3. REVIEW OF RELEVANT EXPERIENCES RELATED TO HOSPITAL AUTONOMY AND TRANSACTION COST ECONOMICS

The Purchaser-Provider Split (PPS), as shown in chapter 2, implies the separation of the traditional vertically integrated structure of public health care systems into purchasers and providers. It is expected that this split, which, in the case of public health care networks, takes place through the autonomisation of public hospitals, will result in providers being exposed to market pressures.

These and other assumptions are assessed in this chapter through the relevant experiences in hospital autonomy in both developed and developing countries. Although some papers refer to countrywide analyses of hospital autonomy, other papers refer to specific hospital cases within a country. Table 3.1. provides a summary of the cases included in this chapter, and a more detailed description of each case is given in Annex 1. This review of cases shows how TCE rationales as well as non-TCE rationales underlie the hospital autonomy policy. It also comments on the nature and extent of autonomy and the outcomes of the policy. Some of the papers included in this chapter have already been commented on in chapter 2 regarding their main points related to theory and general topics; in this chapter they will be reviewed from the viewpoint of their country-specific features. Other papers related to TCE in health services and other sectors are also reviewed in sections 3.2. and 3.3.

Interestingly, except for UK and New Zealand, the papers summarised in table 3.1. do not mention transaction costs. This does not mean that transaction costs rationales for hospital autonomy were absent, but rather ignored. However, although the literature on the transaction costs of hospital autonomy is evidently limited, the review of the cases in this chapter and in annex 1 gives a useful background for many of the issues addressed in chapters 6 to 9. These will be re-taken in chapter 9 and 10.

The last section of this chapter provides a critique of the reviewed papers in terms of their assumptions and interpretation of the findings. It also points at issues neglected in research on the topic.

The strategies adopted for this literature review were the following:

- For the papers on hospital autonomy: a initial review of Govindaraj and Chawla (1996) and Preker and Harding (2003) provided the initial list of case studies and some of the basic literature on the topic.
- A search in Medline and EconLit provided additional sources of references on hospital autonomy and transaction cost economics. Keywords used were: transaction cost economics, purchaser-provider split, hospital autonomy, autonomisation, hospital policy, public hospitals.
- A Google search for gray literature and other papers outside peer review journals was also carried out. The keywords were the same and the search was done for papers in English and in Spanish.
- Given that the literature on hospital autonomy is not too vast, Medline, EconLit and Google quickly ended up with the same references. This was overcome by using a wide range of terms related to hospitals.
- The gray literature from Colombia was found either through the sources described above, or through personal requests to researchers known for their work on related topics. Official reports and documents were either downloaded from governmental web pages or requested personally from public officers.

3.1. Empirical evidence on the effects of hospital autonomisation

The three rationales for hospital autonomisation that were mentioned in chapter 2, i.e., inefficiency of bureaucracy, fiscal pressures and cost-effective spending, underlie a move towards hospital autonomisation in developing countries during the nineties, partly fuelled by the World Bank (World Bank, 1993) and other bilateral agencies (Batley, 1999). However, evidence on the effects of autonomisation is rather limited. Although some research has focused on the outcomes of autonomy in terms of efficiency, quality and equity, part of the evidence is circumscribed to analysing the progress through the path to autonomisation (e.g., Preker and Harding, 2003).

The experiences summarised in table 3.1. illustrate a wide range of variation in aspects of hospital autonomy. Regarding decision rights, they range from the more restricted experiences in Sub Saharian Africa countries to the wider ones in the UK and to the almost *laissez-faire* experience of Chinese hospitals. Organisation of hospitals range from the individually-based of most experiences to the horizontally-integrated experiences of Hong-Kong, Singapore and the Andra Pradesh province in India. The

outcomes of autonomisation also show a wide range, from the less or negligible effects of the Sub Saharian Africa to the higher effects (although not necessarily welfare maximising) of Chinese hospitals.

Table 3.1. Summary of reviewed cases.

