA AND THE CARIBBEAN. (ENGLISH AND SPANISH)

3. ANÁLISIS DEL SECTOR SALUD EN PARAGUAY *(PRELIMINARY VERSION)*. (SPANISH ONLY)

4. CLEARINGHOUSE ON HEALTH SECTOR REFORM. (ENGLISH AND SPANISH)

5. FINAL REPORT – REGIONAL FORUM ON PROVIDER PAYMENT MECHANISMS (LIMA, PERU, 16-17 NOVEMBER, 1998). (ENGLISH AND SPANISH)

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11. CUENTAS NACIONALES DE SALUD: MÉXICO. (SPANISH ONLY)

12. CUENTAS NACIONALES DE SALUD: PERÚ. (SPANISH ONLY)

13. CUENTAS NACIONALES DE SALUD: REPÚBLICA DOMINICANA *(PRELIMINARY VERSION)*. (SPANISH ONLY)

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24. USING NATIONAL HEALTH ACCOUNTS TO MAKE HEALTH SECTOR POLICY: FINDING OF A LATIN AMERICA/CARIBBEAN REGIONAL WORKSHOP. (ENGLISH AND SPANISH)

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26. PARTNERSHIPS BETWEEN THE PUBLIC SECTOR AND NON-GOVERNMENTAL ORGANIZATIONS: THE NGO ROLE IN HEALTH SECTOR REFORM. (ENGLISH/SPANISH)

27. ANÁLISIS DEL PLAN MAESTRO DE INVERSIONES EN SALUD (PMIS) DE NICARAGUA. (SPANISH ONLY)

28. PLAN DE INVERSIONES DEL MINISTERIO DE SALUD 2000-2002. *(IN PROGRESS)*

29. DECENTRALIZATION OF HEALTH SYSTEMS IN LATIN AMERICA: A COMPARATIVE STUDY OF CHILE, COLOMBIA, AND BOLIVIA. (ENGLISH AND SPANISH)

30. GUIDELINES FOR PROMOTING DECENTRALIZATION OF HEALTH SYSTEMS IN LATIN AMERICA. (ENGLISH AND SPANISH)

31. METHODOLOGICAL GUIDELINES FOR APPLIED RESEARCH ON DECENTRALIZATION OF HEALTH SYSTEMS IN LATIN AMERICA. (ENGLISH ONLY)

32. APPLIED RESEARCH ON DECENTRALIZATION OF HEALTH CARE SYSTEMS IN LATIN AMERICA: COLOMBIA CASE STUDY. (ENGLISH ONLY)

33. APPLIED RESEARCH ON DECENTRALIZATION OF HEALTH CARE SYSTEMS IN LATIN AMERICA: CHILE CASE STUDY. (ENGLISH ONLY)

34. APPLIED RESEARCH ON DECENTRALIZATION OF HEALTH CARE SYSTEMS IN LATIN AMERICA: BOLIVIA CASE STUDY. (ENGLISH ONLY)

35. LA DESCENTRALIZACIÓN DE LOS SERVICIOS DE SALUD EN BOLIVIA. (SPANISH ONLY)

36. ENHANCING THE POLITICAL FEASIBILITY OF HEALTH REFORM: A COMPARATIVE ANALYSIS OF CHILE, COLOMBIA, AND MEXICO. (ENGLISH AND SPANISH)

37. GUIDELINES FOR ENHANCING THE POLITICAL FEASIBILITY OF HEALTH REFORM IN LATIN AMERICA. (ENGLISH AND SPANISH)

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47. POLICY TOOLKIT FOR STRENGTHENING HEALTH SECTOR REFORM. (ENGLISH AND SPANISH))