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Administrative staff empowerment and organizational development in Peruvian public hospitals

Empoderamiento del personal administrativo y desarrollo organizacional en hospitales públicos peruanos

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Abstract

This study aimed to explain the effect of an empowerment model for administrative-process workers on organizational development in hospitals belonging to the Ica Healthcare Network, Peru. A quantitative, non-experimental, cross-sectional, correlational-causal study was conducted with a probabilistic sample of 351 workers from a population of 2,042. Two Likert-type questionnaires were administered and validated through expert judgment, internal consistency, and confirmatory factor analysis. The instruments showed satisfactory properties: α = .97, ω = .87, χ^2/df = 2.14, CFI = .94, TLI = .93, GFI = .92, RMSEA = .061, and SRMR = .045. Overall empowerment was mainly moderate (51.0%), whereas organizational development reached an efficient level among 55.3% of participants. The correlation between both variables was strong and statistically significant (rho = .816; p < .001), with a coefficient of determination of 66.5%. Teamwork showed the strongest association (rho = .796; R^2 = .591), followed by continuous improvement, technical skills, decision-making autonomy, and effective communication. The study concludes that an institutional empowerment model, integrated with technical training, regulated autonomy, communication, continuous improvement, and collaborative work, may strengthen hospital organizational development and guide human resource policies in public healthcare networks.

Keywords: Employee empowerment, organizational development, hospital management.

Resumen

El objetivo del estudio fue explicar el efecto del modelo de empoderamiento de los trabajadores que participan en procesos administrativos sobre el desarrollo organizacional en hospitales de la Red Asistencial Ica, Perú. Se realizó un estudio cuantitativo, no experimental, transversal y correlacional-causal con una muestra probabilística de 351 trabajadores de una población de 2042. Se aplicaron dos cuestionarios tipo Likert, validados mediante juicio de expertos, consistencia interna y análisis factorial confirmatorio. Los instrumentos mostraron propiedades satisfactorias: α = .97, ω = .87, χ^2/gl = 2.14, CFI = .94, TLI = .93, GFI = .92, RMSEA = .061 y SRMR = .045. El empoderamiento global fue predominantemente moderado (51.0%), mientras que el desarrollo organizacional alcanzó nivel eficiente en 55.3% de los participantes. La correlación entre ambas variables fue fuerte y significativa (rho = .816; p < .001), con un coeficiente de determinación de 66.5%. La dimensión con mayor asociación fue el trabajo en equipo (rho = .796; R^2 = .591), seguida por la mejora continua, las habilidades técnicas, la autonomía decisional y la comunicación efectiva. Se concluye que un modelo institucional de empoderamiento, articulado con capacitación técnica, autonomía regulada, comunicación, mejora continua y trabajo colaborativo, puede fortalecer el desarrollo organizacional hospitalario y orientar políticas de gestión humana en redes públicas de salud.

Palabras clave: Empoderamiento laboral, desarrollo organizacional, gestión hospitalaria.

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Introduction

Public hospitals face mounting pressure to sustain quality, timeliness, and safety in their services amid budgetary constraints, shifting care demands, and the push for administrative digitalization. In this context, human talent management cannot be reduced to formal compliance with job descriptions; rather, it requires creating conditions in which workers understand processes, participate in decisions, propose improvements, and coordinate with other teams. Workplace empowerment offers a response to this challenge because it combines structural resources, perceived competence, autonomy, and a sense of contribution, elements that enhance teams' capacity to act responsibly within institutional objectives (Spreitzer, 1995; Rappaport, 1981).

In health care organizations, empowerment carries additional relevance because administrative efficiency indirectly affects patient experience, care continuity, and resource allocation. Evidence indicates that empowerment practices are associated with satisfaction, commitment, performance, and quality outcomes in hospitals and health services (Choi et al., 2016; Goedhart et al., 2017; Metcalf et al., 2019). Likewise, recent studies show that structural empowerment can improve organizational indicators when combined with a favorable social climate, frontline manager resilience, and participative leadership (Jankelová et al., 2024; Dahleez et al., 2022). These findings suggest that empowerment does not operate as an isolated practice but rather as a system of conditions that enables coordination, learning, and continuous improvement.