Country	Nature and extent of reform	Implementation	Effects	Comments	References
Ghana	Two teaching hospitals Contracting, personnel management, selling/ buying property.	Restricted b/c strategic decisions were kept at the MOH and cabinet. Human resource (HR) management still centralised.	Limited effect due to government reluctance to yield control to hospitals and ambiguous interpretation of autonomy.	Limited number of hospitals, little transfer of decision rights, limited overall effect.	Mills et al (2001), Govindaraj et al (1996), Suriyawongpaisal (n.d.).
Kenya	One tertiary care hospital.	Board responsible for assets, liabilities and management. Certain flexibility in HR management and procurement.	User fee revenues reached 10% of total revenues. Positive assessment from external audit.	User fees still minor share of revenues. An initial management contract was overturned by hospital workers.	Collins et al (1996).
Uganda	Study describes three pair wise comparisons. Hospitals allowed to keep user-fee revenues.	Still high restrictions in HR.	Limited resource mobilisation because safety-net effect. Improvements in efficiency not related to autonomy status.	Expected efficiency/quality improvements not achieved, because of reduced overall funding, irregularity of payment of hospital grants, and increased demands on hospital sector	Ssengooba et al (2002), Hanson et al (2002), Akello (2004).
Zambia	Creation of a central board for contracting hospital services. Adoption of basic benefit package, services outside it charged to patients	Contracts weakly enforced. Resistance from civil workers to be transferred to hospitals.	No relevant improvements in performance. Limited resource mobilisation. High dependence on central budgets. Incentives for hospitals	MOH kept appointment rights, which reduced accountability	Hanson et al (2002), Kamwanga et al (2003), McPake and Hanson (2004).

	at cost recovery rates.		to attract paying patients and restrict access to the poor.		
Zimbabwe	Limited to one tertiary care center.	Central government kept a high level of control on budget, procurement and HR. User fees set below cost by government, causing deficits and need for bailouts from government.	No conclusive evidence of effects, when compared to matched hospital.	The system kept its highly centralised structure.	Needleman et al (1996).
China	Government transfers frozen in the early eighties, hospitals allowed to charge fees. Socially important services subject to fee schedule, while other fees were freely set by hospital. *Laissez-faire* approach to hospital policy.	Distorted incentives led to overprovision of unregulated-fee services and under-provision of the regulated ones.	Large increase in user-fee revenues. Accelerated growth in country-level health care spending. Over-response to incentives of payment mechanisms: demand inducement for retrospective, skimping on care for prospective. Long stays for per-diems.	Some experiences with insurers involved in care management show lower growth rates. No explicit analysis of the effects of autonomy, so results cannot be clearly attributed to autonomy.	Liu and Mills (2005), Cong and Hu (2005), Eggleston and Yip (2004), Eggleston et al (2006), Meng et al (2004), Yip and Eggleston (2004).
Hong Kong	Hospital Authority (HA) created to manage the 13 hospitals.	HA faced a hard budget constraint, and highly autonomous except for revenues (97% depending on local authority).	Budget discipline, reduced overcrowding, better patient and staff satisfaction, better network coordination.	Paradoxically, closer to integration. No market exposure. Challenges assumptions of hospital autonomy.	Yip and Hsiao (2003)
Indonesia	Retention of, and freedom to use user-fee revenues. Freedom to set fees.	Autonomy was granted to hospitals showing higher fee revenues, growth of fee revenues, and utilisation rates.	Fee revenues are high in Indonesia. No significant difference with non-autonomous hospitals. Government transfers	Fee retention was abolished in 1997	Bossert et al (1997), Lieberman and Alkatiri (2003), WHO (2006a), Knowles and Marzolf (n.d.).

