ACTA SCIENTIFIC NUTRITIONAL HEALTH

Volume 3 Issue 4 April 2019

Research Article

Organizational Management by Processes in the Local Health System

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Received: February 21, 2019; **Published:** March 21, 2019

Abstract

The study presents the alternative experience of applying the two theoretical management models that the Ministry of Health of Ecuador proposes, facilitating the analysis of information, its relevance, the technical support of the teams, the management of costs and finances in the exercise of health care and organizational climate. The methodology applied was quantitative in relation to global performance indicators and qualitative to assess the level of district organizational climate. This study uses as research techniques, the analysis of indicators, participant observation, open interviews and discussion groups, which generate the following reports: baseline and epistemology of the local health system. The study concludes that the local system of ministerial health, compromises of managerial dyslexia that would cause organizational dysfunction, due to the practice of two models of management not necessarily complementary, that is, the classic vertical bureaucratic system and the process management model that obeys a participatory system by objectives. However, the application of this last model improves the organizational climate and coverage results without supplementary financial cost.

Keywords: Organizational Management; Health Processes; Local System

Introduction

The International Conference on Primary Health Care of Alma-Ata, held in Kazakhstan, from September 6 to 12, 1978, was the most important health event of the time. The conference was organized by WHO/PAHO and UNICEF, and sponsored by the USSR. The Alma-Ata Declaration proclaimed the importance of primary health care as the methodological skill to improve the health level of the world's populations. The positioning was «Health for all in the year 2000». This process sought to oppose the centralist health system and low coverages. Currently, almost four decades later, there is a consensual affirmation that health systems based on primary health care transcend their equity and health outcomes.

In 1920, the Dawson Report on the future of medical and related services, made clear the need to talk about the network concept, when the Dawson report proposed that in order to "achieve the success of any health service plan, unity is indispensable" of ideas and purposes, as well as complete and reciprocal communication between [...] associated hospitals, secondary and primary centers and home services, regardless of whether the centers are located in the countryside or in the city1". In addition, the same report stated that "the first principle of good administration requires that when a special function is to be undertaken, it is carried out by a single governing body for the whole community that needs the service, and not for the different sectors of the community have different governing bodies [1].

Consequently, the principle of a single governing body implies a centralized management system, at the Ministerial level, a bureaucratic classic management system, based on fixed regulations established by a central level. However, the basic question is, if the primary care strategy is applicable with an exclusively vertical, centralized and bureaucratic management model.

The word management is used to refer to the group of highly qualified employees who are responsible for directing and managing the affairs of a company. The term also allows referring to the position held by the general manager (or manager) of the company, who fulfills various functions: coordinate internal resources, represent the company in front of third parties and control the goals and objectives. However, among the main managerial functions is included, facilitating the analysis of information, its relevance, efficiency, quality of care, representation. However, the nuance, the ductility, the integrality and the fluidity that is granted to the specific way of implementing the management is fundamental in the institutional success. Is it, therefore, the participatory management by objectives, under the modality of organizational management by processes, the appropriate tactic of implementation of primary care?

The current study presents the alternative experience to combine the two models in the management of the local health system, facilitating the analysis of information, its relevance, efficiency,

quality of care, technical support of the teams, negotiation of management agreements and the management of costs and finances in the exercise of health care. The main strategies adopted in the experience include the use of management information for decision making and the strengthening of critical competencies for analysis, the execution of anticipatory or corrective actions, the evaluation of performance and the management of change in the institution. In addition to coordinated processes of vertical and transversal level with a model of attention focused on people, including both external and internal customer in the process.

The health system of Ecuador corresponds according to the democratic reform of the State, in ensuring the collective good, becoming a fundamental actor of democratic reform. This process is administered by the National Secretariat for Development Planning (SENPLADES), which coordinates decentralization and deconcentration in public institutions; using the process management model that aims at more efficient and participatory institutions. There are four processes in permanent inter-relational dynamics: the governing process whose mission is to guide the institutional management, the substantive processes that generate and manage processes and services for internal and external users, and adjective processes of advice and support that generate and manage products and services for the governing, substantive and for themselves processes.

Finally, the deconcentrated processes that generate products and services in decentralized instances. At the central level there are five general coordinations: those related to strategic development in health, general planning, strategic management, legal advice, financial administration and three national directorates: cooperation and international relations, communication, image and press; finally, internal audit. Subsequently, and in direct hierarchical relationship with the structure of the Ministry of Public Health, there are the Deputy Ministries of Health Surveillance and Governance, and Comprehensive Health Care (AIS). The Vice Ministry of Surveillance contains the national undersecretaries of governance, surveillance and promotion - equality of public health. The viceministry of AIS includes the national undersecretaries of provision and guarantee of the quality of health services. Each of the named sub-secretariats has numerous addresses assigned.

