6. TYPES OF RELATIONSHIPS BETWEEN ESEs AND PURCHASERS

This chapter analyses the research question from the perspective of the first specific objective, which states:

To describe and analyse the existing types of relationships between ESEs (autonomous hospitals) and purchasers, within a continuum between spot contracting and long-term relationships

This chapter analyses whether the market conditions resulting from the PPS create a competitive[1] environment for the allocation of contracts regarding the major types of services contracted, and how such conditions relate to the observed types of relationships (the following chapter analyses the role of transaction costs in shaping the observed types of relationships). Despite vertical dis-integration between the SOH and ESEs, it is still possible that a preexisting local bilateral monopoly prevents contracts from working as compared to how they would work if a competitive provider market emerged from the PPS. Regarding relationships with ARSs, it is also possible that if a given ESE enjoyed local monopoly power, its bargaining power will yield a different outcome as compared to an ESE with no such monopoly power. Regulations related to ARS-ESE relationships can also create distortions to bargaining power.

This chapter is organised under four headings: methods, findings, discussion and conclusions. Under the first heading, the details of the methods are described in those aspects that go beyond the general description given in chapter five. The findings are described by separating them into two blocks: Block 6.1. describes the findings related to contracts with the SOH, which include three subsections: contracts for services to the uninsured, contracts for PAB services, and the ambulance contracts. At the end of these subsections, a classification of the relationships between the SOH and ESEs is proposed. Block 6.2. describes the findings related to contracts with ARSs. The findings are summarised in a short block (6.3.) by testing the propositions set out at the beginning against the reported findings. The findings and conclusions are further presented under separate headings.

[1] Competitiveness in this thesis refers to how dispersed the market is among the participants. The more dispersed, i.e., the lower the market share of the participants, the more competitive the market.

Methods

ESEs have contractual relationships with two large types of contractors: the SOH and ARSs. As shown in chapter 4, the SOH contracts are basically of three types: 1) personal services for the uninsured and for the enrolled in the SS regarding interventions not covered by the POS-S; 2) interventions included in the Public Health Plan (PAB); and 3) operation of ambulance services. Regarding contracts with ARSs, they vary between capitation and fee-for-service contracts.

The propositions to be tested in this chapter, regarding contracts both with the SOH and ARSs, are:

- **Proposition 1**: Long-term relationships are more likely to occur due to the presence of a pre-existing bilateral monopoly, i.e., the SOH and the ESE at the local level are the only purchaser and provider respectively, both before and after the PPS.
- **Proposition 2**: Spot-contracting is less likely to occur than longer-term relationships, even for undifferentiated services.
- **Proposition 3**: When a bilateral monopoly emerges from the PPS, the parties to the relationship have no exit option; it predisposes the relationships to become conflict-burdened, instead of cooperative.
- **Proposition 4**: Competitive markets would lead to relationships of a shorter-term than those of bilateral monopolies

Table 6.1. shows the ESEs that were interviewed with some basic data that will be referred to in this and the following three chapters. Table 6.2 shows the purchasers that were interviewed. The information collected through interviews and secondary sources of data was also used for chapters 7, 8 and 9.

As will be shown below, in a first attempt to classify relationships within the continuum from spot contracting to long-term relationships, a new variable emerged in the analysis. It was found that all the relationships were long-term but for other reasons that will be explained in detail in the findings section. Thus, from the perspective of transaction costs, it turned out to be more relevant to comment on how cooperative the relationships were between the SOH and ESEs.

Although cooperation can be an extensive and complex construct, it is taken here with a simpler meaning. The statements of ESE managers during the interviews regarding their relationships with the SOH made it possible to clearly classify these relationships into positive or negative. On the positive side, some managers reported their willingness to adopt changes in payment mechanisms and other SOH policies earlier than other managers, and reported good interpersonal relationships with the Secretary of Health and other SOH officers. On the negative side, other managers reported their dissatisfaction with some SOH policies and their strategic moves to oppose the adoption of those policies. They also reported less than friendly interpersonal relationships with the Secretary of Health and other SOH officers, and consequently reported more frequent and intense conflicts with the SOH. The clear separation of ESEs into these two groups was easy because the interviewees' responses were very explicit. Cooperation was also stable through time, so no manager reported a shift from one side to the other.

Based on these two clearly different categories, ESE-SOH relationships were classified as cooperative or less-cooperative (openly non-cooperative relationships were not found). These perceptions synthesised a subjective assessment derived from the interviews A standardized measure of cooperation was not warranted in the context of this thesis because such a measure would have been more useful for quantitative analysis purposes and to assure an adequate level of external validity. By contrast, keeping a simple two-category variable (cooperation vs less cooperation) was enough to support the argument that hospital autonomy creates new dynamics between ESEs and payers and to explore how these dynamics can be associated with other variables extracted from the available data.

Regarding relationships with ARS, these were classified as cooperative or adversarial, based on the researcher's subjective perceptions about the statements from interviewees, in a similar way to that used for ESE-SOH relationships.

Table 6.1. Basic data on ESEs

Code of ESE§	Number of beds	Level of complexity†	Total revenues (2002)‡	Revenues from SOH as a proportion of total revenues	Fixed labor costs as a proportion of total costs*
IIIA	172	III	46.00	0.44	0.75
IIIB	329	III	44.84	0.57	0.64
IIIC	170	III	42.54	0.56	0.28
IIID	176	III	18.34	0.69	0.66
IIIE	174	III	16.69	0.66	0.88
IIA	211	II	19.43	0.80	0.73
IIB	104	II	18.53	0.65	0.23
IIC	106	II	17.83	0.74	0.77
IID	73	II	10.40	0.73	0.81
IIE	47	II	9.73	0.66	0.76
IIF	65	II	8.58	0.76	0.73
IIG	68	II	6.35	0.68	0.80
IA	28	I	14.53	0.84	0.82
IB	32	I	11.97	0.63	0.33
IC	49	I	10.93	0.67	0.49
ID	20	I	10.75	0.53	0.48
IE	39	I	9.59	0.72	0.53
IF	15	I	9.45	0.67	0.66
IG	13	I	5.95	0.77	0.78
IH	12	I	5.83	0.80	0.71
IJ	23	I	4.13	0.82	0.65
IK	6	I	1.04	0.78	0.51

§ Codes are separated into III, II and I, according to level of complexity of the ESE

†Level III is the highest complexity

‡Total revenues in 10E*9 Colombian pesos.

*The term fixed labor refers to those employees under civil service regulations, with indefinite-duration employment contracts. The equivalent term in the UK is “permanent staff.” These employees are a fixed cost to ESEs because they cannot be fired or their contracted hours reduced when demand falls.

Table 6.2.

Basic data on purchasers

Name of purchaser	Characteristic
Secretariat of Health	Local health authority
ARSI	ARS nonprofit
ARSII	ARS nonprofit
ARSIII	ARS for profit
ARSIV	ARS for profit
ARSV	ARS for profit

Findings

6.1. Relationships with SOH

6.1.1. Contracts for services to the uninsured

These contracts entailed personal services to the uninsured and those services excluded from the POS-S of the SS enrolees, as shown in table 4.1. As explained in chapter 4, these contracts were based on the FGPP system, subject to an annual cap on billings for each ESE. Given that ESEs depended in large part on the revenues generated by this contract for their survival, both the SOH and the ESE expected to renew the contracts every year. Thus, ESEs did not have to compete for these contracts. For example, when asked about competitive awarding of contracts and automatic renewal, the manager of IIG reported that:

"...the SOH writes the contracts for the 22 ESEs [to guarantee the funding of their operating expenses] and to make sure the uninsured are provided care. However, (...) we know the SOH could contract out these same services with private providers and it would be equally able to cover the uninsured. But (...) it is necessary to keep public providers for PAB and P&P activities, and because of local market characteristics. For instance, in the locality[2] *there is not a private level II hospital. IIG is the only ESE."*

And the manager of IJ commented, in similar terms:

[2] Bogota is divided into 19 localities, each with its local Mayor and local administrative boards.

"... it is a contract of successive tract[3]*. Every year we will have to provide care for the uninsured; every year there will be a responsible, the territorial entity [i.e., the SOH], and an executing entity, which is [the ESE]. It could be the case that the conditions of contracting change, but it is permanent, continuous, so to speak."*

Managers' awareness of their ESEs' role as safety net providers was evidenced by statements like that of the manager of IB:

"The SOH has a paternalistic position vis à vis hospitals, they try to support us, to negotiate (...) In any case, the fact that we are public entities with our unique features and fixed costs, obviously restrict our being competitive (...) in addition, the fact that we have to take care of a patient whether he can pay or not, makes us a different category of hospital."

And the view of an SOH officer reinforced this perception:

"…although the open agenda [of the SOH] was to make ESEs become efficient, the hidden agenda was that no ESE was to be closed."

Indeed, the SOH viewed the contracts for the uninsured as the basic revenues for ESE to survive, providing a safe source to pay their fixed labor costs and part of their consumables and variable labor costs. But some ESE managers had a negative perception of this dependence from the SOH, as acknowledged by the manager of IIIC:

"...we have no autonomy whatsoever because the SOH exerts a strong control on ESEs through the contract, and we are all SOH-dependent."

