

## **Health Sector Reform and the Regulation and Management of Health Professionals: A Case Study from Chile**

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### **Abstract**

This paper provides an overview of main issues facing the human resources function in the public sector health services in Chile in the late 1990's. The paper examines the main characteristics of the Chilean health sector, from an HR perspective, and focuses on two key aspects of HR in health services-performance management and the regulation of the work of doctors and nurses. The paper provides a national level country case study of these two issues during health sector reform, placing the main HR related objectives of reform within the context of the key characteristics of the Chilean system.

Health sector reform in Chile, as in many countries in 1990's has focused on structural change, cost containment, the introduction of market mechanisms, and an increased emphasis on consumer involvement and choice. Whilst it is possible to identify common challenges in HR during health sector reform, it is also important to recognise that the country context, in terms of socio-economic, legal, political and cultural factors will play a fundamental role in determining what HR responses are viable and effective.

The complexity, plurality and highly regulated nature of the Chilean system is highlighted in the paper. Any attempt to change HR policy and practice has to take account of the need to assess the impact and constraints of current legislation and regulation. Over the longer term it is likely that legislative change will be required to facilitate and to fully develop the flexibilities and local management capacity in HR required to best meet the health priorities set by the Chilean government.

**Key words:** health reform, health professionals, regulation, management.

### **Introduction**

This paper provides an overview of main issues facing the human resources function in the public sector health services in Chile in the late 1990's. The paper is based on consultancy work funded by the Department for International Development (DFID) of the United Kingdom, under a consultancy contract managed by Health and Life Sciences Partnership (HLSP).

The paper examines the main characteristics of the Chilean health sector, from an HR perspective, and focuses on two key aspects of HR in health services - performance management and the regulation of the work of doctors and nurses. The paper provides a national level country case study of these two issues during health sector reform, placing the main HR related objectives of reform within the context of the key characteristics of the Chilean system.

### **HR and Health Sector Reform**

Health sector reform in Chile, as in many countries in 1990's has focused on structural change, cost containment, the introduction of market mechanisms, and an increased emphasis on consumer involvement and choice<sup>(1-3)</sup>. It is evident from policy research in various countries that the methods used to manage human resources in

health care can in themselves be major constraints or facilitators in achieving the objectives of health sector reform<sup>(4-10)</sup>.

The focus on HR practice during the reform of public sector health systems can be characterised as the attempt to develop more “efficient” management practices into a public sector environment, sometimes characterised as “new public management”, with all the changes in organisational priorities that this will require (see Table 1).

**Table 1 The shifting emphasis of the HR function, during health sector reform**

<b>From:</b>	<b>To:</b>
Staff welfare orientated	Business orientated
Generalist service	Specialist function
Training	Appraisal and development
Collective relations with staff	Individualised relations
Negotiation	Consultation, communication

Source: Buchan J, Seccombe I (1994)<sup>(4)</sup> and Buchan J (2000)<sup>(10)</sup>

Whilst it is possible to identify common challenges in HR during health sector reform, it is also important to recognise that the country context, in terms of socio-economic, legal, political and cultural factors will play a fundamental role in determining what HR responses are viable and effective. The situation in Chile places specific constraints on changes in the approach to managing HR in the health sector.

### **The Country Context: HR and Health Sector Reform in Chile**

Chile has a population of 15 million. The health sector comprises both public and private sector providers, with the private insurance system regulated by the Ministry of Health<sup>(11)</sup>. The public sector health system (SNSS - Sistema Nacional de Servicios de Salud) is financed by governmental contribution and by a mandatory health insurance paid by workers.

Reform of the public sector health system was based on four principles: equity, decentralisation, satisfaction of the user and user participation<sup>(11)</sup>. These four principles underpinned an approach to restructuring and reform which was aimed at developing annual objectives at national level for the system, and specifying performance targets (“management agreements”) for individual public sector health providers.