		Restrictions in HR management.	increased. Negative effect on equity.		
Singapore	Similar to Hong Kong, but hospitals enjoyed more autonomy.	Hospitals retain surpluses, but government covers deficits. Freedom to set fees.	Patient-driven competition and Medical Savings Accounts led to rapid inflation and expansion of capacity.	Increased hospital output achieved at a high aggregate welfare cost	Phua (2003), Wagstaff (2005), Hsiao (1995).
Malaysia	One single tertiary care hospital, the National Heart Institute (NHI)	Hospital created as autonomous from the beginning.	Price competition reduced price/cost ratios of NHI but also other hospitals.	Brand new hospital without previous costs rigidities	Hussein et al (2003).
India (Andra Pradesh)	Hospital authority (APVVP) created in 1986 to manage 162 hospitals, similar to Hong-Kong horizontal integration.	Budget rigidities not overcome, HR centrally managed.	Increased revenues from user fees and other sources, but no significant effect of resource mobilisation.	Fluctuations in leadership opened room for government to take over again control of high stakes involved in the management of the network	Chawla and George (1996), Govindaraj and Chawla (1996), Mills et al (2001).
Pakistan	Managerial and financial autonomy delimited by performance agreements and lines of accountability.	Four hospitals pilot tested in 1998, then 8 more.	Pilot tests show large increases in ancillary tests, improvements in HR management. But boards of directors were passive.	"Remote control autonomy": no meaningful decision rights actually transferred to hospitals. Increases in output due to fee-for-service, not necessarily efficient	Balal (2006), Government of North West Frontier Province (2006).
Lebanon	Corporatised hospitals had to sign contracts with purchasers.	Board seats and manager appointment, exposed to capture. Board decisions still subject to MOH approval.	Outcomes varied more according to personalities in place than to regulations and institutions.	Lack of coordination between principals in the Board.	Eid (2001).
Tunisia	22 teaching hospitals given formal decision rights.	Actual decision rights still at the central government. Budget cuts as a strategy to force	No improvements attributable to autonomy.	Appears paradoxical that this experience is included in a review of hospital autonomy	Achouri and Jarawan (2003).

		hospitals to increase user fee revenues.			
Brazil (Sao Paulo)	Public-private partnerships (OSS) to manage public hospitals. Not aimed at resource mobilisation.	Contracts for block transfer of money: 90% contingent upon performance, 10% contingent on the submission of data. Main partners are NGOs. HR management more flexible among OSS.	Perception that OSS hospitals perform better than non-OSS hospitals.	Reputation effects among NGOs assured good performances	Rinne (2005).
Peru	User fees introduced. Study focuses on five urban hospitals.	User fees with exemptions managed by social worker, exposed to gaming by both social worker and patients.	Decreased hospital services to the poor. Disordered growth of supply to attract paying patients.	Author points out that motivation for autonomy is lack of funding at the central level.	Arroyo (1999).
Argentina	Public hospitals traditionally cross subsidised Obras Sociales. Autonomy aimed at cutting cross subsidy.	HR management was not transferred to hospitals.	Increased revenues from Obras Sociales, but wide variations between hospitals.	No real autonomy because HR management kept unmodified.	Tobar (n.d.), Lloyd-Sherlock (2005), Abrantes (2003).
Portugal	31 hospitals given autonomy, subject to private legislation.	Autonomous Hospitals created their boards of directors and faced a hard budget constraint. Complete migration to private law has not taken place.	Improved internal management and procurement. Labor regime more flexible but still posing difficulties, greater flexibility for investment and planning. Good outcomes depend on individual leadership. Loss of network coordination.	Best studies on hospital autonomy, but still unable to rule out selection bias	Gouveia et al (2006), Costa and Lopes (2005).

Eastern Europe and Former Socialist Economies	Autonomisation in the context of collapse of socialist governments.	Third parties not allowed to selectively contract providers. HR management kept centralised.	Contracts wielded little power as accountability devices. Results dependent on individual leadership. Local governments had no incentive to downsize hospital redundant capacity.	Social health insurance created opportunities for market exposure but not being able to selectively contract gave little incentive for hospitals to compete	Jakab et al (2002b), Kozierkiewicz and Karski (2001), Nuri (2001), Delcheva and Balavanova (2001), Rose and Gotsadze (2001).
United Kingdom	Hospitals converted into Trusts. Allowed to decide on fixed assets, retaining surpluses and borrowing.	Bilateral monopolies emerged in most settings.	Bilateral monopolies reduced competition to meaningless levels. Little major measurable change.	Expected benefits not realised because incentives were too weak, restrictions too strong	Ham (2003), Mays (2000), Le Grand (1999), NHS (2004), Marini and Street (2006).
New Zealand	Health authorities bought services from hospitals within hard budget constraint.	First minutes highly detailed, later became simpler. In 2000, relationships were shifted from competition to cooperation, no market exposure.	No major efficiency gains.	Interesting case, where policy flinched from PPS to more cooperation.	Ashton et al (2004), Ashton (2005).
USA district hospitals	Board members of district hospitals are publicly elected.	Support for elections depends on promises to hold budget controlled, to avoid taxation. Thus, manager compensation is not competitive.	Lower performance of district hospitals as compared to private ones.	Not a reform in itself but illustrative of dynamics of public hospitals.	Eldenburg and Krishnan (2003).

