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Internal management contracts within the context of the Humanization Policy: experimenting with methodology within the reference frame of co-management

Contratos internos de gestão no contexto da Política de Humanização: experimentando uma metodologia no referencial da cogestão

Contratos internos de gestión en el contexto de la Política de Humanización: experimentando una metodología en el referencial de la cogestión

Serafim Barbosa Santos Filho[I]; Vera de Oliveira Nunes Figueiredo[II]

[I]Ministério da Saúde, Política Nacional de Humanização (MS/PNH). Rua Gonçalves Dias, 60/901. Belo Horizonte, MG, Brasil 30.140-061. <serafimsantos@terra.com.br>
[II]MS/PNH

ABSTRACT

This paper describes the experience of implementing internal management contracts in a public hospital. These contracts are understood as tools within the context of co-management and, within the perspective of humanization, as interventions in healthcare and management practices. With this focus, the methodological lines of the collective construction of such contracts and the indicators for the implementation process are presented. Through the process of agreed targets and participative evaluation, the following results were observed: in addition to increasing the institutional efficiency and effectiveness, the effects unleashed through these tools revealed their

potential for transforming the work relationships, promoting co-responsibility between subjects and teams, adding value to workers and forming commitment networks for improved care.

Keywords: Management contract. Humanization of care. Planning. Health management.

RESUMO

Neste artigo descreve-se a experiência de implementação de contratos internos de gestão em um hospital público. Os contratos são compreendidos como dispositivos no contexto da cogestão e na perspectiva da humanização como intervenção nas práticas de atenção e gestão em saúde. Nesse enfoque, apresentam-se os eixos metodológicos de sua construção coletiva e os indicadores do processo de implementação. Com o processo de pactuação de metas e avaliação participativa, observam-se os seguintes resultados: além de aumentar a eficiência e eficácia institucional, os efeitos desencadeados com esses dispositivos revelam seu potencial de transformação das relações de trabalho, promoção de corresponsabilização entre os sujeitos/equipes, valorização dos trabalhadores e formação de redes de compromisso para melhoria da atenção.

Palavras-chave: Contrato de gestão. Humanização da assistência. Planejamento. Gestão em saúde.

RESUMEN

En este artículo se describe la experiencia de implementación de contratos internos de gestión en un hospital público. Los contratos se entienden como dispositivos en el contexto de cogestión y en la perspectiva de Humanización como intervención en las prácticas de atención y gestión en salud. En este enfoque se presentan los ejes metodológicos de su construcción colectiva y los indicadores del proceso de implementación. Con el proceso de pactación de metas y evaluación participativa, se observan los siguientes resultados: además de aumentar eficiencia y eficacia institucional, los efectos desencadenados con tales dispositivos revelan su potencial de transformación de las relaciones de trabajo, promoción de co-responsabilización entre los sujetos/equipos, evaluación de los trabajadores y formación de redes de compromiso para mejoría de la atención.

Palabras clave: Contrato de gestión. Humanización de la asistencia. Planeamiento. Gestión en salud.

INTRODUCTION

The National Humanization Policy/NHP (Política Nacional de Humanização/PNH) articulates a set of frameworks and instruments for triggering processes.

In the theoretical-political milestone of the NHP (Brasil, 2008; Benevides, Passos, 2005), principle is understood as what gives support to and triggers a certain movement in the perspective of public policy. There are three basic principles: the transversality principle, indicating new standards of relationship and communication between subjects and services and seeking the change of the knowledge borders and of the power territories; the undissociability principle, indicating the undissociability between care and management and affirming that there is an inseparable relation between ways of caring and ways of work management and appropriation; and the assertion of the protagonism and the autonomy of subjects and collectives, implying attitudes of co-responsibility in the management and caring processes. Guidelines are understood as general orientation of policies, capable of directing changes in the scope of care and management in the following sense: co-management, extended clinic and patient reception; work and health workers' valorization; defense of the user's rights and of the fomentation to collectives and networks. On the other hand, tools are understood as the translation of guidelines into work processes arrangements which are in operation in order to either stimulate or boost attention and management practices. There are several tools incorporated by the NHP. This paper highlights two of them: the tools of collegiate management (collegiate managers) and the tools of contractualization (management contracts) because of their direct relations with the co-management guideline, approach of this paper.

