Improving Performance in Brazil's Health Sector: Comparing Personnel Management & Performance in São Paulo's Traditional Public & "Social Organization" Hospitals

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INTRODUCTION

Beginning in the late 1990s the government of São Paulo adopted a new management model to administer a group of state public hospitals. Social Organizations in Health (Organizações Sociais em Saúde – OSS) were created by statute to enable a formal partnership between the state and non-profit private sector organizations. Under this OSS model, the government provides budgetary transfers to cover the costs of running the hospital, but responsibility for day-to-day administration is delegated to certified non-profit organizations. The State Secretariat of Health (SES) negotiates and signs a performance contract with each of these hospital managers, committing budgetary resources from the public treasury in exchange for specific performance outputs. The managers, in turn, are granted far greater flexibility than their counterparts in traditional state hospitals to run the hospital in the manner they consider best-suited to meet their performance targets. In 2004, sixteen public hospitals in São Paulo were administered on a contract basis as Social Organizations in Health, rather than as traditional units within the hierarchical structure of the Secretariat.[2]

São Paulo is not alone in attempting organizational reform of this kind. OSS hospitals are illustrative of a national and international trend toward corporatization (or "autonomization") of government services that expand the so-called "non-state public sector." There are interesting theoretical arguments in the literature (discussed below) for why corporatization may improve financial and facilities management, and thereby improve hospital performance. Yet human resources are the mainstay of healthcare provision, and clearly the largest expense. Thus, it is perhaps surprising that the literature on contract-style reforms in developing countries devotes little attention to labor relations within corporatized bodies. One reason for this shortcoming, as noted by Harding and Preker (2003:53), is that most governments reforming their healthcare systems have been "unwilling or unable to transfer control over labor, recruitment, salaries, staff mix, and the like and have instead left employees in the civil service, employed directly by the health ministry." Thus, even as managers have been granted greater financial autonomy and been made accountable for results, the existing public sector employment rules typically have been left in place.

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[2] Of the 16 hospitals, 13 operated under Law 846/98 as Social Organizations, while 3 operated through a contract between the Secretariat of Health and universities.

In São Paulo, meanwhile, human resource management rules do indeed differ between OSS and traditional state hospitals. Through the OSS reform São Paulo has attempted to transform the incentives facing healthcare personnel at the point of service delivery, and thereby improve the efficiency and quality of care. Those personnel management differences, and how they affect – if at all – the relationship between hospital managers and their staff, are essential to understand corporatization theory in real-world hospital settings. Thus, the São Paulo experience is a compelling case for analysis. The central question of this study is: How do the incentives facing managers and staff working in São Paulo's OSS hospitals actually differ from traditional public hospitals, and what is their impact?

CONTRACTING FOR HEALTHCARE IN SÃO PAULO'S OSS MODEL

São Paulo's OSS hospital model initially grew out of the federal government's 1998 constitutional reform, which established a legal framework for autonomous "Social Organizations." Constitutional Amendment No. 19 enabled private sector, non-profit organizations to utilize public resources (material and financial) to provide public services that are "not-exclusive to the state."[3] These Social Organizations would enjoy management, budget, and financial autonomy while remaining accountable to government under a performance contract. The performance contracts were to specify the period of the contract, the resources provided by government, the expected outputs, the criteria for evaluation of performance, and the rights and obligations of the managers.

In São Paulo the state government subsequently sanctioned its own Social Organization law (No. 846/98) for the state's health sector, based upon the federal law 9.637/98.[4] The state law specified that only a non-profit organization could qualify as an OSS, and an OSS-administered hospital could only provide services as part of Brazil's Unified Health System (SUS). These hospitals clearly are **not** private. The patrimony remains publicly-owned.

The first step in implementing the OSS model was for non-profit organizations to apply to the state for certification as Social Organizations in Health. If an organization satisfies the criteria for certification, then it is legally authorized by the Governor to enter into a contract with the state Secretariat of Health (SES) to manage a public hospital.[5] (An important criterion is that the non-profit must show a minimum of five years of experience administering health programs or

[3] The underlying rationale for Constitutional Amendment No. 19 (June 5, 1998) was set out in the 1995 "White Paper on the Reform of the State Apparatus" produced by the Ministry of Federal Administration and State Reform (MARE). The White Paper asserted that "rigid hierarchical standards … controlling processes instead of results [produced an administrative system] shown to be stultified and inefficient and, therefore, incapable of coping with the magnitude and complexity of the challenges established by the process of economic globalization" (Brazil 1995:9-10). The solution MARE proposed is for the "State [to abandon] its role as executor and direct renderer of services, while preserving its task of regulator and provider or fosterer of such services" (Brazil 1995:17). Social Organizations are defined by Art. 1 of the corresponding Law 9.637 (1998) as "*pessoas jurídicas de direito privado, sem fins lucrativos, cujas atividades são dirigidas ao ensino, à pesquisa científica, ao desenvolvimento tecnológico, à proteção e preservação do meio ambiente, à cultura e à saúde*."

[4] There are a few differences between the federal rules and São Paulo's OSS model. One important difference is that under federal rules regular government employees transferring to a Social Organization (OS) would receive their former pay and could receive an additional payment from the resources of the OS. In São Paulo, however, a second payment is not permitted.

[5] Lei Complementar no. 846, approved June 4, 1998, specifies the conditions for an organization to qualify as an OSS.

services. São Paulo certainly enjoys an advantage over other Brazilian states in having a number of reputable non-governmental organizations in the health field.)

The next step is for the SES to negotiate a hospital management contract with the OSS. The management contracts between the SES and OSS specify the volume of different services to be performed each month (e.g., inpatient and outpatient services, medical consultations) in exchange for a specified budget (a prospective payment block contract). As the hospital is required to meet monthly performance goals, 90 percent of the annual budget agreed between the SES and hospital administrator is delivered in monthly installments. Performance within ±15 percent of stipulated targets is permissible without affecting disbursements. However, if the quantity of services delivered falls to 75-84.9 percent of the agreed targets, then the financial disbursement is reduced by 10 percent. If output falls below 75 percent, then payment is reduced by 30 percent.

The remaining ten percent of the budget is delivered quarterly, contingent upon the hospital submitting properly coded data on their patients and the treatments or services provided. This 10-percent provision reflects some "learning by doing." The OSS model, as initially drawn up in 1998, allocated 100 percent of funds 12 monthly installments. However, since 2001, 10 percent of the agreed budget is delivered quarterly, contingent upon reporting output and quality indicators to the SES and to the OSS Evaluation Commission.[6] This is a sensible mechanism to ameliorate, if not to eliminate, the SES' information disadvantage vis-à-vis the OSS hospitals.

OSS contracts are typically fine-tuned through regular dialogue between hospital directors and the supervisory unit of the Secretariat of Health. Adjustments are made from one annual contract to the next, but can also be made by consensus within the operational period of a given contract.

OSS accounts are audited *ex post* by the state's SUS Council of Health and Court of Accounts (*Tribunal de Contas*). Thus, the governance arrangements for OSS hospitals are a hybrid of market and hierarchical control. In large part, the OSS model is designed to allow hospital managers to exercise control over the most important factor of production, namely, labor. While there may be multiple factors to explain why the government of São Paulo adopted this management model (see Box 1), at the forefront is the desire for improved staff performance.

[6] Notably, the government of São Paulo has demonstrated its willingness to enforce this provision. For example, during its first semester of operation, the OSS Hospital Mario Covas did not produce a proper accounting, and as a result had ten percent of its budget withheld until adequate data were delivered to the Secretariat.

Box 1: Why OSS hospitals appeared in São Paulo

The decision by the government of São Paulo to experiment with OSS hospitals was not motivated solely by a conviction that applying recent theories of effective human resource management would improve service delivery. There was a compelling practical motivation, as well. During the administration of Governor Mario Covas (1995-2001), the state completed construction of a number of new hospitals that were initiated during the 1980s under Governor André Franco Montoro. That presented the government with a dilemma. The federal Camata Law (No. 82/1995) stipulated that a state government's wage bill could not exceed 70 percent of current revenues. As São Paulo already was struggling to come into compliance with the Camata limits, designating these new hospitals as OSSs provided a convenient solution: the new OSS employees would be paid from the public purse – via the budget transfer to the hospital – but their salaries would not count toward the statutory limits, as they are not direct state employees. The numbers clearly are significant. São Paulo's sixteen contract hospitals employ roughly 20,000 employees, more than 20 percent of total employment in the state health sector.[†]

The federal Fiscal Responsibility Law (Complementary Law No. 101, May 4, 2000) largely adopted the public employee expenditure rules of the Camata Law. Under the Fiscal Responsibility Law (LRF), personnel expenditures – including active and retired employees and all forms of monetary compensation, as well as employer pension contributions – cannot exceed 60 percent of Current Liquid Revenue (defined as current income minus constitutional and legal transfers and employer contributions toward the pension system). However, personnel providing services "contracted out" to private sector organizations are considered by the LRF to be "Other Personnel Expenditures" and do not count toward the 60-percent cap.

Any state that reaches 95 percent of the cap is barred from increasing salaries or employment. If the cap is exceeded, voluntary transfers and credit from the federal government is suspended. This created an incentive for employment via cooperatives and Social Organizations.

[†] Note: Overall, the state of São Paulo employs roughly 650,000 people in direct administration and another 150,000 in foundations, autarchies and other autonomous bodies (which includes contract hospitals).

