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POWER ASYMMETRY IN DYAD BETWEEN A PRIVATE AND A PUBLIC ENTITY – THE HOLD-UP PHENOMENON

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ABSTRACT

This study aimed to analyze an inter-organizational relation of a dyad of the healthcare area, one being public and the other private. In light of the Transaction Cost Theory and Inter-organizational Relations, establishing the cooperation relationship was necessary to optimize public resources, besides the specificity of the transacted asset, which was health care in emergency situations. Transparency in the negotiations to establish a formal contract, however, proved to be insufficient to solve conflicts that were not predicted, as well as the suspension of payment by the public agent due to the inability to manage the budget.

Keywords: Hospital; Dyad; Cooperation; Opportunism.

1. INTRODUCTION

When the topic is about public policies, the notion that public bureaucracy is unable to do an efficient management is common (Misoczky, 2001). In the Brazilian case, one of the reforms destined to raise the governance capability (transforming policies into reality) emerged in the 1980s, by involving two different topics: health and financial autonomy (Bresser-Pereira et Spink, 1998). With the economic resources being rare, a way to make a better use of these is through its efficient allocation, what is called by Bresser-Pereira *et* Spink (1998) as a citizen-oriented, managerial public administration.

In order to meet this, the modern states were divided into 4 sectors (Bresser-Pereira et Spink, 1998): strategic core, exclusive activities, non-exclusive activities, and production of goods and services sector. The non-exclusive activities include education, health, cultural and research activities as government bonds. They are under its control, being funded or supported by it, and they can be provided by private entities. More details appear in section 2.1.

Because of the need to modernize the Brazilian state, in 1995, the Plan for the Reform of the State Apparatus was prepared. It enabled the redefinition of the role of the public entity, which is no longer directly responsible for the economic and social development, while strengthening its position to promote and regulate this development (Souza et al., 2010).

From this new role for the state, the process of contractualization emerges, referring to a health strategy, whose contractual instrument establishes goals and indicators and types of services to be provided to society. Thus, higher control and quality of the health service is achieved, while the responsibilities of the contractor and the contracted parties are defined (Abrúcio, 2006). These mechanisms are necessary when the state is no longer able to solve the problems unilaterally, which demands for joint solutions (Geddes, 2014).

Therefore, it is shared governance, which enables greater flexibility in face of changes in context and the necessary stability for long-term projects. The legal requirements (contract) enable the necessary stability for the services being offered and legitimize the relation of the organizations involved (Sandfort et Milward, 2014).

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That said, this study attempts to analyze the existing relations in a dyad of a public entity and a private entity. Contractualized in September 2008, these entities severed their relationship in July 2014. This ended up with the closing of the Municipal Emergency Care Unit that was working in the hospital facilities, where one of the parties became hostage (hold-up) of the other.

The present article is structured in five sections. Starting with this first introductory section, the second section presents the theoretical foundation, based on three thematic axes: the contractualization, the Transaction Cost Theory, and the inter-organization relations. In the third section, the methodology used to carry out the study and the study unity are presented. In the fourth section, the main analyses in terms of the relationships between these organizations are discussed. Finally, in the fifth section, the final considerations are made, followed by the references used in the study and preparation of this paper.

2. THEORETICAL BACKGROUND

This section is focused on creating the theoretical bases for the discussion made in the next section. Therefore, the three thematic axes already mentioned are presented: the contractualization, the Transaction Cost Theory, and the inter-organization relations.

2.1 Contractualization

It is a process legitimated by a contract between the local manager of the Unified Health System (hereby SUS), represented by the state or the city council and the legal representative of a hospital. In this context, the provision of assistance services is regulated by goals, indicators, and services receiving monthly control both by the public contractor and by the representatives of the Municipal Health Council. It is composed by representative individuals of the society and does not provide remuneration for its members (Sediyama, 2013).

