Constructing: Relationships, Human Resource Management and Culture of Quality
The Case of Hospital do Subúrbio, a Brazilian Healthcare Public-Private Partnership

by

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Dedication

Once upon a time, there was a little girl who used to browse through the pages of a children's travel book and dream of all the places she would go someday. To that girl.

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Abstract

Public-Private Partnerships (PPPs) are an internationally proposed way to deal with perfunctory public administration by private sector management. Since 2010, the northern state of Bahia, Brazil has engaged in a PPP, Hospital do Subúrbio (HS), to provide urgency/emergency health services. While critics of public hospitals in Brazil report inadequate quality and safety, HS is the only public hospital that has reached the highest level of accreditation in the state. Given the management difficulties experienced by public administration in many countries, the challenges and best practices from HS can be used analytically to inform human resource management and hospital quality in Bahia, Brazil, as well as in countries that are seeking ways to deal with poor management of public hospitals.

Between May-October, 2018 and July 2019-February 2020, I conducted an ethnographic case study which consisted of 107 semi-structured interviews, participant observation and document review in Salvador, Bahia, Brazil, to critically identify and evaluate the implementation of Hospital do Subúrbio.

In Chapter 3, I seek to understand the external and shifting coalitions of support and opposition that should be identified and understood as part of evaluating the feasibility, implementation and sustainability of complex projects. I find that HS has established various levels of "embedded autonomy" with three main actors – the Secretary of Health, the local community and the Municipality of Salvador. Using evidence from my study, I conclude that care should be taken when advocating for PPPs under the assumption that the state is able to monitor project implementation. The case of HS also offers an opportunity to consider the importance of politics and the potential shifts in support and opposition that could occur over election cycles and leadership changes as well as opportunistic partisan behaviors that might arise given different sub-national arrangements and actors involved in service delivery. Furthermore, I conclude that creating opportunities to construct partnerships with local communities in grassroots ways can be instrumental for project implementation.

In Chapter 4, I seek to understand the construction of Human Resource Management for healthcare organizations. I show that HS has managed to achieve low turnover and absenteeism through implementing various HRM approaches during the lifetime of the project. I organize my findings around four themes, namely 1) Hiring and Evaluation, 2) Professional Development and Actualization, 3) Empowerment and 4) Sense of Meaning. While scholars in the past have identified some of the same HRM practices as important elements in high performing organizations, especially in environments where they would not have been expected to do so, my research explores not the mere presence or absence of such HRM practices but their construction over time. This is important as my research could provide lessons about how to create more high-performing organizations, precisely through the identification of HRM processes of construction.

In Chapter 5, I seek to understand the processes involved in constructing a culture of quality and quality improvement at HS. Similar to the construction of HRM processes in Chapter 4, this chapter explores not the mere presence or absence of a culture of quality and quality improvement but its construction over time. Considering Chapters 4 and 5 together, I also conclude that even though effective private sector management is the case at HS, caution must be taken when PPP assumptions are made about a taken-for-granted standard of effective private sector management.

Chapter 1: Introduction

Over the past three decades, Brazil's publicly funded Unified Health System —the *Sistema Único de Saúde (SUS)*— has drastically improved access to healthcare, including primary and tertiary care. Over 75 percent of the population rely on the SUS for their healthcare, making public hospitals a vital lifeline for the majority of people in Brazil.

However, these significant achievements are tempered by other factors. Critics of public hospitals point to long waiting times, inadequate quality care and poor safety (Costa 2017; Lewis, Malik & Penteado, 2015). In 2009, researchers found that 67 percent of adverse events in hospitals were likely preventable (Mendes et. al. 2009, Paim et. al. 2011), while a follow up study using two-stage review of medical records found approximately 1.3 adverse events for every 10 hospital admissions with 43 percent of adverse events being likely preventable (Mendes et. al. 2018).

Other criticisms focus on inefficiencies within the system. Approximately 70 percent of Brazil's public health funding is spent on public hospitals, but hospitals lack incentives for increased efficiency (Lewis, Malik & Penteado, 2015). In 2008, La Forgia and Cuttolenc described Brazilian hospitals as expensive "black boxes" with respect to their plurality of organizational arrangements, managerial behaviors and their uneven and unmeasured performance. In 2007, a World Bank report on municipal and state hospitals in Brazil identified human resource management as the main problem affecting hospital facility performance, citing low productivity, work shirking, absenteeism, and mismatch between personnel skills and facility requirements as the most prevalent challenges in their health facilities (World Bank 2007).

Underperformance among public hospitals is also concerning because it is likely to exacerbate inequalities among the Brazilian population. Some sub-groups are financially able to seek higher quality hospital services in the private sector through employment insurance plans or out of pocket payments, while those who cannot afford such alternative arrangements rely on public hospitals.

Brazil's healthcare story is far from unique. For the past three decades, many Low- and Middle-Income countries (LMICs) have been experimenting with solutions to deal with poorly performing and inefficient health care delivery systems. Starting in the early 1990s, many high-income countries (HICs) emphasized the superiority of private sector management over public administration in delivering public services at lower costs by introducing market pressures and performance standards (Hood, 1991; Pollitt, Van Thiel & Homburg, 2007). Public-private partnerships, arrangements in which governments use public resources to contract with the for-profit or not-for-profit sector to deliver infrastructure and/or health services, gained traction as a neo-liberal policy and governance tool for efficiently delivering health care services by consultancy firms as well as multilateral development agencies (Verhoest et al., 2015).

In 2010, the northern state of Bahia, launched a public-private partnership (PPP) to create Hospital do Subúrbio (HS), a new, 313-bed hospital facility in its capital city of Salvador. Although Brazil has had experience contracting out health services both to the non-profit and for-profit private sectors since the 1990s, HS was the first hospital PPP in the state and in the country. The PPP engaged two for-profit companies in the form of a for-profit consortium, Prodal, responsible for equipping and operating the clinical and non-clinical services of the hospital facility (World Bank, 2013). Hospital do Subúrbio has been reported as having "dramatically improved emergency hospital services for one million people in Salvador" (World Bank, 2013), has been named one of the 100 most innovative global projects (KPMG, 2012) and has reached the highest national level of accreditation (HS, 2020).

Despite its noted success in providing urgent and emergency care for the population of Salvador over the last nine years, the hospital governance strategy employed in the implementation of Hospital do Subúrbio is under-researched. Little is known about the conditions that have made Hospital do Subúrbio an acclaimed PPP case. Given the management difficulties experienced by direct administration hospitals in many LMICs, including Brazil, and the extent to which HS has been held up as a model of excellence, HS provides a unique opportunity to understand what such a hospital model entails and to uncover the factors and elements involved in its success. The challenges, lessons and best practices explored in this dissertation through the case of HS can be used analytically to inform management hospital practices in Bahia and throughout Brazil, as well as in other LMICs that are seeking ways to deal with mismanaged public hospitals with low quality and health outcomes. Thus, HS serves as a

critical case to generate in-depth knowledge rather than seeking limited insight across multiple possible hospital cases (Emmel, 2013).

In order to understand the case of HS, some further context is necessary. The next section defines PPPs and outlines what is known and not known about the outcomes from these experiments.

What is known about Public-Private Partnerships (PPPs)?

The variety of initiatives carrying the label "PPP" might be confusing to many. For the purpose of this study, a PPP is defined as an initiative whereby "a public authority contracts with a private company to design, build, finance (or partially finance), and operate a healthcare facility for a fixed period after which time ownership reverts to the public health authority". This PPP type is formally known as the Private Finance Initiative (PFI) or Design-Build-Finance-Operate (DBFO) PPP model (McIntosh et al. 2015).

PPP initiatives originally gained popularity for different big infrastructure projects such as transport (roads and rail services), followed by prisons and information technology services and last, by health and education projects (Shaoul, 2005). Traditionally, this PPP set-up in healthcare results when a government has difficulties providing adequate capital investments for health facilities and thus may decide to jointly fund the construction of those facilities with capital investments from the private sector. Construction is followed by giving a long-term concession to the private for-profit firm to manage the facilities and deliver health services. In turn, the private firm receives a guaranteed annual payment for delivering a pre-specified and agreed-on volume of health services. Under this arrangement, it is in the private partner's interest to improve the efficiency of the PPP unit and reduce costs to increase profits. PPP contracts are usually long, and concession can last up to 30 years, a period after which control of the facilities and their operation is typically handed over to the public sector.

The benefits often attributed to PPPs rest on a number of assumptions. In general, in addition to leveraging infrastructure construction capital, there is an assumption that governments can use PPPs as a mechanism to improve managerial capacity, maintain costs and increase efficiency by leveraging the private sector (World Bank, 2016). Therefore, the objective of governments using PPPs is often to achieve improved value for money (VFM), that is, improved services for the same or less amount of money than the public sector would have spent

on a similar project (Grimsey & Lewis, 2005). Theoretically, a PPP also carries the prospect of being able to produce an innovative service that would not be possible if the public and private sectors continued to operate separately from each other (Greve & Hodge, 2005). Another major assumption made when advocating for PPPs has been that the state is theoretically able to provide a regulatory and monitoring role for PPP contracts (Lieberherr, Maarse & Jeurissen, 2016) and that combined with all the assumptions made for the private sector capacity, a PPP can offer the possibility to bring together the best of both worlds – the public and private (Hodge, Greve, & Biygautane, 2018).

In healthcare, PPPs are assumed to promise a greater efficiency, quality and accountability for health service delivery (McIntosh, Shauness & Wettenhall, 1997). The private sector is usually assumed to possess the expertise and management skills to manage hospitals, clinics or health insurance operations.

However, all these are strong assumptions that should be researched rather than assumed if we are to consider whether PPPs have advantages over other organizational models, including publicly administered organizations. Public-private partnerships in healthcare have been operating mostly in HICs and have shown mixed performance results (Barlow, Roehrich & Wright, 2013; Grimsey and Lewis, 2005; McKee, Edwards & Atun, 2006). These studies usually focus on cost and some limited health outcomes and health quality indicators (Nikolic & Maikisch, 2006). In addition, the failure of some PPP projects has not been explored in detail beyond reasons surrounding the PPP funding model or the government's willingness and ability to renegotiate the contract (English, 2005).

Similar to PPPs in HICs, the experience of PPPs in LMICs is not extensively studied or documented in the academic literature. The International Finance Corporation (IFC)/World Bank Group lists signed PPP projects in Brazil, India, Mexico, Nigeria and Turkey (IFC, 2019). Information for each of these projects includes a project description, the role of the World Bank in the contract and a few outcome indicators but no further public evaluation of the project. Although surprising, this is partly the case because IFC Advisory Services are hired for advising the government on structuring the contract, the bidding process and evaluation of the bidding partners but bear minimal responsibility for monitoring and evaluation of the PPPs in-country once the contract is signed (personal communication, July 2019). Even though evaluation of IFC projects post contract signing are carried out by the Independent Evaluation Group (IEG), those

evaluations are not always publicly available. No such evaluation is available for Hospital do Subúrbio.

Furthermore, desk research on the PPP projects listed by IFC yields no in-depth knowledge of project implementation that could be used for knowledge dissemination and for understanding successful implementation of similar project initiatives. This might be the case because successful or failed implementation remains in private practice, there is commercial confidentiality and lack of transparency, limited access to PPP stakeholders and implementers, low institutional memory and very few academics studying health PPPs.

Among the PPPs listed by the IFC/World Bank, the only hospital PPP that has received academic attention in LMICs is the Queen Mamohato Memorial Hospital (QMMH) in Lesotho, Africa. Some studies have been conducted on the Lesotho PPP, with their focus on improvement of clinical and non-clinical performance as well as reduction of corruption practices when comparing between the old referral hospital and QMMH (McIntosh et al., 2015; Vian et al., 2015; Vian et al., 2017). In addition, concerns have been raised by Oxfam International about the unaffordability of the PPP model to the Ministry of Health and Social Welfare and the diverting of resources from rural primary health care to urban hospital care because of the QMMH (Marriott, 2014).

While a plethora of articles exists on how to navigate the PPP bidding process, the contract and the risks associated with a project, there are no recommendations on how to navigate organizational behavior within PPPs. Examination of micro-level processes such as management and human resource processes would improve our understanding on how local actors are able to manage institutional complexity, align with the PPP goals and be able to drive implementation of PPP successfully. Understanding the context, culture and logics of the actors would further enable us to design appropriate incentives and strategies for different actors and thus better draft PPP contracts as well as better facilitate successful implementation of PPPs. To this end, throughout this dissertation I examine human resource management and organizational culture as moderating factors to meeting quality and performance standards within HS, a Brazilian hospital PPP.

The next section introduces the case of HS and explains why this case was chosen for this study, providing needed context for understanding my core findings.

The case of Hospital do Subúrbio

Even though PPPs are predominantly used and perceived as financial models for infrastructure, I would like to instead consider them as organizational models and investigate how the PPP of HS, could serve as a model that can provide insights on internal organization and management for health service quality improvement and health outcomes.

Hospital do Subúrbio was purposefully chosen as the hospital case to be studied after considering the array of PPPs in LMICs (IFC, 2019). Given the high public spending on hospitals in any given health system, I wished to study whether and how a private sector entity could improve the core functioning of a complex organization such as a hospital instead of the delivery of specific medical services adjacent to hospital structures such as dialysis, pathology or radiology. As such, the hospital criterion excluded any PPPs for delivering dialysis, pathology or radiology services from the PPP IFC list.

Second, I wished to choose a hospital PPP which included the responsibility for the management of clinical operations of a hospital and not solely the responsibility for either the upfront hospital infrastructure or the provision of hospital equipment. This criterion was primarily defined after consideration of the high cost of human resources in hospitals which is often not accompanied by performance or absenteeism indicators. Third, time of operation was another factor for considering PPP cases as candidates; my preference was for a hospital PPP that had been in operation for 5 years by the time I started my study as that time allows for maturation of learning processes while it also allows experiencing different leadership changes due to elections.

It is important to highlight that over decades, the Brazilian national Universal Health System (*Sistema Unico de Saúde; SUS*), has sought different ways to combine the way it delivers health care services: through directly administered public hospitals, through indirectly administered hospitals managed by contracting non-profit social organizations (*Organizações Sociais; OS*) as well as through contracts for many health procedures from philanthropic or private providers (Paim et al., 2011).

In 2007, Jacques Wagner, the governor elected for the state of Bahia assumed his role with a strong mandate for prioritizing health improvements and delegated autonomy to execute that mandate to the Secretary of Health of the State of Bahia (*Secretaria da Saúde da Bahia; SESAB*). As such, the period between 2007-2011 was characterized by many investments in

health for both direct and indirect administration of hospitals. At the same time, the state was also willing to experiment and innovate with different organizational models that could contribute positively to the mission of the government for health as priority, including attempting the first hospital PPP in Bahia and in Brazil (Former SESAB Management Team Member, Interview, June 2018). While this was the first health PPP in the state and the country, there was already existing PPP legislation (11.079/04) for regulation and promotion of PPPs at the national level as well as the state level (9.290/04) since 2004.

As such, in 2010, the state of Bahia adopted a PPP approach to provide urgency and emergency healthcare services to a projected 1 million population in its capital city, Salvador. To do so, the state government of Bahia partnered with the private, for-profit consortium Prodal, composed of Promedica, a Bahian health care company and Dalkia, a French facilities management company based in Sao Paulo, Brazil for implementing HS, a new, 313-bed hospital facility. Prodal invested approximately $23 million in the first year of its operation to equip and operate the clinical and non-clinical services of the hospital facility and was expected to invest another $9 million over the ten-year concession time of the project from 2010-2020 (World Bank, 2013).

Given the PPP definition aforementioned, HS can be classified as a *type* of a DBFO PPP. I say it is a *type* of DBFO PPP as it is only financed (F) and Operated (O) by the private partner for a period of 10 years, with the possibility of a one-time renewal. However, it diverts from the DBFO PPP model in the sense that the hospital venture was never designed (D) or built (B) by the private sector as would be expected in a traditional infrastructure DBFO PPP; instead, the public sector designed and built the hospital. This is an important distinction to make as HS as the partnership includes the management of clinical personnel which adds complexity rather than the provision of infrastructure usually sought after in more traditional PFI/DBFO models. Thus, HS provides the opportunity to explore the impact of management and operations for performance in this hospital organizational model. Given the results of this research, there is no evidence to suggest that the relative success of HS as Finance-Operate model is advantageous to the DBFO model.

It is important to note that in addition to the national 2004 PPP law, a payment mechanism was established as a state law in 2009 to mitigate the government's risk of defaulting payments, thus guaranteeing the disbursement of monthly payments to the private sector partner

and increasing interest by private sector entities to even bid on the project in the first place (IFC, 2019). To create transparency in the bidding process, HS was presented and auctioned as a project at the Stock Exchange in Sao Paulo with Prodal winning the bid against the only other bid, another Bahian based private consortium (Sefaz, 2009). Following, the PPP transaction was structured with help from the IFC such that the monthly global payment made to Prodal was linked to target quantitative (70%) and qualitative (30%) performance indicators. Pre-defined penalties would be retrospectively applied if performance (quantitative) and quality indicators were not met as defined by the contract. In addition to the monthly global payment, the government would be responsible for reimbursing Prodal for any cases beyond the health services agreed upon in the signed contract. As part of the contract, SESAB was expected to monitor, evaluate and regulate the HS contract through a Monitoring Committee. In addition to the presence of a Monitoring Committee within SESAB, the contract required the auditing of performance indicators by an external qualified Independent Auditor who would be chosen by SESAB and remunerated by Prodal. It is important to note that patients seeking care at HS receive treatment free of any fees by presenting their national SUS patient card and the hospital does not receive any patients under any private health insurance schemes.

As previously mentioned, since its implementation, HS has been reported as having "dramatically improved emergency hospital services for one million people in Salvador" (World Bank, 2013), has been named one of the 100 most innovative global projects (KPMG, 2012) and has reached the highest national level of accreditation (HS, 2020). Despite its noted success for providing urgent and emergency care for the population in Salvador in the last nine years, the hospital governance strategy employed in the implementation of HS during the lifetime of the project is under-researched. Even though earlier research has investigated the decision-making process about implementing HS as the first PPP in Brazil (Carrera, 2012), little is known about the conditions during the life-time of the project that have made HS an acclaimed PPP case. Given the lack of quality experienced in direct administration hospitals in Brazil, as in many developing nations, and the extent to which HS has been held up as a model of excellence, HS provides a unique opportunity to uncover the factors and elements involved in its success.

Structure of the dissertation and main findings

This chapter introduced the motivation for my dissertation and the rationale behind my chosen case. The next chapter, Chapter 2, provides the methodology employed in this research to elucidate the factors involved in the implementation of the HS case. Further chapters outline my findings.

In my first paper (Chapter 3), I seek to understand the external and shifting coalitions of support and opposition that should be identified and understood as part of evaluation for feasibility, implementation and sustainability of future PPP projects as well as similar (development) projects. I find that HS has established various levels of "embedded autonomy" (Evans, 1995) with the three actors involved – the Secretary of Health, the Municipality of Salvador and the Local community. Using evidence from my study, I conclude that care should be taken when advocating for PPPs under the assumption that the state is able to provide a regulatory and monitoring team for such a complex PPP project. I also conclude that creating opportunities to construct partnerships and engage with the local community in grassroots ways is instrumental in buffering the relationships with the other actors.

Lessons from the case of HS can be used by country policy makers when considering the implementation of PPPs or similar development projects as well by bilateral or multilateral partners which advocate for and provide consulting to governments interested in implementing PPPs or development projects more broadly. Chapter 3 demonstrates the importance of considering political actors, partisan relationships and shifts in priorities and agendas over time and election cycles. It demonstrates the importance of predicting such behaviors that could create resistance and/or prevent program sustainability and designing appropriate tools to mitigate some of those possible political risks. While these lessons can be applied to many countries, the case of HS demonstrates that it might be particularly important to consider the local beneficiaries and how a program might be affecting community livelihoods in some contexts more than in others. This might be particularly important in Low- and Middle-Income countries with higher power distance between the population and the implementers than in High-Income countries.

In my second paper (Chapter 4), I seek to understand and document the construction of Human Resource Management for healthcare organizations. I organize my findings around four themes namely 1) Hiring and Evaluation, 2) Professional Development and Actualization, 3) Empowerment and 4) Sense of Meaning. While scholars in the past have identified some of the

same HRM practices as important elements in performing organizations, my research explores not the mere presence or absence of such HRM practices but their construction over time.

In my third paper (Chapter 5), I seek to understand the processes involved in the construction of a culture of quality and quality improvement at HS that has been impacting the quality of services delivered at HS. Similar to the construction of HRM processes in Chapter 4, this paper explores not the mere presence or absence of a culture of quality and quality improvement but its construction over time. Considering Chapters 4 and 5 together, I also conclude that even though effective private sector management is the case at HS, it is a conscious construction and caution must be taken when PPP assumptions are made about a taken-for-granted, homogeneous, and non-investigated standard of private sector management. Lessons from Chapters 4 and 5 show how local policy makers as well as bilateral or multilateral consultants considering the implementation of PPPs or similar healthcare development projects should consider the construction of HRM for employee commitment and performance, his resulting in the reported quality of healthcare at HS. The case of HS also shows the importance of designing local approaches while considering the local professional context as well as professional practices in the local organizational field – just like the case of HS, the appropriate incentives to instill intrinsic motivation can be designed as a result of local knowledge, local behavior, local assessment and local designing of HRM practices and incentives.

The three papers are held together by the notion of understanding processes of construction rather than the more static notion of presence/absence of certain organizational characteristics that reflect organizational performance – the three papers revolve around the construction of relationships, the construction of HRM approaches and the construction of culture of quality and quality improvement. The case of HS provides insights specific to PPPs policy while at the same time allows for generalizability and transferability of concepts about construction of processes for organizational performance to other PPPs as well as other hospital settings.

Finally, Chapter 6 provides a conclusion of the overall findings of the dissertation, including implications for theory and policy.

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Chapter 2: Methodology

Between May-October 2018 (5 months) and July 2019-February 2020 (7 months), I conducted an ethnographic case study which consisted of semi-structured interviews and participant observation in Salvador, Bahia, Brazil as explained below. Utilizing ethnography involved spending considerable time in the field and gaining access as an observant at both Hospital do Subúrbio (HS) and the Secretary of Health of the State of Bahia (SESAB). In this process, it was of crucial importance as an investigator to respect the hospital's flow as an urgency/emergency hospital and participants' subsequent availability and professional space to participate in my study.

Study methodology

Case study design: My choice of a case study design approach was informed by the scope of my dissertation which has been to critically assess the factors that have been influencing implementation of HS over the lifetime of the project. First, unlike statistical methods, I wished to assess whether and how different variables mattered with respect to the outcome of interest rather than to assess how much a specific variable mattered over other variables. Second, a case studies design has the potential for achieving high conceptual validity, that is, identifying the indicators that best represent the theoretical concepts that the researcher aims to investigate. Third, case studies offer the potential for investigating causal complexity as well as exploring causal mechanisms in detail (George & Bennett, 2005). In addition, HS serves as a critical case to generate in-depth knowledge to better understand the implementation of HS to-date rather than seeking limited insight across multiple possible hospital cases (Emmel, 2013).

Grounded Theory: Following Grounded Theory as suggested by Strauss & Corbin (1990) and Charmaz (2014), initial broader concepts and observations from the literature and existing research (as opposed to entering the research with a "blank slate" as per Glaser & Strauss (1967)), contributed to the selection of the case of HS as outlined in the introduction (p. 6) as

well as to the planning of the research about what kinds of data to collect to achieve conceptual validity and to best answer the overarching research question of the study. While Glaser and Strauss (1967) assumed theory is discovered solely from the data, Charmaz (2014) assumes that theories are not discovered but rather constructed by the study researchers in relation to their interactions with participants in the research setting. This is especially so in my choice of the ethnographic case study method. As explained more thoroughly below, ethnography entails high levels of embeddedness, thus leading to relationship building, comfort and trust with participants over time. I regularly chose to have lunch, to wait in team offices and to attend after-work social events at both HS and SESAB as part of immersing myself in the networks of my participants and the culture overall. These interactions were important in constructing the purposive sampling frame of study participants, in iteratively constructing the interview guides to inform the research direction as well as in constructing the resulting, emerging theories from the research process.

Project approval

Prior to conducting the research, my study was reviewed and approved by the Institutional Review Board at the University of Michigan. The study was also approved by the Ethics Committee of the School of Pharmacy at the Federal University of Bahia (UFBA). Consent from the directorate of HS had to be obtained and be included in the Ethics Committee application as part of the approval process for conducting research at HS. In addition, informed consent to participate in the study was required by UFBA from all participants to be interviewed on the premises of HS. Informed consent involved informing the participant about the purpose of the study, about potential risks and benefits of participation, ensuring the confidentiality of personal identification and that the participation of subjects in the study is entirely voluntary (Appendix A).

Selection of interviewees

Selection of interviewees for the study was based on purposive and snowball sampling. I began with purposive sampling of technical officers in the Secretary of Health of the State of Bahia (SESAB) and the Secretary of Finance of the State of Bahia (*Secretaria da Fazenda; Sefaz*) who were involved with the HS project in 2018-2020 when I conducted my study. As I had little

information about the HS project itself and the range of actors involved in its implementation in the beginning of the study, I did not define strict inclusion/exclusion criteria for my interviewees and instead depended primarily on indications from my main informants. However, as I learned more about HS and the actors involved in its implementation over time, I prioritized contacting and including participants that were directly involved with the HS implementation either in 2010 at the start of hospital operations or in 2018-2020 when I was conducting my study. During my interview with the initially identified participants, I asked them to recommend other officers that were involved with the implementation of the HS project in the beginning of its operations in 2010 or in 2018-2020 at the time of our interview and could provide insights into my study.

I approached purposive selection of interviewees at HS in a similar way. I first began with purposive sampling of managers that could share their experiences with respect to the challenges and opportunities of the implementation of HS, quality improvement efforts at HS as well as organizational behavior of employees at HS. When I interviewed the managers at HS, I asked them to suggest other HS employees that they thought my study would benefit from. If a physician, nurse or manager gave a presentation and I found their work relevant to my study, I approached them directly and asked them whether I could arrange an appointment with them. As previously, during my interview with them, I also asked them if they could suggest other staff at HS that they thought could provide insights for my study. I continued this process over the two periods of my ethnography until I reached saturation of data. This resulted in a sample of managers, coordinators, quality team members, pharmacists, physicians, nurses, nursing technicians and social workers at HS. In addition, as I realized multi-employment is a prevalent practice in the Brazilian medical field, when snowball sampling, I asked for the possibility to interview HS employees who held part-time positions in public hospitals in particular as to be able to get their perspectives about their respective working environments.

Semi-structured interviews

I conducted interviews with the selected interviewees through purposive and snowball sampling as explained above, resulting in 107 interviews. Of the 107 interviews, seven (7) participants were contacted and interviewed twice, while three (3) participants were interviewed three times, at different times throughout the project as their position was important for the study and I needed to seek their perspective as the data collection and analysis progressed to clarify doubts,

triangulate or confirm information. Of the 107 interviews, only 1 was conducted in English; the remaining 106 interviews were conducted in Brazilian Portuguese as I have advanced understanding of speaking and understanding of Brazilian Portuguese. In addition, the interview transcripts were analyzed in Brazilian Portuguese. I translated the participant quotes used as illustrations of evidence in this study from Brazilian Portuguese to English. While I did not translate each participant quote word for word, my intention was to stay as close to the participant quote as possible, but most importantly capture the key words and the overall meaning of the participants' perspectives. Many of the people I interviewed have multiple affiliations at HS and other health facilities. When I refer to them with respect to the perspectives they shared with me in the text, I am listing their primary affiliation. Each of the 107 interviews lasted between approximately 20 minutes and 3 hours. All interviewees were asked for permission to record the interview. The majority of the interviews (82/107; approximately 3,850 minutes/64 hours) were recorded. The remaining, (25/107; approximately 30hrs) were not recorded either by interviewee choice or because the interview occurred over lunch or dinner in public spaces and recording was not ideal. A list of organizations whose members participated in my study is provided in Appendix B.

The interview questions were formulated to gather information about three broad aspects of the HS project, namely a) the views of (political and technical) stakeholders about HS and its relationships with different actors, b) the perspectives on organizational behavior and behavior at HS, and c) the views about service delivery and quality improvement projects at HS as compared to public administration hospitals. The interview questions were designed as open-ended questions and each interview guide was modified in an iterative approach, building on information from previous interviews as well as depending on the interviewee, their experience and their connection to the HS project. The interview guides were also modified depending on the participant's expertise in relation to HS and the relevant perspectives he/she could contribute to the study. Five (5) examples of interview guides are presented in Appendix C representing interview guides prepared for HS managers, for former and current SESAB officers associated with the HS contract, and for nurses.

Interviews were conducted one-on-one with the exception of 5/107 interviews which were conducted in pairs of participants. I conducted the interviews in my participants' offices or in settings chosen by the participants as they felt most comfortable and convenient for their

working schedules. The interviews recorded were transcribed by a Brazilian professional and later analyzed in Brazilian Portuguese. For non-recorded interviews, I depended on descriptive notes I took during and following the interview. When taking descriptive field notes, I tried to include as many quotations as possible. If quotations were not possible, I tried to capture specific words as used by the interviewee. Following each interview, with or without recording, I took additional descriptive notes to capture different aspects about the interview regarding the participant and/or our interaction, the participant's reactions to some questions as opposed to others, and the participant's body language and non-verbal communication which would be difficult to capture from the interview transcript alone. In addition to descriptive field notes, memos also included reflective field notes, including personal accounts of what I learned during the interview and how it related to other participants' perspectives in previous interviews or the study in general. I particularly noted aspects of the interviews that could help modify existing interview questions and to formulate new interview questions to better understand aspects of the study. Reflective field notes also included possible interpretations of the data and possible themes that could be emerging from the data, confirmations, and speculations, ideas or hypotheses about the data, all in relation and comparison with other data collected up to that point. Last, in reflective field notes, I noted my role in the interaction with the participant and how I could improve for the remaining interactions/interviews with the participants in the study.

Within Grounded Theory methodology, while Glaser and Strauss (1967) consider research as inductive, Strauss and Corbin (1990) emphasize the research principle behind Grounded Theory as being both inductive (emerging from the data) and deductive (confirming the data) in a process of abductive/retroductive reasoning which combines both induction and deduction interactively throughout the research process. I approached my study in a similar fashion. First, purposeful participant selection based on data was an iterative process about who could give me new insights as well as confirm some research aspects. In addition, the interview guides were generated iteratively using data from previous interviews, observations or document reviews to generate new data as well as to confirm previously collected data throughout the research.

Interviews were no longer sought when theoretical saturation was reached. Theoretical saturation included data saturation and thematic saturation. Data saturation was determined in the data collection through not encountering any new data emerging from the interview process. In

addition, theoretical saturation was determined in the data analysis with occurring repetitions of the same codes and additional data unlikely to lead to any new codes or subsequent emergent conceptual categories and themes.

Participant Observation

To complement semi-structured interviews, I observed participants at HS in their professional lives for approximately a 11-month period between June-October 2018 and July 2019-February 2020 through 32 meetings (approximately 57 hours). These included formally scheduled weekly HS leadership meetings, meetings between HS and community leaders for presentation of indicators, accreditation preparation meetings, nursing staff meetings, organizational behavior trainings, selective hiring sessions, permanent education trainings, hospital rounds, auditing of processes, and staff practice evaluations. During and after each event, I took as many descriptive field notes as possible to capture as much information about the event's content, issues discussed as well as record participant reactions and interactions with other employees, especially as it related to quality improvement and organizational behavior at HS. When taking descriptive field notes, I tried to include as many quotations as possible. If quotations were not captured, I tried to note specific words as used by the participants involved in the observation.

As with interviews above, following each observation event, I took additional descriptive notes to capture different aspects about the event regarding the participants and/or their interactions, as well as the participants' reactions and body language and non-verbal communication. In addition to descriptive field notes, memos about the observation events also included reflective field notes, including personal accounts of what I learned during the observation and how it related to other observations or participants' perspectives in interviews. I particularly noted aspects of the observations that could help modify existing interview questions and formulate new interview questions to better understand aspects of the study. Reflective field notes also included possible interpretations of the data and possible themes that could be emerging from the data, confirmations, speculations, ideas or hypotheses about the data, all in relation and comparison with other data collected up to that point through interviews or other observations.

Ethnography entails high levels of embeddedness in the society where a study is taking place as well as continuous presence and embeddedness at the loci of research more specifically,

thus leading to relationship building, comfort and trust with participants over time. I regularly had lunch, spent time waiting in team offices and attended after-work social events at both HS and SESAB as part of immersing myself in the networks of my participants and the culture overall. As such, interactions with many of my study participants involved interactions beyond a formal interview or attendance at a formal meeting. As such, information relevant to my study that was shared with me in such instances was used to iteratively formulate questions which subsequently became part of my formal interview guides throughout the research. In some cases, this was not possible as the information was sensitive for informants to share in a formal interview setting but they volunteered that information with me in informal conversations. As such, information shared with me outside formal interviews or observations but occurring in conversations with study participants and informants at the main loci of research (HS and SESAB) or with medical professionals outside the main loci of research are referred to in the study as "personal communication." In addition to my participant observations at HS as described above, I also attended lectures at UFBA, mainly as they related to the Extension Course "Monitoring and Evaluation of the Public Hospital Network (*Monitoramento e Avaliação da Rede Própria*) offered for SESAB technical officers. This constituted another locus of interaction and network building with SESAB technical officers.

Document Review

In addition to interviews and observation, I conducted document review. Document review included the HS PPP contract, documents on the construction of hospital indicators, hospital audit documents, accreditation evaluation documents, select meeting minutes, HS's official website, the Secretary of Finance website, and the HS epidemiological bulletin for hospital performance indicators. In case I came across questions or doubts in the document review that were relevant to my study and I needed further clarification for, I made sure to include them in my interview guide. Online records of personnel turnover and absenteeism were reviewed and calculated with HS human resources personnel. For publicly available documents, a reference is used in the text to indicate the document title as well as the date when the document was reviewed. For non-publicly available documents to which I was given confidential access, I use the term "Document Review" and include the date of review. If I consulted the document at various times throughout my field research, I labelled the document review time frame as "2018-

2020."