The discussion presented here takes as a reference the debate that Campos has been making on the management practices of the healthcare sector (Campos, 2006, 2003, 2000). The conception of co-management presumes the expansion of collective and public spaces, making feasible the exercise of the dialogue and of the consensus on differences. It is a model that includes the different individuals in the analysis and decision-making processes. One of the co-management hallmarks is the perspective of shared construction of knowledge (and interventions), considering the subjectivities and singularities of subjects and collectives (Brasil, 2008; Campos, 2006, 2003, 2000). The collegiate managers and the equivalent collective spaces are tools which incorporate that conception as an strategy for extending and transversing a 'participatory' and 'co-managed' way of operating services and teams. The collegiates are conceived as spaces/instances that bring together

workers and management representatives used to conceive and to evaluate proposals made by several actors (workers, managers and users), deciding on directive and operational plans and ensuring the sharing of power of different members, the co-analysis, the co-decision and the co-evaluation of proposals, targets, indicators and specific aspects of the articulation of the local process of work.

Those guidelines and instances merge into a perspective that NHP nominates the way to 'triple inclusion' in the health production process: inclusion of different subjects (managers, workers, users); inclusion of the collectives (whether the workers in their group organization or the organized social movement); and inclusion of the social analyzers, here understood as everything that can trigger analysis of what/on what is established, provoking other forms of being and doing health care (Barros, 2007).

The proposal of Internal Management Contracts/IMC (Contratos Internos de Gestão/CIG) is enclosed in that context. Contracts as negotiation and agreement between parties, as tools of dialogue and engagement of commitments and responsibilities (the bias of co-responsibility) on objectives and targets in tune with the needs of the parties negotiating/agreeing. It is especially considered with regard to its potential to foster interactions, to place subjects/teams in dialogue to build changes, generating new relationship and communication standards within the health care organizations/health services.

Campos (2006, p.59) reiterates the concept of social contract in its sociological sense, which says "establishing new relationships that alter rules, laws and behaviors according to a well set out agreement." He considers that, according to that perspective, the contract means or points to building commitment between subjects, a situation that is realized from "displacements" of position and of new compositions within institutions and organizations. That conception hinges on the theory/method that the author proposes to co-management of collectives, comprising as coproduction of situations, subjects and organizations (Campos, 2006, 2000).

This paper describes the experience of implementing an internal management contract in a public hospital, seeking to enhance its potential for mobilizing the subjects in their workplaces/workrelations, giving rise to a routine exercise of sharing in the form of what is proposed as co-management. When analyzing that experience, the main objective is to stand out its *process*, highlighting the methodological lines (of conduction) put

into practice to ensure coherence with the desired pedagogical-participatory perspective regarding the contracts.

The service/hospital and the context of implementing the management contract

The Hospital Odilon Behrens (HOB/BH) is integrated to the municipal network of the Unified Health System (Sistema Único de Saúde - SUS) of Belo Horizonte, being a reference to other regions of Minas Gerais State as well. The 63-year old hospital is both a general and an emergency hospital. It has about four hundred beds, offering 35 medical specialties and attending around five hundred patients a day in clinic, traumatologic and dentistry emergencies.

Amid the advancements in the quality of services offered, the Hospital has taken important initiatives towards improving its care and management model. In that sense, systematic actions were taken by the group that took over management in 2003[1], emerging with the challenge of reorganizing its structure and dynamics, creating a collective availability (of management, interest, and will) for carrying out institutional changes (availability deemed essential for the success of interventions).

As development of a Seminar held in 2003, several workshops and other seminars were organized for broadening discussions and for guiding action fronts in different scopes, all of them towards 'ex[1]periencing co-management', that is, making several institutional movements converge on an exercise enhancing co-management as an expected process and result (by introducing a different management model). Thus, the following was made: administrative reforms, restructuration of physical facilities and other investments for fitting the work spaces/environments, rebuilding of multiprofessional teams, permanent negotiation tables resumption (tripartite tables of negotiation on labour related issues), reorganization and expansion of ongoing education activities and implementation of collective and collegiate management instances.

In order to help deepening those reforms and building workteams, a Management Development course[2] started in 2005, lasting a year and a half,

[1] Team composed of: Susana M. Moreira Rates (Hospital Superintendent), Miriam M. Souza, Yara C. N. Barbosa, Andréia A. Torres e Maria Helena dos Santos (Board members) – Group responsible for articulating and fostering the entire local management renewal process, incorporating support, conducting and sharing the implementation of actions, building together day by day the strategies of facing different problems that were emerging in the own process.

[2] Course conducted by Gastão Wagner de Sousa Campos.

with subsequent occasional updating. That institutional agenda was permeated by the discussion of a management participatory model.