The contractualization resulted from the state modernization, when it was divided into four sectors (Bresser-Pereira et Spink, 1998):

a) Strategic core – composed by the parliament, courts, president (or first-minister), besides ministers and main servants;

b) Exclusive activities – those that directly guarantee that laws and public policies are observed, thus, they include armed forces, police, regulatory, financial, development and social security agencies, etc.;

c) Non-exclusive agencies are all services the state provides to society, either through the private sector or through public non-state sector. As already mentioned, this is where the health sector is placed;

d) Production of goods and services sector – composed by the state companies.

The process of contractualization meets the demands of non-exclusive activities and can be divided into three stages: negotiation, construction of contract, and management. In the negotiation stage, the public entity discloses which services and volume it intends to hire, what attracts private service provider organizations. Considering hospital services, the choice options end up being reduced due to two factors: proximity from those who will use the service and capacity of attendance (Alcoforado, 2005; Carr-Hill et al., 1997).

Once the organization that will be part of this dyad – relationship established between two actors (Wasserman et Faust, 1994) – is chosen, they start to identify the performance indicators that will be stated in the contractual instrument, also called agreement. In this contract, everything that was hired is defined: charges, financial resources, forms of control and penalties for the parties, besides the operative plans describing the qualitative and quantitative goals that were hired (Sediyama, 2013). Management is the coordination stage that occurs after the contract is signed, when the indicators agreed in the previous stage are analyzed monthly, while consequently assessing the provider's performance (Alcoforado, 2005).

Once the processes involved in contractualization are understood, it is important to know the reasons why the public entity seeks, through inter-organizational cooperation, the provision of hospital services to society. To this end, it is interesting to approach the Transaction Cost Theory.

2.2 Transaction Cost Theory (TCT)

According to Williamson (1985), any transaction that can be formulated as a contraction problem can be examined through the scope of the TCT. The author proposes as a basic analysis unit any transaction that implicates passing one good or service in preparation from one agent to another.

The limited rationality of the agents, the uncertainty associated to the environment and risk of opportunistic behavior by the parties are said to be the origin of the transaction costs, besides the specificity of the transacted asset (Fiani, 2013). Opportunism, according to Williamson (1993), would not only result from the non-revealed risks before or after the transaction, since the individuals involved could lie, omit the truth, cheat, or even steal at some point.

Electronic Journal of Management & System
Volume 12, Number 3, 2017, pp. 286-294
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In this case, an optimal governance would only reflect the minimization of transaction costs (Williamson, 1985). Thus, the question made by TCT is whether it is better to produce a service or a good inside the firm than searching for other firms. This is why Williamson (1975) defends that the specialization level of a company is what makes the reduction of production costs possible. Therefore, it would be more logical to acquire some components of a product, for example, in relationships with other organizations that are specialized in the component required. In these cases, a common governance to achieve the goals becomes a common interest for the agents involved in this inter-organizational relation.

2.3 Inter-organizational relations (IOR)

There are many examples of inter-organizational relations focusing on cooperation for achieving a higher performance compared to the one achieved while acting individually (Mandell et Keast, 2014). As it is argued by Castells (2000), facing a context full of technological, economic, social, and environmental changes, organizations tend to search for flexibility, which includes new ways for inter-organizational relations.

The cooperation networks can be understood as a model of organization of independent companies, comprising a formal structure, where cooperation searches for joint actions (Balestrin et Verschoore, 2008). Naturally, facing the complexity of such relationships, the coordination exercise, where independent organizations interact with each other, is necessary (Grandori et Soda, 1995).

From the efficiency of this relationship management, the balance between the many actors, besides the benefits perceive by them, will emerge (Zawislak, 2000). The objective of the governance is, therefore, to reduce the uncertainty degree in relationships, besides predicting not only the parties' demands and attitudes, but also the variations of economic environments (Demsetz, 1990).

When studying the causes leading the organization to participate in an inter-organizational relation, Oliver (1990) pointed six contingencies:

1. Need – can result from legal or regulatory demands;
2. Asymmetry – in a situation of resource scarcity, there can be organizations using cooperation to dominate resources and activities from other organizations;
3. Reciprocity – search for cooperation, collaboration, and coordination aiming at common objectives;
4. Efficiency – better use of the internal resources;
5. Stability – facilitates the organizational adaptation to an environ of constant uncertainties; and
6. Legitimacy – when acting jointly, the image is reinforced or improved.

