8. COEXISTENCE OF HIERARCHICAL RELATIONSHIPS

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

To describe and analyse the coexistence of hierarchical relationships and their interaction with contractual relationships between the autonomous hospitals and the Secretariat of Health of Bogota

It is hypothesised that the PPS, by shifting from a vertically integrated structure to a contract-based one, will cause a net reduction in transaction costs and the net effect on hospital performance will be positive. However, the evidence shown in chapters 6 and 7 does not seem to support this assumption, at least regarding SOH-ESE relationships, although it seems to be more obvious in the case of ARSs, particularly for level II and III services. Regarding the SOH, there are many other reasons that explain the observed relationships, as will be seen in chapter 9. In this chapter, the incomplete migration towards arms-length relationships will be analysed, with respect to how the SOH restricts autonomy by keeping control over certain aspects of hospital behaviour.

The propositions to be tested in this chapter are derived from the framework developed in the theoretical review in chapter 2, reflecting the New Public Management approach (Walsh, 1995) and Preker and Harding (2003), and further described in chapter 3 through the country experiences analysed in the latter's World Bank publication. These propositions are:

- **Proposition 1**: The relationships between ESEs and the SOH are successfully shifted from a hierarchical type to an arms-length type as a result of their transformation into autonomous entities.
- **Proposition 2**: Shifting the day-to-day management to the hospital locus is optimal because it allows managers to match hospital responses to local market needs.
- **Proposition 3**: The market environment will be enough to keep ESEs from adopting undesired responses to autonomy, so the SOH can keep its arms-length relationship.

Findings

8.1.ESEs responses to autonomy

In a hypothetical situation, granting autonomy to public hospital is expected to result in a competitive market where ESEs invest effort in attracting contracts and patients to generate revenue. Such a competitive environment would force ESEs to improve efficiency and quality lest they are forced to leave the market for poor performance. Good performers are supposed to increase their market share and a net welfare gain will be achieved. It is also expected that responses to competitive forces will lead hospitals to adopt strategies that improve their performance but not at the expense of other hospitals, that is to say, a positive-sum game. This contrasts with the situation previous to autonomy, where the hospital received a supply-side budget based on historical costs and irrespective of output and overall performance. However, given the presence of transaction costs, competitive relationships may turn into small numbers bargaining, to the extent that RSI and contract incompleteness force the search for specialised governance structures, specifically long-term relationships.

Within the shift to the PPS, it is expected that contracts will serve as the regulatory framework for the contracting parties that make sure performance (in terms of outputs, efficiency and quality) will be related to revenues for the ESE. Thus, contracts become the pivotal point around which the parties materialise their market interactions.

These responses on the ESE side are the ones that would be expected from the theoretical basis of the PPS, at least those argued by the NPM. This type of responses could be named “desired responses”. Nonetheless, ESEs can adopt a different type of responses that can be called “undesired” because they do not allow the expected welfare gains to be achieved. ESEs can either not react at all and remain in their role as passive users of resources, or they can overreact and cause harm to other competing ESEs. It can also be said that they are given room to use autonomy for purposes other than improved welfare, namely, for personal benefit. Both desired and undesired responses were ascertained in the interviews with ESE managers and SOH officers.

As shown in chapter 4, the unfulfilled expectation of universal coverage with a comprehensive package implied that the SOH had to keep three simultaneous roles: 1)

as purchaser, 2) as regulator, and 3) as owner of ESEs. In this halfway situation where the ESEs still face demand for services not covered by the SS and for services to the uninsured, autonomy also falls in the middle. In fact, ESE managers considered they were enjoying a mixed type of autonomy, because the SOH still exerted too much influence on their decision-making. Decision rights will be analysed below, but at this time it is worth illustrating this mixed autonomy status with a quote from the manager of IIIB:

"I believe the SOH has lacked smartness and political maturity in managing the inter-institutional relationship with ESEs. It plays within the independence-interdependence-dependence spectrum. So, when it is to their advantage, we are autonomous and decentralised, but when it isn't we are their children and there is an absolute centralism. (…) On the one hand, the SOH is forcing us to become firm-like entities and generate institutional development to be sustainable and competitive. But on the other hand it deepens dependence by establishing a contract with prices that are deleterious to the ESEs."

The manager of IJ raised similar complaints:

"…for matters of cost, you are [an autonomous] ESE, but for matters of policies, they are not policies but mandates."

Whatever the perceived or actual level of autonomy enjoyed by ESEs, there were variations in their responses to autonomy. The next section will analyse the desired and the undesired responses, as well as the strategies the SOH adopts to respond to the undesired responses.

8.1.1. Desired responses to autonomy

It was shown in chapter 6 that both SOH officers and ESE managers recognise that the contract exerts a strong pressure to comply with performance. It was also shown that Competition is not relevant for ESE-SOH relationships because of the problem of mutual dependence stemming from an *ex-ante* bilateral monopoly. However, autonomy not only relates to more flexibility to respond to the competitive environment, but also to make decisions related to the day-to-day management of the ESE. In this sense, ESE

managers recognised that they were able to make decisions based on local needs in a better way than it used to be under the centralised structure. The manager of IIA said:

"…Mistakes were made like acquiring or receiving equipment from the extinguished National Hospital Fund[1] or from agreements with the Spanish government. They sent equipment to hospitals without a previous demand study or without knowing what possibilities the equipment had to perform within that field. (…) Today we think better: if I am purchasing an item of equipment I have to know what the market is, the survival of the equipment, the environment."

Another example is that of IIIC, where the manager reshaped the ESE's service portfolio according to market research done at the community level:

"The ESE carried out a market research study based on which we knew what our patients wanted, who our competitors were, and we fine tuned it in terms of costs (what was profitable and what wasn't), (…) We found that our client wants trauma care [because of the high violence rates of the area]. (…) . When we closed down Internal Medicine, we signed an agreement with IIID …"

Reshaping the supply of services also took place at level I ESEs, e.g., the manager of IF closing several health centers. On the side of the market for ARS services whether competition is strong or weak, it has forced ESEs to improve their responsiveness to patients and the community, as shown in the case of IB or IIF, where creating patient loyalty is a strategy to enhance their bargaining position vis à vis ARSs.

ESEs like IIIC and IIB reacted to competition by strongly increasing output, which was achieved by increasing short-term labor. This allowed them to reduce the ESEs' share of fixed labor and increase their flexibility to fluctuations in demand. According to these two managers, this strategy increased efficiency in input mix, which has meant a strong competitive advantage for these ESEs. On the side of large hospitals with a high share of fixed labor, like IIIE, the SOH has invested effort to make them more competitive by giving the necessary resources for restructuring. This has had evident results, as shown by a SOH officer:

[1] The National Hospital Fund was a national-level public organisation responsible for the acquisition of technology equipment for the public hospitals. It also provided support in maintenance and repairs. The Fund carried out large purchases on behalf of all hospitals, not always matching local needs and demand.

"…people living close to IIIE showed up at IIIC, due to the problems they were having at IIIE. To the extent that we leveraged [IIIE], and the community recognised again that it offered services, that people had their needs satisfied, it grew again and at this moment it is about to close the gap, after having a gap of CP$ 4.000 million a year."

In general, it could be said that the competitive forces of the market for services to SS enrollees caused a positive change in the attitude of managers to improve performance. The opinion of the manager of IIC summarises this perception:

"… It cannot be said that there is one single hospital that remains seated and staring around, as many of them were four years ago, certainly not realising what they were into."

Regarding decision rights about input mix, autonomy was positive for managers as they were able to match decision making with local needs. For example, for short-term hiring and firing of workers, the manager of IIE commented:

"…there is total freedom [to hire and fire short-term workers], but it is managed exclusively according to service needs."

The purchasing alliance to buy drugs and consumables, as shown in chapter 7, also allowed procurement decisions to be better matched to local needs. Although it was not explicitly said by any interviewee, it was clear that managers had total autonomy to decide the amounts they wanted to purchase. They were also free to opt-out of the alliance if they found better prices outside the alliance or if they had cash available to take advantage of early-payment discounts.

So, it is evident that ESEs showed a set of desired responses that made it likely to conclude that autonomy was able to yield a net welfare gain. The examples shown above illustrate how they invested effort in improving efficiency and quality (at least in terms of responsiveness to patients and the community). However, having higher latitude to make decisions without the direct control of the Health Authority, ESEs would be able to take negative actions as well as positive actions.

8.1.2. Undesired responses to autonomy

On the side of undesired responses, they can be classified into three groups: abuse of autonomy, no response, and responsiveness to other principals. These three categories will be analysed separately in the following paragraphs.