From that period it has been consolidated the implementation of a set of tools straightly related to the National Humanization Policy/NHP, covering the diverse spheres of management/care. Important tools for reorganizing the work process, as the 'Patient Reception with Ratings' (organization of the process and teams for the attendance protocol based on the users' clinical priorities), were being articulated to other innovations, such as the 'open visit' (hospital reorganization for extending the visiting hours to the inpatients) and several projects in tune with the co-management guidelines, besides all the investment in the perspective of 'ambience' (new architectural design of the physical facilities for providing more comfort and interaction of users and workers).

This paper aims to illustrate how the internal management contracts were constituted as a tool guiding all those movements. They will be addressed in their *methodology of implementation* and in what is proposed as a perspective of *evaluative monitoring*, an area (of evaluation) that has also been subject of discussions/methodological adjustments in the frame of NHP (Santos-Filho, 2008, 2007a, 2007b; Brasil, 2006). With that analytic approach, the objective is to contribute by highlighting some *'ways of doing'* that can function as *'indicators-analyzers'* of the implementation/monitoring process, thus helping strengthening those instruments as 'catalysts tools' of many other ones as well as helping in the sustainability of those initiatives.

Co-management guideline and the embryo of the management contract at HOB

It is necessary to emphasize that the investments in the organization of collegiate managers can be considered as the embryo of the Internal Management Contracts, spreaded across all sectors of the Hospital, therefore leaving the co-management hallmark as an institutional guideline.

Those collegiates, composed by managers, coordinators and workers of each unit, started to function as systematic moments of discussion on issues of collective interest, proposals, targets, setting priorities and challenges. The proposals built in those spaces were also presented to the Local Board of Health and priorities were defined for the Master Plan of the Hospital (plan for the years 2005 to 2008).

It is thus established an initiative that will be the setting for the introduction of management contracts. It is also determined that the proposed articulation implies a political-methodological direction of analysis towards drawing

attention to the fact that it comprises the implementation (and continuity) of that *contratual logic* necessarily within the co-management guideline.

The bases of internal management contracts in the local reality

The proposal of management contracts was implemented in the context of the collegiate work spaces. And what is defined as contract bases would be: (i) the conception of management exercised in the routine of the Hospital; and (ii) what they (the contracts) can bring as *'components/challenges'*, that is, the potential of being *'indicators/analyzers'* of the entire management. Therefore, the act of evaluating the contracts (and their 'fulfillment of targets') would not be an act (action) connected to them, but rather an act inherent to their experimentation/insertion (Santos-Filho, 2008).

And what was/is the management conception that was validated at the HOB? The one that is referred to as collegiate management, in a political-institutional model to enhance the relationships among workers, users and management aiming at: (i) democratization of work processes; (ii) care qualification for users; and (iii) inclusion of health professionals in the scope of management.

The methodology of implementing internal management contracts: spiral movements

The context previously mentioned opens all the *movements* described afterwards and performed together, but which are separated here only to emphasize certain 'passages'. Analytical categories are built inside them, providing information that can serve to guide new experiences. The idea of movement that is intended to emphasize implies the spiral perspective, coming and going in understanding, planning, carrying out and monitoring the implementation of management contracts.

That is to say that a systematic methodology is also being applied (inside what is proposed as *'evaluative monitoring'*), enabling the recovery of daily tasks as a recording-reflection form of that/on that way of doing.

First movements

The management contracts were offered as a proposal/target within the discussions of the "Management Development Course" held between 2005 and 2006. Since then the implementation of the contracts was treated as a priority by the Hospital Board and broadly discussed and validated by the Extended Collegiate Management/ECM (composed by a representative of each Production Unit, managers, teaching coordinators and board). That process triggered a growing interest of managers, coordinators and workers,

who saw in it the potential to change the work processes in their production units as well as in the whole Hospital. In this manner, the decision of implementing the tool was a collective commitment to make the HOB a referral hospital at the Unified Health System (SUS) in care humanization and health management.

The contract as a means of *agreed guidelines* embodied in the objectives, targets and indicators (linked to the care and management model) was set as *objective and local strategy,* and for that purpose it would be implemented in a decentralized manner and with the participation of everybody, profiting by the existing collegiates. It should make explicit the commitments between the hospital board and the hospital units/teams, pressuposing the involvement, appreciation and quality, reaching managers, workers and users.

Deepening the understanding of contracts was taking place with the continuous resumption of their objectives in the reality and situation of the HOB and thought as involvement of the 'sectorial' collectives (units) in the definition of (quantitative and qualitative) targets, processes and and outcomes indicators and design of action plans based on targets. The process would be formalized by means of a term of commitment.

