MANAGEMENT STRATEGIES IN SMALL HOSPITALS FACING NEW TENDENCIES OF HEALTH MANAGEMENT

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ABSTRACT

The present article is the result of a comparative study of the management strategies of hospitals in the North-western Frontier Region of Rio Grande do Sul, facing the new tendencies in health management. There is in the region a network of small hospitals, being civil society organizations, with a community nature and origin.

The new policies of health management, the depletion of traditional models of health management and the new tendencies for the area, indicate difficulties facing the service quality, economic sustainability, technological obsolescence and the required

resolution levels. The study can be defined as exploratory and the information was obtained through profound interviews and documental and bibliographical research.

The public policies are producing new challenges for the sustainability and survival of small hospitals, located in geographically peripheral regions. The strategies could contribute to the hospital organizations, as to the references to give priority to the public policies of health financing, the improvement of health conditions and the lives of the involved population.

KEY WORDS Strategies, Health Management, Performance, Hospitals.

INTRODUCTION

The scientific and technological advances, in every human knowledge areas, happen at an increasing velocity. New strategies and attitudes are required from the organizations, accompanied by changes, new status and technical – managing competences. Globalization creates new possibilities and consumption desires. In the context, the traditional way of acting is no longer enough, to attend the consumers´ desires, added to the necessity of economical sustainability.

Public policies and health organizations are affected by these challenges as well, by their nature, business and service characteristics. Their characteristics resemble social organizations, where according to Tenório (2001) some peculiarities are emphasized, for example: strategic planning, when it exists, it tends to be conditioned by the financing sources, the delimitation of the mission, objectives and goals, and the evaluation of the results, are not always clearly established and understood by everybody, evaluation is also complicated by the qualitative and non - commercial characteristics of the involved activities, their managers present a profile more towards

the political and social validation of the controllers, instead of the technical and managing capacity, among others.

The importance of hospitals, in the health productive services system is unquestionable, despite the public policies of detaching contact with the centralized model in hospitals. Some hospitals are more affected than others, depending on the juridical nature, size, complexity, resolution level, among others. The hospitals are distinguished in different models: public state hospitals, private hospitals without profit goals or Philanthropists, and private profitable hospitals.

A hospital is defined by Bittar (1996) as a complex institution, where the industrial activities are mixed with science, technology and procedures used directly on human beings, with social, cultural and educating components, interfering in the structure, in the process and in the results.

The philanthropist sector, in our country, according to Portela et al. (2002), is responsible for nearly a third of the existing Brazilian hospitals. There are 1,917 units, with approximately 132 thousand beds; most of the services are for the Sole Health System (SUS). This large network, spread throughout the whole national territory, is very heterogenic in the managing, technological, profiles, and assisting practices structures. In this sector, we find the most of the “Santas Casas” (Holy Homes) and hospitals without profit goals. The private profitable hospitals have, a diversity of structures, from clinics to great hospital complexes. Most of the times, they are limited to the attention of private patients and private agreements. Therefore, most of the private hospitals maintain a greater number of financing alternatives sources, to allow their administration, integrating private and public sources – SUS.

In the public sector there are hospitals joined to the three government spheres, that is to say, municipal, state, and federal hospitals or foundations. The public

hospitals also present a great diversity as well, varying between local or mixed units even to great complexity university hospitals.

The present study was done with base in three small hospitals, located in the North-western Frontier Region of Rio Grande do Sul. One tried to design a comparison between the strategies and the managing guidelines for the management of these hospitals, being one of them a community and philanthropist nature, another philanthropist, maintained by a religious congregation, and the last one, profitable private. .

STUDY REFERENCES AND CONTEXTUALIZATION

Studying the strategies of hospital organizations requires one to understand their organizational nature, and the public and health policies. The historical context that produced the hospital organizations, justifies the current existence of these structures, as well, it allows understanding the community nature, public not state, of small size which in priority characterize them.

Within the last years, according to Silva (1998), significant changes happened through adaptation of new technical – assisting models. These preventive models, focused on health and not on illness, contributed in the implementation of the Sole Health System – SUS, besides the priority of the technical-professional procedures (medical doctors, pharmacists, and technologist), the system hierarchy, the accelerated renewal of knowledge, the greater presence and use of the genetic engineering, among others. Such approaches, despite providing an improvement in the population's health attention, they challenge and determine new roles for hospitals, under the technological aspects, accompanying innovations, the reduction of the number of hospitalizations and time the patient remains there. Adding to this context, due to the changes of the relationships with financing agents (SUS, Agreements, and private

patients), the challenges of survival and economical and financial sustainability, of these organizations.

The international tendency that has to do with hospital organizations, according to Mattos (2000), is the deshospitalization. In the United States, during 2004, were necessary 1.2 millions beds to supply the necessities of the system, as, in 2000, 424,000 were enough, that indicates a reduction in 1/3 in the amount of necessary beds to supply an advanced system as the American one (MATOS, 2000). According to the same author, in Brazil, the number of hospitals increased 30% during the period from 1994 to 1999, due to the increase in the number of additions of individuals to health programs. Estimates indicate that 45% of the installed capacity in Brazil would be enough to attend the demand.

