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# Hospital governance model for holistic patient care in a level ii-2 hospital, Jaén, Cajamarca – 2025

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**Abstract**

The research will contribute to Sustainable Development Goal (SDG) 17, "Partnerships for the Goals," through Target 17, "Foster and promote effective partnerships in the public, public-private, and civil society spheres." The overall objective was to propose a hospital governance model to improve holistic patient care in a Level II2 hospital in Jaén, Cajamarca, 2025. The methodology was applied, quantitative, descriptive, and cross-sectional. The study population consisted of 242 professionals working at the Level II hospital (healthcare staff from the areas of General Medicine, Gynecology-Obstetrics, Pediatrics, Surgery-Traumatology, and Emergency and Critical Care). The results showed a hospital system that faces both structural and operational challenges, highlighting an inadequate hospital governance gap of 83.47% and 80.17% of healthcare staff that does not demonstrate commitment to holistic care, considering that the humanization of care and effective governance are established as fundamental pillars to modify the current reality. Through the implementation of international evidence-based tactics, adapted to the local context, it could pave the way for more equitable, inclusive, and high-quality public health.

**Keywords:** Health services, Health policy, Risk management, Right to health.

## Introduction

Global health governance faces significant challenges (such as shortages of human and financial resources), as well as a lack of effective structures to prevent pandemics, which became evident during the COVID-19 crisis. Despite the guidelines issued by the World Health Organization (WHO), many governments did not implement them adequately, resulting in outbreaks and an overload of health services. Furthermore, the difficulty in promoting a holistic approach to patient care persists, often limited to the physical treatment of pathologies (1).

The diminishing prominence of the WHO in global health governance has been attributed to the increasing intervention of organizations such as the World Bank, the Global Fund, and private foundations, which have fragmented international cooperation and weakened the sustainability of health systems, particularly in regions such as Africa, Latin America, and Southeast Asia. In contrast, countries like Cuba have developed effective strategies based on comprehensive primary care, achieving a more equitable and organized response to the pandemic, despite prolonged economic limitations (2,3).

In the Peruvian context, the Ministry of Health (MINSA) exercises governance and regulation of health services, coordinating with regional and local governments. However, structural deficiencies persist (such as inadequate infrastructure, insufficient equipment, lack of training for holistic care, issues with patient treatment, and delays in administrative processes). This situation worsened during the pandemic, when hospitals prioritized the care of COVID-19 patients, neglecting chronic diseases and causing economic losses due to poor inventory management (4-6).

The Level II-2 Hospital in Jaén, Cajamarca, serves as a referral center in northeastern Peru due to its range of specialties and strategic location. Despite implementing a Personnel Development Plan to strengthen skills and improve care, it faces limitations in infrastructure, medical equipment, and availability of specialists. These deficiencies have led to the collapse of some services and the transfer of patients to higher-complexity hospitals (7).

Finally, intangible issues (such as a poor work environment, lack of assertive communication, and inadequate treatment of patients) affect service quality. In this context, there is a need for a multi-level hospital governance model that allows for

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resource articulation, capacity optimization, and the promotion of holistic care based on ethics, commitment, and relational health, thus seeking to improve the experience and outcomes in patient care (8).

## Methods

The research was applied in nature, as it aimed to solve a specific problem using knowledge generated from basic research and enriching it with a scientific and cultural approach (9,10). It was developed under a quantitative approach, which allowed for the collection and analysis of numerical data from the variables based on indicators obtained through questions, employing techniques such as descriptive, exploratory, inferential analysis, modeling, and testing (11,12). The adopted design was non-experimental, cross-sectional, and descriptive, as the variables were not manipulated and the study was conducted at a specific moment. Additionally, it had a propositional character, aimed at describing the phenomenon and proposing solutions or improvements, with a descriptive scope that allowed for a detailed analysis of the problem.

The study variables were Hospital Governance, defined as the set of structures, processes, and mechanisms for making strategic decisions, managing resources, and ensuring the quality and efficiency of health services, involving the participation of managers, professionals, and patients to guarantee ethical and legal compliance (13); and Holistic Patient Care, understood as a comprehensive approach that considers the physical, emotional, spiritual, and social aspects of the person, seeking personalized and coordinated care among various professionals (14). For the first variable, three dimensions were considered: public health protection, individual health protection, and rights protection; for the second, holistic support and relational health.