Abuse of autonomy

Abuse of autonomy can take two different features: 1) it can be just poor judgment because of myopia, or 2) deliberate decision making that causes harm to the ESE, other ESEs, or welfare losses in general. Although myopia could have been due to either lack of information or ignorance, this decomposition was not addressed in the interviews.

One clear case of myopia due to ignorance was the budget indiscipline that prevailed during the years of fee-for-service payments i.e., before 1999, when the FGPP was introduced. During those years, ESE managers had autonomy to design and execute the budget, but some of them made wrong decisions that caused the ESEs to run large deficits before the end of the year. The most common mistake, pointed out by SOH officers and some ESE managers, was to increase operating costs on the expectation that future revenues would generate the money to pay for them. Thus, budgeting used to be based on expectations, which frequently proved optimistic. But when the gap between expected and actual revenues was evident, it was difficult to pull back the increased costs. This caused these ESEs to run deficits that had to be bailed out by the SOH. But bailouts came only after a painful period of conflict involving the SOH, the ESE, the community and ESE workers. Myopia also caused costly bottlenecks due to poor planning, that increased the risk of deficits. Procurement of drugs is a good example: reduced and erratic cash flows increased the risk that the ESE had to make last-minute purchase of drugs at much higher prices than what they would have to pay had they adequately planned their needs in advance.

Network coordination was affected by myopic poor judgment in the way each ESE defined its service portfolios. Although most ESEs were unable to make large investments in technology, they were still able to open some services with lower entry barriers. The case of mammographs evidenced poor judgment that led to redundant supply, as reported by the manager of IIA:

"…until four years ago [1999], hospitals acquire equipment by contacting influential people rather than based on studies. (…) I don't understand how, with a mammograph three kilometers from here which was 70% underutilised, a new one was to be placed in IIA. And it was set up; today it is 60% underutilised. And IIIE [has another one that is underutilised] at 30%."

ESE's penchant for higher complexity of services provided was also evidenced. Myopic poor judgment might lead to redundant services, as pointed out by an SOH officer:

"…They all want to set up operating rooms, increase their level [of complexity], acquire the latest technology, but the city might need other things…"

ESEs themselves recognised that lack of network coordination was taking place and it was causing negative effects, as pointed out by the manager of IIIE:

"…we can't shoot everywhere and keep doing everything, because the market does not support it."

Regarding deliberate decision making that causes welfare losses, abuse of autonomy took several features. The case most commonly pointed out by managers and SOH officers was a very aggressive competitive strategy adopted by some ESEs to attract ARSs contracts. As has been mentioned before in this and the two preceding chapters, IIB and IIIC adopted very aggressive price strategies, based on their low-cost competitive advantage. IIC and IB also were aggressive but to a lesser extent. These strategies triggered a price war during the early 2000s within fee-for-service contracts, which still persisted after the shift towards capitation contracts in terms of the percentage of the premium that was transferred from ARSs to ESEs.

These aggressive strategies should be considered abuse of autonomy because they ended up in a zero- or even negative-sum game for the SOH. Given its responsibility for keeping ESEs open (to avoid the political costs of closing a hospital) a price war would only cause contracts moving from one ESE to other with no net gain to the SOH because it would increase SOH's bailouts to the losers, while lower prices would mean

increased profits for ARSs. This situation was clearly recognised by several interviewees, and can be clearly illustrated by the manager of IIC:

"… in a first stage there was fierce competition to be the best and outperform at whatever cost; it didn't matter if the nearest hospital is sinking provided my hospital is doing something (…) We had a huge growth during the last two years at the expense of IIIB, (…) the trend to cannibalise ourselves is almost natural."

The manager of IIB was very open in his justification for aggressive competitive behaviour. On the one hand, he did not receive bailouts from the SOH via performance agreements. But on the other hand he had to guarantee revenues to keep the ESE sustainable, so he could not afford to be passive and he had to look for resources wherever he saw them. He claimed that:

"…If I leave an ESE without [contracts], that's none of my business; it is the ESE's fault for not moving on."

Collusion between ESEs to attract larger contracts was also a strategy that hurt those ESEs outside the cartel. During 2002, the ESEs that were part of the southern subnetwork (one of the four subnetworks the 22 ESEs were divided in), joined to make a proposal to capitate level II and III services to the largest ARSs in the city. They got the contract and patients were referred from all over the city to the southern ESEs. The manager of IF reported:

"…We agreed to capitate 'en bloc,' and that way we hurt the rest of the ESEs."

The manager of IIF, one of the members of this cartel, clarified that the original idea was to include all ESEs, but only those in the southern subnetwork decided to enter:

"…some [ESEs] were hurt because they were not alert at that moment. We did not act without warning. All the people were called, and indeed the strategy was proposed from the southern subnetwork to all the ESEs in the city. They didn't want to accept it, so we proceeded."

And the manager of IIIC, the leader of the cartel, was also outspoken about the foot-dragging reaction of other ESEs:

"…they started to propose thousands of analyses (we say that so much analysis causes paralysis) then we broke the market. (…) I hurt them hard."

On the opposite side of collusion, some ESEs deliberately adopted strategies to hurt neighbouring hospitals. This was particularly worrisome in the case of capitated contracts, when patients showed up at out-of-network ESEs and a counterbill was generated. The manager of IIC considered it was a mistake to capitate population from other areas because it increased the risk of counterbillings. With respect to a situation with a contract that IIE signed with an ARS, the manager of IIC said:

"… in fact, I blew up that contract just with counterbillings"

On the side of the losers, complaints were also heard on the same lines, although managers were less likely to openly admit they were losers. The manager of IIIA mentioned:

"… We have been on the other side. We have been hurt by IIIC's contracting policies, and they grab enrollees living close to [our hospital]."

And the manager of IIG complained about the bundling strategies of IB that attracted patients to their facilities instead of IIG, even though they lived closer to IIG:

"…IB offers (…) a series of services that are not level I but level II (…) they offer them as a marketing strategy (…) no one reimburses them for these services but it is a hook (…) to attract patients and we, at IIG, end up with difficulties to attract patients."

and IB's price strategy to reduce counterbillings also affected IIG:

"…IB negotiated with ARS a reduction in the percentage of the premium in exchange for abolishing counterbillings.(…) and one of the ESEs that generated most counterbillings was IIG and particularly to IB. That meant the ARS made it harder for its enrollees to show up at IIG."

On the side of the SOH, their concern for a negative-sum game was expressed in this statement:

"…one SS enrollee that is taken by one ESE is lost by another ESE. So, if a given ESE grows its market share and takes 80% of SS enrollees, what is left for the rest? And [they are left] with their capacity [idle]. (…) it could be said that the market pinches them, but that is false: expenditures end up being absorbed by the SOH, because hospitals are [never] shut down"

The manager of IIIC himself recognised the risk of a negative-sum game and the effects on the SOH:

"…The stance of the SOH is that IIIC must not grow larger because it is pushing IIA, IIIE, IIIA, etc…into bankruptcy. It is also necessary to understand the point of the SOH."

Given the incentives inherent in the FGPP system, some ESEs were also abusing their autonomy by engaging in cream skimming. The wide variance showed by some FGPP categories meant wide room for cream skimming. Again, IIIA's complaints about IIIC's strategies were clearly illustrative:

"…IIIC sends us the unprofitable patients (…) Or they operate on the patient, bill the best part and then refer him to us with the complications (…). The only policy we adopted here is 'we do not turn away patients' because the patient who shows up at IIIA has nowhere else to go."

A last concern with regards to abuse of autonomy is that managers have more room to use the ESE for their own benefit, at the expense of the ESE and generating a net loss to the SOH. Although this is tantamount to corruption, it can also be the case that managers used the ESE for their own career concerns. Although the first case was not ascertained about in the interviews, it was not mentioned by any interviewee. The second case, career concerns, was explicitly mentioned only by one manager but in a negative sense, i.e., making decisions very carefully to avoid future problems:

"…everybody is watching you. (…) I work and push things forward whatever it takes, but I know everybody investigates. One moves, indeed, to protect one's CV."

No response to autonomy

Some ESEs were not challenged by their new competencies, but they rather stayed passive. This could be explained by two different reasons: on the one hand, it may be due to lack of managerial leadership, and on the other hand it may be due to excess rigidities that did not allow the manager to exert leadership. As quoted above:

"… It cannot be said that there is one single hospital that remains seated and staring around, as many of them were four years ago, certainly not realising what they were into."