But the SOH also aimed at improving the match between supply and demand. A key tool for that purpose was the annual billing caps, which had two different implications, as put by two SOH officers. One of them said:

"…between 1996 and 1999 the SOH paid on a fee-for-service basis, and some ESEs doubled their budget and grew quickly (...) These ESEs wanted to keep that [dynamic],

[3] A legal term implying, for this particular situation, short-term continuous contracts in the context of a long-term relationship, instead of a single long-term contract.

with the argument that they were the efficient ones, the ones who should survive, but this situation could not be supported by any system. We found that for Intensive Care Units, pulse oximetries were costing us more than doctors' fees. They carried out oximetries every hour (...) Later on we set the billing caps, because they learned to bill and to work the package: if a patient showed up at the A&E service, they kept him for 24 hours to charge the inpatient day."

And the other SOH officer said:

"...we were aware beforehand that some [ESEs] were unable to cover their expenses with a billing cap that was estimated based on minimum essential expenditures (MEE). These were the ESEs that exceeded the billing cap (...) Other ESEs had a [billing cap] higher than their output capacity (...) and there were two instances here: the lazy ESEs and the failed ones [i.e., those facing structural problems difficult to solve, like geographic location and high fixed labor costs]. On the side of the failed ones, some of them had not enough demand, like IK, IIIE, IF."

As said in chapter 4, the billing cap was estimated based on each ESE's Minimum Essential Expenditures. Fixed costs typically were the result of previous SOH decisions on where to invest in capacity, while variable costs were the result of previous ESEs' effort to increase output during the FFS era and the SOH willingness to compensate those outputs. Therefore, the SOH considered that it would be difficult to sharply reduce budgets to force output downturns (among overproducers) and output increases or capacity downsizings (among underproducers). An SOH officer explained this situation:

"...those who were high demand inducers (...) were unable to reduce production costs. When we shifted from historic budgeting to FFS payments, we compelled [ESEs] to bill everything. Then when we shifted to FGPP, they were unable to suddenly change the cassette towards restriction.(...) But [ESEs with] rigid fixed labor structure (...) low productivity and poorly designed processes (...) had to produce many more units to generate enough revenues to cover their operating costs,(...) but they were unable to, which forced many [of these ESEs] to enter a vicious circle of decline."

Accordingly, the SOH policy meant a commitment to keep the previous pattern of costs with piecemeal adjustments of each ESE's billing cap to force output and capacity adjustments to actual demand.

ESE managers acknowledged that to the extent that they increased their share of revenues from sales of services to ARSs, and other purchasers, the SOH contracts lost relevance for ESEs and managers were able to enjoy more autonomy. In addition, they were able to expand the overall budget of the ESE because the billing cap set by the SOH only applied to the services sold to the SOH, and not to the services sold to other purchasers. However, ESE's incentive to increasing sales to ARSs was limited by the slow growth of SS enrolment, as shown in chapter 4.

Thus, the limited expectations to increase billings to other parties kept the contracts with the SOH as key for ESE survival. Therefore, there was a clear relationship of mutual dependence. As it turned out that all SOH-ESE relationships were long term because of *ex-ante* bilateral monopolies that would emerge as *ex-post* bilateral monopolies, and not as a result of a choice of the parties, a more relevant question was the extent of cooperation (as defined in the methods section of this chapter) that these relationships showed. As non-cooperation is in itself a source of transaction costs and cooperation reduces transaction costs, it was found that analysing cooperation and the variables that were associated with higher or lower degrees of it, was a very relevant question.

The relationships observed between ESEs and SOH regarding the contract for services to the uninsured[4] varied from close cooperation to less cooperation. The varying degrees of cooperation were evidenced through the two major sources of disputes between ESEs and SOH: the payment mechanism (the FGPP), and the billing cap.

Regarding the FGPP, negative views were openly expressed by managers. For example, the manager of IIIC said:

[4] Given that PAB and ambulance service contracts were much smaller, their dynamics were embedded in those of the larger contract for the uninsured. As will be shown below, the only exception is IK, where the PAB contract made up three fourths of the ESE's revenues.

"...I filed a suit against the contract, when the FGPP started, because I considered it was hurting ESEs.(...). FGPP rates are about 20% below SOAT fees"[5]

The manager of IIID commented:

"The FGPP is perverse because it has remained unmodified for two years. It does not take into account the prices of inputs and the costs of qualified labor. In addition, public utilities increased their rates by 40% last year."

An early reaction against the adoption of FGPP by the SOH was led by IIIC, which had shown the largest increase in output during the fee-for-service era with a very flexible scheme of labor costs. Shifting to FGPP meant a radical slowdown of output production which was difficult for the ESE to achieve in one or two months.

Regarding the billing cap, it was found to be a continuous source of conflict for some ESEs that provided services above the cap but were not compensated for those services. Some hospitals were very cautious not to exceed the cap, as IIIC, whose manager pointed out, when asked about exceeding the cap:

"No way! It is tracked on a day to day basis. The strategy is to reach the edge of the billing cap"

The manager of IH also commented:

"...[Monitoring costs] are a daily issue. In fact we have an auditor, mainly for billings. If ones does not keep track of it, one could exceed the billing cap, and there's where the problems arise."

Other ESEs exceeded the billing cap, either because they were unable to constrain excess demand (like IIF or IIB) or because they allowed this excess demand to exceed the limits (like IB and IC). ESEs in the former group, more than those in the latter, had persistent disputes with the SOH to get these overprovisions compensated, but the SOH

[5] As explained in chapter 4, SOAT is a parallel insurance system that pays for services provided to victims of car accidents. It was created in the early nineties and it designed its own fee schedule to reimburse hospitals. This schedule has been used as a reference for the pricing of fee-for-service contracts in the SS and the EBS, although it has been progressively abandoned for other schedules with lower fees.

was very inflexible and argued that those were social surpluses that the ESE had to produce for the community. The manager of IJ explained this in the following words:

"...I can exceed the [billing] cap but I lose whatever bills are above it. [the SOH] calls it social surpluses, i.e., what society thanks to the ESE for having done more than what was purchased."

According to an SOH officer, it was in year 2001 when they started the policy to deny bills exceeding the billing cap; it was then that they decided to dub this uncompensated care "social surpluses." But positive views of uncompensated care were also found. For example, that of the manager of IC, who stated:

"...for this ESE, [the cap] has been progressively increased according to how its billings have evolved. If [the SOH] sees the ESE is exceeding the cap, they have tried to increase the cap for the following year (...) If I demonstrate [to the SOH] that we are exceeding the cap, I will be able to get a higher amount for next year's contract. Last year we had a cap of CP 390 million a month, and this year it was increased to CP440. (...) therefore, we have [used the strategy to exceed the cap] as a battlehorse[6] for the negotiation of the next year contract."

With a different perspective that was not found with any other manager, the manager of IB's positive view of uncompensated care was:

"On the one hand it is not only my belief but it is also the hospital's: it is a social enterprise and our goal is not economic profits but to deliver care. On the other hand, if one puts access barriers, people start to judge badly the hospital, and the time will come when not even the [billing cap] is achieved. We have a very good image in the locality because we do not deny services."

The importance of the FGPP and the billing cap as the two largest sources of disputes between ESEs and the SOH make them an adequate field to test the levels of cooperation. It could be argued that manager's level of cooperation depends, among other factors, on:

[6] A colloquial expression in Colombia to give the idea of a recurrent argument that is relentlessly used with the objective of achieving a concession that is unlikely to be won with other means.

a. The degree of monopoly power enjoyed by the ESE.
b. Its level of total revenues.
c. Its level of inefficiency.
d. Its level of dependence on revenues from the SOH.
e. The manager's career concerns.

These five variables are described and analysed in the following paragraphs of this section. Three of them were used for a further analysis to predict cooperation or less-cooperation as shown below.

a. The degree of monopoly power enjoyed by the ESE

As shown above, it was clear that the SOH and the ESE were in a lock-in situation, which was crucial to explain why, before 1999, some ESEs overspent the budget and delayed the payment of salaries to their employees. This game was described by an SOH officer in these words:

"...up to 1999, the political environment favoured the ESEs. (...) they spent their budgets paying short-term employees and other expenditures [first], whereas salaries for the civil servants were left [unpaid]. Then [civil servants] went on strike and forced the SOH to find the money [to pay overdue salaries] whatever it took."

Another SOH officer tells a story that happened before 1999 and clearly reinforces this dynamic:

"Expenditures end up being absorbed by the SOH, because hospitals are [never] shut down. Three women chained themselves at El Guavio Hospital because we planned to close 6 beds out of 40."

This game was repeated several times until 1999, when the SOH decided to change the payment system to the FGPP and set the billing caps. In addition, some regulations were passed at the City Council to restrict ESE's budgetary autonomy, as will be seen in chapter 8.