THE PURPORTED BENEFITS … AND CHALLENGES … OF CORPORATIZATION

Corporatization is associated with the "new public management" or "reinventing government" reforms that began in New Zealand and Great Britain during the 1980s, and over the next decade influenced government reformers around the globe.[7] The "new public management" (NPM) endorses the "high powered" incentives of markets – whenever feasible – in contrast to the weak and often untoward incentives of government bureaucracies. Thus, if government is producing goods or services that the private sector can produce more efficiently (e.g., transport or telecommunication services) then the proposed remedy is privatization … with perhaps a regulatory role for government. Meanwhile, if markets alone are ill-suited to provide the type and amount of services that are socially desirable (e.g., due to externalities, public goods issues, equity concerns, or other market "failures") then the NPM prescription is to introduce market

[7] See L. R. Jones 2004 for a recent debate on the meaning and merits of "new public management." The article also has a number of references to recent studies of NPM-style reforms (and counter-reforms).

incentives *into* government.[8] Hospital corporatization is consistent with this prescription. Government retains public ownership of the hospital and public responsibility for healthcare, but introduces organizational reforms intended to improve performance by mimicking private sector incentives. Procedural (*ex ante*) controls are reduced, while simultaneously focusing managerial attention and accountability on outputs.

A key characteristic of corporatization is that it separates the payer (state government) from the provider (hospital management and staff). The payer (i.e., the principal) specifies the specific goals or outputs desired. Operational decisions are then left largely to the discretion of provider (i.e., the agent). Procedural monitoring by the principal is kept to a minimum, as a management contract supplants hierarchical control as the means through which public resources are allocated and performance accountability measures are specified.

The rationale for this payer-provider split is to encourage greater mission clarity and better align the individual incentives of managers and service delivery personnel with public policy goals. However, notwithstanding the potential merits of this approach, corporatization reforms cannot escape the challenges of *delegated discretion* that are inherent to principal-agent relationships. In fact, there is a layering of principal-agent relationships in corporatization reforms of this kind. For instance, São Paulo's Secretariat of Health has delegated decision-making authority to the managers of particular public hospitals. Thus, there is a key principal-agent relationship between the Secretariat of Health (principal) and the hospital manager (agent). In addition, there is a principal-agent dilemma for hospital managers (principals) and their staff (agents).

When putting contract-style reforms into practice, transaction costs – defined by North (1990:14) as the "cost of measuring and enforcing agreements" – can be prohibitive. As government has a fundamental interest in the *quality* as well as quantity of health services delivered, the health sector presents an archetypal "multitask agency problem" (Holmstrom and Milgrom 1991): hospital managers are expected to meet or exceed suitable service standards while simultaneously controlling costs and responding to demands that are difficult to predict, let alone control. Management contracts are inherently incomplete, as it is impossible to anticipate every contingency and specify all actions in a contract in a way that would be enforceable. Thus, the effective performance of the system will depend on discretion of the front-line managers and service providers over whom the principal (the government) has only limited control. It is exceedingly difficult in these instances for the principal to verify actions by the agent to keep costs down or improve quality.[9]

In such a situation, why should a hospital manager, in the exercise of his delegated discretion through corporatization, be expected to behave in ways consistent with the preferences of the principal? From an economist's point-of-view an efficient solution is to confer upon the agent (in this case the hospital manager) the rights of a "residual claimant." In short, the manager is granted the rights to the surplus (or part of it), so that he has a strong incentive to monitor the activities of his staff to eliminate shirking and ensure efficient services.[10] A number of

[8] In an oft-used metaphor of the new public management, governments are instructed to "steer" rather than "row." NPM relies heavily on the economic mantras of competition and entrepreneurial spirit which, it is argued, can be incorporated into the institutional culture of the state. See Osborne and Gaebler (1992).

[9] The prominent role of firms as economic actors – despite their "low powered" internal incentives – can be understood as a practical response to mitigate he problem of information asymmetry and the difficulty of coordinating group efforts (Miller 1992).

[10] Another way to create the same incentive is to award performance pay for managers based upon meeting annual targets, which may include cost reductions.

corporatization reforms have included provisions that give managers (and occasionally staff) a material interest in residual resources. Clearly, a prospective payment contract provides a powerful incentive to reduce costs if a significant share of any savings can be retained by managers as the residual claimant.[11] São Paulo's OSS hospitals may retain a budget surplus and carry it over into the following financial year. However, this does not translate into individual incentives for hospital directors and staff since they are not allowed to appropriate part of that surplus in the form of a performance bonus (as sometimes happens in the private sector). In both traditional and OSS hospitals managers are paid a fixed salary without bonuses for producing more or better health services for less.[12]

Corporatization reforms often allow hospitals to earn revenue under market conditions rather than rely solely on a budget allocation (Harding and Preker 2003). However, this is not true of the OSS model in São Paulo. OSS hospitals are part of the national SUS healthcare system and are not allowed to charge patients for medical services. In addition, the hospitals are not directly reimbursed by the SUS for those invoices. The SUS funds go directly to the state treasury. Moreover, OSS hospitals are expressly prohibited from establishing agreements with private health plans. The OSS are entitled to raise and retain revenues from their parking facility or a café on hospital grounds; but these revenues are insignificant as a share of the overall hospital budget. Thus, OSS hospitals are wholly dependent upon agreed transfers from the state treasury.[13]

Where the number of patients to be treated and the cost of treatment are known in advance (e.g., for routine, non-emergency procedures), then fixed budget contracts may work reasonably well, as it may be relatively easy for the principal to monitor basic quantities such as these. Prospective payment contracts provide a powerful incentive to reduce costs if a significant share of any savings can be retained by managers or the hospital as the residual claimant. The risk, though, is that quality may suffer or resources may go underutilized.[14] For instance, a hospital may close wards and leave people untreated if they already have met their numerical goals under a performance contract.[15]

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[11] Cost reimbursement schemes offer incentives to maximize the quantity of services delivered, provided the reimbursement rates are adequate. However, cost reimbursement generally does not provide an incentive to reduce costs.

[12] The manager of an OS *may* receive a salary that is greater than that of a typical hospital. However, there are no financial performance incentives. Managers cannot appropriate part of any surplus.

[13] A "residual claimant" may not be needed where the number of patients to be treated and the cost of treatment are known in advance (e.g., for routine, non-emergency procedures). Then, fixed budget contracts may work well, as it may be relatively easy for the principal to monitor basic quantities such as these. The risk, though, in contracting for routine procedures and more sophisticated prospective payment contracts, is that quality may suffer or resources may go underutilized. For instance, a hospital may close wards and leave people untreated if they already have met their numerical goals under a performance contract. (This is not merely a theoretical concern. At the OSS hospital Mario Covas our interviews revealed that mammogram equipment had gone underutilized, not for lack of demand but because the hospital had already met its numerical target for mammograms under the contract.) The challenge, then, is how to expand the decision-making power of hospital managers without threatening the mission of Brazil's Unified Health System (SUS).

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As mentioned above, OSS contracts can be fine-tuned through regular dialogue between hospital directors and supervisory staff of the Secretariat of Health. Under the conditions that the purchaser receives sufficient information about quality, and the provider cares about renewing the contract, "relational contracts" such as these provide a framework for continual improvements (Milgrom and Roberts 1992). Selecting established NGOs – as São Paulo has done – to lead corporatized hospitals can help to support these relational contracts, as these NGOs generally are concerned about their reputation, and presumably will be interested in sustaining a long-term contractual relationship. Regular dialogue also increases the likelihood for natural alignment of goals between government and the service provider, which reduces the risk that service quality will suffer in the face of the monitoring challenges described above.

Naturally, if an OSS fails to complete its contract, it risks losing the renewal of the concession. What gives the government of São Paulo an important advantage is the presence of other NGOs that are capable of, and may be interested in, taking over management of any given hospital (i.e., a credible "exit" option). (This condition may not hold in other locations in Brazil.) While this option is rarely used, one NGO already lost its OSS contract over a dispute about the hospital performance and the adequacy of the government funding.[16] For its part, the government must be careful not to lower service quality unwittingly by ratcheting downward its budget transfers to OSS hospitals when renegotiating annual performance contracts.

PERFORMANCE DIFFERENCES BETWEEN OSS AND DIRECT ADMINISTRATION HOSPITALS

While the São Paulo OSS model does not yet have a lengthy track record, early data on efficiency and quality indicate that the OSS model compares favorably to the traditional hierarchical administrative model. A study by the World Bank (2006, forthcoming) on hospital performance in Brazil examined performance data from 2003 for 12 OSS hospitals and a sample of 10 direct administration hospitals in São Paulo of comparable size and complexity. First, the study dispelled the notion that OSS hospitals have benefited from a higher level of financial resources than their traditional public sector counterparts. The 2003 data showed no statistically significant difference in the amount of resources at the disposal of OSS and traditional public hospitals. The study then examined output, efficiency, and quality data for each cohort, and found that OSS performance was either the same or superior in all categories. The key finding is that OSS hospitals have produced more numerous and/or superior services with the same overall quantity of resources.

Table 1 presents the comparative data from 2003 on hospital bed utilization. The OSS hospitals examined by the World Bank study offered 35 percent more patient admissions for each hospital bed. In relation to surgical beds, patient admissions were 61 percent higher.

[16] This was the case of the Hospital Geral de Itapevi run by Associação Sanatorinhos in 2005.

Table 1: Patient Indicators of Allocative Efficiency in OSS & Direct Administration Hospitals, 2003

Indicators of allocative efficiency	Avg. among OSS hospitals (N=12)	Avg. among direct administration hospitals (N=10)
Period between patients when hospital bed is vacant (days)	1.2	3.9
Occupancy Rate (%)	80.5	63.2
Avg. Patient Stay in Surgical Clinic (days)	4.2	5.4
Avg. Patient Stay Overall (days)	4.8	5.9

Source: SES/SP, DATASUS, and CNES data, presented in World Bank (2006, forthcoming).

Quality indicators also show that the OSS hospitals perform as well as or better than their direct administration counterparts. For instance, overall mortality was lower in 2003 in OSS hospitals than in direct administration hospitals. Meanwhile, mortality rates were practically the same in the medical, surgical, and pediatrics sections of OSS and traditional public hospitals (Table 2).