HR: human resources

3.2. Evidence on the impact of NPM policies in other sectors

Other sectors of the economy with a longer history of experimentation with NPM policies have much to tell the health sector. A study of twelve cases of state-owned enterprises (mostly public utilities), by Shirley and Xu (1998), shows that shifting from historic budgeting to output-based budgets with the mediation of a contract does not necessarily lead to the achievement of efficiency-enhancing or quality-improving goals. This is due to the presence of large information asymmetries favoring enterprises' managers, the limited likelihood of punishment and low level of rewards, and the lack of government commitments to encourage the provider to incur RSI. This same general conclusion is arrived at by the World Bank (1995) in its world-wide analysis of autonomisation reforms of non-health state-owned enterprises, which Shirley and Xu's study is part of.

On the side of government's regulatory capacity, Schick (1998) reinforces this argument by showing that NPM expected outcomes are unlikely to be achieved in developing countries, due to the large informal economy, lack of adequate and strong institutions and a lack of discipline by the government. It is in this precise context where Batley (1999) shows that NPM reforms in developing countries have shown limited results, due in part to the implementation of "only one side of the liberal equation" namely, decentralisation, autonomisation or privatisation of public providers; the other side of the equation –strengthening government's regulatory capacity to protect consumer interests, has been left unattended. He suggests that "the indirect management of service provision may be more complex technically and in terms of political accountability than direct administration." This statement suggests a key issue of transaction costs in the PPS. As commented above, TCE has largely been ignored in the research agenda, at least that of health services research.

3.3. Evidence on the role of transaction costs (and beyond) in the PPS

The experiences summarised in table 3.1. show that the literature on hospital autonomy in developing countries gives little attention to the theoretical framework of TCE. This could be explained because the two stronger rationales for autonomisation, i.e., fiscal pressures and cost-effective spending, have nothing to do with TCE but with more

pragmatic responses to public policy challenges. But the other rationale for hospital autonomy, i.e. reducing the transaction costs associated with the inefficiency of bureaucracies, is strongly related to the TCE theoretical framework (Harding and Preker, 2003). Avoiding the transaction costs of vertically integrated structures implies the separation of purchaser and provider, and a shift to a contract-based relationship. In consequence, setting up such a contract-based relationship, in a context of hospital autonomy, would require the mediation of a more explicit, better designed and strongly enforced contract, and this would necessarily require the consideration of transaction costs and the TCE framework. Nonetheless, TCE also allows a prediction that the effectiveness of contracts and performance agreements is likely to be less than expected, given the information asymmetry that favors the provider, the weakness of incentives and penalties, and the lack of commitments by the purchaser, as shown by Shirley and Xu (1998) and the World Bank (1995).

At least from a theoretical perspective, the role of transaction costs in the PPS has been emphasised more strongly in the developed world (Le Grand and Bartlett 1993, p. 210, Robinson 1999). In developing countries, only recently has Preker et al (2000) proposed an analytical framework that appeals to TCE rationales for the analysis of "make-or-buy" decisions in the health sector. However, not many studies on the role of TCE in the PPS are found in the literature; even less are found with respect to developing countries.

In one study, Allen (2002) analysed the transaction costs involved in the contracting of nursing services in the United Kingdom. In her in-depth case-study, large information asymmetries, the absence of a threat of exit by the purchaser, and the presence of human specific assets, led the author to conclude that transaction costs are higher in contracting nursing services, which justifies unified ownership.

The study by Marini and Street (2006) that is mentioned in Annex 1 is another TCE-based approach to the NHS. However, their study restricts the transaction cost analysis to those costs related to contracting. They measure them in terms of changes in administrative costs on both provider and purchaser, and conclude that these costs are larger due to the new activity-based payment mechanism. Interestingly, the authors do not mention any role for RSI, and all the costs they address in the analysis are related to contract incompleteness.

