

1. INTRODUCTION

Public hospitals are an important component of health policy in all health care systems in the world, because they use a very important share of health care resources in all countries. For example, in many western European countries, hospitals absorb about 50% of the total health care budget; in the countries of the former Soviet Union this figure goes up to 70% (McKee and Healy, 2002). Peters et al (2000) report that about half of the 48 Sub Saharan Africa countries spend 45% or more of the public sector budget on hospitals, whereas Nandakumar et al (2004) show that Malawi, Tanzania, South Africa, Tunisia and Yemen, devoted about half of total country health care expenditures to hospitals (both public and private). These figures ranged between one third and one half for other countries like Djibouti, Egypt, Iran, Jordan, Ecuador, Guatemala and Nicaragua.

However, policy related to public hospitals has been relatively neglected in the debates in developing countries, perhaps due to a larger focus on cost-effective interventions in settings outside the hospitals (Hanson et al, 2001). But public hospitals' status as providers of last resort and their high political visibility (McPake, 1996) imply unique policy challenges to improving their performance in terms of increased efficiency and better quality.

Public hospital networks in developing countries have traditionally been arranged in vertically integrated structures, mostly run by the Ministry of Health, which manages hospitals as administrative units. This arrangement has shown weaknesses related to the lack of incentives to make hospitals work efficiently and provide high quality services.

Therefore, hospital policy seems to be desperately looking for a way out of the blind alley of low-powered incentives, inefficiency and poor quality. In these vein, several policies have been tried to improve hospital performance. One of them is the separation of providers from purchasers, the so called Purchaser Provider Split (PPS). The PPS has been proposed by the advocates of a new role for the State, as suggested by the New Public Management approach (Walsh, 1995). This approach suggest that the State should focus its efforts on setting policies and assuring financing, but direct provision should be contracted out to other parties. In the case of public hospitals, it does not mean outright privatisation but a shift from a hierarchical relationship to a contract-

based one. This shift requires public hospitals to work as autonomous entities and enjoy the necessary decision rights to make such autonomy meaningful. It is expected that shifting from a vertically integrated structure to an arms-length relationship would solve the maladaptation problems of the former. But the latter also shows problems of maladaptation.

It could be argued that Transaction Cost Economics (TCE) provides a useful analytical framework to test this expectation. From an economic perspective, thinking in terms of TCE is useful because a shift from one governance structure to another is just a search for a governance structure that reduces the maladaptation problems that emerge *ex-post* in a relationship, i.e., their transaction costs. In fact, the New Public Management approach to the government as a commissioner of services on behalf of citizens but not as a direct producer, rests on a TCE-based rationale.

TCE predicts that the presence of Relationship Specific Investments (RSI) and contract incompleteness explain why two trading parties engage in a relationship that differs from the typical neoclassical paradigm of discrete anonymous exchanges. The features of these relationships aim at reducing uncertainty and its consequent room for opportunism and bounded rationality. Otherwise, the parties would be unable to deal with these factors and the exchange would never take place.

In this vein, this thesis carries out a TCE analysis of the relationships between the 22 autonomous hospitals of Bogota, Colombia, and their major purchasers, namely the Secretariat of Health of Bogota (SOH) and five health insurance carriers. The objective of the research is to determine the role of transaction costs in shaping the relationships between these 22 hospitals and their purchasers, and to describe and analyse the extent of autonomy that the SOH has granted to hospitals. It also tests the usefulness of the TCE framework and other New Institutional Economic theories in explaining the findings.

The thesis is organised in eleven chapters. The first three chapters provide the background for the thesis, i.e., the theories relevant for the analysis (chapter 2), the empirical evidence on hospital autonomisation and other TCE-related evidence in hospital reform (chapter 3) and a description of the Colombian context (chapter 4). Chapter 2 reviews the New Institutional Economic theories and gives a larger emphasis

to TCE. It also reviews the rationales for hospital autonomy and highlights the lack of theoretical models for hospital behaviour in public contexts in developing countries as a large limitation for doing research on hospital policy. Chapter 3 provides a review of experiences in hospital autonomy in both developed and developing countries and the available literature on TCE analyses of hospital reforms. Chapter 4 provides the details of the Colombian context, its health care reform passed in 1993 and its implications for hospital policy. It also gives details on the experience of Bogota and reviews the available empirical evidence on this experience.

Chapter 5 summarises the research question and methods. The findings and a final discussion and conclusions are addressed in the remaining six chapters. Chapter 6 shows the findings regarding the observed types of relationships between hospitals and their purchasers. These relationships show some characteristics that, according to TCE theory, are expected to be shaped by Relationship-Specific Investments and contract incompleteness. This expectation is addressed in chapter 7. Chapter 8 analyses the coexistence of hierarchical relationships with the SOH, given that autonomy of public hospitals is usually restricted in some respects in other country cases. In the Bogota case, it was considered useful to analyse the extent to which these hierarchical relationships coexist with contractual relationships, the justification for such vertical restraints and their effects on hospital autonomy. Chapter 9 analyses the usefulness of TCE and other New Institutional Economic theories to explain the findings. Given that TCE has been mostly developed within the context of private for profit firms, it is interesting that the New Public Management approach rests on a TCE rationale. Thus, it is necessary to explore other theories to search for better predictions of the observed findings.

Although each chapter between 6 and 9 has a discussion restricted to the specific topic of the chapter, a final discussion of overall topics is done in chapter 10. This chapter also reflects on the limitations of the thesis, the implications for policy and further research questions. The overall conclusions of the thesis are summarised in chapter 11.