Table 2: Mortality Rates in Direct Administration & OSS Hospitals, 2003

Mortality Rates	Avg. among direct administration hospitals (N=10) (%)	Avg. among OSS hospitals (N=12) (%)
Overall	5.3	3.8
Surgical clinic	3.6	2.61
Medical clinic	11.96	11.64
Pediatric clinic	2.63	2.80

Source: DATASUS/SIH-SUS, presented in World Bank (2006, forthcoming).

The two hospital groups (OSS and traditional) in the World Bank (2006) study serve populations with similar health problems, as indicated by the patient data. However, in considering these performance indicators it should be noted that many OSS hospitals are "closed door" – meaning their demand is controlled though a referral process – rather than "open door" hospitals, which attend to spontaneous emergency and urgent care 24 hours a day.

HUMAN RESOURCE MANAGEMENT IN SÃO PAULO'S HOSPITALS

As a prelude to comparing human resource management in traditional, OSS, and private hospitals, it is first necessary to summarize the disparate forms of employment in Brazil's healthcare sector.

Legal Basis of Employment

In 1990 the Single Juridical Regime for public employees (Law 8.112) was approved, in compliance with a provision of the 1988 Constitution. Employees hired for a legally-established career post (*cargo*) anywhere in the public sector must be selected through a competitive merit process via written examination (*concurso público*). These statutory employees (*estatutarios*) have legal protections against dismissal after two years of service. Each traditional direct administration hospital in São Paulo has its own establishment list (*padrão de lotação*) of

authorized posts. (The most recent lists date from 1994.) If there is a vacancy, the hospital manager may hire a new employee for that post from the top of the list of *concusados* (i.e., those who have passed the merit exam) without further authorization from the Secretariat of Health. If there is no vacant post and yet an employee is desperately needed, the hospital may hire a *concursado* on a temporary basis (*pro laborio*).[17]

In 1974 the government of São Paulo approved specific legislation for employment in the state's hospitals. Law 500/74 was promoted at the time as a way to enable hospitals to be more agile in meeting their specific and immediate personnel needs. Employees hired under Law 500 are selected via an assessment of their resume, not by the more time-consuming *concurso*, which often is not conducted for narrow medical specialties.[18] These "Law 500" employees receive identical salaries and benefits as *estatutarios*, except they do not receive a reward for their academic title (*licença premio*) or length of service (*sexenio*).[19] In principle, these personnel were hired only for a two-year term, with no promise of job stability. In practice, however, their job stability and protections also became the equivalent of *estatutarios*.[20]

Many healthcare professionals, whether in the private or public sector, are hired under private sector labor legislation (*Consolidação das Leis do Trabalho* - CLT). In the public sector, selection under the CLT is via a "selective process" to occupy a *funcão atividade*. This selective process amounts to checking an employee's qualifications to ensure that they are suitable for the position, but does not require a competitive procedure for selection. There is no statutory impediment to firing a CLT employee "without cause." (The employee is simply entitled to an indemnity payment.) It is rare, however, for CLT employees in the public sector to be fired. In addition, Brazil's labor courts often confer the same kind of protection to CLT employees (*celetistas*) as they do to *estatutarios*, although the legal basis for doing so is questionable.

In some cases state hospitals have met their personnel needs via cooperatives, wherein the employment relationship is not between the state (or hospital) and an individual, but rather between the state (or hospital) and a union of professional employees. The union (*cooperativa*) assumes the contractual obligation to ensure that a certain number of professional hours are provided to the hospital, as specified under a contract with the facility. These personnel must have certain qualifications, but the actual people who show up to provide the service are completely interchangeable – contractually and in practice. The pay per hour is higher when working through a cooperative than it is for regular CLT or *estatutario* employees. However, cooperative workers receive no benefits, and are paid only for hours worked. Thus, their pay can vary considerably from month to month.

In 1999 there were approximately 23,800 doctors working as *estatutarios* in the state of São Paulo, equal to 46 percent of all doctors with a formal employment link (public and private sector

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[17] The *padrão de lotação* is issued by decree by the governor. As medical technologies and procedures change there are regular conflicts as hospitals request an expanded *padrão* – typically without offering the elimination of any existing positions. If a facility has a vacancy it is entitled to hire someone to fill that post without receiving any additional permission from the governor. NB: The posts of former federal employees who work in hospital facilities that were transferred to the state do appear in the *padrão de lotação*. However, they are not *cargos* of the state. This means that when these employees retire, the hospital can not fill the post.

[18] Law 500/78 specifies only a "preference" for those who have passed a *concurso*.

[19] The *licença prêmio* is an award of 90 days of leave for every 5 years of employment. The *sexenio* is a monetary award received after 20 years of service that is equivalent to one-sixth of the value of the four *quinquenios* that an employee of 20 years will have earned.

[20] See Complementary Law 180/78.

combined). Overall, the public sector accounted for slightly more than 60 percent of all medical jobs in São Paulo in 2000 (Cremesp 2002:7).

While we do not have detailed comparative data for all OSS hospitals, there were no *estatutario* employees at any of the seven OSS hospitals in our sample for this study.[21] In fact, OSS employees are almost exclusively *celetistas* (CLT), which is the form of employment most commonly used in private sector hospitals. *Cooperativa* personnel can also be found at some OSS hospitals. However, the importance of cooperatives as a form of hospital employment has diminished in recent years, in part as a result of a 2003 change in federal tax law that added to the costs of independent hiring, thereby eliminating the tax advantages that had been available by hiring labor through cooperatives.[22] The experience of the OSS Hospital Mario Covas is illustrative. When the hospital opened in November 2001 the director decided to hire almost all medical staff via cooperatives. As the director explained in our interview, the factors that led to this decision were short-lived. The hospital was just getting underway, and there were many unknowns. Satisfying the hospitals labor needs through cooperatives offered greater flexibility and reduced risks since cooperatives represent only a short-term labor commitment on the part of the hospital. Still, as hospital managers at Mario Covas developed firmer expectations about the future, most cooperative employees were gradually converted to or replaced by CLT employees – thereby establishing a direct employment relationship between the hospital and employee.[23]

Multiple Jobs

Healthcare professionals in Brazil typically do not have just one job at one facility. Most often they hold two or more jobs simultaneously. A 2001 survey by Cremesp/Nescon found that fewer than 20 percent of doctors have a single employment tie (Cremesp 2002:9). Nurses, too, commonly hold more than one job at one facility. While there are no systematic data on multiple job-holding by nurses, the estimates provided by the nurses we interviewed were that at least 60 percent have two employment ties.

In December 1997, Complementary Law 840 reduced the work week for a doctor's post in the state public sector from 40 hours to 20 hours – which is the same as federal doctors.[24] Earlier that year São Paulo's doctors mobilized to demand a pay raise, but the state was in a dire fiscal situation. The reduction in hours (without reducing pay) was a means to respond to labor pressure without a direct additional cost to the treasury. Doctors were then able to combine two jobs (and two salaries) at different public hospitals for a total of 40 hours per week.

For doctors and dental surgeons who already have an employment link with the state, it is possible to work extra shifts in addition to their regular hours, either at the hospital where they

[21] While it is legally permitted for a public employee to transfer to an OS, there is no incentive for employees or OS directors to seek such a transfer.

[22] The trend away from *cooperativa* employment is visible nationally, not only in São Paulo. For example, the Ceará Seccretariat of Health found that cooperatives actually turned out to be more expensive for the government, and presented greater management difficulties, than hiring someone as a staff employee. Cooperative employment has been targeted for gradual elimination there.

[23] There are still cooperative employees in the specialties of anesthesiology, heart surgery, and radiology. The cooperative contract with radiologists also makes them responsible for film and other inputs, as well as equipment maintenance.

[24] X-ray technicians and laboratory workers also have a 20 hour work week (LC 848).

normally work, or at another facility. These 12-hour shifts are known as *plantões*.[25] Most doctors work more than 40-hours per week through a combination of posts at public and private hospitals, *plantões*, private practice, and hours assisting on surgical teams on a fee-for-service basis. The 40-hour limit is for public posts only.

The standard employment contract for nurses is 30 hours per week. A maximum of 40 hours are allowed at any single facility, but some nurses combine 36-hour positions at two different hospitals.[26] Among nurse assistants, holding two jobs is believed to be even more common than it is for nurses. Nurse assistants can have 30, 36, or 40 hour work schedules. Many combine 30 hour schedules at two facilities.

COMPARING HUMAN RESOURCE MANAGEMENT IN OSS AND TRADITIONAL PUBLIC HOSPITALS

To gather data for this analysis of human resource management, a survey instrument and focus-group interviews were carried out in a sample of 20 São Paulo hospitals. (See Appendix A for a description of the hospitals included in the sample. The survey instrument and guide for open-ended focus-group interviews are presented in Appendix B and Appendix C, respectively.) A common perception of senior staff in the Secretariat of Health – supported by many of the healthcare professionals we interviewed – is that efficiency and productivity are generally superior in the OSS hospitals than in their traditional hospital counterparts. That perception is substantiated by a separate World Bank analysis of 2003 hospital performance data (2006, forthcoming). Likewise, the data on occupancy rates and employees per hospital bed for the hospitals in our present research sample (Table 4) support the same conclusion: OSS performance is generally superior. Most of the doctors we interviewed at OSS hospitals also maintained a job at a direct administration facility. Thus, it seems evident that traditional public hospitals are able to attract many doctors of the same caliber as those working for OSSs. Are there important differences in human resource management for healthcare professionals in OSS and traditional state hospitals that might explain the performance differences?