Data analysis

All interview transcripts and digital notes were imported and analyzed in MAXQDA, a qualitative software package for qualitative data organization and analysis. Data from the conducted interviews and observations were simultaneously analyzed to identify codes relevant to the three broad aspects of the dissertation study, namely a) the views of (political and technical) stakeholders about HS and its relationships with different actors, b) the perspectives on organizational behavior and behavior at HS, and c) the views about service delivery and quality improvement projects at HS as compared to public administration hospitals and. While conducting the data analysis in MAXQDA, I additionally kept an Excel spreadsheet with three separate tabs and organized the assigned codes reflecting the three aforementioned aspects of the study. In addition to analyzing and organizing the codes around my three overarching research questions, I was open to and I inductively identified concepts that I did not have going into the research study.

For my data analysis, as for my study methodology overall, I used a grounded theory approach (Charmaz, 2014; Glaser & Strauss, 1967; Strauss & Corbin, 1990). Initially, every interview was analyzed in open coding. Codes assigned to the data were either in-vivo codes as used by the participants in their own words or codes as I assigned to portions of the data to describe my understanding of what the participants shared with me. A total of 5,483 codes were generated. Following, the generated codes were used to capture the larger categories and themes emerging from the data, giving rise to the categories and themes presented in each of the subsequent chapters. This coding approach was followed for interview transcripts, participant observations and field notes. Throughout the analysis, consistent with the Grounded Theory approach, codes and categories were constantly compared to already generated codes and categories for similarities, differences and gaps (Charmaz, 2014; Glaser & Strauss, 1967). It is important to note that data analysis was not limited to the process of coding and theme development. Data analysis occurred interactively throughout the study through data collection, through descriptive and reflective field notes, through purposeful participant selection as well as through the constant iterative process of generating the interview guides used for the generation of new data.

As mentioned in the beginning of this chapter, while Glaser and Strauss (1967) assumed Grounded Theory to be discovered solely from the data, I position myself and my research in the Charmaz (2014) variant of Grounded Theory. Charmaz (2014) assumes a more constructivist approach and posits that theories are not discovered but instead constructed by the study researchers in relation to their interactions with participants in the research setting. The constructivist approach to Grounded Theory is particularly suited to ethnography. Ethnography entails high levels of embeddedness, thus leading to relationship building, comfort and trust with participants over time. I regularly chose to have lunch, to wait in team offices and to attend after-work social events at both HS and SESAB as part of immersing myself in the networks of my participants and the culture overall. These interactions were important since the beginning of the study in constructing the purposive sampling frame of study participants, in constructing the interview guides to inform the research direction but also in constructing the resulting, emerging theories from the research process, combining the richness of all study interviews, observations and interactions from the ethnography.

Maintaining rigor

The SAGE Encyclopedia for Qualitative Methods outlines many approaches to achieving rigor in qualitative research including constant comparison, credibility, triangulation and member checking(*Jensen, 2008; Rothbauer, 2008; Sandelowski, 2008; Stern, 2008*). The following approaches were integral in achieving rigor in my study:

Constant comparison: As previously mentioned, the sampling, data generation and data analysis were reviewed interactively and comparatively throughout the study through purposeful participant selection, through the constant iterative process of generating the interview guides used for the generation of new data collection, as well as descriptive and reflective field notes.

Credibility: Sampling widely across HS as well as SESAB adds credibility to my study. In SESAB, I sampled across departments that were involved with or related to the HS project at two different times, in 2010 and in 2018-2020 when I conducted the study through both purposive and snowball sampling. In addition, at HS, I sampled across the organization with my final sample including leadership members, managers, physicians, emergency nurses as well as

quality team nurses. Conversely, the study would lack credibility had I interviewed only the managers or only the doctors at HS. The choice of an open-ended, semi-structured interview guide was chosen to add credibility to the study as opposed to a closed, structured interview guide. An open-ended, semi-structured interview allowed participants to share their perspectives rather than permitting the study and myself as the researcher to define the context a priori without being open to alternative, additional or more thorough explanation of the data and subsequently the data analysis. In turn, to increase credibility, methodological procedures such as Triangulation and Member checking were employed:

Triangulation: The study draws credibility from comparing data across different methods of data collection such as interviews, observation and record review. As expected, each type of data source provided different angles to either contribute to, confirm or deepen the understanding of a phenomenon. In addition, as mentioned above, data was confirmed through comparisons across different study participants at the different sites involved in the study.

Member checking: As previously mentioned, of the 107 interviews, seven (7) participants were contacted and interviewed twice, while three (3) participants were interviewed three (3) times, at different times throughout the project between 2018-2020, as their position was important for the study and I needed to seek their perspective as the data collection and analysis progressed to clarify doubts or confirm information.

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Chapter 3:

External and Shifting Coalitions of Support and Opposition Should be Identified and Understood as Part of Evaluation for Feasibility, Implementation and Sustainability of PPPs

INTRODUCTION

Autonomy and embeddedness are necessarily relational concepts: from whom is an organization autonomous, and in what is it embedded? This insight dates back to at least Durkheim who noted that in exchange relations, "contracts represent stable exchange relationships through social ties where contractual law and social morality bind actors and prevent them from behaving opportunistically" (Pickering, 2001, p. 293). Durkheim also posits that "in a contract, not everything is contractual" (Pickering, 2001, p. 293), meaning that contracts are embedded in societal rules that go beyond the negotiated, legal terms of the contracts themselves.

Directly discussing Brazil, Peter Evans (1995) describes successful developmental states (or successful developmental parts of states) as having "embedded autonomy"; states "possess a combination of bureaucratic insulation and autonomy while they are also connected to their surrounding social structure through social ties and institutionalized communication channels for continual negotiation and re-negotiation of goals and policies" (Evans, 1995, p. 59). For Evans, the internal organization of states comes close to Weberian bureaucracy which gives states autonomy. However, contrary to Weber who suggests that autonomy means insulation and separation from society, Evans posits that states are inevitably embedded in social ties which bind them to society. For Evans, the combination of different levels of autonomy and embeddedness contribute to state development. Referring to Durkheim's "non-contractual elements of the contract", Evans further posits that "the smooth operation of exchange over the long run requires the dense, deeply developed medium of trust and culturally shared understandings, " adding that "exchange can reinforce these other kinds of ties but it cannot be sustained in their absence" (Evans, 1995, p. 26).

Durkheim and Evans are especially suited for framing this paper as Hospital do Subúrbio (HS) is a Public-Private Partnership (PPP) project bound by a legal contract with the Secretary of Health of the State of Bahia (*Secretaria da Saúde da Bahia; SESAB*) while at the same time the PPP project implementation has been positively influenced by the community in which HS is embedded in as well as the municipality of Salvador, both of whom are important actors separate from the formal, legal HS PPP contract with the state government. This chapter will show that creating opportunities to construct partnerships and engage with local communities through grassroots approaches could be instrumental in contributing to project operations as well as in buffering the relationships with other possible actors. As Ferguson (1994) showed from his early work in Lesotho, Africa, a livestock and range management project was destroyed after year 1 of its implementation – "by the end of the next year, the fence had been cut or knocked down in many places, the gates had been stolen… the office of the association manager had been burned down and the officer in charge of the program was said to be fearing for his life" (Ferguson, 1994, p. 171). Ferguson reminds us of the resistance, destruction and ultimate project failure when community project beneficiaries and their livelihoods are not fully considered in project implementation and a development project does not gain a level of embeddedness in the community where it is implemented.

In addition, while HS is an autonomous organization with its highly organized internal environment and highly selective meritocratic recruitment and performance evaluation processes (to be examined in Chapter 4), HS is also highly embedded in professional norms, expectations and practices. Chapter 4 will also show how HS uses knowledge from its embeddedness to formulate, re-formulate and strengthen its internal operations.

Engagement of project stakeholders is broadly encouraged in PPP feasibility studies (Delmon, 2014; IFC, 2020; IFC consultant, personal communication, August 2020). However, there is a process gap between references to stakeholders that should be considered and *how (the processes through which)* stakeholders are considered and engaged in practical ways that are actually meaningful at gaining embeddedness for better PPP project implementation. Managing different stakeholders for PPP implementation also requires different approaches depending on the nature of relationships with stakeholders and the legal, political and social power embedded in their ties.

The team of directors at Hospital do Subúrbio had to differently negotiate and/or manage its relationship, embeddedness and autonomy with the major actors external to HS: through its legal contract with SESAB, through its partnership with the surrounding local community and through the interdependence of patients with the Municipality of Salvador. As such, the research question that this paper aims to answer is: *How has HS been able to engage with major actors and better manage external and shifting coalitions of support and opposition for implementation and sustainability of the HS project?* This study has implications on how to evaluate future PPP feasibility considering the importance and proper management of relationships with relevant major actors during the life of a PPP project. Furthermore, managing actors through understanding their motivations and incentives, through contractual and non-contractual relationships, is not only important for future PPP feasibility evaluation and implementation but project implementation more broadly, in healthcare as well as in other social service delivery sectors (i.e. education).

Creating an autonomous hospital

In 2007, Jacques Wagner, the Worker's Party (*Partido de Trabalhadores; PT)* elected governor for the state of Bahia, assumed his role with a strong mandate for prioritizing health improvements and delegated autonomy to execute that mandate to Jorge Solla, the Secretary of Health of the State of Bahia (SESAB) at the time. The period between 2007-2011 was characterized by many investments in health and public hospitals: SESAB claimed to have inaugurated 3 hospitals and amplified services in other existing public hospitals, contracted about 8,000 employees through civil service examination, while it also increased the salaries of medical professionals among other health related improvements. In addition, SESAB planned on building two new hospitals. As there was no new urgency/emergency hospital in Salvador since the 90s, one of the two hospitals was to be an urgency/emergency hospital in the city of Salvador (Former SESAB Management Team Member, Interview, June 2018). Even though the PPP model is one propagated by multilateral organizations like the World Bank, there are no indications from this research that HS was an externally imposed project on the state. Drawing from various interviews, it seems that the World Bank and the IFC were consulted for the project as it was the first PPP in the State and the country but it was a decision of the government to engage in such a project and later seek consultation how to draft the contract and aid the state

government to design the project. The reasons to implement the HS PPP project outlined below confirm earlier research which investigated the decision-making process of implementing HS as the first PPP in Brazil (Carrera, 2012).

First, the decision to engage in a PPP to deliver HS as an urgency/emergency hospital has been primarily claimed as a financial one. The Brazilian Law of Fiscal Responsibility (*Lei de Responsabilidade Fiscal; LRF*) determines that the spending on public employees employed by the state across sectors cannot exceed 60 percent of the state Net Current Revenue (*Receita Corrente Liquida; RCL*). Non-compliance with LRF results in penalties on future federal transfers to the sub-national levels, the state in this case, so sub-national governments try their best to avoid exceeding the LRF limit (Former SESAB Management Team Member, Interview, June 2018, Former SESAB Technical Officer, Interview, June 2018).

Second, given the limitations of LRF on personnel hiring, SESAB and more specifically Ex-Secretary Solla decided to consider an alternative organizational model for the new hospital of HS. The options included contracting the not-for-profit OS hospitals or introducing the first PPP in the country and the state. The decision of the state government to adopt a PPP approach was based on the experience of Jorge Solla who knew first-hand the challenges with the other organizational models including not-for-profit hospitals many of which dealt with delays in payments from SESAB as well as had a contractual focus on production rather than quality of services (Document Review, 2018-2020). In addition, there was no OS hospital with an urgency/emergency profile in the state which added to the question of whether an OS would be possible for an urgency/emergency hospital (Sefaz Technical Officer, Interview, September 2018).

Third, delivery of quality services, especially urgency and emergency services, in a suburban, distant and isolated area in Salvador was of major concern. The delivery of quality services would be challenged by the commitment of personnel to work at a hospital which was located in such a remote location as HS. Some participants shared:

[HS] was at the end of the world. There was no asphalt, no public transport to get there. That is to say, what doctor wants to go [work] there? … it was not a place that anyone wanted to go to work… they had no interest in working there (Technical officer, Interview, June 2018).

We have few medical professionals, and with several specialties, it would be really difficult to put a neurosurgeon, anesthesiologist, vascular surgeon, [even if we were able to implement HS] under a direct [public] management hospital (Former SESAB Management Team Member, Interview, June 2018).

Due to the location, it was feared that it would be difficult to recruit state doctors to work in the region that was dangerous and a region far from the middle and upper-middle class housing centers (Sefaz Technical Officer, Interview, September 2018).

Trying to explain the difficulties of public administration which led to deciding to advocate for and implement HS as a PPP, a study participant shared:

We did a study and found broken equipment and sub-utilized equipment for many days due to maintenance problems, due to lack of personnel, lack of a functioning imaging center... So technological lag and an inefficient management model result in low productivity. Obviously a low productivity today in the imaging field means more time for inpatients in addition to other indicators... It makes diagnosis difficult. It causes delays (Former SESAB Management Team Member, Interview, June 2018).

As previously mentioned, while HS was the first health PPP in the state and the country in 2010, there was already existing PPP legislation at the national (11.079/04) and state level (9.290/04) for the regulation and promotion of PPPs. In addition, in the state of Bahia specifically, the proposal for a PPP was new for health but it was not new for other sectors as the state already implemented a PPP for the Submarine Emissary Project in 2006. Structurally, the state had an active PPP unit at the Secretary of Finance of the State of Bahia (*Secretaria da Fazenda; Sefaz*), mechanisms which were built in place to mitigate the risk of government payment default as well as a determined spending cap for PPP state projects of 5% of RCL across sectors (Document Review, 2018-2020; Sefaz, 2020). In 2010, when two new hospitals were being considered at the state level (an urgency/emergency hospital in Salvador and a childrens' hospital in a city near Salvador), a choice had to be made about which one would be implemented as a PPP given the 5% RCL state limit on PPPs across sectors (Former SESAB Management Team Member, Interview, June 2018). Considering the possible challenges with

commitment of high specialty doctors in a remote environment for an urgency/emergency hospital like HS, SESAB and the state government decided on HS as the hospital for PPP implementation. In addition to some resistance created (explained more thoroughly below), many participants shared a puzzle that intrigued them: how was it possible that PT, a socialist, center-left party decided to propose, mobilize and implement HS as a PPP, a neoliberal policy tool? As a response, a study participant shared:

There is a very broad debate about what a socialist party is and if we can consider the PT to be a socialist party. I think I would hardly define the government of the state of Bahia as a socialist government. It is far from that. First, [the government] is not a PT government; the governor is PT, but the government is a coalition of several parties (Former SESAB Management Team Member, Interview, July 2018).

It is important to highlight that over decades, the Brazilian national Universal Health System (*Sistema Unico de Saúde; SUS*), has sought different ways to combine the way it delivers health care services: through directly administered public hospitals, through indirectly administered hospitals managed by contracting OSs, non-profit social organizations as mentioned above, as well as through contracts for many health procedures from philanthropic or private providers (Paim et al., 2011). Considering, proposing and implementing a PPP for HS was claimed as another form to complement the various modalities in which services are already offered in the country and the state:

SUS has sought to combine [models of healthcare delivery]. I have defended a more heterodox view myself. I think we have to use several alternatives within a system of this nature. We have to strengthen direct management and we did this with civil service examination, with an improvement in salary standards. We strengthened the relationship with social organizations. And we also experimented with PPPs (Former SESAB Management Team Member, Interview, July 2018).

Following its creation, HS had to manage different relationships. These included a) the relationship between HS and SESAB which implemented the HS project itself, but which underwent leadership changes following election in 2015, b) the relationship between HS and the

local suburban communities surrounding HS as well as c) the relationship between HS and the municipality of Salvador. The next section will explain these relationships in detail.

RESULTS

The results of this paper will provide evidence about how HS managed its relationships with respect to major actors external to HS over time and how that mattered for the HS project implementation and its sustainability over the past 10 years. This section will predominantly provide evidence for the relationship between HS and the State of Bahia, more specifically the Secretary of Health (SESAB) which is the responsible actor and representative of the government for the HS project. Second, the results will provide evidence for the relationship which was developed over time between HS and the local neighborhoods in the vicinity of HS. Third, this section will also refer to evidence for the interdependent relationship between HS and the municipality of the city of Salvador. Taken together, the results will provide evidence about how HS managed to gain "embedded autonomy" by constructing and/or managing its "contractual and non-contractual" relationships with its different external actors over time and election cycles.

Relationship with the State Government

HS as a political project

HS was a political project spearheaded by a PT Governor and a PT Secretary of Health in the State. The choice for the location of HS was technical as well as political; the area where HS is located serves as the entry to Salvador from the interior of the state, it is near the main state highway where there is high incidence of traffic accidents, while the broader area encompasses extremely low-income neighborhoods where primary care is very low, with few low performance primary health care units (*Unidade Basica de Saúde; UBS*) and community emergency care units (*Unidade de Pronto Atendimento; UPA*) (Document review, 2018-2020; State Health Council Member, Interview, September 2018; Community leaders, Interview, October 2018). Even though an urgency/emergency hospital would not provide for the unmet primary health needs of the population, it signaled that the PT party initiated a health-related project considering the population of the region, a forgotten population, an invisible population, while it also served as a gateway to urgency/emergency services for the rest of the population of

Bahia. In addition, commerce is concentrated in Periperi while the neighborhoods of Periperi and the attached neighborhoods of Paripe and Plataforma constitute some of the most populated areas in Salvador for building political support (Community leaders, Interview, October 2018; Casa Civil, 2020). Furthermore, the inauguration of the hospital was planned for the 13th of September 2010, with number 13 representing the Worker's Party Superior Electoral Court Identification Number, thus sealing HS as a legacy of the PT party and the specific administration at the time (Document Review, 2018-2020).

The resistance

The technical and political intentions of the government to introduce HS as a PPP were met with ideological resistance within the PT party, within groups of technical experts in SESAB, with workers' trade unions as well as with the broader suburb community. Some technical experts in SESAB and workers' trade unions met the project with resistance as an ideologically neoliberal tool which reflected the inability of the government to provide health services for its population while it also reflected strongly held positions about workers' rights and advocating for employment stability of health employees. While the project management for the HS project was assigned to technical experts who were strongly affiliated with the PT party, it was subsequently sub-delegated to other experts in SESAB to diminish intra-party tension (Former SESAB Technical Officer, Interview, August 2018). Like many technocrats in SESAB, trade union representatives saw HS as another project reflecting a shift away from state ownership and strengthening of SUS to privatization, thus weakening of the SUS ideology (Trade Union officer, Interview, September 2018, State Health Council Member, Interview, September 2018; SESAB Technical Officer, Interview, October 2018). Furthermore, SESAB had to face resistance from the suburban community in which HS was to be constructed. It has been reported that even before HS was operating, construction of the hospital had to stop many times because bodies were found and needed to be identified before construction could continue. In addition, there were threats from the drug dealers about building a hospital at the specific site (Sefaz Technical Officer, Interview, September 2018; State Health Council Member, Interview, September 2018).

The HS PPP has been described as a project of the government, drawing communication about the project across various secretaries, including SESAB as the representative of the project, the Secretary of Finance (*Sefaz*), the State Attorney General's Office (*Procuradoria*

Geral do Estado; PGE), the Secretary of Administration, the Secretary of Planning and Casa Civil. In addition to the agreement and collaboration across many secretaries to implement HS, many participants overall highlighted the networking skills of the Secretary of Health himself to deal with the members of the government, his party, the technical experts in SESAB, the unions as well as the community to decrease as much resistance as possible, commenting than no one else other than Ex-Secretary Solla and no other party than the PT party could have dealt with the resistance from any of the these actors better to continue towards implementation of HS, technically and politically (SESAB, Technical Officer, Interview, June 2018; Sefaz Technical Officer, Interview, September 2018; SESAB Technical Officer, Interview, September 2018; SESAB Technical Officer, Interview, October 2018). One of these study participants specifically shared:

A crucial point was that it was a left-wing government that was convincing the medical profession and the healthcare sector [to accept the HS PPP project]. If it were another non-left government, it would be difficult to accomplish this project because there would have been strikes, there would be a series of judicial measures. So, however paradoxical it sounds that a leftist government attempted this project, it was extremely important to convince the medical class, the unions, the associations of doctors, the nursing associations, all actors in health to accept this form of hiring and to break the paradigm that a PPP is a privatization process…

The same participant continued:

For you to have an idea, the hospital construction had to stop several times because the site of construction was an area for discarding corpses. They had to stop, call the police, identify the bodies. There were threats from drug dealers in the region who did not want the hospital project. At this point again, the left-wing government was important in working with the community and convincing the community. It is paradoxical that a left-wing government takes on a PPP, but in this specific case, if it were not a left-wing government, this project would hardly have succeeded... it would be of no use to just assign the police to arrest the drug dealers if you did not have the population's support. The project would not have worked (Sefaz Technical Officer, Interview, September 2018).

While the resistance was one minor challenge in the decision-making and ultimate implementation of HS, other challenges arose over time. These included contract monitoring challenges, calculation and payment of extra demand for services as well as regulation of high severity patients between SESAB and HS. These challenges will be explained next.

Contract Monitoring challenges

The government who established HS under Governor Jacques Wagner and Secretary of Health Jorge Solla completed a first 4-year term from 2007-2011 and a second 4-year term from 2011-2015. In 2015, the party in power, PT, did not change, however, the new actors who assumed leadership since then have chosen to build an alternative legacy in health for the state, focusing on the establishment of policlinics across the state. Even though HS survived as a project, the results below will show that a number of challenges in the contractual relationship between HS and SESAB arose over time.

As already mentioned, as part of the contract, SESAB was expected to monitor, evaluate and regulate the HS project/contract through the Monitoring and Management Committee (*Comissao de Acompanhamento e Monitoramento, hereby referred to as PPP Monitoring Committee/SESAB*). However, that monitoring process has been very fragmented and was met with many administrative and structural challenges embedded within SESAB. These challenges were present from 2010 until 2015 when the project started but they became even more challenging and complicated to deal with between 2015-2020 with the change in SESAB leadership. As interviewees shared, in the beginning of project implementation from 2010-2015, the PPP Monitoring Committee was composed of a rather stable team. Despite stable, the team was composed of nursing professionals by training who were assigned technical positions in SESAB but who were never trained in dealing with PPPs, monitoring of indicators or the legal terms of such a complex PPP contract. One technical officer shared that her hesitation about the HS PPP project when it was presented was precisely because she was unsure of the capacity of the state to monitor and regulate such a complex, long project. She shared:

We had never dealt with this type of contract. Once the project was approved and the work started, SESAB had to set up a specific and exclusive commission to monitor the [HS PPP] contract because it was a contract requirement. If you ask me 'was this commission prepared?'

... No, we had to improvise… We were learning as we were doing. [We were] changing the tires while the car was moving (Former SESAB Technical Officer, Interview, June 2018).

One technical expert shared her experience with respect to the perfunctory preparation of the SESAB Committee to take on responsibility for monitoring the HS contract from the beginning of the project:

> *There was no training on how to do the monitoring /how to act. There was only a course given by Sefaz but [that was] on what a PPP is in a macro perspective. [We received] no [training on] monitoring, on how to measure indicators, how to analyze indicators* (SESAB Technical Officer, Interview, January 2020).

Despite this technical experience challenge and as there was also no legal expert on the committee, the committee members worked closely with the technical and legal officers of the PPP unit housed in Sefaz to resolve any doubts or concerns regarding the HS contract. Despite getting help from Sefaz in the beginning of HS operations, issues with regards to extra payments, performance penalty payment adjustments and contract remodeling due in 2015 remained as the three major pending issues that were very challenging to be resolve over time (SESAB Technical Officer, Interview, September 2018; SESAB Technical Officer, Interview, January 2020; Document Review, 2018-2020).

Having experience with the instability and the high turnover of technical officers in SESAB and considering the complexity of the HS contract as well as necessity for institutional memory especially for such a project over its projected 10-year duration, the Superintendence of Comprehensive Health Care (*Superintendência de Atenção Integral à Saúde; SAIS*) which housed the SESAB Monitoring Committee in 2010 wished to assign public employees to the committee (Former SESAB Technical Officer, Interview, January 2020; SESAB Technical Officer, Interview, September 2018). Having regulatory functions exercised by employees who will not result in high turnover as a possible way for better structures and institutional memory is a logical assumption some other study participants also shared (SUS Auditing Body Officer, Interview, September 2018). However, evidence shows that assigning public employees to the HS project did not prevent their high turnover on the committee and their choice to leave for another project or sector within SESAB. Overall, during the life of the HS contract from 2010-

2019, there have been 8 committees with about 18 different people joining and leaving the committee, with anywhere between 1 and 5 people serving on the committee at any given time (Document Review: History of Monitoring Committee of Contract 030/2010 Ordinances, October 2019). Reasons for leaving the committee include personal, family or health reasons, as well as frustration with the inability to handle the demands of a project like HS, including the inability to conduct technical visits, calculate the extra payments, participate in the contract remodeling, represent the project in different meetings or audits, argue/defend the project, select the Independent Evaluator or receive state authorities and auditors about the project (SESAB Technical Officer, Interview, September 2018; SESAB Technical Officer, Interview, January 2020; Document Review, October 2019). A study participant shared:

The HS contract was like "hot potato" - no one could take it and would pass it on to the next person. It was like this: 'See if you can get someone to come!" [to work on the HS contract commission]. It is difficult to have fixed staff. Many people prepare reports as needed but it is rare to have a fixed person to make project progress (SESAB Technical Officer, Interview, January 2020).

It should also be added that the members considered to be officially on the committee as published in the official diary (*diario official*) of the state were neither exclusive to the HS PPP contract nor working full time on the committee; instead, some shared their working time with other sectors in SESAB or were dividing their time between two more PPP projects as those were developed and added under the responsibility of the same committee. A participant expressed that despite the apparent challenges from the beginning, SESAB was "*lucky to have Prodal*" for running HS and added that even though the first commissions had a number of challenges, they accomplished a more effective communication between SESAB, Prodal and Sefaz in their attempts to reach resolutions (SESAB Technical Officer, January 2020; SESAB Technical Officer, Interview, February 2020). Lack of proper governance and monitoring from the SESAB Monitoring Committee has been cited as a risk to the contract and the government itself:

I think that there is no system defined in the contract that is efficient if you do not have a trained and somewhat permanent monitoring during the process. Quantity [of capable people] matters . They [SESAB] also claim that they cannot handle the monitoring because of the [low]

number of personnel. Training matters too. You lose a lot when the person starts to understand the complexity [of such a project] and has to leave because the Secretary of health changed. In short, you jeopardize the contract (State Attorney General Office Member, Interview, September 2018).

A participant added:

We were lucky that we found a competent partner and it is working. What if it didn't work? This is a problem. It is an unknown so it is a risk (Former SESAB Technical Officer, Interview, June 2018).

Study participants shared that in 2015 with the change in SESAB leadership, the incoming new Superindendent of SAIS did not want to assume responsibility of HS within his unit, therefore the HS contract (and subsequently the HS Committee) moved to the Secretary's Office (*Gabinete do Secretario*) until it was undertaken back by SAIS with yet another incoming Superindendent in 2016 (HS Management Team Member, August 2018; Sefaz Technical Officer, Interview, September 2018; SESAB Technical Officer (2), Interview, January 2020; Document Review, October 2019). One participant shared her concern with the responsibility with respect to the HS contract:

No one called himself owner of/responsible for Subúrbio. We had that a lot. It was in limbo. Who is responsible for Hospital do Subúrbio? SAIS used to say: 'It is not mine because it is PPP… what belongs to [our] network are only the public units managed directly and the units under indirect management by social organizations.' Truth be told, it was always very loose with Hospital do Subúrbio (SESAB Patient Regulation Technical Officer, Interview, August 2018).

An auditor shared his perspective on the consistent lack of a regulatory role of SESAB:

[SESAB] has not set up an effective regulation control system, with [the appropriate] structure [for the HS contract]… we have pointed out that a lot in our [audit] reports, but we have not yet sensitized [SESAB to make that change]… The technical structure in SESAB is very insufficient… They do not have a process, they do not have a procedure [in place]… They did not institute a control, they left a person stuck between different demands of the contract in a

demobilized way, so [that person] cannot even think… The SESAB structure is already like that. SESAB's control structure is terrible for all contracts, not only for [the HS] PPP contract (SUS Auditing Body Officer, Interview, September 2018).

Another participant explained the impact of this high turnover of personnel in SESAB and lack of institutionalization of processes:

These constant team changes are terrifying because you do not have a mechanism [in place]. [As such] you lose all the history and all the memory [of any processes]. That is really very terrible… There is no contact [of people who served on the committee before], we look for documentation and we don't find it, it is all loose (SUS Auditing Body Officer, Interview, October 2018).

Taken together, the evidence of lack of PPP technical expertise and the high turnover of members on the Monitoring Committee show that regulation by the SESAB monitoring committee has been very weak, unstable and exposed the HS contract to various risks. Even though the HS as a project was secured via a legal contract and could keep its autonomy through its contractual terms, the contract was embedded in a perfunctory public administration structure. This meant that the HS Management Team had to constantly manage the rotating actors that joined and left the project, with very little to no institutional memory for the Monitoring Committee. Given this situation, there was no room for building a long-term relationship between HS and SESAB as partners on the HS project and for the relationship to be effective towards fulfilling the monitoring obligations of the HS contract through a true partnership between HS and SESAB.

As the Monitoring Committee was weak and unstable and fulfilling its contractual responsibilities was a persistent challenge, SAIS/SESAB decided to engage other bodies to provide oversight to the HS contract. This included engaging the Independent Evaluator and the SESAB Auditing body as well as forming the Mediation Committee in an attempt to resolve long-standing contractual discrepancies. The next session will explain those aspects.

The Independent Evaluator, Auditing Body and Mediation Committee

As mentioned above, one of the biggest challenges and points of contention of the HS contract over time has been the issue of extra payments for HS's delivering services above the pre-determined volume of services defined in the contract. While the contractual monthly disbursement is made to Prodal every month without any delays via a legal payment mechanism, extra payments for extra demand were made to Prodal only in the first three years of the HS project, with no extra payments made thereafter for the remaining 6 years of the project. The HS contract remodeling which was built in the PPP contract and which aimed to resolve any contractual issues based on the experience of the partnership in the first 5 years from 2010-2015 was not completed before the 2007-2015 political leadership left office or after the 2015-2019 leadership assumed office. The remodeling proposal was designed to precisely address the allocation of risk and extra payments resulting from the demand for extra services at HS. In February 2020, the contract remodeling due in 2015 had still not been completed. It also remains unclear how the extra patient demand is calculated and by whom with some claiming that it is Prodal who calculates it and some claiming that it is the Independent Evaluator that has that responsibility. Even after a mediation committee intervention in late 2019, one pending issue remaining has been how to better assign that responsibility for calculation of extra payments between SESAB, the Independent Evaluator and Prodal (Document Review, 2018-2020), an issue that could have been resolved in 2015, or via better communication between SESAB and HS.

As explained above, the instability of the Monitoring and Management Committee and the unresolved challenges with respect to extra payments due to extra service demand, contract remodeling and penalty payment adjustments based on indicators, remained across both leaderships in SESAB during 2010-2015 and 2015-2020. Trying to make-up for the weak monitoring team, two of the latest SESAB approaches in 2018 have been to engage more with a) the HS contract Independent Evaluator hired as part of the PPP contract as well as with b) the SUS Auditing Body housed in SESAB. These approaches to shift more monitoring and auditing responsibilities to the SUS Auditing Body have been met with criticism by Sefaz as well as HS, claiming that SESAB has been attempting to monitor HS in the same way it has been monitoring and managing its directly and indirectly managed hospitals, without having full understanding that the premise of a PPP contract is based on delivered performance, not on the mechanisms employed to reach that level of performance, creating tension between HS and SESAB and its

traditional ways of bureaucratic control (Sefaz Technical Officer, Interview, September 2018; HS Management Team Member, Interview, June 2018).

These results show that the perfunctory role of the Monitoring Commission left a lot of monitoring gaps and unresolved issues across management teams in SESAB. In an ad-hoc approach to resolve some of these issues, SESAB gave more control to the SUS Auditing Body, creating tension between HS and SESAB and its traditional ways of bureaucratic control. As SESAB and HS could not solve their contractual pending issues through dialogue and communication, a mediation committee was formed in 2019. The role of the mediation committee for resolution of pending issues is a contract element to reach resolution for unsettled issues between SESAB and HS without resorting to justice as that alternative would be a very costly and lengthy path for resolving contractual challenges (Document Review, 2018-2020; SESAB Technical Officer, Interview, January 2020). It is also worth mentioning that Dalkia, the company which originally partnered with Promedica to form the Prodal consortium to bid and win the HS contract, decided to withdraw itself from the consortium in 2016 after all the aforementioned pending issues, especially SESAB's inability to fulfill the extra payments, leaving Promedica as the sole owner of the HS contract (Technical Officer, Interview, June 2018). As these results continue to show collectively, HS kept its autonomy and continued with its clinical operations through its legal contract, but it had to manage its increasingly challenging and unresolved contractual relationship with SESAB. This is important to consider for assessing the feasibility of future PPPs in which the government taking on such a complex project might not be technically ready to manage such a project and itself pose a huge risk to the project itself though its inability to monitor and regulate the PPP contract.

Case Severity and Regulation of High Severity Patients via Patient Regulation/SESAB

In addition to the challenges with respect to payments associated with extra service demand, contract remodeling and penalty payment adjustments, HS and SESAB had to find ways to better communicate and navigate a coordinated approach with respect to providing services to high complexity patients and fulfilling the needs of the health system network more broadly as determined by SESAB's Superintendency of Management of Health Care Regulation Systems (hereby Patient Regulation/SESAB) (*Superintendencia de Gestão dos Sistemas de Regulação da Atenção à Saúde*). The Patient regulation system is a patient referral system created to manage

patient needs within SUS. Before its creation, patients needed to seek care from hospital to hospital on their own. However, with the creation of such a referral system, patient referrals to hospitals or patient transfers from hospital to hospital based on clinical severity, suffering and health risks (SESAB, 2020).