Second movements

Those movements enhance the launched initiatives and funnel temselves into a more focused methodological perspective. Thus, it is being defined a political-operational work agenda through several meetings distributed throughout the Hospital and aiming to directly or indirectly involve all the workers. One could say that the meetings were organized in two or three types, first as 'preparatory' meetings and then as 'sensitization' meetings, following up with local situational diagnostics.

The diagnosis 'phase' was an extensive process, guided by specific instruments and intensive monitoring by management advisors, including the support of a consultant linked to the National Humanization Policy. The elaboration of the diagnosis, since the moment of drafting specific tools for each production unit (elaboration that took place in the Management Development Course), was already a broad and intense process of involvement of the units collectives, leading to a real opportunity for workers to understand the meaning and reach of those initiatives. Together with the diagnosis should start the discussions on investment priorities, that is, discuss about in what should be 'invested to change in that unit'.

The conclusion of diagnosis, discussions about problems and investment priorities close what is considered here as second movements, around which began a more systematic monitoring by a group that was being built up with that function.

Third movements

The third movements represent returns to the collectives of what had been previously discussed (in the context of diagnoses) and articulate themselves with the definition of priorities to be translated into 'targets', giving rise to action plans with monitoring indicators.

At that point it was important a more focused and formative discussion on the composition methodology of the action plans as well as of meaningful indicators for its monitoring. It was then held a workshop with representatives from the entire Hospital, addressing specific planning and evaluation categories and adjusting them to both the context of the contracts and the of formative evaluation, which is a reference NHP has been working with. Thus, the first 'standardization' of categories to make the contract instruments is constituted, clarifying the extent and the specificities of the triad objectives-targets-indicators.

Movements of making the contract instruments followed, now showing the 'background definitions' (needs, choices and priorities) but also exercising the objective formatting of targets and plans (as the standardizations previously validated).

That work phase was intensively monitored by a team set up for closer monitoring of the work. And that monitoring begins to assume a strategic function of team formation (particularly of the support group) to get familiar with the planning and evaluation categories. The moment becomes interesting by what can be collectively clarified in terms of 'effectively viable changes' taking into account the diverse contextual variables, rather than the formatting issues in themselves. In other words, by trying to translate the 'priorities' into 'concrete targets and indicators', one can notice that several 'intentions' need more 'problematization' and negotiations in order to be implemented and thus to be predicted as 'viable targets' (within the planned time). On the other hand, it is also an important opportunity of settlement (and compatibilization) with regard to what was thought as 'priorities' and in which 'scope of targets and indicators' they 'fit' to truly demonstrate the extent of change.

The process culminated in the drafting of 44 internal management contracts, representing all production units of the Hospital.

A special movement

Concluding the stages of elaboration, it must be emphasized the important movement of articulation with the Local Board of Health in the contracting process. That was the movement that culminated in the formal signature of the 44 contracts (in May 2007, approximately six months after informal conversation started), denominated in terms of commitment, with the presence of all participants who helped elaborating them. That movement was full of meaning in the scope of 'commitments', co-responsibility, until the scope of 'festive', of shared satisfaction with the process. It is relevant to mention this *'movement indicator'*, of *'inclusion indicator'*.

Movements of monitoring the implementation of contracts

For the monitoring of the implementation of contracts (for the year 2007) a Strategic Group of Support for Monitoring the Management Contracts (GEACG) was established in February. The group was composed of management advisers, a representative of the Education and Research Coordination and a representative of the Medical Records and Statistics Service Coordination. The role of the Group was to elaborate the methodology and the instruments for the execution of work.

The Group already began to take an active role in the preparatory phases of the contracts, designing monitoring strategies with managers and board. Its operation was being established according to the own requirements of the process, which demands different types of skills for its conduction. The first steps included/have included the formulation of instruments/matrices along with the direction and they will be offered for adjustments and collective validation insofar each unit works in the contract. It was necessary to define the parameters for distributing incentives/ rewards and a systematic agenda for monitoring as well.

The processes were resumed and updated in that agenda, and strategies for their deployment/continuity were agreed upon. It was conducted a survey per unit of production/board of the already established or in process contracts. Moreover, it was carried out a mapping of the situation and beginning of the discussion with managers, coordinators and directors and developed instruments to facilitate the operationalization/completion of contracts. Understanding that targets and indicators of the overall contract of the Hospital (signed with the Municipal Secretary of Health and the Ministry of Health) are challenges to the entire body of the hospital, they started being integrated to all internal contracts. It was also necessary the completion and refinement of the whole planning 'chain' inserted in the contract, with the discussion of verification sources of targets/indicators,

deadlines and responsibles, besides the detailing of actions to the viability of the targets. Everything was carried out in meetings with representatives of the collectives/units. It is noteworthy that the movement was not only an instrumental one, but rather a movement to the collective *validation* of the entire process – expensive attitude in the perspective of participatory evaluation and fomented by the Hospital management.