Establishment Control and Staff Composition

Brazil's Fiscal Responsibility Law sets an upper limit for government personnel expenditures (60 percent of the net current revenues for state and municipal governments). Consistent with that law, each OSS contract includes a provision mandating that the hospital wage bill may not exceed 70 percent of the hospital's overall budget. At the time of the first OSS contracts, personnel expenditures in traditional public hospitals ranged from roughly 60 percent to 68 percent, so the 70 percent cap is not meant to be onerous.[27] So long as OSS directors do not exceed that 70 percent limit they are free to decide how many staff, with what skills, are appropriate to fulfill the hospital's mission. Although personnel working for OSS hospitals are not included in the state government's personnel expenditures, this is a good practice that encourages efficiency in human resource use at each OSS hospital.

[25] There is a legal limit of 12 *plantões* per month. The idea of creating *plantões* for nurses, as well, has been under discussion but is not permitted at the present time.

[26] This is the case for "Flavia," a neonatal intensive care nurse at Hospital Mario Covas who participated in our focus group discussion. She works 36 hours per week for the OS and another 36 hours per week at a private hospital. A survey by the *Conselho da Enfermagem* found that average monthly (combined) income for nurses in São Paulo was R$ 3,500 to R$4,000.

[27] A World Bank (2006, forthcoming) analysis found that average personnel costs represented 68% of total expenditures among the 12 OSS hospitals examined in the study.

In traditional public hospitals the number of employees, by type, is given by the hospital's establishment list. The director has no responsibility or control over this allotment of personnel, as the authorization to hire additional staff at a traditional public hospital (and foundation hospital) is made by the state Secretariat of Health. In contrast, at each of the OSS and private hospitals in our sample, the hospital's General Directorate will make the decision whether or not to hire additional personnel. Likewise, directors of OSS, private, and foundation hospitals all indicated that they have authority to determine where to make budget cuts in the event of a shortfall.

As Table 3 indicates, OSS hospital directors in the exercise of their establishment authority have hired professional staff in markedly different proportions to what is found in the establishment lists (*padrão de lotação*) of traditional direct administration hospitals. The data indicate that OSS hospitals rely to a greater extent on fully-qualified nurses, and less on doctors. That is precisely the kind of staffing mix that many healthcare analysts advocate to provide quality care at lower cost.[28] In addition, the number of employees per hospital bed at traditional direct administration hospitals was considerably higher, on average, than at OSS and private hospitals in our study sample (Table 4).

Table 3: Staff Composition in Direct Administration & OSS Hospitals, 2003

Personnel hours contracted (40 hour equivalents)	Avg. among direct administration hospitals (N=10)	Avg. among OSS hospitals (N=12)	Difference (OSS/direct administration)
Doctors	203.15	143.80	(71%)
Nurses	40.50	54.09	33%
Nurse Assistants	256.81	234.12	(92%)

Source: SES/SP, DATASUS, and CNES data, presented in World Bank (2006, forthcoming).

Table 4: Number of Employees per Hospital Bed (among hospitals in study sample)

Employees per Bed	Traditional Public	Public with Foundation	OSS	Private
2 – 3.9	2	-	-	1
4 – 4.5	-	-	5	2
4.6 – 5	-	-	2	-
5.1 – 7	3	2	-	1
7+	2	-	-	-

Source: Results of research questionnaire applied in a sample of 20 São Paulo hospitals. The questionnaire appears in Appendix B.

Personnel Selection

Personnel in traditional public hospitals are selected via written examination (*concurso público*). In contrast, the directors of OSS and private hospitals included in our sample stated that personnel selection at their hospitals is based upon an analysis of curriculums, interviews, and (sometimes) practical exams. These directors unanimously affirmed that they have autonomy to hire a

[28] See, for example, Edwards, Wyatt and McKee (2004). I am grateful to April Harding for suggesting this source.

professional whom they consider qualified, without further interference. In contrast, the directors at traditional public hospitals (and foundation hospitals) confirmed that they lack that independence.

As the procedures for selection and appointment differ, so does the time required from the moment a decision is made to hire someone for a position to the day that new employee arrives for work. Whereas the elapsed time for **all** of the OSS, private, and foundation hospitals in our study was less than a month, at the traditional public hospitals that elapsed time ranged from one month to more than six months (Table 5).

Table 5: Average Elapsed Time between Initiating a Hiring Process & Employee Arriving to Work (among hospitals in study sample)

Elapsed Time	Direct administration	Public with Foundation	OSS	Private
1 month	3	2	7	4
2 months	1	-	-	-
6 months	1	-	-	-
> 6 months	2	-	-	-

Source: Results of research questionnaire applied in a sample of 20 São Paulo hospitals. The questionnaire appears in Appendix B.

Salary Determination

In traditional direct administration hospitals salaries are paid and accounted for centrally, and salary scales are also determined centrally for all categories. The director's budgetary authority, as confirmed by our study visits, is limited to medicines and other recurrent costs.

Meanwhile, the vast majority of OSS employees are hired under the private sector CLT law. In fact, while there are a few OSS managers who hire some labor through cooperatives, at most OSS hospitals **all** employees are *celetistas*. (The decision is up to the OSS director.) These hospital directors can set/negotiate the pay levels for their CLT and *cooperativa* staff. The realities of the labor market, not statutes, are the binding constraint.

Focus group interviews with doctors and nurses at the hospitals in our sample revealed that, in certain instances, pay for a given post was somewhat higher at an OSS. Generally, however, the healthcare professionals we interviewed reported that their pay on a per hour basis was closely comparable at direct administration and OSS hospitals.[29] Unfortunately, comparing hourly wages between traditional public and OSS hospitals is complicated by an oft-mentioned practice at direct administration hospitals whereby individual doctors and nurses reach an informal agreement with hospital administrators to receive their full pay while working less than the full number of prescribed hours. The purported rationale for this "understanding" between health

[29] "Marcos," a surgeon who joined one of our focus groups, works 24 hours per week as a *celetista* employee with an OSS, another 24 hours (in 2 *plantões*) as a statutory employee with a municipal hospital in São Paulo, and an additional 20 hours per week in a private clinic. Interestingly, it is the municipal hospital that pays far better than the other two. NB: There is a 40 hour per week limit for a surgeon in public hospitals. Although this should apply to Marcos's situation, there is no authority that keeps track of hours worked in public hospitals operated by different levels of government.

professionals and their managers is the modest pay scale that applies in the traditional state system. The practice clearly is not rare, but is impossible to quantify.[30]

A list of the non-salary benefits offered to employees at direct administration, OSS, and private hospitals was gathered through the study questionnaire. Benefits are somewhat better at OSS than direct administration facilities, and better still at private hospitals (Table 6). Private hospitals are also the arena where doctors can earn much higher pay than at OSS or direct administration hospitals. However, focus group participants consistently asserted this was only true for doctors with well-established reputations working at prestigious private hospitals.

Table 6: Comparing Employment Benefits (among hospitals in study sample)

Benefit	Traditional Public	OSS	Private	Public w/ Foundation
Food subsidy	√	√	-	-
Transportation subsidy	√	√	-	-
Cesta básica	-	√	-	-
Education subsidy	-	√	-	-
Private health plan	-	-	√	√
Private dental plan	-	-	√	√
Life insurance	-	-	√	√
Private retirement plan	-	-	√	√

Source: Results of research questionnaire applied in a sample of 20 São Paulo hospitals. The questionnaire appears in Appendix B.

Performance Pay

It is perhaps interesting to note that traditional public hospitals – and not the OSS hospitals – have a version of performance pay based upon a quarterly evaluation. Unfortunately, the poor design of the Special Incentive Reward (PI) undermines its potential use as a performance incentive mechanism (

Box 2). In all but the most extreme cases the evaluation is a *pro forma* exercise. Indeed, a doctor at one of the public hospitals mentioned that some of his superiors who have filled out his evaluation did not even know him, let alone his work. Likewise, nurses that work with him are evaluated by the head nurse (which seems appropriate), but without consulting him for his opinions (which seems regrettable).It is important to note that for most jobs it is notoriously difficult to implement an effective pay for performance system – whether in Brazil or anywhere else. In fact, pay is not closely related to performance in many organizations that claim to have merit increase systems (Baker et. al. 1988). The cost of dealing with the problems engendered by merit pay systems may simply outweigh the benefits they offer. A strong pay-for-performance scheme "motivates people to do exactly what they are told to do" (Baker et. al. 1988). However, it is often difficult to specify precisely what someone should do, which can lead to perverse outcomes. Moreover, merit-pay systems may encourage employees to expend unproductive effort in "gaming" the system to measure and evaluate output.

None of the OSSs visited for this study had a pay for performance plan, though the directors have the authority to establish such a plan if they choose.

Career Development

"Ana" is one of the doctors interviewed for this study. She works 24 hours per week as a general surgeon at an OSS, another 30 hours per week, on average, at a traditional public hospital, and 12 more hours per week at a private hospital. On occasion, Ana also joins a surgery team for operations performed at other hospitals. She earns considerably less per hour for her work at the traditional public hospital, largely because one third of her time there is donated for free. Why does she work there if her hours could be fully remunerated by working elsewhere?

Ana told us that the public hospital is where she did her residency, so she feels a certain emotional commitment to the hospital. But more importantly, her work there allows her to continue to develop her skills in her specialty of plastic surgery. In contrast, her work at the OSS and private hospital is in general surgery, and does not allow her to utilize and develop those specific skills.

A common theme of our interviews with surgeons is that the large public hospitals treat patients with more varied and uncommon medical pathologies than those at OSS and private sector hospitals. This feature can make the public hospitals a more intellectually and professionally stimulating place to work for many doctors.

