Journal of Business Research xxx (2016) xxx–xxx

Contents lists available at ScienceDirect

Journal of Business Research

Tomás Romero Hospital

John C. Ickis [a,*], María José Gutiérrez [b]

[a] INCAE Business School, Alajuela, Costa Rica
[b] INCAE Business School, Alajuela, Costa Rica

ARTICLE INFO

Article history:
Received 1 September 2015
Received in revised form 1 December 2015
Accepted 1 January 2016
Available online xxxx

Keywords:
Costa Rica
Hospital management
Integrated practice units
Organizational change

ABSTRACT

This teaching case presents a decision to implement a "strategy of value creation," based on multi-disciplinary teams organized by acute health conditions, in a hospital organized by areas of specialization, in functional units. The case describes how a new management team of "Hospital Romero" has achieved several organizational changes, including greater and more productive communication between new and veteran staff, improved relations with the labor union, and support from community groups. However, the team encounters strong resistance to the implementation of an IPU (integrated practice unit), which is a multi-disciplinary team to provide integral attention throughout the treatment cycle related to the diabetic foot. The case puts the reader in the position of Dr. Juan Contreras, the Medical Subdirector of the Hospital, who must evaluate alternatives to overcome this resistance. This case is based upon semi-structured, in-depth interviews with hospital staff, participant observation, and the analysis of hospital reports and statistics. The names of some individuals and places have been changed at the request of the Hospital administration.

1. Introduction

In October 2015 Dr. Juan Contreras, Medical Subdirector of the "Tomás Romero" Hospital (TRH), was reflecting on the achievements of the past few months and considering the next steps to be taken in his quest to transform the TRH into "the best hospital in Latin America." Dr. Contreras, a surgeon from the University of Costa Rica, had begun his career in private practice. Later, he gained experience at the major public hospital in Costa Rica, part of the social security system, in the capital city of San José. This experience, during which he identified opportunities for improved administration, motivated him to enroll in the Executive MBA at INCAE, a well-known Central American business school. His first administrative position was in the small city of Grecia, in the northern central part of the country, under the leadership of Dr. Sebastián Zúñiga, who would later become his superior at the TRH.

When an opportunity arose to participate in an executive program at Harvard University with Michael Porter, based on the book *Reinventing Health Care* (Porter & Teisberg, 2006) Dr. Contreras accepted immediately. Impressed by Porter's "value creation strategy", he sought to implement a central part of that strategy, the integrated practice unit (IPU). (After consulting with colleagues, he believed that patients suffering from diabetes, and specifically from the diabetic foot (which often required amputation), could benefit from the IPU, an innovation in which multi-disciplinary teams were responsible for the entire cycle of treatment. He was aware, however, that there could be resistance to this change in a hospital organized by areas of specialization.

2. The situation at TRH, April 2014

Until 2010, the Costa Rican social security system provided health services in Valencia, a major city, in a hospital of just under 1000 staff members (including medics, nurses, health technicians and support personnel), housed in a small building. Notwithstanding the physical space limitations, hospital personnel enjoyed a spirit of camaraderie, as many were from the same generation, born in the 1940s in that same building and having been school classmates.

As the city grew, the government built a new hospital to fulfill the needs of a greater population (see selected demographic data for Costa Rica, Fig. 1). Construction began in December 2006 and the new hospital opened in May 2010, at a cost of US$95 million. During nearly four years of construction, community members and hospital staff watched the progress of the new building with excitement and admiration. The new installations included six buildings with a total space of 37,000 m^2 and a capacity of 238 beds. Between 2011 and 2014, the hospital staff grew to almost 3000 people. The TRH went on to become the hospital with one of the largest budgets in the entire social security system. The new staff was much younger, highly specialized and mostly from the capital city of San José and its surroundings.

The planners created a number of job openings in the new hospital that was based on an optimal operations model, but a financial crisis in the social security system forced a reduction in the number of new positions available in the higher-paid categories. This crisis, combined with an oversupply of professionals at the national level, resulted in

* Corresponding author.
E-mail addresses: john.ickis@incae.edu (J.C. Ickis), mjgutierrezm@gmail.com (M.J. Gutiérrez).

http://dx.doi.org/10.1016/j.jbusres.2016.01.044
0148-2963/

Costa Rica: Selected Demographic Data

(In thousands of inhabitants)