Even if such contingencies, individually, are already sufficient for establishing IORs, Oliver (1990) argues that they can also occur concomitantly.

As the present study involves a dyad, it is also important to present the concepts by Provan *et* Kennis (2007) regarding power asymmetry. The authors stress that the legitimacy of an organization can lead it to a leadership position in this relation. Geddes (2014) states that most partnerships are characterized by severe inequalities in power and capacity between the partnerships. Another important concept is the one discussed by D'Aveni, Dagnino, *et* Smith (2010), when dealing with the ethical considerations of the competitive advantages of monopolistic positions or oligopoly behaviors. The author who most probably presents the characteristics that can affect an inter-organizational relation is Fiani (2013).

The author stresses that a limited number of agents able to participate in a transaction and the specificity of the transacted assets can create, simultaneously, few producers apt to offer them and few plaintiffs apt to acquire them. This can generate the hostage problem (hold-up), when one of the parties becomes vulnerable for having invested in a specific asset, thus having the relations broken by the other party or pressure for the increase of the bargain power from the non-hostage party. The specificity of the assets is a necessary condition for the rise of the risks associated to opportunistic attitudes (Fiani, 2013). In the case of hospital assistance, the specificity also occurs because of the geographical location (accessibility), which will determine the attendance time.

A revision on the access to the health services showed some evidence (Carr-Hill et al., 1997): the use of primary health care is sensitive to distance, both for urban and rural populations, with this being particularly important for preventive services or for managing diseases in non-symptomatic stages; and there is evidence of a negative association for emergency services as well.

Moreover, since each organization aims to maximize its efficiency, the transaction costs end up rising due to the necessity of monitoring and controlling the behavior of each organization (Williams, 2005). The rise in the costs of a partnership was also discussed by Geddes (2014). The author stresses that the potential lack of transparency and responsibility rise costs and the lack of trust becomes a variable to become an important barrier in the partnerships.

Electronic Journal of Management & System
Volume 12, Number 1, 2017, pp. 286-294
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In the case of public administration, the use of organizational networks is directly related to the optimization of human and financial resources, besides countering the inefficiency of some public policies (Souza et Maçaneiro, 2014). This is why the Federal Constitution of 1988 sought to transfer the central power to locations where assistance is directly practiced. This means that, in the hospital case, transferring resources from the federal entity directly to the municipality and, once this municipality is aware of the peculiarities of its context, it must apply the funds received, always with the knowledge and consent of society (Junqueira, 2000).

3. METHODOLOGY

The research strategy used is the descriptive case study (Yin, 2001). According to Yin (2001, p. 23), a case study is an empirical investigation that investigates a contemporary phenomenon inside its context of real life, especially when the boundaries between phenomenon and context are not clearly defined. Yin states that the investigation of a case study deals with a technically unique situation, where there will be more interest variables than data points out and, consequently, it is based on several evidence sources. Thus, it benefits from the previous development of theoretical propositions to conduct the data collection and analysis.

The use of case studies is also justified, once this study deals with an exploratory research, according to Zaltamn *et* Burger (1975), for this type of research is applied when the available evidence is contradictory or insufficient to establish formal hypotheses or detect new concepts. In this case, the documental analysis and the participant observation, since one of the authors of the present study was part of the process of negotiation and control, representing the private entity until February 2012, besides the news covered in the media and the formal letter of the private entity, emitted in July 2014, when the suspension of the activities of the Municipal Emergency Care Unit was announced.

Yin (2001) stresses that the participant observation is a special form of research, where the researcher can perform many functions inside the case study and actually participate in the events being studied, while benefiting from the unique opportunities to collect data and preventing the observed phenomena from being restricted to that universe. The most interesting opportunity, in this specific case, is related to the ability in obtaining permission to participate in the events to groups, which are inaccessible to scientific investigation.