There are instances, certainly, when OSS directors can offer employees attractive professional development opportunities. "Marta" is an infectious disease specialist, hired as Chief of Section for infectious disease control when the OSS where she works first opened. She works 30 hours per week at the OSS. She also works in the same specialty at Hospital das Clínicas (a large public teaching hospital), but with far less responsibility. Consequently, Ana earns more than three times the amount per hour for her work as Chief of Section at the OSS (R$43.90/hour) than at Hospital das Clínicas (R$13.40/hour). Still, Ana explained she does not wish to give up her employment tie with Hospital das Clínicas because patients with rare diseases are treated there, which simply would not occur at an OSS hospital. That exposure boosts her professional qualifications and experience.

Box 2: The special incentive award

In 1998, a special incentive award (*Prêmio de Incentivo Especial* – PI) was created for doctors, sanitary workers (*medico sanitarista*) and dental surgeons employed at traditional public hospitals in São Paulo. (See Resolução Conjunta SS/SAM no. 3, May 17, 1998.) Nurses, auxiliary nurses, and other professionals directly involved in healthcare delivery are now also eligible for this PI. However, there are problems both in the design and implementation of this award.

For doctors, calculating the value of the reward is rather complex. Each month the human resources staff in each public hospital must tally the number of consultations, treatments, and/or surgeries performed by each doctor. Depending upon the specialty and service performed, the award is valued between R$2.00 and $2.67 per service, with a cap on the total number of eligible consultations/treatments that ranges from 158 to 352, depending upon the employee's work day (12 hours vs. 20 hours) and specialty (e.g., psychiatry, doctor, sanitary worker). (See Resolução SS-111, Secretaria de Estado da Saúde, June 19, 1998.) Multiplying the number of consultations/treatments by their unit value yields the maximum amount per month that the doctor can potentially receive for "incentive pay" that month.[†] The actual amount of the PI award can be less.

Eligible employees (including doctors, nurses, etc.) are entitled to 50 percent of the total possible incentive pay due simply to the fact that they are employees of the Secretariat of Health. Another 30 percent depends upon the institutional evaluation, while the remaining 20 percent is contingent upon receiving a satisfactory individual evaluation.[‡]

There is a maximum of 20 possible points on the individual evaluation form. With 11 points or higher, an employee is entitled to 100 percent of the one-fifth of the PI that is determined by the individual evaluation. With a score of 10 points the employee is awarded 50 percent; and anything less, 0 percent. On the evaluation form, an employee receives 5 points simply by showing up to work on time. Thus, it is quite easy to accumulate at least 11 points. Indeed, in the records of Hospital Brigadeiro, for the month of July 2004, of the 982 individual evaluations, 944 (96 percent) received a score of 11 or higher, while 38 (4 percent) received a score of 10 points. Not a single person received a score below 10. The Director of Hospital Brigadeiro acknowledged that PI is primarily a reward for reasonable attendance, not efficiency or effort. Thus, the PI largely fails to serve its purported role: namely, encouraging greater effort on the part of health care employees. In practice, it is largely an input to base pay and not a "reward" for performance.

[†] Note: The PI for anesthesiologists and surgeons is calculated a bit differently. They receive a certain number of points depending upon the length of time of a particular surgery. They are then awarded $R20.00 for each point, up to a maximum of 50 points. (See the *Memorando Circular* STRH, April 28, 2000.) It is perhaps a design flaw that doctors are punished financially for attending a medical conference, because that is not compensated under the PI formula.
[‡] Note: If on approved leave or vacation, doctors, sanitary workers, and dental surgeons are entitled to receive the same PI award earned during their last full month of work.

It is possible that OSS directors can offer more internal promotion opportunities based upon merit than traditional state hospitals. Further study is needed, however, to determine the extent of this difference. On the whole, professional development opportunities for doctors and nurses often appear to be greater in traditional state hospitals than at OSS facilities, largely due to the greater variety and complexity of illnesses handled by the traditional public hospitals.

Performance Evaluation and Supervision

OSS and private hospitals often appear to have better information than their traditional public sector counterparts regarding hospital efficiency and personnel. For example, only three of the seven traditional public hospitals in our sample were able to provide data on their rate of absenteeism. Similarly, none of these seven hospitals could provide data on employee turnover (Table 7).

Table 7: Employee Turnover Rates (among hospitals in study sample)

Turnover (Percent)	Direct administration (N=7)	Public with Foundation (N=2)	OSS (N=7)	Private (N=4)
0 – 1	-	1	1	1
1.1 – 2	-	1	3	-
2.1 – 3	-	-	2	-
3.1 – 4	-	-	1	-
4.1 +	-	-	-	3
Data unavailable/ No response	7	-	-	-

Source: Results of research questionnaire applied in a sample of 20 São Paulo hospitals. The questionnaire appears in Appendix B.

There is little doubt that supervision can be very poor at traditional public hospitals. However, it is possible to identify traditional public hospitals where supervision appears to be excellent. The Hospital Vila Penteado maintains monthly data for all medical personnel with the type of activity performed (e.g., consultation, surgical procedure, UTI, neo-natal, & ultrasound), and the quantities for each service. These data are used for calculating the Special Incentive Reward (discussed below), but they are also used by the senior managers at the hospital to track the "productivity" of all the medical specialists, and identify areas or individuals where some intervention or discussion might be warranted.

Certain public hospitals, as well as OSSs, also have begun to gather systematic information from their patients on the quality of their service. The *Conte Comigo* ("Count on Me") program began in seven direct administration hospitals in September 2003. The stated aims of the program are to offer support to patients and visitors to the hospital, to help them get where they need to be, and to transmit criticisms and suggestions to medical personnel and managers. The *Conte Comigo* teams prepare a monthly report for the directors of each division within the hospital, based upon the number of surveys they gather each month (300 to 400 in the case of Hospital Brigadeiro). These teams also collect specific criticisms concerning a particular doctor or staff member. Those are forwarded to the attention of the division directors for a reply. Then, the *Conte Comigo* staff communicates that response back to the patient.

The seven OSSs we visited all maintained a wealth of information on the number of services performed, by hospital units and by individuals. Yet, it was not clear from our focus group interviews that doctors believe **formal** supervision procedures are more prevalent or rigorous at an OSS than at other public facilities. Performance contracts between the SES and the OSS specify specific outputs. However, at none of the OSS hospitals in our sample did the director

then allocate or directly assign a portion of those outputs to individual staff members as a performance measure.

Disciplinary Actions

In all of the hospitals in our sample, the typical formal means of punishment for poor performance were a written notice, suspension, and finally removal. In the public hospitals it was also possible (at least in principle) to deny an employee their monthly performance award, as discussed in Box 2.2.

Informal incentive mechanisms, including those related to discipline, are discussed below. Table 8 summarizes formal human resource management authorities by hospital type.

Table 8: Managerial discretion over human resource decisions, by hospital type

	Direct administration	OSS	Private
Define personnel needs within budget constraints (establishment control & staff composition)	No	Yes	Yes
Discretion to hire or fire according to the needs of the hospital	No	Yes	Yes
In hiring, selection of best-qualified candidate as judged by hospital director	No	Yes	Yes
Determine compensation levels (pay and benefits)	No	Yes	Yes
Link monetary incentives to performance	No†	Yes†	Yes

† Note: Although managers do not have the authority to set performance incentives, there is a performance award (discussed in Box 2) for employees of traditional public hospitals in São Paulo. Meanwhile, although OSS managers acknowledge that they have the authority to enact a monetary performance award system for their employees, none of the managers in our sample of 7 OSSs made any such awards.

THE POWER OF INFORMAL INCENTIVES (THROUGH FORMAL AND INFORMAL RULES)

Comparing key features of OSS and traditional public hospitals *as employers*, and then examining the employment choices of a sample of healthcare professionals reveals the complexity of personal utility functions. Labor economists often adopt a narrow view of human preferences, with a parsimonious utility-maximizing assumption whereby workers make individual calculations to trade off money vs. leisure. Clearly, the employment choices made by the healthcare professionals in our São Paulo focus groups reflect utility functions that are far more complex than the parsimonious model suggests.

Our hospital interviews confirmed the common perception that multiple-job-holding by healthcare professionals is, in large part, a strategy to minimize risk. (The "frame" within which these professionals make their employment decisions is marked by the memory of unpredictable changes in pay and employment in both the public and private sectors.) Nevertheless, it is clear from these interviews that risk-aversion is inadequate to explain their employment choices, particularly when professionals have not just two, but three and four employment ties. Generally we were told that posts in traditional public hospitals were better for (i) security; (ii) professional development; and (iii) flexibility with hours/schedule. A job at an OSS, meanwhile, was

considered superior for (i) its "organization" (professionalism) as a place to work, and (ii) the opportunity to be affiliated with a prestigious institution. (The same was true of the foundation hospitals.) As for private hospitals, these could offer a sense of prestige, and the potential for better pay. Thus, a mix of employment ties can satisfy a range of diverse objectives. Reducing risk is merely one of them.

Based upon our analysis of 20 hospitals in São Paulo, including focus-group discussions with healthcare personnel in these facilities, there is either little or no evidence to claim the superior performance of OSS hospitals results from higher salaries, performance pay, superior career development opportunities, or even formal supervision mechanisms. If the "managerial autonomy" enjoyed by the managers of OSS hospitals is important to explain differences in performance, then where do we see it? The key answer appears to be staff composition, the processes of staff selection, and the possibility to dismiss employees.[31]

When the OSS Hospital Carapicuíba (Santorinhos) prepared to open in October 1998, the director decided to hire all his staff as *celetistas*. Not a single *concurso* was held. The director and his senior managers looked to the School of Medicine for potential employees, asking for recommendations and advertising through informal networks. They asked promising candidates to come in for interviews, and hired whoever seemed to be the best fit for the organization. Department heads made their selections, which then had to be approved by the hospital director. All doctors at Hospital Carapicuíba were hired in this semi-informal manner.