The literature distinguishes between psychological and structural empowerment. The former refers to the subjective experience of meaning, competence, self-determination, and impact at work (Spreitzer, 1995). The latter pertains to actual access to information, support, resources, and opportunities that enable effective performance (Fragkos et al., 2020; Goedhart et al., 2017). In Latin American public hospitals, both dimensions are often strained by rigid hierarchical structures, centralized decision-making, and training gaps. Consequently, workers with operational knowledge of everyday problems may be excluded from decisions that directly affect administrative processes. This disconnect limits innovation, reduces motivation, and hinders organizational adaptation.

The Ica Healthcare Network constitutes a pertinent context for examining this relationship because its hospitals depend on administrative processes that connect human resources, logistics, document management, clinical information, patient care, and operational support. The absence of an explicit empowerment model may translate into excessive supervisor dependence, processing delays, low participation, insufficient communication, and a weak improvement culture. From an organizational perspective, these conditions affect three components of institutional development: organizational structure, teamwork, and human relations. The problem is not merely about increasing training but about articulating technical capabilities with regulated autonomy, effective communication, commitment to improvement, and cross-area collaboration.

Several studies support this approach. Fanelli et al. (2020) identified that the most relevant managerial competencies for public health care organizations include results-based quality assessment, process management, competency strengthening, communication, and participative leadership. Alrige et al. (2022) found that granting discretion to modify processes and recognizing performance contributes to health worker performance in critical contexts. Al-Rjoub et al. (2023) showed that empowerment relates significantly to continuous improvement in both public and private hospitals. Taken together, these studies suggest that hospital organizational development depends on the quality of practices that enable workers to solve problems, learn, and coordinate.

Nevertheless, an empirical gap persists in the analysis of hospital administrative staff, as most evidence concentrates on nursing, clinical managers, or care workers. Administrative personnel perform functions that sustain hospital operational capacity yet typically receive less attention in leadership and organizational development models. This study therefore contributes evidence from a Peruvian public network and proposes an integrated reading of five empowerment dimensions: knowledge and technical

skills, autonomous decision-making, effective communication, commitment to continuous improvement, and teamwork.

The objective was to explain how an empowerment model for workers involved in administrative processes affects organizational development in hospitals within the Ica Healthcare Network. The general hypothesis posited that empowerment is significantly associated with organizational development. Additionally, the relationship of each empowerment dimension with organizational development was assessed to identify institutional intervention priorities.

The article addresses a health management audience interested in applicable evidence. Accordingly, beyond reporting statistical associations, it translates findings into organizational design criteria. This emphasis is appropriate for management and public health journals because it moves from an extended diagnostic thesis to a manuscript with a specific contribution: showing which empowerment dimensions have the greatest explanatory capacity and how they can be converted into administrative improvement lines. Along these lines, empowerment is understood as a decision-making and learning architecture that links people, processes, and institutional outcomes.

Methodology

A quantitative, non-experimental, cross-sectional study was conducted. The scope was correlational-causal, insofar as the magnitude of association and the percentage of organizational development variance explained by empowerment and its dimensions were estimated. This design was appropriate because the variables were measured in their natural context without experimental manipulation, and because the purpose was to examine observable organizational relationships among administrative workers in public hospitals. The population consisted of 2,042 workers from hospitals within the Ica Healthcare Network involved in administrative processes.

The probabilistic sample included 351 participants. Selection responded to criteria of institutional representativeness and availability of workers performing coordination, document support, resource management, administrative care, and operational support activities. Inclusion criteria required participation in the network's administrative processes; incomplete or inconsistent responses were excluded. Two Likert-type questionnaires were administered. The empowerment instrument included five dimensions: knowledge and technical skills, autonomous decision-making capacity, effective communication skills, commitment to continuous improvement, and capacity to work in teams.