Ashton (1998) analysed four services in New Zealand (rest homes, surgical services, primary health care and mental services), in four dimensions: frequency of transactions, uncertainty, asset specificity, and problems of measurability. She found that the higher any of these dimensions, the higher the transaction costs and the higher the likelihood of a long-term relationship. An important point that is raised by Ashton is that health care services are not a homogeneous family of products. Such heterogeneity implies different transaction costs associated with different levels of information asymmetry, uncertainty, complexity and so on. Accordingly, following Williamson's proposition that governance structures align with transactions to reduce transaction costs, it should be expected that the PPS is applied differently and not across the table for all types of health care services.

On this line of reasoning, Preker et al (2000) suggest that some services are more amenable for contracting out than others, according to how contestable and how measurable they are. Their proposed framework suggests that services or products whose markets are highly contestable and their outputs easily measured are easy to contract out, whereas those with low contestability and which are difficult to measure are better to be produced in-house. For example, services like routine diagnostic activities are more easily contracted out than inpatient care. This contrasts with the PPS approach of across-the-table contracting out, when it is obvious that not all health care services exhibit the same contestability and measurability attributes.

Although not directly related to a PPS, the experience of government contracting out with private providers is relevant from the TCE perspective. Palmer (2001) found that contracts with private providers in South Africa were largely incomplete, given difficulties in specifying contractual terms, and in monitoring contract execution. She explicitly analyses in a descriptive way the transaction costs of already existing contracts with private sector providers, and mentions the unwillingness of private providers to invest in improvements of facilities in order to comply with contract terms, given the relationship specificity of these improvements and the short term of the contracts (one year). In another paper, Palmer and Mills (2005) find that contracting for primary care services in rural areas is more likely to evolve toward the relational type of MacNeil's taxonomy. This is explained because of the noncompetitive environment that surrounds the contracts, and the broad range of services delivered. In contrast, another

contract in a more competitive environment and with a narrower range of services appeared to operate in a more formal than relational way. Another paper by Palmer and Mills (2003) analysed bounded rationality and opportunism in these same contracts, and they find that serious contractual difficulties pervade these relationships. However, the fact that doctors in rural areas are the only resource the government has to provide primary care services to the poor in rural areas, creates a mutual dependence that does not allow for an adequate solution of maladaptation problems.

Guinness (2006) also found similar characteristics in contracts between the government and NGOs for the provision of HIV prevention interventions in southern India. Contract incompleteness and human-type RSI were found to be pervasive, causing contract difficulties. Accordingly, the relationships show a tendency towards more hierarchical control.

On these same lines of contracting out, a review of ten cases in seven developing countries involving contracts between government and private providers for the latter's provision of primary care and public health services shows contracts were more successful for those services that had observable outputs or outcomes, or those involving changes easy to implement. In contrast, contracts for services involving deep behavioural changes, like sexual behaviour or reproductive health, were not so successful (Loevinsohn and Harding, 2005).

In a review of the evidence on the market for social services in the United States, Propper (1993) argues that unobservability of outcomes and quality, professional knowledge, and the major role of the government as a purchaser, turns the contracting process into long-term relationships, where contracts are usually renewed with the incumbents and competition rapidly decreases.

Another relevant finding in the US experience regards how safety-net hospitals react to government financing policies. Zuckerman et al (2001) found that during the early Nineties, safety-net hospitals were able to improve efficiency, although hospitals with a large share of uncompensated care were more likely to face financial distress. A follow-up of this study (Bazzoli et al, 2005) showed that non-safety-net hospitals were more likely to close down services that attracted the indigent, in order to reduce uncompensated care. This reinforces the finding among Sub Saharan Africa countries

and in Peru, in terms of increasing the services for the paying patients whereas restricting access to the indigent.

Besides Allen's, a number of studies have focused on the issue of contract incompleteness and contracting costs in the NHS internal market reforms, although not necessarily from a TCE perspective. Spurgeon et al (1997) analysed a series of contracts between providers (Trusts and GP-fundholders) and local health authorities, finding lack of formality in contractual language, informal procedures for the resolution of disputes, and a focus on easily measurable attributes (waiting times, information provided to patients) rather than relevant but difficult to measure ones (clinical outcomes). An analysis by Checkland (1997) focused on the nature of the contractual relationship between purchaser and provider. Given the limited binding force of the contracts and their inherent incompleteness, he concludes that the contract is not the leading force in the purchaser-provider relationships. Crawshaw et al (2000) found that contracts on complex issues like infectious disease control had little input from the technical experts, and the contracts were unable to reduce the transaction costs involved in the risks inherent given the externalities of infectious diseases.