And the experience of IIIC and the southern network with the cartel also illustrates how the other ESEs lacked the leadership to envision the challenges posed by the environment and take advantage of the competitive advantage that the cartel would have provided them. As pointed out by the manager of IIC:

"…there are more aggressive hospitals in the marketplace, and that has happened all the time, whereas others are more cautious and had lagged because of that."

Regarding excess rigidities, it was clear that ESEs with high fixed labor costs were in a weaker position vis à vis their lower-cost counterparts. This allowed the latter to be more aggressive, whereas the former, rather than cautious, had no other choice but to be stuck and seeing the others win the race for contracts. But this line of reasoning was also valid for aggressive ESEs like IIIC, IIB and IB during the fee-for-service era. The difference thus boils down to leadership, because the managers of these ESEs were very aggressive in increasing short-term labor to increase output. In the medium term, these ESEs turned the fixed/variable labor ratio upside down just by increasing the variable labor share of total labor.

But this strategy implied the possibility to grow. Perhaps the cases of IIIA and IIIE exemplify how, in the presence of little room for growth, it was difficult to adopt an aggressive competitive strategy. On the side of IIIE, the ESE is cornered in an area with

a limited referral base of population. In addition, it had a high share of fixed labor costs[2]. On the side of IIIA, they were a large hospital with a high share of fixed labor costs and severe organisational weaknesses.

Another factor associated with no response to autonomy was the budget indiscipline that led ESEs to run deficits, which managers frequently faced by delaying salaries to workers. An SOH officer pointed out the negative effects of these delays:

"...they felt they had the right to have [the ESE] as a temporary refuge because they were not paid their salaries."

Therefore, ESEs showing low or no-response to the competitive environment were also in a catch-22 situation whereby they were unable to improve performance because of low morale, but they could not improve morale (i.e., catch up with salary obligations) because they were unable to improve performance.

Responsiveness to other principals

ESEs are public organisations which, by definition, have no owners but the public purse. This nebulous and uninvolved ownership is complicated by the fact that public organisations have several principals, who partly represent the ultimate principal. In the case of public hospitals, these can be said to be: community organisations, health care workers, local politicians and health authorities. To the extent that these principals have their agendas aligned, there would be no problem because the ESE manager would know what to do in all the states of affairs. However, the problem arises because these principals have conflicting agendas and their influence on managers' decision making is diverse.

Depending on their capacity to influence managers' decision making, each of these groups will be able to deviate the manager's agenda from welfare maximisation (provided the manager is a welfare maximiser). In a vertically integrated hierarchy, the lines of influence of these principals are exerted in a different way as compared to the way they are exerted in an autonomous entity like an ESE. Given the assumption that autonomy improves hospital performance, it is necessary to consider the extent to which

[2] Before being restructured in 2002.

influence activities from other principals reduce or increase the possibility that such an assumption holds true.

Following Eid (2001), agendas of the principals can be simplified in these terms: the community aims at a wider portfolio of services, and less time and monetary costs. Workers aim at long-term stability and/or better wages. Local politicians aim at more jobs available or participation in the ESE budget to the benefit of their patronisers or for personal benefit. And the SOH aims at sustainability under the current circumstances, as pointed out in chapter 7. No matter the SOH has more and stronger knobs to control the ESE, as will be shown below, managers can also respond to these other actors outside the influence of the SOH. When asked if ESE managers lose autonomy when these three groups exert influence on managers' agendas, an SOH officer said:

"…No, I believe that a good manager has to understand the three logics. If you look at them, they have a common purpose because they complement each other and enable the survival of the [ESE]: the fact that one is concerned not for the budget constraint but for rationalising and assuring sustainability."

In the following paragraphs, issues about the agendas of these three principals (community, health care workers, and politicians) will be analysed further.

Regarding the agenda of the *community*, their preference to have closer facilities and more comprehensive service portfolios clashed with SOH efforts to reduce ESE idle capacity. The case of IK, placed in a rural area with a very dispersed and small population, is appropriate to illustrate this point:

"…I had the case of a population that wanted a nurse and pharmacy services 24 hours a day, when it is not economically sustainable and it is onerous for the hospital. They pressed to have it but I was autonomous to make the decision to say: 'I will not give you that, but let's see what other things I can give you that compensate for that situation.'"

IF's account of closing peripheral points of service was a similar situation whereby the manager had to negotiate other services to appease community's demands for bricks and mortar.

The SOH was also conscious of community demands and the conflicts it would generate with ESEs when it comes to improve efficiency. An SOH officer clearly singled out the inherent conflicts of these agendas and his view of plausible explanations:

"…It is normal that people want their problem to be solved. People don't worry about being referred [to other ESEs]; what they care about is that the network functioning is transparent for them (…) otherwise it would be necessary to build a level III hospital in each place of Bogota, which is impossible. (…) However, what we currently do is that we send the patient, he has to queue again, wait for a new authorisation, and wait to see if he will be given an appointment. When this is the case, anybody wants a hospital close [to the place of residence]."

Regarding *health care workers*, their agenda of more stability and higher wages is evident, but their influence on managerial decision making depended on how powerful labor unions were within each ESE. Most managers, except those of IIIE and IIIA, considered that labor unions were rather powerless. They complained that unions only worried about protecting their interests irrespective of the best social welfare. This was clear even after the era of salary delays was overcome.

Centralised labor negotiations are preferred by trans-organisational unions, but dispersing decision making to ESEs as a result of autonomy has weakened this centralist approach. The manager of IB reported that:

"...the union is not strong here, but I still have to speak with the hard-line union leaders of Bogota. They come here (...) and I have to seat and negotiate with them."

And the manager of IC reported that:

"...I do not have members of those (trans-organisational unions) among my employees, who cause larger difficulties in labor relationships.(...) The labor unions we have are very local."

In general, ESE managers refer to labor unions as non-interfering with decision-making, at least regarding the most relevant issues. They faced strong resistance from unions

only when they tried to reduce privileges or fire workers, but they considered it was part of the day-to-day issues a manager has to deal with.

Regarding the third principal, *politicians*, it is important to remember that Bogota is a special type of administrative unit, because it is a municipality and a department at the same time. It is divided into 19 local areas called "localities". There is a Mayor of the city (the District Mayor) and a City Council, but each of the 19 localities has its own local Mayor and local administrative board (LAB). These locality authorities are publicly elected by the citizens residing in the locality. The local Mayors manage an important part of the overall district budget, and the LAB is the overseeing body, the local equivalent to the City Council. The local Mayor has some latitude over the use of resources to satisfy local needs in terms of health care, infrastructure, education, etc. Thus, although SOH-related revenues flow directly from the SOH to the ESE, the power of local Mayors to channel additional resources to the ESEs cannot be ignored by ESE managers, specifically level I and sometimes level II ESE managers[3]. If they want to bring revenues from local Mayoralties, they have to sign contracts for diverse types of services like public health (additional to the ones they contract with the SOH as PAB), social support, etc. However, managers commented that their possibility to attract these resources depended on their willingness to cooperate with local politicians, which implies playing the quid-pro-quo game, political patronage, and sometimes, as was subtly insinuated by some managers, playing the game of corruption.

Politicians, either at the local, district or national level, found it very attractive to exert pressure at ESEs to obtain jobs for political patronage. It is particularly true for those ESEs that have a high number of short-term contracts, like IIIC:

"…that's why [politicians] push so hard on us, because there are 690 jobs to help politicians."

The types of relationships found between ESE managers and local politicians can be classified within three groups: those openly cooperative, those openly adversarial, and those in between. Among the openly cooperative, a few managers proactively approached the local politicians, in the expectation of bringing additional resources to the ESE for different reasons. For example, the manager of IIB stated that:

[3] Local Mayoralties do not sign contacts with level III ESEs.

"…it sounds awful, but for these contracts [with local Mayoralties] one has to manage some public relations. I don't mean to engage in political patronage, I want to clarif (…). The thing is that if a LAB member, or the local Mayor come here, I welcome them and cooperate. I think it is a mutual [benefit].

Explaining the reasons for being proactive with LAB and local Mayors, the manager argued:

"…Other hospitals have been bailed out but not IIB. What we have done is to find money from other sources [to add them to the budget], either from local Mayoralties, ARSs or other type, to be able to stay open."

The manager of IIE found in the local Mayoralty a key source of money for capacity expansion:

"…we will build a new three-storey facility very good for the community. The local Mayoralty is contributing about 61% of total investment (…) so they feel empowered to say what to do and not to do."