Movements of evaluative monitoring and measurement of targets

In order to subsidize measurement, a support agenda for the Contract Monitoring Group (GEAC) was emphasized, helping to define a measurement methodology which was not guided by a simple 'accomplishment review' of targets, but rather a methodology that would bring a pedagogical perspective in its essence. It was proposed that the measurement would be established from a logic of *evaluative-formative monitoring*. That methodology has been applied in NHP, based on the convergence of references of the participatory-formative evaluation with the NHP principles/guidelines (Santos-Filho, 2008; Hartz, Silva, 2005; Silva, 2004; Hartz, 1997). We have built a methodology using a logical-evaluation model, incorporating classical evaluation categories such as 'targets' and 'indicators', but aiming at expanding and resignifying some of their dimensions and attributes (processes and outcomes dimensions; reliability and accuracy attributes etc). Above all, we have explored and expanded its *formative* perspective towards being put into effect/exercised as moments of learning, of redirections, and of course corrections in the process itself. A logic in which the collectives, instead of feeling themselves supervised and punished (as in an external audit) feel themselves included to discuss problems related to targets and their extent and, above all, to repactuate what is deemed relevant and agreed between the parties - this whole process being in itself a learning-by-doing, doing-learning process. Here attention is called not only for the 'contracts implementation,' but for the need to simultaneously 'analyse them', exercising an evaluation **of** and **on** the process, a dimension that is very expensive in *evaluative monitoring* in NHP and that also had the opportunity of experimenting while giving support to that process at HOB.

The monitoring agenda included: (i) evaluative moments with each collective (with a dialogical measurement framework, identifying and explaining the problems and their immediate causes; explanations of objectives, targets and indicators that were not clear in their 'intent' and formulation; adjustments and redefinitions of targets and indicators); (ii) summaries of evaluations and discussions with the Hospital management, emphasizing the critical aspects; (iii) systematized return of evaluations to

the collectives with a 'new measurement' based on what had been agreed upon and redefined; (iv) report writing with situation mappings, joining different understanding focuses (not only as rough results, but aggregate to deeper analysis, justifications etc.). Next, (v) all the systematized material was presented to the collectives, already pointing to pertinent targets for the coming year contracts. At the end of ten months of work/movements, (vi) the entire analysis and evaluation process of the contracts was presented in a moment of 'celebration of results' at a meeting including managers, coordinators, workers, administrators and guests. It was an assessment workshop to analyse the management contracts (its power and prospects for sustainability).

The activity of direct monitoring/targets measurement is proposed to be held every two months.

Indicators of processes and movements

All the effort to address the actions related to humanization policies, always under an evaluative perspective, seeks to evaluate if they have been able to help "changing" the services' routine (processes and work relationships).

What the internal management contracts allowed?

Afterwards, some lines of 'consequences' of the contracting process are synthesized, understanding them as movement 'indicators' and their achievements/results. These lines were marked from the direct monitoring of that process in different 'intervention-observation, participant-support' situations. That monitoring was carried out sometimes with the extended team of the Hospital, other times with a smaller monitoring group, and other times in a dialogue on the forms of support for specific conceptual and methodological problematizations. That is a relevant information to demarcate that the formative evaluation requires a concrete proximity between the actors who experience and the ones who help to explore-analyze the whole situation, therefore neither happening externally nor by an external actor to the process.

As for the results achievement on the basis of predicted targets

The achievement of the planned targets is detailed in other documents. The *results* show the process success in achieving/carrying out what was considered being priority and relevant for the first contract. In this paper, some illustrative data of the 'overall performance' of contracts closely bound to the boards (the 44 production units are linked to five boards) are mentioned and the 'indicatives' of the triggered/changed processes are highlighted.

84% of all contractualised targets between the production units and the Hospital management were achieved, demonstrating the effort of each Production Unit (hospital sector) and their respective boards. Each contract fulfilled (achieved targets) was matched to an incentive (proportional to performance) as a reward.

Some examples of targets illustrate important results be it in the organization of each unit be it in its performance. Some management indicators are emphasized below.