A semi-structured questionnaire was also created to be applied in the interviews with two health professionals. The sample is not probabilistic, but chosen by convenience. Data were obtained through primary sources, with a direct approach being used during the interviews. In the step of data analysis, a content analysis was developed (Bardin, 2005), aiming to achieve the objective of this study.

To ensure the anonymity of the two interviewees, these are identified as Interviewee 1 (I1) and Interviewee 2 (I2). I1 was part of the board of the hospital organization responsible for negotiating and preparing the contract between the Emergency Care Unit and the hospital and has been working in this segment for 15 years. Currently, this person is responsible for the board of other philanthropic hospital, also being contractualized. The I2 used to work as the negotiation from the part of the public entity when preparing the contractualization and nowadays it occupies a directive function in the Municipal Health Office of the same municipality.

The organization that is the unit of analysis of this study is located in the central region of the state of Rio Grande do Sul, Brazil, and was acquired by a private, community college, in 2003 for the creation of a Medicine course in 2006. In 2014, it had 234 beds, 900 employees, and 934 mean admissions per month, 1671 mean outpatient procedures per month, and 950 surgeries per month, with a permanence rate of 4.93 days per patient. It is reference for 37 municipalities in the specialties of traumatology and cardiovascular areas in the region.

4. DATA ANALYSES

4.1 A brief history of the relation between private entity and public entity obtained through documental analysis and participant observation

The hospital is contractualized with the municipality, where its headquarters are located, since September 2008. Other contract, specific for the Municipal Emergency Care Unit (PA), was created and became effective from August 2009, with the unit operating in the hospital's facilities.

The preparation of the contract started in June 2008 and it was signed in July 2009, becoming effective in 1st August of the same year. The delay in the negotiations involved since the discussion about funds for costing until the definition in terms of how the volume of services to be provided really was, since the numbers in the PA, already existing in the municipal structure, was not supported by the statements of their own employees in charge of the assistance in that location. The author of this study was part of these negotiations. Moreover, there was a strong political pressure for the PA to operate only after the leave of the party that was ahead of the government of the municipality until 2008, so that the inauguration would only take place under the new government.

Electronic Journal of Management & System
Volume 12, Number 3, 2017, pp. 286-294
DOI: 10.20985/1980-5160.2017.v12n3.973

The discussion on the real volume of attendance gained a special dimension, for it was the basis of the planning of the new structure. From this planning, the quantity of beds, equipment and personnel was defined, which would determine the fixed cost and, consequently, the value of the contract. It was not intended to earn profits for the hospital with the PA, because later it would serve as a training field for courses connected to health; however, there was the need for a balance point of the activity, otherwise it would disrupt the hospital's bills even more. The supervision of the quantitative and qualitative goals was made both by employees of the Municipal Health Office and members of the Municipal Health Council in monthly meetings for accountability.

The control of the volume of entries was made by representatives of the municipal office that was also responsible for approving or refusing attendance from other cities. To use the attendance of the PA, the user presented his/her SUS card. When the user was not from that municipality, the reception employee of the PA would inform about the Municipal Health Office staff in the PA. Frequently, they returned with a new card, what may explain the roll of 200 thousand SUS cards for a population estimated in 120 thousand people, as seen during the participant observation.

As the initial cap was 270 attendances by the fixed value, whenever this limit was exceeded, in the years 2009 and 2010, the exceeding should be paid in the following month. In the years of 2011 and 2012, a new cap was established: 230 attendances per day, since the municipality started refusing attendances more frequently, whenever there were cases that could be solved in the municipal service station. However, an important factor that, without drawing the necessary attention from the public entity, made the service management more difficult. The hospital with which the public entity also had a partnership exceeded the volume of services from the start, because it was the one that received more patients from the PA that was installed in the facilities of the Municipal Health Office and, as well as the PA located in the hospital, it had the right to receive the exceeding values in the following month. Besides the hospital where the PA was located, other two hospitals in the city were also contractualized to receive patients from the PA. Its size, however, was around 50% smaller than the hospital's where the PA was located. One of them did not have the support for several specialties, thus limiting the possibility of sending these to low complexity clinical cases.