As shown in this quote, the manager has to trade off decision space with politicians for new financial resources. The same manager added:

"…they exert a lot of influence. They call me to the LAB, sometimes with justification, others without it. There are personal, political and community interests at play (…) some LAB members try to manipulate me to satisfy other interests."

The case of IE also illustrates the importance of attracting these monies for capacity expansion:

"…I have found support on the side of the local Mayoralty. Indeed, more support than from the ESE's Board of Directors. I have felt the local Mayoralty (…) has provided resources to improve the hospital (…) and will help me expand the emergency and surgery wards. That is to say, I have felt the local Mayoralty has been my ally."

On the side of the managers who openly oppose interactions with politicians, other arguments were raised. The manager of IC was outspoken about this issue:

"…I do not agree with what it means to have a contract with [the local Mayoralty]. They don't either share my view and we have stayed isolated from each other. The ESE doesn't get these monies because (and this will be the same while I stay here) I will not accept pressure to hire people or contract firms if they do not comply with selection criteria. (…)."

A different line of influence that politicians use to exert pressure on ESEs, according to several managers, is that of political control: they called the managers to debates at the City Council or at the LAB, or they threatened enquiries by the official controlling agencies that would eventually end up in prosecution. These threats were used as mechanisms to blackmail managers, because the politician offered his help to the manager to stop the enquiry in exchange for jobs, contracts or special treatment to their constituents as patients. In this sense the manager of IIIA commented:

"…What they come here for is to request exemptions for patients, but in these cases the same rules are applied to all. Now the new [LAB members] were meant to call me for a debate [at the LAB] because I never received them at my office."

When asked about the risks of assuming such a challenging attitude, given their power to entangle her, she acknowledged that she has been the target of political attacks:

"…my appointment was indicted three days later because I am not supported by any politician."

On the side of the group in between the two extremes of openly cooperative and openly adversarial, they assumed a mixed attitude to comply with politicians' demands but at the same time to comply with due processes. The manager of IB put it in these terms:

"…it takes a good handling of public relations, but it doesn't mean the local Mayor can come here and tell me 'I want a health post there'. (…) it is about sitting down and talking about how the ESE is doing (…) but there is no influence."

Hiring workers best exemplifies how the mixed strategy worked. The manager of IE explained it in the typical terms that other ESEs also handled the issue:

"…the [local] Mayor sometimes sends CVs, but these are entered into a selection process like any other candidate. And we contract out labor with a cooperative and it is there where the selection process takes place."

8.2. SOH mechanisms to deal with undesirable ESE responses

If, as a result of the PPS, the ESEs adopted only desirable responses it would be easy for the SOH to focus on its stewardship function and keep an arms-length relationship mediated by a contract. However, as has been clearly shown, ESEs can either over-react or under-react to the new competencies they acquired when granted autonomy. Their actions can have negative effects not only on the ESE itself but also on other ESEs, downstream purchasers, patients or the society at large. In addition, the fact that the SOH was perceived as the ultimate body responsible for hospital survival, made it responsible for poor ESE performance, as was shown in chapter 6, and this issue was at the root of the lock-in situation.

Accordingly, the SOH has to minimise the undesirable responses and maximise the desirable ones, as well as to minimise the negative impact of undesirable responses when they cannot be avoided. The regulations that granted autonomy to public hospitals also defined the control knobs for the SOH to prevent ESEs from adopting undesirable responses to autonomy, the so-called tutelage function. These control knobs can be identified as:

- Decision rights: ESEs were not transferred absolute control over all the decision rights in the same way a private firm has.
- Accountability devices: ESEs were accountable to the SOH via market mechanisms (contracts, peer pressure, best-hospital contest), ownership mechanisms (Boards of Directors, community organisations) and regulatory mechanism (performance agreements, decrees, Council legislations, licensing requirements, public health, supervisory functions).

It is clear that the SOH plays three roles simultaneously: a role of purchaser, a role of owner, and a role of regulator. These roles can eventually conflict as will be seen below.

8.2.1. Incomplete transfer of decision rights

Regarding decision rights, the most evident control knob was budget design and execution. As seen above, the evolution of autonomy allowed for budget indiscipline among some ESEs during the early years of autonomy, which caused delayed salary payments and consequent strikes. It backfired on the SOH, which had to bailout the ESEs to keep them open. This vicious circle was broken by introducing budget discipline and making sure that managers gave priority to paying salaries on time. With this purpose, the City Council issued the decree # 1138 in year 2000, which established the guidelines regarding budgeting. The most important changes introduced by this decree were: 1) ESEs are autonomous to transfer money between line items within the two large blocks (investment and recurrent) but not between these blocks. 2) Any transfer between line items within each of the two large blocks had to be approved by the Board of Directors. 3) Any transfer between the two large blocks, and any addition to the budget, had to be approved by the City Council of fiscal control (Confis). 4) The process of budget design starts with the ESE proposing the lines of revenues and expenditures according to the general guidelines set by the SOH and the District Mayor. The ESE gets the no-objection from the Board of Directors; then it is taken to the SOH for approval; then the SOH takes it to Confis for final approval.

The SOH also required that the ESE projected the budget for the next year based on realistic and not optimistic expectations of revenues. Although there was uncertainty in any case, a good proxy of next year revenues was the present year revenues. These were not just billed revenues but the actual cash collected. The purpose was to make sure that managers were not making the same mistake of the past: overestimating revenues and then hiring labor and increasing inventories to respond to a demand that did not materialise. An SOH officer described the strategy to avoid this trap:

"… what we require from them was that they avail of the revenue to hire labor. Not necessarily to have the money [at the bank] but at least to make sure that if the manager was to hire five or ten workers, revenues would grow by the same amount."

The benefits of preventing deficits were clear in terms of avoiding further delays in payment of worker salaries, and, ultimately, damage to worker morale, as put by an SOH officer:

"…while the worker has his salary guaranteed, he starts playing for the hospital, and it stops being a temporary refuge. We were able to start ratcheting down and have doctors either work the contracted hours or resign."

ESE managers revealed mixed feelings about this rigidity. On the one hand, they resented the lack of maneuver. The manager of IIG said:

"… it is as though the budget were not the ESE's. It is for you to spend it but not up to you to decide how."

They also complained that budget rigidities made them less responsive to market signals and less competitive vis à vis their private counterparts. Nonetheless, other managers considered that it was sound to have some control, given the experiences of the past about budget indiscipline. The manager of IIA pointed out:

"…we [designed and executed the budget] in a responsible and ordered way, but unfortunately others didn't. They transferred money from salaries to other budget items, and they ran out of money by November to pay salaries, and the SOH had to solve the problem. Hence the Secretary of Finance decision to require their approval of transfers by the Board of Directors or by Confis."

The manager of IIIC favoured budget controls:

"…we think that's the way it has to be. Besides, the bad reputation that [public] hospitals are bottomless pits has to be abolished."

Managers also recognised that budget controls were tighter when the ESE enjoyed a lower level of autonomy, i.e., when it depended more on SOH revenues, as shown in chapter 6. In contrast to the general view that budget guidelines were too rigid, the manager of IIIC considered that his colleagues were very passive. He showed with his

own experience that budget rigidities can be overcome with short-term credits with the banks. A summarising quote from an SOH officer says:

"…Budget flexibility depends on what stage the ESE is in. The farther it is from closing the gap, the more [budget] restrictions and emphasis on salaries, inputs, utilities, i.e., the minimum essentials. If it is incurring any additional expenses, it is because it has the money."

Another decision right that is partially controlled by the SOH is the design and execution of the strategic plan. As shown above, some ESEs adopted competitive strategies that improved their performance but at the expense of other ESEs, the SOH or society at large. Thus, the SOH had to keep some control over strategic moves and it was exerted through the approval of the strategic plans, making sure they agreed with the overall health policies at the city level, and social policies at the District level. It had to do partly with the issue of network coordination. The manager of IID commented:

"…I have full autonomy to propose my institutional development plan and the annual operative plan, but I have to include some SOH policy guidelines that frame my plan, and the government plan of the District Mayor (…) we [the ESEs] are all the same family."