According to Kongstued (2001 apud Bertici and Meister, 2003), other facts related to deshospitalization are the technological development, the increase of life expectancy and quality of life, and the high hospital costs, which stimulate the public policies and the private organization to favour the preventive actions and centralized and domicile attention. Adding to this context the policies of epidemic control and prevention, immunization programs (vaccination). An example is expressed by the vaccination against influenza “flu”, made a priority in the population with greater risk of respiratory infections (people who are more than 60 years old).

Other particularities of the hospital organizations, as to a specific structural configuration, have to be considered. As professional bureaucracies (Mintzberg, 1979 and 2000), the hospitals gather people with a high technical formation in their functions, which have a high degree of control over their work processes and that, many times; they hardly use the physical installations of hospitals for the exercise of a part of their activities. This fact makes more complex the relationships between the organizations and the professionals, as they do not consider being committed to the practice and

procedures that the organization is looking for to adopt, carrying out a greater control over the reach of the objectives of the institution.

Until the beginning of the 1990's, the health focus was on the curative aspects. At present the public policies and the health systems are facing health prevention and promotion. This new focus (techno - assistance model), associated to the new technologies, and the lack of management professionalism, justifies a new hospital strategic configuration, highlighting survival. The hospital, in this new context, according to Mezomo (2000), can not just have an internal vision and its focus being external as well, and in the satisfaction of its clients´ necessities. To attend to these necessities, it has to improve its procedures and innovate, in order to obtain new and efficient organizational processes. The vision of future and its insertion in the rest of public policies of health management, has to be a part of this new reality, identifying the tendencies and the new attributions and competences of the traditional health establishments, especially the small hospitals, located in periphery regions and in small ounties.

The constitution of health networks contributes in the qualification of public health policies, and in the rest of the areas. The contextual characterization of the region, in which this study was done, contemplates an own, socio-economical, policy, and cultural structure and therefore differentiated to the rest of the state of Rio Grande do Sul and to Brazil. The current configuration of the region was structured through a colonization process, starting off from the end of the XIX century, with descendants from European immigrants. In this process, due to the limited presence of the State, the immigrant communities assumed the responsibility of building structures in response to the priority necessities of the time, (education, health, religion, economy, culture and others).

In this process, the communities built their hospital organizations, preceding inclusive in the formation and the emancipation processes of the ounties. The historical evolution was in charge of building a network of small hospitals, most of them community hospitals (Charity hospitals), and/or of religious confessions, in the North-western Frontier Region of Rio Grande do Sul. The historical evolution of the region, formed at present by 21 ounties, is detailed by Christiensen (2001), Rotta (1999) and Dallabrida and Büttenbender (2003).

The three hospitals selected as reference of this study have their origin and structures in convergences with the historical-evolutionary process of the region (BÜTTENBENDER and RIGHI, 2004). Because of this, a brief characterization of each hospital organization is presented. The Hospital Campina, is maintained by the, Padre Benito Meister Cultural Assisting Association Hospital, from Campina das Missoes/RS, an organization without profit goals (philanthropist), with a community nature, it was founded on 27th May 1965. The main activities are concentrated in hospitalization services, ambulatory services, and health promotion and prevention activities. The structure of 2,772 m2 composed of 61 beds, ambulatory, surgical/obstetrical centre, administrative sector and supporting services. The following services are rendered: hospitalization in basic clinics (medical clinic, general sugary, anaesthesia, paediatrics, gynaecology, and obstetrics); low and medium complexity ambulatory assistance, including (24 hours on duty) emergency services for urgent emergencies; health preventive activities, through the family health programme, and diagnosis supporting services, (radiology, electrocardiogram, clinic analysis, pathological/cytological anatomy).

The San Jose Hospital, at Giruá /RS is supported by the Literature and Welfare Association, located in Porto Alegre/RS, an organization without profit goals (philanthropist), confessional nature, working since 1936. The structure is made up of 3,800 m2 of built area, distributed in 50 beds, hospitalization sector, ambulatory,

surgical and obstetrical centre (three surgeries, and one for childbirth), a post-surgical recovering room, transfusing agency, administrative and supporting sectors. Services are attended in areas such as: hospitalization, (medical clinic, general surgery, anaesthesia, paediatrics, gynaecology and obstetrics, urology, tromatology, cardiology, gastroenterology), low and medium complexity ambulatory assistance, including 24 hours emergency room for urgency/emergency, and supporting services for diagnosis (radiology, electrocardiogram, ultrasound, clinic analysis, pathological/cytology anatomy, psychosocial / psychotherapy assistance, endoscopies and mammography).

The Tucunduva Hospital, of Tucunduva / RS, is supported by a private organization, formed by a Limited Responsibility Society, founded on 21st April 1940. Till 1977 the Hospital was called San Francisco de Asis Hospital Society Ltd.. The current structure is composed by a built area of 1,310 m2, distributed in 33 beds, ambulatory, emergency room, doctors and dentists´ consulting rooms, treatment room, and a bed for medical observation. The hospital attends the following services: hospitalization (medical clinic, general surgery, anaesthesiology, paediatrics, gynaecology and obstetrics), low and medium complexity ambulatory assistance, (only to private patients and agreements and some cases referred by the local public manager, including the 24 hour emergency room), diagnosis supporting services, (electrocardiogram, ultrasound, clinic analysis, and pathological/cytological anatomy).