The organizational development instrument assessed organizational structure, teamwork, and human relations. Indicator construction followed the logic of psychological and structural empowerment, where perceived competence must be complemented by institutional conditions that enable performance (Spreitzer, 1995; Fragkos et al., 2020). Content validity was reviewed by experts, and internal consistency was estimated using Cronbach's alpha and McDonald's omega.

The instrument structure allowed differentiation among personal competencies, coordination conditions, and perceptions of institutional functioning. This differentiation was relevant for avoiding a generic reading of empowerment and for recognizing that not all dimensions affect organizational development equally. Thus, the analysis was not limited to contrasting two global variables but examined components susceptible to intervention by hospital management.

Table 1 summarizes the psychometric and fit indicators. The obtained values were satisfactory, as internal consistency exceeded the commonly accepted threshold of .70 and confirmatory factor analysis fit indices fell within adequate ranges. Hu and Bentler (1999) recommend considering incremental indices near or above .90 and standardized residuals below .08 as evidence of acceptable fit; under this criterion, the measurement model was appropriate for analyzing relationships among variables.

Table 1. *Reliability and fit evidence for the measurement model*

Indicator	Obtained value	Acceptance criterion	Interpretation
Cronbach's Alpha (α)	.97	≥ .70	Excellent

McDonald's Omega (ω)	.87	≥ .70	Excellent
χ^2/df	2.14	≤ 3.00	Optimal fit
CFI	.94	≥ .90	Good fit
TLI	.93	≥ .90	Good fit
GFI	.92	≥ .90	Good fit
RMSEA	.061	≤ .08	Acceptable
SRMR	.045	≤ .08	Excellent

Processing included descriptive analysis by performance level and inferential analysis. Because the normality test showed significance below .005, Spearman's rho coefficient was employed. To interpret effect size, the coefficient of determination was calculated from the reported associations. Statistical significance was set at $p < .001$. The study respected principles of confidentiality, voluntariness, and academic use of information, avoiding individual participant identification.

Descriptive level interpretation was conducted with applied criteria. The deficient level was understood as a signal of organizational vulnerability requiring immediate intervention; the moderate level was considered a functional yet unstable condition that could improve with systematic policies; and the efficient level was interpreted as a strength to be consolidated and connected with other processes. This criterion allowed converting percentages into management priorities and avoided a purely statistical reading of results. In hospital institutions, a moderate dimension does not necessarily imply failure, but it does indicate stagnation risk when combined with high demand, regulatory rigidity, or absence of managerial feedback.

Results

Descriptive analysis showed that overall empowerment concentrated at the moderate level, whereas organizational development predominantly reached the efficient level. This difference indicates that the network possesses functional organizational foundations but has not homogeneously consolidated the conditions of autonomy, learning, and participation that characterize an institutional empowerment model. A dimensional reading identifies specific gaps: communication skills and teamwork showed efficient predominance, while technical skills, decision-making autonomy, and continuous improvement were mainly situated at the moderate level.