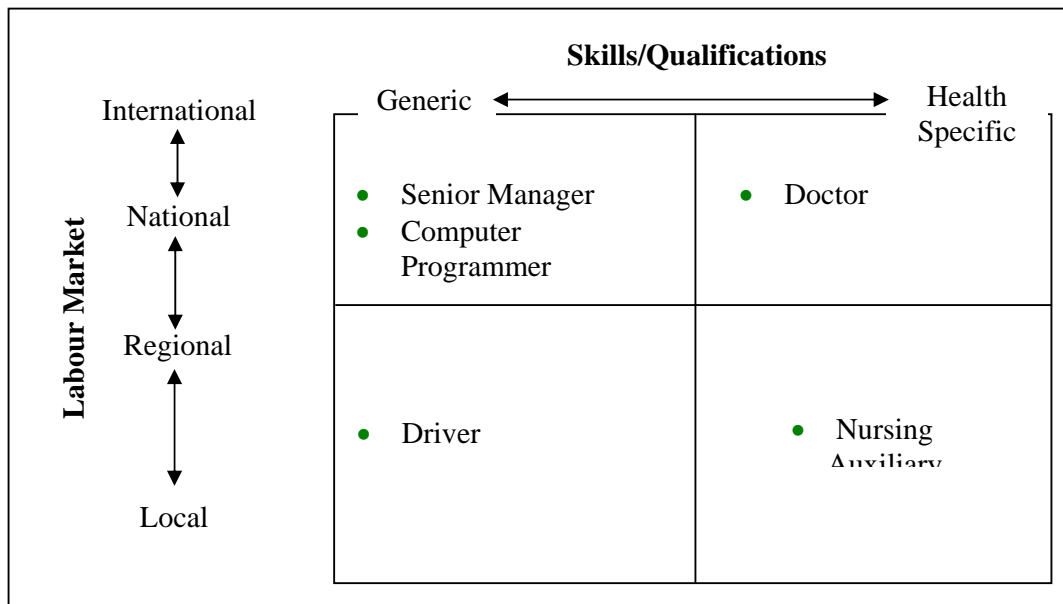
The Chilean health system is complex and fragmented with a large, diverse and growing private sector. This has a major impact on the health care labour market, and on local and national level HR policy and practice in the health sector. There are many “players” in the system - MINSAL, the Ministry of Education (MINEDUC), public and private sector employers, professional associations, trade unions, universities and other training providers etc. The linkages and lines of communication between these players are often informal or ad-hoc, but they all have a role to play in improving national and local level HR policy and practice.

The HR focus within SNSS at national level is directed through the Division of Human Resources at MINSAL. The Division has a strategic focus, but is relatively recently established, and comparatively under - resourced, in terms of the available

number and skills of staff in relation to its requirements to deliver a broad based policy agenda. As a relatively new Division within the Ministry it also has to establish closer working links with other Ministries on a number of issues, such as legislative change and educational policy and practice.

Given limited resources, MINSAL has to focus its initial priority efforts on groups of workers operating in regional and national labour markets and with health sector specific skills and qualifications, where it has the greatest scope for control and influence. These groups can be differentiated by considering Matrix 1, below. Health sector reform objectives, timescale and resources will determine which groups should be identified as priorities for intervention. In the case of Chile, it was the health specific occupations operating in regional/national labour markets occupying the upper right quadrant of the matrix which were priorities for MINSAL (e.g. doctors and nurses).

**Diagram 1 HR policy matrix**



Source: Buchan J, 2000.

### **Staffing in the Chilean Public Sector Health System**

The public sector health system in Chile employs approximately 64,800 staff, with a further 16,500 employed at the primary care level, administered by local municipalities. The public sector system is organised in 29 regionally based units - Servicios de Salud (Servicios).

The Servicios are the main unit of organisation, in terms of the management of human resources, linking with the national level Division of Human Resources at MINSAL) MINSAL retains the budget for staffing which is not decentralised. Each Servicio is responsible for managing a number of hospitals and rural or urban clinics. In total there are approximately 200 hospitals and a further 2,400 clinics within the public system

The composition of the public sector workforce is shown in Table 2. The employment relationship between staff and employer is highly regulated in the

Chilean health system and a fundamental distinction is made between staff employed under law 15.076 (doctors, dentists) and other staff, employed under law 18.076 (which also covers other areas of the public section - 180,000 staff in total).