In addition to monopoly power, the market for ESEs services was found to lack contestability. As quoted from the manager of IIG, no matter that the SOH was able to contract out to private providers, it never did so because it had a commitment to keep the public hospitals operating. Moreover, the exit option was seen as politically costly. As the quotes from the two SOH officers above showed, a public hospital is never shut down, because the community will immediately react to protect their hospital. An SOH officer commented on this lock-in situation:

"…unlike in the private sector, a wrong decision [of an ESE manager] does not end up in the owners capitalising the company. Here, a loss ends up beheading the one who is supposed to rule. There is an idea in the collective imaginary that the SOH has a political responsibility."

The following quote from the manager of IIIA, an ESE with a complex problem of internal politics with labor unions, illustrates the general perception of no exit option for the SOH. When she tried to face the organisational problems of the ESE and reduce redundant labor, one of the labor union leaders told her:

"…let them work unnoticed [as ghost, or unproductive workers]; the SOH sends in the money later on and the ESE will be able to pay their salaries anyway. The SOH will not let this hospital to be shut down. Don't be foolish."

However, on the side of patients, some ESEs had no such monopoly power. To the extent that the contracts for the uninsured allowed for patients to freely move to other ESEs (because the uninsured were not identified in the contract), freedom of choice stimulated ESEs to attract patients in order to increase services billed to the SOH (subject to the billing cap, of course). This dynamic was more common for higher complexity services than for primary care. It can be illustrated by the manager of IIB :

"...the uninsured shows up at IIB (...) he prefers to come here because he knows we [don't put access barriers here] and provide [seamless care], so the next time, that patient will not go to another ESE because he knows his [health] problems will not be solved. Instead, he comes directly to IIB because we solve his problem without trouble."

Patient-driven competition at higher complexity services was found to be particularly hurting two hospitals: IIIE and IIG. IIIE is almost cornered at the outer eastern side of the city, and has two competitors closely located but also closer to the central area of the city. One is IIID and the other is IIA. The manager of IIIE reported that not only the neighbourhoods surrounding the ESE did not provide a large enough referral base for a tertiary care hospital, but people living between IIIE and the two closer ESEs very often preferred to go to these two competitors because they were closer to other tertiary care hospitals, means of transportation were readily available and a wider portfolio of services was also available. The case of IIG was similar. Its manager reported, when he complained about the marketing strategies of IB, a neighbouring ESE, that:

"...IB offers (...) a series of services that are not level I but level II (...) It provides them as a value-added marketing strategy (...) for example: pediatrician, gyneco-obstetrician, orthopedic surgeon. (...) Apparently no purchaser reimburses those services but (...) it attracts people that we, at IIG, have difficulties to attract."

b. Level of total revenues

The degree of cooperation was found to relate to the level of total revenues of the ESE. Table 6.1. shows the values for each ESE. These values were categorised into high if total revenues > 12*E09 Colombian pesos, and low otherwise (see table 6.3. below). It was found that managers of high-revenue ESEs (i.e., the highest complexity ones) were more likely to express dissatisfaction with the SOH because of the FGPP system, as shown by the quotes above from the managers of IIIC, IIID and IIIB. In fact, the manager of IIIC boasted about his leadership in the reaction against the FGPP, because he, as he himself recognised, was in a better position to do so.

On the side of low-revenue ESEs (mostly level I and II ESEs), they were found to be more likely to cooperate with the SOH. They were prone to consider the SOH a "good daddy" who cares for the well-being of their children.

And the manager of IIG said:

"...one knows they will give one their hand at any moment. It is tacitly admitted: 'work at these prices, I know if you don't do well, somehow we push it forward together'"

Low-revenue ESEs' cooperation was manifested by their quickly adopting the FGPP system and all the directions from the SOH. For example, the manager of IIE stated that:

"...I believe I was the first to sign the [FGPP] contract. (…) when I sign the contract [the SOH] makes a downpayment and one depends on that."

Similarly, a general positive view of the SOH as the local health authority was manifested by the manager of ID:

"... one is an executor, so one just executes the directions of the SOH. Sometimes one disagrees with those directions, but of course they fulfil their obligations to direct health actions in the City."

A more cynical view of those managers showing cooperative behavior was stated by the manager of IIIC:

"… [the SOH] keeps a group of managers that are genuflect and submissive, who are very likely to have deficits and trouble inside [their ESEs]. They have no other choice but to kneel to the Secretary. [The Secretary] settles the conflict through his authority."

c. Level of inefficiency

The decision to cooperate could also be related to the level of inefficiency of ESEs related to fixed costs. Although no data on costs were collected, it could be argued that ESEs with a higher share of costs represented by fixed labor (i.e., civil servants with costly entitlements and job rigidities) were less able to react to fluctuations in demand or to business opportunities. The continuous data of this variable, shown in table 6.1., were categorised into high fixed-labor cost ESEs, i.e., those showing fixed labor costs higher than 60% of total revenues, and low fixed-labor otherwise.

The above quote from the SOH officer suggested that the most relevant component of fixed costs is personnel, specifically, as acknowledged by all the interviewees, those

employed under civil service regulations, because they can only be removed after a costly process.

It could be hypothesised that ESEs with high fixed costs would be more likely to cooperate with the SOH, because it will make easier for the ESE manager to get additional money to pay those fixed costs. On the contrary, it could be hypothesised that managers facing high fixed costs are more likely to experience conflict with the SOH because the latter would have more power to influence decision making at the ESE level, as compared to ESEs where such dependence is lower. However, it was not found that high-fixed-cost ESEs were clearly more or less likely to report conflicting relationships with the SOH.

d. Level of dependence on revenues from the SOH

Regarding this variable, the continuous data in table 6.1. were categorised into high- and low-dependence, as shown in table 6.3. below. High-dependence ESEs were those where more than 2/3 of total revenues came from SOH. As shown at the beginning of the findings section, ESEs tried to increase their revenues from purchasers other than the SOH as a strategy to increase their autonomy. In fact, it was found that ESEs that had been able to increase their revenues from other sources (ARSs, local mayoralties, EPSs, etc), were able to enjoy less oversight from the SOH. A quote from the manager of IIIC illustrates this point:

"We are very autonomous, mainly because 49% of our revenues come from other purchasers [i.e., other than the SOH], and that is money the Secretary cannot control. However, I am not totally free to use that money because the budget is approved by the board of directors, and it includes representatives from the Mayor and the Secretary. But as my outcomes have been very good, I strongly lead the Board, and I have had wide autonomy. (…) my relationship with the Board has been good."

The proportion of revenues coming from the SOH (see table 6.1.) was repeatedly shown by managers as an indicator of how dependent they were on the SOH. However, among the 22 ESEs, no manager felt independent enough to ignore the impact of SOH policies or procedures. Although some enjoyed more independence than others, it was not found

that ESEs enjoying lower (higher) dependence were more (less) likely to experience conflict with the SOH.

e. Manager's career concerns

This variable mainly refers to managers' expectations to be re-elected or to leave the ESE for a better job. It is important to note at this point, that the selection of ESE managers in Bogota has been quite transparent and meritocratic during the three previous administrations, as pointed out by several managers. For example, the manager of ID said:

"…the Board puts me in the short list of three candidates, but when it goes to the Mayor, the Secretary of Health says 'I think this is the best of the three.'"

If managers wanted to be reelected, they had, among other factors, to show good performance in terms of output, financial sustainability and less dependence on bailouts from the SOH. Given the influence of the board members representing the SOH and the Mayor in this reelection process, managers who expected to be reelected had to satisfy these members of the Board of Directors, because they were the ones who made the nominations for the following period. The manager of IF described it in the following terms:

"For example, last year, when I closed several health centers, someone said that I had ruined my re-election. However, I started working with the community to show them what the ESE had done. We give concessions (in the good sense of the word) and when the community say 'what are you giving us in exchange of those five centers?' I say 'I'll give you the service of collecting samples for lab tests, or the 'health path',[7] etc.' Then for the re-election process one has to show that what one has done is good but what is coming later is better."

It was also found that personal relationships between the manager and the SOH played a role in managers' level of cooperation with the SOH. It would be expected that if the Secretary of Health wanted to implement a policy that would face resistance, he would

[7] The "health path" is an outreach program that consists of a minivan that goes around the neighbourhoods in the area of influence of the ESE. It carries out home visits and provides transportation services for patients to and from the ESE.

be more likely to start with a manager with whom he had a good interpersonal relationship. This was pointed out by the manager of IIIB who had disruptive relationships with the Secretary, and he referred to another manager as:

"…[the manager of that ESE] calls [the Secretary] 'little boss' and she does whatever he says. Instead, [the Secretary] is rude with me and I answer 'you are [such and such], you have to respect me' and so on"

In the opposite sense, good personal relationships can be considered a means to increase the chances of success, as was considered by the manager of IK:

"…If you do not get along with the SOH [officers], you will do bad. But when do you not get along? When you do not manage, do not show efficiency (…) or when you challenge the Secretary."

Accordingly, beyond the role of the Board of Directors in the reelection process, good relationships with the Secretary of Health were important. As shown in chapter 4, it is the Mayor who officially appoints the manager, but in the case of Bogota, he usually asked the Secretary to make the choice from the short list sent by the Board of Directors.[8]

6.1.2. Contracts for public health services (PAB)

Being a District, Bogota has competencies both as a department and as a municipality. Regarding public health interventions, Bogota receives transfers from the GSP to contract with ESEs for the provision of PAB services. PAB contracts are signed with level I and II ESEs only. ESEs do not have to compete for these contracts, as the SOH designs them and defines what activities are to be undertaken and their respective inputs.