The consequences of poor network coordination, that were described before, were dealt with at the SOH through clear guidelines for ESEs to interact. In addition, the SOH was doing what Law 715 of 2001 required it to do, i.e. make public hospitals within a given geographical area to operate as a network, exploiting complementarities. In this sense, an SOH officer said:

"…some ESEs say the SOH is stifling their growth. For example [the manager of IIIC] wanted to sublet two floors at [a private hospital] to double the ESE's capacity.(…) We told him 'why don't you rent capacity at IIIA, IIE, or somewhere else.' If some of them are underutilised, it has to be first with public hospitals. (…) they have to understand they are part of a network, and autonomy does not mean you are an individual unconnected to the network. (…) Autonomy cannot be understood as 'I do whatever I feel like'"

Decision rights with regards to procurement were largely transferred to ESEs. However, they were encouraged by the SOH to participate in the purchasing alliance, which was led by the SOH itself. An SOH officer explained:

"…what we facilitate and require from ESEs is that they share their capabilities [of purchasing] without limiting their autonomy but taking advantage of economies of scale for the benefit of all. (…) the only thing we say is 'these are the reference prices [that the purchasing alliance has negotiated], you can opt-out for lower prices if you want, but you cannot pay higher prices.'"

Oversight agencies keep track of ESEs' procurement decisions and if they detect an ESE that bought some drug at a higher price than that of the alliance, they are widely publicised. This quote from an SOH officer describes the dynamics of this process:

"…social punishment, the colleagues' scoff, is more important. We chose the items and those who were above the price [of the alliance], no matter it was for one pill, were listed. And that made them all join the last purchase round."

A last aspect of decision rights that was found was that of purchasing and selling off of fixed assets. ESE managers had a maximum amount of money to make purchases autonomously (500 monthly minimum wages). For any purchase above this amount they were required to obtain the approval of the Board of Directors and the SOH. In addition, capacity expansions were made only with resources provided directly by the SOH, which restricted ESEs' choices for expansion. Capacity expansions financed with resources from the local Mayoralties, like those of IIG and IIE, had been previously approved through the SOH. In order to assure rationality for small purchases below the 500 minimum wage threshold, the managers had to submit a project at the beginning of each year for the approval of the SOH. These projects contained all the fixed asset purchases scheduled for the year. This restriction was surprisingly found to have different meanings for managers. While IG and IE considered they were restricted to the submission of projects even for minor purchases like a computer, IIIC, IIB, IA and ID considered they were completely free to make small purchases without any prior approval.

However, the more self-sufficient the ESEs, i.e., the larger the share of revenues from sources other than the SOH, the less controls the SOH exerted over purchasing decisions. As summarised by an SOH officer:

"…large investments are made with resources from the SOH and small investments are made as they see fit. And those who are self-sufficient and have surpluses, make purchases on their own."

But the SOH still kept the power to control a disordered growth of supply, particularly that involving large capital investments, so as to avoid costly duplication of supply. The manager of IB, one of the more autonomous ESEs, explained this:

"…If I say that I want to build operating rooms because my demand justifies it, the SOH will never approve that, because IIG is just ten blocks from here and they have operating rooms."

For selling fixed assets there was no restriction if it involved out-of-order equipment, but otherwise it required the positive votes of the two representatives of the community at the Board of Directors (or three representatives, for Boards with nine members). This was not seen by managers as a restriction to autonomy.

8.2.2. Accountability devices

In addition to the incomplete transfer of decision rights, the SOH used accountability devices as complementary lines of influence over ESEs, as put by an SOH officer:

"…what we do is to generate the corresponding pressures through the Boards of Directors, the contracts and the performance agreements."

The most obvious accountability device, related to market accountability, was the contract itself. As has been clearly shown before, contracts were relevant for making ESEs behave as the SOH desired. The manager of IIIC commented on the force of contracts,

"…we have no autonomy because the SOH controls us very tightly. As we are all SOH-dependent, it ends up setting the rules of the game through the contract."

Bilateral monopoly situations were not seen as factors weakening the strength of contracts. One important advantage of contracts, was that the SOH exerted control over ESEs' portfolios and kept complementarities for them to work as a network. This control was exerted through the SOH decisions on what to buy and from whom:

"… when [ESEs] are opening new services, we define if we buy them or not. (…) It is unlikely that [ESEs] open services disorderedly to sell to the SOH. Some of them open [services] on their own, because they consider they have clients somewhere else."

From the side of ESEs they also acknowledged the power of SOH's contracting to shape their supply of services. The manager of IIG acknowledged:

"…I cannot open an intermediate care unit as a strategy to attract pregnant women and more high risk deliveries. That depends on the SOH's willingness to purchase it from us."

As shown in chapter 7, the power of contracts is not utilised to improve quality of care; but contracts are still a key component to force ESEs to improve performance in terms of self-sustainability. This is a departure from historic budgeting.

A second accountability device is the participation of the SOH and the Mayor in the Board of Directors of all ESEs. These two delegate their participation to officers that are qualified to deal with budgetary issues as well as with technical issues of health policy. Boards of Directors are made up of six members, but the ESEs that absorbed other ESEs during the merger processes of 1999 have nine board members. In these cases, the SOH has two seats and the municipal authorities have one.

The SOH exerted a strong influence through these Board members, and shaped managers' decision making to make it fit to the guidelines set by the SOH and the District government. All managers recognised this line of influence, as exemplified in this statement from the manager of IIG:

"…They never say 'I have the money, I am the boss' but they say 'I am the president (of the Board of Directors)' or 'I represent the Secretary of Health'. Despite they are only two Board members, they ostensibly influence the Board of Directors."

And the SOH viewed this line of influence as a key one:

"…the mechanism we use to press [ESEs] is: the Board of Directors. And the stockholders are entitled to define policies at the Board."

The influence of these members was strengthened by the fact that the other members of the Board were rather passive, mostly because of their limited skills to deal with key issues of hospital management, as clearly stated by the manager of IA:

"…the three representatives of the community trust take what [the representative of the SOH]says at face value, and they think he must know why he says that. (…) They have the perspective of the community but when it comes to make strong decisions regarding budget, they are absolutely null and they are pulled [by the SOH representative]."

These Board members made sure budgeting, strategic planning, procurement, capacity expansion, etc., were adequately controlled. In fact, as agents to the ultimate owners of the ESE (the society at large), the objective function of these members was supposed to be aggregate welfare, as pointed out by the manager of IID:

"… Out of the 9 members of the Board, only 3 are thinking (…) in Bogota, in how the ESE is being managed, how it gets forward."

Some managers viewed the role of the Board in general as positive for the ESE. For example, the manager of IC said:

"…the only thing we have had here is unconstrained support to what we are implementing. But that happens to the extent that they see the hospital is not doing blunders. If they see the ESE is departing from [SOH] policy, they would likely call us to reflection or to conciliation."

The manager of IE acknowledged the influence of Board representatives of the Mayor and the SOH, as a positive factor to align ESE agendas with SOH policies:

"…I believe the [SOH and Mayor representatives] have to exert influence, because in any case, they dictate the public health guidelines and we, as public institutions, have to aim at the same [point]."

However, other ESE managers had a negative view about the influence of these Board members (the representatives of the SOH and the Mayor). The manager of IIG, openly stated that:

"…I believe [their agenda] is more directed to make the will of the SOH and of the District Mayor, instead of that of the manager or the ESE."

The manager of IIF pointed out that he perceived the conflict of interests that these members are involved in:

"…to the extent that they have that information and they are officers of the central administration, they assume the role of Board members but at the same time the role of the central administration, (…) many times the aspirations of the District do not coincide with those of the ESE."

The manager of IJ manifested his concern for the excessive focus of the Board on budgetary issues, as a consequence of the budgeting restrictions imposed by decree 1138, and the role of SOH and Mayor representatives to comply with this regulation:

"…it is all about revenues, expenditure plans, receivables, and economic crash plan. That is the essence of the Board."

Given the strong influence of the Board as an accountability mechanism and the stronger role of SOH and Mayor representatives in the Board, some managers acted proactively to win the support of these members or the Board in general. The manager of IK admitted that:

"…no matter the manager wants it or not, he has to negotiate with Board members."

The manager of IA had a two-step strategy:

"…if I succeed in persuading the Board president (who represents the SOH), the rest of the members follow him."

And the manager of IIIC underscored the fact that good performing ESEs were more likely to avoid a strong influence from the Board:

"…as my outcomes have been very good, I strongly lead the Board, and I have had wide autonomy. (…)."

The ultimate line of influence the SOH exerts through the Board is the election and appointment of the manager, as briefly shown in chapter 6. Given this, managers have a strong incentive to align their agendas to that of the SOH and the Mayor. In this sense, the manager of ID said:

"…there is a hierarchical relationship because 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.'"