The population consisted of 655 healthcare workers from a Level II-2 hospital, including doctors, nurses, obstetricians, nursing technicians, nutritionists, and diagnostic support staff (15). The sample, determined with a 5% margin of error and a 95% confidence level, was 242 collaborators selected through non-probabilistic convenience sampling, considering established inclusion and exclusion criteria to ensure the relevance of the participants (16).

The data collection technique was the survey, applied through a structured questionnaire developed by the researcher (17). For the hospital governance variable, the instrument included 28 items distributed across three dimensions; and for holistic care, 23 items grouped into two dimensions. Responses were measured on a five-category Likert scale. The validity of the instrument was established through expert judgment, and its reliability, evaluated in a pilot test with 20 workers, yielded a Cronbach's alpha of 0.886, indicating high internal consistency.

The analysis method was deductive, starting from general premises to reach specific conclusions (18). Descriptive statistics were used to process the data, identify patterns, and characterize the studied phenomenon. Regarding ethical aspects, compliance with the Code of Ethics in research of César Vallejo University was ensured, guaranteeing informed consent, confidentiality of information, and voluntary participation of respondents (19).

## Results

**Table 1.** Public health protection dimension assessment

| Category | Range | Frequency | Percentage |
|---|---|---|---|
| Poor | 18-35 | 77 | 31,8 |
| Fair | 36-44 | 118 | 48,8 |
| Good | 45-57 | 47 | 19,4 |
| Total | | 242 | 100,0 |

The results shown in Table 1 demonstrate that healthcare staff are in a fair position regarding the protection of public health. This is reflected in the opinion of 48.8%. On the other hand, 31.8% mention that it is poor, and only 19.4% indicate that it is good. The result reflects that staff do not agree with the planning and execution of processes, strategic decision-making, and management and handling of resources that contribute to improving the quality of services in terms of disaster prevention or emergency cases. This is in addition to the wait time that users may experience due to delays in care or the number of patients assigned by each attending physician. This is also considered a negative point in the assessment of this dimension.

**Table 2.** Assessment of the individual health protection dimension

| Category | Range | Frequency | Percentage |
|---|---|---|---|
| Poor | 19-26 | 74 | 30,6 |
| Fair | 27-29 | 131 | 54,1 |
| Good | 30-32 | 37 | 15,3 |
| Total | | 242 | 100,0 |

The results reflected in Table 2 highlight the opinions of healthcare staff regarding the individual health protection dimension. The result reflects a fair rating, which was provided by 54.1% of respondents. 30.6% reported it as poor, and only 15.3% indicated it was good. This revealed an 84.7% gap in individual health protection, due to a vertical, rather than horizontal, relationship in decision-making regarding a patient's diagnosis and the provision of personalized care. They maintain that patients are not informed about the benefits or services provided by the hospital. Furthermore, not all staff provide information to patients, and there are areas that do not contribute to adequate patient care.

**Table 3.** Scoring of the dimension of protection of rights

| Category | Range | Frequency | Percentage |
|---|---|---|---|
| Poor | 15-18 | 73 | 30,2 |
| Fair | 19-22 | 97 | 40,1 |
| Good | 23-25 | 72 | 29,7 |
| Total | | 242 | 100,0 |

The results shown in Table 6 reflect that 40.1% of healthcare staff believe that the protection of insured rights is fair. Similarly, 30.2% were rated as poor, and 29.7% were rated as good. This represents a 70.3% gap in the protection of patient rights, such as access to comprehensive health services. This means that there is little participation by the regional government in the development of projects that would improve health care. It is also noted that there is insufficient participation by the hospital management team in the immediate response to a patient's complaint during a medical consultation or administrative procedure. This negative assessment must be addressed to minimize the impact in the near future.