In the Technical Board: therapeutic projects design (attendance care project, considering the uniqueness and the needs of each case) to 100% of critically ill patients of the Medical Clinic; multiprofessional teams formation which are established as a reference for users and increased family support to the therapeutic project of the patient in the Surgical Unit; 5% reduction of average hospital stay (admission), considering the previous period; 50% reduction in the number of pressure ulcers acquired in the wards; optimization of the units occupancy rate from the update (routine and in real time update) of the handling of patients (deaths, transfers, hospital admissions and hospital discharges); reduction of time concerning bed replacement interval for up two hours; communication improvement among all related units; increased dialogue among the committees (Hospital Infection Control, Medical Records Review Commission, Hospital Deaths Commission); and protocols standardization and/or updating in several units and implementation of employee satisfaction questionnaire.

In the Diagnostic and Therapeutic Support Board: reduction of delivery time for laboratory test results; reduction in more than 95% in the use of glutaraldehyde (at the Sterilization Central); development of medication coding with bar codes to implement the computerized system in the pharmacies central storeroom; reduction in the preparation of not used blood components (transfusional agency); elaboration of the parenteral and enteral nutrition manual; implementation of the radiation protection plan; implementation of new routines in the Human Milk Bank, in the Laundry and in other sectors, in addition to the standardization and/or updating of protocols in several units.

In the Urgency and Emergency Board (and Ambulatory Care) the focuses were the changes in the Red Room/Polytrauma Room by directing investments in order to monitor care for different types of cases/demands. It is also worth mentioning the right of patients to receive visits in the Red Room and in the Yellow Room at the Urgency and Emergency Unit. In relation to the Observation Room, it is emphasized the care of the

multiprofessional team regarding the inpatients as well as the systematic way of night shifts, once the leveling is assured during the day period. As for the Ambulatory, a very important target achieved for the municipal Unified Health System (SUS) of Belo Horizonte was the consolidation of the Medical Specialties Center, with the regionalization of the secondary care for 35 specialties (establishing itself as a reference for important areas of the city). Other meaningful results include: implementation of oral health program for patients of the Cerebrovascular Accident Unit; expansion of active search to include patients in the home care program, contributing in the reduction of unnecessary hospitalization; reorganization of flows, work processes, implementation of new routines, systematic way of shifts, improvement of records and conducting surveys of user satisfaction.

In the Administrative Board, the management contract provided more speed in the release of processes for purchasing and interface improvement with the units in general. That currently represents an important change for ensuring material without shortages, having in mind the large consumption derived from the expansion of the health care complexity degree of the Hospital. Additionally, there are also significant improvements in the fulfilment of purchases regarding acquisitions prior to the contracts.

In the Work, Education and Research Administrative Board, it deserves to be highlighted the approval and actions to implement the Multiprofessional Residency Project and the evaluation of internships with the training institutions with operations in the hospital. The Unit responsible for those actions achieved 100% of its targets. It is also worth noticing the strong movement of the entire team of the People Management Unit to achieve important targets such as the regularization of more than 80% of the staff, turning into effective workers the candidates approved in the public examination, and the implementation of a new personnel management system (payroll and frequency). It must be added the satisfaction survey with the internal users of SAME, which represents an important target in improving work flows and work relationships among the sectors.

It is necessary to reaffirm the importance not only of the achievement of those targets in the strict sense, but also of what was put in motion/of what was changed throughout the hospital, reminding that everything involved from the technical and health care areas up to the most commonly peripheral sectors, as the legal and administrative areas.

The following topics focus some of the indicators of the processes that supported and reflected a general expansion of the intra-institutional dialogue.

Regarding the capacity of mobilization, of network heating and of co-management learning

The contracting process generated movement within the Hospital, causing displacements of different natures: displacements of physical facilities, of workflows and affectives establishments, reflecting an attitude of constructive solidarity (it was evident the movement of sectors helping each other in order to face difficulties and to achieve targets). There was an increase of people inclusion (a larger number and different actors) to take part in pacts, looking for the allies increase to carry forward the work plans/targets. A *resource* and a *consequence* of all that were the communication establishment or improvement and the integration between subjects/production units based on the needs, including interface needs to achieve/fulfill common targets.

We consider that those are indicative situations of the co-management strengthening by observing their repercussion in different contexts: in attitudes that express a different way of clinical management (sharing of knowledge and behavior among professionals, advancing towards a stronger integration to direct approaches to users); and in attitudes related to the work processes reorganization (re-articulation of actions, practices and arrangements, with the agreed incorporation of protocols guiding the practice) which are permeated by attempting a different way of managing the production units/sectors (a different way that 'involves' subjects, aiming at inducing their participation which values listening, welcomes suggestions and operates with sharing and joint deliberations).