According to SOH officers, it is an explicit policy of the SOH to contract all PAB services with the ESEs, even if it can find lower-cost providers in the private sector.

[8] This was the case at least until 2003. During the 2004-2007 administration, the Mayor has been more directly involved in the selection of ESE managers. This finding was reported by three managers interviewed during 2004.

Thus, ESEs did not perceive a threat that the SOH contracted out PAB services to private providers, as put by the manager of IIC:

"… that possibility is always there, but so far they [the SOH] haven't even considered it. It is very likely that they can find lower prices in the marketplace, because our labor costs are higher."

An extreme case is that of IK, which is a small ESE located in a totally rural area in the southern part of Bogota. According to the manager of this ESE, this area is affected by armed conflict and the national government has decided to enhance its presence in order to raise community support. Part of this strategy is to increase investment in health, and the ESE seems to receive special considerations from the SOH in terms of budgeting. As a result, three fourths of the ESE's revenues were provided by the PAB contract despite the fact that its area of influence covered a small population of about 2,600 individuals. The manager reported no concern for the bargaining position of the SOH and the fact that the ESE was a monopoly did not affect the relationship.

6.1.3. Contracts for ambulance services

As shown in chapter 4, Bogota decided to set up a centrally operated network of ambulances by bringing the vehicles to a single location, the Center for the Regulation of Emergencies (CRU). ESEs had their own vehicles and crews, and they contracted with the SOH for putting these in the CRU.

Similar to the contracts for services to the uninsured and the PAB contracts, ESE managers reported that the granting of ambulance contracts by the SOH was not competitive. However, although managers were allowed to discretionally decide if they wanted to contract with the SOH to put their ambulances at the CRU, most managers preferred to contract and put all or some of their ambulances at the CRU. One of the reasons had to do with the costs of the crews: most ambulance drivers are a special category of civil servants called official workers, who enjoy a very rigid variant of civil service regulations and entitlements, which makes them costly and difficult to deal with, as pointed out by the manager of IID:

"...I would prefer to fire all drivers who are official workers (...) they are good for nothing. Unfortunately (...) official workers have that tremendous problem: tricks, misconduct, laziness, union-labor leave, proneness to stay idle."

The manager of IIC clearly illustrated why he had an incentive to contract with the SOH:

"...our four ambulances (...) mean a monthly loss of about CP100 million, basically because of salary costs. [The revenues from the SOH contract] do not cover these costs, but if we do not contract, we have nothing to do with them.(...) The contract helps me to defray expenses, because otherwise I would have to bring them here to do nothing."

Given the incentive to contract on the side of the ESE, the SOH is very strict in demanding the fulfilment of technical criteria of equipment and vehicle, and the ESE has no other choice than to invest to abide by these requirements. In this regard, the manager of IA reported that:

"...ESEs are full of ambulances (...) then the CRU ran a sort of contest and performed exhaustive examination of equipment within the ambulances. Those which pass the examination are contracted, and those which fail are left idle at the ESE."

However, some ESEs decided to keep at least one ambulance at its facilities instead of putting it at the CRU, because they use it for their transportation needs.

Given that the ESE managers had discretion to put ambulances in the CRU (there was an exit option), and most of them considered the compensation was adequate, the relationship in this particular contract was found to run very smoothly. Exit option, adequate compensation and a rather competitive market for ambulance services, made it more likely that the relationships were of a short-term type. However, it was found that they were long-term with automatic renewal to the incumbents.

6.1.4. Classifying the relationships between ESEs and the SOH

According to the findings shown, relationships between ESEs and SOH for the three types of contracts were found to be long-term, and contracts were always renewed to the

incumbent. As shown above, the fact that both parties were locked in as a result of mutual dependency (except for ambulances), forced them into a long-term relationship. Consequently, long-term relationships in this case were not the result of decisions made *ex-ante* by the parties. Rather, the parties were forced exogenously to hold a long-term relationship. The fact that it was exogenously determined did not guarantee that the relationship would be cooperative; on the contrary, as each party knew that the other had no exit option, non-cooperation, under certain circumstances, was a strategy that could be effective to extract rents or quasi-rents, and at the same time was a source of transaction costs.

At this point the key question is: what are the variables that explain an ESE's decision to cooperate or not? It could be argued that cooperation was a strategy to reduce transaction costs, and non-cooperation caused inconveniences that increased transaction costs. Therefore, cooperation would be a consequence, and noncooperation a cause, of transaction costs. This question deserves a specific analysis. ESE's choice of strategy (cooperate, not cooperate) could be said to depend on what it expected to gain in terms of rents or quasi-rents by holding up the SOH. If the gains of holding up the SOH were larger than the risks and costs involved in a non-cooperation strategy, the ESE would act accordingly.

As shown in the methods section of this chapter, this analysis starts by classifying ESEs within one of two categories of relationships: cooperative and less-cooperative. Among the five explanatory variables discussed above, three were considered relevant for this analysis: level of total revenues, dependence on SOH contracts and fixed-labor costs (civil servants) as a share of total revenues. Table 6.3. shows the classification of ESEs according to the cooperation variable and the explanatory variables.

Table 6.3.

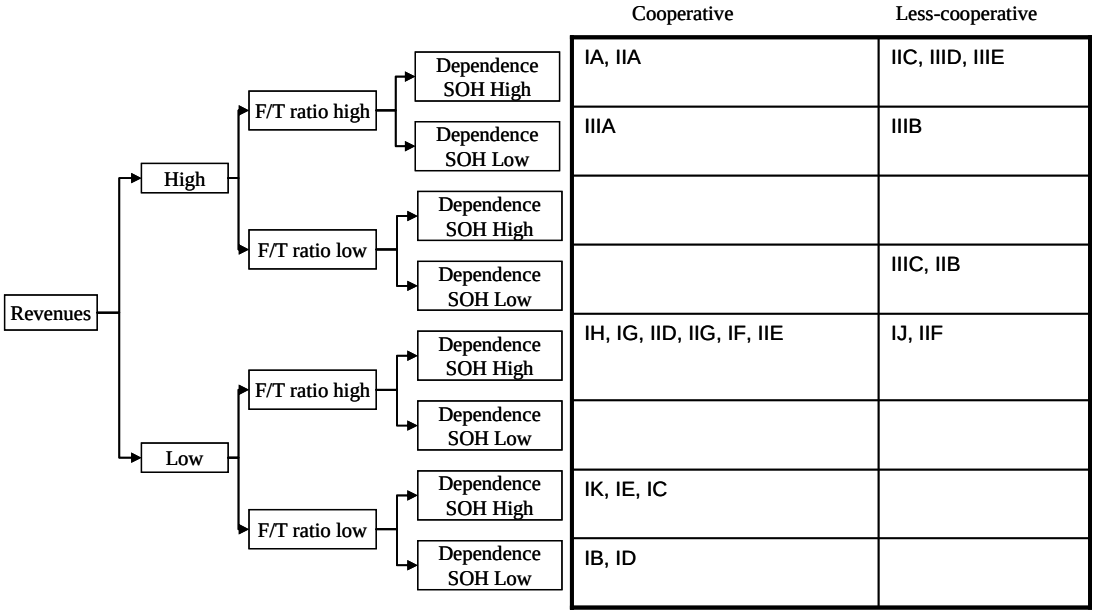
Categorisation of variables associated with cooperation between ESEs and SOH

	Cooperative/less cooperative	Level of total revenues	Dependence on SOH	Fixed labor costs
IIIA	Cooperative	High	Low	High
IIIB	Less-cooperative	High	Low	High
IIIC	Less-cooperative	High	Low	Low
IIA	Cooperative	High	High	High
IIB	Less-cooperative	High	Low	Low
IIID	Less-cooperative	High	High	High
IIC	Less-cooperative	High	High	High
IIIE	Less-cooperative	High	High	High
IA	Cooperative	High	High	High
IB	Cooperative	Low	Low	Low
IC	Cooperative	Low	High	Low
ID	Cooperative	Low	Low	Low
IID	Cooperative	Low	High	High
IIE	Cooperative	Low	High	High
IE	Cooperative	Low	High	Low
IF	Cooperative	Low	High	High
IIF	Less-cooperative	Low	High	High
IIG	Cooperative	Low	High	High
IG	Cooperative	Low	High	High
IH	Cooperative	Low	High	High
IJ	Less-cooperative	Low	High	High
IK	Cooperative	Low	High	Low

It can be seen that six out of nine high-revenue ESEs showed less-cooperative behaviour (as said above, openly non-cooperative behaviour was not found). The three exceptions to this finding were ESEs IIIA, IA, and IIA, which had high fixed labor costs. In contrast, ESEs with low revenues were more likely to show cooperative behaviour; 11 out of 13 low-revenue ESEs showed such willingness to cooperate with the SOH. Figure 6.1. shows these associations.

Figure 6.1.