3.4. A critical analysis of the literature

The cases analysed in this chapter show the relevant empirical evidence on hospital autonomy and TCE-related empirical papers.[1] The chapter also analyses some relevant evidence from other fields of the public sector. The limited evidence on the effects of transaction costs on purchaser-provider relationships, and on the effects of hospital autonomisation, adds to the need for further research on these topics, but it is also clear that the available evidence has important limitations that will be discussed in this section.

The experiences summarised in Preker and Harding (2003), and Jakab et al (2002a) are based on Harding and Preker's (2003) framework. These include Indonesia, Singapore, Malaysia, Tunisia, Hong Kong, Eastern Europe and Former Socialist economies. However, most of the studies are restricted to vague indicators of the decision rights enjoyed by the hospital executives. One striking feature of these reports is that they count as successful those experiences that have advanced consistently in the five key

[1] Unless otherwise indicated, the references for the countries in this section are those listed in table 3.1.

elements of this group of indicators. Moreover, Jakab et al call "dysfunctional" those reforms that advance at different rates in the five elements. Equating success to the uniform advance in each of the five elements seems to be an oversimplification as no robust evidence supports the claims for autonomy in developing countries, even less for the convenience of uniform advance through the five elements of decision making. In fact, Jakab et al (p. 36), recognise this lack of evidence when they state that "…there are few robust analyses evaluating performance impact of organisational reforms."

Concerns on the scarcity of robust analyses on outcomes is increased when the reported empirical evidence is reviewed. It suggests, in general, that the expected benefits of autonomisation in terms of efficiency and quality have not been realised, and the growth of public spending on hospitals has not been controlled.

Within this context of no evidence, Harding and Preker (2003) appeal to two main arguments to support their claim for autonomy as a superior solution to hospital malfunctioning. On the one hand, they appeal to the well-known structural weaknesses of the public sector and the more flexible and responsive features of the private sector. Taking a middle path between private and public approaches would have the advantages of private sector discipline and flexible procedures, while keeping public ownership and orientation. This argument underlies the inefficiency-of-bureaucracy, letting-managers-manage rationales mentioned before and, although not explicitly acknowledged, it is a TCE argument. On the other hand, Harding and Preker refer to the previous successful experiences of a first worldwide wave of privatisation of state-owned enterprises producing commercial goods and services, plus a second wave of privatisation/Corporatisation of public utilities (World Bank, 1995). According to their argument, the extension of these experiences to social services seems a reasonable next step in the path towards a new view on the role of the State, as promoted by the NPM approach. In addition, the NPM-type reforms undertaken by some OECD countries, and specifically those related to the Purchaser-Provider Split in Beveridge-type health care systems, are taken as a justifiable argument to promote hospital autonomisation in developing countries. Another argument for this assumption is that western European Bismarck-type health systems have always had independent hospitals and that they work in a socially responsible way (Jakab et al, 2002a).

However, historical differences pointed out by Polidano (1999), and recent developments reported by Hanson et al (2001), suggest that the reality in developing countries may be different enough to question whether the same results would be obtained. These authors' arguments go in the same lines of those of Schick (1998) and Batley (1999) that were mentioned in section 3.2. regarding concerns for institutional capacity to exert an adequate control of autonomous entities.

In a more cynical reflection, Healy and McKee (2002a) remark that reforms are more driven by ideology than by evidence on policy content and means to implement it. Referring to the radical reforms in the ex-communist countries, evidence and its lack thereof is replaced by a reaction to the existing paradigms, i.e., a rejection of the past. They also point out on the same lines of Polidano, that the institutional framework underlying reforms in western Europe is very different to the one that emerged in eastern Europe countries after the fall of communism. This makes it unlikely that embracing reforms that have worked in other contexts will lead to better health system outcomes in the ex-communist countries (Healy and McKee, 2002b).