Approximately two thirds of staff in total are employed under a contract which in practice represents a "job for life". This "titulare" contract guarantees continuous employment up to or beyond the official retirement age of 60 for women and 65 for men. It is extremely difficult for an employer to dismiss an employee on a titulaire contract; there are also restrictions on the extent to which these staff can be moved between jobs or locations within the Servicio.

**Table 2 Distribution of health personnel, public sector, December 1997.**

Medical	7,990
Dental	1,045
Biochemical/Chemical Pharmacists	309
Ciclo * Destinacion	2,219
<b>Sub Total (15.076 Law)</b>	<b>11,563</b>
Managers	1,630
Professionals	10,033
of which (nurses)	(3,554)
(midwives)	(2,087)
Technical**	23,084
Administrative	9,121
Auxiliary	12,953
<b>Sub Total (18.834 Law)</b>	<b>56,821</b>
Total	68,382

Note: \* Junior medical staff on rural postings

\*\* includes paramedic auxiliaries

Source: MINSAL, IMPERSAL, JANUARY 1998.

Most of the remaining 35% of staff are employed on recurring one year contracts (all renewed at the beginning of the calendar year). The third group is a small number of staff (approximately 2,000 in total) employed on an "honorario" or short term basis, often on a fee for service.

The honorario contract represents the main option for management currently attempting to increase labour flexibility, but its use is constrained by legislation. Staff on honorario contracts cannot be used to replace titulaire staff or to carry out work normally under the responsibility of titulaire posts.

There is a 'top down' allocation of titulaire posts. The government (MINSAL) decides on the number of titulaire posts in each servicio and each servicio will in turn allocate titulaire posts to each hospital. When a vacancy arises there is normally an automatic process of replacement - usually the vacant post will be filled by a more junior staff member, creating a vacancy to be filled further 'down' the staff hierarchy - a form of "dead men's shoes".

Recruitment and selection mainly is the responsibility of the servicio; where there is the need to replace or recruit a larger number of staff there will be a form of open competition. The number and allocation of titular posts is regulated - servicio and hospitals cannot create more, even if they had available funds. Senior management posts are appointed rather than recruited.

The majority of staff work on a full time basis (44 hours per week) other than medical staff, large numbers of whom contract for 11, 22, 28 or 33 hours per week to give themselves more time for private practice. More than half of doctors (63%) contract for 28 hours or less (MINSAL-INPERSAL).

Many SNSS staff are members of one of the trade unions/professional associations active in the sector - notably the Chilean Medical Association and the Federation of University Health professionals which represents nurses, midwives, speech therapists, etc. Since the re-establishment of democracy in Chile there has been a pluralist approach to employment relations, but without a tradition of established mechanisms for consultation, negotiation or arbitration there have often been employee relations problems and strikes (most recently in 1996).

### **Performance Management**

Absenteeism from work was reported to be a major problem, as in many other countries, with little line management "ownership" of the problem. Reduction in absenteeism levels have been established as one of the main HR targets within the system (see below). Absence levels are monitored throughout the health system and data is aggregated at hospital, servicio and MINSAL levels.

Establishing a systematic approach to managing and monitoring the performance of individuals and organisations has been highlighted as a key element of health sector reform<sup>(6)</sup>. In Chile, the framework for monitoring the performance of organisations is the "management agreement".

The "agreements" are a form of a yearly organisational performance agreement, between MINSAL and each Servicio, using identified targets and goals as the basis of performance management and monitoring.

Nine of the fifty-five "management agreements" between MINSAL and servicios relate specifically to HR indicators. In outline, the nine agreements relate to:

- 1) Decentralisation to servicio level of the management of the 'ciclo'; the career posting mechanism for recently qualified medical staff.
- 2) Improvements in levels of training of physicians and other professionals for work in primary care and 'shortage' specialties.
- 3) Analysis of areas of staff shortage for nurses and doctors, with targets for 50% improvement relating to medical staff and 25% relating to nurses.
- 4) Full implementation of a monitoring system and follow up action on two main HR indicators - staff utilisation in relation to staffing hours worked, and staff absenteeism.
- 5) Establishment of employee participation mechanisms in larger hospitals.
- 6) Development of interventions to reduce levels of absenteeism.
- 7) Development of a monitoring system and appropriate interventions to improve occupational health.