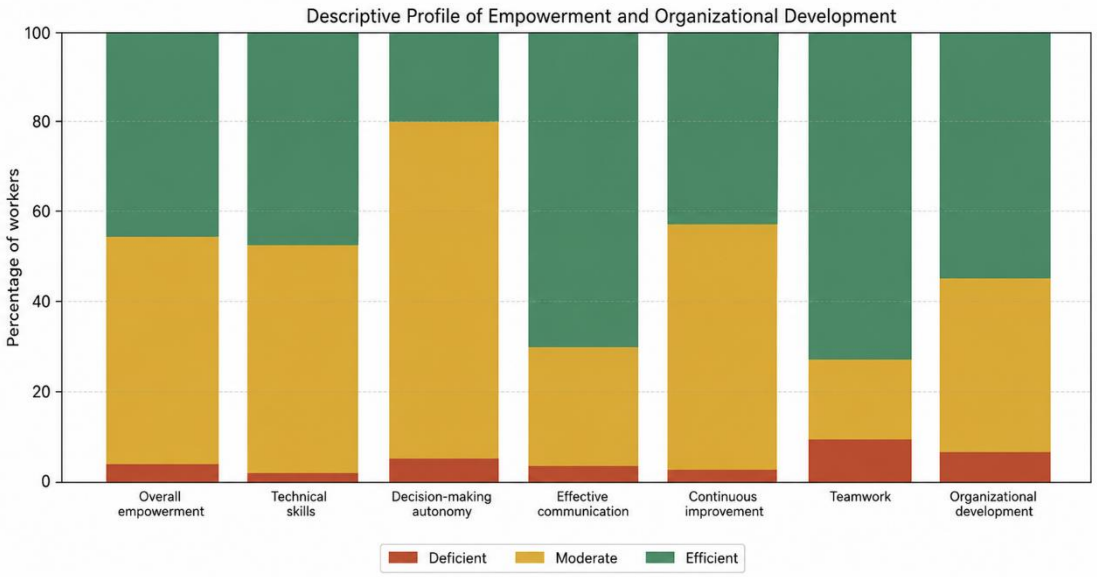
Table 2. *Percentage distribution of main variables and dimensions*

Variable or dimension	Deficient (%)	Moderate (%)	Efficient (%)	Predominant level
Overall empowerment	3.4	51.0	45.6	Moderate
Knowledge and technical skills	1.7	51.6	46.7	Moderate
Autonomous decision-making	4.8	75.2	19.9	Moderate
Effective communication	3.7	25.4	70.9	Efficient
Commitment to continuous improvement	2.8	53.8	43.3	Moderate
Capacity to work in teams	8.5	17.7	73.8	Efficient
Overall organizational development	6.6	38.2	55.3	Efficient
Organizational structure	12.3	35.9	51.9	Efficient
Organizational teamwork	13.4	31.9	54.7	Efficient
Human relations	12.8	35.0	52.1	Efficient

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Figure 1 displays the percentage predominance by dimension. Effective communication and teamwork exceeded 70% at the efficient level; however, decision-making autonomy presented the highest moderate percentage (75.2%). This finding is important because autonomy constitutes a central component of empowerment: if workers communicate and collaborate but lack clear margins for deciding, the organization retains an incomplete participative structure. Likewise, commitment to continuous improvement remained at the moderate level for more than half of participants, suggesting the need to institutionalize learning and feedback routines.

Figure 1. *Descriptive profile of predominant levels in empowerment and organizational development dimensions.*



Inferential analysis confirmed the general hypothesis. Overall empowerment was strongly and significantly associated with organizational development (rho = .816; $p < .001$), with $R^2 = .665$. This result indicates that the empowerment model explains 66.5% of the observed variation in organizational development. In practical terms, the effect magnitude suggests that human resource policies aimed at strengthening empowerment would have not a marginal but a structural impact on the network's capacity to coordinate, adapt, and sustain productive labor relations.

Table 3. *Associations between empowerment, dimensions, and organizational development*

Predictor	Spearman's Rho	p	R^2 (%)	Interpretation
Overall empowerment	.816	< .001	66.5	Strong
Knowledge and technical skills	.358	< .001	22.8	Moderate
Autonomous decision-making	.324	< .001	20.5	Moderate
Effective communication	.267	< .001	17.1	Low positive
Commitment to continuous improvement	.437	< .001	19.1	Moderate
Capacity to work in teams	.796	< .001	59.1	Very strong

Among the dimensions, capacity to work in teams exhibited the highest relationship with organizational development (rho = .796; $R^2 = .591$). This result is consistent with the interdependent nature of hospital administrative work, where processes rarely belong to a single unit and depend on cross-area

coordination, clarity of responsibilities, and collaborative problem resolution. The second most relevant association was continuous improvement (rho = .437), followed by technical knowledge (rho = .358), decision-making autonomy (rho = .324), and effective communication (rho = .267). Although communication obtained the highest efficient descriptive level, its direct association was lower, suggesting that good communication alone is insufficient if not accompanied by technical capacities, operational authority, and improvement mechanisms.