Therefore, it can be said that the case for autonomy is based on imported assumptions from other sectors that differ from health care in substantial respects. Industrial and commercial sectors are clearly very good candidates for privatisation, as the discipline of capital-, input- and output-markets in a context of reasonably competitive markets, force competitors to increase their performance via higher quality and lower prices. The second wave of privatisation, however, shows that the NPM assumptions can fail when a public monopoly is transformed into a private monopoly. *Ex-ante* and *ex-post* agency problems pervade the relationships between regulator and the private player.

But when it comes to the delivery of social services in general, and health care services in particular, new limitations to the extrapolations show up. One key limitation is the noncontractibility of technical quality, which opens room for inefficient care (either too much or too little care depending on the payment mechanism). This limitation raises concern about the emphasis put on market exposure in terms of patient choice, because poorly informed patients are not in a good position to be the driving force for technical quality competition in a market-based health care system (Propper et al, 2006). Patient-driven competition is more likely to result in a race for those able to pay, if the hospital is paid on a fee-for-service basis. If it is paid on a prospective basis, hospitals are likely

to engage in cream-skimming behaviour to avoid costly cases, or to engage in skimping on care. Patient-driven competition is also likely to force providers to compete on those attributes that, though observable to the consumer, are weak proxies of technical quality, like interpersonal manners, comfortable facilities and state-of-the-art equipment. Regarding these two latter, the Singapore experience is a clear illustration of the risks inherent to patient-driven competition. Hence the UK's strategy to set up an internal market, where market exposure was restricted to third party-purchasers. These were supposed to be well informed, and able to control opportunistic behaviour on the provider side. However, monopolistic purchasing does not necessarily work in the best interest of patients, as health authorities can become unresponsive to patients' demands and expectations, and their contracting behaviour would accordingly deviate from social welfare maximisation. Competitive purchasing is thus another alternative, although it entails the same risks associated with asymmetric information. It could be argued though, that if some regulations and competitive incentives are put in place, third parties would be more likely to avoid inefficient behaviour.

Regarding the emergence of bilateral monopolies as a result of the separation of provider and purchaser, market-like forces in terms of competition "for" the market, rather competition "in" the market can solve for this problem. This is what Baumol (1982) calls contestability of a market, and Preker et al (2000) appeal to this concept to avoid the anti-competitive effect of bilateral monopolies in the PPS in health care. It is interesting to note that none of the experiences analysed considered the possibility of contestability. Even those cases where contestability has been tried, it has been deferred. In the case of Kenyatta National Hospital, where an administration contract was considered in the first place, contestability was squashed by hospital workers. The case of the NHS also prevents the use of contestability because of high fixed costs at the Trust level that would have to be shifted to the remaining services in case a purchaser switched to other provider (Goddard and Mannion, 1998).

It could be said that in the absence of competition or contestability, the existence of a contract at least serves as an instrument for accountability, regulation and incentive setting (Mills, 1997), although a lower impact would be expected in such a bilateral monopoly situation. This is what in fact was reported for the UK. In the case of Zambia, contracts were weakly enforced whereas in Portugal they were meaningless as a planning tool because they were signed six months into the year's contract period.

Among Eastern European Countries and Former Socialist Countries, contracts lacked force because purchasers were not allowed to engage in selective contracting with hospitals.

Extrapolating assumptions from other sectors or countries to justify hospital autonomy in developing countries is a risky undertaking, not only because of those differences inherent to health care that are known *ex-ante*. It is also risky because implementation can show unexpected responses that are not adequately mapped and understood due to the lack of solid theoretical frameworks to carry out systematic empirical studies. Thus, actual results are interpreted in different ways and it is difficult to conclude what works under what circumstances. Obviously it is very difficult to set up rigorously randomised trials, and none has been undertaken so far; except for Gouveia et al's report on Portugal, no other research has been done with such rigor. However, the ultimate weakness of all the reported studies, including Gouveia et al's, is their lack of randomisation, which does not allow ruling out selection bias. It is thus possible to disregard all the reports of successful experiences by saying that those hospitals were more likely to succeed because of pre-existing advantages.