Intended as a medium/high complexity hospital, HS was criticized for attending only a small percentage of high intensity patients, although their numbers as a proportion of total cases did increase over time. While SESAB criticized HS for delivering only a small percentage (less than 10 percent) of high complexity emergency services, there was also an understanding that this was mainly due to the nature of an open-door hospital in an area of very sparse primary care services and acknowledged the efforts of the hospital to work with the community to shift the delivery of low/medium cases to medium/high severity cares as mandated by the HS contract over time. As Figure 1 shows, the number of non-urgent (blue) and slightly urgent (green) cases decreased by about 30 percent and 21 percent respectively over time while the number of urgent (yellow) and very urgent (red) cases increased by about 42 percent and 8 percent respectively between 2010 and 2018. These percentages take into consideration that the total number of cases decreased by 60 percent (71,672 adult cases in 2010 as compared to 29030 adult emergency cases in 2018) mainly due to the decreased number of low/medium cases.

Along with the criticism about attending a small number of high complexity emergency patients, HS was also criticized for not accepting patients from other institutions in the health system as requested by the Patient Regulation/SESAB. Prior to 2018, there was little communication to align goals and approach this challenge between SESAB and HS but there have been consistent meetings since the beginning of 2018 in order to deal with these two challenges of low high severity case delivery and better regulation especially of high risk patients between hospitals units in the health system (Patient Regulation Technical Officer, Interview, August 2018; Observation, 2018-2020; Document Review, 2018-2020). Communication between SESAB and HS increased the numbers of patients regulated by month (SESAB-HS Patient Regulation Meeting, Observation, September 2018; HS Weekly Meeting, Observation, February 2020). A participant shared with regards to the new approach for communication between HS and SESAB:

I think it is not just communication, it is [also] political will. It is a desire to do it. Today he [the current Secretary of Health] has political will that he did not have before. I do not know

why. With political will, you can assemble a team, [and hold the team] accountable. Undoubtedly, control mechanisms are still very scarce; [there is] lack of personnel, lack of structure, lack of know-how, lack of everything. But at least there is a greater will, without a doubt (SUS Auditing Body Officer, Interview, October 2018).

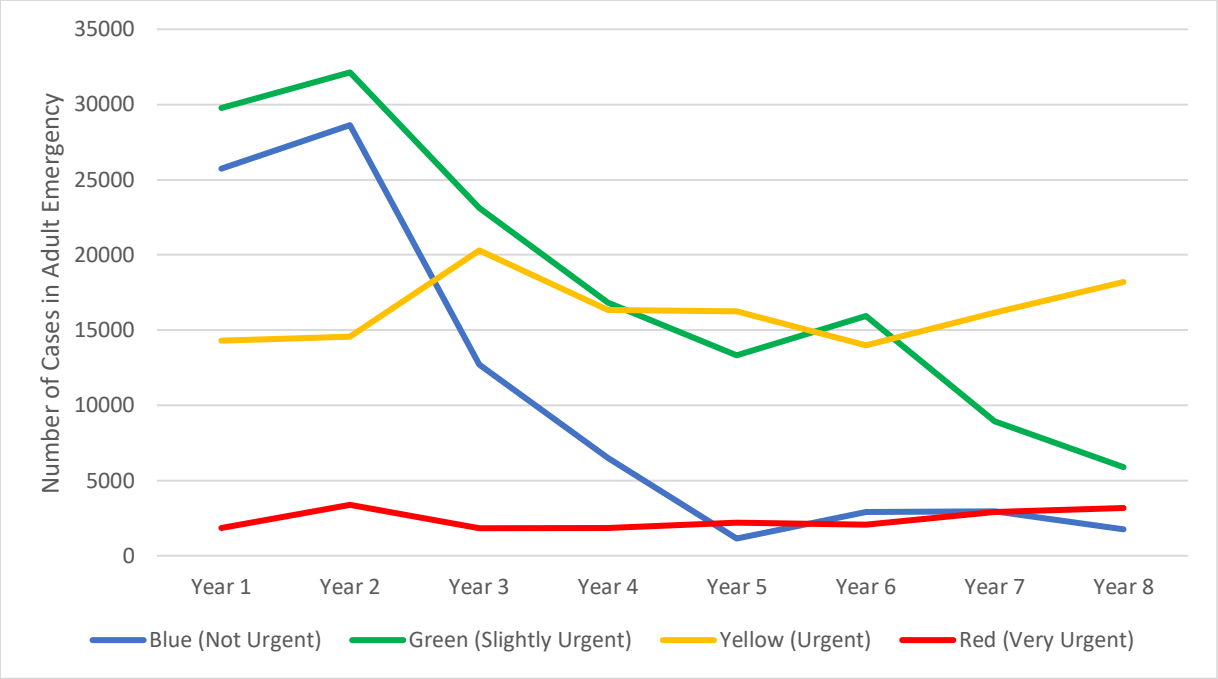

Figure 1. Number of cases by risk classification in adult emergency at Hospital do Subúrbio (HS), Year 1-8 (Source: HS Epidemiological Bulletin, 2017-2018).

Even though political capture was not cited as a concern or a factor in deciding the open-door design of HS in 2010 instead of a reference hospital regulated by SESAB, there were concerns that given the weakness of regulation of patients, HS would be taken advantage of by having only critical patients directed to HS through the regulation of patients in SESAB (Former SESAB Technical Officer, Interview, October 2019). As this was a concern in the early years of the project, SAIS/SESAB had produced documentation noting that a patient treated at HS through Patient Regulation and receiving exit should be counted as five hospital exits instead of one hospital exit at HS. However, due to the personnel turnover in SAIS/SESAB, there was no history about the logic of such a decision. Even with the reasoning finally traced through audits, it was determined that legally, the SAIS documentation could not have amended the HS contract; this legal issue and its implications on indicator reporting for HS became a contract challenge to

be resolved retrospectively by the mediation committee in 2019 (Document Review, 2018-2020; SUS Auditing Body Officer, Interview, September, 2018; SUS Auditing Body Officer, Interview, October 2018). Finding about the invalid HS contract amendment by SAIS brought about more challenges in retrospectively calculating indicator fulfillment at HS as some contract indicators seem to depend on the number of patient exits at HS.

Throughout the 9 years of operations, there have been political attempts to indicate patients for treatment at HS. Even though the team of directors at HS refuses to simply accept any patients at HS via political indication, HS acknowledges that the Center for Patient Regulation, which would normally refer patients to HS might be somewhat slow and unable to absorb all the demand for transfers in a way to provide timely patient care. As such, as a response to such indications for treatment, HS asks that 1) the indicated patients seek care at HS if their condition is within the HS clinical profile and 2) the indicated patient will not just be given priority once he/she reaches HS; instead, he/she will go through a risk classification assessment based on other patients at HS at the time. One study participant shared:

There is also [tendency to treat patients by indication], but if that is also within the institution's profile. For example, it is not [possible to] bring a patient with a cancer [related] condition to HS. One may come through an indication but [the candidate's clinical condition has to be] within the profile of the hospital…" In addition, she continued: "He/she will not have priority… the normal process today [requires] every patient to enter HS through [SESAB's] Patient Regulation system. However, Patient Regulation cannot absorb all the demand in a short period of time… So, it goes like this: if Maria and Joana are in a similar clinical situation within the profile of HS and Maria is politically indicated and Joana is not, I will not prioritize Maria regardless of Joana. That doesn't exist either. [Accepting instances of indications] happens more in pediatrics because there are more available beds… but we will not take a patient out of a bed in order to be able to give it to someone else. We will not see a patient on the [regulation] screen who is more serious and give [treatment priority] to another who is not [as serious but indicated] (HS Management team member, interview, October 2018).

The results from this section show that HS and SESAB had a number of challenges to deal with, including a technically weak and unstable monitoring team, delays and confusion about the calculation and payment of healthcare services beyond the contract as well as a weak

regulation of high severity patients. As shown in Figure 1, the decrease of non-urgent and slightly urgent cases did not happen without consistent efforts between HS and the local community. This relationship between HS and the local community will be the focus of the next section of this paper.

Relationship with the Local Community

The suburb region where HS is located is one of the 18 administrative regions in the city of Salvador and consists of 22 districts/neighborhoods, with HS located in the district of Periperi. The population in the suburban region surrounding HS is predominantly black, low-educated and low-income. In contrast, the management and medical teams at HS are predominantly white.

Hospital do Subúrbio was constructed not only in a low-income but also in a remote and violent suburban area of Salvador. In addition to finding corpses and receiving threats during the construction phase of the hospital as mentioned earlier, a HS employee also suffered a knife assault in the beginning of the hospital implementation (HS Management Team Member, Interview, August 2018; Sefaz Technical Officer, Interview, September 2018; State Health Council Member, Interview, September 2018). As a result, employees felt very unsafe. Many study participants expressed the lack of safety and the distant location of HS as factors that contributed to the high personnel turnover in 2010-2011 at the beginning of hospital operations (HS Employee, Interview, June 2018; Document Review, 2018-2020).

Second, in addition to safety concerns, the community found it difficult to understand the urgency/emergency profile of the hospital and HS had to work with the community and community leaders for better communication, sensitization and education regarding the hospital profile and the type of patients HS could not treat. In 2012, it was reported that the relatives of a patient who died of leptospirosis invaded the hospital with the coffin of the deceased patient body to protest the death of their relative (Globo, 2012). A study participant shared:

... we had to work with the community to [help them] understand the purpose of the institution. [We had to explain] that the hospital has a risk classification. Many people questioned why the hospital did not serve them and instead directed them to other service units in the community. So, we called/included the community leaders. They come to the hospital for a meeting during which the hospital indicators are explained to them and we discuss how we can

contribute and collaborate with each other. This approach was essential as they increasingly understood the purpose of the institution. Today we suffer less with this issue of demand deviation (HS Management Team Member, Interview, June 2018).

Another participant shared:

You have to talk to the people and say: 'If you have an ingrown toenail, don't go to the hospital', because the hospital has a certain profile. You have to raise awareness; you cannot force a patient not to go or prohibit entry; it is an open-door hospital. You have to communicate, convince the population that if they are in queue being treated for an ingrown toenail, they are taking the spot of someone who was shot, had an accident on the road, [or] has a heart or respiratory problem (Technical officer, Interview, June 2018).

Members of the suburban community shared how they value that HS accepts to be in communication with poor people "in flip-flops and without a diploma" and expressed their concerns about a possible different partner taking over the HS contract:

We do not know if those who might come to administer [HS] will have this patience, if they will want to be talking to people in flip-flops who do not have a diploma, because unfortunately there are people who only want to talk to other people if they have a diploma… if they have an expensive jacket… (Community Leaders, Interview, October 2018).

Community leaders also shared that they value the role that they have between HS and the community and they take pride in the education they engage in as part of their leadership responsibilities:

Wherever I go, I talk [to people about not going to HS for minor health issues]… It is also a leadership ... It is so important… I am always passing information and guiding people, in my community, in other places… Sometimes, we, as a community have a health fair. We do some of the education there as well. We explain that checking blood pressure and blood glucose are the obligation of the municipality, [to be done] at the UBS. We have to look for an UBS because when we occupy the space of trauma [at HS], those who need assistance there at that moment may die because [the spots] are being occupied by people who are only feeling a headache (Community leaders, Interview, October 2018).

Even though low severity cases have decreased drastically between 2010-2019, seeking care at HS for low severity concerns is still an on-going challenge 9 years later into the project (Document Review, 2018-2020, Patient Regulation Meeting, September 2018; Figure 1). As such, HS continues the communication, sensitization and education with the community members and leaders whenever there is an opportunity to do so with the message that the people that cannot be treated at HS 'are not less important but their medical complexity is less important' (HS-Community Leaders Meeting, Observation, July 24, 2018).

Given the need to overcome the aforementioned initial safety concerns as well as ongoing education about the HS profile, HS established relationships with the community through various approaches including involvement of community leaders from the beginning of operations, forming informal income generating partnerships with the surrounding community, advocating for and bringing advantages for other sectors in the community, and hiring people from the community. Each of these approaches are further explained below:

Involving community leaders since the beginning

The relationship that HS has built with the surrounding suburban communities over time has been highlighted and praised by many study participants (SESAB Technical Officer, Interview, June 2018; Sefaz Technical Officer, Interview, September 2018; HS Management Team Member, Interview, June 2018). Through consistent communication, the community embraced the project and the sense of insecurity that was very prevalent in the beginning has been significantly reduced over time (HS Management Team Member, Interview, June 2018; Community leaders, Interview, October 2018). In the beginning, HS had to directly sensitize the community and communicate that HS was there for the population and if the employees were being attacked, the hospital could not operate; as such, it would not be able to treat them and their families in case needed. This work was also accomplished via communication with community leaders who were involved and invited to HS since the beginning of hospital operations. The communication with the community leaders has included regular trimester meetings during which the HS trimester results are presented to the community leaders. These meetings also serve as a forum for community leaders to get together and have a communication with HS as well as state and municipal representatives that are invited as well. The trimester

meetings at HS mean are of tremendous value to the community leaders. They express their gratitude for being considered, for being invited to the hospital, that a presentation is made for the that the HS directors know them by name. Attendees during the HS-Community leader meetings, express that HS is the only hospital that invites and accepts members of the community in their slippers, meaning that they accept the community members despite being of a low socioeconomic status (Community Meeting Observation, October 2019).

In addition to the trimester community leader meetings, HS invites the community and community representatives to join HS to celebrate Christmas mass at the hospital as well as the birthday/inauguration of the hospital with HS personnel (Community Leaders, Interview, October 2018; Observation, 2018-2020). Furthermore, if a community event is happening (such as the health fairs mentioned previously by the study participant) and the community members invite HS to attend, HS sends a representative to participate at their event in their respective district, something which the community members value a lot (HS Management Team Member, Interview, July 2018). HS visibility in the community as well as community member visibility at HS is very important for community engagement considering the high-power distance that exists between the predominantly black, low-educated, low-income suburban communities and the predominantly white, medically trained HS Management team. This is important as these relationships build partnership, community members feel HS hospital as part of their community and they are willing to go in their respective district communities and educate the population about the hospital profile as part of their contribution to the sustainability of the hospital (Community Leaders, Interview, October 2018).

Forming Informal partnerships

In an effort to build relationship with the community, HS has also been supporting approaches that could be benefiting the community and the specific low-income population. To give an example, HS has been providing a community cooperative with cardboard boxes that it would otherwise discard, and the cooperative repurposes or sells them. Likewise, instead of disposing of machinery that is broken or no longer in use at HS, HS provides that material to members in the community who collect or sell the iron material and other equipment parts (HS Management Team Member, Interview, July 2018). Last, HS has indirectly brought income opportunities for members of the community including food stands and funeral services around the hospital where

none existed before (Community leaders, Interview, October 2018; Observation, 2018-2020). While it might seem unnecessary to consider such seemingly minor arrangements as collaborations with cardboard boxes or old machinery collectors in the community, they provide practical examples of how HS has engaged with the community in meaningful ways for community members to feel supported by HS. As mentioned before, this is particularly important in a place like HS and its vicinities, characterized by high-power distance between the low socioeconomic status community members and the hospital administrators and medical professionals.

Offering advantages for sectors outside health

In addition to informal partnerships described above, HS provided advantages in the health sector for the suburban communities surrounding HS but also in other sectors such as transport, illumination, roads, and garbage collection for the suburban area surrounding the hospital. A study participant shared these challenges and opportunities:

> *... the difficulty was the lack of insertion and participation of other segments of the public sector in the location of HS. We did not have public transport, we did not have lighting, we did not have a completed road. It was very difficult to attract health professionals. This it was a great challenge that we had in the first 6 months of operation of the hospital. It was a very high turnover of personnel because this region here was known for the [challenging] community, for corpses that were thrown here because it is an area of extreme violence, drug trafficking, factions, a very harsh population. The interesting thing is that over time they learned how to respect the hospital and the initial difficulties were overcome because the hospital had the capacity not only to resolve health issues, but [to strengthen aspects of] other public sectors [in the area]. We sought to slowly settle issues of transportation, lighting, road building, garbage collection, sanitation. So, the hospital brought countless benefits to the community* (HS Management Team Member, Interview, August 2018).

All these wins in other sectors outside health were not solely the result of interventions by HS. While some changes were initiated and made possible with the help of Ex-Secretary Solla who advocated and implemented the HS project, other changes could not have happened without demands and demonstrations from the community members themselves who acknowledge these

efforts and who also talk proudly of their own involvement and efforts to get public transport to reach HS as part of their leadership and community participation responsibilities (Community leaders, Interview, October 2018).

Hiring people from the community

In another effort to embed itself more in the community, HS seeks to employ qualified workers that live in the surrounding communities. At the same time, the employees can take the messages from HS in their communities, while the communities feel they have representatives acting in a hospital that has become reference for the city and the state. This helps to develop another sense of relationship between HS and the community, going beyond just educating the community to use the hospital as effectively as possible according to its urgency/emergency profile (HS Management Team Member, Interview, June 2018; HS Nurse (3), Interview, January 2020; Observations, 2018-2020). Second, in addition to employing full time personnel from the community, HS seeks to give opportunities to young people from the community as 'young apprentices' at HS as a way to introduce them to the formal world of work (Observation, 2018-2020). HS is registered with the Company-School Integration Center (*Centro de Integração Empresa-Escola; CIEE*) and has been requesting that only candidates from the surrounding communities are forwarded to HS for consideration of young apprentices. Selection of young apprentices follows the same 3-step, meritocratic process for employment as all other cadres of personnel at HS (Young apprentice selection process, Observation, October 2019).

Taken together, the results from this section show that HS has strategically chosen to engage with the local community members in practical and meaningful ways for community members to feel supported by HS beyond the provision of health services at HS itself. These approaches include forming and maintaining informal partnerships with community leaders, through informal income-generating partnerships, through contributing to the advancement of sectors outside health and by hiring people from the community. Even though some approaches such as inviting the community for Christmas mass, showing up at a community event or forming partnerships with recycling machinery cooperatives might seem too simplistic to make a difference, the results highlight that forming these relationships is particularly important in a place like HS if one considers its surrounding communities and the high power distance between

the predominantly black, low-educated, low-income suburban communities and the predominantly white, medically trained HS Management team.

This section referred to the local community as the second important actor in the HS project. The next section will discuss the third and last actor, the Municipality of Salvador.

Relationship with the Municipal Government

Before we understand the results of this section, it is important to briefly point to health financing and responsibilities in the Brazilian sub-national governments as those are relevant structural challenges for the HS project. Brazilian health financing has a somewhat unusual division between state and municipal responsibilities. Fiscal federalism scholars tend to recommend that health system tasks such as responsibility for finance should exist at the highest levels of government while implementation and policy areas such as primary care should exist at the lower levels of government (Adolph, Greer & Massard da Fonseca, 2012). By contrast, the health system of Brazil is organized in such a way that health services are both financed and organized at subnational levels with the municipality level being primarily responsible for primary health care and the state being responsible for tertiary care (Arretche & Massard da Fonseca, 2018). Even though the Union spends the most on public health through financial transfers to the state and municipal sub-levels, the Union's total spending on health has been decreasing while the subnational financing participation at both the state and municipality levels through their own revenue collections has been increasing over time, reaching 27% of health spending in 2008 (Arretche & Massard da Fonseca, 2018, p. 152).

This arrangement of financing and separating health service delivery responsibility in the Brazilian health system has the potential to give rise to incentives for opportunistic behaviors between the two levels of government and the two levels of health service delivery. In the specific case of HS, the State of Bahia is governed by the Worker's Party (*PT; Partido de Trabalhadores*) while the Municipality of Salvador is governed by the opposing Democratic Party (*DEM; Democratas*). As such, in addition to financial incentives that are most likely to arise from sub-national allocation of financing and responsibilities, such a situation in the case of the state of Bahia and the Municipality of Salvador creates additional partisan incentives for opportunistic behaviors between the different subnational governing levels.

Salvador has been cited as one of the cities with the least primary health coverage among all cities in the northeast of Brazil. While sources disagree on the precise coverage, the Ministry of Health reports Salvador as having 47% coverage in primary care – this low coverage takes into consideration the availability of primary care health facilities as well as the Family Health Program (Programa Saúde Família), a landmark strategy within primary care (Conass, 2019; Ministry of Health, 2019). The antagonistic nature of the relationship between the state and the municipality is not a secret one with the state referring to the municipality in a written announcement officially published on the SESAB website: "It is worrisome that the mayor of the country's fourth largest capital, in his second term, demonstrates that he still has not understood that the health care of a population should not be offered mostly in emergency units. Public health is not done in the Emergency Care Unit!" (SESAB, 2018). This section will provide evidence related to the importance of understanding the politics at the municipal and state levels, how they have impacted the dynamics for health and healthcare delivery at HS and how HS was able to manage that relationship.

Visibility of Unmet Primary Health Needs

Study participants expressed that HS gave visibility to the issue of precariousness of basic care in the suburban region. As people did not have access to primary care services and barely have any functioning UPAs as well, they sought and continue to seek care at HS. As such, patients seeking care at HS have highlighted the primary health unmet needs in the area (State Health Council Member, Interview, September 2018). In addition, during the trimester community leadership meetings at HS, community leaders as well as community health workers share their challenging experiences with the population seeking primary health services in the different districts in the suburban region (HS-Community Leaders Meeting, Observation, July 2018; October 2019). During these meetings, the most prevalent topic of concern is the huge unmet need for primary and secondary care in the suburban districts. Community leaders describe how they need to go from health facility to health facility in the community (their district but also other districts) seeking care unsuccessfully: despite their struggles to find care, they are not attended, medication is not available or medical equipment is broken. Community leader meeting participants emphasize that there are no primary health units in the Periperi district of the suburban region where HS is located so people either go to the only available secondary care unit

available or HS. In addition, community leaders advocate that before the municipality opens any facilities in the community, there has to be some guarantee for their functionality as it is common for new units to be unable to help patients seeking care with barely anyone there to attend patients (Community Meeting Observation, July 2018; October 2019).

A community member described one's challenging efforts to access care:

A person from Periperi does not know where to seek an answer for a health issue. To find services, one has to 'do a pilgrimage' [to hospitals around the city]. Or that person can die at home (Community leaders, Interview, October 2018).

The impact of unmet primary health needs which are mostly non-urgent or slightly urgent patient cases are discussed in the community leader meetings at HS and are evident in the patient flow at HS (Figure 1). This challenge the relationship of HS with SESAB and the state government while the jeopardize the financial sustainability of HS.

A participant very accurately shared the role that primary care plays in the community and the impact on the functioning of HS:

HS needs the district. If the [health units in the] district do not work, if the network doesn't work, HS will feel the consequences. [A person might have] a toothache or a headache but HS is a trauma hospital. However, a person in pain does not want to know [that]. The person wants to go for the best care [to HS]… the community health agents are doing their work [to educate the population] but the city government is coming in the opposite direction (Community leaders, Interview, October 2018).

While evidence shows that HS has been making efforts to educate the population in Periperi and the surrounding districts about the HS profile in an effort to decrease the number of non-urgent and slightly urgent patient cases at HS, the experiences of study participants provide evidence that the municipality acts in an antagonistic approach to HS by precisely depriving the area of primary care facilities. Even if the patients know they should not be visiting HS, they have no options but to seek care either at the only secondary care facility available in the district or at HS.

The antagonism between the state and the municipality is strengthened by the visibility of HS as a state project. The capacity of the state to build HS, such a visible project in the specific

area is considered a success for the state, the municipality's partisan opponent. A study participant shared:

HS emerged in the middle of nowhere. I believe that if any citizen before Hospital do Subúrbio were to be asked [about the existence of a hospital], he/she would not imagine that a hospital could emerged in that area. Nobody would imagine [that] because it was an area that was used to illegally dispose of bodies… So it was a very undervalued place. HS was born next to the highway, in a space that few people knew. It was a big event for a hospital of that kind to emerge there (State Health Council Member, Interview, September 2018).

Another participant talked not only about the municipality in relation to health but also about the initial resistance of the municipality to improve sectors such as transport, further describing the community efforts as invisible battles with the municipality:

The people in the community also had to fight for public transport in the beginning of the implementation of HS: the two running bus lines did not go up to HS; as the transport sector is the responsibility of the municipality, the municipality did not want to provide the transport in order to challenge access to the hospital, thus avoiding and providing an obstacle to valuing the state and HS as a state project. Community members closed the roads to demand transportation that would reach HS… Many fights are not visible (Community leader, Interview, October 2018)

In addition, it has been suggested that some health services are very centralized in some districts compared to others with no health services, based on political party affiliation and the size of the population. The same study participant as above explained the scarcity of available services in some parts of Salvador over others:

If you look at the suburb region, it has more state than municipal services. You can also see that the city center leans more to the right. So, in the city center you see that there is a little more of the presence of the municipality, the care of the municipality (State Health Council Member, Interview, September 2018).

The municipality is also constantly reported to be playing a 'political game of closing and opening health facilities' to show that they are giving something to the different suburban

districts/communities while the distribution of facilities is very political. Speaking in the voice of the municipality, a community leader explained:

As I do not want any of these [health units] to improve, as I do not want to lose my gold stamp to always come here to earn my gold [votes], I am not going to make many improvements. If I give everything they ask, then I will come [back] and promise what so that I can have their vote next time? I will give them just a little. Drop by drop. I will try to put out the fire, but I will help just with a drop. Next year I'll be back again and give two more drops (Community leaders, Interview, October 2018).

A study participant explained how the municipality shuffles primary care teams or community health workers between districts for electoral purposes, leaving some districts with less resources than others. As all communities are part of the same region, the number of available primary care units and community health agents that get reported to the Ministry of Health to account for federal transfers for primary health care reflects the overall provision of services on paper. However, what happens in reality is a completely different story with an unequal distribution of primary care services along political/party lines (Community Member, personal communication, October 2018). As such, participants explained that the municipality took away the primary care unit and replaced it with a secondary care facility which is not as functional and scattered all the community health agents from the Periperi community to the other districts in the suburban region. Subsequently, as already mentioned, the Periperi residents have only one secondary care facility to seek services at and HS.

The results from this section show that the actions of the municipality had influenced access to HS in the beginning of the project as well as patient flow to HS through the lack of provision of primary care services throughout the life of the project. Even though HS encouraged interaction with SESAB and the community leaders, HS also acknowledged the challenging position of community members with respect to the lack of access to primary care while it also respected the sub-national responsibility assigned to the municipality for primary care provision.

DISCUSSION

In this paper, I used empirical qualitative data collected between 2018-2020, to show how Hospital do Subúrbio has been able to navigate the different challenges with major actors external to the hospital, namely SESAB, the local community and the municipality of Salvador. The data show that even though there have been challenges that needed to be resolved with all actors, the relationship between HS and SESAB was bounded by a legal contract while the relationship between HS and the municipality was bounded by the assignment of different health service responsibilities to sub-national governments. Both of these conditions limited relationship building to mitigate some of the rising challenges between HS and SESAB as well as between HS and the municipality. In contrast to the limited relationship building and establishing embeddedness with SESAB and the municipality to solve rising challenges, HS has been able to construct a positive relationship with the surrounding local community over time; this relationship has also been able to mitigate some of the challenges with SESAB and the municipality, mainly through educating the community about the profile of HS as an urgency/emergency hospital and thus better managing non-urgent patient flow to HS. The results also show that HS achieved a different level of "embedded autonomy" (Evans, 1995) with each of the three main actors. Being more embedded than autonomous with respect to the relationship it constructed over time with the community, HS prevented local community resistance and possible project opposition.

One major assumption when advocating for PPPs has been that the state is theoretically able to provide a regulatory and monitoring role for PPP contracts (Lieberherr, Maarse & Jeurissen, 2016). As such, under that widely held PPP assumption, looking at the HS project from the outside and considering its acclaimed success, one explanation could be that HS has been implemented and sustained due to the appropriate regulation, monitoring, and evaluation of the contract by the state government and as agreed on in the contract. At the same time, looking at formal published ordinances, one can confirm that there was a Monitoring Commission assigned to the HS contract. However, the existence of a Monitoring Commission on paper is different from the existence of an active, well-functioning Monitoring Commission that is able to fulfill its contractual obligations. This case study has shown that regulation by the SESAB monitoring committee was very perfunctory and exposed the HS contract to various risks instead of closely monitoring those risks. The results showed a lack of preparation and training to take on a complex project like HS laden with legal, technical and political challenges. The HS PPP

showcases the potentially added risks to public administration when public management is not adequately prepared for PPP project regulation. Perfunctory monitoring is not a problem specific to Brazil, in the same way that the perfunctory monitoring committee responsibilities within SESAB are not specific to the HS PPP contract. Based on study participants experiences, the capacity challenges that the HS contract has been facing with SESAB spans across other contracts of service delivery. Both the potential technical capacity as well as the potential high turnover of assigned team members should be evaluated very carefully when deciding whether a public partner is able to contribute to an institutionalized, stable team to lead a similar complex project in the future; if efforts to such an institutional and human resource investment cannot be made in public administration, care should be taken to engage with a project of that complexity as that could mean added risks to the government.

As evident in the results, one major challenge of the HS contract and subsequently its relationship with SESAB has been extra demand for services and subsequently demand for extra payments in addition to the HS contract monthly payments. One could argue that HS viewed the extra demand for services and the potential to be remunerated for delivering services beyond the contract agreement. One could therefore argue that HS took advantage of that scenario and did not engage in strategies to decrease the non-urgent and slightly urgent cases presenting at HS and until after the patient regulation intervention by SESAB in 2018. However, that hypothesis does not hold true as Figure 1 shows that lower risk cases have been decreasing since Year 2 of the HS project. One could further argue that efforts were made to decrease non-urgent and slightly urgent cases from Year 2 onwards because HS realized that receiving renumeration for extra payments would be uncertain and extra payments would not be made timely like the monthly payments which were made throughout the project without any delays; as such, mobilizing efforts to decrease non-urgent and slightly urgent cases was the logical decision to make while that decision also matched the profile of HS as an urgency/emergency hospital.

Related to HS's profile as an urgency/emergency hospital, one could additionally argue that HS has been successful in meeting its contractual performance indicators because it has not been attending urgent and very urgent risk patients as per its designated profile but instead, a high proportion of slightly urgent and non-urgent cases. That could have been true during the first few years of operation, but the results do not support that hypothesis beyond Year 2/3. As Figure 1 shows, the non-urgent and slightly urgent cases in adult emergency were reduced by

about 30 percent and 21 percent respectively between Year 1 to Year 8 while the urgent and very urgent cases increased by about 43 percent and 8 percent respectively from Year 1 to Year 8.

To fully understand these results which also impact the delivery of extra services and subsequently pending extra payments, it is important to consider the different factors at play: First, it is important to consider the scarcity of primary and secondary care services in the suburban region, the tendency of patients to seek care at HS and the time involved in educating and changing behavior in a low-literacy and low-income population about the HS profile. Second, implementing a reference hospital in which access was only via central Patient Regulation in a region that was already deprived of primary, secondary or tertiary care could have had negative impacts to launching or sustaining the HS project from a community perspective. The HS project was presented to the community as the 'hospital of the suburb' (*Hospital do Subúrbio*) for which the community leaders and communities were willing to work alongside with and advocate for in their communities as 'their' hospital. Third, it is important to understand that even though HS makes efforts, which are not invisible to SESAB, to educate the community about not seeking care for lower severity cases, HS cannot control how many urgent or very urgent cases are received at HS unless it accepts those cases through SESAB's Patient Regulation. However, it should be noted that participants referred to the Patient Regulation at SESAB as weak, captive and with the potential to use the regulation process as a political tool for preferential patient regulation along political party lines. HS leadership claims 'there is no party here; the party is health,' referring to its stance from the very beginning to be separated from political capture both in the hiring process as well as in the regulation of patients.

Furthermore, to add to community as well as politically embedded issues of patient regulation systems, knowledge of health system changes occurring at the same time outside HS is crucial for better understanding trends in patient seeking care at HS. Along with educating the population, some secondary care facilities were inaugurated in different districts within the suburban region after 2011/2012 and this could have diverted some of the demand from HS. In addition, SESAB initiated a project to locate secondary care facilities as gateways to some major hospitals in Salvador, precisely as a way to treat patients with less than urgent matters that would allow room for more urgent cases to be treated at the hospitals themselves (SESAB Technical Officer 1, Interview, September 2018; SESAB Technical Officer 2, Interview, September 2018). This was discussed for HS as well, but it was not politically feasible. As a result, a combination

of education and the initiative of other secondary care facilities opening elsewhere around the city diverted some primary and secondary care case patients from reaching HS. At the same time, better and more consistent communication between SESAB Patient Regulation and HS helped with directing urgent and very urgent cases to HS for treatment. Last, it should be noted that regulation of patients is not clearly defined in the HS contract (SESAB, 2009). Drawing from the complex interactions of the factors outlined above, one possible way for improvement for possible similar projects could be a better consideration of these different factors where available and a better definition of the role of Patient Regulation in the contract. The issues of extra service delivery and patient regulation could have been resolved at the 5-year remodeling due in 2015 but that did not happen, leaving no room for these matters to be reviewed and resolved mid-way through the project as anticipated in the contract.

Policy makers interested in the idea of PPPs should be very careful in considering them as policy instrument as PPPs and evaluating the existing conditions in the policy environment as success depends on having a sufficient level of monitoring on the public side and a competent private partner on the other, with good communication between them with built-in check points for re-evaluation of contract conditions and improvement. Either of those elements missing could pose a lot of challenges in contractual and administrative problems and/or clinical outcomes. As the case of HS shows, the assumption about the regulatory role of the state put forth in PPPs does not hold true. In the case of HS, a weak state monitoring team gave HS more autonomy from the state to continue delivering quality services. However, this was the case because HS proved to be a serious, competent partner and data show that it put efforts even beyond what the contract demanded. However, if the private partner had not been competent at delivering what the contract demanded, and the state team to monitor HS was also weak, HS would likely be unable to deliver quality health services and it would have likely been a failed project.

It should be noted that the HS contract is coming to an end in September 2020. The last few years have marked not only addressing some of the 9-year old on-going challenges but also deciding whether SESAB will renew the HS contract with Prodal for a second (and final) term of another 10 years from 2020-2030. Participants shared suspicions that under the new contract, HS will no longer be an open-door hospital but instead will serve as a reference hospital for the state; as such, patients will be directed to HS primarily via Patient Regulation in SESAB(HS

Management Team Members, Interview, October 2018). Even though some study participants present themselves as positive about the participation demanded of HS in regulation of patients in the last few years and the positive effects that that could have on the health system and integrating HS more in the health system (HS Weekly Leadership Meeting, Observation, 2019), there are also concerns that regulation of patients could be laden with political motivations and HS will likely be used as a political tool for regulation of patients; this could have impacts on the preferential regulation of patients along party lines and resulting equity of healthcare access (Nurse, Interview, February 2020).