In relation to the mission of the health system, this is based on the exercise of governance, regulation, planning, coordination, control and management of the Ecuadorian Public Health through governance and health monitoring and control and guaranteeing the right to health. Health through the provision of individual care services, disease prevention, health promotion and equality, health governance, research and development of science and technology; articulation of the actors of the system, in order to guarantee the right to Health. The right to health is linked to the vision of the Ministry of Public Health, which will fully exercise the governance of the National Health System, with a reference model in Latin America that prioritizes the promotion of health and the prevention of diseases, with high levels of quality care, with warmth, guaranteeing the integral health of the population and universal access to a network of services, with the coordinated participation of public, private and community organizations.

The implementation of health policies with a vision of rights have achieved important advances in the coverage of services, including the Ministry of Health receives significant recognition from the United Nations for the creation of inter-institutional health networks [2]. However, and despite the notable progress made worldwide in the accessibility of health services, researchers still recommend gaps between community and individual needs and the effectiveness of services [3].

Locally, the policy MAIS-FCI can also be understood as a reflection of the relaunch of Primary Care in renewed health by the World Health Organization in 2008, which rescues the precautionary approach, the sectorality and strengthening health delivery networks as main strategies for guaranteeing the right to health of the people [4]. There is even a very important investment in health in the country, which has had an impact on the number of services that increased from 16 million in 2006 to 34 million in 2011. The percentage of the general budget of the State that was destined to Health in 2011 was 5.9% and in 2012, 6.8% [5].

Health in 2016 had an expense of 2,427 million and for this year 2017 it is raised 2,800 million, which means an increase of 15 percent, corresponding to 7.6% of the global budget [6]. Therefore, the importance of the managerial organization of the health system, in accordance with its mission, is fundamental, not only in terms of effectiveness and efficiency but also in terms of consistency between its normative elements and practical operation, together with the pertinence of its organizational logic in relation to the social, cultural and economic context of the country. This is, in these times, a priority not only in the training and preparation of managers but especially in the generalization of a management culture that influences the conception and operation of strategies, structures, models and the way how the service is organized, borrowed and insured, always thinking of the best health with the most rational use of resources. If not part of this conception, any system however good it may be, risks losing sustainability [7].

Ecuador currently invests an average of USD 175 per inhabitant per year from the Ministry of Health. This information is contextualized with the necessary requirements to be able to obtain the millennium development goals worldwide, which have ranges between 74-984 USD (average 271) per person and per year [8].

Establishing a culture of evidence-based decisions is a need that is denoted in neighboring health contexts [9]. The management capacity to reflect on their own decisions and establish long-term corrections would produce a state of resilience of the health systems, generating capacity to absorb, adapt and transform their actions when exposed to pandemics, natural disasters, conflicts, facilitating control and reaction of its structures and functions [10]. The importance in health of consolidating a culture of work organizations in teams is also highly recommended [11].

The promotion of health systems with organizational cultures oriented to the search for permanent quality, redefining the roles of the teams providing services and strengthening patient-centered management, with their participation as an actor, is fundamental in the development of treatment and monitoring of chronic noncommunicable diseases [12].

Materials and Methods

The health district of Cotacachi is established by ministerial agreement 003345 of May 17, 2013, passing its nomination from area 3 to district 10d03. The district health system consists of 1 basic hospital with 23 beds and 14 operational units of the first level of care (4 health posts and 10 health centers type A, in an area of 1,725 km2 and a population of 50,490 inhabitants, of which, 51% are women. The complementary health system consists of an ambulatory care unit of the IESS and 6 dispensaries of rural social insurance, to more than 20 private practices.

In August 2017, the district office of the Ministry of Health decided to organize and develop a process to formulate a management baseline of the management processes of the aforementioned health institution. This process has two categories of references: quantitative in relation to global performance indicators and qualitative to assess the level of organizational climate per operational unit. This baseline uses research techniques, participant observation, open interviews and discussion groups, which generate the following reports: baseline and epistemology of the local health system.

After this process of identification and formulation of the diagnosis of the organizational system of the local health system, the strategic management action plan was established with the aim of improving the use of health information and the work environment, and indicators of the relevance of the system in relation to the social and demographic context of the District. The strategic management action plan was established under the perspective of organizational management by processes, and operationally with three axes of action: processes of meetings of coordination and vertical complementarity between the district directorate and the enabling and substantive processes, promotion of the horizontal coordination between the enabling and substantive processes, development of a process of management seminars based on strategic planning and personal development in the 15 operating units.