For nurses, the director chose a more formal process for interviewing and evaluating potential candidates; but again, none of the nurses were selected from a list of *concusados*. Five employees were hired through formal, public advertisement of the positions, but managers and the director were disappointed with the quality of the resulting hires. That experience strengthened their belief that word-of-mouth recommendations were the best way to identify the best staff for the organization. The OSS Hospital Mario Covas selects staff in the same way. In these settings managers are empowered to search for personnel that are both highly qualified <u>and</u> a good fit for the organization.

The direct administration hospital Vila Penteado opened in 1991. By all accounts it is one of the best performing traditional public hospitals. It is unique in that the hospital has had only one director since it opened; but the director still must overcome specific challenges or obstacles to put together a dedicated staff. State hospital managers cannot select staff they believe are best suited for their facility. If they have a vacancy they must hire the person highest on the list of *concursados* for that position. There is no opportunity to interview even a small number of pre-qualified candidates to determine who would be the best fit for the organization. There is no flexibility or discretion.

The overall number of staff is another aspect where the director of a traditional public hospital has no authority. At Vila Penteado the number of 341 doctors is the same today as 13 years ago when the hospital opened. The establishment list has not been changed, so turnover is the only

[31] An alternative explanation, which relies neither on formal nor informal human resource management rules, is a variant of the so-called "Hawthorne effect," whereby worker behavior may differ (and in this case improve) not because of the content of the reform or "experiment" employed, but simply because the workers know they are being studied (or are subject to increased attention, as in the case of a high-profile reform). In this case, however, one would expect the positive "Hawthorne effect" to be temporary, as the initial excitement or attention created by first establishing a Social Organization gradually wears away. Social Organizations have now been operating in São Paulo for more than five years, in some cases.

way that the hospital managers can change the staffing profile. For example, if the hospital wants to add a burn unit, the director can not simply advertise for the correct medical specialists and hire those that are needed. He can only build this new capacity gradually as those with other specialties retire or for other reasons leave the hospital.

Turnover rates were high at Hospital Vila Penteado during its first years of operation. Firing a statutory employee is exceedingly difficult. Still, the director (and other senior managers) could make it unpleasant for employees who did not perform well by regularly providing feedback and criticism, making certain that shirking would not be tolerated. Eventually personnel who were not committed to the goals and culture of the hospital sought transfers to other facilities (which helped the performance of Vila Penteado, but simply transferred the problem elsewhere). Turnover rates are now lower than in the first years since the hospital has developed a certain reputation, which tends to screen out some unsuitable candidates. However, the problem has not gone away. The director is generally pleased with new staff named to fill vacancies in pediatrics and intensive medicine; but he is regularly disappointed with almost a third of the staff in the clinical area. There is no trial period, and no simple way to discipline or fire a poor performer.

One option for disciplining a bad doctor in a traditional public hospital is to make a formal complaint to the Regional Medical Council (CRM), which is a professional body that doctors must join in order to practice medicine in the public or private sector. This option has two important limitations, however. First, the CRM investigates and judges potential malpractice or ethical infractions, not complaints that a doctor is merely inefficient or unproductive. Second, the process can be extremely slow: 4-5 years from the time of the initial complaint until final resolution. The CRM will first carry out a preliminary evaluation to decide whether a disciplinary case is warranted. Then, if the CRM determines that it is justified, a disciplinary procedure is launched. Various parties can be called to testify. Penalties range from (i) confidential warning, (ii) confidential censure, (iii) public censure, (iv) suspension (usually 30 days), and (v) dismissal (disaccreditation).

Many managers will conclude that denouncing an unprofessional doctor to the CRM is simply not worth the trouble. As the president of CRM explained, "when you denounce someone you cannot be sure of the outcome; but you likely will continue to work in the same hospital with that person until the disciplinary proceeding is finally concluded." Even if the person is eventually dismissed, the manager cannot be certain that the one named to fill that vacancy will be any better.

In Brazil, as in other countries, managers are often reluctant to fire, penalize or give poor performance evaluations. After all, the manager is not the owner of residual claims, so there is not a strong incentive for a manager/director to suffer the costs – in terms of time, personal conflict, etc. – associated with penalizing or firing an employee in the interest of greater efficiency. Clearly, however, the costs for disciplining an employee at an OSS are much lower than in traditional direct administration hospitals. Two doctors were fired from the OSS Hospital Mario Covas in 2003, and another was fired in 2004. A fourth doctor was "dismissed" from Hospital Mario Covas at the end of his probation period. (Under the CLT legislation, managers also have the benefit of a three-month probationary period to see if a new employee is a good fit for the organization.) Each of those actions could be taken relatively quickly. Meanwhile, the director of Hospital Vila Penteado began a disciplinary process in the year 2001 to fire a doctor for malpractice. Eventually, as the process was nearing conclusion in 2004, the doctor resigned to evade an official sanction.

The performance advantage, on average, of OSS hospitals appears to result largely from the ability of OSS managers to use information networks and informal incentives in personnel selection. Can this informality be abused? Certainly. On the other hand, it enables senior managers to assemble a group of employees with a common commitment to an organizational mission and culture. That collective spirit is difficult to quantify but terribly important. It helps to align the goals of principal and agent, thereby reducing monitoring costs and generating levels of performance that can only be induced, not forced. It is impossible for any manager to observe his subordinates constantly. The best hospitals are those where employees want to do good work and where they believe that their colleagues have the same commitment. Where this is true, then employees are likely to give their best ("cooperate") in the belief that their colleagues will do the same. If, on the other hand, an employee believes that his colleagues will evade their work whenever possible ("defect"), the probability that the employee also will shirk increases substantially (Miller 1992).[32]

A professional, committed organizational culture created and sustained by skilled managers is a setting that supports the reciprocal cooperation that underlies highly effective and efficient organizations. If the organizational culture is one in which cooperation is expected, then there are informal but powerful means to punish a "defector." The Hospital Vila Penteado offered an interesting illustration. Nurses often arrange among themselves to swap shifts (e.g., because one of the nurses needs a three-day weekend for a trip out of town). However, nurse supervisors must approve those requests. Generally, they do. However, as a form of punishment (and to induce cooperation) supervisors do not approve requests for a schedule change when made by nurses who have showed up to work late or in other ways been "defectors." The supervisors are quite clear with subordinates about their reasons for approving or denying a request such as this. The message is "I'll cooperate with you if you cooperate with me (and the rest of the hospital staff) in delivering high-quality, efficient health services at this hospital."

The Vila Penteado example demonstrates that an environment of collective cooperation toward a common goal can be induced and nurtured at direct administration hospitals, as well as OSS and private organizations. It is important to recognize, however, that a well-meaning OSS manager has important tools at his disposal that his counterpart at a direct administration hospital lacks. And that can make all the difference.

CONCLUSIONS AND POLICY IMPLICATIONS

How can the hierarchical organization of public administration work better through non-traditional management of human resources? A key premise of the coporatization model as a solution to improve organizational performance is that managerial flexibility is granted to the manager of the corporatized organization. To meet the organization's specified performance targets, the chief executive officer needs the ability to adjust the mix of resources (inputs) in the way he deems the most appropriate. Thus, *ex ante* input control is relaxed in exchange for *ex post* accountability for results.

In São Paulo, OSS managers do indeed enjoy higher levels of discretion in different dimensions of hospital management, including staffing. They are free to recruit professionals of their choice without following the rigid public exams (*concursos*). To the extent that hospitals depend for their performance on their staff's cooperative behavior with each other, it is tremendously

[32] "The principal knows, in general terms, what he wants the agent to do, but the range of possible actions that the agent can take, and the range of possible outcomes, is enormous." (Baker et. al. 1988:598).

important that directors can recruit professionals that they deem are good fit for the organization. (They are also able to dismiss staff with performance problems, which is nearly impossible in direct administration hospitals.) Our study did not investigate in detail how medical professionals work together as a team inside each of the OSS hospitals. However, it is our hypothesis, having discarded a number of alternative explanations, that cooperative collective behavior is indispensable to achieving organizational goals, and that the directors' ability to mold their own teams is an essential ingredient of effective hospital organizations.

The descriptive data gathered from our field research at 20 São Paulo hospitals is consistent with the data analysis of the World Bank study on hospital performance (2006, forthcoming): OSS hospitals as a group have outperformed their direct administration counterparts. The public perception of the OSS reform is also positive, so much so that the government is exploring the possibility of extending the model to additional state hospitals. It is easy to overstate, however, the magnitude of the difference between these hospital types, and to oversimplify the explanation for the superior OSS performance. Thus, there is reason for modesty in "selling" the OSS model, noting that there are practical limitations to expanding this organizational innovation throughout the broader healthcare system.

First, we must acknowledge that the oft-maligned large, less efficient state hospitals produce positive externalities for the health system as a whole in São Paulo. As our focus-group interviews demonstrated, OSS hospitals are spared the toughest, least common, and most expensive medical cases that are handled by the large public teaching hospitals. Many doctors and nurses learn their craft at those hospitals, tackling the broadest range of medical cases. They can then take their talents to positions in OSS and private sector hospitals. The private sector, we were told, does not hire nurses without experience, and the public sector provides that experience.