A third accountability device is that of performance agreements (PAs). These were utilised to achieve specific goals related to the ESE and the overall goals of the SOH. For ESEs that were below the desired productivity levels, PAs involved important transfers of money to fill the gap between the billing cap and actual billings, but conditional on reductions in fixed labor, improvements in administrative procedures, commitments to pay salaries first, and so on. ESEs that were self-sustainable also signed PAs (with no money transferred) but the goals were more related to quality indicators. These PAs were viewed by the SOH as clear control knobs for aligning ESEs agendas with the SOH's, as was indicated by an SOH officer:

"…PAs are direct [mechanisms of pressure]. PAs with bailouts are aimed at closing gaps [in factors that negatively influence performance] and closing those gaps requires them to assume certain behaviours."

ESE managers had mixed views of PAs: some considered they were part of the SOH obligation to exert the tutelage function. Among underproducing ESEs some managers considered they were good and helped the ESE reduce operating costs and increase outputs, while others viewed them as a restriction to autonomy. The managers of the self-sustainable ESEs say these PAs set goals that were easily achieved and they did not see PAs as a restriction to autonomy, except the manager of IIIC. However, some managers considered that ESEs receiving bailouts via PAs were poor performers. Thus, bailed out ESE managers were all the time struggling to get rid of PAs. For example, the manager of IID said:

"… after the merger, the ESE received in year 2001 4 billion pesos, in year 2002 only 3.5 billion, and for year 2003 we are aspiring to reduce it to (…) 2.2 billion. (…) the ESE, regardless it is receiving a subsidy, via PA, is approaching breakeven."

The manager of IIIA also revealed the same concern:

"…in 2001 we received 14 billion pesos, 2 billion in 2002, 1.4 billion in 2003. And the goal is not to receive [any bailout]. (…) to me, it became a matter of pride, a matter of why I need a bailout; I have to be able to generate all the revenues [and avoid the need for PAs].(…) IIF and IIIC boast about their not having PAs."

The manager of IJ was more cynical about the supportive role of PAs, in the same lines of those proud of not having bailouts:

"…let me tell you that it turns out to be more expensive when [the SOH] bails me out, because they rub it on your face for the rest of your life. (…). And they say 'you are the freeloader, inefficient, you manager have to leave.'"

A key point that was raised by some managers was that PA bailouts were possibly being used for cross subsidising the SS because ESEs were able to engage in price wars that were compensated with the PAs. This reverse subsidisation was a major point that received attention among interviewees. The point was exposed by the manager of IIB:

"…many ESEs don't have cost accounting systems and they lower their prices blindfolded in order to compete. (…) those ESEs are clearly subsidised [through PAs].

(…) I don't agree with that. If my father is subsidising me for a living, I cannot squander that money in other things [like competing] for other markets. (…) Do it when you are independent and get into the business you want."

And the manager of IJ also pointed at this issue:

"…the SOH and the ESE end up subsidising the ARS, because if the money was not enough [to cover costs], then here is the PA."

The SOH was also concerned for this issue and a sound strategy to prevent this was to avoid giving bailouts to ESEs that were being used at full capacity. However, this strategy was not enough to prevent ESEs with idle capacity from engaging in that reverse cross subsidisation, as put by an SOH officer:

"…I can't say there is or there isn't [reverse cross subsidisation]. The only evidence is that ESEs are not denying care to uninsured in order to get the SS enrollee. If the ESE has a PA because it has not closed the gap, it is because it still has idle capacity. But I don't know if there is cross subsidisation towards the SS."

This assumption of the SOH officer proved wrong, as the manager of IIIA clearly stated:

"...if I have a patient from an ARS and another from the SOH [waiting for a bed at the intensive care unit], I take the ARS patient because ICU is very well paid [by ARSs]."

Other accountability devices were also used to complement the three most important devices. One of these was the contest for the best hospital, which was seen as a good opportunity to test themselves, as commented by the manager of IF:

"…That kind of competition is very good. We carried out a pre-test session with all the personnel, and I think the stress it generates is good."

Monthly manager meetings were also a control knob for the SOH. These meetings were used by the Secretary of Health and other officers of the SOH to keep track of the

evolution of indicators and the performance of the ESEs. As described by the manager of IA:

"…we hold monthly meetings of managers, where the Secretary communicates his policies and guidelines. In these meetings the SOH takes stock [of each hospital]: 'your goal is this, why haven't you met it, what has happened?'"

A fourth accountability device on the SOH side was its role as local health authority. This function is not the same as the tutelage function, because it is more related to overseeing that all providers, public or private, fulfill licensing requirements to operate. It also implies that the SOH has the responsibility for public health regulations that affect all providers, such as following up of nosocomial infections or maternal deaths. In this sense, ESEs acknowledged that the SOH exerted control over them in terms of physical capacity, to complement the control knobs to assure a coordinated network. When asked about the freedom to purchase high-complexity equipment of any type, the manager of ID, a level I ESE, pointed out that:

"… we have a restriction vis à vis the SOH: the guidelines they set for levels of complexity. In addition, licensing requirements do not allow me to do so."

On the same lines, the manager of IA stated that:

"…in addition, according to the decree on licensing requirements, we have to have sufficiency of equipment and infrastructure, and that is approved by the SOH. So a new service cannot be opened if it doesn't have that authorisation from the SOH."

These mechanisms are all formal, i.e., they were clearly stated as the lines of influence the SOH had over ESEs. In addition, informal mechanisms were also used. One of these mechanisms was the direct influence of the Secretary over the managers. This influence was recognised with varying degrees of intensity, and certainly inversely related to the ESE self-sustainability as stated by the IIIC manager:

"…The Secretary calls and reproves me, but one thing is what he says and a different thing is how the market works. The only option is that they go to the Minister of Health and have him issue a decree prohibiting X activity."

A contrasting situation was found in a conflict between IIE and IIB, a very self-sustained ESE, where the intervention of the Secretary was explicit. The manager of IIE told the story in these lines:

"…IIB and IIIC are always chasing [the population of my area], so much that I had to call the manager of IIB to stop him from hurting me, because he was taking 4,500 SS enrollees away from me(…). I begged him not to do that and he said no. Then I had to call the Secretary, (…) fortunately the manager was in the process of reelection at that time, and when the Secretary called him, he immediately left that population alone."

Sometimes the Secretary gets directly involved in decision-making. The manager of IG reported that:

"… last year I refused to appoint doctors for social obligatory service[4] because they are very expensive, but [at the SOH] they said that I had to appoint them."

And the manager of IJ reported that:

"…I had a case here with an ARS that had half of the SS market share in the locality, but that contract generated 40% losses. I called them to renegotiate but they did not want, so I decided not to sign [the next contract]. The Secretary said 'you have to sign a contract' but I said I had no reason to contract. (…) I didn't sign a contract because I am the manager and I am autonomous. But on the other hand [at the SOH] they defamed me. One bit more and I would have had to leave."

But it was very clear that the Secretary does not get involved in the issue of price wars between ESEs when they compete for contracts with ARSs. He clearly stated that it was a risky business:

"…we don't meddle into that because the day we get involved, we end up crucified. (…) what we do is to authorise ARS to administer the SS (…). But the negotiation and the mechanisms are defined by the ESEs themselves (...) The risk is too high if one

[4] After graduation, doctors have to fulfill the requirement to work during one year at a public hospital before receiving their authorisation to practise medicine.

intervenes (...) Back in 1996 we led a joint negotiation [between ESEs and] ARS. After seven months we came to an agreement. But the meeting was hardly finished and 40% of ESEs had already changed the agreement and taken the majority of the market."

And the ESE managers recognised that the SOH kept its distance from the competitive wars between them, as illustrated by this quote from the manager of IG:

"… the SOH gets involved only when it sees that things are very complicated. They just suggest. (…) they suggest us not to step on our own hoses.[5] *"*

Even in the case of the aggressive ESEs, the Secretary seemed to be willing to play the game of allowing foot-dragging ESEs to be pushed to the edge, just by turning a blind eye on the aggressive ones, as illustrated by the manager of IIIC:

"…Indeed, the SOH has accepted that IIIC breaks the market, because it has taught the others to move on. This year I told the Secretary 'I will break the market (…)" and he says 'I don't know what you are doing…' so there is the implicit consent"

Peer pressure was reported as a powerful yet informal accountability device. As shown above, managers who had a negative view of PAs created an environment of rivalry among them to reduce their dependence on the SOH as a proof of their competence as managers. A quote from an SOH officer makes this point clear:

"…[peer pressure] was not explicitly imposed by the SOH but it arose among managers, partly because the Secretary of Health said that performance agreements were meant to adjust inefficiencies, and not necessarily structural but also functional inefficiencies."