The confusing way of mapping the findings of diverse studies is evident in Preker and Harding's review. On the one hand, although they recognise the inherent trade-offs in setting goals, these are not clearly exposed. In fact, one of the most frequently acknowledged tradeoffs is that between resource mobilisation and equity in access to the poor. The case of Singapore is clear proof that increased autonomy was successful in terms of hospital growth and increase in revenues, but at a serious cost in terms of allocative efficiency and increased wages for physicians in the public sector. On the other hand, the cases reviewed involve many different types of vertical and horizontal dis-integration of public sector networks. Decentralisation involves dis-integration across the horizontal boundaries of the organisation, whereas autonomisation involves dis-integration across its vertical boundaries. If a public hierarchy that owns hospitals is decentralised to regional or local authorities, but these are still the owners of the hospitals, it cannot be called hospital autonomy. Nor if the hospital network is spun off from the purchaser and kept as a single multihospital network, could this be called autonomisation.

One contradictory finding is that Hsiao and Yip's report on the Hong-Kong experience, which is counted as successful in Preker and Harding's book, was in fact an act of de-autonomisation whereby hospitals were put under the command of a single hospital authority. The cases of India (Andra Pradesh), and Singapore, which are counted as successful, are also cases of horizontal integration rather than autonomy. These cases raise a key question: does it mean that the right way to go is not to autonomise but to go for wide-span horizontal integration?

With regards to the experiences in Sub Saharan Africa, Sao Paulo, China, Indonesia, Portugal, Eastern Europe, former socialist economies and the United Kingdom, they are more autonomy-like in terms of vertical disintegration without horizontal integration. However, there are mixed findings in terms of what can be called a "successful" experience. Perhaps the cases of Eastern Europe and former socialist economies point towards the disfunctionalities suggested by Jakab et al (2003) when progress through the five elements of decision rights at the hospital level does not take place uniformly. These country cases (Eastern Europe and former socialist economies) share the common challenge of reducing overcapacity, lack of incentives at the local health authority to hold the hospital accountable, and rigid civil service regulations. It could be argued that the disfunctionality argument suggested by Jakab et al for these countries is valid inasmuch as they have been unable to reduce overcapacity at the expected rate. However, extending this experience to developing countries is not straightforward. As overcapacity is not generally an issue in developing countries (on the contrary, it is insufficient capacity, particularly at tertiary care facilities), it is unlikely that the principle of desirability of uniform pattern of advance applies in the same manner in these contexts. In fact, resource mobilisation was possible in many of the cases despite civil service constraints, and the limited increases in fee collections were better explained by users' plain inability to pay rather than civil service rigidities.

One important point that has been overlooked in all the papers reviewed, except Eid's (Lebanon), is the role of governance and how it works. The other papers just mention the existence of a board of directors, and sometimes how it is composed. However, governance arrangements are very important as they are expected to replace the direct oversight of health authorities in the vertically integrated structure. Although in for-profit firms the board of directors is seen as a second-best solution to reduce agency problems, its survival is enough evidence to assert that its role is important although not

clearly understood (Hermalin and Weisbach, 2003). The expectation that board members in a public hospital will act as perfect agents of an ideal principal is even less warranted than in the private for-profit sector, because of the multiple-task, multiple-principal problem mentioned above. Thus, a board's ability to replace direct oversight is rather limited, and it is also vulnerable to capture by special interest groups. Even in the context of Foundation Trusts in the United Kingdom, where transparent stakeholder participation is actively promoted, skeptics point out at the possibility of capture (Klein, 2003).

Regarding developing countries, McPake (1996) also underscores the lack of evidence. Cynicism about this non-evidence-based policy is exacerbated when, reportedly, developing countries implement hospital autonomy to satisfy lenders' demands for structural adjustment programs, but it is largely a nominal reform without much actual implementation. Regarding the extent of autonomy, McPake argues that the more limited the extent, as for instance, not devolving human resources management, the less likely hospital managers are to take responsibility for hospital performance.

3.5. Concluding remarks

The evidence reviewed here and in annex 1 shows that no conclusions can be made about the effects of hospital autonomisation on overall hospital performance, not to mention social welfare. TCE rationales have been scarcely studied in the process of autonomisation in developing countries. This is surprising, due to the obvious implications of shifting from a hierarchical relationship to a contract-based one in terms of arrangements to govern transactions. In addition, the lack of theoretical models that help map the findings of empirical work make it more difficult to interpret findings. As rejection of the past or externally drafted agendas seem to be the driving force, empirical evidence is all the more important to assess the real effectiveness of hospital autonomisation and exert a real evidence-based policy making.