There are multiple situations that illustrate that ability to set up a process of co-management and co-managed networks at the Hospital. Some interrelated examples are mentioned here as they are seen as the real chance of consolidating that way of working. The pediatric area emphasizes an outstanding difference between its first contract (in 2007) and the following one (in 2008) - the latter already being elaborated to include all areas related to the infant, broadening its scope of processes, sectors, services, subjects, focuses, flows etc., carrying out all the necessary changes to achieve the care line for child care, a fact that was generated by the movement of the first contract. Another example to be mentioned was the contract of the laboratory/diagnostic support, which extrapolated internal targets and moved towards seeking the 'network satisfaction', that is, looking for the mutual satisfaction of workers and client sectors.

Regarding the ability to give rise to situations-analyzers

The process was giving rise to problems, therefore gaining visibility not only the 'innovation' initiatives in management, but also the 'inconveniences' felt and expressed by means of 'difficulties in understanding', tensions arising out of the need of problematizations, dealing with different opinions and interests and with competing projects, situations that in many times led to attitudes of 'resistance' and of 'retreat', but also attitudes of being alert to strategies for avoiding demobilization. We emphasize that the main 'strategy' was the one of *including* the problems, dealing with them as collective 'topics of agenda'. Thus, aiming at understanding the situations-problems as *analyzers* (Barros, 2007), they started showing the lacks and the potentialities of the process – lacks that showed annoyance of various orders and potentialities in the sense of valuing indications of people's availability for dealing collectively with situations. These observations attest the challenges that come with the *institutional choices/ institutional decisions*, the concrete challenges to operate the democratization of work processes, the 'choices' that bring many consequences and require constant vigilance in setting directions.

As for people's satisfaction

Perception of increased satisfaction of all involved -- managers, coordinators, workers and Hospital Board -- manifested in a more collective way in several meetings. That satisfaction was expressed both in relation to what had been achieved and to the way of working, getting involved, managing. In the following topic it is presented an illustrative satisfaction indicator of that situation.

Regarding learning in the way of evaluating, measuring and perceiving the own work

It is noteworthy that scope of repercussion considering the learning that occurred in the way to evaluate, enabling to materialize (in an instrumental practice) the discourse/guidelines of co-management and of formative evaluation. In other words, it was in the day by day evaluative monitoring that the 'group responsible for measurement' was learning the following: not to have a prescriptive and supervisory approach; have more security/autonomy for 'having an appraising look without having to exclude anything'; learn how to engage the colleague as a partner, rather than as 'someone who has to reach a target/pay a debt'; learn how to analyse the very concept of targets – their understanding and formulation within a specific objective, their ability to reflect intentions, their constraints, parameters and sources of verification, their possibility for prediction rather

than their hardness of looking for a result at any cost' or for guiding the measurent/outcome to obtain an absolute value.

It is also very important to highlight that the attitude of the 'evaluator' changes to one of 'help', of giving support, in order to both helping to reformulate the contract and helping the collectives to make actions and targets feasible, assignment that was once considered as 'unthinkable', 'inappropriate', according to the discourse of some members of the group.

Thus, the contracts were experienced operating with a (successful) logic of successive adjustments, linked to the *evaluative monitoring* (Santos-Filho, 2008). It is a matter of methodological logic that, having as a reference the formative evaluation, allows making adjustments whenever necessary to match (or get closer to matching as much as possible) the *planning* of actions, targets, of the *real needs* indicators of processes and of subjects in their environment.

From the perspective of the evaluative monitoring, the contract is reframed as a *locus/agreement space* with regard to what *makes sense* in the context of each collective.

In a moment of extended evaluation, we mentioned two situations indicating the richness of the movement. In one of them, we called attention to the fact that a great deal of targets/results of those contracts could have been dealt with by means of a harder and linear perspective of 'certification' or of 'quality control' (within a prescriptive and externally controlled perspective). However, they were being treated in a co-constructive way, therefore being the challenge and the innovative character of the contracts. Hence, it is not only the definition of 'good' targets (pertinent targets), but the process of defining, enabling and measuring them as well. The other situation was related to the perception of people's satisfaction with both what they had carried out and achieved and with the reflection they were doing collectively about it and with the readiness for organizing the next contract. We are talking about a 'coefficient of passion' that was being expressed in that work mode, with that type of insertion. And by means of that alive *'information-indicator'* of satisfaction, we associate to what we understand on the field of Workers' Health as a need to understand that the workers' motivation neither takes place nor can be 'demanded' in an abstract way, but rather that motivation is something that emerges **with** the work, **from within** a (special, unique, collective) way to perform the work, to make it come true.