- 8) Analysis of organisational "climate", staff job satisfaction, morale and motivation.
- 9) Development of pilot projects in association with staff, to improve quality of care in emergency care and intensive care (8 Servicios only).

The two main data-based performance indicators in this system - utilisation (number of activities/staffing hours) and absenteeism (hours "lost"/total hours) were defined centrally at MINSAL. The Health Service Management Unit at MINSAL is responsible for developing the performance monitoring approach and for auditing and monitoring returns. Staff from the Unit will also work with Servicio staff to improve data returns and to identify mechanisms for improving performance related to the indicators.

There is a data return every four months; data is consolidated for an annual report, which is published. The report shows, for each servicio the trends in the indicators and the agreed performance targets.

The incentive for compliance and improvement within this system is that the 'top' 25% of Servicios (i.e. those who have best met or exceeded targets) have access, proportionate to their ranking order, to an additional central fund. There is no sanction for "poor" performers.

At the time of the consultancy work, the system had not been functioning for a sufficient timescale for as assessment of its impact. It was however providing a structured basis for performance based dialogue between the centre and the Servicios. The system was also being reviewed by the Health Service Management Unit with the objectives of refining the approach, developing additional indicators (the goal is to identify output measures, not just process measures) and examining methods of increasing the use of the incentives approach. Whilst it focuses on the level of the Servicio, it also draws on hospital level information, which is not used separately because of difficulties in weighting data for case mix, variations in organisational profile, etc.

In relation to the performance of individual employees, a performance related element to pay determination exists (the "qualification" system) but its implementation has largely fallen into disrepute - more than 90% of staff throughout the system are rated "excellent" (Lista 1) on a four scale rating. Level 4 which could lead to dismissal, is rarely scored.

In practice, the system does not operate as an effective approach to performance appraisal, it is used as a mechanism for allocating additional pay to staff, rather than as a means of identifying training and development needs.

### **Regulation of the Work of Doctors and Nurses**

Regulation of work can take a number of forms. In this section, two main elements of the regulatory process in Chile are examined. Firstly, the regulation of the clinical practice of health professionals is examined- this element is usually referred to as regulation and/or certification. Secondly, the regulation of the work of SNSS employees is examined- this relates primarily to the legislative framework for the employment of workers in the Chilean public sector.

There are at least three possible models of the regulation of health professionals: self regulation, where the profession itself takes on the responsibility of standard setting and maintaining professional conduct; "state sponsored" self regulation, where there is some input from government, but only in terms of resource

allocation; and state regulation, where the processes of regulation and certification are the responsibility of a government department or agency. The introduction of free-market policies in Chile since the 1980s led to a situation where there was no statutory requirement for health professionals to be registered in order to practice (such a requirement did exist prior to the military dictatorship of the 1970's and 1980's). Possession of the relevant degree was sufficient to allow individuals to undertake professional practice. In the medical profession there was also no statutory/regulatory framework for the accreditation of specialists; a voluntary approach has been maintained in which a number of organisations played a role. These were:

- The Chilean Medical association (Colegio Medical - CM) which retains an involvement in ethical issues and in standard setting.
- The university medical departments which train doctors, play a role in self accreditation of curriculum through their own association and (in the case of the Department of Medicine, University of Chile) accredit and monitor the inflow of doctors from abroad. There is mutual recognition of medical qualifications with a number of other South American countries, a reported increase in inflow (mainly from Peru, Ecuador, Cuba) and reported concern about the quality of some of their doctors.
- The government which through MINSAL actively maintains contact with the other organisations, is keen to improve the regulatory process, but has no regulatory responsibilities in relation to the registration of individual health professionals.
- The specialty medical associations which are voluntary membership bodies lobbying for their own specific interests.
- CONASEM - National Corporation for Certified Medical Specialties - was established in 1984 and acts independently. It is a non profit private corporation established by the CM, the "old" university departments and specialty medical associations. There is MINSAL representation on CONASEM but only as observer status. Its role is to promote the use of accreditation for medical specialties. The approach is voluntary (a doctor can practice in any field of medicine without accreditation, providing he has an approved medical degree).