Associations between cooperative/non-cooperative relationships and the explanatory variables*



	Cooperative	Less-cooperative
High / F/T ratio high / Dependence SOH High	IA, IIA	IIC, IIID, IIIE
High / F/T ratio high / Dependence SOH Low	IIIA	IIIB
High / F/T ratio low / Dependence SOH High		
High / F/T ratio low / Dependence SOH Low		IIIC, IIB
Low / F/T ratio high / Dependence SOH High	IH, IG, IID, IIG, IF, IIE	IJ, IIF
Low / F/T ratio high / Dependence SOH Low		
Low / F/T ratio low / Dependence SOH High	IK, IE, IC	
Low / F/T ratio low / Dependence SOH Low	IB, ID	

*(F/T ratio: fixed-labor costs to total operating revenues).

Within a conflict-burdened relationship, it could be argued that the parties were more predisposed to ignore contract terms if the no-exit restriction gives enough room for such strategy. However, on the side of ESEs the contract minutes were seen as serious commitments to be honoured, as could be inferred from the interviews, by the high level of attention that all managers showed on preparing, signing and executing contracts. On the side of the SOH it was also considered that contracts were a very important piece of the relationship as shown by an SOH officer:

"...a dynamic in which [the ESE] needs the money from the SOH, and the SOH needs to guarantee services for the population, led us to seek that for each peso spent a peso of services were provided. And the best way to make sure that to happen is using a contract. I don't believe one can simply say to them 'carry out these ten activities for us and that's it.' Instead, the contract is much more [serious]. Contracts make managers move on (...) It is a matter of making sure that for each peso transferred there is one peso in services."

On the side of the less cooperative ESEs, they knew they were able to challenge the SOH but they also knew there was an equilibrium point beyond which they had to yield to the bargaining power of the SOH. The case of IIIC clearly illustrates this situation: the ESE challenged the FGPP in early 2000 by not signing the first contract, but it ended yielding a couple of months later, because it needed the revenues from the contract to be able to operate. IIID was another example of conflicting relationship, but regarding a number of A&E visits that were not compensated by the SOH. This ESE entered into the FGPP contract, although reluctantly, but the conflicts in the relationship did not affect the FGPP contract beyond the transaction costs associated with less cooperation.

Other ESE managers viewed the possibility to challenge the SOH as a losing game, as said by the manager of IIE:

"I implement policies, I do not make them.(…) I do not swim against the tide. I believe I was the first to sign the [FGPP] contract."

6.2. Relationships with subsidised insurance plans

ARSs and ESEs signed diverse types of contracts, differing mostly on the payment mechanism. The most common contracts at level I ESEs involved capitation payments for level I services, i.e., primary care and low complexity inpatient care. Services included in the capitation package slightly differed between ESEs, as well as the percentage of the premium that was paid for those services. Level II and level III ESEs most commonly signed fee-for-service contracts, although capitated contracts increasingly replaced them in 2002. A third type of contract involved the so called "packages" i.e., a bundled set of services with a single payment for each package. Normal delivery, hernia repair and cataract extraction are examples of these packages.

A key component in the negotiations on capitated contracts was found to be the issue of counterbillings. It was a major point in the interviews with ESE managers[9] and ARS officers. These referred to those services that the capitated ESE was supposed to

[9] Three exceptions were: IIIE, which, at the time of the interview, had not had capitation contracts; IIID, which had just started a capitation contract, but the services contracted (tertiary care) were unlikely to be provided by other ESEs; and ID, whose manager interrupted the interview before a more detailed analysis of the relationships with ARSs could be ascertained.

provide, but for any reason (usually A&E care, or advanced labor) the patient showed up at other ESE. The second ESE billed the ARS for the provided services on a fee-for-service basis, and the ARS paid the bill. But given that this service should have been provided by the first ESE with its capitated budget, the ARS discounted the amounts paid to other ESEs from the capitation the first ESE would receive in the following period. ESE managers usually entered into cooperative strategies to avoid counterbillings, mostly setting up call centers to authorise "out-of-network" services or sending an ambulance to the second ESE to bring the patient to its facilities. Counterbillings were in fact negative revenues, but they were reported by managers to usually be a manageable proportion of an ESE revenues.

One of the most common complaints among ESE managers was ARS's opportunism, mainly regarding denials[10] of payments to ESEs. The manager of IJ described this opportunistic behaviour in the following terms:

"...ARSs are happy, because whenever there are grey zones they impose their criteria. But the ESE [manager] says the same, so we never come to an agreement. In the end we conciliate to pay half and half, but in practice it meant the ESE lost its half."

The manager of IIE had a view about the stronger bargaining position of ARSs:

"...The negotiation with ARSs have hurt us enormously, because they hold the panhandle[11] and they contract with whoever, however and wherever they want. Some of us have bent sometimes to that game, so as not to lose enrollees or contracts."

However, some ESE managers tried to bridge the information gap related to ARSs opportunistic tricks by hiring former administrative staff from those entities. Quotes from the managers of IE and IIIA put this clearly:

[10] Denial is a managed care concept that applies mostly in fee-for-service contracts. Two major sources of denials can be identified: administrative and medical necessity. Administrative denials originate in inadequate submission of bills to the purchaser, either for errors in writing a bill or for services billed that are outside the benefit package. Denials for medical necessity refer to services that, in spite of being included in the benefit package, are considered medically unnecessary. It includes not only questioning the provision of a given service to the patient in the first place, but also the frequency with which the service is provided to the same patient. As will be shown in chapter 7, the grey boundaries of benefit packages and medical necessity open a large room for opportunistic behaviour on both the provider and the purchaser sides.

[11] A colloquial expression to describe a situation in which two persons or entities are involved, but one of them controls it to the annoyance of the other.

"… people working here with me have gone through everything: providers, insurers, reinsurers, territorial entities, so they know all the secrets..."

"…my subdirector worked at the other side and he knows the game of ARSs. He managed our capitated contracts as they used to manage them at ARSs."

However negative the attitude towards some ARSs, managers entered into contractual relationships with them. After all, as shown above, ESEs could not afford to ignore that increasing their share of revenues from ARSs would mean less dependence on contracts with the SOH, and consequently more autonomy. Therefore, they actively encouraged contractual relationships with ARSs. This proactive attitude was reflected in diverse degrees of aggressive competitive behaviour to attract ARS contracts. IIIC, IIB, IIF, IIC and IB were found to be aggressively proactive in their approach to ARSs, whereas IIG and IIIE were found to be less proactive. The other ESEs were in between.

Given that Bogota is the largest urban center in the country, the regulations for compulsory contracting that were commented on in chapter 4 (50% of the premium should be contracted with ESEs), were easily circumvented by some ARSs by setting their provider networks far from the place of residence of the enrollee (to create access barriers), but still "within the municipality" of Bogota. Thus, the SOH introduced contract clauses to ARS-SOH contracts requiring them to contract 40% of the premium with the ESE in the locality, at least for level I services. The remaining 10% was required to be contracted with Level II ESEs within one of the four sub-networks created by the SOH for the whole city, and any level III ESEs in the city. These contractual regulations shaped competitiveness of contracting between ARSs and ESEs.
Law 715 had an immediate effect at the beginning of the new contractual periods in March 2002. Managers of level I ESEs perceived that until 2001 they had to go to ARSs and put considerable effort in getting contracts, but as of 2002 they enjoyed a strengthened bargaining position vis à vis ARSs. For example, the manager of IG said that:

"...Let's say that [the market for ARSs] was more competitive before Law 715. When law 715 said that 50% [of the SS premium] had to be contracted with the public network, it made [ARSs] to look for us. Before then, they didn't even want to look at us.

[Law 715] somehow decreased competition with private providers.(...) One knows [ARSs] renew the contract but mostly because they have to. But one has to do the job (...) not so much for the contract itself as for the number of people they wan to capitate to the ESE."

And, as would be expected from these regulatory restrictions, competition was reduced, as exemplified by the comment from the manager of IF:

"...now we respect the locality [restriction]. But before then, I had patients from other localities and vice-versa. It was a very intense fight (...) Now we are somehow more disciplined."

For level II and level III ESEs, competition for ARSs contracts was reported by the managers as still intense. An intermediate case between level I and level III illustrates these differences. IIC also provides level I services, so this ESE moves in two different markets. According to its manager:

"Regarding level I, we are a monopoly at the locality (...) at level II the game is different: there we have to compete with IIIB, IIE and IIIC."

A case in point illustrates how competition set aside less competitive ESEs: according to the manager of IIG, the ESE had a period during the beginning of 2002 when there was no manager appointed, and the temporary manager did not make any effort to attract contracts with ARSs given his conservative approach to avoid commitments that had to be honoured by someone else in the near future. During that period, surrounding ESEs won contracts for population within the area of IIG, and IIG ended up with no ARS contracts, which caused it serious financial difficulties and a high dependence on SOH contracts.

Competition for contracts regarding level III services is fiercest, as SOH-ARS contracts stipulate that these services can be contracted with any level III ESE within the city. An officer from ARSII, reported large differences in capitation rates:

"...[competition] was mostly based on prices, and there were wide differences: IIIB bid at 15% of premium for level III capitation, whereas IIIC bid for 9%, at most 10%."