The internal management contracts function, therefore, as a tool that strengthens the shared management, producing other ways to advance the

accomplishment of proposals for the organization of hospital care and of the work process of producing health and subjectivity.

Levels of challenges

It is proposed to address the challenges also as axis of analysis of the entire process and that bring 'indicatives' of what can/needs to be changed, including to help the sustainability of the open fronts.

Being essential tools for strengthening the co-management model, the contracts (i) should be better tailored as *tools-means* to increase integration and inter-relationship among the production units in order to achieve related targets; (ii) should also be a *means* to provoke increased workers' participation (in the case of some production units); and (iii) should consolidate the collegiate of the units as the legitimate instances to validate and collectively operate the process.

From the most instrumental point of view, in the new contracts one should take care of the refinement of its directive-organizer line - the tripod objectives-targets-indicators by: (i) reviewing the 'quality of the objectives' so as to give them more precision and guiding, linking them to the overall objectives in a more consistent and targeted way; (ii) improving the evaluation criteria and the criteria of dealing with the categorizations, mixing parameters not to be bound to 'measures/absolute coefficients'; (iii) improving, on the other hand, specific measurement criteria, especially regarding the indicators that depend on each other sectors. Moreover, one should permeate the entire evaluation scheme with simplified but significant techniques of careful consideration and of 'correction factors'.

It is important to anticipate and to agree upon a 'contracting agenda' inside the *evaluative monitoring* that can be a reference as regards the definition of timelines and responsibles for 'pulling' the different movements, steps, systematizations etc.

In the context and in the track of this whole process, the challenge that presents itself as the most necessary for an 'institutional agenda' seems to be that of strategies to increase the degree of agreement with the workers' network to carry forward the principle and the concrete co-management instruments.

COLLABORATORS

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REFERENCES

BARROS, R.B. **Grupo**: a afirmação de um simulacro. Porto Alegre: Sulina/Ed. UFRGS, 2007.

BENEVIDES, R.; PASSOS, E. A humanização como dimensão pública das políticas de saúde. **Cienc. Saude Colet.**, v.10, n.3, p.561-71, 2005.

BRASIL. Ministério da Saúde. **Humanizasus**: documento base para gestores e trabalhadores do SUS. Brasília: Ministério da Saúde, 2008.

BRASIL. Ministério da Saúde. **Monitoramento e Avaliação na Política Nacional de Humanização na rede de Atenção e Gestão do SUS**: manual com eixos avaliativos e indicadores de referência. Brasília: Ministério da Saúde, 2006.

CAMPOS, G.W.S. Clínica e saúde coletiva compartilhadas: teoria Paidéia e reformulação ampliada do trabalho em saúde. In: CAMPOS, G.W.S. et al. (Orgs.). **Tratado de Saúde Coletiva**. São Paulo: Hucitec/ Fiocruz, 2006. p.53-92.

_____. **Saúde Paidéia**. São Paulo: Hucitec, 2003.

_____. **Um método para análise e co-gestão de coletivos**. São Paulo: Hucitec, 2000.

HARTZ, Z.M.A. **Avaliação em saúde**: dos modelos conceituais à prática na análise da implantação de programas. Rio de Janeiro: Fiocruz, 1997.

HARTZ, Z.M.A.; SILVA, L.M.V. **Avaliação em saúde**: dos modelos teóricos à prática na avaliação de programas e sistemas de saúde. Rio de Janeiro: Fiocruz, 2005.

SANTOS-FILHO, S.B. **Avaliação como dispositivo de humanização da atenção e gestão em saúde**. Relatório de consultoria. Brasília: Ministério da Saúde, 2008.

_____. Perspectivas da avaliação na Política Nacional de Humanização: aspectos conceituais e metodológicos. **Cienc. Saude Colet.**, v.12, n.4, p.999-1010, 2007a.

_____. Indicadores de valorização do trabalho e trabalhadores da saúde: construindo o conceito de valorização a partir de uma perspectiva analítica. In: SANTOS-FILHO, S.B.; BARROS, M.E.B (Orgs.). **Trabalhador da saúde**: muito prazer! Protagonismo dos trabalhadores na gestão do trabalho em saúde. Ijuí: Ed. Unijuí, 2007b. p.143-71.

SILVA, J.F. **Avaliação na perspectiva formativa-reguladora:** pressupostos teóricos e práticos. Porto Alegre: Mediação, 2004.

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