METHODOLOGICAL REFERENCES

The theme and the problem of this study, based on Marconi and Lakatos (1996) and Vergara (2000), was to verify the importance, innovative and differentiated approaching, as well as, the necessities required by the organizations. The study attended the matter. Which are the strategies and managing guidelines, currently

adopted by the hospital administrations, facing the challenges of economical sustainability, and the tendencies in the health area?

The general objective was to carry out an organizational diagnosis and present a comparative of managing strategies, facing the tendencies in the health area. In a specific way, the study as well looked to: identifying the main organizational characteristics, the strategic references, internal characteristics, to do a comparative analysis, identifying convergences and divergences, and to suggest strategies to the hospitals and suggestions to give priority to health management public policies.

The research is characterized as being explorative whereby documental and bibliographical information was used, besides profound interviews. The study was done from August to October 2004, the data being collected in the hospitals themselves, through direct observation, interviews, and documental consultation, involving County Halls, the 14º Regional Health Coordinator, State Health Secretary and the Health Ministry.

The data collected was analyzed and interpreted under the light of theoretical and bibliographical references, attending to the objectives of this study. Starting off from the research, viewing the managing qualification and the other organizational developing processes.

DIAGNOSIS AND ANALYSIS OF THE STUDY

In the diagnosis and analysis of the study it was considered, that the hospital organizations, because the presence of professions with a high degree of technical knowledge in the essence of their main activities, tend to develop models and systems that favour this knowledge and organize the leading structures that distinguish the competence and technical skills as preponderant elements in the organizational spaces, according to Mintzberg's (2000) contributions. In this section are presented the internal characteristics, convergences and divergences, strategic references, managing

guidelines, relationship with public and private policies, and tendencies to the hospital sector.

INTERNAL CHARACTERISTICS, CONVERGENCES AND DIVERGENCES

The analysis of the internal characteristics, convergences and divergences, was limited to the physical structure, to the services, power structure, planning preparation, and the people managing. The physical structure differs in size, built area, and physical arrangements, but in the whole organizations have an occupation rate quite under the installed capacity. This idleness is at the cost of the services. The physical spaces planned in a hospital centred age and that, at present, with the increase of public services in the basic network and preventive health services, become partially idle. Insofar as the promotion and prevention actions are intensified, this reaffirms the tendency to the increasing idleness of these hospitals.

The basic clinics are present in every studied unit. The San Jose Hospital maintains some specialities such as urology, cardiology, and tromatology. In the supporting services, the Giruá Hospital has the services of ultrasound, endoscopes and mammography that differentiate it from the rest. The Tucunduva Hospital does not have radiology service, important supporting equipment for diagnosis. Despite these differences in the services, the procedures are limited basically to a low and medium complexity.

The tax variable presents a significant differentiation between the studied organizations. In the Campina and Giruá Hospitals, philanthropist, a competitive advantage is verified in relation to the Tucunduva Hospital, especially in the exemptions of some taxes and tributary immunity.

According to the “Holy Homes Federation” and Philanthropist Hospitals in Rio Grande do Sul, the private hospitals which give services to the Sole Health System, in the RS State, are responsible for 66.6% of the beds and for the 70% of attention. In Table 1, we could verify the volume of attention given by the studied hospitals, according to the agreement.

Table 1: Distribution of services rendered by the hospitals. Year 2003

Kind of attention	**Campina**	**San José**	**Tucunduva**
% Hospitalizations SUS	72.94	58.00	49.00
% Private hospitalizations	11.51	4.00	8.00
% Hospitalization other agreements	15.55	38.00	43.00
% Ambulatory attention SUS	90.25	90.00	-
% Private ambulatory attention	8.48	3.00	24.00
% Ambulatory attention other agreements	1.27 %	7.00	76.00

Source: Studied hospitals (2004).

The power structure presents itself constituted in a different way. The Campina Hospital has a wide social framework, and the General Meetings represent the largest decision organ. Following, in hierarchy, the Board, and the Fiscal Council, the President, the Management Director and the Technical Director. The San Jose Hospital, as a maintained or branch entity, is subordinated to the main office, that has a

Directing Council, apart from staff for demands on accountancy, payment tables, and matters related to philanthropy. The following one is the Hospital General Direction, the Management Director, and the Technical Director. In the Tucunduva Hospital, the society assembly, made up of seven partners, with limited responsibilities quotas, is the decision making sovereign or maximum organ. Followed by the Management Director and the Technical Director. Starting off from the Management Director and from the Technical Director, the hierarchical structure is quite similar in the three organizations, that is to say, followed by the sector or department chiefs and, and finally, it has an operational framework. In the specific case of the San Jose Hospital, several activities are focused to the integrated management, (confessor organization), that maintain other structures.

The planning of the Campina and San Jose hospitals are formal but differ in their application. For the San Jose Hospital, the main office produces the general guidelines, which are references for the subsidiary branch. The subsidiary branch, within its vision and mission, defines its planning, dividing it into different levels. In the Campina Hospital, the process of planning, obeys a different flow. It is built with the participation of the intermediate heads and officials that produce a planning proposal. Later, this proposal is submitted to the appraisal of the Direction, and to the General Assembly. In the Tucunduva Hospital, the planning is developed by the High Direction and is presented in a more informal way.