A final point was found in the interviews, and it has to do with other reasons the SOH has to keep control over ESEs. The reasons shown above were related to the SOH objective to guarantee sustainability to ESEs, as said by the SOH officer. In general terms, these are expected to be welfare maximising measures. But other measures can

[5] This is a colloquial expression to illustrate lack of coordination in a collective task, when individual moves of team members obstruct the other members' and the whole team's performance, as when firemen, trying to put out a fire, step on their team-mates' hoses.

be welfare reducing. For example, the manager of IG was cynical about well-intentioned rationales for control. Instead, she said:

"…I believe it is not in the interest of the SOH that we become as good as we could be, because by the time ESEs [become fully autonomous], the SOH will be reduced to its minimal expression."

Political patronage was another concern. When autonomy to hire and fire is shifted from the SOH to the ESEs, the SOH loses the power to play the game of patronage. Regarding this point, an SOH officer commented:

"…while we were [at the SOH], we did not send [CVs] to ESE managers. Now[6]*it is by force, the SOH is sending CVs, they call [ESE managers] openly."*

And the manager of IIIA reported:

"…it is political-political, and it is already known what politician will be given the manager position, and they arrange the Board of Directors to make it happen."

Underscoring the differences between the three previous District Administrations and the new one that started in 2004, the manager of IIIC said:

"…there are like waves of true autonomy and then the government pulls back to centralisation, to reduce autonomy. It depends on the government, the Mayor, many variables."

8.3.Summary of findings

To summarise the findings of this chapter on the coexistence of hierarchical relationships, the propositions set out at the beginning are tested against the reported findings:

[6] This officer refers to the previous District Administration. The new District Administration started in 2004.

- **Proposition 1**: The relationships between ESEs and the SOH are successfully shifted from a hierarchical type to an arms-length type as a result of their transformation into autonomous entities.

This proposition is rejected, because, although ESEs enjoy more autonomy as compared to their previous vertically integrated structure, autonomy has not advanced up to the point of an arms-length relationship with the SOH. In fact, it was evident that the SOH still keeps control over decision rights through its ownership role. This role is exerted through its participation at the Board of Directors or through the use of Performance Agreements. In addition, not only has advance been halfway but for some key decision rights like budget design and execution, these rights were actually pulled back.

- **Proposition 2**: Shifting the day-to-day management to the hospital locus is optimal because it allows managers to match hospital responses to local market needs.

This proposition is confirmed as a necessary condition to improve hospital performance. It is clear that a better match has been achieved between hospital decisions regarding both supply of services and input mix, vis à vis local demand for services. However, it is unlikely that the sole granting of decision rights to the ESE manager gives the incentives to improve hospital performance in terms of improved quality and efficiency. Accordingly, the SOH keeps its control knobs over ESEs in terms of limiting decision rights and taking part in decision making through its participation in the Board of Directors.

- **Proposition 3**: The market environment will be enough to keep ESEs from adopting undesired responses to autonomy, so the SOH can keep its arms-length relationship.

This proposition is rejected, because ESEs can adopt aggressive competitive strategies that end up in a negative sum game. Given that they are not residual claimants, they can adopt risky behaviours that pass failures on to the SOH. Other ESEs having cost disadvantages that are difficult to overcome, cannot react to market signals, even if they wish to do so. Accordingly, the SOH has to keep the control knobs to make sure that

those who abuse autonomy do not hurt the others and cause a negative sum outcome, and to make sure that those with structural disadvantages are able to overcome them.

Discussion

As noted above, moving from a vertically integrated structure to a separation between purchaser and provider is expected to have two major consequences: transaction costs are reduced, as proposed by the NPM approach, and market exposure will ensue, as proposed by Harding and Preker (2003). These two expected consequences are based on the strong assumption that public hospitals, once autonomised, will behave like private firms, and a competitive market environment will emerge. As a result of these two expected consequences, it is also expected that hospital performance will improve in terms of efficiency and quality, and a net social welfare gain will be achieved.

Chapters 6 and 7 have shown that the assumptions on the reduction of transaction costs do not hold as expected by the advocates of the PPS. Indeed, although they cannot be accurately measured, it was shown that there are other types of transaction costs. It cannot be said as well that these different types of transaction costs are higher or lower than those of the vertically integrated structure, so as to rule out or rule in the predictions of NPM. In addition, these costs seem to have little effect in shaping the observed payer provider relationships in terms of governance structures.

In this chapter, it has been shown that a complete PPS has not taken place as expected, i.e., an arms-length relationship where the health authority focuses on its stewardship role while the purchasing function is exerted through third parties. Even if the system design would not introduce competing third parties like in the Colombia case, the evidence found in this research regarding ESEs' undesired responses to autonomy makes it unlikely that health authorities are able to keep an arms-length relationship as purchasers of health services for their population. Instead, hospital decision rights are restricted to a lesser or greater extent.

Following Harding and Preker (2003), one key advantage of the PPS is shifting the day-to-day decision making to the hospital instead of the centralised feature of vertical integration. The expectation of this shift to the local level is that decision making will better match local needs, both regarding the demand and the supply of health care. This

assumption seems correct through the findings shown above, for decisions related to personnel, procurement, purchasing of fixed assets and determination of the service portfolio. It was also shown that ESE managers are in a better position to judge their needs of human resources to respond to demand fluctuations, but it is more likely to work well at those ESEs with a low fixed-to-total ratio of labor.

However, it cannot be argued that desired responses are always obtained just by granting managers more autonomy, because they can still use that autonomy to make wrong day to day decisions. It was shown that aggressive competitive strategies can end up in a negative sum game, managers can exhibit poor judgment, or their strategic moves can undermine network coordination. It was also shown that other managers were less prone to act proactively or they were entangled by the rigidities of civil service. Therefore, a more fundamental explanation is necessary to understand the other factors related to good or poor hospital responses to autonomy.

One important factor that cannot be underestimated is that ESEs are still public organisations. The fact that they enjoy more autonomy than other vertically integrated structures of the government raises the challenges of having a public organisation without adequate controls from a higher authority. But no matter how much further they advance in their autonomy, they still keep their public nature. As shown in chapter 2, it implies three major differences as compared to a private firm: 1) ESEs lack a clear objective function, 2) they lack a residual claimant and 3) they lack a single principal. These three factors make it less likely that shifting day-to-day decision making to the ESE leads to the desired outcomes in terms of improved quality and efficiency.

It could be argued that the lack of a clear and unidimensional objective function, with observable and verifiable outcomes, gives room for managers to pursue other goals including their own benefit at the expense of that of the ESE. Although some managers clearly stated that the ESEs function was to maximise social welfare, whatever their interpretation of social welfare, others considered that the objective function was to assure sustainability to the hospital. Others like IIIC and IIB boasted about their surpluses and how they had been able to use them to increase capacity or acquire equipment.

An objective function that was not explicit from the interviews, but can be inferred, based on theoretical models of hospital behaviour, and some of the points raised by the interviewees, is the prestige that hospital managers derive from technology and level of complexity. According to Newhouse (1973), decision makers at hospitals increase revenues by investing in services that increase prestige. The optimal point of production depends on the utility function of the decision maker, which includes prestige. In this line, it was seen that ESE managers wanted to increase the complexity of their portfolio, by introducing more specialties and high-tech equipment. It obviously challenged the ability of the SOH to keep network coordination, and to optimise the supply of services by avoiding costly overlaps.

Perhaps the most important attribute of a public sector organisation that shapes ESE responses to autonomy, is the lack of a clearly identifiable residual claimant. Although Harding and Preker (2003) argue that it is very important to grant residual claimant status to public hospitals, it is unlikely that ESEs, having no identifiable principal, would have a strong incentive to maximise welfare just because they were allowed to retain surpluses. On the one hand, the fact that managers are not residual claimants and they can use surpluses for improving ESE performance but without facing the costs of losses, makes them excessively risk prone. This coincides with the finding reported by the SOH: when the ESE succeeded, the manager claimed the success, but when it failed, the manager blamed the SOH. On the other hand, managers were still able to use decision rights to transfer property rights to other interest groups around the hospital, like labor unions or local politicians or to their own pockets. In this sense, managers would be using autonomy to their own benefit and not to the benefit of the ultimate principal, i.e., the community.

Depending on their power and ability to exert influence, other principals (the community, hospital workers and politicians) were able to deviate the ESE manager decision-making from maximising social welfare. The findings shown above indicate that hospital workers and labor unions were rather powerless. The community was also less powerful to exert influence, although improved responsiveness to patients certainly improved relationships with the community. But their ability to unduly influence decision-making was limited by their limited skills to interact with Board members and the management itself. This was also reported by Castano et al (2005).