After five months of development of the management process, a participatory evaluation system was organized, with the objective of establishing the impact of the process both quantitatively and qualitatively.

Results

The preparation of the baseline allowed for a comparative exercise of the results obtained in the areas of care coverage and organizational climate.

During the assessment process and baseline established in August 2017, several global indicators of monitoring and analysis of management were established. These were the following:

- Coverage care - person: 32.6%
- Average financial investment per inquiry: 18.3 USD
- Budget allocated per inhabitant: 96.5 USD
- Proportion of personnel in direct patient care: 79%
- Percentage of the budget allocated to direct care activities (consumer goods and services - program 53: 11.07%

With a cut-off date of January 31, 2018, the evolution of these indicators determined the following results:

- Coverage care - person: 72%
- Average financial investment per inquiry: 19.8 USD
- Budget allocated per inhabitant: 101.7 USD
- Proportion of personnel in direct patient care: 79%
- Percentage of the budget allocated to direct care activities (consumer goods and services - program 53: 12.6%

The person care coverage is a fundamental indicator to analyze the health system's insertion capacity in the global population. Initially, the baseline analysis confused the first and subsequent consultations, but in a statistical effort it was possible to identify each of the patients seen in the first consultation with names and

surnames. This indicator showed a positive evolution from 32.6 to 72%, however it shows us a still high percentage of people without access to promotional or preventive services, taking into account that one third of the population of the canton has affiliation to the peasant insurance. The importance lies in the existence of "pockets" of population without access to the health system despite the high coverage established by orthodox indicators.

In relation to the average financial investment per consultation, the variation is very slight, from 18.3 to 19.8 USD per consultation. Although we do not have data with similar methodology for calculating costs, in other countries there are rates of USD 11.22 per query, which allows us to establish the importance of monitoring system efficiency, especially in relation to bureaucratic procedures that increase costs.

The budget allocated per inhabitant varied from 96.5 to 101.7 considering a minimum variation in relation to the development of the budget. At an international level, a range between USD 50 to 800 is considered.

The proportion of personnel in direct patient care remained stable throughout the year at 79%. It is considered that 80% is the optimal value. In relation to the percentage of the budget allocated to direct care activities (consumer goods and services - program 53, it evolves from 11.07 to 12.6%) It is fundamental to note that although the distribution of human talent is very convenient in the sense of being oriented to direct attention, however there is a budget imbalance, which has an excessive tendency towards fixed costs (wages) on consumer goods and services.

Finally, the diagnosis of the organizational climate was used based on the modified Litwin and Stringer model, which refers to the existing environment among the members of the organization, being closely linked to the degree of employee motivation and specifically indicates the motivational properties of the organizational environment. The criteria evaluated were: organizational structure, responsibility, relationships and cooperation. The organizational climate varied from the authoritarian paternalist, based on a climate of condescending trust and reward / punishment to the participatory group, based on a climate where the decision-making was distributed in each of the levels of the district. A horizontal communication was developed with a relationship of trust and co-responsibility between superiors and subordinates, which resulted in an increase of 14% of patients seen in relation to the previous year.

Discussion

In a first conceptual analysis, the direction consists of executing the planned, in implementing the actions agreed through the administration and management. "Directing involves directing, influencing and motivating employees to perform essential tasks, guiding a group of individuals to achieve the company's objectives", defines Rodríguez Sifontes [13]. Along the same lines, the authors Koontz and Lo'Donnell [14], for whom business management supposes "the executive function of guiding and supervising subordinates", while Henri Fayol [15] considers this area of management as "making the social group work once constituted, obtaining the maximum possible results of the elements that make up his unit in the interest of the organization". However, the director has a strategic role. You must align your team with the objectives of the company, which is the same as ensuring compliance with those objectives. You must plan, roughly, what will be done and how to meet the general objectives of your area. He will participate in the making of general decisions and will be the link between his department and the general direction. The department director depends on the general manager and is the head of his sector. The coordinator, however, is expected to coordinate an interdisciplinary or interdepartmental team, although often it is only a synonym for boss. These positions may have more or less responsibility for the results but do not usually have decision-making power. The problem of coordination is transformed, therefore, in the problem of establishing an appropriate and efficient system of communication and control between the executive unit and the units in charge of the different tasks. To solve the problems that this lack of coordinating delegation will produce, a complementary system must be established or maintained that allows the subordinates themselves, by initiative and conviction, to coordinate their work.