In the identification of the profile and the education level of the officials in the studied entities, contained in Table 2, a high percentage of officials with a low education level are perceived. This is presented as a limiting factor for the qualification and interferes negatively in the development of these organizations. The index of people with a higher education is placed in the media of ten per cent, of the total of people that compose the organization.

Converging with the Alves´ definition (2003), the innovating management to be implemented in the organization, should be centred in the individual, since the individual is the great cause of changes in the organization. In an increasingly competitive environment, the enterprises have to establish clear and well defined strategies, that for Fleury and Fleury (1997) allow an evaluation of the potentialities of the available resources, so as to, orient the organization and define the necessary learning processes and training.

The definition of the organizational strategies has to offer its members a seducing destiny. For Mintzberg (2001) the strategic intention has to define the direction and viability. The current health model in small hospitals, during the last years, give signals of exhaustion and viability is no longer assured. The challenges of management of people are many. For Calderaro (2004) the people's management has well defined technical and scientific means, increased by the cultural aspects that involve the organization. For Ramires (2002) the training programs are more and more important in the strategic rule of the high administration and of the people's management in hospitals.

Table 2: Information related to the Hospitals Personnel

Information about the Personnel	**Campina**	**San José**	**Tucunduva**
Nº of officials contract CLT	64	74	28
% Female	82.81	79.73	82.14
% Male	17.19	20.27	17.86
% Uncompleted Basic Education	23.44	27.03	39.29

% Completed Basic Education	6.25	9.46	7.14
% Uncompleted Middle Education	9.38	17.57	10.71
% Completed Middle Education	45.31	29.73	21.43
% Uncompleted High Education	4.69	6.76	10.71
% Completed High Education	10.94	9.46	10.71
% Specialization	4.69	-	-
Nº that attend to formal education	13	10	01
% Basic Education	-	-	-
% Middle Education	84.62	50	-
% High Education	15.38	50	100
% Officials with + than 10 years in the enterprise	28.13	30	07
Total of people (officials/autonomous/third)	81	97	35

Source: Hospital Human Resources Department of (2004)

Training is not done very often and is insufficient. The internal training programs as the external ones, are considered disperse and limited in their final objectives, due to the absence of a people's continued training and developing program.

The mechanism of evaluation of performance, are also done in a discontinued way. In terms of remuneration, it is basically limited to the definitions of the collective

work agreements. Despite that a significant percentage of the invoicing of these entities is applied to the payment of the personnel (40%, 55% and 34% respectively in the Campina, San Jose and Tucunduva Hospitals, during 2003), the institutions are still far from being attractive as to remuneration. Another factor which competes to a more increased percentage of invoicing commitment with the payment to the personnel is due to the uninterrupted functioning of the hospitals, be it during the night, as during the weekends. The small hospitals compete, for higher level professionals, with public and private services, that is to say, municipal managers from bigger cities and hospitals from bigger centres, that have better remuneration levels.

One limitation in management, facing the hospitals, refers to the relationship between medical professionals and hospitals. Most of them are not officials, but they are professionals that render services and have a significant interference in the hospital organization management. The doctor is who determines and prescribes the treatment, and is not always worried about the treatment cost. The doctor is not paid by the hospital organization, which means that there is not always a commitment between this professional and the hospital organization. According to Machline el at (1983), in a hospital there are four power centres: the High Direction, the Administration, the medical doctors and the other professionals. In a hospital organization, the doctors have a substantial influence on every organizational level; they have great autonomy on their work and professional authority over other people in the organization. For Galbraith and Lawler (1995), the hospitals are professional bureaucracies, since they depend on skills patterns and not on processes. The hospitals depend on trained professionals, specialized people, to perform the tasks and, therefore, they are apart from a great part of the power.

STRATEGIC REFERENCES

To achieve determined objectives, it is necessary to establish a plan. According to Correa (2004), the business plan arises as an effective option and it is more and more required by the market, consisting in an analysis of the company in all its aspects, financing, economical, marketing and technological. Besides the analysis of the enterprise, it foresees an analysis of the competition, investment and expansion necessities, revision of prices and profit margins. If investment is indispensable, even more important it is to analyze its viability. According to Montgomery and Porter (1998), different from natural competition, where each species has a unique advantage, in the search for the resources they need, the strategy has to be deliberately and carefully studied. Natural competition is evolutionary, as strategy is revolutionary. The formulation of strategies finds its origin in the mission, in the vision and in the organization principles. Despite of not to be formalized, the Dr. Oswaldo Teixeira Hospital has a plan that is communicated to the members of the organization in an informal way. This way of disclosure of the planning, despite operating in small organizations, presents itself as inefficient in bigger organizations.

According to Stoner; Freeman (1985), the concept of strategy can be defined through two perspectives. The first one is what does the organization try to do, and the second one is what the organization is doing now. In the first perspective, the strategy is a wide program to define and achieve the organization objectives and to develop its missions. In the second perspective, the strategy correspond to an answers pattern that the organization produces to its environment, through the times, reacting passively and only adapting itself to its environment when the necessity arises, performing an active role through the strategic management, getting ahead of changes. Although the hospital managers are reacting, what happens is more an adjustment to the environment, that is to say, a passive reaction. What was observed in the studied

hospitals was anticipation to other organizations which had not yet reacted, but this cannot be called a pro-active management strategic. It is just a reaction.