Second, there are political constraints to expanding the OSS model that did not have to be confronted head-on when the first OSSs were established. Recall that São Paulo's OSS experiment was launched in brand new hospitals where construction had just been completed. Therefore, they did not provoke strong labor opposition. Converting a direct administration hospital into an OSS is a different matter, as evident in the experience of Hospital das Clínicas Luzia de Pinho Melo. When a new wing was added to this hospital, increasing its size from 50 to 300 beds, the state initially intended to administer the "new" section of the hospital as an OSS while the "old" section would continue under traditional direct administration. It soon became clear, however, that two administrative models operating in the same facility was untenable. Thus, the SES determined to convert administration of the entire hospital and its 660 current state employees to OSS management. Several key reassurances were offered to current employees to avoid judicial challenges and mitigate labor union unrest before the OSS management contract took effect in October 2004: i) no employee would lose their current employment tie as a state employee; ii) salaries (including the PI) would not be reduced; iii) those who did not wish to remain at the hospital administered as an OSS could receive a transfer to another state facility. One year later, only 268 (41 percent) of those 660 employees remained under the new OSS management.[33]

The experience of Hospital das Clínicas Luzia de Pinho Melo appears to confirm the supposition that many health sector employees prefer the less demanding work rules often found in conventional public administration hospitals, including the opportunity to negotiate their own

[33] Data kindly provided by Dr. Nacime Salomão Mansur, Superintendent of UNIFESP-affiliated Hosptials.

work schedules, thereby facilitating multiple job-holding.[34] Moreover, it suggests that widespread conversions would run up against a daunting political and fiscal obstacle: the need to find posts for all the disgruntled employees seeking a transfer from their newly-converted OSS. For obvious reasons, these problems were sidestepped when OSS hospitals were created from scratch.

How, then, might the positive elements of the OSS model be extended? In late 2005 the *Ambulatorio Maria Zelia*, with 470 employees, was transferred from direct administration to OSS management, suggesting that the performance contract model has not yet reached its limit in São Paulo's public health system. However, if we are correct in assuming that the OSS model cannot fully replace traditional public hospitals, how might human resource management in direct administration hospitals be improved, drawing upon lessons from the OSS experience? The analysis presented here suggests three possibilities: i) improving procedures to discipline/fire, ii) enhancing managers' authority to hire, and iii) a more radical reform to create a new employment regime for healthcare professionals.

In 2002 the *Procuradoria Geral do Estado de São Paulo* promoted the *Via Rapida* ("Rapid Path") as a means to hasten administrative procedures to dismiss non-performing or shoddy public employees. However, the Complementary Law that established the *Via Rápida* retains centralized disciplinary procedures, with a guaranteed right to defense that requires depositions of the relevant persons involved (e.g., managers, co-workers, subordinates). Thus, the practical effect of this policy has been minimal, at best. A true "*via rápida*" will require a re-balancing of the legitimate rights and protections of the employee with the legitimate need of the state to discipline or dismiss those employees who, to the detriment of their fellow citizens, do not adequately fulfill their work-related responsibilities. In that way, non-performing (or "defecting") employees could be fired in a timely manner, rather than simply being transferred.

The second option centers on the authority to hire: granting public hospital managers greater discretion over staff composition and selection. For example, by allowing hospital directors to interview the top 3-5 people who sit atop the list of *concursados*, the merit principle would be protected while simultaneously enabling the director to shape the culture of the organization to generate greater collective commitment to the goals of the hospital. As we have seen from the field research for this study, generating cooperation does not require a pay-for-performance system. However, it does require managerial skill. Some managers can generate commitment and cooperation even under existing employment rules (e.g., the director of Vila Penteado). But heroic, highly-talented managers are scarce. Adapting discretionary features of staff composition, personnel selection and dismissal in the OSS model to direct administration hospitals should, in the hands of well-intentioned managers, generate improved hospital performance.

While either of the first two options would be fraught with political and legal challenges, a third option is to craft for the state's health sector employees an entirely new employment regime – at least for all new hires – that has more in common with the present-day CLT regime. We recognize that the constitutional mandate of a Single Juridical Regime for public employees in Brazil is a powerful obstacle to such a change. However, we believe, as well, that the case for reform is compelling.

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[34] According to the data provided by Dr.Nacime Salomão Mansur, the demand that employees fulfill their formal hourly schedules -- even as they received higher pay -- was the reason given by 102 doctors and 67 nurses/nurse assistants who chose to leave Hospital das Clínicas Luzia de Pinho Melo once it was converted to an OSS. Altogether, 121 doctors and 186 nurses/nurse assistants left the hospital for other public sector posts.

APPENDIX A. Hospitals in São Paulo Research Sample†

The study sample includes seven traditional state hospitals, seven OSS, four private hospitals, and two public hospitals supported by foundations. At each of the hospitals visited, small focus group interviews were conducted with doctors and nurses – outside the presence of their managers – to gather their observations about the hospitals where they work, and explore the reasons for their employment choices. The questionnaire and core focus group questions are presented in Appendix B.

Hospital Characteristics	Type		No.
Legal Status	Direct administration		07
	Public (with Foundation)		02
	OSS		07
	Private		04
Type of Services	Secondary/tertiary		18
	Tertiary		01
	"Quaternário"		01
Size (by no. of beds)	Small	< 100	02
	Medium	101 – 200	06
	Large	201 – 400	11
	Extra-large	> 400	01
Year of inauguration	Public (with Foundation)	1888–1980	02
	Direct administration	1948–1998	07
	Private	1965–2004	04
	OSS	1998–2003	07

Source: Research questionnaire – "Características dos Hospitais."

† Note: In addition to these 20 hospitals where a uniform instrument was applied, valuable information was also obtained during preliminary visits and interviews at the following hospitals:

- Brigadeiro (direct administration)
- Vila Penteado (direct administration)
- Mario Covas (OSS)
- Carapicuiba (OSS)
- Sumaré (foundation/university)

APPENDIX B. Research Questionnaires Applied in São Paulo Hospitals

I – DADOS DA INSTITUIÇÃO

Nome: ____
Endereço: ____________________________________ CEP: ____________
FAX: ______________________ e-mail __________________________

Natureza jurídica da Instituição:
Público ( ) Privado ( )

Característica da Instituição:
Administração Direta ( )
Autarquía ( )
Fundação ( )
OSS ( )
Outras ( ) Quais? ____________________________

Data de início das atividades _____/______/_______

Nome do Diretor Geral
Formação / Perfil

- Possui Curso de Administração Hospitalar ou Equivalente?
- Há quanto tempo exerce o cargo de diretor?
- Como foi feita a sua indicação para diretor?
- Existe algum instrumento ou mecanismo que avalie seu desempenho no hospital? Qual?

- Você considera 2004 um ano de exito para o Hospital? Por quê?
- Quais foram as principais metas adotadas? E como foram selecionadas?
- E para 2005 quais as metas que você pretende atingir?

II – PERFIL DO HOSPITAL

Porte do hospital em relação ao nº de leitos instalados:
Pequeno até 49 leitos ( )
Médio 50 – 149 leitos ( )
Grande 150 – 500 leitos ( )
Extra-grande, acima de 500 leitos ( )

Complexidade do Hospital no Sistema de Saúde __________________

Tipo do Hospital:
Geral ( )
Especialidades ( ) Quais? ____________________________
Taxa de ocupação (%):
Taxa de permanencia (%):
Número de Leitos Operacionais:
Número de Leitos por Especialidade:
Número de funcionários por leito:
Dados da Produção do Hospital (Exercício 2004):

Número de consultas ambulatoriais:
Número de consultas emergenciais:
Número de Exames (SADT):
Número de Internações:
Número de Cirurgias:

III – INFORMAÇÃO ACESSO E CONTROLE

- Existe um banco de dados no hospital com informações sobre pessoal?
- Quem administra esse banco de dados?
- Com que frequência é atualizado?
- Como é feita a coleta de informações?
- Que tipo de informações consta desse banco de dados?
- De que forma a Direção do Hospital se utiliza desses dados e que decisões são tomadas em relação aos mesmos?

IV – CONTROLE DE PAGAMENTO

- Qual a fonte de recursos para o pagamento de pessoal?
- Há diversas fontes de recursos para o pagamento de pessoal?
- Alguma vez houve dificuldades financeiras para pagar o pessoal? E que medidas foram tomadas?
- Quando há cortes orçamentários o diretor tem autoridade para decidir onde cortar?
- Há alguma espécie de orçamento participativo?

V – POLÍTICA DE RECURSOS HUMANOS

- Existe a área de recursos humanos:
  SIM ( ) NÃO ( )

[Anexar o organograma]

- Quais as formas de contratação de pessoal?
  - Estatutário ( )
  - Emergência (733,3131) ( )
  - Temporário (Lei 500) ( )
  - CLT ( )
  - Cooperativa ( )
  - Terceirização ( ) em que área: _________________
  - Prestação de services ( )
- Quais serviços são contratados pelo hospital?
  - Limpeza ( )
  - Segurança ( )
  - Alimentação ( )
  - Lavanderia ( )
  - Outros ( )
- A contratação para um ou mais serviços acima descritos é recente (nos últimos 3 anos)?
  SIM ( ) NÂO ( )

Taxa de absentismo (%)

Taxa de rotatividade (%)
Números de Ações Trabalhista (Exercício de 2004):
Tipos de Ações Trabalhista:

- Qual a contribuição dos serviços abaixo relacionados para o bom desempenho do hospital, pontue de um a dez:
  - Recursos Humanos ( )
  - Recursos Materiais ( )
  - Recursos Financieros ( )
- Existem atividades ou ações que ajudem a fortalecer o compromisso dos funcionários com as metas do hospital?
- Quais os principais obstáculos com relação ao Recursos Humanos e que procedimento você adota para removê-los?

VI – RECRUTAMENTO E SELEÇÃO

- Quais as formas de recrutamento utilizadas pela Instituição?
  Recrutamento interno ( )
  Recrutamento externo:
  - Jornais ( )
  - Diário Oficial ( )
  - Outros ( ) Quais?

- Quais as formas de seleção de pessoal utilizadas pela Instituição?
  - Concurso público ( )
  - Prova prática ( )
  - Entrevista ( )
    - Dinâmica ( )
    - Teste Psicológico ( )
    - Análise de Currículo ( )
    - Seleção ( )
    - Outros ( ) Quais?