When the PA was installed in the hospital's structure, the volume of hospital admissions rose around 20%, probably rushed by the presence of specialists of several medical and available areas, in the remunerated on-call regimen, in order to call for the physicians on duty working in the PA. It accelerated the diagnosis and the medical conduct, noteworthy in the case of emergency surgeries. This service was not available in the previous PA installed in the Municipal office that required the admission in one of the three hospitals of the municipal network, which could take several days, leading to a severe delay in making the diagnosis by a specialist and generating unwanted consequences in the patient's recovery.

As a result, there was an expressive improvement in terms of providing service to patients that started to have access to a faster medical diagnosis, besides solving their pathologies. Moreover, it had all the necessary equipment for life maintenance in an observation room, since, not rarely, ICU bed were necessary, without having to recur to the Hospital Beds State Center.

There was, however, an important mismatch between the quantitative values hired with the hospital and the financial capacity of the local municipality office, since the exceeding values were not estimated in the municipal budget. All the exceeding existing until March 2010 was renegotiated, with the monthly payment of the debts added to the values already predicted in the contractualization. In 2012, the values corresponding to the values overdue in 2011 were renegotiated in monthly installments.

In 2013, a new change in municipal government caused further delay in tuition transfers, this time regarding the contract because of the PA. The impasse regarding the payment of retroactive debts prevented the development of a new contract in December 2013, being extended until July 2014, when the direction of the sponsor (University) and the Hospital held a press conference, saying that negotiations were closed and they would not extend the contract not only due to legal impeachment, but due to the lack of economic and financial sustainability of the PA.

This interview took place on July 28, 2014, causing, by the part of the city hall, the decree of intervention to those facilities. As the public entity had no staff in quantity and capacity for the volume of attendances, the Public Ministry intervened with the negotiations between the parties, establishing a new contract on August 7th, 2014. Among the actions taken, the most decisive was the pressure on the municipal manager, to seek new sources of funding by the federal entity, as it was proven that the services were provided but were not reimbursed.

In order to assist in understanding the research problem, a semi-structured questionnaire was presented to two different professionals (one representing the contracting part, and the other representing the contracted, as indicated in the methodology). Only two questions were made, because we sought to understand the moments before the contract was signed for the establishment of the PA in the hospital. The first question was about the difficulties of establishing the real number of existing attendances

Electronic Journal of Management & System
Volume 12, Number 1, 2017, pp. 286-294
DOI: 10.20985/1980-5160.2017.v12n3.973

in the old structure of the PA and the one planned for the new structure to be hired.

I1, who was representing the hospital during the negotiations, indicated strong concern with the expected volume of attendances to the PA, because, while the representatives of public management declared a number of 220 visits/day in the already existing PA, employees in that sector who were part of the first meeting indicated up to 300 visits/day, stressing that sometimes they had to seek help with the SAMU (removal service and mobile service emergency care) that was based in the same location. This would impact not only on the design of the teams, but also on the physical structure and would be reflected in damage to the hospital's image before the society, besides the difficulties to providing quality care. The interviewee added that, in the following meetings, employees of the already existing PA no longer attended the meetings, which also generated distrust regarding the remaining negotiators of the public manager.

I2, being a representative of the public entity, stated that the public management understood at the time that there should be a higher counterpart from the hospital part, since the university, the public's sponsor, would use the PA as a training field for the courses connected to health. Therefore, it would be fair if they could help in paying the expense. Regarding the employees of the PA that informed there were higher volumes of attendance, the interviewee remembered that they were approved by means of a public contest and did not fear to be reprimanded, but were prevented from frequenting the subsequent meetings.

The second question attempted to understand whether the parties involved had already made simulations in case there was a bigger volume of attendances to be made, which would mean inability to manage the budget for the public entity and, a bigger volume of attendances than the PA and hospital's capacity would allow for the private entity. This could yield dissatisfaction by the users and the community.