The formulation of the management strategy, according to Mintzberg (2001), is an organizational process inseparable from the structure, from the behaviour and from the culture of the organization. The strategies are essentially formulated to face the competition. The population is more and more conscious about the benefits of prevention and less dependent on hospitals. Suppliers, mainly of specialized workmen, as doctors and other professionals who create private clinics and manage the more lucrative services towards those clinics. As substitute products/services, we could cite the different clinics and companies which supply supporting services for diagnosis or treatment, besides the preventive programs developed by the public managers or by contracted enterprises with agreements.

The establishment of partnerships with the local managers presents itself as a new choice that could represent a competitive position and that could, inclusive; minimize the entering of new rivals. In the case of the Campina Hospital, the performance in the promotion and prevention, if it produced positive results, will increase the fidelity and will avoid another rival in this activity. The proposal of the San Jose Hospital, as to the implantation of a Regional Centre of Physical and Hearing Rehabilitation, providing prosthesis, involving a wide supporting project with the physical area and technological support, represents a differentiation strategy that has as a goal to create singularities to the consumers. The situation of the Tucunduva hospital differs from the others, since the partners are planning to get out of the hospital activity and are introducing a des-investment plan.

To make an analysis of the connections of the entities to public and private health policies, it is necessary to analyze the percentage of resources proceeding from the services agreed with the public managers from the different government spheres, that

could be verified in Table 3. One should also analyze the resources proceeding from the private agreements and from private attention as well. One must report, that the high percentage of municipal participation, in the case of the San Jose Hospital, is according to the full health management, assumed by the Giruá County. The difficulties faced by the hospitals have a very strong relationship with the high percentage of services rendered by the SUS.

Table 3: Percentage of Public Resources according to the Government sphere. Year 2003.

Government spheres	**Campina**	**San José**	**Tucunduva**
% Union	37.07	3.00	42.16
% State	17.14	2.00	38.02
% Ounties	45.54	95.00	19.61

Source: Accountancy records of the hospitals: Campina. San Jose and Tucunduva. 2003.

LIMITATIONS AND STRANGULATIONS

To understand the limitations and main strangulations, an analysis was done, of the scenario of the period when the hospitals were founded (decades 1940 – 1950's) that present significant differences in comparison with the current scenario that involves the reality of the hospitals. In the scenario of the period, among others, we found the following characteristics: great difficulties for the access to health services, due to long distances, isolation and dislocation difficulties, limited offer of health services in the public network, preventive programs basically limited to immunization, primary illness led to death, currently eradicated illness were epidemics (for example: smallpox), high percentage of rural population formed by small farmers, large families, complete absence of infrastructure, most of the population were descendants from

European immigrants, presence of a strong community spirit, preoccupation about creating infrastructure (religion, education and health), the hospital as the only known health centre, has the necessity of settling a doctor inside the community.

In the current scenario the following are outstanding: population migration from small to bigger ounties; increase in life expectancy and quality of basic health attendance, increasing direction of the public resources to promotion and prevention areas, through implantation and through the incentive of Family Health Programs; gradual and significant retreat of the resources in the healing area (changes in the technological – assisting models); right to free access to health services; reduction of birth rates; public managers assume the basic health assistance; entrance to the hospitals in the complementary assistance of public health services (SUS); new technologies and increase in resolution capacity of the large centres; fast technological obsolescence of the equipment and health processes.

The reduction of resources proceeding from the invoicing with Hospitalization Authorization (AIH´s) has directly affected the reality of the Campina Hospital. For example, the reduction of the value of R$213,446,17 in 2000, to scarcely R$177,278.20 in 2003, is a concrete characterization of this reality. The reduction of the physical non quantitative top of AIHs at hand, have been proportionally greater than the re-adjustments given by the SUS. The perception of the repercussion and of the impact of a reduction in the invoicing is explicit, facing the increase in water cost, electricity, telecommunication, cooking gas, or facing an increase in the price of medicines and of labourers, which took place during this period.

Analyzing the occupation rate of 48.7% in the Campina Hospital. 42% in the Oswaldo Teixeira Hospital and 60% in the San Jose Hospital, it is clear that the main limiting factor is related to the market acting of these hospitals. Lack of demand is a factor responsible for the disinterest of specialized professionals, mainly doctors that

have their remuneration based on the production volume. Another factor, inserted in the current scenario, is the remuneration tables of the agreements with the SUS and the private agreements, that forced by the loss of purchasing power, their insured demand, every time, less.

According to Hamel and Parlad (1995), there are great differences between enterprises in the market and the competitive impact that they are capable of enforcing, with a determined amount of resources. The limitation of resources is not necessarily an obstacle to the conquest of leadership, neither the abundant availability of resources, is a guarantee of continuing in the leadership. The essence of taking advantage of the resources is to do more, with fewer resources. In the case of the hospitals, besides the lack of resources, the lack of specialized professionals and technological obsolescence. The high percentage of patients depending on the SUS, allied to the low values paid by the low and medium complexity procedures, lead to insolvency. On one hand, the service suppliers depend on production and on invoicing and, on the other hand, the public managers impose tables and physical/budgetary quotes to whom may need them.