As ARSs were allowed to choose the level III ESE they wanted to contract with, ESEs had to invest time and effort to attract these clients. Although all level II and III ESE managers reported they were very active in attracting ARSs, IIIC and IIB were pointed at by most managers to be the most aggressive competitors: these two ESEs signed capitation contracts that included all the enrollees of several ARSs, reducing the market share of the other less aggressive ESEs. The IIIC manager justified this aggressive behaviour by arguing that they (IIIC and IIB) initially invited all the ESEs in the city in 2001 to collectively bargain for a better deal, but the other ESEs were very hesitant and went into lengthy processes to analyse the terms and conditions of participation in the collective bargaining. Then, the manager of IIIC decided to go by himself arguing that *"…so much analysis causes paralysis…"*. IIB manager joined him and they caught a large contract for level II and III services, leaving a smaller share to the other ESEs.

ESE managers reported that aggressiveness of competitive behaviour and, consequently, contractual relationships with ARSs, was highly determined by average costs at the ESEs. In an opposite sense to that shown for ESE-SOH relationships, a lower F/T ratio was reported as a competitive advantage that ESEs exploited to undercut competing ESEs to attract ARSs. In addition, a low F/T ratio meant greater ESE flexibility to increase and decrease short-term employees according to demand. As reported by to the manager of IIE:

"...The legislation allows me to shift workers according to strict needs [of the production process]. But whenever I shift a [fixed labor] worker, I have a problem. It is unusual that no problems arise. (...) [Whereas with short-term workers] I have total freedom, and they are hired exclusively according to needs [of the production process]."

ESEs like IIIC and IIB, which had the lowest share of fixed labor, had a competitive advantage because their lower costs let them charge lower prices, making them more attractive to ARSs. On the side of ESEs with high fixed costs caused by a high share of civil service FTEs, their competitive disadvantage was seen to put an additional burden on their efforts to attract ARSs' contracts. This situation is illustrated with the perception of the manager of IIIE that had not been restructured until 2002:

"...in fact we had problems because some [ARSs] turned away from us. In addition, when capitation took off, we could not join the trend because our costs were too high at that moment.[The cause of high costs was basically] human resources, because our fringe benefit index[12] was about 0.8 and we managed to decrease it to 0.4, 0.5 [thanks to the restructuring process]; it has allowed us to be more competitive, but we still cannot decrease [our costs] to the levels of IIIC and IIB."

ARSs enjoyed diverse perceptions among ESE managers. Some ARSs were perceived as desirable trading parties, whereas others were negatively considered. ARSI was widely regarded by most ESE managers as the best client. It was followed by ARSII and ARSIII with mixed feelings among managers. On the side of poor-reputation clients, ESE managers pointed at ARSIV, Caprecom, and some small ARS (Pijaos, Fondo de Loteros). However, a clear categorisation like the one carried out for ESE-SOH relationships cannot be made for ESE-ARS relationships because not all the relationships were addressed with all the ESE managers or ARS officers. However, it is illustrative to show how the relationships with ARSI and ARSIV worked, as they are at the two extremes (positive and negative, respectively) of perceptions among ESE managers.

Contractual relationships with negatively perceived ARSs can be described as full of ambivalence, because although these third party purchasers were seen with a negative attitude, ESEs were increasing their efforts to attract their contracts. For example, the relationship between IG and ARSIV, an ARS that was repeatedly reported as a problematic client, illustrates this point:

"...we cannot [consider not to sell services to ARSIV]. The three localities [in the ESE's area of influence] have a very small SS population of about 30,000 enrollees, whereas [the locality of] Bosa has about 100,000. Therefore, if I say no to ARSIV, I lose at least 30% of those 30,000 enrollees.

Some ESEs were also very selective when it came to put effort to attract contracts. The manager of IIF commented on this selective contracting:

[12] The value of fringe benefits (i.e., additional amounts that have to be legally paid to a worker besides the basic monthly salary), as a proportion of the basic salary. Fringe benefits are particularly high for civil servants and even higher for official workers, the most costly category of civil servants.

"…we were very careful to define what ARSs we would contract with. We were strict in defining which of them were more likely to experience difficulties in payments, and that allowed us to have a better cash flow as compared to other [ESEs]."

Some ESEs however could not afford to be selective because of cash needs, as put by the manager of IF:

"… however sometimes the budget issue is so complicated that one has to say 'how much you give, I take it' no matter it is a one-point difference, because one needs liquidity."

Similar to the relationships with the SOH, the sense of contracting with undesirable ARSs because there is no other choice, makes it more difficult to create a long-term win-win relationship. In fact, managers complain all the time about ARSs contracting strategies, and their opportunistic behaviour, as illustrated by the following quotes:

The manager of IF said:

"...besides the fact that they are despicable, they try to include more things [in the contract] for less money, and every year is a long wrestle."

The manager of IIE said:

"...I find a lot of adverse selection [in capitation contracts]; ARSIV sends us the high risk population."

A more detailed analysis of adverse selection in capitated contracts, and of denials in fee-for-service contracts, will be undertaken in chapter 7, within the analysis of contract incompleteness as a source of transaction costs.

In contrast, IIB and IIIC, whose competitive advantage in terms of lower fixed costs allowed them to build long-term relationships with ARSs, illustrate the positive side of perceptions of ARSs. The manager of IIIC said:

"ARSI will never leave IIIC, because there is no other hospital with better quality standards and so ductile to work with, where both managers can meet up to see these variables and work them out. They have serious service problems with other hospitals. For example they say they do not sign contracts with IIIB, and in fact they contracted all the [northern network] with IIC…"

And the manager of IIB stated:

" the other thing we try to manage in the [follow-up] committees with ARSs is [to say] 'listen, we are doing well (…) we have no difficulties we expect to continue with you'; then [they say] 'OK, let's continue with this.' 'Yes, we have had excellent relationships, we have [built] an important strategic unity and we want to continue with you.'"

These two ESEs (IIIC and IIB) illustrate how a competitive advantage can pave the way for building trust and generate win-win situations. This is particularly true with ARSs that are considered the most desirable trading parties, with whom trust, it could be argued, is more likely to result in long-term relationships. The manager of IIB said:

"...there is a sense of reciprocity with ARSs; (...) there is something in the ambience [implying that] IIB helped me when I needed it, so we have to keep going with this. It is something intangible..."

And the manager of IIIC said:

"...we negotiate [the capitation contracts] like with ARSI, with which we negotiated on a month-to-month basis until the contract is profitable for both parties. (...) ARSI is a very proactive firm. We almost consider each other a partner. (...) [but] it was a very difficult learning process..."

Other level II and III ESEs also illustrate their proneness to build win-win situations, again with the most desirable ARSs, given the power of the latter to exert choice. In this regard, the manager of IIID said:

"...with ARSI we have a contracting mechanism we call 'monitored fee-for-service' for Intensive Care Unit services. (...) we have not had problems with ARSI (...) both of us win..."

And the manager of IIC said:

"...When I started here ARSI did not want to hear from us. Now they are married to us. And they are not easy to negotiate with. They are perhaps the most independent to negotiate..."

Regarding conflict-burdened relationships, the story looks different from the side of ARSs. They also complain about ESEs opportunistic behaviour and point out severe administrative weaknesses.

An officer of one ARS raised the issue of captive populations that they were forced to contract with the local ESE:

"…law 715 forces us to contract with public providers, no matter they are good, mean or poor quality providers. Unfortunately we cannot select the provider we prefer […] but when the [government] controlling agents and the SOH come to check, rather than asking if we are providing good quality care, what they ask is if we are fulfilling the 50% compulsory contracting.(…) Many hospitals, because of their exclusiveness in a given area, work their model of care at their convenience, because I have nowhere to go. And that is in Bogota, let alone small municipalities where the ESE is the only provider."

This same officer complained about poor administrative capabilities among ESEs that created tensions with the ARS:

"From my previous experience [as manager of a public hospital] I know [ESEs] have a very poor billing system, because [before the reform] they did not need to issue bills. Now, with law 100 they have to bill, and only now an organisational culture is starting to emerge, because the civil servants do not care if they produce or not, if they bill or not, and it creates difficulties for the administrative structure of the hospital. It has to turn itself over into a billing culture. When [the ESE] sends an incomplete bill [to the

ARS] or does not attach the supporting documentation, the ARS denies payments, […] but when resources are scarce and each one is looking for the best share of that money, coherent control barriers have to be created."

Another ARS complained that despite they had very detailed claims databases built with information from their vertically integrated primary care providers, ESEs distrusted their ARS's information and were not interested in building detailed databases but just getting the money. The ARS officer stated:

"I, with my data, they, with their economic motive, it was very difficult to settle something, and even less putting it as a contingency that can be foreseen in the contract."