I1 believed that there would be less supervision of the other two hospitals for receiving the patients coming from the PA, while avoiding overcrowding, but the interviewee feared that the surrounding municipalities started to send patients close to emergency, what would lead to a dangerous situation in face of the physical and human resources predicted for the demand. However, no simulation was made.

I2 predicted that the funding would be insufficient, since politically it would not be interesting to refuse all the patients from other municipalities. I2 stressed that the main managers were people connected to political parties and the regional interests would be more important than the local ones in several moments, as it had already happened in the PA structure itself. They knew that the budget would not be enough for the cost of the activities hired, but they believed that, for being a community hospital, the hired party would still provide care, even if it did not received the payment that was due. I2 reminded that some directors of the universities were linked to political parties and would probably have, equally, other interests in terms of the care provided to patients originated from other municipalities.

4.2 Analysis based on theoretical background

The hiring by the public entity of a private entity for hospital attendance meets what was established by Williamson (1975, 1985, 1993), because they are searching for a specialist organization, when there is no ability for it to be done in the contracting organization.

This case can also be analyzed under the perspective of Oliver (1990) regarding the six contingencies, leading organization to participate in a network:

1. Need – health is a State duty, but because it is a non-exclusive activity, it may be transmitted to private entities. For the sponsor that acquired the hospital, the existence of a specific PA for SUS enabled the qualification of the courses connected to health;

2. Asymmetry – scarce resources and cooperation enable its best use. In addition, the public entity, the support staff must be hired after a public service exam, which means little management capacity on their performance. In private institutions, there is a greater flexibility in managing human resources. There is, however, a knowledge asymmetry. On one hand, the public entity was aware of its inability to pay for the established contracts. However, there is, on the hospital's part, a knowledge domain necessary to make more complex activities, besides its relationship with the clinical body, what gave them a bigger margin for negotiation;

3. Reciprocity – there are, clearly, cooperation, collaboration, and coordination, since monthly spreadsheets with quantitative and qualitative goals were presented, in addition to several renegotiation of past due amounts;

4. Efficiency – the best use of public resources meant faster service of the presented pathologies, resulting in a greater chance of patients' recovery;

5. Stability – emergencies generate a high need for organizational adaptation and this is noteworthy, as the service was regularly working. The interruption

Electronic Journal of Management & System
Volume 12, Number 3, 2017, pp. 286-294
DOI: 10.20985/1980-5160.2017.v12n3.973

of its offer and the of intervention indicate a serious disruption of this stability, which is also reflected in the next section;

6. Legitimacy – there was a remarkable worsening of the image of the public manager as the one responsible for interrupting the attendance due to the lack of the overdue payments. On the provider side, there was a reinforcement in terms of the legitimacy of the organization before society, because, once the public interview about the termination of the PA activities and the reason why they made this decision, there was no clarification contrary to the offered information by the provider, by the part of the public manager.

Asymmetry and legitimacy, in this case, were the main factors that led to a temporary termination of the activities. It must be remembered that, facing the possession of intangible (knowledge) and tangible assets (equipment), the hospital reinforces the concepts of Provan *et* Kennis (2007) regarding power asymmetry. Such resources end up leading the hospital to serve as a leader in this relation, giving more legitimacy before society.

However, when making a unique activity whose characteristics distinguishes them from other service activities (location and speed of attendance), the hospital assumes a monopolistic behavior, that can bring ethical consequences for this relation (D'aveni et al., 2010), including those resultingfrom accessibility (Carr-Hill et al., 1997).

The public entity appears, in these cases, as a hostage of the assistance made by private organizations, forcing it to accept contractual impositions that can reduce efficiency in managing the resources, and its refusal will impact on the efficiency of the services being offered. It is a case of opportunism discussed by Williamson (1993) and specificity of asset (Fiani, 2013), since the attendance time, in this case, interferes directly with the choice capacity of whom demands the service.