Another factor that produces difficulties is the vertiginous growth of bureaucracy inside the hospitals. The hospitals suffer impositions from several professional councils (Regional Medicine Councils, Nursing, Pharmacy, Nutrition, Radiology, etc.), pressures from different unions and legislations. Adding to the structure, maintenance of different commissions and committees, (Control Commission of Hospital Infections, Commission for the Humanization of Health Services, Transfusion Commission. Cipa. etc).

HOSPITAL SECTOR TENDENCIES

The tendencies point to new directions in health management and for hospitals. According to the World Health Organization, there are ten great risks to health, responsible for 40% of deaths in the whole planet. Of these, nine of them are directly

related to people's vices and habits, quality of water, iron deficiency and environment pollution by solid fuels. Tobacco and alcohol decimate million of people every year. AIDS, a sexually transmitted disease, most of the times could be perfectly controlled, but it is not. There are 1.5 billion people overweight, of which 300 million are morbid obese. Then, it is easy to understand the necessity to promote changes in the management of the sector, promoting preventive medicine in detriment of the healing medicine. Insofar as the anachronic model is changed, investing in health, improving people's life quality, lots of resources would be economized, the companies´ profits would be increased, without punishing the consumer. But, for this to happen, the public managers need to establish partnerships with private entities, specially philanthropist ones, with clear rules and well defined policies.

According to Bross (2003), the ways to provide health assistance are undergoing profound modifications: the predominantly assisting model, that attends in function of the demands, is progressively adapting to actions recommended by the sanitary model that acts more intensively together with the communities and to the environment, promoting health and preventing diseases and accidents. This conversion of cares, clearly hospital centred, starting off from illnesses with new ways to orientate and to manage group and individual health, is necessary, as well, due to the geometrical progression of covering costs that become higher, by the increase in life expectancy, and by the introduction of procedures starting off from the techniques and technologies, whose investment worth and operation make non viable the costs to the public or private systems.

The dishospitalization, according to Ramires (2002), as, the creation of the "day hospital", can reduce the hospitalization period, the same as those patients who need hospitalization within the current system. By the "day hospital" the patients are daily attended in the hospital to receive necessary treatment, returning later to their homes. Two or three consecutive days of treatment by this system, could solve most of the

situations, without the necessity of prolonged hospitalizations that have a significant impact on the reduction of costs. Home assistance, faces problems of logistics in the studied region. It is a model that adapts itself better in regions of greater demographic density. According to Vecina Network (2004), in Sao Paulo city, there are associations, with 12 private entities that contract personnel and manage the functioning of the PSF´s 700 teams. What is fundamental in the public-private partnership is the accompanying of results and the transparency of using of public resources, together with councils' controls.

The public hospitals are remunerated basically by the SUS, but the private ones, through several kinds of payment sources. According to Salu (2004), in public health, hierarchization is the most efficient way of using the SUS´s resources, with the primary assistance being done by many UBS (Basic Health Unit) with a low cost, the secondary is done by units of another type, and the cost is a little higher, and so on, reaching the high complexity hospitals, and a high cost, only those patients that really need this resource. On the part of the private initiative, the reality is very different. The role of the UBS ends up being a doctor's consulting room, or an emergency room in the hospital itself. To make the doctor transfer a patient to private assistance, or to the private agreement, it is necessary to offer some advantage: comfort, services, etc. which does not happen in the public area. To attract a patient directly to its emergency room, the private hospital has to offer accessory products to the patient, besides the health care, strictly speaking, which neither happens in the public area. What goes against the private area is the fall in the average hospitalization time, associated to the technological inflation of the procedures, fall of the people's purchasing power to contract a health insurance, and the competition, which does not exist in the public area, factors that cause a reduction in the occupation rate.

According to Ramires (2002), the public hospitals only have conditions to develop themselves to an excellence level if they have a private supporting foundation or if they

were considered with larger public budgets. The binomial Incor and Zerbini Foundation sponsored the assistance of patients in the private area, (private, agreements and health insurances), in a proportion of 25%, assuring recipes that would never exist if the aid from the Institute were restricted to the SUS. The public network, for Ramires (2002), is looking for a restructure, because its current model is no more able to attend to the population and the nation's demands. Innovative experiences are under way, as the Family Health Program and the basic health units. The interrelation of the basic health units to the hospital centres will materialize the reference and counter-reference system.

Modern and current technology, according to Almeida Network o (2004), is necessary to appreciate the technical team's work (doctors. nurses. pharmacists. etc), without it the results offered by modern machines will continue being limited. He defends a new concept of management quality and rationalizing that consists in the use of modern technology, in a rational way, without exaggeration in order to complement the doctor's clinical diagnosis, avoiding wastes. A new attitude is being enhanced in the public/private programs, as for example: family doctor programs, preventive medicine (mainly immunization-vaccination campaigns), constant perfection of the technical-assisting models, among others. The public/private partnerships are indispensable, involving not only the health sector but the education sector, basic sanitation, security, among others.

The maintenance of basic clinics and of the services that support the diagnosis compatible with the basic clinics, are pointed out by the directors from the San Jose and Campina Hospitals, followed by actions towards promotions and prevention through partnerships with municipal and state managers. Another tendency that is being presented consists in the budgeting of small hospitals, according to what is foreseen in "Portaria" Nº 1,044 of 2nd June 2004, from the Health Ministry, which is about the mixed units and whose main aspects are described next:

The institutions must be localized in ounties with a population of up to 30 thousand people and that present coverage by the PSF – Family Health Program equal or superior to 70% of the population.