The evolution of relationships between ESEs and ARSs can be illustrated with the case of an ARS that experienced rapid growth in enrolment. According to an officer from this ARS, at the beginning it had a small and dispersed population, and it contracted level I services with the local ESE, mostly on a capitation basis. These relationships were smooth, as they paid 54% of the premium as a per-member-per-month payment, which was considered adequate by ESEs. When enrolment in this ARS accelerated, they decided to create their own primary care network, and realised that the services they were contracting with ESEs cost between 10 and 15 points less of the premium. With this information at hand, the ARS proposed to ESEs to lower the percentage of the premium by 15 points, which meant a sharp reduction in revenues for ESEs. Obviously, ESEs reacted negatively and the relationships turned thorny. Then the ARS decided to bring part of level I services to its own network and contracted the remainder with ESEs, creating two problems: overcrowding of its own network and a slash of ESEs revenues (it was before the 50% compulsory contracting regulation of Law 715). ESEs responded by offering discounts on the capitation contracts, although not as big as 15 points; in the end, they agreed to lower by 8 points. As a result of this negotiation, the other ARSs followed in the footsteps of this leader and capitation rates were reduced for the subsequent round of negotiations.

This experience also shows that ESEs were able to strengthen their bargaining position by winning the support of the local community. In the game between this ARS and one level I ESE, when the ARS decided to take its enrollees to its own primary care

network, community organisations stepped in to compel the ARS to keep the contract with the ESE, arguing that it meant an important share of ESE's revenues. They threatened to switch to another ARS if their request to bring the contract to the ESE was ignored. The ARS had no other choice but to sign the contract with the ESE, no matter it was able to provide the same services at lower cost at its own primary care facilities.

Regardless of the level of conflict affecting the relationships between ARSs and ESEs, it was found that such conflict was not large enough to start legal actions at the courts. Perhaps the most serious threat of litigation occurred when one level I ESE faced counterbillings from an ARS that were larger than the capitation payment it would receive from the ARS for that month. The ESE manager threatened to terminate the contract and take it to the courts, but he finally agreed to pay the balance. On the side of this ARS, the officer made it clear that the large amount of counterbillings was explained because the ESE had accumulated several months of those counterbillings.

Early termination of contracts was not reported by ESE managers, except the manager of IIIC. He reported that he introduced a clause in the contracts with ARSs according to which the parties agreed that if the contract was causing losses it had to be terminated early. However, this clause only had to be applied once, with a contract with ARSIV. This contract entailed capitation for level II and III services, for a population whose level I services were delivered by ARSIV's own providers. The manager of IIIC was afraid that this mix of providers was likely to generate incentives to over refer patients to the hospital, but thanks to the close monitoring of utilisation rates, the ESE detected it was generating losses and it was cancelled. Beyond this particular case, no other case of early termination was reported by IIIC or by any other ESE.

Spot-contract-type relationships were ascertained with IIG, the ESE that had no ARS contracts during 2002 and whose population had been captured by other ESEs, as reported above. According to the manager of this ESE, patients in the ESE's catchment area were required to go to other ESEs, although for A&E services they were allowed to show up at IIG. These consultations were reimbursed to the ESE on a fee-for-service basis, but with the prior authorisation of the ARS.

This relationship between purchaser and provider for the provision of A&E services might be considered of a spot-contract type, because there was no concern for past and

future performance, and the contact was discrete. Moreover, the purchaser kept an arms-length relationship with the provider and they interacted through a bill. When the manager was asked what differences could exist between this sort of spot-contract type of relationship and a relationship mediated by a contract, with a longer-term perspective, so as to prefer a contract-based one, he openly favoured a contract-based relationship for several reasons. First, he said the demand for A&E consultations was highly uncertain and was only part of the service portfolio the ESE offered. Second, the existence of a contract, either capitation or fee-for-service based, assured a cash flow that was uncertain without a contract. However, the ESE had to compete with other ESEs to win the contract, and that competition was strongly focused on prices. Given that IIB and IIIC had cost advantages that allowed them to underprice costlier competitors, IIG would not be able to get a contract if it put prices at least equal to its average costs. Thus, it had to reduce prices to get the contracts, even at the risk of making losses, because otherwise the ESE was at risk of not receiving even the cash to pay for its operating expenses, let alone their fixed long-term costs. The manager showed this tradeoff with the following numbers:

"…I billed 42 million pesos to one ARS in January, 46 in February,51 in March, and 59 in April, on a fee-for-service basis for A&E services. We are looking for a capitation contract […] that would generate 20 million a month, to manage the risks of all the local population, related to level II interventions. It seems that it is better not to have a [capitation] contract [and keep receiving the fee-for-service payments for A&E visits]. However, if I do not contract, I run the risk that the ARS contract that same population with another ESE, and I will end up billing less than 20 million pesos. Then I have to take the risk of signing a contract, no matter it is cheaper, at the expense of revenues, but I will be able to hold the clientele."

The approach of the manager of IIF to spot contracts was also very practical. Although he tried to be selective and contract only with good trading parties, he was aware that not signing a contract with a bad ARS meant that those enrollees residing in the area would show up at the ESE's A&E service. Although A&E visits could be billed to the ARS, the fact that it was a bad ARS made it difficult to get the bills paid. Thus, he pointed out that it was better to sign a contract as a tool to exert more pressure on the ARS and increase the likelihood of getting the bills paid.

Although the vast majority of revenues were raised through contract-based relationships, ESEs delivered care to many patients paid by third party purchasers with whom they had no contracts, or for services directly paid by patients. These were clearly spot-contracts but their share of revenues was not only small but also spread over a large number of entities. Therefore, it did not make sense for ESE managers to engage in contractual relationships with these minor purchasers.

In summary, relationships between ESEs and ARSs were found to vary between adversarial and cooperative. ARSs, like ARSI, regarded as desirable trading parties by ESEs were associated with cooperative relationships and more likely to become a win-win situation. Low-cost ESEs were found to be more likely to strengthen their ties with the attractive ARSs, because of their greater flexibility to adapt to purchaser's demands. In contrast, ARSs regarded as undesirable trading parties, like ARSIV, were associated with more adversarial relationships. ARSIV was the most clearly identified with a negative view, and other minor ARSs were also in this category. ESEs which were able to select their trading parties were more likely to terminate a relationship once a contract period was finished.

On the side of ARSs, relationships were more adversarial when, having no choice of provider, they were forced to contract with an ESE that showed administrative deficiencies or problems in quality of care as perceived by the enrollee. This was most commonly observed with level I ESEs, whose contracts with ARSs were protected by compulsory contracting regulations. In contrast, relationships were found to be cooperative when ARSs had alternative providers and found an ESE willing to respond to their needs. Accordingly, relationships with level III ESEs, where competition was found to be more intense, tended to be more relational when the parties found each other a desirable trading party, as exemplified by the relationship between IIIC and ARSI.

6.3. Summary of findings on relationships between ESEs and purchasers

To summarise the findings, the propositions listed in exhibit 6.1. are tested against the reported findings.

- **Proposition 1**: Long-term relationships are more likely to occur due to the presence of a pre-existing bilateral monopoly, i.e., the SOH and the ESE at the local level are the only purchaser and provider respectively, both before and after the PPS.

This proposition was confirmed, but to different degrees. Relationships with the SOH were found to be long-term because they are locked-in to each other as a result of an *ex-ante* bilateral monopoly and an *ex-post* commitment of the SOH to keep the safety net hospitals open. Regarding ARS, they were found to be long-term with level I ESEs because of the compulsory 50% contracting regulation (40% with level I, 10% with other levels), which created a monopoly power on the ESE side but not monopsony power on ARS. But regarding level II and III services, relationships with ARS were found to be more cooperative because, having choice, the parties were more interested in those willing to build win-win situations.

- **Proposition 2**: Spot-contracting is less likely to occur than longer-term relationships, even for undifferentiated services.

This proposition was confirmed, at least with regards to ARS contracts. Even for undifferentiated services, spot contracts were unlikely because a formal relationship with the purchaser was desirable to guarantee a predictable flow of revenues and to decrease the likelihood of payment denials. Although spot contracts were typical for very small clients, their aggregate amounts were a very small share of total revenues, which made it worthless to engage in contractual relationships.

- **Proposition 3**: When a bilateral monopoly emerges from the PPS, the parties to the relationship have no exit option; it predisposes the relationships to become conflict-burdened, instead of cooperative.

This proposition was confirmed both for SOH and ARS contracts. However, for SOH contracts it was clear that not all the ESEs were prone to conflict; it was more likely to occur with high-revenue ESEs. Regarding contracts with ARSs, level I ESEs were more likely to show less cooperative relationships. Due to the fact that level II or III ESE markets were more competitive, it was more likely that well meaning trading parties looked to each other to build a long-term vision.

- **Proposition 4**: Competitive markets would lead to relationships of a shorter-term than those of bilateral monopolies

This proposition was rejected for ESE-ARS contracts, and did not apply for ESE-SOH contracts. Although this proposition assumed that more competitive markets would make long-term relationships unnecessary, the findings showed that when ESEs had to compete for ARS contracts for level II and III services, they were more likely to build win-win relationships with ARS, particularly when the ESE was more flexible to adapt to -and hence choose- their trading parties. This was associated with longer-term relationships. The role of transaction costs in shaping this trend towards long-term relationships will be analysed in the next chapter.