Year		1990	2000	2010	2013	2014	2015	2018
Total Population		3,029.336	3,872.343	4,533.894	4,713.164	4,773.119	4,832.227	5,003.393
% urban*		50%	59%	72%	75%	76%	N/A	N/A
% seniors total population	> 60 years	N/A	7.6%	8.3%	10.3%	10.7%	11.1%	12.4%
	> 70 years	N/A	3.5%	3.8%	4.6%	4.7%	4.8%	5.2%
Population, City of San José		N/A	1,367.088	1,513.924	1,561.141	1,576.884	1,592.521	1,635.144
Population, City of Valencia		N/A	360.772	453.946	475.838	483.154	490.426	512.172
Population, City of Aragón		N/A	728.057	888.928	932.208	946.607	960.748	1,002.917
Population, City of Castilla		N/A	439.645	497.544	512.023	516.831	521.504	533.795

Source: National Statistics and Census Institute (INEC): Total population by calendar year (1990), Total estimated population (2000 – 2010) and Total projected population (2013-2018) on June 30, by age groups and by province. Except percentage urban population (*), which takes data from the World Bank, available at http://datos.bancomundial.org/indicador/SP.URB.TOTL.IN.ZS

Life expectancy at birth					
Year	1990-1995	1995-2000	2000-2005	2005-2010	2010-2015
Age	76.83	77.06	78.66	79.32	79.39

Source: National Statistics and Census Institute (INEC)

Fig. 1. Costa Rica: selected demographic data (in thousands of inhabitants).
Source: National Statistics and Census Institute (INEC): total population by calendar year (1990), total estimated population (2000–2010) and total projected population (2013–2018) on June 30, by age groups and by province. Except percentage urban population (*), which takes data from the World Bank, available at http://datos.bancomundial.org/indicador/SP.URB.TOTL.IN.ZS. Source: National Statistics and Census Institute (INEC).

many applicants accepting positions below their level of qualifications. Specialized health technicians could be found in auxiliary positions, physical therapists as secretaries, general doctors in the emergency ward, and head nurses as nursing assistants, all with lower salaries. This situation led to high frustration levels among the new staff and a negative organizational environment.

There was friction between the new staff and the veterans, many of whom had been in the social security system for 20 to 30 years. The new, younger professionals often wanted to make changes and implement new procedures. In the emergency ward, young doctors specialized in the treatment of emergencies sought to impose norms, which some general physicians who had worked in that ward for decades resisted. Soon, however, other priorities such as the reduction of long waiting lists for laboratory tests and surgery overshadowed these concerns with procedural changes.

Health authorities had recently upgraded the TRH from a peripheral hospital to a regional hospital, both within the second tier of the Costa Rican social security system's three-tier hierarchy. The top tier included highly specialized medical and surgical services such as neurosurgery and the treatment of complex oncological pathologies. Primary care units, known as EBAIS (Spanish acronym for "basic integral health assistance team") provided services at the base of the pyramid, in the first tier. Though designed to serve a population of 3 to 4000, these in fact ranged from 2500 to 8000. Also in the first tier were health centers and some peripheral clinics, organized in 105 health areas throughout the country. There were no health centers surrounding Valencia, so the EBAIS teams referred all patients who required further attention directly to the TRH.

As a regional hospital, the TRH offered five basic health services: pediatrics, surgery, internal medicine, gynecology/obstetrics and orthopedics, additional to emergencies, services such as clinical laboratory and radiology, and external consultations (see organizational chart, Fig. 2). There were long waiting lists in all basic areas at the beginning of 2014. In the radiology and images area, where four out of eight technicians had quit, the situation was serious: the waiting list for ultrasound exceeded 40,000, 7000 patients awaited surgery, and 3500 CAT scans had never been reported.

In early 2014 Dr. Zúñiga, Medical Director of the TRH, invited Dr. Contreras to make a presentation to his department heads on value creation in the health system, based on concepts from the Porter seminar. It was immediately after this presentation that Dr. Zúñiga offered him the position as Medical Subdirector. "The situation is very frustrating," Dr. Zúñiga cautioned him. "The unions are highly empowered and drop by my office every day with one complaint or another. There are daily complaints from patients and there is a lack of coordination among medical services. It is time for a change." Dr. Contreras accepted the challenge. When entering on April 21, his first day of work, he faced a nurses' strike. During his second week on the job, there was a protest by patients in the gynecology area over lack of attention.

3. Changes, 2014–2015

One of the first lines of action taken by the new management team was to mediate conflicts between the old and new staff in the emergency, pathology, radiology and gynecology units. Where resignations had occurred, new heads of units were hired and given training in interpersonal relations and customer service. Dr. Contreras insisted that the staff greet each other in the hospital corridors. He set the example, visiting all floors and conversing with people at all levels in the

Please cite this article as: Ickis, J.C., & Gutiérrez, M.J., Tomás Romero Hospital, *Journal of Business Research* (2016), http://dx.doi.org/10.1016/j.jbusres.2016.01.044