The studied hospitals will have between 5 and 30 beds registered in the CNES – National Register of Health Establishments, with a fitting structure to attend the basic specialities (medical clinic. paediatrics. and obstetrics), besides deontological emergencies.

They must sign goals contracts, where there will be established the installation of manager councils and they cannot hospitalize more than 5% of the population from the included areas, per year.

An occupation rate of 80% is provided for, with a permanence average of 4 days.

The value foreseen, for financing the institutions will have as a base the amount of the resources paid by the production from the base year 2003, increased by the financial impact of all adjustments granted until the date of contracting these hospitals, the amount initially foreseen was approximately of R$1,471.80 per bed per month, amount that is not mentioned in the “portaria”.

The financing will be global (extinction of the AIHs) and the payments will be shared between the Health Ministry and the Health Secretariat, with 50% for each one.

According to information from the Rio Grande do Sul Health State Secretary, there are 68 “gauchos” hospitals that obey the “portaria” parameters and that could be candidates for the Program, which adhesion is optional.

The mixed unit could represent a future solution to small hospitals. There would be flexibility and perfection in the legislation to cause advances, so that the different forms of hospital constitution could be carried out, respecting regional peculiarities.

The “Portaria” Nº 1,044 in its current form did not have a favourable evaluation by the hospitals studied. Things such as the creation of manager councils, in the purposed patterns, represent an intervention in the hospital organization. Such councils cannot directly interfere in the management without assuming risks and responsibilities with the directors of these entities. The budgeting within the negotiated parameters, could become interesting to the hospitals and to the managers, stimulating inclusive the hospitals performance in preventive actions, once that, in this situation, the interest would not be in the production and in the invoicing, but in the reduction of the number of assistances or hospitalizations.

There are some market niches in determined areas that could be explored by the studied hospitals. Whereby, a deeper study is needed, as, besides the lack of capacity of investment, that requires partnerships, the studied hospitals compete against the regional hospitals in unequal conditions, because of market matters, of access and supporting services, not very well prepared.

In the case of the Campina Hospital, a new strategy is observed, facing prevention. The hospital, through an agreement with the local sector, in a partnership system, started to coordinate two teams from the Family Health Program – PSF. In the case of the San Jose Hospital, the innovative strategy is faces the implantation of a Regional Centre of Physical and Hearing Rehabilitation, providing prosthesis involving a wide supporting project with the physical and technological area. In the case of the Tucunduva Hospital, due to its constitution, in this case, a Society with profit goals, having therefore higher taxes, according to the Administrative Director, they are planning to get out of the activity. The Dr Oswaldo Teixeira Hospital plans to sell the hospital or to develop a de-investment process to get out of the activity without having to compromise the partners’ patrimony.

The closing of hospitals, besides being a tendency, has been a current reality in the region throughout the last two years. Only in Tucunduva County, there were three hospitals, one of them in Vila Pratos, another in Vila Machado, nowadays the Novo Machacdo County, both closed. In the north-western hospital area – Association of Hospitals from the Northwestern Rio Grande do Sul State, from several private profitable hospitals, only two are still open, the hospital at Tucunduva and at Horizontina. Private hospitals, such as one at Tuparendi and another at D. Bosco in Santa Rosa, were taken over by entities without profit goals, but others closed down.

The slowness and the lack of a more effective supporting from the state manager make these initiatives extremely vulnerable. It is necessary the establishment of clear policies that define the roles and the responsibilities of the involved parts. The new strategies could represent the viability of the organizations, in the meantime, the lack of clear and defined policies maintain the organization vulnerability, and changes in the direction of the public policies could bring them serious consequences. For Righi (2004), in the "environment of power relationships" in health the characteristics are determined, greatly by the decentralization process, that alters the relationships of power and puts the ounties, inside a dispute for the formulation capacity of different managing and assistance proposals, in a Collective Health field, and by the social control over the sector. The novelty is in recognizing that in the heterogenic action of the local actors, an important factor to the constitution of spaces that create conditions for transformation and for the possibilities of producing new organizations and of a new design of the health assistance network .

The preoccupation of the directors of the studied hospitals, with the lack of a clear definition to the public/private partnerships, capable to adapt themselves to the local specialities, is corroborated by Righi (2004), when he affirms that, on the contrary of the current hegemonic logic in a field of the organization of the basic network of assistance, that induces to a homogenization of the assistance network and to the

reproduction of programs, the study points to the potential of these periphery and devaluated places, as privileged places for the invention of new ways of producing management and health cares, despite the situations of great instability, situation in which the institutions can “be on the edge”, that is to say, the hospital could close down at any moment.

According to Tachizawa, Resende (2000), it is not possible to have a cost strategy and have a highly qualified and expensive team, luxurious installations, heavy expenses in training or publicity, or to maintain a differentiation strategy with a standardized assistance, precarious installations, and little qualified human resources. In the case of the hospitals, what seems to be reasonable is the adoption of a cost strategy, mainly for SUS´ patients and a differentiation strategy for private patients and private agreements that require a differentiated assistance.