Chapter 3 focused on the evaluation of HS implementation with respect to its external actors and the embedded autonomy it gained through its interactions with them. Even though managing the politics and power in the external environment is important at gaining embedded autonomy with respect to SESAB, the local community and the Municipality of Salvador, embedded autonomy alone cannot explain HS's organizational success. It is therefore important to look at the internal processes employed by HS to deliver quality health services. The next chapter, Chapter 4, will focus on the evaluation of another major assumption made for PPPs that the private sector brings private human resource management (HRM) approaches to effectively manage the operations of a PPP contract. As such, Chapter 4 will specifically focus on how HS has been able to construct its HRM approaches over time, thus contributing to the performance and acclaimed success of the hospital over the past 9 years.

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Chapter 4:

Identifying the Process of Construction of Human Resource Management for Healthcare Delivery: What can Hospital do Subúrbio, a Brazilian hospital PPP, teach us?

INTRODUCTION

Scholarship in public administration (Grindle, 1997; McDonnell, 2017) identifies high performing organizations as having elements of autonomy, recruitment and performance standards, internal evaluation processes, non-financial motivations, teamwork and participation in decision making. These studies show the presence of such elements as important in performing organizations but they do not inform us about how organizations achieved those elements. What I will argue in this paper is that good management does not simply exist or does not simply happen without effort in organizations. Good management is a process of construction; it is guided by human resources, by consistent signaling and by processes which are revised and adjusted iteratively to reach specific sets of goals for better organizational performance. The notion of an invisible force responsible for management might be partly so in healthcare organizations as they constitute a locus of clinical activity, guided by predominantly clinical staff who receive minimal to no management training during their professional education. The purpose of this paper is to demonstrate how Human Resource Management (HRM) strategies can be constructed, implemented and sustained for successful healthcare delivery using the case of Hospital do Subúrbio (HS).

Human Resources Management in healthcare could be broadly defined as a system or bundles of strategies and activities focused on the management of clinical and non-clinical employees inside a health organization with the aim of achieving the goals of the organization (Kabene et al., 2006; Pfeffer & Veiga, 1999). While HRM revolves around the management of people and bringing change in organizations through people, management is a much broader concept which encompasses HRM but also includes other forms of organizational management such as financial management or technological management.

In this paper, I am also choosing to use the term HRM instead of the closely related terms of organizational culture or organizational behavior. This is a conscious decision as I consider HRM to be the blueprint which is designed and used purposively by management to build individual and collective identity and organizational culture (i.e. this is how we do things), which will in parallel guide organizational behavior (i.e. this is how employees behave) to collectively improve organizational performance. While HRM strategies are technical and can be applied in a new or existing and changing organization, identity and culture formation and subsequent organizational behavior are psychological and adaptive; as such, it takes time to form identity, culture and behavior, requiring constant and consistent signaling about HRM strategies originally put in place. How HRM contributes to organizational culture and behavior also adds to the argument how management does not simply exist in organizations but instead, it is constructed over time and the existence of HRM strategies in place is an important way of contributing to culture, behavior and overall management for organizational effectiveness. In addition, HRM approaches might be more helpful for formulating policy and practical recommendations: HRM approaches are more likely to be identifiable, teachable and transferable to other organizations and their establishment and associated enactment might provide more guidelines in doing so than the closely associated organizational concepts of organizational culture and behavior which themselves result from strategically constructed and implemented HRM approaches.

Survey results on Brazilian facilities (World Bank, 2007), identify HRM as one of the most important factors affecting facility performance. La Forgia and Cuttolenc (2008) find that performance evaluation is rare in public hospitals in Brazil while managers have little influence over hiring or training in their respective facilities resulting in unqualified and uncommitted staff. Dismissals of civil servants can be extremely complex and lengthy processes that managers prefer not to even initiate such proceedings. While there is no systematic way to measure absenteeism in the directly administered hospitals in Brazil, according to La Forgia and Cuttolenc both state and municipal managers report a high number of workers on sick leave without any substitutes. Lorenzetti et al. (2014) identified lack of continuing education, high turnover of managers partly due to political reasons, and low participation and decision-making of nurses as some of the issues affecting public hospital performance. In addition, Rocha et al. (2014) noted the prevalent valuation of the biomedical model and submission of other professionals to physicians, lack of teamwork and interdisciplinary work, weak interpersonal

relationships and continuous education for nursing staff. Given the aforementioned literature, we would expect HS to suffer some of the same human resource aspects which would in turn affect its performance. On the contrary, HS has been named one of the 100 most innovative global projects (KPMG, 2012), it has been reported as having "dramatically improved emergency hospital services for one million people in Salvador" (World Bank, 2013) and it is the only public hospital to have reached the highest national level of accreditation in the state of Bahia (HS, 2020). The difference between what we would expect from the aforementioned literature and the acclaimed quality of healthcare services delivery by HS to-date raises the research question that I aim to explore for this paper: *How has HS constructed, implemented and sustained HRM strategies that distinguish its operations in delivering quality health services from other hospitals?*

Before presenting the results of this study and answering how HS has been constructing, implementing and sustaining HRM strategies to deliver quality health services, I will take a step back to locate my study in the background research about the importance of HRM to deliver improved healthcare services, further highlighting the importance of studying, understanding and applying HRM approaches to healthcare in developed and developing nations alike. Following, I will present and discuss the results of this study.

HRM and High-Income Countries

Earlier work has suggested that HRM can encompass many practices some of which include but are not limited to recruitment, performance appraisal, training, participation and team building (Pfeffer, 1998). In a literature review of HRM and performance in health organizations, Harris et al. (2007) found a suggestive relationship between HRM and performance, however they noted that there were surprisingly few studies investigating the relationship between HRM and performance in the health sector. A study by West et al. (2006) shows that HRM has a significant relationship with patient mortality suggesting that hospitals should focus on HRM as an important tool to improve healthcare delivery and patient outcomes. West et al., defined HRM with respect to performance management, training, participation and use of teams, among other HRM approaches. The authors do not themselves identify the mechanisms mediating the relationship between HRM and patient mortality but suggest that their strong relationship is likely resulting from a combination of HRM practices that are mutually reinforcing each other.

The authors draw from previous HRM literature to suggest that a combination of practices including clear definitions of roles and the expected goals of employees and the organization due to performance systems in place, higher knowledge and skills due to training, higher commitment due to participation and decision-making and higher coordination due to team training and learning. They also suggest that all or a combination of these factors could lead to higher performance, satisfaction and therefore less turnover (West et al., 2006). Even though the authors acknowledge the combined and interdependent effects of HRM approaches on healthcare delivery, they propose identifying HRM approaches that could differentially impact healthcare delivery and patient outcomes; that could possibly lead to possible prioritization for specific HRM approaches. West et al. also highlight that while HRM systems are formally formulated at the organizational level, they are lived, experienced and enacted at the individual and team/group levels before their effect (outcome indicators such as hospital patient mortality) can be measured collectively back at the organizational level. This challenge of establishing cross-level mediation suggests that qualitative approaches to studying HRM approaches is well suited to providing insights about the effectiveness of HRM strategies.

Another study by Morey et al. 2002, who applied an Emergency Team Coordination Course initially developed for aviation crew resource management to emergency room employees across nine teaching and community Emergency Departments (ED) in the U.S. showed a positive effect on team member attitudes and a reduction in ED clinical error rates from 30.9 to 4.4 percent between experimental groups comparing between course training pre- and post-tests. While these results support previous work showing that improved teamwork among caregivers is important in error reduction (Leap et al., 1998), West et al., 2006, suggest that when hospital staff work in teams, they are more likely to deal with uncertainty not only through their formal training but also through shared learning and tacit knowledge (as opposed to formal or explicit knowledge) associated with team-based work. This could be especially so in a high uncertainty, critical setting like the ED.

It is also important to note some work by Gittell (2009) in U.S. health facilities who acknowledges the power of relationships and the coordination of work through relationships of shared goals, shared knowledge and mutual respect. Gitell explains that coordination among care providers is not only a technical activity but a relational activity and shows that relational coordination enables shorter hospital stays, higher levels of patient-perceived quality of care and

improved clinical outcomes (Gittell, 2009, page 40). Combined with HRM approaches such as selection, performance and job design as well as frequent, timely, accurate and problem-solving communication, Gitell proposes relational coordination as an integral component of a high-performance healthcare system which scores high in quality and efficiency performance (Gitell, 2009, page 213).

Furthermore, recent work by the Institute of Healthcare Improvement (IHI) highlights a set of five interrelated domains termed as the "human side of change" that health organizations can use for organizational improvement efforts. These include the following approaches: unleash intrinsic motivation, co-design people-driven change, co-produce in authentic relationship, distribute power and adapt in action (IHI, 2018; page 4).

HRM and Low- and Middle-Income Countries

In addition to work in HICs as outlined above, some research in LMICs has identified different HRM approaches for organizational performance, especially as that relates to performance in public organizations. Grindle (1997) highlighted the difference between developed and developing countries with respect to studies on management and organizational output at the time. In her study, she noted that while developed countries were considering the importance of quality of management, such as training, teamwork, decision making and leadership with respect to organizational performance since the late 1990s, developing countries were more concerned around structures and rules and paid little attention to performance-based management, participation and teamwork. In Grindle's work, which included assessing the capacity of organizations to deliver agricultural extension services or maternal-child health services in six (6) developing countries, twelve (12) of her fifteen (15) identified successful cases emphasized management aspects such as autonomy for hiring and firing, setting employee performance standards and internal monitoring and evaluation processes as well as promoting multidisciplinary teamwork and participation in planning and decision making. Additionally, Grindle talks about "mystique" or the power of mission driven organizations and collectively attributes organizational performance in her successful organizations due to "organizational culture" which comprises the HRM mentioned and a mission driven culture.

Twenty years later, in her research on interstices - or high performing niches - within institutionally diverse developing African nations, McDonnell (2017), similar to Grindle (1997),

describes interstices as having a combination of autonomy, recruitment standards, non-financial motivations, internal coping practices and the ability to discipline problematic members. Similar to Grindle, in addition to the aforementioned human resource strategies, McDonell identifies organizational ethos as an additional driver for success. She collectively attributes the performance of her studied interstices that make them very distinct from poor-performing organizations as organizational "characteristics."

In summary, while Grindle and McDonnell talk about organizational culture and organizational characteristics to explain their results, they both explain performance as part of approaches that are primarily HRM approaches. Second, both Grindle and McDonnell talk about the presence of such HRM approaches but they do not explain how those HRM were constructed and maintained in their higher-performing organizations. My motivation for this paper is therefore to show how the construction of these HRM processes looks like using empirical data from the case of HS. My empirical data from this case will further provide clear guidelines for constructing and implementing HRM approaches for better policy and practical recommendations as well as transferability and generalizability across organizations.

Moving to studies more specific to health and healthcare in LMICs, the absence of a properly trained and motivated workforce as well as turnover of health workers had been accepted as key constraints for health organizations and for achieving the UN's Millenium Development Goals (WHO, 2006). Similarly, they are likely to continue to be a key constraint in achieving the Sustainable Development Goals. Chaudhury et al. (2006) reported absenteeism rates as high as 35 percent across primary care facilities in Bangladesh, India, Indonesia, Peru, and Uganda with rarely any disciplinary actions taken for these absences. A systematic review by Willis-Shattuck et al. (2008), identified major themes for motivation of health workers including: hospital infrastructure, resource availability, career development, continuing education, hospital management and recognition/appreciation while in their empirical study of a well-performing regional hospital in Ghana, Marchal et al., 2010, also found various HRM approaches such as training and development, information sharing, access to management, teamwork and recognition as elements that could stimulate health worker commitment. In addition, Chimwaza et al., 2014, identified that factors cited by health workers for leaving their jobs included unfair treatment, lack of recognition, delays in salary payments and lack of criteria for promotion. In 2015, Bradley and colleagues, sought to draw attention to management in

global health, advocating management as particularly important for low-income settings, especially as those settings are more concerned with the efficient use of limited resources available. Bradley et al. advocate for eight core competencies including human resource management and specifically recruitment and retention, education and training, compensation, employee relations, performance evaluation and mentoring of providers in health systems (Bradley et al., 2015). This call highlights the lack of research on the topic and the importance of my research to study, understand and apply HRM approaches to healthcare in developing and developed nations alike.

In summary, all the aforementioned studies both in HIC and LMICs reveal that HRM is an important aspect for employee commitment, retention and subsequent organizational performance. Even though all the aforementioned studies identify HRM for ultimate organizational performance, they state that HRM are important to be in place but they do not offer lessons about the construction of these HRM elements and the micro-processes through which they are constructed and maintained in organizations.

From HRM in hospitals to HRM in hospital PPPs

As I have presented so far, research on HRM as it relates to healthcare performance has been relatively perfunctory. Similarly, considering and researching HRM as it relates to healthcare performance within specific organizational models, such as PPPs, has been perfunctory as well, in both HICs and LMICs. While there is a plethora of articles on how to navigate the bidding process, the contract, and the risks associated with PPP projects, there are no recommendations on project implementation or internal organizational management approaches within PPP projects. From a practice perspective, the perception of management seems to vary between practitioners or consultants engaged in the field of PPPs. In a conversation with a PPP expert in Brazil, I was asked: “What do human resources have to do with PPPs?” In a separate conversation with another PPP expert in Brazil, I was also asked: “If a PPP project is about the life of the project and management and operations determine the life of the project, why is there barely any research on successful implementation through investigating management and operations in PPPs?”

Public-private partnerships in healthcare have been operating mostly in HICs and have shown mixed performance results (Barlow, Roehrich & Wright, 2013; Grimsey and Lewis,

2005). Studies usually focused on cost, flexibility, complexity and quality issues (McKee, Edwards & Atun, 2006), or governance aspects (Lieberherr, Maarse & Jeurissen, 2016) but with limited presentation of evidence on health outcomes and health quality (Nikolic & Maikisch, 2006).

Drawing lessons from PPPs in LMICs is also limited as the only hospital PPP that includes clinical and non-clinical services in LMICs is the Queen Mamohato Memorial Hospital (QMMH) in Lesotho, Africa. Studies conducted on the Lesotho PPP have found that clinical and non-clinical performance improved between the old referral hospital and the new QMMH hospital. While the authors compared clinical performance data, they also offered a few explanations to account for the differences observed between the two hospitals. Some of the explanations they offered related to the modern infrastructure and equipment at the new hospital, decision-making through electronically collected data, and a different management structure which consisted of clearer policies and guidelines, feedback and accountability for performance and increased opportunities for training and development (McIntosh et al., 2015; Vian et al., 2015). It was also found that corruption practices were reduced when comparing between the old referral hospital and the new QMMH hospital (Vian et al., 2017). Similar to Grindle and McDonnell above, McIntosh et al. (2015) and Vian et al. (2015) talk about the presence of HRM approaches in their higher performing hospital but they do not explain how those HRM were constructed and implemented. This strengthens even further my motivation for this paper to show how the construction and implementation of HRM processes looks like for better policy and practical recommendations and generalizability across organizations, using empirical data from the case of HS.

Hospital Management and Human Resource Management in Brazil

After reviewing the literature on HRM and healthcare and HIC as well as LMICs with some minimal references to PPPs in particular, it is important to review the literature on HRM and healthcare in Brazil more specifically in order to better contextualize the case of HS, the case of investigation and analysis in this study, before we can analytically draw generalizable conclusions about these HRM approaches and how they would apply in other settings.

In 2007, a World Bank report on municipal and state hospital facilities in Brazil identified human resource management as the main problem affecting hospital facility

performance, citing low productivity, work shirking, absenteeism, and mismatch between personnel skills and facility requirements as the most prevalent challenges in their health facilities (World Bank, 2007). In addition to these results, La Forgia and Cuttolenc (2008) find that performance evaluation is rare in public hospitals in Brazil while managers have little influence over training in their respective facilities. In the directly administered hospitals, facility managers have little to no influence over recruitment, salary definition, or dismissal of civil servant medical professionals. Once employed and after a 3-year probation, lifetime employment with civil servant benefits is guaranteed. In addition, dismissals for civil servants are extremely complex and lengthy processes that managers do not initiate such processes unless in very rare cases. These human resource practices have been reported to contribute to "the selection and retention of unqualified and low-performing staff who are not committed to the facility or public service" (La Forgia & Cuttolenc, 2008). While there is no systematic way to measure absenteeism in the directly administered hospitals in Brazil, according to La Forgia and Cuttolenc both state and municipal managers report a high number of workers on sick leave without any substitutes. More recent studies confirm that the HRM issues identified by La Forgia and Cuttolenc in 2008 persist in hospitals in Brazil. Lorenzetti et al. (2014) identified lack of continuing education, high turnover of managers partly due to political reasons, and low participation and decision-making of nurses as some of the issues affecting public hospital performance. In addition, Rocha et al. (2014) identified the prevalent valuation of the biomedical model and submission of other professionals to medical doctors, lack of teamwork and interdisciplinary work, weak interpersonal relationships and continuous education for nursing staff. Furthermore, a literature review including studies internationally and in Brazil by Farias (2017) identified interpersonal problems, clear definition of processes, participatory management, hospital accreditation and technological innovation as issues that need to be upgraded for improving hospital management. As mentioned earlier, the difference between what we would expect from the aforementioned literature of health services in Brazilian health facilities and the acclaimed quality of healthcare services delivery by HS to-date raises the research question that I aim to explore for this paper: *How has HS constructed, implemented and sustained HRM strategies that distinguish its operations in delivering quality health services?* The answer to this research question will also allow me to explore the assumption made for supporting PPPs which is that the private sector is able to deliver better services through better

management practices. My study aims to ask and analytically show what private management approaches those can be, how they were constructed and implemented at HS and which ones can be generalized to other hospital PPPs, other non-PPP hospitals or even across sectors (i.e. education) for better service delivery.

In the next section, I will show that low turnover and low absenteeism represent the HRM success at HS.

The HRM success of HS

The simplest form of evidence for HRM success at HS can be found in two key statistics: staff turnover and absenteeism.

Low Staff Turnover: Record reviews at HS (Figure 2) show that staff turnover at HS decreased from 16.23 percent in 2010 to 7.97 percent in 2011 to 3.04 percent in 2012 and even further down to 1.14 percent in 2019. While these figures represent the average yearly rate of turnover of hospital personnel, it is worth noting that in the beginning of the operation of HS, some months experienced over 30 percent turnover; this means that more than one third of staff would leave their jobs days or weeks after being hired. This high turnover can be explained not solely by the high number of dismissals but by the high number of hires which happened during some months over others in HS's implantation phase. Reasons for the high turnover overall included perceived lack of safety, lack of illumination as well as distance of hospital from metropolitan Salvador. It was also reported that many employees might not had expected the level of demand at HS to be as high/similar to that of a private hospital; they expected HS to be "one more public hospital where they would do what they wanted." After realizing that those behaviors would not be tolerated at HS, they opted to leave their job at HS. Even though this happened predominantly in the beginning with new hires, it still happens today but to a much lesser extent (HS Management Team Member, Interview, June 2018; Nurse, Interview, September 2018; HS Employee, Interview, September 2018). As Figure 2 shows, the turnover rate at HS at 1.14 percent in 2019 was reported to be below the Brazilian National Association of Private Hospitals (Associação Nacional de Hospitais Privados; ANAHP) at 1.81 percent.

Absenteeism: While absenteeism data were not recorded for HS in 2010, according to record reviews of data collected since 2011, absenteeism at HS, which is recorded via a

biometric system for all employees employed through CLT, has been very low and stable, under 3 percent, for the past 7 years. Absenteeism for 2019 was reported at 1.49 percent which, like professional turnover, was below ANAHP levels at 2.42 percent.

In contrast to these results at HS, the systematic monitoring of absenteeism is rare in publicly administered hospitals in Brazil (Document Review, 2018-2020; La Forgia and Cuttolenc, 2008) while absenteeism is often high in health facilities in developing countries (Chaudhury et al. 2006).

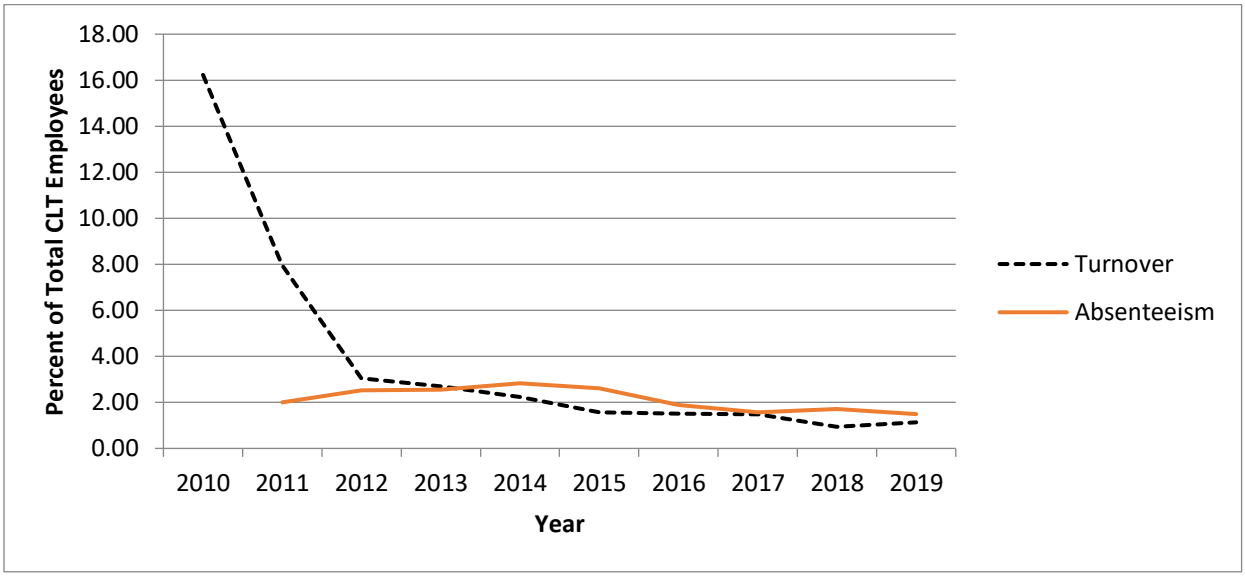

Figure 2. Staff turnover and absenteeism at Hospital do Subúrbio (HS), 2010 - 2019.

In the next section, I will show how HS has managed to achieve the presented low turnover and absenteeism levels through implementing various HRM approaches during the lifetime of the project.

RESULTS

Using empirical qualitative data from my study, this section will present and provide evidence for the construction of various HRM approaches at HS as important factors that ultimately impact the hospital's performance. The following section is broken into four main themes, namely 1) Hiring and Evaluation, 2) Professional Development and Actualization, 3) Empowerment and 4) Sense of Meaning. Each theme consists of categories which emerged from

the empirical data and provide evidence to support the category and collectively the overall theme. Even though the aim of this paper was to broadly study HRM strategies at HS, the specific themes and each of their associated categories emerged inductively from the empirical research. Where possible, I compare the evidence of the HRM approaches at HS to hospitals under public administration as a way to demonstrate the heterogeneity which exists in HRM approaches across healthcare facilities. The themes and the associated categories within them encompass established themes from the aforementioned background literature on HRM and performance in organizations including the importance of autonomy for recruitment, performance standards and evaluation, training and development, recognition, participation in decision-making processes and teamwork. It should also be noted that the themes and categories as presented in this study are not meant to be presented as exclusive from each other. For example, I present Leadership Development as a category under the overarching theme of Empowerment (Theme 3) but Leadership Development could also be a category under Professional Development and Actualization (Theme 2). Likewise, I present Recognition and Opportunity for Growth under Professional Development and Actualization (Theme 2) but Recognition and Opportunity for Growth could also be a category under Empowerment (Theme 3). My intention is not to show evidence about which theme or category matters more or by how much one matters more than the other in explaining the successful construction of effective HRM practices at HS. Instead, my study is about understanding the complex process of constructing multiple HRM approaches and the strength of their interactions. The inability to put boundaries around each category or theme as exclusive from others adds richness to the study as it precisely eludes to the many interactive and multi-pronged ways we need to think about the construction of HRM approaches for organizational performance.

The results begin with the first theme of Hiring and Evaluation.

Theme 1: Hiring and Evaluation

Category 1: Meritocratic Employment Processes

Since the beginning of its operations in 2010, meritocratic hiring at HS has occurred through a selective hiring process (*processo seletivo*). Selective hiring at HS involves three phases: a review of qualifications through resumes, a written qualification and an interactive session with team members of the department to be hired into. A HS management member

described the hiring process as follows:

Each professional category has a slightly different process; in the case of assistance areas, direct assistance to the patient, it goes through three stages. The first stage is the selection [of candidates through] resumes, the second is the written test and the third is a group dynamic. Through that dynamic process, we get to know a little bit about the professional's profile. We usually simulate a challenging situation to see how candidates behave in light of that situation. During that process, we perceive some aspects such as whether the candidate interacts well [with others], whether the candidate has an interpersonal relationship with others, whether he/she is an individualist (HS Management Team Member, Interview, June 2018).

Nursing technicians interviewed in my study confirmed having followed the three-step selective process in their hiring as outlined by the HS management team member above (Nurse Technicians, Interview, October 2018).

Even though meritocratic approaches are applied to hiring at HS, HS disqualifies applicants from certain institutions as the technical qualifications of applicants from certain institutions might not meet the educational/technical qualification standards required at HS. To illustrate that, a study participant shared:

There are institutions that I sincerely do not even want to participate in the [selective hiring] process because we know about the lower quality of teaching. I will have many difficulties because in addition to working [with the employee] on all the behavioral issues, I will also have to work with [the employee's] qualifications. That is not possible. I need the professional to arrive here [technically] prepared (HS Management Team Member, Interview, October 2018).

Even though there were political attempts to indicate direct hiring of personnel at the beginning of HS operations, HS leadership suggested that job seeking individuals should follow HS's meritocratic hiring procedures and based on the openings available (HS Management Team Member, Interview, January 2020). HS management additionally claims:

We are a not a political party, we are a hospital (Community Leader Meeting, Observation, July 2018).

Another HS management team member participant shared:

Although there was [political] indication, the candidates went through the selection process and the prerogative to join the HS team was to be approved in the process. There has been no situation in which the candidate did not do well in the selective process and stayed at HS. That does not exist (HS Management Team Member, Interview, October 2018).

When asked about a potential preferred model of choice for a hospital, a former SESAB technical officer and a strong advocate of SUS shared:

Management without political interference. Political interference with management is a very serious problem in the state. So, if [Bahia were] a less patrimonial state, a more neutral state, it would be possible to do direct administration [right]… (Former SESAB Technical Officer, Interview, June 2018).

Another SESAB technical officer shared:

A unit's senior manager is usually appointed. He is selected based on competence aspects but also based on political affiliation or political position. The guy is there, but he doesn't have a background in the unit, he doesn't have a connection with the unit. And you cannot take the guy out because he is indicated by a party. What do you do then?… You find a way to bypass that person. You leave the guy there like the Queen of England (Former SESAB Technical Officer, Interview, July 2018).

When asked to share what potential aspects would need to change for a public hospital to work better, a participant who worked for 14 years at a public hospital shared:

I think it would have to start from zero again. Because they [people in hospital management positions] are always all political appointees. So, we don't see anyone with a real desire to make things work (Medical Doctor, Interview, September 2018).

In addition to political pressures for bypassing meritocratic employment practices at HS as described above, HS also received offers from representatives of third-party specialty medicine cooperatives who suggested getting paid for contracting a certain number for physician specialists while only providing half the physicians paid for to actually provide clinical services

at HS. Such proposals were not tolerated and the physician proposing such a scheme was dismissed from HS (HS Management Team Member, personal communication, December 2019).

The evidence I presented above suggests good meritocratic hiring practices but also active rejection of political interference practices for hiring at HS. Even though these practices at HS seem to be different than what is usually practiced in the public sector, once hired into HS, further strategies were employed to monitor employees with respect to their working hours. As such, the next category will discuss reporting and monitoring of working hours.

Category 2: Reporting and Monitoring Working Hours

Before discussing monitoring of working hours at HS, it is important to briefly explain employment schemes for medical professionals. In Brazil, there are three predominant employment schemes for health professionals: 1) as civil servants through a competitive examination (*concurso publico*), 2) through third-party companies or cooperatives of health personnel or 3) as individuals through private law (*Pessoa Juridica; PJ,* in the case of physicians and *Consolidação das Leis do Trabalho; CLT*, in the case of other health service professionals). Under schemes 2 and 3, employment is not through competitive examination, it is not a lifetime guarantee, salaries are determined by the market and recruitment and dismissal are determined by the organization that employees are hired into. No employees at HS are hired as civil servants nor HS accepts that employees transfer and practice their civil service rights at HS. Instead, employees at HS are hired as *PJ* in the case of physicians or *CLT* in the case of all other clinical and non-clinical professionals. Even though contracting through *PJ* and *CLT* adds fear and uncertainty about job stability compared to the traditional civil service positions, it should be highlighted that medical professionals who would prefer to work in state hospitals as civil servants no longer have that option in Bahia. As many of my study participants mentioned, there has been no civil service competitive examination for placements of health professionals at the state level, for placements in both administrative positions in SESAB and in public hospitals, since 2008. That implies that whoever is a civil servant in health facilities at the state level today acquired that status prior to 2008.

All CLT contracted employees at HS report working hours through a biometric control system. Working hours are collected and reported in the HS Information Technology (IT) system daily and analyzed by the Human Resource department weekly and monthly for trends to be

discussed with the individual sectors. The system collects production and cost: how many hours/days employees are supposed to work, number of days off, whether the hours/days off where excused or not, the number of lost hours and the cost of those hours to HS (IT system/Document Review, October 2018). An interviewee shared that prior to instituting a biometric control system, employees at HS were found swiping identity cards of co-workers to report working time. The employees involved were dismissed without warning, signaling that such behavior and practices would not be tolerated at HS (Nurse, personal communication, January 2020).

Even though reporting working hours are monitored at HS, they are a representation of the physical presence of employees but they do not inform the hospital about employee performance in their respective sectors or the hospital as a whole. As such, performance evaluation, discussed next, is another important HRM approach at HS.

Category 3: Performance Evaluation

Employee performance evaluation is practiced continuously and systematically at HS, assessing technical as well as behavioral skills. To share the prominent culture of constant performance evaluation, a physician shared that at HS, one "lives by being evaluated" (Medical doctor, Interview, June 2018). Performance evaluation at HS is presented as having different stages including: a) upfront knowledge of the items on which employees will be evaluated on, clarity of the performance criteria, the period of evaluation and the expected results, b) systematic performance monitoring according to standards set in each sector and c) a formal 180-degree evaluation composed of a self-evaluation, an evaluation of the assigned manager, and a dialogue between them (HS Human Resources Competency meeting, Observation, August 2018).

In addition to an employee's formal performance evaluation, performance is also evaluated through audits conducted by the Permanent Education and Service Quality teams internal to HS on specific topics chosen per month in addition to protocol adhesion and practice supervision (Registry Audit, Observation, January 2020; Nurse, Interview, January 2020). Furthermore, in addition to performance at the individual level, performance is evaluated at the departmental and organizational level. This is accomplished though benchmarking performance against contractual indicators, through the formal process of national accreditation as well as through the adoption of institutionalization of accreditation-like methodologies. All of these

performance evaluation approaches are discussed in detail in the next chapter (Chapter 5) as part of providing evidence for the processes involved in building a culture of quality and quality improvement at HS.

In contrast to performance evaluation at HS, performance evaluation, like systematic monitoring of absenteeism discussed previously, seems to be rare in publicly administered hospitals. Some participants shared their experiences with regards to lack of evaluation in the public sector. A study participant described his experience as follows:

There is no evaluation there. [Repeated:]There is no evaluation. When employees enter as civil servants, there is a provisional period of three years. After they spend three years, they are called, they fill out a form and they sign. It is not an assessment really. Do you know why it is not evaluated? Because nobody really accompanies you to see how you are really performing… The important thing is just to have the assessment form filled out. Is it filled? Is it OK? That is the end of the story. Now the evaluation process here is continuous due to the daily supervision, the professional records, if you are working, what time you arrive, your absences; so [performance monitoring] really exists here. There, it does not really (Nurse, Interview, September 2019).

When asked about performance evaluation in the public hospital where she works, another study participant sarcastically asked:

[Evaluation] Where? [Evaluation] Of what? [Evaluation] From whom? (Medical Doctor, Interview, September 2018).

In addition to formal processes of performance evaluation, study participants expressed their frustration with respect to the performance of medical professionals during night shifts in the public sector in comparison to HS. A nurse who works at HS and at a public hospital shared the difference between the behavior of doctors during a night shift at the two institutions:

I said to her [the coordinator at the public hospital]: '…I don't care if whatever doctor comes to sleep here all night or if he has been doing it for years. I don't care. Every time I will write it in the registry of events and I will wake him up as many times as I need. It is not my job to wake him up, but I am thinking of the patient. I have no problem being called to defend my decision. Because I'm going to tell him: 'Sir, I didn't know that you chose your profession to sleep through the night'… That day, five doctors were scheduled to be on shift and there was only one [because

the rest were resting]. Here [at HS], if you have five doctors on shift, you have five doctors evaluating, asking for medical tests, discharging, asking for transfers. That is agility (Nurse, Interview, August 2018).

Another nurse who works at a different public hospital than the nurse above also described similar experiences during night shifts:

Nothing stops here [at HS]… at night, the hospital doesn't stop, it continues in the same way that it works during the day... There [at the public hospital] that doesn't happen. There, at night, many sectors stop or stop doing what they should be doing, postponing it so that the personnel on shift does it during the [next] day. And that ends up in the accumulation of patients and overloading of the service [during the day]. Here, services do not stop. X-ray or tomography services do not stop. The operating room does not stop. And if a reduced flow is identified in a certain period, it is evaluated to see why that is. The nursing coordinator and the medical coordinator verify what is happening. For example, if there is a period during the night that the operating room stops performing surgery here, [they question]: What is the reason that a patient is waiting for surgery? What is the logic? If the room is available, the material is available, and a patient is waiting, why not operate? In other places that does not happen because of the behavior of the medical category; if the doctor does not want to do surgery, he does not do it. Not here. Here it is not the professional who says he doesn't want to perform surgery. The surgery does not happen only if the patient is not in the clinical condition to have surgery. But in other places, if the doctors say they do not want to have surgery at night, they don't [perform it]… As a result, many professionals want to work in what period? At night, associating the night period as a period to do nothing. That is wrong (Nurse, Interview, September 2018).