Discussion

As shown in chapter 2, the NPM approach assumes that the PPS reduces the transaction costs of vertically integrated structures (Walsh, 1995). This rationale applies in Middle-Income countries because some efficiency and quality gains can be expected from more autonomy at the hospital level. But the critique to the PPS shows that given the transaction costs typical of contractual relationships in health care, it should be expected that 1) purchaser-provider relationships evolve towards long-term arrangements and competition is severely reduced; 2) *ex-ante* bilateral monopolies do not allow for the emergence of competitive markets after the PPS, and the parties keep their exclusive long-term relationships; and 3) contracts are automatically renewed to the incumbents, and no litigation or early termination is possible because there is no exit option for both parties. Within this context, the critics of the PPS propose that contracts lose their force as binding laws to the parties, and the expected quality and efficiency gains of shifting from a vertically integrated to a contract-based (if not competitive) relationship are not realised (Mays, 2000).

This is what has been reported in the UK by Checkland (1997) and by Crashaw et al (2000). In fact, when the relationships become “too intimate”, as predicted by Bartlett and Le Grand (1993), lack of competition is more likely to deaden the force of contracts. During the first years of the PPS in the United Kingdom, there was a very strong bilateral monopoly whereby the only purchaser was the Regional Health

Authority (GP Fundholders represented a minor share of revenues for Trusts) and the only provider was the local Hospital Trust. Although in most markets there were alternative providers, health authorities avoided pushing providers too hard.

The experience of the NHS Trusts would make it possible to predict the same outcome in the case of Bogota. Indeed, as shown in the findings section of this chapter, long-term relationships between ESEs and the SOH were not the result of the parties trying to reduce transaction costs but rather the natural consequence of the political costs of exerting choice and the no-exit restriction on both sides of the relationship. This lock-in situation created room for using conflict as a strategic lever, but only up to a certain point because ESEs also knew they needed the money from the SOH contracts. The SOH also knew that it was unwise to asphyxiate an ESE because it would have had to pay the costs (including political costs) caused by the SOH itself. These findings look similar to those reported for the UK.

This is a major finding of this research that changed key aspects of the original research question**.** According to the original assumptions, the TCE rationale assumes that the PPS has lower transaction costs than the vertically integrated structure. Once the PPS takes place, the presence of RSI or contract incompleteness shapes the relationships between the spot-contract/long-term-exclusive-contract continuum. In other words, the type of relationship that is observed between purchaser and provider is a result of the influence of transaction costs related to RSI and contract incompleteness.

But given the *ex-ante* bilateral monopoly and the no-exit restriction that prevails in all SOH-ESE relationships the dynamics are completely different. Long-term relationships are a consequence of bilateral monopoly and no-exit, which can be used by ESEs to play strategically with the SOH. Although relationships are long-term, such length is exogenously determined by the politics of public hospitals and health care reform,[13] and not as a choice of the parties to reduce transaction costs, as expected from theory.

Consequently, the spot-contract/long-term continuum becomes less relevant to analyse the evolution of ESE-SOH relationships and those between ARS and ESEs for level I services. In contrast, it becomes much more enlightening to analyse how cooperative the

[13] The public choice perspective will be analysed in more detail in chapter 9.

relationships are, as it can provide more insights about the role of transaction costs both as a cause and as a consequence of cooperation.

Two key questions arise at this point of the analysis: 1) given the existence of an *ex-ante* bilateral monopoly and the no-exit restriction, both known in advance of the adoption of hospital reforms in 1993, why should we have expected the emergence of a competitive or at least a contestable market as a result of the PPS? And 2) why should we expect that, even in the absence of competition or contestability, contracts would serve the purpose of forcing ESEs to shift from input-based to output-based budgeting?

Regarding the first question, it was obvious that in the absence of competition and contestability, the bargaining power of ESEs was still high and lack of market exposure allowed them to protect rents. Public hospitals are, by definition, safety-net providers, which makes them a monopoly for the poor-uninsured communities, particularly those providing level I services and (to a minor extent) level II services. For high-complexity hospitals the problem is less directly related to local communities but the politics are similar because they are also safety net providers for tertiary care and they cannot be closed without a strong political reaction and public opinion rejection. Thus, it is unwise to expect that the PPS would result in a competitive market if no other provider is interested in delivering care for the poor, unless it is compensated at market prices.

But it could be argued that the SOH was able to break these bilateral monopolies by just exerting contestability, because, following Baumol (1982), no matter there will always be one single ESE in a given poor neighbourhood, monopoly power is reduced if the SOH has the option to sign a contract with a different operator for a subsequent period. But the exit option was not possible because there was an accumulated burden of civil service costs and idle capacity that could not be quickly reduced. Civil servants were also able to exert enough power to avoid quick and costless substitution, thus making the market non-contestable. But in the end, no ESE manager considered that the SOH would exert contestability in terms of shifting to contracts with third parties for the administration of ESEs. Neither on the side of the SOH, officers ever mentioned the possibility to exert such contestability.

Regarding the second question, no matter the bilateral monopoly and the no-exit restriction, the SOH still had a lever at hand which explains managers' compliance to

contract terms: the appointment of the ESE manager. If the performance of the ESE is lower than expected, the SOH has the power to terminate the contract with the manager through its influence on the ESE's Board of Directors, or at least, it has the power not to re-elect a poor performer. Given that this influence is high (with varying degrees of intensity), it makes it possible for the SOH to assure managers' compliance to its policies and to contractual terms. This point will be addressed in more detail in chapter 8.

Suffice it to say here that managers who felt less strong in their management role were more likely to cooperate with the SOH, and this sense of strength apparently decreased as reelection approached. In fact, as shown by Castano et al (2005), ESE managers showed a more aggressive behaviour at the beginning of their office term that evolved toward more conciliatory behaviour when they were approaching the end of their term if they wished to be reelected.

In contrast to ESE-SOH relationships, the TCE argument for long-term relationships does apply for the ESE-ARS relationship. Although level I services showed the same dynamic as the SOH-ESE bilateral monopoly (i.e., the no-exit restriction and the conflict game as a strategy to extract rents), level II and III services showed that a more competitive context leads to the outcomes predicted by TCE, i.e., closer relationships, and a higher concern for building trust, both creating the bases for long-term relationships. This suggests that MacNeil's (1978) prediction of relational contracts also applies in this case. In addition, the almost non-existence of spot contract relationships between ARSs and ESEs favours the argument of transaction costs involved in the exchanges between purchasers and providers. The role of these transaction costs will be analysed in chapter 7.

In the search for long-term relationships with ARSs, low-cost ESEs had a competitive advantage that allowed them to be more flexible and adapt to ARS expectations. Knowing that the more revenues they generated from ARSs, the more autonomous they would become vis à vis the SOH, these ESEs adopted an openly pro-ARS strategy. But their competitive advantage not only allowed them to attract contracts with ARSs, but also to be selective as to whom they wished to establish a long-term relationship with. This created a different context for transactions, as compared to ESEs that, because they desperately needed the money from these contracts, viewed ARSs as a necessary evil. In

this latter context, ESEs begrudgingly engaged in long-term relationships to assure the needed cash, but conflict was fueled by this sense of impotence and no choice in dealing with an undesirable trading party.

An interesting finding is the almost absence of spot contracting. And it is not explained just because ARSs were required to contract at least 40% of the premium with local-area level I ESEs. The arguments raised by managers against arms-length spot-contract relationships clearly show that they consider spot contracting undesirable, except for very small purchasers or services paid directly by patients, given their small share of revenues. Perhaps ESEs' concern for assured cash flows is a reasonable argument that has nothing to do with the fact that they are dealing with health care services. That is to say, closer contractual relationships are not inspired by the objective to provide better health care but just by a pragmatic approach to revenues. Interestingly, no matter that contracts for "packages" (accumulated hernia repairs, hysterectomies, cholecystectomies, etc) could be of a spot type, they were signed with the same parties with whom they had longer-term relationships involving capitated or fee-for-service contracts.

Conclusions

It can be concluded from the findings reported in this chapter that the PPS has resulted in a bilateral monopoly vis à vis the SOH, with a no-exit restriction. This could have been predicted before the 1993 reforms because of the public hospital's role as provider of last resort in a market where no other safety net hospital operated. Thus, the question turns into how cooperative these ESE-SOH relationships are, because transaction costs are both a cause and a consequence of the observed level of cooperation. It was found that high-revenue ESEs were less likely to invest in a cooperative relationship, and they were more likely to challenge SOH policies and contractual clauses. However, it is argued that SOH control of managers' continuity in their jobs also encouraged a cooperative attitude, at least among those who wished to be re-elected.

Regarding relationships with ARSs, wherever restrictions to competition created distortions to the ESE-ARS relationship, conflict and short-term vision prevailed. The compulsory 50% contracting with ESEs (40% with local-area level I ESEs) created a rigid frame that ARSs complained about, and tensions within the relationships quickly

emerged. This finding contrasts with the findings observed for level II and III, where geographic restrictions were less rigid. A more competitive market opened room for ESEs to build long-term relationships with those ARSs they considered desirable trading parties. On the side of these ARSs, they also evidenced willingness to create such collaborative long-term relationships. Spot contracts were considered undesirable by ESE managers, and they always preferred longer-term relationships.