Table 4. *Intervention priorities derived from results*

Priority	Empirical evidence	Management implication
Strengthen teamwork	Highest association with organizational development (rho = .796; R^2 = 59.1%)	Create cross-area teams with shared goals, brief follow-up meetings, and explicit responsibilities.
Institutionalize continuous improvement	53.8% at moderate level; significant association	Implement process review cycles, record improvement opportunities, and indicator-based learning.
Develop regulated autonomy	75.2% at moderate level	Define permissible decision levels, escalation pathways, and criteria for problem-solving without excessive supervision.
Update technical skills	51.6% at moderate level	Train in document management, regulations, digital tools, and basic process analysis.
Integrate communication with decisions	Communication efficient, but lower rho (.267)	Transform communication into effective coordination, verifiable agreements, and institutional feedback.

The results support understanding empowerment as an integrated model. The organization already possesses relational strengths, reflected in communication and collaborative work; however, these strengths must connect with operational decisions, continuous learning, and technical competencies. Otherwise, collaboration may remain limited to interpersonal goodwill without translating into process changes or sustainable improvements.

A complementary reading of Table 3 shows that dimensions with higher descriptive levels were not necessarily those with greater explanatory weight. Effective communication, for instance, showed efficient predominance but a lower direct association with organizational development. This may be explained because communication serves an enabling function: it facilitates information exchange but requires decision-making authority, technical competencies, and follow-up routines to become organizational improvement. In contrast, teamwork combines interaction, co-responsibility, and task coordination, bringing it closer to the evaluated components of organizational development. This distinction is useful for management because it avoids investing exclusively in communication workshops and instead orients intervention toward teams with goals, indicators, and problem-solving capacity.

From an operational standpoint, the findings suggest that the Ica Healthcare Network could organize empowerment into three levels. The first level corresponds to individual competencies, encompassing technical skills, regulatory knowledge, and digital tool proficiency. The second level corresponds to action conditions, including regulated autonomy, available information, and escalation criteria. The third level corresponds to collective coordination, integrating communication, teamwork, and continuous improvement. Organizational development emerges when the three levels function in an articulated manner; if any one weakens, the empowerment effect fragments.

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Discussion

The main finding was the strong association between empowerment and organizational development in hospitals of the Ica Healthcare Network. This evidence aligns with the conception of Spreitzer (1995) that empowerment manifests when individuals perceive meaning, competence, self-determination, and impact in their work. In the studied context, such conditions are not only desirable for individual motivation but also link to the structure, teamwork, and human relations that sustain organizational development. The magnitude of the overall coefficient (rho = .816) shows that empowerment functions as an institutional capacity, not merely as a personal attitude.

This result also converges with studies conducted in health services. Choi et al. (2016) demonstrated that empowerment mediates the relationship between transformational leadership and job satisfaction among health care personnel, reinforcing the idea that leadership produces better outcomes when it distributes resources, trust, and agency. Jankelová et al. (2024) found that structural empowerment relates to hospital ratings through social climate and frontline manager resilience. In both cases, evidence suggests that empowerment acquires value when it modifies the organizational conditions that enable action, collaboration, and sustained results.

The dimension with the greatest effect was teamwork. This finding is consistent with hospital logic, where process continuity depends on interdependencies among units. Metcalf et al. (2019) showed that quality practices and staff empowerment influence hospital unit performance, especially when integrated with improvement and coordination routines. Similarly, Fanelli et al. (2020) emphasized that managerial competencies in public health organizations include participative leadership and process management. In the Ica Healthcare Network, the high association of teamwork indicates that organizational development strengthens when units cease operating as isolated compartments and build shared responsibilities.