The aim of the coordination is to link the organizational structures resulting from the division of labor and specialization, which are interconnected in order to achieve the objectives of the company with efficiency. It is said that the limit of the division of labor is at the point where coordination is possible. An important degree of coordination will most likely benefit work that is not routine or predictable, a job in which environmental factors are changing and there is a lot of interdependence. In the case of the health system, it corresponds to an unstable, changing context subject to the demographic, environmental and epidemiological dynamics.

Mary Parker Follet [16] postulated, among others, the principle of direct contact, in which it establishes that coordination must be achieved through collateral or horizontal relationships, for which it is necessary to have an adequate environment for the exchange of ideas and initiatives and for the joint decision-making at the respective level, without it being necessary for them to be knowledge and prior sanction of superiority. Coordination through this principle is also considered as a horizontal integration method, which

highlights the importance of understanding the activities, capacities and abilities of the other members, in order to achieve cooperation among all of them. That's why a good communication system is necessary.

Through this understanding problems are solved by adjustments, since conflicting sources disappear. These principles indicate that the method to obtain coordination is fundamentally horizontal. The need for a continuous exchange of information can hardly be ignored. The company never remains immutable. In this analysis, therefore, we detect a kind of managerial dyslexia in the organization of ministerial structures, since two conflicting management concepts are established, coordination managing directions and directions managing deconcentrated processes. In the typology of Enríquez's organizations [17], it proposes three types: feudale, bureaucratic and cooperative. The system of management by processes locates the estates of the Ministry of Public Health as an institution of organic structure - cooperative. Among its categories we could list the following: The permanent redefinition of functions based on interaction with an accent given to knowledge to solve real problems, network of authority relations with horizontality based on institutional objectives, shared responsibility, open communications, importance of adherence and commitment of its members, preponderance of competencies, leadership style based on consultation and group relations, decisions based on consensus [18].

Comparing these categories, we can easily identify them within the current ministerial management model, however, the structural management model of the MSP also responds to a mechanical logic, where differentiation and specialization predominate, with precise delimitation of rights and responsibilities, importance of the level hierarchical, strict control of personnel, limited dissemination of information by levels, importance of verticality, loyalty of members to the hierarchy, leadership based on the individual relationship on the groups. This logic is identified with the directive vision at the expense of the perspective of organic coordination.

Moreover, health service managers are obliged to adapt to the constant changes and "reforms" in the environment; changes of multifactorial origin that determine that only the services with flexible and adaptable management will be able to perform with acceptable levels of efficiency according to the Methodology of Productive Management of Health Services (MGPSS) PAHO.

On the other hand, business management puts the emphasis, not so much on the organization of resources, as on the planning of the processes to carry out the objectives of the corporation. In this sense, Augusto Uribe [19] conceives corporate management as "the strategic management of the organization". In general terms, the general idea among the different authors is that management brings with it a broader and holistic view of the organization, while business administration focuses on the internal structure of the company. Similarly, Professor Carlos Valencia [20] explains that business management focuses on the horizontal and transversal aspects, while the administration is responsible for functional and vertical development.

Conclusions

The local health system compromises of a managerial dyslexia that causes organizational dysfunction, due to the practice of two management models that are not necessarily complementary, that is, the classic bureaucratic system and the process management model that obeys a participatory system by objectives.

The management vision is focused almost exclusively on the search for efficacy and efficiency, disregarding the importance of the conception of an appropriate organizational climate that generates confidence and productivity in the local health system. The fragile use of health and financial information, produced by the vertical management system, in the analysis, reflection and decision-making at the local level, hinders the process of continuous learning of the health organization. The development of long-term processes of training and continuous training in management is essential for the coordination staff at all levels, empowering learning from real scenarios, in the daily practice of management that the local system of health produces.

It is recommended that these processes be designed and implemented at a regional or national level, taking into account the particularities of each of the local systems, seeking the pertinence of the decisions and actions in each specific context.

The segmentation of the health system, conceived as the coexistence of subsystems with different financing, compartmentalized, that cover diverse segments of the population, generally according to their capacity to pay (IESS, private sector, insurers) requires establishing complementarity and synergy to avoid duplicating actions and generate unnecessary bureaucratic expenses such as the cost-covering program among state health institutions. Similarly, the fragmentation of the local health system, that is, the coexistence of several units or establishments that are not integrated into the health care network, that is, the private sector with aims and non-profits, which in certain spaces, work in parallel with the national health system.

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