In contrast, politicians were found to be quite able to exert pressure, but some managers protected the ESE from being used for political patronage by sticking to the rules for hiring personnel. However, other managers took advantage of their autonomy to hire and fire short-term workers to play the game of politicians. It seems that this behaviour was strategically oriented to the benefit of the ESE, but it might also be the case that they used it for personal benefit. However, the latter was not found or at least was not openly recognised by any manager. The argument can be made that a vertically integrated structure is more vulnerable to political interests that lead to decisions that reflect down the hierarchy to make local hospitals respond to upper-level interests. This undue influence could be reduced through the PPS, and decision-making at the local level would have more room to respond to local needs.

This is the line of Frant's (1996) argument of de-politicising transactions to reduce the effect of high-powered incentives in the public sector. However, it can also be argued that local decision-making is exposed to the same influence, because politicians just shift their focus from centralised to peripheral decision-making, i.e., they focus their efforts for political patronage wherever the decision is made. This new dynamic was evident from the interviews, so politicians' influence is not avoided just by the PPS. The fact that some managers were not willing to play the quid-pro-quo game while others were, is no different from the fact that some central authorities in a vertically integrated structure play that game and others not. The only difference is the locus where the game is played, but the dynamic of high-powered incentives is kept largely unaffected. Therefore, the findings do not seem to confirm the argument proposed by Frant (1996), since autonomisation does not seem to adequately de-politicise the public health network.

Lack of market accountability (because of information asymmetries that made quality competition ineffective), and lack of ownership accountability (because of multiple principals and lack of a unidimensional, observable and verifiable objective function), gave wide room for managers to make decisions that did not lead to welfare maximisation or even reduced such welfare. This behaviour can be explained by both pure myopia and deliberate malfeasance.

On the lines of the previous paragraphs, it was predictable that if ESEs were completely left to themselves, welfare gains would not have been achieved. Thus, according to this

evidence, the expectations of the advocates of the PPS were not fulfilled. In contrast, health authorities tend to grant restricted decision rights to public hospitals and keep control knobs to make sure hospital behaviour is aligned with the objective of aggregate welfare. However, it is not automatically true that the health authority will be the perfect agent of the society at large. If the health authority, in this case the SOH, is openly opposed to political patronage or to tolerating corruption and inefficiency, it could be said that this contributes to improve social welfare. But this cannot be assured. In fact, comments by the managers about political maneuvering reappearing during the new administration that started in 2004, made the ghosts of the past come back. It was clear from the interviews, that during the past three District administrations, political patronage was largely reduced, so it can be assumed that the SOH, at least during those years, was more concerned for aggregate welfare and for the well functioning of ESEs as one element to achieve such better welfare.

The SOH exerted control over ESEs through three basic lines: its presence in the Board of Directors, the contracts for the provision of services, and the performance agreements. These three lines of control revealed two separate roles for the SOH: its role as owner (Board of Directors, and PAs), and as purchaser (contracts). The SOH also played the role of regulator, which implied other functions regarding licensing requirements and public health concerns. It was obvious that to the extent that these roles implied conflicts of interests, they would be less likely to be clearly performed. For example, as owner and as purchaser, the SOH should be able to exert enough pressure on the ESE to make sure quality was optimal. However, if it clamped down too hard on the ESE, it would probably have to terminate the contract because of suboptimal quality, as was shown in chapter 7. But the SOH knew it had to tolerate certain degrees of inefficiency and quality because otherwise it would have to face a political turmoil if the ESE was closed. Thus, it only issued penalties when it had to do with extreme cases or when it related to peripheral aspects of quality.

Playing its role as owner, the SOH exerted control over decision rights. The most obvious line of influence was its participation in the Board of Directors, where it exerted a dominant role vis à vis the other members of the Board. It could be said that this influence was positive, to the extent that the key decisions that affect overall SOH or District policy had to be discussed in the Board. It is also clear that to the extent that the manager had a better performance, or the ESE depended less on the SOH for

revenues, it was more likely that the influence exerted through the Board was less intrusive. Indeed, through the Board of Directors, the SOH was still able to keep its influence over ESE decision making regarding the SS market, so as to keep an adequate balance of competitive forces and protect stability of other ESEs.

ESEs obviously resented control from the SOH and they would prefer more autonomy. Even though some managers recognised that controls were necessary because some of their colleagues were blundering, other managers resented that control. In addition, it was the legal responsibility of the SOH to exert the tutelage function. But SOH controls over budget were the most clear illustration of how the pros and cons of autonomy have to be put in balance. When ESEs enjoyed autonomy over budget decisions, many overspent the budget or inflated it based on unrealistic expectations. As a consequence, when those expectations proved optimistic and they fell short of revenues, the ESE passed the problem onto the SOH, in the expectation that it would not allow the ESE to be closed down. This game also led some ESEs to delay salary payments to their employees, creating a vicious circle whereby morale went down, productivity was slashed, and the manager had no means to make up for the disaster, therefore making it impossible to improve hospital performance.

The strategy adopted by SOH was to bail out hospitals but at the same time set rigid budget regulations and use PAs to force managers to make some decisions to break the vicious circle of delayed salaries, low morale, poor performance. Thus, it was a sort of pulling back on decision rights, forced by the evidence that the effects of autonomy without accountability mechanisms can lead to poor decision making. In fact, these restrictions were progressively relaxed again as ESEs showed more maturity, better performance, and their larger autonomy (in terms of less dependence on SOH for revenues) allowed them to retake decision rights, particularly regarding budget design and execution. But the degree of autonomy in this matter is still more restricted than it was before the year 2000.

The evidence shown in this chapter does not support the claim that health authorities do not loosen their controls over autonomous hospitals because they lose power to the periphery. Instead, it supports the idea that to the extent that the health authority has a clear objective function to maximise welfare and it is willing to keep political patronage

at bay, it can exert a positive influence on autonomous hospitals, even if it implies to take back some decision rights from ESEs.

Regarding market exposure as a mechanism to force ESEs to improve performance, it could be said that the evidence is mixed, as shown in chapters 6 and 7. It would be expected that exposing ESEs to a competitive market would force them to improve performance in a positive sum game. But the partial results of market exposure suggest that ESEs can use autonomy to engage in price wars that lead to a negative sum game that would backfire on the SOH, as it would have to bailout the losers, whereas the winners can keep the surpluses to spend as they see fit. Certainly, a large transfer of rents to ARS would have taken place.

As a reaction to these price wars, the national government and the SOH passed regulations to protect the losers, particularly level I ESEs, by requiring ARSs to compulsorily contract at least 40% of the premium with the local ESE. This regulation certainly reduced market exposure and apparently did not make sense within the market-based approach of the 1993 reform. But it also could be said that protecting ESEs at risk of being excluded from the market made sense; otherwise, the SOH would have to pay the net losses of the competitive outcome, because the hidden agenda said that hospitals are never closed down. Regarding market exposure at level II and III ESEs, aggressive competitive strategies were not openly opposed by the SOH, but it rather helped the less competitive ESEs overcome their weaknesses by giving them the money for reducing fixed labor and increasing short-term employees. In general, PAs are being used as ownership mechanisms to help ESEs break the vicious circle of structural restrictions and make them more competitive.

Conclusions

It could be said, based on the evidence shown here, that the SOH, being halfway to an endpoint that was never achieved (universal coverage with a comprehensive package), assumed a role of steward, owner and purchaser with a coherent mix of control knobs to make sure ESEs improved performance on a piecemeal basis. This halfway autonomy cannot be said to be a failure on the path towards autonomy but rather the result of a necessary governance structure that guarantees social welfare halfway from market-based interactions. As pointed out by Arrow (1963), "…when markets fail to produce

an optimum state, society will, to some extent at least, recognise the gap and non-market social institutions will arise attempting to bridge it." Thus, it could be said that granting certain degrees of decision rights with some degree of market exposure, will at least create the forces necessary to improve the overall performance of the system, as compared to the performance that would be achieved either with a vertically integrated structure or a purely market-based one. This is quite similar to what is pointed out by Evans (1981) for the Canadian hospitals: they are indirectly controlled by the government through the budget and capital investments, but decision rights are largely transferred to the hospital itself.

The findings shown in this chapter provide evidence that hierarchical relationships are preserved in the PPS. Decision rights are transferred to the ESEs, but the SOH keeps control knobs to make sure managers will not use autonomy in the wrong way. This incomplete transfer of decision rights stems from the fact that ESEs can use autonomy for other purposes without improving social welfare because they do not face a clear objective function, residual claims cannot be adequately allocated and multiple principals influence decision-making.