Both interviewees, in turn, reinforced the concepts by Geddes (2014). The lack of transparency and responsibility of the parties raised the transaction costs, including the time that it took to establish the contract, and the lack of trust were probably the most important reason for creating barriers in this partnership, then culminating in the termination of the service and decree of intervention by the part of the public entity. Apparently, there was an opportunistic attitude from part to part, since, while the public entity was already aware of its inability to manage the budget beforehand (*moral hazard*), the use of the PA structure as a training field by hospital and the university parties actually yielded advantages to the private entity, because it turned the courses connected to health more qualified, and it became a way to attract new students. Regarding the hostage situation, the asset specificity generated a problem for both parties (Fianni, 2013). On one hand, there were no other agents capable of offering the service required by the public entity, giving the hospital a leadership position in the relation; on the other, the hospital made investments and hired personnel for a service that could only be destined to the public manager. When the hospital was not paid by the services provided, the last option was to terminate the activities of that sector and pay for the termination costs from the entire personnel.

The figure below presents the processes involved in building this inter-organizational relation between the public and the private entity:

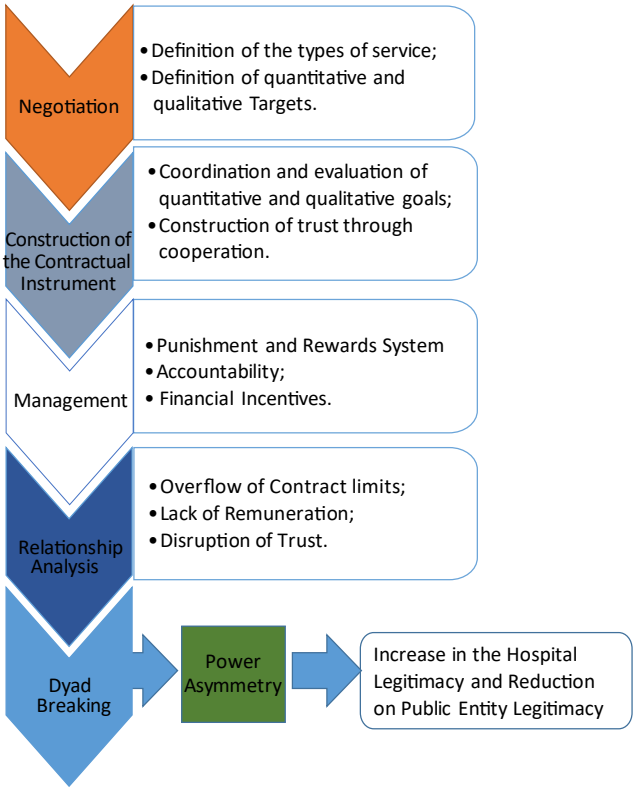

Figure: Flow of a dyad between the public entity and the private entity.
Source: The author.

5. FINAL CONSIDERATIONS

Establishing cooperation between the public and the private management is essential to offer the better use of scarce resources. Moreover, because it is a service highly dependent on the specialized knowledge of the human resources, of the need for constant technological updating, and with a high initial investment, the private hospitals provide a servi-

Electronic Journal of Management & System
Volume 12, Number 1, 2017, pp. 286-294
DOI: 10.20985/1980-5160.2017.v12n3.973

ce to society in several regions, where the public authorities do not offer another alternative.

However, exactly in this capacity of attendance and detection of tangible and intangible assets, power asymmetry can lead an inter-organization relation to disruption. In the case of hospital attendance, it is interesting for the public power to search for more than one partner, as a way to balance the existing powers, minimizing potential opportunistic behaviors.

Moreover, contrary to the popular belief, injunctions may be given, ordering the immediate admission of a patient in a given ICU – whether it is in a public or private hospital. The point is not the non-desire to provide care, but the capacity to provide it. If it is not possible to admit a patient, it is because there are no beds. Due to the nature of the service, private or public hospitals are not confounded with first aid stations that attend through the SUS, where, in case there is a lack of rooms, a patient can be put in a hospital bed in the corridor. In these stations, there is no possibility to rise the capacity beyond which they were built. Because of this, the transparency of the public agent is important when defining the quantitative goals of attendance, improvement on the governance capability, and higher transparency in the relationships with the partners.

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