While HS has been following standard private sector practices for meritocratic hiring, employee hours reporting, and constant performance evaluation as explained above, it also included other human resource management practices that facilitated an organizational culture of employee commitment and participation. These factors, described in detail below, appear to be at least as important as the formal performance management practices described above.

Theme 2: Professional Development and Actualization

Category 1: Institutional Presence

First, it is important to highlight multi-employment as a very common practice in the Brazilian health sector. As a means to increase their income, health professionals commit to various employment posts, at various locations and under different contracts and hiring schemes. Multi-employment raises several concerns including the sense of affiliation with the health institutions at which medical professionals are employed as well as the quality of health services they are actually delivering. This is less so for nurses than physicians. Nurses are contractually expected to work a minimum of 36 weekly hours at any given institution. Due to their expected 36-hr week contracts, nurses cannot be away from a given institution for more than a maximum of three to five days. However, there is no such contractual commitment for physicians. Some study participants reported that multi-employment can be especially challenging for physicians (especially specialty physicians) as they might end up serving a different institution, under a different contract, every day of the week. In a document review of a shift schedule in the radiology department of a public hospital, I noted that a different radiologist was assigned to the required 6-hr shift every day of the week. Each radiologist therefore had a 6-hr shift at the specific hospital department only once a week (Document Review, SESAB ME Team Field Visit, February 2020). By extension, this means that each of the physicians working at this radiology clinic works at another one or more health facilities for the rest of the days of the week. By extension, this also means that if one of the physicians finds a replacement for his/her weekly 6-hr shift, he/she might not have a contact with the specific facility for 15 days, or more. This is considered normal for physicians in Brazil.

A physician expressed a concerning effect of multi-employment eluding to a psychological effect that arises from a perfunctory link with any specific health organization:

> *What is missing is the link with the organization, the relationship, not doing things in a mechanical, automatic way* (Medical Doctor, personal communication, July 2019).

Talking about the different ways in which multi-employment can have implications on the emotional connection to colleagues, patients and the organization, a participant shared:

The communication, the integration with the multidisciplinary team [is affected]. The doctor who only comes here [at HS] once a week or once a month cannot integrate with the nurse who comes here a few times [a week]. So, not only does he not adhere to the protocol or the quality

policies, but he is also unable to have effective communication [with his colleagues]. As he also comes here sporadically, he also cannot connect with patients or with other non-clinical collaborators. He himself is not able to perceive that work is important because it is a job that he can easily discard, because he has no prejudice either professionally or financially because the impact [of his sporadic shift at HS] is small. As such, if he doesn't adhere to the place, it is not important [to him]; his whole culture, his head, his concentration is on other things. So, it is as if it were a transit time, a side job. Subsequently, he has no commitment [to the institution]. It doesn't even have to be a lack of commitment built mentally, consciously; [the commitment] is no longer there due to the circumstances themselves. The circumstances lead this professional to have no commitment and the lack of commitment will naturally affect the quality of work (HS, Management Team Member, Interview, January 2020).

Despite being embedded in the local professional environment where multi-employment is prevalent, HS emphasizes the continuity of clinical practice at HS. As such, many HS physicians hold a constant job at HS during the week (up to 44 hours) instead of having to rotate between shift locations every day of the week. In addition, HS asks for a minimum commitment of 12 hours per week at HS for physicians, with current efforts to increase that working load requirement to 24 hours per week. A study participant shared that this was not the case from the beginning of HS operations but something that evolved over time:

> *…the hospital [HS] has a clinical body that lives the [daily] routine, that contributes to a higher commitment with quality, with the institution, with the protocols, with patient safety, every day, rather than every day being a doctor that is not imbricated in this routine of the institution… that was a difficulty in the beginning. In the beginning the teams changed a lot…* (HS Management Team Member, Interview, June 2018)

Talking about multi-employment, another study participant shared his concerns about the lack of institutional presence by physicians:

… [we had to deal with the issue of] "one more hospital where I work." We worked hard on this concept of professional presence [for the physician] to effectively get to know the institution… we call [the phenomenon] 'hummingbird doctor', that is, a doctor who is going from hospital to hospital, working in 3, 4 hospitals. It is not possible [for a physician] to offer

adequate assistance, going from there to here like that (HS Management Team Member, Interview, August 2018).

These results show that HS acknowledges the potential impacts of multi-employment on physician commitment and thus makes efforts to enable more institutional presence at HS. It is important to note that multi-employment and the issues associated with it are not in any way eliminated at HS. Even though employees are encouraged to work more hours at HS, they still hold at least one shift per week in the public sector. This is especially so for employees who secured a civil service position in the health sector at the state level prior to 2008. In addition to suggesting an increase in the number of working hours at HS as mentioned above, the next category will explain how HS has been able not only to recommend an increase in working hours at HS but also what professional development approaches have been encouraged to help motivate institutional presence for physicians at HS.

Category 2: Career Development

While permanent education and employee trainings should be part of HS as broadly defined in the PPP contract (SESAB, 2009), different approaches have been institutionalized to create a sense of professional development and actualization for different cadres of medical personnel at HS. These approaches have been somewhat different for physicians and other medical professionals, taking into account their hiring schemes, contractual working hour obligations as well as their professional negotiating power in the labor market. First, as of 2014, HS has instituted the medical residency program in many specialties and has been able to integrate many of the trained physicians as full-time employees. From residents who completed the program until 2016, 92 percent were absorbed as employees at HS (HS, 2020). Second, HS management is trying to encourage doctors to build a career as opposed to the normal tendency of physicians to hold various positions in various health facilities. A study participant shared:

Although [multi-employment] is a problem that we observe, we try to educate our doctors. [We say]: "You have to try to build a career instead of being scattered, being in several places at the same time. In 15, 20 years you will still be young enough to work, but you will be a person who has no reference, you will be in the same situation." So we say: "Try to invest, to focus a little

more." This is even part of our conversations with doctors since they come to HS. We have many young doctors and many have been with us for many years (HS Management Team Member, Interview, January 2020).

Even though these efforts to encourage medical doctors to have more stable positions have been successful to engage professionals and reduce multi-employment at HS, challenges still exist with some specialties, even ones to which HS is willing to offer higher salaries. A weekly leadership meeting at HS, focused on the inability of HS to capture anesthesiologists. According to the information shared in the presentation, there are only about 38 anesthesiologists formed every year in the state of Bahia and there is a high demand for them in all hospitals. As part of a possible solution, HS presented the idea to create a medical residency program in anesthesiology as that will insert anesthesiologists at HS earlier on in their careers and that will likely create more fidelity of those professionals at HS (HS Weekly Leadership Meeting, Observation, January 2020).

While efforts are made to create more fidelity of physicians at HS through the medical residency programs and through messages about a career construction through stability at HS, efforts are also made to create professional development opportunities for nursing staff, which makes up about 60 percent of HS employees. In contrast to doctors, nursing professionals do not have labor market power and the approaches crafted at HS as explained below seem to take that into consideration. Before understanding how the approaches chosen by HS matter and to better contextualize the evidence, it is relevant to highlight the professional context as well as labor possibilities for nursing school graduates.

Study participants explained that nursing graduates are preferred for signing up with third party companies and cooperatives that are contracted to provide services in different health facilities because these third party organizations usually take advantage of the nurses' lack of expertise and their need to be inserted into the labor market and offer them entry level nursing positions with very low salaries (HS Nurse, Interview, January 2020). Participants shared that nursing salaries vary between third-party companies that nursing professionals sign up with. All the aforementioned factors are likely to create a lot of distress and high volatility for the nursing profession; as such, when an opportunity arises to take another position, even with a minimal difference in salary, nurses are willing to change jobs, therefore leaving their post, and

subsequently contributing to the high turnover in health facilities observed overall (Nurse, Interview, January 2020).

In contrast to this brief nursing professional background, HS offers the internship program, a program for nursing students who want to seek more experience as part of their curricular or extracurricular activities. Second, HS offers the "trainee" program, a program specifically designed for recently formed nursing professionals but without on-the-job experience (HS, 2020). HS has strategically created an equal amount of trainee positions as intern positions such that there is a trainee position to transition to if candidates do well as nursing interns (Nurse, Interview, January 2020). This is likely to be a motivation for interns to perform well and stay in the program as it is a secure path and introduction in the labor market for the nursing profession after graduation from nursing school. This is a strategic HRM approach as the professionals have already been exposed to the organizational culture at HS and they already have been trained to know what to expect at HS. Third, graduating nursing trainees remain as part of a registry and HS draws as needed from this registry for new hires. Nurses express pride to have been accepted as trainees at HS when they graduated from nursing school and to have been hired later on as full-time employees at HS, especially given HS's current reputation in the city (Nurse, Interview, August 2008; Nurse 1, Interview, January 2020; Nurse 2, Interview, January 2020). This HRM approach which is catered more towards young professionals entering the labor market is likely to influence the gratitude and subsequently the commitment they feel towards HS and its success.

It is worth noting that trainee programs exist in some private hospitals but they are met with suspicion as trainee programs are perceived as a way to hire recent nursing graduates for low wages and cause layoffs of older members of the nursing cadre, imitating what the third party companies and cooperatives are doing but under the sleek title of "trainee" (Nurse, Interview, January 2020; UFBA Professor, personal communication, April 2020). Likewise, when the trainee program started at HS, older nurses were resistant to the trainee program because of the aforementioned widely held notions about such programs and out of fear of losing their jobs. HS leadership had to convince the nursing professionals resisting the trainee program that the purpose of trainee implementation was to form new professionals into the profession, not to lay off the older nursing staff (Nurse, Interview, January 2020; Nurse, personal communication, January 2020).

Even though career development through formal programs such as the internship and trainee programs is important for employees, study participants also highlighted recognition and opportunities for employee growth at HS. The next category will present the evidence to show how recognition and opportunities for growth are experienced by study participants at HS.

Category 3: Recognition/appreciation and opportunities for professional growth

First, participants express how recognition/appreciation is valued as part of daily routine. A study participant shared:

In the day-to-day work, nurses are praised for their work; they meet with their team… [the team] compliments them and share this information. [Also] when you are an employee you have the right to take the day off on your birthday. If you have worked properly and you do not miss work, you have the right to your time off. It ends up being something of value (Nurse, Interview, January 2020).

Second, study participants expressed pride and gratitude to be recognized for their performance at HS and for that performance recognition to have led to different opportunities for professional growth within the organization. While study participants reported proud and grateful to be seen and to be given opportunities as individuals, they also referred to colleagues who were given opportunities to grow in the organization. These included promotions of nurses from healthcare delivery to permanent education roles, advancement of nurses from trainee to full-time nurse to coordinator, transition from day nursing coordination to night nursing coordination (Nurse, Interview, August 2008; Nurse 1, Interview, January2020; Nurse 2, Interview, January 2020; Nurse 3, Interview, January 2020). One study participant shared:

I know [X] from the [y] service who took over from [W]; it is an opportunity. There is appreciation here. When an opportunity arises, they really recognize [employees] (Nurse, Interview, January 2020).

Even though participants express the sense of recognition and appreciation at HS could be enhanced through better salary, they also understand the professional environment outside HS:

We have appreciation, but it can be better. Besides employee appreciation, the salary could improve… In other hospitals that I know and I have already worked at, we see absurd attitudes

of all kinds. There is no value in the nursing professional or the nursing technician. The medical category is the one that is valued, because of the status and all that. There is also no appreciation because the nurse's salary has dropped a lot. There were hospitals that fired several nurses with 10 or 20 years of experience to be able to hire new nurses with a salary of less than half (Nurse, Interview, January 2020).

Third, the experience at HS does not only provide employees with opportunities with HS but offers them opportunities elsewhere, in other health facilities:

Regarding Hospital do Subúrbio, I see many nurses, myself included, that like to work here. I was already invited to work in other places recently. They called me for a coordination role at another hospital but [I did not accept] ... I like it here. I feel valued here (Nurse, Interview, January 2020).

Another study participant shared:

I already had some external offers. I had one just now, but I have a feeling of gratitude for the hospital. You can't repay that except with this feeling that you belong here, so I have no interest today in going elsewhere. It was a very good offer, a position above what I occupy, but I don't want to. I want to stay here. I feel good, I work well, I do a good job, I see results. I recognize that the hospital has invested on me, so I want to repay this investment. If the hospital had not seen the potential in me, perhaps I would still continue as an assistance nurse (Nurse, Interview, October 2018).

This section showed how employees at HS feel appreciated/recognized and how that influences their decision to stay at HS even when better employment opportunities arise. The next session will show how the availability of materials as well as organizational structure matters to employees and their professional actualization as well.

Category 4: Resources and enabling/safe environment to practice their profession

In addition to appreciation and opportunities for career growth, doctors as well as nurses at HS express that they feel they have the opportunity to practice what they have studied given the resources available to them at HS. A physician shared:

You have both technological and human support for you to be able to practice cutting edge medicine. Even though a SUS hospital, you can do a very good job. This is what motivates me to continue [here]… [Here] I am able to practice everything I learned during my residence and more. This is what motivates me. In other hospitals you have the normal SUS difficulties; sometimes you don't have material, sometimes it takes a little longer to receive the test results (Physician, Interview, October 2018).

A nurse at HS who also held a position at a public institution described her frustration with regards to her experience at the public institution and all the undermining efforts she has experienced to secure resources for her patients:

… They [some medical professionals in the public sector] think they have no individual obligation [when the material they need is not there]. They [think they] have the obligation to do [a procedure] if they have the material it but if they don't have the material, they don't [see it as their responsibility to] have to look for what is needed. Available resources [to perform your job] have to be present [as the bare minimum]. For me it was a professional commitment and a personal responsibility [to do my job] so I left my house on Saturday or Sunday morning to go to the other sectors [at the public hospital], call the other coordinators and ask for 20 syringes. Because I had patients in the pediatric line who needed that material [the next day]. And it frustrates you, it undermines you as a professional, it wears you out. After two and a half years I asked to leave (Nurse, Interview, February 2020).

Another nurse at HS who holds a position at a public hospital different to the nurse above shared:

There is a lot of bureaucracy. To give you an idea, to get a plastic box like that one [showing the box] at the public hospital [I work at] takes several requests. The system is not even computerized. It takes several written requests. I experienced it myself. My coordination [at the public hospital] was trying to put together surgery kits with boxes like those there [showing the box again]. It has been 14 years that I am there. My coordinator got the boxes 5 or 6 years after requesting. Here [at HS], if I place an order today, the purchase will be made and the next scheduled delivery, I will have it…

… the tenders [in public hospitals] are slow, time consuming. Buying equipment is very difficult. If an equipment were to break today, there would be a bid and at least 3 companies will need to bid. When we receive the material, it might be 2 years later. It is possible when the obsolete equipment arrives, it already needs updating. There will be the need to open a bid again to buy the system update. For example, monitors were bought at the public hospital where I work. When they arrived they needed a module with a system update to work… (Nurse, Interview, January 2020)

The state of radiology sectors in public hospitals was further described as precarious with respect to outdated x-ray and CT equipment and maintenance. CT scanners in different public hospitals in the state of Bahia were reported to be out of service for 2-6 months either due to the need of an x-ray tube, software configuration or fuse replacement. At the same time, it took hospitalized patients up to 20-30 days to perform CT or MRI exams, while reports took 7-10 days to be released, with some hospitals only having reports for 10-20% of the diagnostic exams performed (Technical Officer, personal communication, April 2019).

In addition to material resources, participants refer to organizational structures in place that allow them to practice their profession. One of the starkest conversations I experienced was with a nurse at HS who also worked at another public institution. She expressed confusion, anger, anxiety and burnout at the practices, structures of work, availability of health personnel and materials available at the other institution. At the same time, she repeatedly used the word "smooth/unconcerned" (*tranquilo*) throughout the interview to describe her shift at HS even though an emergency department is not a typical "smooth" or "unconcerned" work environment. She explained that because of inadequate coordination structures, she does not feel sure that she is doing what she should be doing at the public institution. On the contrary, she expressed great admiration for her coordinator at HS and the structures in place which create a sense of safety for her to practice her profession, even in an environment of emergency crisis (Nurse, Interview, January 2020). Furthermore, another study participant mentioned that the structures build at HS and the resulting high level of communication do not permit that a problem of communication remains as such for a long time (HS Management Team Member, Interview, January 2020).

Furthermore, participants talked about the importance of the existence of protocols and conducting their job with less fear because of the existence of protocols. Even though protocols

could be considered technical tools that serve to bring about organized and homogeneous practices in health organizations, a study participant referred to protocols as tools that could represent the use of a common language that unites and serves as a means of better communication but also as a psychological tool that provides professionals with a sense of safety at HS:

That's the point about the protocol, the language is universal, everyone will speak the same language. Another thing about the protocol is the security it brings to the patient and the professional (Nurse, interview, January 2020)

Theme 3: Empowerment

Category 1: Access to HS Hierarchy

Before presenting the results of how HS employees have increased access to hierarchy within the organization, it is important to briefly mention how hierarchy is reflected in Brazilian organizational culture and how it could be important with respect to some of the HRM approaches implemented at HS. Based on Hofstede's work (1991) on the impact of national culture on managerial practices, Brazil's national culture, and by extension the Brazilian organization, was reported to be characterized by a high-power distance. In high-power distance relationships, there is hierarchy which represents inequality, subordinates expect to be told what to do and income distribution is very uneven. As presented by Acadiana da Silveira & Crubelatte (2007) in their analysis of the Brazilian literature on national and organizational structure, Prates & Barros (1997) had proposed the existence of a concentration of power between the leader and institutional subsystems. Even though Alcadipani Da Silveira & Crubelatte generally criticize the literature for not taking into account the plurality of different organizations in a heterogeneous country like Brazil, they find that the Brazilian cultural aspects as originally presented by Hofstede are widely accepted in the literature.

Even though study participants acknowledge and respect the organizational hierarchy that is associated with different job titles at HS, study participants also express access to higher levels of the management hierarchy at HS. First, voice is strongly encouraged through participation in group discussions such as the weekly leadership meetings. HS sends clear messages about wanting to keep a constant dialogue about what is working as much as what is not working in the

different teams and sectors and updating the performance evaluation process (HS Weekly Leadership Meetings, Observation, 2018-2020).

Encouraging voice is confirmed from observations during management rounds (Management Rounds, Observation, January 2020) where employees reached out to the visiting manager to ask if they could speak with her, followed by an open invitation to go to her office to do so whenever possible. This level of interaction has the potential of making the invisible employee visible and it is a form of empowerment to feel seen and for their opinion to matter. In addition to management rounds as a space/time to have that level of interaction, employees interact with management in the cafeteria where all employees and management gather on a daily basis to have lunch (Observation, 2018-2020).

In addition, employees feel comfortable to voice their opinion to their managers if and when needed; one employee shared about her manager:

[The manager] gives us the liberty to talk to her. Her door is always open. I feel safe with this management. There is no fear to talk. I can say what I think would be best for staff and the patients. The same study participant also referred to organizational management structures are offering a sense of safety: *It is two of us coordinating the sector; that helps in decision making and it gives a sense of security for good management* (Nurse, Interview, October, 2018).

Another nurse shared:

We have this access to the management team, to the nursing coordination. [X, a management team member] is really accessible; she makes a point of being at all the trainings as well as open to receiving people. [Y, another management team member] is like that as well (Nurse, Interview, January 2020).

Combining data from two nurses, it is evident that access to hierarchy at HS allows not only openness to reach out to management for problems but openness to share ideas about possible solutions. While a nurse explained how HS management was open to her making a presentation about a process for improving surgery scheduling that she experienced at another institution, another nurse expressed that it is impossible to share ideas with leadership at the public hospital (Nurse 1, Interview, January 2020; Nurse 2, Interview, January 2020).

Study participants referred not only to less hierarchy with respect to management at HS but also less hierarchy among different professional categories and how that contributed to teamwork at HS. As such, the next session will focus on the importance of teamwork at HS.

Category 2: Professional Teamwork

It is clear from interviews across the organization as well as observed interactions at the HS weekly leadership meetings that HS is characterized by less professional hierarchy as well as by more intra-disciplinary and inter-disciplinary teamwork.

First, as an attempt to signal less professional hierarchy at HS, management refers to employees including physicians, nurses, pharmacists and social workers across the organization as "collaborators." That was a deliberate strategic decision which now has become part of how employees refer to other colleagues at HS (Observation, 2018-2020; HS Management Team Member, Interview, January 2020).

Trying to explain the notion of less hierarchy among professionals, a study participant shared with me*:*

We are used to the slave culture… If I get to a higher level and you are not at a higher level, I have to dominate you and you will do what I want, but you will not necessarily do it as you would have to... This has a lot to do with health. Sometimes the medical category wants nursing to do something and the nurses want the technicians to do it [because of that hierarchy]…Here [at HS], we have a coexistence between the categories; between medicine, nursing, physiotherapy, cleaning support, laboratory support. There is respect, but there is not that hierarchy as if the medical professional were a supreme being as we see in other places. So, this ends up captivating the team to stay; I think that's why I chose to work here (Nurse, Interview, September 2018).

Even though study participants talked about recognition/appreciation and the opportunities for growth that they experience at HS at the individual level and how that contributes to their professional development and actualization, nurses in specific talked about how they receive appreciation and recognition for nursing as a profession. As reported by nursing interviewees who hold employment at HS and other public and private institutions, the sense of professional appreciation and recognition is especially highlighted for nursing

professionals at HS. Their HS experience contrasts their experience as nursing professionals in other public as well as private organizations that they have been part of in the past or that they were part of at the time of the study. A nurse participant shared:

In Brazil, you will not arrive at an institution and see nursing having a level of visibility with management as here [at HS]. You do not see that. In general, nobody considers nursing fundamental. [The director at HS] has this vision about nursing and she says it all the time: you cannot do assistance without a partnership with nursing, without valuing nursing. In the private sector, that does not happen in general. In the other private hospital where I worked, the superior [voice] is always the doctor, the star is always the doctor. There is a high demand for nursing but there is no real appreciation, because if the doctor arrives and speaks louder, it doesn't matter if you are right; he speaks louder, he is the doctor and period (Nurse, Interview, January 2020).

As eluded by this study participant, one aspect of the experience at HS is appreciation of nurses in general but also more specifically appreciation of nurses by physicians and a decrease in the power distance between the two professional groups. This is important as professional hierarchy and power distance between physicians and other health professionals is likely to affect communication, coordination, team building and ultimately patient care. As such, HS management has been making constant efforts to minimize the professional power status divide and distance between physicians and the rest of the health professionals at HS. Many participants referred to elements and instances of this divide between physicians and other health professionals but they have highlighted the constant efforts made by HS leadership to emphasize team building among professionals, to value all professionals alike and to decrease the professional hierarchy power gap between physicians and nurses. Talking about challenges that were overcome in the year before, a nurse mentioned:

[We achieved] a better relationship between the night nursing coordinator and the medical team, a better understanding of our role. An even greater recognition of some specialties regarding our role as well... HS itself does not have much of a problem with the medical hierarchy because [the director] highlights the importance of nurses, she makes the message very clear: there is no medical team or nursing team. Everyone is a team (Nurse, interview, January 2020).

Another nurse expressed her satisfaction with her team members and the diminished power distance between physicians and other professionals on her team:

I love working [in department X at HS]. It is like a family here. We have a very good relationship [amongst all of us]: between technicians, nurses and doctors, so much so that the team we have here, the openness we have with the entire group, it is not like saying "I am a doctor" or "I am a nurse", no, it is a group, a team, we work together. Technicians here have access to the doctor, and in some [other] hospitals they do not; [technicians] have to go to the nurse and then to the doctor. Not here. Here, [the technician] goes up to the doctor [and asks:] "Doctor, the pressure [of the patient] behaves like this, what do we do?" There is this connection, this openness is very good…of course there are several disagreements [just like] we have at home, but they are resolved here and they do not need to be handled by the coordination team (Nurse, interview, February 2020).

A study participant shared that in some institutions, the power hierarchy between medical doctors and nurses is made very explicit in the contracts signed when taking on a position. A study participant referred to a public hospital where "Level 1 Resident does not speak to Level 3 Resident or with the shift chief" (SESAB Technical Officer, personal communication, January 2020).

While teamwork training prior to December 2018 was done depending on perceived need and after requests from different sectors themselves, behavioral trainings are now more systematic and are done for personnel directly involved with health service delivery but also with supporting personnel. These trainings offer a space for conversation among colleagues, for getting to know each other, to bring issues they are dealing with in their respective sectors and share ideas how to manage those issues better. In addition to getting to know each other, behavioral trainings also provide a space where employees engage in team building exercises which highlight their role and the role of their sector for the functioning of the hospital overall (Behavior trainings, Observation, August, 2019; October, 2019).

As part of teamwork, employees perceive themselves as contributing to the collective efforts of HS. One interviewee eluded to how important teamwork is for her work while describing her different experiences at a public hospital and HS:

[In the public hospital]… I felt like a grain of sand on a beach. This is how we feel inside the public service with public management; we feel a grain of sand on a huge beach. Then you say: Why am I going to do it if nobody else does?.... Here, each one is a gear, each one is a small gear helping the other and that will give a great result there in the front. And if such a piece is missing, it is a big loss. So here I am gear, there I am a little grain of sand on a beach (Nurse, Interview, August 2018)

Furthermore, a physician further suggested that group involvement at HS could likely affect absenteeism:

This involvement of the group that works at the hospital, that enjoys working at the hospital, contributes to the reduced absenteeism today (Medical Doctor, Interview, October 2018).

Category 3: Leadership Development

Nursing interns as auditors: Leadership responsibility is assigned at different levels at HS. As part of continued process quality improvement, members of the Permanent Education and Service Quality teams conduct audits of different processes at HS. As the aforementioned teams are small to reach the auditing goal of at least 80 percent of nursing stuff which includes nurses and nursing technicians at HS, nursing interns (which are at the bottom of the professional hierarchy in terms of training after nursing staff and nursing trainees) are allocated auditing responsibility as well as part of their internship requirements (Nurse, Interview, January 2020). This is a HS leadership strategic decision which is aimed at developing leadership qualities for interns from a young stage as well as for the interns to learn certain institutional processes for when they themselves advance to trainee nurses or nurses at HS. Assigning auditing authority to nursing interns is a strategic decision for empowering young professionals through leadership responsibility. This leadership initiative nurtures feelings of value, empowerment, appreciation and recognition by leadership and by colleagues alike. As other initiatives that carry unsaid, embedded expectations of hierarchy, this initiative was initially met with resistance from nurses who did not understand how a nursing intern would have the responsibility to audit their nursing practices. Therefore, in a hierarchical culture and in a profession that is not generally valued, receiving such an empowerment through auditing participation from a young intern stage creates a sense of being valued and has had the potential of creating stronger bonds of loyalty as well as

higher participation and productivity at HS. This further encourages them to choose to stay at HS when they have an option for choosing another employment opportunity after their internship and trainee stages at HS. This is not unusual as many employers know the standard of training that interns, trainees and employees receive at HS and seek to capture HS employees. Assigning auditing authority to nursing interns is therefore a long-term beneficial strategy for both the nursing professionals who are able to gain competitive skills by being exposed to the standards of process quality early on in their career and for the hospital which is able to retain the trained employees, thus maintaining a culture of process quality for longer.

Nursing night shift coordinators assume leadership role: Nurses at HS are given leadership responsibility on night shifts and it brings tremendous pride to them as nursing professionals to be entrusted with such leadership duties (Nurse, Interview, January 2020). It is especially important to consider the value of this strategic leadership decision given the background of hierarchical relationships in Brazilian culture, in Bahian patrimonial culture but also in the medical profession which generally praises the medical doctor over the nursing professional. Over time, HS leadership has placed a lot of emphasis on the important role of nurses and teamwork among all professionals at HS. As such, through constant and consistent signaling of messages about the role of nurses and teamwork, HS leadership was able to minimize some initial resistance from medical doctors, especially some specialty medical doctors who showed signs of resistance at the idea of a nursing coordinator acting on behalf of HS leadership on night shifts. This long-term, consistent signaling and the outcome of diminished resistance and acceptance of the significant role of the night shift coordinator have resulted in additional feelings of pride and appreciation for the nursing shift coordinators not only by leadership but by all staff including medical doctors. This example to encourage more horizontal leadership between medical and nursing stuff and to give leadership authority to nursing staff shows how consistent and persistent efforts by leadership can have the power to shift traditional hierarchical norms within organizational cultures.

Theme 4: Sense of meaning for a functional SUS that delivers quality care

Sense of personal meaning: While some staff members state that HS is a private hospital, most staff members at HS consider HS a public hospital, run by a private management. There is a clear distinction that for the patient, HS is a public hospital where there is no payment made by

patients to access the hospital just like any public hospital under SUS but on the inside, HS is run like a private hospital with structures and processes in place that are very different from those in public hospitals. This is a constant signaling approach on behalf of the HS executive team which repeatedly presents and emphasizes HS as a public hospital from the initial stages of hiring, to the weekly leadership meetings with medical and nursing coordinators and in organizational behavior trainings focused on teamwork (Observation, 2018-2020).

Staff members express feelings of pride that they are working for and are part of a public hospital that delivers results while the public experience they had before as patients or employees was a dysfunctional, unresponsive and low-quality public health system. As such, staff members find it stimulating to see SUS working in practice and themselves as active participants towards that goal. A nurse shared:

... one idealizes SUS. In its essence, in theory, SUS is wonderful. At university we start to say: "if it were all [really] like [it is on paper], it would be beautiful and wonderful." You arrive at the hospital [HS] where you see that people are fighting to enforce what is written [in SUS]. It is captivating, wonderful, it encourages you to work, to come [here]. When there is a challenge, you don't feel challenged. You say: "I will not give up; I will make it happen because I know my patient will benefit." That is very stimulating... it is stimulating every day (Nurse, Interview, January 2020).

This gives meaning to their work not only in relation to their contribution to the organization but ultimately in relation to their contribution to society. The creation of a profound meaning for their contribution to a functional SUS is likely to be additionally creating a sense of belonging, positively affecting employee turnover, absenteeism, motivation as well as employee commitment for delivering the best care possible at HS. It is also important to highlight that many employees at HS come from and/or live in the low-income, sub-urban communities surrounding HS, with their families in the area as well. This is an added source of personal meaning to them as HS (and they, as part of HS) are serving not only contributing to the vision of a functional SUS for the city of Salvador but they are contributing to a vision of a functional SUS in their own particular community, and to their own families or neighbors. In turn, their sense of meaning might come from the pride they receive from the community itself which recognizes them as HS workers in the community (Nurse, Interview, January 2020).

When asked why the choice to work at HS, a nurse shared:

I think that in Brazil, the history of SUS has been one of a lot of struggle since the beginning; we see many examples where public hospitals in SUS are not able to maintain the quality of care that people experience here [at HS]. This quality of care is not only for patients but also for health professionals.

The same participant explained how sensitizing the HS staff about their contribution to SUS has been strategic and part of signaling the importance and mission of HS:

… [it was important to] sensitize the professional and show him/her that SUS is possible. It was presented like this: 'What are you doing [by working here]? You are strengthening something that started almost thirty years ago, which was the formation of SUS. What we are doing here is for every hospital to do and for every public service to do.' I think that was the formula (Nurse, Interview, September 2019).

A participant who has been working at HS since 2010 also shared:

I am very proud that the hospital [HS] has passed the 1st, the 2nd, and the 3rd level [of accreditation]. I have been very proud, even about minimal aspects from the 1st level that are already part of the culture and were not before. Knowing that we are part of this story [of HS] is really relevant (Nurse, Interview, January 2020).

Co-construction and shared sense of meaning: In addition, leadership emphasizes the long co-construction of HS into the public hospital that it is today and recognizes everyone's contribution in that co-construction. Messages regarding the public nature of the hospital, its co-construction as well as appreciation for everyone's work and contribution to HS are constantly shared with all intermediate and front-line staff members, medical as well as non-medical staff. This is done through direct interactions with leadership in meetings, indirectly through the medical and nursing coordinators, as well as through social activities at the hospital such as the HS anniversary or Christmas celebrations (Observation, 2018-2020). Messages about the co-construction of HS and appreciation for all staff members elevates the staff members' sense of personal, professional as well as a shared organizational meaning they attach to HS. A nurse

shared:

I just want to leave [the public hospital I work at] with the feeling that I did everything I could. That I did everything that was within my reach. I didn't do more because I didn't have the tools to do more, because the institution didn't give me more tools to do my job or because it was the patient's therapeutic limitation. But I did everything I could [for me]. That is what encourages me in my other hospital. I am not going to do it for the institution. Here [at HS], do I do it for me? I do it because of my sense of accomplishment, but I do it for the institution too. Why? Because here I understand that I am not a speck on a beach. Here I am a fundamental piece (Nurse, Interview, August 2018).

Another employee at HS shared:

There is a feeling of belonging to what you do; I am here and I belong to the hospital. I feel it in the words of the employees, I see it in the work commitment they develop and they also say that they like the project here. There is a feeling of great pride in the team for the work we do because it is a public hospital (HS staff member, Interview, September 2018).

DISCUSSION

Using qualitative empirical data, this paper explored how different HRM practices were constructed and adopted internally at HS as important factors for the hospital's performance while considering its embeddedness in the local socio-cultural and medical professional context of Salvador, Bahia, Brazil. This study provides evidence that while the PPP contract seems to be an important condition for success, the internal HRM approaches adopted by HS provide evidence as to how HS was able to fulfill its contractual indicators over time.