Continuous improvement showed a moderate and significant relationship. Although not the dimension with the highest coefficient, its strategic importance is considerable because it connects everyday learning with institutional sustainability. Al-Rjoub et al. (2023) found a significant relationship between empowerment and continuous improvement in hospitals, with differences between public and private institutions attributable to bureaucratic rigidity and competitive pressure. In the studied network, the moderate predominance of commitment to continuous improvement suggests that favorable initiatives or dispositions exist, but a fully systematized culture of process review, data-based learning, and change tracking has not yet been established.

Knowledge and technical skills showed a moderate relationship with organizational development. This finding confirms that training remains a necessary but insufficient condition. Paarima et al. (2020) evidenced that nurse managers' competencies include technical, human, and conceptual skills; therefore, improving procedural mastery alone does not guarantee organizational development if not accompanied by communication, autonomy, and systemic vision. In hospital administrative processes, technical skills should include digital tool use, regulatory understanding, information management, and workflow analysis.

Decision-making autonomy was one of the dimensions with the highest percentage at the moderate level. This point merits attention because the empowerment literature identifies self-determination as a central component of the experience of control and responsibility (Spreitzer, 1995; Rotter, 1966). Alrige et al. (2022) found that discretion to modify processes was one of the empowerment practices with the greatest effect on performance during the pandemic. In the Ica Healthcare Network, the moderate autonomy level may reflect rigid regulatory frameworks or a vertical supervision culture. The goal is not to promote uncontrolled decisions but to establish regulated autonomy: clear limits, escalation pathways, documented criteria, and traceable accountability.

Effective communication showed efficient predominance, yet its association with organizational development was the lowest. This result does not contradict the importance of communication; rather, it indicates that its effect may be mediated by other conditions. Dahleez et al. (2022) reported that empowering leadership improves work behaviors through safety climate, suggesting that communication requires a context of trust, psychological safety, and operational authority to translate into performance. Kahn (1990) also argued that personal engagement at work depends on psychological conditions of meaning, safety, and availability. Thus, communicating clearly is indispensable, but organizational development requires communication to lead to coordination, decisions, and learning.

The results have direct implications for public health network management. First, empowerment should be formalized as a human management model, not as an isolated training program. Second, interventions should prioritize cross-area teams because collaborative work explained a substantial proportion of organizational development variation. Third, autonomy should be designed with explicit rules to avoid both excessive dependence and decisional informality. Fourth, continuous improvement requires indicators, periodic review spaces, and mechanisms for administrative staff proposals to be evaluated and responded to.

Another implication involves redefining the role of middle managers. In traditional hierarchical models, management operates as an authorization point; in an empowering model, it acts as a facilitator of resources, clarity, and learning. This change does not eliminate authority but orients it toward removing obstacles, prioritizing problems, and sustaining standards. International evidence on empowering leadership indicates that outcomes improve when workers perceive support for acting while having clear rules that reduce uncertainty (Dahleez et al., 2022). In the Ica Healthcare Network, this transition would be particularly useful for repetitive administrative processes that consume managerial time and could be resolved through delegated protocols.

Theoretically, this study contributes evidence by integrating psychological and structural empowerment among hospital administrative staff. Prior research has often concentrated on nursing or clinical managers; however, administrative processes also shape hospital responsiveness. Fragkos et al. (2020) showed that structural empowerment predicts organizational commitment in nursing, while Goedhart et al. (2017) linked nurse empowerment to quality outcomes. The present study extends that logic to administrative workers and demonstrates that organizational development depends on cross-cutting conditions of participation, knowledge, collaboration, and improvement.