The inter-relationship between these organisations, each with its own objectives, had created a situation where there was no 'lead' organisation with responsibility for regulation of doctors, and no universal register or requirement for periodic re-regulation. The approach to the resolution of issues of professional misconduct relied primarily on judicial process and malpractice suits. The absence of any mandatory registration/ certification and periodic re-certification of individual health professionals meant it was difficult to maintain standards or stimulate continuous professional education and updating of skills.

There was a general recognition that the approach to regulation in Chile, which was characterised by voluntarism, required redesign to better meet the needs for standard setting, accreditation of education providers and regulation of health professionals. It is likely that there will be an emphasis on professional self regulation, within a framework agreed with the state ( through MINSAL and

MINEDUC). It is also clear that the priority groups for such intervention should be the occupations bound in the upper right quadrant of Matrix 1- doctors, dentists and other health professionals such as nurses who are mobile in national labour markets.

A model has to be developed which is acceptable to these parties but which also reflects the need to account for the needs of the user. Consideration is being given to the potential to link regulation to professional conduct and standards setting, to identify the best method of accrediting university departments, and to the accreditation of specialities. The scope for developing a universal “live” register for each profession which would assist in maintaining professional standards and in workforce monitoring and planning is also being discussed. The establishment of a “live” register, by periodic re-registration could also serve as the basis of a system for maintaining professional competence through re-certification.

In relation to the **regulation/legislation of employment**, the SNSS functions within a legislative framework which limits flexible employment practices. Working patterns and working time are centrally controlled. Staffing levels and mix are centrally determined. Staff in the “titulare” grades in practice can occupy their posts for life. The legal framework in which HR policy and practice is conducted in the SNSS in Chile is therefore characterised by “top down” prescriptive legislation. This has led to inflexibilities in the system, in terms of the scope for local level managers to establish flexible working practices and so improve organisational efficiency and quality of service

The absence of an effective performance appraisal system, the “job for life” position of SNSS staff in titular grades and the lack of any professional misconduct mechanisms (other than a recourse to judicial process, which precludes poorer sections of society from taking up cases) can be identified as major constraints on the effective management of doctors and nurses. The situation regarding professional misconduct may fall more naturally within the area of professional self-regulation but as noted earlier in the paper, there is no single identifiable body which has independent authority in this area and no universal register to serve as the foundation for establishing a professional conduct approach linked to agreed standards.

The challenge for MINSAL is to support a strengthening of the management approach to HR, linked to the establishment of an effective performance appraisal approach and proper consultation and negotiation with staff. In relation to professional misconduct, there is a clear need to establish an appropriate mechanism which reduces over-reliance on judicial process

Changes in the legislative framework would free up the system and encourage greater employment flexibility. MINSAL is currently reviewing current legislation with the objective of identifying priorities for reform. One area for examination is to free up current legislative constraints to enable Servicios to employ staff on part time contracts, with no commensurate reduction in their benefits. The fact that only full time staff are eligible currently for some additional payments is a major disincentive to work part time, as is the associated problem that current full time posts cannot easily be divided into two or more part time posts.

## **Summary and Conclusions**

The main HR challenges in the SNSS in Chile parallel those in many other countries undergoing health sector reform. These relate to encouraging flexibility and responsiveness in working practices, improving planning and performance



management arrangements, and achieving positive change in the legal and regulatory environment in order to support improved standards of clinical practice.

In the late 1990's it was strengthening management capacity in HR and identifying and implementing new HR policies and procedures for the health system, working in association with other government departments, health manager and staff organisation.

In meeting the HR challenges, the complexity, plurality and highly regulated nature of the Chilean system has to be recognised. Any attempt to change HR policy and practice has to take account of the need to assess the impact and constraints of current legislation and regulation. Whilst this should not be used as an excuse for short term inaction; over the longer term it is likely that legislative change will be required to facilitate and to fully develop the flexibilities and local management capacity needed to best meet the health priorities set by the Chilean government.

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