One explanation is that HS has been able to deliver results because it is bound by a legal contract. Indeed, the PPP contract is guided by law and the signed contract holds the private sector accountable to deliver results as measured by a defined set of indicators. However, results would not have been achieved only through organizational autonomy. While the legal contract gave autonomy to HS, HS implemented HRM strategies that enabled it to deliver its results over time. Another explanation is that HS has been able to stay in business and survive as a project because it is making profit. In both cases, HS would not be delivering results, and would be

financially penalized had it not been able to put major efforts on human resource management practices which vary significantly from the practices and human resource management approaches in publicly administered hospitals (and some private hospitals alike).

An alternative explanation to the success of HS with respect to HRM is higher salaries paid by the private sector. Many participants have expressed that in the first years of the HS implantation in 2010, the HS approach to attract personnel was to offer higher salaries than market salaries. The PPP model was a new proposal (for the state and the country) at the time and there was a lot of uncertainty if it was going to be a viable, let alone successful project. In addition, HS was in a dangerous sub-urban area far from the urban city of Salvador, with no public transportation reaching the hospital. Salaries above average market value (reaching up to 40% above market value (HS Management Team Member, Interview, January 2020) were therefore an initial approach to attract medical professionals to work at HS. However, over time, all the other human resource approaches explained in this paper were implemented. Currently, salaries at HS are reported to be at varying levels depending on specialties, ranging from higher-than-market value to average to lower-than-average market value. In addition, given the HS reputation, other hospitals now attempt to capture HS employees by offering them higher salaries, many times with success. Even though HS staff members are indeed captured by other institutions, HS depends on the same human resource management approaches build over time to retain its staff members.

Even though a direct comparison of salaries cannot be made between HS, direct public administration, indirect public administration and the private sector for every medical specialty and at different levels for nursing professionals in this study, participants have expressed great appreciation for being paid on time at HS. That is naturally very important to any worker, especially when they contrast salary disbursements made by HS on time to salary disbursements being delayed (with no legal repercussions) up to 90 days in the public sector. It is also important to recall that as there has been no civil examination since 2008, nursing professionals do not have the option of working for public health facilities as public employees. The salaries determined by third party companies under which nursing professionals sign up with and which the public sector hires to delivery services in public institutions vary from company to company, with little to no consideration of salary history. The nursing professionals also do not have a choice of health facility but are assigned in facilities where the third-party company is

contracted. As already mentioned, third -party companies also fire experienced, older nurses to hire newly formed nurses at minimum wages. Combining salary and working conditions, the nursing profession in Brazil is shared as being very devalued. Therefore, the combination of a stable salary that is paid on time as well as working conditions and practices that respect the nursing profession make nursing staff choose to stay at HS.

HS also provides an example of performing beyond the basic requirements of the PPP contract; while permanent education should be part of HS as broadly defined in the PPP contract, HS has institutionalized additional training programs catered to professionals at different stages in their careers. In addition, while the PPP contract required that HS reached the Level 1 accreditation standard within 24 months of its operations in 2012, HS reached the third and highest level of accreditation by the National Accreditation Organization by 2016. One could further argue that these accomplishments were made as to win the contract again. That could be true to an extent. However, what should be highlighted is that building an organizational culture and dealing with daily challenges from the surrounding cultural and professional context with actors who navigate and respond to the different expectations of those contexts on a daily basis takes a lot of time and consistent efforts to come to life. Organizational culture, community, respect, sense of belonging and meaning cannot be constructed overnight, especially when their construction has to stand at odds and compete with patrimonial cultures and professional norms.

HS has implemented many of the aforementioned HRM practices at different times during the last 9 years. As a result, the impact of one approach or a group of approaches on HRM over another and ultimately on patient outcomes cannot be isolated and studied individually. To be working at HS now is an important professional victory laden with honor and pride as expressed by many of my participants. This means that hired staff members enter HS strongly influenced by the prestige of the selection process as well as the (evolving) prestige of HS as a well-known and respected hospital in Salvador and the state. Carrying this prestige and honor of selection into HS is likely to have effects on collaborator dedication and organizational performance. However, as that initial excitement and effects on performance might naturally diminish over time, the HS leadership team has made conscious efforts for complementary human resource management approaches to continue to encourage that initial elevated sense of honor of entering HS. It is worth noting that most, if not all, of the human resource management approaches implemented are not projects that have added extra costs to the operation of HS nor

are they are attached to monetary benefits but instead depend on intrinsic motivation of staff members.

In the beginning of this paper, I mentioned managerial capacity from the private sector as a huge assumption embedded around the conversation and consideration of PPPs. The case of HS validates that assumption. However, this validation cannot be generalized to PPPs more broadly as the human resource management approaches which are chosen and successfully implemented by each different private management company that takes on any given PPP, and can be vastly different, will be crucial in defining the path the PPP takes. It is possible to talk about possibilities to ensure success through lessons learned from my case study, but the original assumption remains an assumption that should be carefully be examined with every different PPP being considered.

The themes and the corresponding categories within them reflect evidence from aforementioned background literature on HRM and performance in organizations in health and beyond health, including the importance of autonomy for recruitment, performance standards and evaluation, training and development, recognition, participation in decision-making processes and teamwork.

First, in structing PPP projects, care must be taken to evaluate the private sector and its management expertise to take on such a project, especially if the regulation of the PPP contract is weak. HS as a case of a hospital PPP demonstrates the importance of having the needed expertise in health care delivery but also demonstrates the importance of knowing the local context and engaging local actors who understand the complex health system terrain and behaviors within the system. This is particularly important given the investment in operations over the life of any PPP which amounts to much higher percentage than the original investments made in infrastructure and equipment. An examination of the professional context and logics would improve our understanding on how local actors are able to manage their institutional complexity, align with the PPP goals and be able to drive implementation of PPPs successfully. The case of HS demonstrates that considering culture and logics enabled HS leadership to design multi-pronged appropriate strategies for human resource management and thus better facilitate successful implementation of HS. The informed approaches implemented by other potential PPPs might be similar or different than those implemented at HS according to the context of the project.

Second, the results of this study could provide important lessons for local implementers managing any model of healthcare delivery as all healthcare delivery involves management and front-line personnel responsible for delivering services. The prevailing attention of Secretaries/Ministries of Health is on the adequate number of health professionals required for health facilities and subsequently, if at all, whether those that are supposed to be present or not at their posts. My study findings show that it is imperative to start thinking about human resource management and organizational behavior approaches for introducing change in departments and organizations, in healthcare and beyond health.

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Chapter 5:
Constructing a Culture of Quality Improvement as an Essential Process in Healthcare Delivery

INTRODUCTION

Healthcare quality is of utmost importance as it impacts the patient healthcare experience and patient morbidity and mortality. Lack of quality health services can discourage patients from seeking care, thus delaying treatment and exacerbating disease while it can also exacerbate inequalities between population sub-groups who are financially able to seek quality hospital services in the private sector and those who cannot afford alternative arrangements to the public hospital.

Like in many Low- and Middle-Income Countries (LMICs), public hospitals in Brazil are criticized for long waiting times, inadequate quality care and poor safety (Costa 2017; La Forgia & Cuttolenc, 2008; Lewis, Malik & Penteado, 2015; Mendes et. al. 2009, Paim et. al. 2011). However, Hospital do Subúrbio (HS) has been highlighted as an acclaimed, successful hospital case; it has been named one of the 100 most innovative global projects (KPMG, 2012), has been reported as having "dramatically improved emergency hospital services for one million people in Salvador" (World Bank, 2013), and has reached the highest national level of national accreditation (HS, 2020). HS is considered a success story because of what we historically (and currently) know about quality and performance of public hospitals in Brazil. The difference between what we would expect from the literature and the healthcare services delivery by HS to-date raises the research question that I aim to explore for this paper: *How has HS constructed a culture of quality and quality improvement in delivering health services that is different than what one would expect from public hospitals?*

Quality Advocacy in Health Systems

Quality and quality improvement approaches in health have been attempted, documented and advocated for in the literature for over three decades. The earliest and one of the most influential frameworks to think about quality in health has been proposed by Avedis Donabedian (Donabedian, 1966). According to Donabedian, quality of care is conceptualized as being determined by structure (resources) and processes (activities) to contribute to the outcome of delivered care. In 2000, the Institute of Medicine (IOM) drew attention to patient safety in the United States (IOM, 2000, 2001) as there was perceived unmet need for effective and quality health services: research up at the time had indicated that as many as 25 percent of hospital deaths could be preventable, while as many as about 30 percent of drugs prescribed and laboratory tests showing abnormal results were neither indicated nor get followed up respectively (Dubois and Brook 1988; Brook et al. 1990; Leape 1994, Weiner et al., 2006). In addition, IOM proposed a six-aim framework for delivering quality health care. These six aims included safe care, effective care, patient-centered care, timely care, efficient care and equitable care (IOM, 2001). Overall, these IOM reports as well as a study by McGlynn et al., 2003, showing that only 54.9 percent of U.S patients received the care recommended for them, highlighted the need and provided the momentum to advocate for quality improvement of healthcare in the U.S. It has been reported that measures and initiatives taken with respect to quality addressed some of the six aforementioned quality domains more than others, with safety and effectiveness being addressed the most and efficiency and equity of care being addressed the least (IOM, 2005).

In addition to the frameworks put forward by Donabedian and IOM in the U.S., the focus on quality and quality improvement in global health in the last two decades has been considered under the bigger umbrella of health system performance and health system strengthening. First, Harvard University's Control Knobs framework (Roberts et al., 2004) represents quality as an intermediate performance measure together with efficiency and access, responsible for the resulting performance goals of health outcomes, patient satisfaction and financial protection. Second, the World Health Organization (WHO) published the Building Blocks Health System Framework (WHO, 2007), which is widely referred to by WHO member states. In this WHO framework quality is considered as a health system component for improved health outcomes along with access, coverage and safety. However, the acknowledgement of quality and the practice of quality in health system strengthening do not seem to be aligned in practice as they are envisioned in the WHO framework. It has been suggested that this is partly because very

little information is shared about what the term 'quality' in the framework means and most importantly how quality can be implemented and achieved at different levels in the health system (Leatherman et al, 2010).

Over time, along with the introduction of the aforementioned quality frameworks, it has also been proposed that quality improvement practices in developing countries could optimize limited resource allocation and use. Thus, while resources could be used towards the same failed processes and outcomes, the same resources combined with quality improvement efforts could have the potential to lead to new processes and outcomes of care (Smits, Leatherman & Berwick, 2002). It has additionally been suggested that as the gap between the care that is actually delivered and the best possible care that could be delivered is larger in developing than in developed countries, quality improvement practices may have even greater potential to improve health outcomes in more restrained resource settings (Leatherman et al., 2010). Despite the reference made to quality in all the aforementioned frameworks globally, quality appears to have remained a concept that needed to be interpreted and applied differently by different national systems and implementing bodies within them. Furthermore, in addition to the lack of clarity on what quality and quality improvement mean in practice, quality experts have shared that while some developing health systems might have attempted quality projects, that experience and knowledge has not been widely shared as part of continuous learning on how quality can be achieved at different levels (Leatherman et al., 2010).

Data Collection and Use as Essential Elements for Quality Improvement

While advocating for quality in health systems and possible approaches to implement quality and quality improvement initiatives, many scholars have also attempted to identify what factors influence the implementation of quality improvement projects and how quality improvement could be better sustained over time (Groene, 2010). From a review of the literature, it has been suggested that quality improvement efforts are challenging as they require sustained leadership, mobilizing, training and supporting clinical and non-clinical staff, establishing effective collaboration across cross-functional sectors and departments and establishing measurement and data systems (Parker et al., 1999; Shortell et al.1998; Weiner et al., 2006). As the quality improvement field has evolved over time, there has been an increased attention about the potential of effectively using quantitative and qualitative data to identify gaps and determine

and accomplish possible improvement strategies in low-income countries (Wagenaar et al., 2017).

Recently Highlighted Importance of Quality in Health Systems

In 2018, the World Health Organization (WHO), the Organization for Economic Co-operation and Development (OECD) and the World Bank have released a report highlighting quality health services as a global imperative to achieve Universal Health Coverage (UHC) (WHO/OECD/WB, 2018). The main premise of this report is that UHC cannot be achieved without quality services. The authors claim that so far, the progress of countries towards UHC has predominantly focused on coverage and financial protection, leaving quality of services in the background. As such, UHC cannot be accomplished if services continue to be less than optimal in terms of effectiveness or safety. The authors also add that quality health services should not be a luxury to be enjoyed only by resource-rich countries. The report and this new call on quality services as essential was motivated by the restated affirmations for continued efforts to achieve UHC under the newly agreed upon Sustainable Development Goals (SDGs) (2015-2030) as well as the sub-optimal quality of health services in LMICs under the Millenium Development Goals (MDGs) (2000-2015). The authors report that adherence to clinical practice guidelines in some LMICs has been reported to often be below 50 percent while provider absenteeism, daily productivity and diagnostic accuracy varied significantly among LMICs as well (Kieny et al., 2018).

Following the WHO/OECD/World Bank report, Kruk et al., 2018, showed that of the 8.6 million yearly deaths in LMICs attributable to poor care and treatable conditions, 3·6 million deaths occur from lack of access to care while 5 million lives could be saved through healthcare quality improvements (Kruk et al., 2018). In their study, Kruk et al. present some data on quality of care in LMICs: 66 percent of the global burden of adverse events from unsafe care and the Disability Adjusted Life Years lost from them occur in LMICs, the surgical rate of infection in LMICs is 6.1 per 100 surgical procedures compared to 0.9 per 100 surgical procedures in the U.S. while the median mortality in emergency departments across 65 hospitals in LMICs is 45 times higher than mortality in U.S. emergency departments (Kruk et al., 2018, pg. e1213). Comparing results from LMICs with the U.S., Kruk and colleagues strongly reiterate the message of the aforementioned WHO/OECD/World Bank report that even though expansion of

UHC is crucial, it will be ineffective unless the quality of services is addressed. As a consequence, Sustainable Development Goal 3 – to ensure healthy lives and promote well-being for all – will likely not be met either. Through their findings and advocacy to highlight the urgent need for quality improvements, Kruk et al. also support earlier suggestions about the great potential of quality initiatives to improve health outcomes in LMICs.

Quality and Quality Improvement Concerns in Brazilian Hospitals

Transitioning from perspectives of quality globally to perspectives of quality in Brazil, in their work on Brazilian hospitals published in 2008, La Forgia and Cuttolenc, had reported that the most worrisome finding in their work was that the quality of care provided in most hospitals was unknown and information was not systematically collected for quality of care evaluations to be possible (La Forgia & Cuttolenc, 2008). This is not to say that there have been no national efforts to attempt quality improvement in the Brazilian health care system. The literature suggests that some efforts have been made, however they do not seem to have been sustainable and as such, it is uncertain how much change they introduced and for how long. For example, La Forgia and colleagues report that in 1995, the Brazilian government adopted the US National Nosocomial Infection Surveillance System (NNISS) for diagnosing and tracking hospital infections. However, only 17 percent of hospitals reported using the NNISS by 2003 while a separate system launched by the MS in 1998 was reported to have been adopted by only about 51 percent of hospitals. Data from a national survey by Marcal dos Santos et al., 2005 conducted across 1009 municipal, 27 state and 4,148 private hospitals, showed that 37 percent of hospitals reported not having any defined criteria for identifying and monitoring nosocomial infections (Marcal dos Santos et al., 2005; La Forgia & Cuttolenc., 2008). In the same study, the authors showed that about 75 percent of hospitals surveyed had a hospital infection control committee while 25 percent did not report having one. La Forgia and Cuttolenc also caution that even though hospitals are required by law to have an infection control committee, there is no evidence to reflect whether those committees are actually functioning in practice. In addition to infection control, an important indicator of quality in health facilities, La Forgia and Cuttolenc also present the absence of standardized practice norms and treatment protocols as well as the inadequacy of record keeping as major gaps contributing to low quality. It should be noted that even though a 12-year old book, La Forgia & Cuttolenc's *Hospital Performance in Brazil - The Search of*

Excellence (2008) still remains a reference for Brazilian hospitals. Quality in hospital management is an under-researched area in Brazil. A literature review conducted on healthcare quality since 2008 in Brazil pointed to very few studies as outlined below. As a result of the lack of research on quality in health facilities, the discourse about healthcare quality in Brazil remains around the older work by La Forgia & Cuttolenc.

More recent reports on the quality of public hospitals in Brazil point to long waiting times, inadequate quality care and poor safety (Costa 2017; Lewis, Malik & Penteado, 2015). While researchers found that 67 percent of adverse events in hospitals were likely preventable (Mendes et. al. 2009, Paim et. al. 2011), a follow up study using two-stage review of medical records found approximately 1.3 adverse events for every 10 hospital admissions with 43 percent of adverse events being likely preventable (Mendes et. al. 2018). Malik (2016) claims that there might be two types of evidence that hospitals in Brazil are increasingly concerned with the issue of quality and safety: one is accreditation of health facilities and the other one is federal legislation compliance with the establishment of patient safety centers within health facilities.

Healthcare quality is important to study as it impacts the patient healthcare experience and patient morbidity and mortality. Lack of quality health services can discourage patients from seeking care when needed while it can also exacerbate inequalities in the population between sub-groups who are financially able to seek quality hospital services in the private sector and those who cannot afford such alternative arrangements, thus delaying treatment and exacerbating disease. HS has been highlighted a success story juxtaposed with what we historically (and currently) know about quality and performance of public hospitals in Brazil. That difference between what we would expect from the literature and the healthcare services delivery by HS to-date raises the research question that I aim to explore in this paper: *How has HS constructed a culture of quality and quality improvement in delivering health services that is different than what one would expect from public hospitals?* To answer the research question of this paper, I will present and discuss the results of the study using Donabedian's Quality Framework. The choice of the specific framework as well as the components of the framework are briefly discussed below.

Donabedian Quality Framework

As briefly mentioned earlier, according to Donabedian (1966), quality of health care is conceptualized as being determined by structure (resources) and processes (activities) that contribute to the outcome of healthcare delivery (survival and health status). More specifically, while structure includes physical and organizational components such as the adequacy of facilities, equipment or medicines, the qualifications and organization of medical staff, and administrative and fiscal aspects of the organization, processes focus on what is done and how it is done through diagnostic and therapeutic procedures, and coordination and continuity of care (Donabedian, 1966). While other frameworks in the health care quality literature include quality as part of health system assessment or present the several components that make up quality in healthcare, I specifically chose the Donabedian framework to analyze and present the results of this study as I wish to study quality as a process of construction and not simply the presence or absence of quality health services at HS. As opposed to Donabedian's framework which considers healthcare quality as a process, Harvard University's Control Knobs and the WHO's Health System Building Blocks frameworks present quality as a more static intermediate outcome or a health system component respectively. I also considered using IOM's framework for analysis and organizing my findings of quality health care at HS. The IOM framework presented quality as composed of 6 aims: safe care, effective care, patient-centered care, timely care, efficient care and equitable care. Even though all these are important aspects of quality that any health system should pay attention to, the IOM framework does not help us conceptualize quality as a process. As such, the Donabedian framework seems most fitting to guide the analysis and organization of my findings as it pays attention to the structural resources but most importantly to the processes that needed to be implemented over time to build a culture of quality and bring about quality improvement in at HS. As Donabedian posits, the relationship between structure and process as well as the relationship between process and outcome are much more complex in practice than how they seem to be separately depicted in his framework (Donabedian, 1966). This is not a concern for my study as I am specifically considering the iterative assessment of structures, processes and outcomes and their complex interactions to inform the construction of a culture of quality improvement at HS.

RESULTS

Using empirical qualitative data from my study, this section will present the quality improvement approaches adopted at HS as important factors for the hospital's performance. First, the results show the achievement of contractual outcomes through quantitative and qualitative indicators as well as the requirement for reaching basic accreditation, both of which do not exist for public hospitals. In addition to contractual obligations, HS has implemented additional process and quality improvement approaches to promote systematic collection, analysis and monitoring of data combined with constant communication and feedback for quality process improvement. In this section, I will demonstrate how, as a result of these processes, HS has established consistent and constant signaling throughout the organization about a culture of promoting healthcare quality at HS. For HS to reach its outputs (contractual indicators and accreditation), processes (lines of treatment, protocols, evaluation and feedback) as well as structures (infrastructure, materials, training, human resources and information technology) contribute to quality and quality improvement efforts. Where possible, I contrast the use of outcomes/outputs, processes and structure for quality improvement at HS to hospitals under public administration as a way to demonstrate the heterogeneity which exists in quality improvement efforts across healthcare facilities.

Outcomes

Contractual Indicators

It is worth remembering that HS is bound to the achievement of pre-defined standards and quantitative and qualitative indicators as agreed and signed upon by the HS partnership contract between the Secretary of Health of the state of Bahia (SESAB) and the private consortium, Prodal. The contractual indicators and the extent to which they are achieved are publicly available by trimester on the HS website since the inauguration of the hospital in 2010 as well as in the form of yearly epidemiological bulletins (HS, 2020). Quantitative and qualitative performance indicators comprise 70 percent and 30 percent of the HS PPP contract respectively. While quantitative indicators report the number of patients for in-patient, urgency, emergency and out-patient care as well as diagnostic services, quality indicators report on different aspects of mortality, hospital acquired infections, hospital re-admission rate, and time to surgery (Appendix D). While HS meets the majority of its contractual qualitative indicators, namely time interval to surgery, ICU re-admission rate, global infection density, central venous catheter

associated infection, post-operative mortality rate, acute myocardial infarction mortality rate, and cerebrovascular accident mortality rate, it faces challenges with respect to patient mortality from sepsis and as a result, with respect to overall institutional mortality rate (HS, 2020).

Even though information is available on all contractual indicators at HS from 2010-2020, it is challenging to make comparisons to other institutions in the city of Salvador or the state of Bahia as data is not systematically collected in most directly administered public hospitals. In very few cases where indicators are collected, they are not publicly available. In addition, comparisons cannot be made to public hospitals that belong to the public health system but are run by OSs as none of those hospitals are urgency/emergency hospitals like HS.

As already mentioned, in contrast to the requirement of closely monitored indicators at HS, systematic collection of indicators is generally not available in public hospitals, with some data collection appearing to only be available from some public hospitals upon request since 2016 (Document Review, April 2019). Second, data collected in the public sector is believed to be rarely used for the purpose of analysis for quality improvement in public hospitals. As an informant cautioned me when discussing possible sources and availability of indicators: "[Data collection/reporting] is for the Englishmen to see" (Professor, personal communication, July 2019). This is an expression used metaphorically to explain the tendency of pretending to have certain systems in place just for the sake of appearances while in reality they are fictitious or ineffective (with the origin of the phrase dating back to the 19th century and reflecting the Brazilian efforts to circumvent their treaty with England on slave trading when they were monitoring ships arriving in Brazil). Third, some data might be collected as needed and requested of public hospitals not in a systematic way but for certain presentations, leadership decisions or audits about malpractice or adverse events (Document Review, February 2020). There have been suggestions to introduce a system of quantitative and qualitative indicators in public administration hospitals, associated with contract conditions if those indicators not met, just like in the case of HS. However, such a proposal has been met and will be most likely be further met with resistance that might deem the proposal and such a possibility inviable (SESAB Technical Officer, Interview, September 2018; SESAB Technical Officer, Interview, July 2019).

The difficulty of evaluating the performance of HS in relation to other hospitals in the health system is part of the overall challenge of creating systematic evaluation of health care quality in Brazil. As part of the National Program for Cost Management (*Programa Nacional de*

*Gestao de Custos; PNGC/ Apuração e Gestão de Custos do SUS; APURASU*S), piloted in Bahia, hospitals are asked to engage with the Coordination of the Economy of Health (*Coordenacao de Economia da Saúde*) in SESAB to participate in the PNGC/APURASUS program, receive training, and contribute to the collection of cost data (PNGC/APURASUS UFBA lecture participation, August 2019; SESAB, 2017). Evaluation of the program shows that many public hospitals are not participating in the program. Some hospitals have participated for some time, then withdrew and then joined the program again. Some other hospitals have challenges to provide quality data for the system and therefore one could doubt the accuracy of the information provided. Data shows that these issues likely stem from lack of a participation requirement and applying accountability tools if standards are not met, both at the state level but also at the hospital level. First, there seems to be a level of decoupling in SESAB: despite an ordinance (*portaria)* with the Secretary of Health himself supporting and urging hospitals to participate, the PNGC/APURASUS program at the Coordination of the Economy of Health is run only by two SESAB employees and despite numerous efforts, the coordination has not been strengthened by increasing the human resource capacity to enable its role in the PNGC/APURASUS program. Second, it is reported that hospitals have not been historically expected to report costing information to the state and it is difficult to change such a path-dependent culture to now think about costs as part of management for a public hospital. Third, high turnover of hospital personnel at the respective participating public hospitals means constant loss of skills and need for constant re-training to understand the program and be able to provide quality data for the system on behalf of every hospital. Lack of upstream commitment from SESAB leadership is likely to influence hospital leadership and subsequently, hospital leadership is likely to affect how seriously personnel within the hospitals take the program and even the effort they put in the system for quality data in case they do decide to participate (PNGC/APURASUS UFBA lecture participation, August 2019; SESAB PNGC/APURASUS Meeting, August 2019).

As presented above, contractual indicators comprise the first set of outcomes to explain the performance and quality of health services delivered by HS. Next, I will present the results from national accreditation as further evidence to demonstrate how HS is highly regarded for the delivery of quality health services.

External Evaluation - National Accreditation

In addition to the quantitative and qualitative contract indicators, HS was contractually bound to reach accreditation within two years of its operation. HS achieved Level 1 accreditation by National Accreditation Organization (*Organização Nacional de Acreditação, ONA*), Level 2 accreditation in 2014 and Level 3 accreditation in 2016. According to ONA, at Level 1, a health facility is considered as "Accredited." At Level 1, "the health organization meets or exceeds, by 70% or more, the quality and safety standards defined by ONA," with the certificate of accreditation being valid for two years. At Level 2, a health facility is considered "Fully accredited." As such, it "fulfills two criteria: a) it meets or exceeds, by 80% or more, quality and safety standards defined by ONA, and b) complies with or exceeds, by 70% or more, the ONA standards of integrated management, with processes occurring in a fluid manner and full communication between activities," with the certificate of full accreditation being valid for two years as well. Last, at Level 3, a health facility is considered "Accredited with Excellence." As such, "the organization needs to meet three criteria: a) meet or exceed, by 90% or more, the quality and safety standards; b) meet or exceed, by 80% or more, the standards of integrated management; and c) meet or exceed, by 70% or more, the ONA standards of Management Excellence, demonstrating an organizational culture of continuous improvement with institutional maturity," with a valid certificate of accreditation for three years (ONA, 2020).

As shown in Table 1, there are currently no ONA Level 1, 2 or 3 accredited public hospitals in the state of Bahia. The only public, 100 percent SUS hospital of all 35 public hospitals in the state that has reached the highest level of ONA accreditation is HS. It is worth noting in Table 1 that 1 of the 5 private hospitals accredited with excellence in the state of Bahia is HS's parent hospital which was the first private hospital to reach accreditation in the state in 2006 (Hospital Jorge Valente, 2020).

Table 1. ONA Accredited hospitals in the state of Bahia (ONA, 2020).

	Public	Private	Philanthropic
Level 1 - Accreditation	0	1	0
Level 2 - Full Accreditation	0	3	0
Level 3 - Accreditation with Excellence	1	5	1
Total	1	9	1

In addition to the formal accreditation visit, it is likely that planning for an accreditation visit provides the opportunity to review processes of care: to organize protocols, to revisit procedures, to become aware of better documenting processes that are officially or unofficially followed or to dialogue about the responsibility or co-responsibility of sectors over defined processes for better coordination (HS Infection Control Team, Observation, August 2019).

In addition to showing that HS has been meeting its contractual indicators and achieving the highest level of quality services as determined by national accreditation, the next section will provide some perceptions of the quality of health services at HS as expressed by study participants.

Perceptions of Quality

Different study participants ranging from state auditors, to doctors and nurses holding positions at HS and other public hospitals, former SESAB technical officers and management team members of other hospitals in Salvador have expressed overall positive views about the quality of care at HS as they have experienced it from their respective organizational positions.

A SUS auditor expressed that he was impressed with the level of agility at HS and the need for public hospitals for such a level of agility:

I went to HS recently and I was delighted with the technical management. It is really an improvement. I was investigating hospitalizations within 24 hours, because we have a SUS guideline that says that hospitalizations can only be identified after 24 hours; before 24 hours, a case is [considered] an emergency procedure that calls for observation up to 24 hours. Only that in 24 hours they [at HS] even do digestive endoscopy on the patient. That is a level of resolubility that left me impressed. It is great because that patient who was going to stay for a week to do an endoscopy had his diagnosis, they ruled out a perforated ulcer and sent him home… This is what we want; this needs to be exported to other units because it is exactly this knowledge we need… We have a big task in the state to distribute beds and make beds available; I think this is important (SUS Auditor, Interview, September 2018).

A physician highlighted the importance of offering timely treatment for patients:

In terms of SUS, there is no other hospital in Bahia like this one, with the support, the surgical center technology, dedicated employees. I think it is a different SUS here. It is not a SUS that other hospitals with direct management have with all the problems… Here you have established protocols. I will give you an example. If you were to see a multiple trauma patient, you could label that patient as 'Route 1.' Classified as Route 1, the patient has to be accompanied by a doctor to Bioimaging and Bioimaging has up to 40 minutes to release the exam report. You have up to 60 minutes to make a decision on how to proceed with the patient. You can get audited on those time frames. I have no problem seeing a patient and having a tomography response within 40 minutes [at HS]. In other places, these time frames are not so established (Physician, Interview, October 2018).

A nurse who works at HS but holds a secondary position in a public hospital also highlighted the importance of timely services as part of quality at HS as something rare in the state:

To give you an idea, a patient who is an emergency, who is at risk of internal bleeding is in the operating room within 15 minutes. This is a big gain. We do not get that anywhere; here in Bahia we do not get that anywhere really. The patient arrives and in fifteen minutes he is in the operating room. There is always a reserved room in the operating center and staff, supplies; everything is there and ready. This is a very good indicator (Nurse, Interview, September 2018).

Contrasting the agility that the study participants shared above, two nurses who work at HS compared their experiences and shared their challenges with delays in elective surgery in public institutions:

At HS, I have never encountered a situation of a patient not going for surgery, in any shift since I have been there, either because the center closed, or because there was no room available or because there was no anesthesiologist. If it happened, it was very sporadic but was not disseminated within the institution. In the public hospital I work at, a patient can wait for two months in the hospital awaiting surgery, after suspending the surgery 5 times, 6 times, 7 times. I prepare the patient and there is no room on the scheduled day for him to have surgery. And the surgery is cancelled again… There is no room because the previous scheduled surgery was scheduled to start at 7 am and finish at 9 am. It was delayed because the physician came in late

or emergency surgery had taken priority. You have 10 rooms but only are 3 working. That elective surgery will be postponed for another day. And the next day, it will be another situation and selective surgery will have to suffer again (Nurse 1, Interview, January 2020).

You see inpatients who stay at the hospital for 20 or 30 days... Every day is the same: 'today there will be no surgery, we put it off for tomorrow, for later' ...[It would have been different] If they had a medical coordination that functioned and had a requirement of x vascular surgeries… but they do not, so the hospital is overcrowded. Someone who goes to work every day can see the wards with all the patients waiting for surgery (Nurse 2, Interview, January 2020).

A study participant who belongs to the management team of a philanthropic hospital in Salvador shared how quality at HS is reflected in the conditions of patients that they occasionally receive from HS:

I know today that a patient who came [here to my hospital] from HS came in a better condition than from hospital X… When certain hospitals are going to send patients here, I'm getting ready that a bomb is going to explode; they did not stabilize the patient, they did not perform a certain procedure, they did not prepare the patient properly, they did not guide the relatives. Now, when that patient is coming from HS, [we know] they have followed all the procedures, they give us an updated medical record… (Hospital Manager, Interview, July 2018).

A former SESAB technical officer shared her view about the PPP project overall:

I would say it has been a good experience, but it might not have been. I think the good experience was also due to a group that has a tradition of providing health care for a long time… The Promédica group proved to be a serious group, a competent group and it is doing a good job. That helped us to achieve this level of satisfaction. It is a hospital that has been showing excellence (Former SESAB Technical Officer, Interview, June 2018).

In addition to achieving the majority of its contractual outcome indicators as well as national accreditation, these perspectives shared by study participants add to the evidence about the quality of services offered by HS.

While the past section focused on quality at HS as shown by outcomes, accreditation and perspectives of study participants, the next section will focus on processes that HS employed to construct a culture of quality and quality improvement over time, therefore achieving the aforementioned outcomes.

Process

This section will focus on providing evidence about the processes which have been introduced at HS over time as a way of constructing a culture of quality that is now prevalent in the organization. Before providing that evidence, it is important to refer back to Table 1 and recall that 1 of the 5 private hospitals accredited with excellence in the state of Bahia is HS's founding parent hospital, Jorge Valente, which was the first private hospital to reach accreditation in the state in 2006. It would therefore be logical to ask if the performance of HS can be attributed to a high level of imprinting (Marquis & Tilcsik, 2013; Stinchcombe, 1965). In the case of HS, that would mean attributing the performance of HS to elements which were adopted from its founding parent hospital and which persisted over time to explain HS's performance to date. As evident from my interviews with study participants who joined HS from the beginning of its operations, there was some level of knowledge transfer or imprinting from the parent private hospital. This included more structural aspects of the project such as adopting the IT system, the HR system, and the Orthoses, Prostheses and Special Materials (*Órteses, Próteses e Materiais Especiais; OPME*). In addition, the employees who managed those processes held positions at both institutions (at Jorge Valente and HS) for a few years before they transitioned as full time employees exclusive to HS (HS Management Team Member 1, Interview, June 2018; HS Management Team Member 2, Interview, June 2018; HS staff member, Interview, September 2018). Jorge Valente is a 144-bed facility, as opposed to 313 beds at HS, with a profile that goes beyond urgency/emergency to include obstetrics, hospitalization in various clinical and surgical areas as well as neonatology and pediatrics (Hospital Jorge Valente, 2020). Last, the location of HS influences the epidemiologic profile of the hospital and is important to mention. While Jorge Valente is centrally located in the city of Salvador, HS is in the suburb of the city and close to the highway. As such, this means that HS receives more motor-vehicle accident patients and polytrauma patients. This is an important aspect as it relates to protocols and lines of care that have been specifically developed over time at HS to deal with the profile of HS as an

urgency/emergency hospital. These aspects contribute to understanding the success of HS as a process of construction as opposed to imprinting which resulted from its founding parent hospital organization.