The main limitation is the cross-sectional design, which prevents establishing strict temporal causality. Although the percentage of explained variance was estimated, associations should be interpreted as evidence of strong relationships rather than experimental proof of causality. Another limitation is the use of self-report, susceptible to social desirability bias. Future research could employ longitudinal designs, structural equation models with mediating variables, analyses by hospital unit, and objective measures of administrative performance. Comparing healthcare networks with different complexity levels would also be useful for assessing whether the relative weight of teamwork, autonomy, and continuous improvement changes according to institutional size.

A practical contribution of this study is the possibility of formulating a hospital administrative empowerment model with five sequential components. The first is diagnosis of competencies and critical processes. This component allows identifying technical gaps, administrative bottlenecks, and areas where hierarchical dependence generates delays. The second is situated training, understood not as general courses but as learning associated with real problems: document management, file traceability, information system use, institutional regulations, and administrative care for beneficiaries. The third is regulated delegation of decisions, through matrices specifying which decisions each role can make, when to escalate a case, and how to document the adopted solution. The fourth is cross-area coordination, based on process teams that integrate administrative and care units when procedures affect service continuity. The fifth is continuous improvement, with simple indicators, periodic review meetings, and formal responses to worker proposals.

This model does not assume transferring managerial responsibilities to administrative staff without support. On the contrary, it requires management to provide information, resources, and feedback. Responsible empowerment demands clarity of objectives, regulatory limits, and accountability mechanisms. When these elements are present, autonomy does not become informal discretion but rather the capacity to solve problems within institutional parameters. This precision is especially important in public hospitals, where administrative decisions must respect regulations, traceability, and equity in resource use.

Implementation should also consider monitoring indicators. In the short term, administrative response times, number of first-level resolved incidents, participation in improvement meetings, and compliance with cross-area agreements could be measured. In the medium term, worker satisfaction, perceived procedural justice, turnover, absenteeism, and coordination quality could be evaluated. In the long term, it would be pertinent to link the model with hospital efficiency indicators, user satisfaction, and care process continuity. In this way, empowerment would cease to be a cultural statement and become an evidence-managed practice.

The analysis also contributes to the discussion on organizational development in public institutions. In bureaucratic contexts, reforms tend to focus on formal structure, procedures, and technology. However, the data show that organizational development depends on how workers use those structures to coordinate, learn, and solve problems. Administrative technology can accelerate procedures only if personnel understand the process, have authority to act, and have teams that integrate information. Therefore, hospital digital transformation must be accompanied by empowerment; otherwise, it may reproduce previous rigidities in electronic formats.

Conclusions

The study confirms that administrative staff empowerment relates strongly and significantly to organizational development in hospitals of the Ica Healthcare Network. The overall model explained 66.5% of organizational development variation, evidencing its relevance for public hospital management. The most influential dimension was teamwork, followed by continuous improvement, technical skills, decision-making autonomy, and effective communication.

The findings suggest that the network possesses relational strengths, especially in communication and collaboration, but requires consolidating regulated autonomy, technical training, and systematic continuous improvement mechanisms. For a Q2 journal, the study's central contribution lies in showing that administrative empowerment is not a peripheral component of health management but a structural factor for improving coordination, adaptation, and human relations in public hospitals. The obtained evidence supports a management agenda based on capabilities: training, delegating, coordinating, learning, and evaluating with explicit criteria of sustainability, traceability, institutional accountability, and verifiable improvement of critical administrative processes.

An institutional empowerment model composed of five lines is recommended: ongoing technical training, regulated delegation of decisions, communication oriented toward agreements, continuous improvement cycles, and cross-area teams with shared goals. These actions would transform individual capabilities into sustainable organizational development, strengthening hospitals' administrative response and the indirect quality of service provided to beneficiaries.

Finally, model application should be gradual and evaluable. A first stage could focus on administrative units with high document loads; a second, on processes connecting clinical and administrative areas; and a third, on institutionalizing shared indicators. This sequence would facilitate organizational learning, reduce resistance to change, and demonstrate results before extending the model network-wide.

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