- O processo seletivo é executado pela:
  - Própria instituição ( )
  - Empresa contratada ( )
    - Outras ( ) Quais?
- Qual a duração que existe entre o processo de seleção até o profissional começar a trabalhar?
  - 3 dias ( )
  - 1 semana ( )
  - 1 mês ( )
  - 2 meses ( )
  - 6 meses ( )
  - + 6 meses ( )
  - Outros ( )

- Os resultados sobre a seleção variam muito de acordo com a forma legal de contratação (Estatutário, Emergência (733,3131), Temporário (lei 500), CLT, Cooperativa, Terceirização)?

- Quais são as vantagens e desvantagens destes regimes do ponto de vista do diretor?

VII – CONTRATAÇÃO

- Quem toma decisões sobre a contratação de funcionários?
- O que o hospital faz quando há necessidade de contratar funcionários? A quem se refere:
  - Secretário da Saúde ( )
  - Cooperativas ( )
  - Contratos temporários ( )
  - Outros ( ) Quais?________________________
- Você tem autonomia para contratar um determinado médico que julgue competente?
- Qual a especialidade mais difícil de contratar?
- Recrutamento dessa especialidade é realizado de forma diferente?
- O hospital tem autonomia para demitir funcionários? Qual o procedimento?
- Quais os fatores que levam a demissões de funcionários?
- Há outras maneiras de punir funcionários por mal desempenho?
- Há interferência de sindicatos/cooperativas quando há demissões? Quais são?
- Qual o número de profissionais treinados e capacitados no exercício de 2004? Indicar o número de profissionais treinados e capacitados por categoria e carga horária (Anexo II)

VIII – PLANEJAMENTO DE RECURSOS HUMANOS

- A instituição possui plano, cargos e salários?
  SIM ( ) NÃO ( )
- Realiza pesquisa de mercado para manter o equilíbrio salarial interno?
  SIM ( ) NÃO ( )
- Quais os benefícios praticados pela Instituição (vale refeição, vale transporte, cesta básica, plano de saúde, plano odontológico, bolsa de estudos, outros)?

XIX – AVALIAÇÃO DE DESEMPENHO

- Existe instrumento de avaliação do desempenho do profissional:
  SIM ( ) NÃO ( )
  Em caso positivo, especificar a periodicidade e os critérios de avaliação.
- Existe premiação por produtividade?
  SIM ( ) NÃO ( )
  Em caso positivo, quais os critérios?
  E quais prêmios?
- O resultado da avaliação de desempenho subsidia:
  - Dispensa do profissional ( )
  - Readaptação do profissional ( )
  - Treinamento e capacitação ( )
  - Promoção ( )
  - Revisão dos critérios de seleção ( )
  - Outros ( ) Quais?________________
- Existe plano de carreira na instituição?
  SIM ( ) NÃO ( )

X – CONTROLE / DISCIPLINAS

- Qual o procedimento informal adotado pelo Diretor ao profissional (médico / enfermeiro) pelo não cumprimento da carga horária ou atraso no plantão?
- Qual a atitude / ação do diretor quando o profissional (médico / enfermeiro), se nega a participar ou colaborar para o desenvolvimento das atividades?
- Nos últimos 3 anos houve algum processo decorrente de erro médico e qual a atuação do CREMESP?
- Nos últimos 3 anos houve algum processo decorrente de erro médico e qual a atuação do COREN?
- Quais procedimentos são mais eficazes para disciplinar os funcionários?

XI – CONTROLE DE PAGAMENTO

- Como são definidos os salários dos profissionais do hospital?
- Existe flexibilidade de pagar os profissionais com base em seu desempenho?
- Existe competição e conflito entre os profissionais? Que procedimento é tomado pela direção do Hospital?

XII – CONTROLE EXTERNO

- Existe controle que fiscaliza a execução orçamentária / folha de pagamento / gestão de pessoal / qualidade de serviço? Se sim, como é a relação com a direção do hospital?
- Os funcionários fazem parte do orgão?
- As decisões desses orgãos tem impacto direto na gestão das atividades do hospital?
- Quando os clientes tem queixas com relação aos serviços oferecidos a quem se reportam?
- As queixas feitas são levadas em consideração e que providências são tomadas?
- Há uma ouvidoria no hospital? E a quem esta se reporta para a discussão dos problemas?
- Os problemas em geral são resolvidos de que forma?

Quantificação dos Recursos Humanos [referência dezembro 2004]

CATEGORIAS PROFISSIONAIS	NÚMERO DE PROFISSIONAIS PRÓPRIOS	TERCEIROS	TOTAL
1. Nível Universitário			
Administrador Empresa			
Analista de Sistema			
Ass. Social			
Biologista			
Biomédico			
Bioquímico			
Enfermeiro			
Engenheiro			
Farmacêutico			
Fisioterapeuta			
Médico			
Nutricionista			
Programador			
Psicologo			
Terapeuta Ocupacional			
Outros Nível Universitário (*)			
Sub-Total Nível Universitário			
2. Nível Médio			
Aux. Enfermagem			
Aux. Serviço			
Escriturário			
Secretárias			
Téc. Enfermagem			
Téc. Laboratório			
Téc. Radiologista			
Outros Nível Médio (*)			
Sub-total Nível Médio			
3. Nível Básico			
Manutenção			
Motorista			
Vigia			
Outros Nível Básico (*)			
Sub-Total Nível Básico			
TOTAL			

0BS: Acrescente linhas, se necessário

TREINAMENTO E DESENVOLVIMENTO
(EXERCÍCIO DE 2004)

NÍVEL UNIVERSITÁRIO

Nome do Curso/Treinamento: ________________________________
Carga horária: ____
Número de Profissionais Treinados: ___________________________
Instituição certificadora_______________________________________

NÍVEL MÉDIO

Nome do Curso/Treinamento: ________________________________
Carga horária: ____
Número de profissionais: _________________________________
Instituição certificadora___________________________________

NÍVEL BÁSICO
Nome do Curso/Treinamento: _______________________________
Carga Horária: ____
Número de Profissionais: ___________________________________

OBS: Acrescentar linhas para cada curso/treinamento realizado

APPENDIX C. Focus Group Interviews in São Paulo Hospitals

PESQUISA QUALITATIVA DE GRUPO FOCAL
Pesquisa de grupo focal, com médicos e enfermeiros das instituições hospitalares

Questões:

Existe política de formação e capacitação na instituição onde trabalha?
Dentre as ações de formação e capacitação, você destacaria alguma que valoriza o profissional e que priorize a melhoria da qualidade dos serviços prestados?
Quem coordena as ações de formação e capacitação na instituição?
Destaque as ações de formação e capacitação voltadas a informação e orientação para a população quanto aos serviços ofertados?
Quais as instituições formadoras parceiras do processo de capacitação de sua instituição?
Existe investimento para o desenvolvimento de pesquisa e ensino?
Quando existe treinamento / formação a solicitação é feita por parte dos profissionais ou é uma imposição da Diretoria?
Existe uma determinada frequência para realização desses treinamentos?
Como você identifica o cumprimento da legislação de pessoal em sua instituição?
Como são realizadas as contratações de pessoal e quais os critérios de seleção?
Como são realizadas as demissões na sua instituição?
Como se dá o cumprimento da carga horária dos profissionais que trabalham na sua instituição?
Quais as medidas disciplinares adotadas por sua instituição? Quais as medidas para estimular a cooperação com as metas do hospital?
A instituição adota mecanismo de incentivo a produtividade/bom desempenho?
Caso positivo, quais os critérios de mensuração?
Quais os mecanismos de promoção e evolução funcional usualmente adotado por sua instituição?
Existe Plano de Carreira na sua Instituição?
Há possibilidade de ascensão profissional para você nesta instituição?
Quantos vínculos empregatícios você tem. Quais são?
Qual a vantagem e desvantagem em trabalhar no setor Público?
Qual a vantagem e desvantagem em trabalhar numa OSS? E num hospital de administração direta?
Qual a vantagem de trabalhar no setor Privado?
Quais os fatores que motivam o profissional médico para que tenham multiplos empregos (classifique de 1 a 10 de acordo com suas prioridades)

- aprendizado/manter-se atualizado na sua especialidade	( )
- salário	( )
- estabilidade	( )
- prestígio institucional	( )
- ligações acadêmicas (residência, mestrado, professor)	( )
- outros	( )
Total	(10)

Quais os fatores que motivam seu emprego no OSS?
(classifique de 1 a 10 de acordo com suas prioridades)

- aprendizado/manter-se atualizado na sua especialidade ( )
- salário ( )
- estabilidade ( )
- flexibilidade de horário ( )
- ambiente/organização/ordem superior ( )
- prestígio institucional ( )
- perspectiva de ascensão profissional na instituição ( )
- ligações acadêmicas (residência, mestrado, professor) ( )
- outros ( )

Total (10)

Hospital de administração direta?
(classifique de 1 a 10 de acordo com suas prioridades)

- aprendizado/manter-se atualizado na sua especialidade ( )
- salário ( )
- estabilidade ( )
- flexibilidade de horário ( )
- ambiente/organização/ordem superior ( )
- prestígio institucional ( )
- perspectiva de ascensão profissional na instituição ( )
- ligações acadêmicas (residência, mestrado, professor) ( )
- outros ( )

Total (10)

Hospital privado?
(classifique de 1 a 10 de acordo com suas prioridades)

- aprendizado/manter-se atualizado na sua especialidade ( )
- salário ( )
- estabilidade ( )
- flexibilidade de horário ( )
- ambiente/organização/ordem superior ( )
- prestígio institucional ( )
- perspectiva de ascensão profissional na instituição ( )
- ligações acadêmicas (residência, mestrado, professor) ( )
- outros ( )

Total (10)

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