The results section below starts with an explanation of how routine benchmarking guided by contractual indicators as well as routine weekly meetings have been used in the process of quality improvement. Following, the results will additionally show that the approaches built over time at HS included the development and implementation of the clinical lines of care starting in 2015, the adoption of internal evaluation procedures in 2016 as well as the on-going development of protocols as they relate to current clinical challenges encountered at HS. The routine attention paid to quality improvement likely contributed to decreased resistance to new processes such as implementing the new lines of care or internal evaluations.

Using contractual indicators as goals

At HS, reference to the contractual indicators is consistently made as the benchmarking standard in presentations by different participants (HS Weekly Meetings, Observation, 2018-2020) while at the end of every trimester, HS presents the hospital's performance results to SESAB as well as community leaders (HS-Community leaders Meeting, Observation, July 2018, October 2019).

In the beginning of the HS project, the measurement of performance through indicators for a 100 percent SUS hospital was described as novelty as no public SUS hospital was ever held to that standard in the state before. A study participant who was invited to consider joining HS and originally declined in 2010 but joined HS later shared her concerns at the time:

"… everything was very new and we wondered: "Will it work? Will it not?" It was very difficult at first to find people because it was a new hospital. Everything was very doubtful; [we did not yet have] a hospital [like that] in the state of Bahia, a hospital of this size with outsourced management" (HS Management Team Member, Interview, June 2018).

While doubtful for many, a participant described the proposal of a project like HS as stimulating for others who wished to participate in such an innovative proposal and described the performance indicators as a guiding mechanism about the direction and goals of the hospital with respect to delivering safe, effective, timely and equitable care:

... [it was a] concept that one was not even used to in the private sector at the time, let alone in SUS. [This model involved] working with a well-defined model of management, a well-defined set of qualitative and quantitative goals to fulfill. To know exactly where you want to get at. And you can do that in a service that is 100% SUS; that [idea] delighted many people

(HS Management team member, Interview, August 2018)

Evidence shows that employees delivering health services seem to know the contractual indicators and use them as benchmarks to guide health service delivery outputs in their respective sectors. A management team member at HS noted the importance of teaching and training collaborators about the indicators even if they are at HS for a small number of working shift hours per week or per month. He noted the existence of indicators as instrumental for the HS project but highlighted that HS needed to place special emphasis on training medical personnel about quality because the indicator standards for quality were new to medical professionals:

I think that first, it was the desire and the involvement of the macro management in qualifying, in training many people… above all, I would say the category of doctors who were not very used to working or having to work with [such structure of quality and standards]. So, I think the first thing was the construction, the process with the construction of the quality of culture that took place here. The management team has a desire [for a quality of culture], wants to fulfill the contractual goal, but there was also had the perception that it would have to be built

(HS Management team member, interview, January 2020)

Holding Weekly Leadership Meetings as a Process for Quality Improvement

To share the prominent culture of constant evaluation for quality and quality improvement, a physician shared that at HS, one "lives by being evaluated" (HS Physician, interview, June 2018). This is evident in the weekly leadership meetings as explained below. One space in which evaluation of quality and quality improvement took place was at the weekly leadership meetings.

The weekly leadership meetings held at HS are open to everyone at the hospital to attend, as long as professionals are not leaving their post unattended. The meetings are structured as presentations given by hospital staff and are meant to serve as a dialogue and communication

between different cadres of staff and the HS leadership and management teams. First, these meetings serve as a forum for conversation about performance, successes and challenges of different departments. Weekly meetings expose participants to a variety of topics such as presentation of the trimester achievement of contractual indicators, sector performance and evaluation, medical protocol development, water filtration, medication costs, permanent education training updates, infection control or occupational health, internal evaluation results and accreditation results to mention a few (HS weekly leadership meetings, Observation, 2018-2020). The weekly meetings are attended by the institution's human resources personnel, leadership members, managers, coordinators, medical doctors, nurses, quality team members, permanent education team members, infection control team members, and representatives all of multi-professional teams as well as members of the IT team (HS weekly meetings, observation, 2018-2020). Participants mentioned the importance of interaction and communication of the different sectors for quality improvement in the weekly meetings as quality depends on the interdependence and communication between the sectors and joint analysis to really understand opportunities for improvement. A participant expressed that even if people do not understand the pathology in case of the presented clinical cases because not everyone attending is medical professional, it is important to understand the ways in which sectors and processes are linked (Nurse, Interview, February 2020). One important characteristic of the weekly meeting presentations is addressing opportunities for improvement together with timelines of improvement completion, many times with a plan of action with responsibilities and timelines assigned to member teams (HS weekly meeting observations, 2018-2020). In the presentations for their sectors, presenters seek to compare HS performance with the contractual indicators but also with studies in the national and international literature. Presenters follow the same pattern of seeking information nationally and internationally when building evidence for protocol development at the hospital (HS weekly meeting, October 2018). Furthermore, presenters use the weekly meeting forums to introduce possible quality improvements as experienced in other hospitals as personnel often have multiple jobs and can be agents of the transferability of lessons between institutions (Nursing coordinator, interview, January 2020).

So far the results have shown that quality improvement efforts at HS were guided by contractual indicators as well as routine weekly meetings. Following, the results will further show that additional approaches built over time at HS including the development and

implementation of the clinical lines of care starting in 2015, the adoption of internal evaluation procedures in 2016 as well as the on-going development of protocols as they relate to current clinical challenges encountered at HS.

Adopting National Accreditation Recommendations

As a result of accreditation recommendations after obtaining full accreditation in 2014, HS has institutionalized lines of care to increase the agility of clinical care and better minimize the risks associated with timely patient flow, especially as it relates to two prevalent diagnoses of HS patients: stroke and trauma (Document Review, 2018-2020; HS, 2020). The lines of care were implemented consecutively with the Cerebrovascular accident (stroke) Care Line first, followed by the Trauma Victim Care Line. These two lines of care were established as to provide a script to efficiently and effectively guide professionals on the appropriate clinical procedures for timely assistance once a patient is given a diagnosis upon arrival. These lines of care were highlighted by many HS participants as having impacted the flow of care and the quality of assistance for patients through the protocols instituted in each (Physician, interview, August 2018; Physician, interview, October 2018; Nurse, interview, February 2020). This is especially important for an urgency/emergency hospital like HS with a high incidence of stroke and trauma, both conditions in which time to diagnosis, time between treatments and decision-making along the line of care could impact the patient and his/her outcomes. In addition, through the implementation of these lines of care, it has been possible to identify opportunities for quality improvement with respect to optimization of protocols within the lines of care as well as consolidate an integrated management among multi-professionals, both of which refine the quality of service delivery to the patient as well as assist in achieving the contractual indicators (Emergency nurse, interview, February 2020; Pediatric nurse, interview, February 2020; HS weekly leadership meetings, observation, 2018-2020; HS, 2020).

Even though the development and implementation of the lines of care was one of the most important and major quality improvements cited by many study participants, other accreditation recommendations for quality improvement have been adopted by HS as well. Two examples are traceability of materials though the Registry of Materials and Inputs (*Cadastro de Materiais e Insumos; CMI)* and risk mapping. First, after accreditation recommendations, HS registry of CMI sector has been able to monitor, document and develop the ability to trace how

materials are being used and for what patient, especially with respect to nosocomial infection. HS weekly meeting attendants, including nurses, physicians and leadership personnel expressed that they did not know this level of control existed at HS (HS weekly meeting, observation, August 2019) while some HS members cited the CMI efforts as a pride for the hospital and also mentioned other hospitals have shown interest and have visited HS to learn from the HS CMI experience. Second, another recommendation by accreditation has been the development of clear guidelines to evaluate the severity, frequency of the hazard occurrence and the possibility of prospectively detecting errors in the clinical processes of care. While the hazard mapping already existed in principle at HS, a clearer and more systematic methodology was requested by the accreditation committee as a quality improvement step (HS weekly meetings, observation, January 2020). This example shows that the process of accreditation has brought not only new recommendations for HS but also helped reinforce existing but less practiced protocols.

This section provided three examples about how both processes were strengthened via recommendations of the accreditation process, namely the development and implementation of clinical lines of care, as well as the strengthening of traceability of materials to better detect infection control as well as risk mapping. It is also important to highlight once more that these were processes of construction at HS. While the suggestions for these procedures were made by the accreditation body, they had to be constructed at HS. In addition to developing processes as suggested by accreditation, HS also adopted internal evaluation procedures. The next section will show how HS adopted and adapted the Tracer evaluation used by accreditation to assess quality of care across the organization but also as part of the training of interns early on in their careers.

Adopting Internal Evaluation Procedures

In addition to the recommendations suggested by the accreditation process, HS has additionally adapted accreditation routines internally as part of process evaluation and quality improvement as explained below.

Since earning the last and highest level of accreditation in 2016, HS has developed an internal holistic evaluation which follows the process of accreditation methodology called Tracer methodology adopted by The Joint Commission since 2004 (Siewert, 2018), with assigned auditor physicians and nurses within HS to conduct the internal Tracer evaluations. Using the Tracer methodology, patients are randomly selected from different lines of care and their cases

closely examined by the auditors, collecting data along the experience of care through the entire health delivery process from the point of patient entry to HS, including interactions of care with bioimaging, laboratory or medication dispensation. It is important to highlight that the IT system is integral to the collection and compilation of this data. Internal Tracer evaluations are conducted every trimester and the results are presented at the hospital's weekly leadership meetings for critical analysis of every patient case involved. Physician and nurse representatives of the lines of care from which patients were randomly selected for evaluation are required to attend the leadership meeting to represent the sector and to help better understand the flow of patient care across the different departments and the decisions made for each patient along the continuum of care as revealed by the Tracer evaluation. The intention of the Tracer is not to find errors and blame any individual but instead to look at the care delivery more holistically and understand the process gaps that lead to errors in care (HS weekly leadership meeting observations, August 2018, July 2019; Accreditation Maintenance Visit, Observation, 2019; Nurse, Interview, October 2018). To give an example, in a Tracer evaluation presentation I attended, the internal HS auditing team had identified issues related to the timing of administered drugs, gaps in filling the patient questionnaire, perfunctory definition for a therapeutic plan and gaps in the identification of patient risks upon arrival (HS weekly leadership meeting, July 2019). The gaps presented as results of Tracer exercises reveal that various quality problems do exist at HS, however, with the multiple monitoring mechanisms in place, risks to patient care can be more detectable and therefore more controlled.

The Tracer methodology has also been adapted and applied by nursing interns and nursing trainees as part of their case study requirements at HS. As such, nursing interns and trainees follow a patient in the different departments they are training in from the patient's point of entry to HS and they analyze the patient risk classification, assignment into a line of care, timing of different parts of care, administered medication. In this way, nursing interns and trainees learn very early on in their training at HS to think of delivery of care as a holistic, systemic process that involves many other departments and interactions of multi-professional teams and not one isolated within a certain department. As mentioned in Chapter 4, the nursing interns by default have a position as nursing trainees at HS and potentially as nurses if a position becomes available. As such, being trained in Tracer methodology was a strategic decision made by HS leadership to instill critical thinking along the continuum of care through the introduction

of Tracer methodology as well from the initiation of individuals at HS (HS permanent education team member, interview, February 2020). Furthermore, it has been decided that different HS sectors will introduce mini-Tracers as well and one of the criteria for choosing the patients to be audited in the respective sectors will be ones who underwent treatment through the intensive care unit as a way to monitor and evaluate the communication between intensive care and different sectors (HS weekly leadership meeting, July 2019).

In contrast to seeking, applying and adapting methodologies for improvement at HS, a nurse who holds employment at both HS and another urgency/emergency public state hospital shared her challenges with trying to implement quality improvement for her sector in the public hospital. She shared her frustration of having to look everywhere outside her sector for improvement examples to see her implementation efforts rejected in the end:

… You cannot institute anything. You go looking … I went to [another public hospital], I went to [a private hospital] which is also a very good private institution… You go to other units to find out what instruments you can implement in your own unit so that you can improve your patient's safety. Then you go, build the material, discuss with the sector, exchange ideas …[and get feedback] if the instrument is good or not. Then you try to implement the instrument and try to adjust. There is no adherence, people treat me badly, people do not want to listen, people are always negative that it will not work, that they are wasting time (Nurse, interview, February 2020).

This section explained how HS has adapted some accreditation routines internally and how those are important for process evaluation for quality improvement. The next section will provide some further evidence about the construction of a culture of quality through Human Resource Management (HRM) approaches which were explored in Chapter 4.

Constructing HRM approaches

Even though Donabedian classifies the qualifications and organization of medical professionals as part of structure, he classifies coordination and continuity of care as part of processes. As I mentioned earlier in Chapter 5 when introducing the Donabedian framework, my study is not concerned with the clear separation between structure and process. My intention is not to show evidence about what matters more (structure or process) or by how much one matters more than the other in explaining quality and the construction of a culture of quality and quality

improvement at HS. Instead, my study is about understanding the complex process of structures and processes towards constructing a culture of quality which also involves elements from the construction of HRM approaches.

In Chapter 4, I showed how the construction of HRM strategies involves Employee hiring and evaluation, Professional Development and Actualization, Empowerment as well as Developing a Sense of Meaning. While all these HRM approaches might have an indirect impact on quality through the qualification, commitment and motivation of employees at HS, some HRM strategies might have more direct impacts on quality and quality improvement than others. One such HRM approach is increasing the institutional presence of physicians and subsequently the increasing of protocol adhesion by physicians at HS.

Talking about how multiemployment affects quality, a study participant shared:

[It affects] the quality. As Dr. [X] put it yesterday, when there is no loyalty [for professionals], it is difficult to get them to understand the process and experience the process. A professional is here today. The same professional could only come be back here in 30 days. So, the changes that occurred in a process, in a protocol, what was necessary to implement in that period, that is lost, there is no continuity. That is different than nursing; as we are contracted through CLT, we have our shifts. The maximum I stay away from the institution is 5 days, no more than that, as that is not allowed. In 5 days, there are no changes that are very significant and that I will be unable to follow upon my return… A person who stayed away from the institution for 1 month, or comes every 15 days, is different. You can't get loyalty and you cannot manage to make him follow the guidelines. So many breaches of protocol are from people who do not have this loyalty to the institution. Sometimes he comes every 15 days and on the next 15-day shift he finds a substitute for his shift. So, he comes every 30 days, or 2 months. How will that person remember the protocol here if he is already in another [post]? (Nurse, interview, January 2020)

Standardization of protocols and variability in protocol adhesion is an issue discussed at meetings such as permanent education and weekly HS leadership meetings. To give an example, a physician shared during a meeting:

It takes me a year to train/convince new doctors to follow the hospital protocols…. [they need to learn that] the days they are here, the decision-making is shared with the radiologist (HS internal meeting, observation, August 2018).

Recalling the issue of protocol standardization mentioned at the weekly HS leadership meetings and the problems that arise when a professional does not experience only one institution, a member of the HS management team shared:

[The physician] will not follow the protocol. She will do a little bit of what she does in a different place. This poses both an operational problem because she will tend to ask for things that are not part of our set of supplies and [it will be a problem] in health delivery because she does not a high level of adherence to what the hospital [protocol] proposes. The hospital has protocols precisely for what it is monitoring, for what it is measuring, [the grounds on which] it is trying to improve. Those who do [things] differently make it more difficult for us to continue this process of continuous improvement (HS management team member, interview, January 2020)

These perspectives were a reminder that constructing a culture of quality and quality improvement has also been achieved through the implementation of various HRM processes. The next section of this chapter will refer to some structural elements which seem to play an important role in the processes aimed at quality improvement at HS.

Structure

Data collection through an Information Technology system

All aspects of quality and quality improvement efforts aforementioned require systematic collection of quantitative and qualitative data for analysis and feedback. The hospital has implemented an Information Technology (IT) system with a team that is dedicated to collecting and analyzing data for the hospital. The IT system in place has been designed to collect various types of information from the time a patient arrives at the hospital until the patient is released from the hospital including detailed information such as minutes to surgery, minutes to receiving laboratory results and all interventions and interactions with different sectors along the line of care. Many participants interviewed at HS referred to the IT system as an essential element in the success of HS (Physician, Interview, August 2018, Nurse, interview, October 2018; Nurse, interview, 2020). The information collected and compiled by the IT team forms the basis of sector meetings as well as the weekly leadership presentation meetings. While the IT system mainly collects quantitative data, the quantitative data is being continually discussed in the

context and reality of the sectors they are respectively generated in for better analysis and sensemaking. This analysis is also presented during leadership meetings as an exercise on how to think about and analyze data for process improvement (HS weekly leadership meeting observations, 2018-2020).

Contrary to the system built at HS, collecting data for analysis and evaluation is a challenge for publicly administered hospitals. Public hospitals are characterized by a dearth of systematically collected information on quantitative and qualitative data, both of which could aid in process and quality improvement. A nurse highlighted the importance of data collected in combination with institutionalized protocols and the importance of both pieces of data for improvement, comparing between HS and the public sector:

... there are no protocols in place that are managed [correctly] in some public sectors… for example, if you look at the [public] hospital I work for, [you can ask:] what is the medication error rate? Nobody manages that. When you manage it, when you follow it, it will help you in [building] the culture [for quality]. We can say 'My error rate is so bad. It can't be that much. We need to improve this indicator. In the public sector you hardly have a managed protocol. I'm not going to say that the public sector does not have that, but most [public hospitals] do not have that. If I don't manage anything, if I don't follow anything, the possibility of error will increase. I can tell you what I know, about the unit I work in the public sector and [compare it to] here [at HS] (Nurse, Interview, June 2018).

My data show a public administration characterized by a tendency to reactive responses as compared to the longer-term planning through data collection and data monitoring at HS. An informant shared with me:

The Secretary of Health (SESAB) "puts out fires." There is no planning, no monitoring [when it comes to quality]. The culture does not exist for that. It is not just an issue with the Secretary of Health but with the Ministry of Health [nationally] as well (SESAB Technical officer, personal communication, September 2019).

For the first time, there is a Monitoring and Evaluation (ME) team in SESAB as of September 2018 and a course on ME has been designed and catered for this technical team through UFBA in 2019. Even though the state of Bahia has 55 public hospitals under its jurisdiction across the state, there is great heterogeneity in hospital size, leadership and

management styles and the presence of monitoring teams in the hospitals for data collection. The intention behind the formation of the ME group has been to create more homogeneity across state hospitals with regards to standards and indicators and have a closer relationship with the units about their functioning through systematic visits and conversation with the units. A SESAB technical officer shared the intentions of the new ME group:

... Of course, we will have the [indicators/] numbers as a starting point... the numbers reflect a capacity of the unit, how far it can go. But we need to understand the internal workings of the unit, why it is not working, why it is not reaching those numbers (SESAB Technical officer, interview, September 2018)

Whether this will be a successful approach that will bring SESAB to adopt more quality approaches across public hospitals in the state is a difficult task and remains to be determined. One of the main aims of the ME team in the beginning is workforce planning and making sure the right number of professionals are allocated to each unit using national and state protocols and recommendations. At the same time, the plan of the ME team is to have an electronic system for collection of indicators that every health unit will voluntarily provide data for in a systematic way. In addition to this big role assigned to the ME team, it is also currently viewed as the team to resolve situations such as case audits some of which were put on hold for years as there was not a specific team to deal with them. In addition to the audits, the ME team also deals with different matters and needs as they arise in the different hospitals such as issues with equipment, human resources and infrastructure (SESAB Technical officer, Interview, January 2020). These ad-hoc activities result in some cancellations of planned ME visits to the health units. As such, it becomes more difficult to remain true to the intentions of the ME team to establish a systematic, long-term relationship with the units and progressively build on the long-term aim of quality improvement (SESAB Technical officer, Interview, January 2020; Audit report review, February 2020; Observation field visits, February 2020).

The collection of information in public hospitals is challenged by the how different sectors are arranged within public hospitals. Talking about structure of public hospitals and how it could impact the quality of care, a study participant shared the difficulties of coordination that arise from how public hospitals are generally structured and how that has implications on their communication and coordination for healthcare delivery:

… in hospitals there is a question of the models of contracted services. In a hospital, the nephrology service is contracted by one company, the emergency department is contracted by another company, the surgical center by another company, so I don't know what that [arrangement] will bring. I [personally] do not even want to be here [as a technical officer in SESAB] to see [the result of those arrangements]. I don't understand how a hospital, a complex organization such as a hospital, is going to manage… each [sector] is a gear where one depends on the other… At what point will [those different sectors] communicate? (SESAB Technical Officer, Interview, September 2018).

In addition to the IT system that is integral to quality improvement as well the impact of the organization of sectors within hospitals and the weak communication and coordination between them, other important elements of structure at HS include the availability of resources, internal coordination structures as well as a focus on protocol development and institutionalization. These elements were described in more detail in Chapter 4 under Category 4: Resources and an enabling/safe environment at HS (page 87-89).

DISCUSSION

Using qualitative empirical data, the results of this study showed the quality improvement approaches adopted at HS as important factors for the hospital's performance. This study provides evidence that while the PPP contract seems to be an important and guiding condition for the acclaimed success of HS, the processes adopted by HS for ensuring quality provide evidence for the focus on processes and structure to reach contractual indicator requirements and accreditation.

First, the results show the importance of conditions defined in the partnership contract for achieving outcomes through quantitative and qualitative indicators as well as a requirement for reaching basic accreditation, both of which do not exist for public hospitals. In addition to contractual obligations, HS has implemented additional internal process and quality improvement approaches to promote systematic collection, analysis and monitoring of data combined with constant communication and feedback for quality process improvement. The results demonstrate how, as a result of these processes, HS has established consistent and

constant signaling throughout the organization about a culture aimed at promoting healthcare quality. For HS to reach its outputs (contractual indicators and accreditation), processes (lines of treatment, protocols, process evaluation and feedback) as well as structures (infrastructure, materials, training, human resources and information technology) contributed to quality and quality improvement efforts. Where possible, I contrasted the use of outcomes/outputs, processes and structure for quality improvement at HS to hospitals under public administration as a way to demonstrate the different approaches to quality and constant and consistent process improvement efforts.

In addition to the empirical data with respect to HS, my results confirm earlier reports from Brazil which suggested that there was a lack of systematic efforts to enforce standards, measure and ensure quality in (public) hospitals (La Forgia & Cuttolenc, 2008). La Forgia and Cuttolenc, had reported that the most worrisome finding in their work was that the quality of care provided in most hospitals was unknown and information was not systematically collected for quality of care evaluations to be possible (La Forgia & Cuttolenc, 2008). In addition to hospital quality regarding infection control, La Forgia and Cuttolenc also presented the absence of standardized practice norms and treatment protocols as well as the inadequacy of record keeping as major gaps contributing to low quality. My study shows that those concerns do exist today. What is even more worrisome from my results is that the situation with respect to data collection, monitoring and evaluation for quality in hospitals has not changed much in the last 10-15 years since La Forgia and Cuttolenc completed and published their work in 2008.

One could claim that HS has been able to deliver results only because it is bound by a legal contract. Indeed, the PPP contract is guided by law and the signed contract holds the private sector accountable to deliver results as measured by a defined set of indicators. As shown in my study, the contractual indicators have a very important role in guiding the project. It is an accountability mechanism in healthcare that the state of Bahia and the country has never encountered before, and HS staff strives to reach those indicators. The importance of the contractual indicators cannot be downplayed but as the evidence shows, it is not the only factor that drives the performance of HS. One could also argue that HS has been able to provide quality services because meeting indicators allows it to be making profit instead of losing revenues through the application of penalties if indicators not met. In both cases, HS would not be delivering results, would be penalized and would not be making profit had it not been able to put

major efforts on quality improvement practices which vary significantly from publicly administered hospitals (and some private hospitals alike). Another alternative explanation could be that Prodal is constantly interested in quality improvement processes to increase its reputation and attract more patients. However, there is no competition for patients or health insurance claims in the case of HS as all patients access the system free of charge with their national SUS card.

It is worth recalling that while the PPP contract required that HS reached Level 1 accreditation within 24 months of its operations in 2012, HS reached the third and highest level of accreditation by the National Accreditation Organization by 2016. It could be argued that these accomplishments were made as to win the contract again. That could be true to an extent as Prodal /HS would like to win the contract again. However, what should be highlighted is that building a culture of quality and dealing with daily challenges from the surrounding cultural and professional context with actors who navigate and respond to different expectations on a daily basis takes a lot of time and consistent efforts to come to life. The history of quality and quality improvement efforts in developed and developing countries over the last 30 years shows that quality projects cannot be implemented overnight, especially when their construction has to stand at odds and compete with patrimonial cultures and path-dependent professional norms in the surrounding context.

Even though my study does not specifically research the impact of the accreditation process on quality improvement, through my study I identified quality improvement practices resulting from the accreditation process. These practices could be suggestive of the benefits of external accreditation and the motivation for other hospitals and health service units to consider accreditation or adoption of quality improvement techniques as used by accreditation bodies for their organizations. Based on my observations, it is possible that even if a hospital goes through the accreditation process but accreditation is not achieved, the monitoring of aforementioned processes might be an invisible gain that might benefit the organization's quality improvement efforts, however most likely short-term more so than long-term. HS gained Level 1 accreditation in 2012, Level 2 accreditation in 2014 and Level 3 accreditation in 2016. Even though accreditation is just one tool for assessing and improving quality every 2 years, it implies embedding elements of quality and a culture of quality improvement in an organization. Accreditation implies a system whose components such as the collection of data on indicators as

well as processes, organization and personnel have to be built over time before the on-site accreditation visits themselves. In addition, the quality potentially brought about by accreditation also has to progress over time if the accreditation is to advance from Level 1 to Level 3 and whether Level 3 has to sustained over time once the highest level of accreditation has been accomplished, as in the case of HS. In addition to the benefits between the accreditation visits and preparing for the accreditation visit, the accreditation process is likely to result in recommendations made by the accreditation team like the introduction of lines of clinical care in the case of HS.

Practically, given the noted quality and quality improvement difficulties experienced by direct administration hospitals in Brazil, as in many developing nations, and the extent to which HS has been held up as a model of excellence, the case of HS provides a unique opportunity to uncover the quality improvement elements involved in its success. The best-practices employed in the case of HS can be used analytically to inform practical quality improvement hospital practices in Bahia, in Brazil, as well as other LMICs that are seeking ways to deal with their mismanaged public hospitals with lower-than-optimal quality health services.

Theoretically, if we consider Donabedian's (1966) quality framework encompassing outcomes as a result of structure/inputs and processes/activities, my case study shows the different ideological and actual positions occupied by HS and public administration respectively in the quality framework. While public administration seems to be evaluating elements of structure as part of monitoring, evaluating and auditing quality, HS seems to have moved beyond the framework's challenges of structure to dynamic processes of process and quality improvement, while fully utilizing the structures (people, infrastructure, materials and information technology) in this dynamic process. To illustrate this with an example, an audit report of public hospitals focused on hospital infrastructure conditions and additionally reported on equipment that had been installed at the hospitals but they were not used at all or they were not functioning properly, as well as broken equipment at the units (Document Review, February 2020). Only two pages of the audit report were devoted on human resources; even so, the references to personnel regarded how many health professionals should be present according to the national registry, absences of personnel that were on schedule but not on shift, as well as personnel that switched shifts without notifying the corresponding coordinating teams. No references were made to processes of quality improvement. On the contrary, as evident in the

results of this paper, HS utilizes an established structure composed of personnel, infrastructure, materials and information technology in a dynamic process of a combination of quality improvements approaches as outlined above.

As mentioned in Chapter 4, Gittell (2009) acknowledges the power of relationships and the coordination of work through relational coordination which involves relationships of shared goals, shared knowledge and mutual respect. Gittell shows that relational coordination enables shorter hospital stays, higher levels of patient-perceived quality of care and improved clinical outcomes (Gittell, 2009, page 40). Combined with HRM approaches such as selection, performance and job design as well as frequent, timely, accurate and problem-solving communication which develops over time, Gittell proposes relational coordination as an integral component of a high-performance healthcare system which aims at high quality and efficiency (Gitell, 2009, page 213). Therefore, while Donabedian focuses on quality as process, Gittell shows how some processes such as relational coordination and communication matter for constructing a culture of quality and quality improvement.

Theoretically, the case of HS as situated and juxtaposed with the local public administration context as well as the history of quality improvement uptakes at the national/state levels indicates that an accountable structure that builds on external as well as internal motivation within organizations is important for performance results. Otherwise, recommended adoption might be weak or initial commitment might be volatile and commitment to the quality improvement initiative will weaken relatively quickly. Despite the efforts to form the SESAB ME team which is envisioned to improve quality in public state hospitals, there is fear that without some form of accountability, the hospitals themselves might not fully participate in the collection of indicators short-term or long-term, thus making the ME team efforts and vision of health service quality improvement inviable.

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Chapter 6: Conclusion

In this dissertation, I presented three perspectives to explain HS's successful implementation, including its relationships with local actors, the development of human resource management approaches and the focus on constructing a culture of quality at HS. All three perspectives to critically identify and understand the implementation of HS emerged from an in-depth ethnographic case study conducted between May-October, 2018 and July 2019-February 2020, which consisted of 107 semi-structured interviews, participant observation, and document review in Salvador, Bahia, Brazil.

In Chapter 3, I sought to understand the external and shifting coalitions of support and opposition that should be identified and understood as part of evaluating the feasibility, implementation and sustainability of future PPP projects as well as similar development projects. I find that HS has established various levels of "embedded autonomy" (Evans, 1995) with the three actors involved – the Secretary of Health (SESAB), the local community and the Municipality of Salvador. Using evidence from my study, I conclude that care should be taken when advocating for PPPs under the assumption that the state is capable of providing a monitoring team to accompany such a complex PPP project. The case of HS also offers a unique opportunity to consider the importance of politics and the potential shifts in support and/or opposition that could occur over election cycles and leadership changes when considering the feasibility and sustainability of projects like PPPs. I additionally conclude that creating opportunities to construct partnerships and engage with local communities through grassroots approaches could be instrumental in contributing to project operations as well as in buffering the relationships with other possible actors. Furthermore, the case of HS also offers the opportunity to consider the importance of politics and the possibility of opportunistic partisan behaviors that might arise when considering different sub-national arrangements and actors involved in service delivery.

In Chapter 4, I sought to understand and document the construction of Human Resource Management for healthcare organizations. I organized my findings around four themes namely

1) Hiring and Evaluation, 2) Professional Development and Actualization, 3) Empowerment and 4) Sense of Meaning, drawing evidence from my empirical research to support the developed themes. While scholars in the past have identified some of the same HRM practices as important elements in performing organizations, especially in environments where they were not expected to be so (Grindle, 1997; McDonnell, 2017; Roll, 2014; Vian, 2017), my research goes beyond just the identification of these HRM practices and their mere presence or absence to explain the high organizational performance at HS. Instead, using evidence from HS, I focus on the process of construction of HRM approaches over the lifetime of the project, taking into account local professional norms and employee experiences. This is a unique contribution as a focus on the construction of HRM practices allows the possibility to not simply identify HRM practices as important for high performing organizations but to replicate these practices and create more HS-like performing organizations for health service delivery.

In Chapter 5, I sought to understand the processes involved in the construction of a culture of quality and quality improvement that has been impacting the quality of services delivered at HS. Similar to the process of construction of HRM processes in Chapter 4, this paper explores not the mere presence or absence of a culture of quality and quality improvement but its construction over time. Similar to the construction of HRM practices, this is also a unique contribution as a focus on the construction of a culture of quality allows the possibility not to just identify quality and quality improvement as important for high performing organizations but to offer approaches as to how to replicate those and other potential approaches with the goal of creating more HS-like performing organizations for health service delivery. Considering Chapters 4 and 5 together, I also conclude that effective private sector management at HS is a conscious process of construction and caution must be taken when PPP assumptions are made about a taken-for-granted, homogeneous, and non-investigated standard of effective private sector management that can be advantageous in PPP ventures.

The three papers are held together by the notion of understanding and evaluating processes of construction rather than identifying the more static notion of presence/absence of certain organizational characteristics that reflect organizational performance - the three papers revolve around the construction of relationships, the construction of HRM approaches and the construction of a culture of quality and quality improvement. The case of HS has implications for theory, generalizability and transferability of concepts about construction of processes for

organizational performance to other PPPs and hospital settings while the insights gained from the case of HS also have implications for policy.

Implications for theory

In my study, I find evidence of the construction of HRM processes as well as the construction of a culture of quality and quality improvement at HS. In both cases, evidence shows that there have been institutional approaches to indicate construction. These are reflected in processes and programs that have been institutionalized consecutively over time at HS. Examples include practices such as the establishment of the medical residency program and the trainee program in the case of HRM or the introduction of the consecutively instituted clinical lines of care and institutionalizing the process of Tracer as adopted from the national accreditation process. However, the process of construction extends beyond institutionalization of formal programs and processes established at the organizational level. Evidence from my research, especially from my field observations, suggests that in addition to consecutive institutionalization of programs, construction also involves elements and processes which include communication, feedback, interactions, reinforcement and encouragement. These elements, even though not formally institutionalized as some other highlighted programs and processes, do not simply exist at HS without planning. Instead, these elements and processes, even though less formal than others, are still strategically and carefully planned by the HS management team lead members.

Elements such as communication, interaction, feedback, reinforcement and encouragement form the basis of learning theories, including social constructivism, social learning and professional identity formation. In social constructivism, the construction of knowledge and production of meaning depends on social interaction (Vygotsky, 1978) while social learning theory posits that individual behaviors are learned and re-enforced from the environment through observation (Bandura, 1977). Furthermore, professional identity theory posits that professionalism is developed and shaped over time considering individual beliefs and values as well as expectations from the social and professional environment (Hafferty & Levinson, 2008).

The identification of these communication elements suggests that HS could be viewed as a social microcosmos where actors are constructing knowledge about their working environment through interaction which involves constant and timely communication, feedback mechanisms,

reinforcement and encouragement (social constructivism) as well as observational learning of others' approaches to problem solving or decision making but also behavior in the workplace (social learning). Over time, both of these aspects influence employee professional identity formation and perception of one's work and could have subsequent implications on employee commitment and performance at the individual, team and organizational level.