FINAL CONSIDERATIONS

The material obtained through the documental indirect research, including the documental and bibliographical research, and the direct documentation, that constitutes the direct intensive observation and the direct extensive observation, allowed a quite diversified analysis. Observing that the sector faces a serious crisis, that has been getting worse mainly during the last two years. Several difficulties were found, and the entities have great challenges to overcome them. In sequence, the main conclusions will be presented and some suggestions to overcome the limitations.

The studied hospitals are unique in the ounties where they are located, that is to say, in the Campina das Missoes County. Giruá County and Tucunduva County, there is only one hospital en each locality. Campina das Missoes and Tucunduva´s population is under 10,000 and Giruá´s population is under 20,000. Adding up the bordering populations, they do not surpass 30,000 inhabitants, in none of the micro regions, seats of these hospitals. Therefore, despite the importance of these entities,

in the complementation of the services to the SUS, and the social role that they develop in their ounties, these factors, by themselves, are not enough to guarantee the maintenance of the studied organizations.

Other alternatives or strategies need to be defined to maintain the availability of the hospital organizations, and not always is the administrative sphere enough to find the required solutions, to support the equilibrium. Sometimes is necessary that the ounties and the State itself, or Unions contribute to the solution of the problems.

The dependence on the Sole Health System can be verified in a clear way analyzing the percentages of assistance given to the public sector. Besides it was verified there was an occupation rate quite different to the real installed capacity. Keeping in mind these two factors it is possible to affirm that it is very difficult that some of the hospital keep themselves alive, without the Sole Health System support. On the other hand, the SUS´ low remunerations produce, as well as increasing difficulties and will end up, making the organizations non viable, if the current conditions were maintained. Situations like those need urgent attention from the managers and from the hospital organizations, under penalty of compromising the assistance to SUS´ consumers: the associations, that optimize the resources in obtaining results, seem to be the solution. If the hospital stops working, what other solution will the manager present? Has the manager the installed capacity to attend the consumers' demand? What is the most viable in each case? Matters like these deserve an analysis and combined solutions.

The improvement of management is a factor that has to be searched for in a permanent way for the hospital sector. It is necessary to invest in training and in the developing of people that act in the organizations, facing the challenges of changes that the present time requires. Management tools, as Marketing, become more and more necessary for a greater closeness to the community. The reduction of hospital

costs, the re-dimension of physical spaces and the reduction of idle spaces are other necessary steps. As an example of reducing costs is the SAME – Medical Recording Service. Many times in the hospitals the patients/clients do not have an only record, they have records at the hospital ambulatorysection, others with the information when they were hospitalized, and another in the sanitary units and so on. It is hard for the health professionals to access to the information, especially by the doctor, which generates a bigger demand of complementary exams and, consequently, raises the assistance cost.

Outsourcing could represent an alternative in the reduction of costs, especially in services such as maintenance, accountancy and support for the diagnosis. Another aspect that deserves attention is training and investments in information technology. Parallel to the improvement of management, there must be an equilibrium relationship, between costs of services and remuneration of these services by the SUS. The conferred resources have to allow the hospitals to do the necessary investments in perfecting the training of people, in the adjustment of installations and equipments. It is not possible to improve the management, if the hospitals that attend to the Sole Health System, need to take conferred resources for the attention of private agreements to subsidize the SUS'.

The commitment of the professionals that act in the hospitals (doctors, nurses, pharmacists, and others) with the results, deserve a profound study. Not only the resulting in the patient being attended to, his recovery, but especially the financial result of the entity, deserves attention from everyone involved, including the medial professionals. The medical professionals need to be committed with the financial health of the hospitals. As to the managing aspect, the small hospitals lack innovative practices.

For the studied hospitals, placed in small interior ounties, only hospitals in the locality, one must define the strategic focus, differencing in terms of complexity and turn towards the actions of basic attention. The PSF – Family Health Program – presents itself as an alternative, but it is necessary that there be an incentive from the public managers to do that. The preventive programs can represent a choice, at a medium term, since the partnerships between the public sector and the Philanthropist hospitals, be regulated through agreements/contracts that clearly express the partners´ rights and obligations. The agreements have to foresee a just remuneration and a payment schedule that has to be constant. Agreements have to be made out in such a way, so as to prevent unilateral and brusque breaks in dealings with the government or government's teams.

The studied hospitals, located in peripheral regions, despite the limited resolution capacity and limited technological contribution, perform a strategic role for health management in these ounties. One might say that they are important organizations in the production of jobs. Meanwhile, these entities will hardly maintain a strategic role, in a medium and long term, if they do not incorporate human and technological resources to differentiate themselves in the market. In the case of the Dr Oswaldo Teixeira Hospital, a private hospital, with profit goals, the partner run the risk of compromising their patrimony, if there were not an effective action to revert the current situation. To get out of the hospital activity seems to be one of the better choices, for the Dr Oswaldo Teixeira Hospital´s partners. Meanwhile, for the Tucunduva County, that situation will represent a loss of an important organization in the social and economical context. Besides meaning the loss of hospital assistance, service provided by the organization, will cause the loss of several direct and indirect jobs. The County will stop attracting public and private resources from the SUS, IPE, UNIMED, among others, that will be directed towards the rest of the ounties, which attend the

hospitalization demand and services provided by the hospital, weakening the County's economy.

The current study presents a set of contributions to perfect the discussions on public policies and health management, as; it aims towards situations that could be experienced, by other organizations of the sector within the region, or outside it.

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