**Table 4.** Assessment of the level of participation of healthcare staff in holistic support.

| Category | Range | Frequency | Percentage |
|---|---|---|---|
| Poor | 34-43 | 98 | 40,5 |
| Fair | 44-47 | 84 | 34,7 |
| Good | 48-58 | 60 | 24,8 |
| Total | | 242 | 100,0 |

The results obtained in the dimension of healthcare staff participation in holistic support showed that 40.5% of the total respondents were "low," which indicates that staff still need to establish a connection with their patients, from the beginning of care until discharge from treatment or hospitalization. Furthermore, healthcare staff do not fully demonstrate empathy. This means that care is not provided by viewing the person as an indivisible whole, as a unique, integral, and specific being in all their spheres, to ensure a healthy state and manage stress and anxiety. Despite this high negative result, 34.7% believe that holistic support is average, highlighting indicators of resolution of patient or companion concerns regarding the diagnosis, treatment, and care provided. Finally, 24.8% considered it good. This indicates that not all patients perform work that excludes empathy or concern for their patients, but rather takes professional ethics into account as part of their daily work.

**Table 5.** Rating the level of participation of healthcare staff in relational health.

| Category | Range | Frequency | Percentage |
|---|---|---|---|
| Poor | 21-32 | 76 | 31,4 |
| Fair | 33-35 | 101 | 41,7 |
| Good | 36-40 | 65 | 26,9 |
| Total | | 242 | 100,0 |

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## Discussion

The evaluation of healthcare staff revealed that public health protection in the hospital is "fair," highlighting deficiencies in emergency planning, long wait times, and inadequate specialized medical follow-up. These findings are consistent with those reported in Galicia, Spain, where ICU bed capacity was insufficient during the pandemic, although with better professional training thanks to consolidated regional models (20). Likewise, high levels of dissatisfaction have been detected in Amazonian hospitals due to infrastructure and equipment problems, indicating that there is a systemic problem in Peru associated with low investment and poor management (21). Models such as the citizen-participatory governance and decentralization model proposed in Mexico could optimize the planning and implementation of public health policies in the country (22).

Regarding individual health, the results show deficiencies in materials, equipment, and medications, as well as a lack of awareness among patients about the benefits, in contrast to what has been documented in Norway and Canada, where a comprehensive approach prioritizes physical, emotional, and psychological dimensions, generating high satisfaction (23). At the national level, a lack of coordination between MINSA, ESSALUD, and the private sector has been noted (24), while in Latin America, the importance of multilevel governance to improve the quality of care has been highlighted (3). This reinforces the need to disseminate the service portfolio, train staff, and promote holistic care in both outpatient and hospital settings.

The protection of rights also received a "fair" rating, reflecting limited hospital governance and insufficient response to complaints. This is consistent with findings in Ecuador, where ethical governance and transparency strengthen health services (26). In Lambayeque, low citizen participation in health management has been identified, a common pattern in Peru (27). Experiences in Colombia, where patient safety training significantly improved the quality of care, demonstrate the value of ongoing training in technical and soft skills to foster empathy and trust (28).

The level of participation of healthcare staff in holistic support was "low," reflecting limited empathy and comprehensive follow-up. This contrasts with what has been reported in Brazil and Bolivia, where shared management between public and private entities optimized resources and improved service quality during the pandemic (6). Similarly, studies among the Awajún and Wampis populations reported that 97% of patients were dissatisfied with staff empathy, highlighting a cultural and structural challenge that could be addressed with ongoing intercultural training (3). International models integrate psychological and professional components before, during, and after treatment (22).

Relational health received a medium rating, with reliability issues in laboratories due to reagent shortages. In several Latin American countries, health governance favors coordination between levels of care and optimizes resources (23). Fragmentation and lack of funding have been noted to reduce the quality of care (33), thus requiring participatory governance models with continuous evaluation (21). Successful international experiences show that the combination of autonomous models and holistic approaches increases efficiency and satisfaction (21), while structural barriers persist in Peru (2,5).

Finally, experiences such as ethical governance in Ecuador (29) and shared management in Brazil and Bolivia (30) offer lessons in transparency, intersectoral collaboration, and ongoing training. The Jaén hospital faces deficiencies in empathy, intercultural approach, and supplies, affecting patient trust. These limitations, coupled with limited investment, long work hours, and weak coordination between sectors, confirm the need for reforms that integrate international strategies adapted to local realities (31).

## Conclusion

The findings showed that public health protection in the hospital setting is perceived as "fair," reflecting

deficiencies in emergency planning, long waiting periods, and a lack of specialized medical follow-up. To optimize efficiency, it is imperative to have governance that prioritizes inter-institutional coordination and staff training in crisis management, ensuring a timely and equitable response for users.

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