Implications for policy

Evidence from the case of HS shows that when considering a PPP, the government actors taking on such a project need to carefully assess their financial capacity but also their technical preparation and capacity to take on and monitor such a project over time. Second, the government actor engaging in such projects needs to better identify and clearly define contractual aspects that could impact the expectations as well as the operational risks of such a project in the future. Third, the government actor responsible also needs to build a better understanding of the contract by engaging systematically with the private partner and with checkpoints to be honored throughout the contract. This will not only allow monitoring but also the building of a partnership, a communication and an exchange of possible lessons which can be disseminated to other facilities. The case of HS also shows that the interest of a policy tool such as a PPP might not endure political cycles. This is especially important to consider in projects such as PPPs in which contracts span decades and thus election cycles, changes in leadership and shifting priorities of the government. A better definition of processes and risks as well as honoring contractual checkpoints could mitigate risks that could arise from shifting priorities of the government by precisely depending more on technical capacity and contractual aspects of the contract.

The case of HS also highlights the importance of considering and actively engaging with actors that extend beyond the contract, namely the community as well as the municipality. As I highlighted in Chapter 3, creating opportunities for constructing partnerships and engaging with local communities in grassroots ways could be instrumental in contributing to project operations. "Considering the stakeholders" as a politically correct or buzz expression in assessing program feasibility, implementation and sustainability should be re-evaluated and approached as a process of relationship and consistent partnership building that takes consistent effort and time. In addition to the importance of politics and the potential shifts in support or opposition that could

occur over election cycles and leadership changes when considering the feasibility and sustainability of projects like PPP mentioned above, the case of HS also offers the opportunity to also consider the importance of potential opportunistic partisan behaviors that might arise when different sub-national arrangements and actors are involved in service delivery. Such actors need to be assessed and strategies need to be discussed as to engage some level of co-responsibility in anticipation of such inevitable partisan antagonistic or opportunistic behaviors. The case of HS shows how the actors mentioned above could pose a risk to the implementation, sustainability and renewal of such a PPP contract.

The case of HS highlights that any government considering such complex and long-term projects as PPPs should engage in a serious evaluation of potential partners for healthcare delivery. Evidence shows that Prodal/HS was a partner that developed the clinical as well as human resource systems to provide quality healthcare services during the last 9 years of the project and has been able to do so despite the highlighted, weak monitoring role and partnership from the state government and the antagonistic behavior of the municipality. However, what if Prodal/HS were to be a weak private partner in addition to the weak state actor and monitoring? Choosing a weak private partner could potentially be a huge risk to the contract and the government, both with respect to the technical capacity of the private sector for optimal service delivery but also with respect to how the private sector takes into account professional norms and designs HRM and organizational behavior approaches to ensure sustainable performance. Even though HRM approaches might not be measurable, it might be possible to think of proxies that could be used to evaluate the private sector capacity to fully engage its employees for a high-performance organization based on experience. For example, in the case of HS, the Director assigned to HS is a medical doctor with training in public health and has held positions in SESAB, the local public sector, the private sector as well as the non-profit sector. Even when assigning capable individuals to leadership positions, leadership changes can happen in the private sector. As such, it is important to think of who could potentially lead such a venture but it is also important to think about contractual obligations to guard the inner workings of a healthcare PPP as much as possible in case of leadership changes. One way the HS contract did that was via the requirement of ONA Level 1 accreditation within two years of operations. With a focus on quality, HS was able to reach Level 3 accreditation, going beyond the contract requirement. However, local experience from public administration with other non-profit

contracts shows that even when such an accreditation requirement is set in contracts, it is not honored and the non-profit organization is not held accountable for not reaching that required standard. This means that given the tendency for not honoring contracts and not being penalized for it, for such tools to be honored, associated accountability mechanisms must be put in the contract.

In the case of HS, a weak state monitoring team gave HS more autonomy from the state to continue delivering quality services. However, as described by study participants, this was the case because HS proved to be a serious, competent partner and data show that it put efforts even beyond what the contract demanded. However, if the private partner had not been competent at delivering what the contract demanded, and the state team to monitor HS were also weak, HS would have likely been unable to deliver quality health services and it could have likely been a failed project.

The case of HS provided a rich, complex case about the different challenges that need to be considered in PPPs as well as in healthcare projects more broadly. Lessons from the case of HS can be used by country policy makers when considering the implementation of PPPs or similar development projects as well by bilateral or multilateral partners which advocate for and provide consulting to governments interested in implementing PPPs or development projects more broadly. Chapter 3 demonstrates the importance of considering political actors, partisan relationships and shifts in priorities and agendas over time and election cycles. It demonstrates the importance of predicting such behaviors that could create resistance and/or prevent program sustainability and designing appropriate tools to mitigate some of those possible political risks. While these lessons can be applied to many countries, the case of HS demonstrates that it might be particularly important to consider the local beneficiaries and how a program might be affecting community livelihoods in some contexts more than in others. This might be particularly important in Low- and Middle-Income countries with higher power distance between the population and the implementers than in High-Income countries. Lessons from Chapters 4 and 5 show how local policy makers as well as bilateral or multilateral consultants considering the implementation of PPPs or similar healthcare development projects should consider the construction of HRM for employee commitment and performance, his resulting in the reported quality of healthcare at HS. The case of HS also shows the importance of designing local approaches while considering the local professional context as well as professional practices in

the local organizational field – just like the case of HS, the appropriate incentives to instill intrinsic motivation can be designed as a result of local knowledge, local behavior, local assessment and local designing of HRM practices and incentives.

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Appendix A: Informed Consent

Informações aos Participantes e
Termo de Consentimento Livre e Esclarecido / Relato de Caso

Título do Estudo: "*Quais fatores influenciam a implementação bem-sucedida de iniciativas de financiamento privado (PFIs) para a prestação de serviços de saúde em países de baixa e média renda (LMICs)?: O caso do Hospital do Subúrbio, uma parceria público-privada (PPP) brasileira"*

Pesquisador Responsável: Maria Joachim

O(a) Senhor(a) está sendo convidado a participar neste estudo. Por favor, leia este documento com bastante atenção antes de assiná-lo. Caso haja alguma palavra ou frase que não consiga entender, converse com o pesquisador responsável pelo estudo ou com um membro da equipe desta pesquisa para esclarecê-los.

Caso concorde em participar, este estudo será realizado por mim, Maria Joachim, doutorada em Administração na Universidade de Michigan, no momento realizando estágio *sandwich* na Escola de Administração da Universidade Federal da Bahia, sob a orientação da Professora Dra.Vera Lúcia Peixoto Santos Mendes.

Este documento explicar o estudo e solicitar a sua permissão para participar da pesquisa.

Objetivo do Estudo
O objetivo desta pesquisa é gerar aprendizagem para Bahia, Brasil e outros LMICs para preencher lacunas práticas na área de gestão hospitalar e teóricas, oferecendo lições para três áreas de estudo acadêmico em saúde global: a economia política da implementação de PFIs em LMICs, as questões de governança e processos como um problema de saúde global para alcance da qualidade, eficiência e eficácia em ambientes hospitalares, bem como os aspectos de comportamento organizacional dos papéis e responsabilidades nesta nova estrutura hospitalar e dos benefícios atuais e potenciais que podem ser gerados com a execução deste trabalho.

Duração do Estudo
A duração do estudo é estimada de 1º de maio até 1º de setembro 1, 2018 (4 meses).

Sua participação
Você foi escolhido(a) para participar por indicação da equipe de profissionais do HOSPITAL DO SUBURBIO. Após entender e concordar em participar, será realizada uma entrevista com você para saber o seu conhecimento e percepção sobre os processos políticos, técnicos e organizacionais relacionadas ao Hospital do Subúrbio. A entrevista será gravada e transcrita. Em nenhum momento a identidade do participante/paciente será revelada a qualquer outra pessoa que não seja o pesquisador responsável.

A sua participação neste estudo consiste em conceder entrevista, cujo tempo médio de duração é de 30 minutos, em local de melhor conveniência para o(a) Sr (a) e no qual o(a) Sr(a) possa se sentir à vontade e sem a possibilidade de interrupções por outras pessoas. Caso sinta qualquer tipo de desconforto interromperemos a entrevista, e o senhor (a) decidirá se continuará ou não e em qual momento.

As informações coletadas serão utilizadas apenas para fins desta pesquisa e todas as medidas serão tomadas para garantir o anonimato de sua identidade. Asseguramos que será respeitada a sua privacidade e que você pode se recusar a participar do estudo e poderá retirar seu consentimento a qualquer momento, sem a necessidade de justificar ou sofrer qualquer prejuízo. Salientamos que sua participação é muito importante, pois contribuirá para os resultados da pesquisa.

Solicitamos também o seu consentimento para a gravação da entrevista, garantindo-se o anonimato. As informações coletada nas entrevistas serão armazenadas e ficarão guardadas na Escola de Administração da UFBA sob responsabilidade da Profa Vera Lúcia Peixoto Santos Mendes e serão destruídas após cinco anos, de acordo com a Resolução 466/12 do Conselho Nacional de Saúde. Será assegurada a assistência durante toda a pesquisa, bem como seu livre acesso a todas as informações e esclarecimentos adicionais sobre o estudo e suas consequências, enfim, tudo que queira saber antes, durante e depois da sua participação.

Asseguramos que as despesas com o projeto serão de inteira responsabilidade do(a) pesquisador(a), e ressaltamos que sua participação é voluntária, ou seja, não haverá nenhum valor monetário a receber ou a pagar por sua participação. No entanto, caso ocorra algum eventual dano decorrente da sua participação neste estudo está garantida a indenização, conforme previsto na Resolução 466/12 do Conselho Nacional de Saúde.

Os resultados deste estudo irão subsidiar a elaboração da Tese de doutorado da autora, e serão utilizados para a construção de artigos científicos que posteriormente serão publicados em periódicos e apresentados em eventos científicos internacionais e nacionais.

Justificativa do Estudo

No Brasil, a reforma da saúde dos últimos 30 anos do Sistema Único de Saúde (SUS) alcançou muitos objetivos na área da saúde, incluindo aumento da cobertura para cerca de 75% da população brasileira e aumento da cobertura de atenção primária. No entanto, como em muitos países de baixo e médio rendimento, os hospitais públicos no Brasil recebem críticas devida as longas filas de espera e a falta de cuidado adequado.

Em um esforço para mais reformas de saúde, o Brasil parece estar experimentando a implementação de parcerias público-privadas (PPPs) em saúde durante quase a última década. Em 2009, o estado da Bahia lançou uma PPP para a implementação do Hospital do Subúrbio, a primeira PPP em saúde no país. Apesar do seu notável sucesso no fornecimento de serviços de emergência e terciários para a população em Salvador nos últimos 7 anos, a estratégia de governança hospitalar empregada na implementação do Hospital do Subúrbio é pouco pesquisada e sabemos pouco sobre as condições políticas, técnicas e organizacionais que fizeram do Hospital do Subúrbio um sucesso. Faz-se necessário pesquisar quais os fatores que influenciam na implementação bem-sucedida deste modelo de gestão hospitalar assim como os desafios, as lições e as melhores práticas existentes no caso do HS e que podem ser difundidas para melhorar as práticas hospitalares na Bahia, no Brasil em geral, bem como em outros países do LMIC que buscam maneiras de lidar com a má administração de seus hospitais públicos.

Participação Voluntária/Desistência do Estudo

A participação neste estudo é totalmente voluntária, ou seja, o participante é totalmente livre para decidir sobre a sua inclusão na pesquisa, bem como da sua exclusão, sem precisar expor a razão da desistência. A não participação no estudo não implicará em nenhuma alteração no acompanhamento médico, tampouco alterará a relação da equipe médica com o mesmo. Após assinar o Termo de Consentimento Livre e Esclarecido (TCLE) o participante terá total liberdade de retirá-lo a qualquer momento e deixar de participar do estudo, se assim o desejar, sem quaisquer prejuízos à continuidade do tratamento e acompanhamento na instituição.

Confidencialidade

Todas as informações coletadas e os resultados de artigos publicados serão analisados em caráter estritamente científico, mantendo-se a confidencialidade (segredo) do participante a todo o momento, ou seja, em nenhum momento os dados que o identifiquem serão divulgados, a menos que seja exigido por lei. Os registros e documentos da pesquisa poderão ser inspecionados por agências

reguladoras e pelo CEP. Os resultados desta pesquisa poderão ser apresentados em reuniões ou publicações, contudo, a identidade dos participantes não será revelada.

Quem Devo Entrar em Contato em Caso de Dúvida

Este consentimento deve ser assinado em duas vias, uma ficará com você e a outra comigo, pesquisadora responsável. Caso você tenha ainda alguma dúvida em relação à pesquisa, ou quiser desistir em qualquer momento, poderá comunicar-se pelo telefone e endereço abaixo ou fazê-lo pessoalmente.

Pesquisador(a) Responsavel: Maria Joachim
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Comitê de Ética em Pesquisa da Escola de Enfermagem da UFBA
Endereço: Escola de Enfermagem da Universidade Federal da Bahia,
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Assinatura:

Declaração de Consentimento Livre e Eclarecido (TCLE)

Concordo em participar da pesquisa "*Quais fatores influenciam a implementação bem-sucedida de iniciativas de financiamento privado (PFI/PPPs) para a prestação de serviços de saúde em países de baixa e média renda (LMICs)?: O caso do Hospital do Subúrbio, uma parceria público-privada (PPP) brasileira*".

Li e entendi o documento de consentimento e o objetivo do estudo, bem como a importância deste estudo, seus possíveis benefícios e riscos. Tive oportunidade de perguntar sobre o estudo e todas as minhas dúvidas foram esclarecidas. Entendo que estou livre para decidir não participar desta pesquisa.
Após a leitura do Termo de Consentimento Livre e Esclarecido (TCLE), compreendi que estou participando deste estudo de forma livre e espontânea, sendo garantido o meu anonimato e sigilo das informações que eu considerar confidenciais. Estou ciente que não terei despesas com o projeto e nem qualquer tipo de remuneração; que será providenciado um espaço para que eu possa responder às perguntas sem interrupções ou interferências de terceiros e que os dados obtidos ficarão guardados pela autora por um período de cinco anos.
Expresso que obtive esclarecimentos e questionamentos respondidos pela pesquisadora MARIA JOACHIM e me considero suficientemente esclarecido(a) a autorizar minha participação nesta pesquisa.

Receberei uma via assinada e datada deste documento.
Entendo que ao assinar este documento, não estou abdicando de nenhum de meus direitos legais.

Nome do Voluntário em Letra de Forma ou à Máquina Data

Assinatura do Voluntário Data

Assinatura da Pessoa Obtendo o Consentimento Data

Importante: Este documento é elaborado e deverá ser assinado em duas vias: uma será entregue ao participante (sujeito da pesquisa) e a outra via ficará com o pesquisador. Todas as páginas deverão ser rubricadas pelo pesquisador, pelo participante da pesquisa ou seu representante legal, em atendimento à CARTA CIRCULAR Nº 003/2011 CONEP/CNS/MS.

Appendix B: List of Organizations Included in the Study

Hospital do Subúrbio

Secretaria de Saúde da Bahia (Sesab) - Secretary of Health of the State of Bahia

Conselho Estadual de Saúde | Sesab – State Health Council

Auditoria do SUS Bahia | Sesab – SUS Audit

Secretaria da Fazenda (Sefaz) - Secretary of Finance

Procuradoria Geral do Estado (PGE) – State Attorney General

Secretaria de Administração (Saeb) - Secretary of Administration

Secretaria da Casa Civil – Civil House Secretary

Sindicato dos Médicos (Sindimed) – Physicians' Union

Sindicato dos Trabalhadores em Saúde (Sindsaúde) – Health Workers' Union

Conselho Regional de Medicina (Cremeb) – Regional Medical Council

Conselho Regional de Enfermagem (Coren) – Regional Nursing Council

Associação Baiana de Medicina (ABM) – Bahian Association of Medicine

Dalkia/Vivante

Appendix C: Interview Guides

1. Interview Guide for HS Managers, June 2018

Maria Joachim
Roteiro de Entrevista: Gerentes, Hospital do Subúrbio

Projeto: *Quais fatores influenciam a implementação bem-sucedida de parcerias publico privadas (PPPs) para a prestação de serviços de saúde em países de baixa e média renda (LMICs)?: O caso do Hospital do Subúrbio, uma parceria público-privada brasileira*

Com a sua permissão, gostaria de gravar esta entrevista. Se em algum momento, você quiser compartilhar algo comigo sem gravar, podemos desligar o gravador. Em qualquer caso, tudo o que dissermos será confidencial e não identificável.

1. O/A Sr./Dr. (a), quando você começou a trabalhar no Hospital do Subúrbio, e qual é o seu papel?

2. Você poderia descrever as modalidades de contratação, remuneração e demissão para diferentes quadros de empregados (enfermeiros, funcionários, técnicos de enfermaria, médicos)?

3. Em sua opinião, quais foram os fatores facilitadores na implementação deste modelo de PPP no HS em relação os recursos humanos no início? E atualmente, 8 anos depois?

4. Em sua opinião, quais foram os principais desafios na implementação do modelo de gestão de PPP em relação os recursos humanos no início? E atualmente, 8 anos depois? Como o hospital superou esses desafios?

5. No início da implementação, havia um enorme problema com um rotatividade de ~30% do pessoal. Por que isso e como foi superado?

6. O (a) Sr/Dr. (a) poderia falar sobre a relação entre HS e a comunidade no início? E hoje, 8 anos depois?

7. Como os indicadores de desempenho são especificados e coletados?

8. Você poderia descrever como o Hospital do Subúrbio desenvolveu diferentes mecanismos de melhoria e eficiência (assistencial e não assistencial)? O que funcionou, não funcionou e por quê?

9. Poderia você falar sobre alguns aspectos (capacitação, capacidade técnica, avaliação, trabalho em equipe, trabalho multidisciplinar) e como são diferentes de um hospital sob administração publica?

10. O que impede que outros hospitais da Bahia ou de outros estados apliquem algumas dos mecanismos/das lições aprendidas no Hospital do Subúrbio?

Saída:
- Existe algum tópico que você acha importante para mim saber em relação os RH e não falamos aqui hoje?

- Seria possível marcar um almoço com algumas pessoas da sua equipe?

- Seria possível assistir algumas reuniões/capacitações?

2. Interview Guide for Former SESAB Technical Officers, June 2018

Maria Joachim

Projeto: *Quais fatores influenciam a implementação bem-sucedida de parcerias publico privadas (PPPs) para a prestação de serviços de saúde em países de baixa e média renda (LMICs)?: O caso do Hospital do Subúrbio, uma parceria público-privada brasileira.*

Com a sua permissão, gostaria de gravar esta entrevista. Se você quiser compartilhar algo comigo sem gravar, podemos desligar o gravador. Em qualquer caso, a nossa conversa será confidencial e não identificável.

1) Parece que a Bahia é o estado com os mais PPPs em saúde e a maioria dos modelos de PPPs em saúde. Por que a primeira PPP em saúde no Brasil começou na Bahia e também porque as PPPs em saúde se replicaram na Bahia? Por que a Bahia e um estado tão inovador?

O Doutor/Doutora começou seu trabalho na SESAB em 2007 até 2014.
2) Quando e por que SESAB decidiu construir o Hospital do Subúrbio?
3) Como foi decidido que Hospital do Subúrbio seria gerenciado como um PPP e não um outro modelo de gestão?

4) Você enfrentou oposição de alguns grupos com a proposta de uma PPP para HS? De quais grupos? Como você lidou com isso?
- Como a opinião desses grupos mudou deste 2010?

5) Qual foi a reação dos outros membros da PT (incluso o governador Jacques Wagner) a uma proposta de uma PPP?

- Como a opinião dos desses membros (incluído o secretario e governador atual) mudou deste 2010?

6) Dado o apoio/a oposição: O enigma continua: como uma instituição insular neoliberal como a HS foi decidida e implementada sob um partido e ideologia socialista?

7) No início, quais foram os desafios (políticos e organizacionais) principais na implementação do modelo de PPP do HS? E atualmente, 8 anos depois?

8) No início quais foram os fatores facilitadores (políticos e organizacionais) na implementação deste modelo de PPP do HS? E atualmente, 8 anos depois?

9) Poderia você falar sobre a relação/parceria entre do governo com a Prodal no início da implementação no HS?
- Como está essa relação agora com um governador e um secretario de Sesab diferentes?

10) Com respeito as leis, tem a Lei de Responsabilidade Fiscal (LRF) mas também o estado tem um limite para no investimento em PPP. Poderia você falar dessas leis e como eles se relacionam com HS?

11) A PPP de HS teve algum objetivo de transferência das lições do setor privado para o setor publico?

12) Poderia você falar como a Sesab estava regulando/participando na PPP do HS?
- Como está essa regulação/participação hoje em dia, 8 anos depois?

13) Como e que a Promedica como empresa local com experiência local ajudou ou prejudicou na implementação do projeto de HS?

14) O que impede que outros hospitais na Bahia apliquem algumas das lições aprendidas no Hospital do Subúrbio?

15) O que impede que outros municípios/estados implementam PPPs bem-sucedidas como HS?

16) Se você/o estado fosse fazer este projeto de PPP de HS de novo, o que você sugeriria fazer diferente?

3. Interview Guide for Nurses, August 2018

Maria Joachim

Projeto: *Quais fatores influenciam a implementação bem-sucedida de parcerias publico privadas (PPPs) para a prestação de serviços de saúde em países de baixa e média renda (LMICs)?: O caso do Hospital do Subúrbio, uma parceria público-privada brasileira*

Com a sua permissão, gostaria de gravar esta entrevista. Se em algum momento, você quiser compartilhar algo comigo sem gravar, podemos desligar o gravador. Em qualquer caso, tudo o que dissermos será confidencial e não identificável.

11. O/A Sr.(a), quando você começou a trabalhar no Hospital do Subúrbio, e qual é o seu papel?

12. Poderia você falar por que você decidiu trabalhar para hospital do Subúrbio?

13. Por que você gosta de trabalhar aqui no HS?

    Eu gostaria falar com você porque você está trabalhando aqui no HS mas também em um outro hospital, verdade? [não tem que revelar o nome d'outro hospital – só se é AD, OS, filantrópico ou privado)

14. Se você fosse comparar os dois ambientes diferentes, o que você diria? Poderia você descrever como e trabalhar aqui e como e trabalhar lá?

15. Poderia descrever como você sinta quando você está no trabalho aqui no HS? Como você sinta quando está no outro hospital?

16. Como você sinta que tem que atuar quando você está no trabalho aqui no HS? Como você sinta que tem que atuar quando está no outro hospital?

17. O que HS oferece que não oferece o outro hospital? O que oferece o outro hospital que não oferece o HS?

18. Poderia você falar sobre alguns processos _____ (abaixo) e como são diferentes entre HS e o outro hospital onde você trabalha?
    - capacitação
    - capacidade técnica
    - treinamento comportamental
    - trabalho em equipe

- trabalho multidisciplinar
- avaliação de pessoal
- outros processos de gestão que você acha essencial?

19. Se você fosse fazer meu estudo, tem alguns aspetos da gestão dos recursos humanos e como isso influencia o sucesso de um hospital que você gostaria de estudar?

4. Interview Guide for SAIS/SESAB Monitoring team, September 2018

Maria Joachim

Projeto: *Quais fatores influenciam a implementação de parcerias publico privadas (PPPs) para a prestação de serviços de saúde em países de baixa e média renda (LMICs)?: O caso do Hospital do Subúrbio, uma parceria público-privada brasileira*

Com a sua permissão, gostaria de gravar esta entrevista. Se em algum momento, você quiser compartilhar algo comigo sem gravar, podemos desligar o gravador. Em qualquer caso, tudo o que dissermos será confidencial e não identificável.

1) O Sr./Sra./Dr./Dra., você poderia brevemente descrever o seu papel/o papel da Superintendência de Atenção Integral da Saúde?

2) Poderia você explicar os processos mais destacados através dos quais a Sesab/SAIS está governando a regulação dos hospitais do estado?

3) Poderia você falar como a Sesab/SAIS tem governado a regulação do contrato do HS comparando entre 2010-2014 e 2014-2018?
- Quais foram os desafios /oportunidades mais destacados no passado? E agora?
- Você acha que eu poderia falar com a pessoa/as pessoas que faziam parte da equipe responsável pelo contrato no passado?

4) Através da sua experiência, como você acha que o tipo de gestão de uma unidade de saúde influencia o comportamento do profissional?

5) Como você acha que o tipo de contratação de um/uma profissional de saúde influencia o comportamento do profissional? [Dra. X sugeriu perguntar você sobre as diferenças em resultados entre servidores efetivos e servidores contratados por serviços.]

6) Como o processo de acreditação ajuda os processos de melhoria de um hospital? Porque a acreditação não é um requisito para os hospitais do estado?

7) Um enigma existe para mim: muitos profissionais de saúde aqui no Brasil têm dois ou mais vínculos em instituições diferentes. Em sua opinião, como é possível que uma pessoa trabalhar em um hospital com muito controle como HS mas também em um hospital de AD com menos controle?

8) Um outro enigma existe para mim: O HS e um hospital de referência porque e gerenciado por uma PPP ou por que e gerenciado pela equipe específica da Prodal? O que você acha?

9) Como você acha que o HS tem impactado o sistema/rede de saúde? Como poderia HS/Sesab medir esse impacto além dos indicadores do contrato?

10) Muitas pessoas falam que HS tem um custo muito grande para o Estado. Vocês têm os custos dos outros hospitais (AD/OSs)? Seria possível ter acesso a esses custos?

11) Que tipo de indicadores a Sesab/SAIS tem dos outros hospitais do estado (hospital publico X/ hospital publico Y)? Seria possível ter acesso a esses indicadores?

12) Muitos estados visitaram HS/Sesab/Sefaz mas ainda HS e a única bata branca no Brasil. Em sua opinião, quais são fatores (políticos, legais, financeiros organizacionais, comportamentais) que impedem que outros municípios/estados implementam PPPs como HS?

13) Se você fosse fazer meu estudo, tem alguns aspetos da gestão dos recursos humanos e como isso influencia o sucesso de um hospital que você gostaria de estudar?

5. Interview Guide for Nurses, January 2020

Maria Joachim

Projeto: Quais fatores influenciam a implementação de parcerias publico privadas para a prestação de serviços de saúde em países de baixa e média renda?: O caso do Hospital do Subúrbio

Com a sua permissão, gostaria de gravar esta entrevista. Se você quiser compartilhar algo comigo sem gravar, podemos desligar o gravador. Em qualquer caso, a nossa conversa será confidencial e não identificável.

1) O Sr/Sra, você mencionou o seu trabalho aqui no HS, depois o vinculo no [hospital W] e ontem você também mencionou que trabalha no [hospital publico X] também. [Vínculos: CLT?]

2) ---Cultura de Qualidade ---
- Como a qualidade é enfatizada nas atividades do dia a dia na sua coordenação? (estrutura/processos)
- Como os colaboradores/coordenadores têm poder para tomar decisões que contribuem para a qualidade?
- Como essas mensagens de qualidade chegam da liderança para você/o ponto de serviço?
- Como foi a sua experiência trazendo [processo x] aqui do [hospital W]?
- Como o HS difere das outras instituições em que você atuou/atua em termos de melhoria da qualidade?

3) --- Multiemprego e terceirização ---
De que maneira você acha que o multiemprego e a terceirização afetam o trabalho em equipe?

De que maneira você acha que o multiemprego e a terceirização afetam a qualidade do atendimento? (exemplo: padronização de protocolos). Você pode me dar outros exemplos que você teve tem no HS?

Você acha que existem problemas que o multiemprego e a terceirização criam separadamente? Como você acha que isso é importante em termos de HS ser um hospital de urgência / emergência?

O que você/a diretoria fez aqui no HS para evitar esses desafios do multiemprego?

4) Que abordagens a diretoria/ você adotou para distribuir poder e liderança aos colaboradores?

5) Quais foram algumas conquistas do ano passado para a sua coordenação?

6) O que estava na sua lista de objetivos mas você não conseguiu? Por que você não conseguiu?

7) Quais são os desafios mais destacados com que você teve/tem que lidar ao dia dia?

8) --- Comportamento ---
Como você acha que o foco nas pessoas ajudou na redução de custos e na qualidade e cultura? Você pode pensar em exemplos específicos? (Dobrar a coordenação relacional entre os trabalhadores da linha de frente permite uma redução de 33% no tempo de internação hospitalar (página 30 Gitell: páginas 34/35).

9) De que maneiras os colaboradores (esp. de departamentos diferentes) interagem e compartilham conhecimento?
Como isso ajuda as relações de trabalho?
Houve algum grupo para resistir mais à coordenação entre profissionais?
Como é isso diferente nos outros vínculos que você teve/tem experiência?

Appendix D: Quantitative and Qualitative Contract Indicators

HS

Quantitative Indicators

07/16/2019 11:18

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Period: 03/14/2019 The06/13/2019 92 days Quarter: 35 Year: 9 Conclusion: 100% Operation: 100%

Hospital Discharge + ICU + Regulation

Activity	Area	Weight	Foreseen	Accomplished	Perc. Real
1	**HOSPITAL INTERNMENT**	**72.45%**	**5,009**	**5,107**	**102.0%**
1.1	Medical clinic		1,419	1,579	111.3%
1.2	Surgical Clinic		946	1,895	200.3%
1.3	Pediatrics		1,051	433	41.2%
1.4	Adult ICU		578	764	132.2%
1.5	Pediatric ICU		116	183	157.8%
1.8	Home care		162	28	17.3%
1.9	Medical / Surgical Clinic II		737	225	30.5%
2	**URGENCY / EMERGENCY / AMBULATORY**	**21.00%**	**53,254**	**77,628**	**145.8%**
2.1	Emergency calls		15,500	14,747	95.1%
2.2	Emergency Room Consultations / Screening / Reception		33,000	54,846	166.2%
2.3	Outpatient Consultations / Accompaniments for Graduates, in the areas of Urology, Orthopedics, Neurosurgery		2,717	4,792	176.4%
2.4	Outpatient Surgical and Orthopedic Procedures		2,037	3,243	159.2%
3	**THERAPEUTIC DIAGNOSTIC SUPPORT SERVICE (SADT)**	**6.55%**	**63,366**	**74,277**	**117.2%**
3.1	Diagnosis in Clinical Laboratory		45,000	52,002	115.6%
3.2	Diagnosis in Radiology		10,100	13,145	130.1%
3.3	Diagnosis by Pathological Anatomy		0	60	
3.4	Ultrasound Diagnosis		2,100	1,460	69.5%
3.5	Diagnosis by Nuclear Magnetic Resonance		360	586	162.8%
3.6	Computed Tomography Diagnosis		3,450	5,685	164.8%
3.7	Diagnosis by Endoscopy		230	59	25.7%
3.8	Diagnostic Methods in Specialties (Electrocardiogram and Electroencephalogram)		1,730	1,280	74.0%
3.9	Hemodynamics		396	0	0.0%
	Number of inpatients:			1	
		Total amount:		**1**	

Qualitative Indicators

Period: 03/14/2019 Thu06/13/2019 **Days:** 92 **Year:** 9 **Quarter:** 3 **Perc. Conclusion:** 100.0%

2 Attention Performance

Indicators		Quarterly Goal / Calculation Memory	Value
2.1	Substitution interval	1 day - Calculation memory: (1 - occupancy rate hospital) x average length of stay / Rate of hospital occupation.	0.2 day (s)
2.2	Renewal Index	Minimum 4.9 - Calculation Memory: Total Outputs / Number of beds	15.6
2.3	Resolubility Index	Minimum 90% - Calculation Memory: Number of Customers departures within 5 days / total number of departures x 100.	65.3%
2.4	User Service Rate in non-emergency regime and Emergency	<= 10% - Calculation Memory: Number of users in non-urgency and emergency regime attended / total number of users served x 100.	1.2%
2.5	Time Interval for Realization Emergency Surgery	<= 60 minutes in 90% of cases - Calculation memory: Time interval between notification of the need for surgery and anesthetic procedure for users who need emergency surgery.	98.5%
2.6	ICU Readmission Rate - Adult During the Same Hospitalization	Maximum of 2.3% - Calculation Memory: Number of re-entry to the Adult ICU during the same hospitalization / Number of Adult ICU exits x 100.	1.0%

3 Quality of Care

Indicators		Quarterly Goal / Calculation Memory	Value
3.1	Global Infection Density Hospital	Maximum of 20 / 1,000 - Calculation Memory: Number of episodes of hospital infection / Total Customers x 1,000 (monthly)	4.9 / 1,000
3.2	Hospital Infection Density Associated with Central Venous Catheter (CVC) in the Adult ICU	Maximum of 4.4 / 1,000 - Calculation Memory: Number of episodes of primary bloodstream infection / Total CVC day x 1,000 (monthly).	3.4 / 1,000
3.3	Institutional Mortality Rate	Maximum of 3.0% for the first and second year of operation. 2.3% maximum from the third year - Calculation Memory: Number of deaths after 24 hours of hospitalization / Total number of exits x 100.	7.90%
3.4	Transoperative Mortality Rate	Maximum 0.51% - Calculation Memory: Number of deaths occurred during surgery / Total Acts Surgical x 100.	0.0%
3.4A	Post-Mortality Rate operative	Maximum 2% - Calculation Memory: Number of deaths occurred within 24 hours after surgery / Total Acts Surgical x 100.	0.3%
3.5	Infarction Mortality Rate Acute Myocardium	Maximum of 15% - Calculation Memory: Number of deaths by Acute Myocardial Infarction / Number of exits hospitals with an acute infarction diagnostic code myocardium x 100.	7.4%

3.6	Accident Mortality Rate Cerebral Vascular	Maximum of 7.4% - Calculation Memory: Number of deaths stroke / number of hospital outlets with code stroke diagnoses x 100.	7.3%
3.6A	Accident Mortality Rate Ischemic Cerebral Vascular	Calculation Memory: Number of deaths per CVA / Number of hospital outlets with a diagnostic code for AVCI x 100.	5.0%
3.7	Customer Mortality Rate with sepsis	Maximum 25% - Calculation Memory: Number of deaths by Sepsis / Number of hospital outlets with diagnosis of sepsis x 100.	51.1%