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Health governance and the public-private relationship in small municipalities

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Abstract *Within the institutional healthcare system, the public and private sectors come into relationship mainly in the context of the execution of medium-complexity health services, especially in small municipalities (SMs). The aim of this study is to analyse the relationship between public managers and private providers in the regional governance process with regard to the factors involved in the contracting process and management and planning mechanisms of medium-complexity actions. This is a qualitative case study conducted in a health region of the state of Paraná via interviews with public and private managers performed from December 2016 to February 2017. Documental analysis of management tools and price schedules in contracts between public and private managers was also performed. The results indicated interdependence in the relationship between public managers and private providers, power asymmetries, interests, and benefits, depending on the type of contract between the municipality and the provider and, of particular note, advantages and clientelistic practices. The incipient planning process and regulatory measures of the municipalities in the region and state indicate the need to invest in actions that favour governance, the regulatory capacity of local governments, and social scrutiny in this region.*

Key words *Public-private relationship, Governance, Regional health planning*

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Introduction

Various countries have sought to increase the efficiency and effectiveness of healthcare systems through the dissemination of decision-making processes, combining healthcare policy decentralization with regionalization. Thus, investments have been made to organize service networks and strengthen regional health authorities[1].

In Brazil, regionalization is included among the principles and guidelines of the Unified Health System (Sistema Único de Saúde – SUS). These guidelines can be seen as a technical-political process with a number of dimensions, including, among various other elements, the distribution of power and the relationships established among governments, public and private organizations, and citizens in a given geographic space[2,3].

Various subjects with different degrees of autonomy are part of the negotiation process that characterizes regional governance. As a general concept, governance refers to the processes of governing, to the reorientation of the types of relationships between State and society, or between governments and private agents and society, encompassing the exercising of power[4].

Governance represents the diversity of interests (public and private) that can be organized and negotiated according to common goals to guarantee the right to health. Among the key elements of governance with regard to the consolidation of the SUS, of particular note is the creation of an institutional environment favourable to the coordination of actors, services, and actions[5].

In Brazil, the current public health system was essentially organized based on the care model established by the purchase of private medical services, thus enabling the participation of this sector[6] in a supplementary[7] and complementary[6] manner.

Some Brazilian researchers have focused on understanding the relationship between the supplementary private sector and the public system—the result of a dual system that provides different forms of access and assistance to citizens. This analysis occurs in the macro-organizational context of the healthcare system, with a particular emphasis on health plans, large medical corporations and reimbursements to the SUS through private plans, the financing of electoral campaigns, and the pressure on political groups exerted by healthcare companies[8,9].

In the local (municipal) context, especially in small municipalities (SMs), the relationship with the private sector occurs to provide healthcare to the users. It mainly covers the purchase of specialist consultations and diagnostic, clinical, surgical, laboratory, and imaging procedures in hospitals, through a contractual relationship with the complementary private sector. These represent the range of healthcare actions characterized by medium complexity (MC)—a realm of the public-private relationship that has been little researched in the country.

MC can be defined as a level of the healthcare system that enables all assistance in the SUS and whose complexity requires specialized professionals and the use of technological resources for diagnostic support and treatment[10]. Currently, it is considered one of the “big bottlenecks” in the Brazilian healthcare system, precisely because of the innumerable differences related to access to this level of care in the health regions, which result from the lack of public investment, skilled labour, service provision, and structural organization of the care networks[11-13].

Thus, the public manager of an SM that has insufficient installed technological capacity to offer medium-complexity services needs to use the services of the complementary private sector, either through agreements with the State entity or through purchase via direct and/or collective healthcare services contracts, even if the provider is located in another municipality or is under state management. Consequently, a group of institutions and actors of interest who are beneficiaries of private assistance is formed[8,14].

In this context, the aim of this study is to analyse the relationship between public managers and providers of the private complementary system in the regional governance process in SMs in a health region of the state of Paraná with regard to the factors concerning the contracting and management and planning mechanisms of medium-complexity services.

Methodology

This is a qualitative case study that is part of a larger study entitled “Interfederative management of the SUS in the organization of regional arrangements for medium-complexity care in the northern macroregion of Paraná”. This study was conducted in a health region consisting of 16 municipalities—all with less than 50,000 inhabitants—considered SMs and located in the northern macroregion of the state.

Healthcare and socioeconomic indicators highlight three predominant characteristics of

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this health region: it consists of municipalities with low economic development, it has adequate primary healthcare services coverage, and it has lowproblem-solving capacity in terms of public healthcare services[15].

According to research by the Região e Redes group[15], the health region studied was the only one in the state of Paraná (and in the whole southern region of Brazil) to be classified as group 1—"Low socioeconomic development and low availability of healthcare services". However, the studied health region belongs and has indicators that are similar to a larger area composed of another 175 regions and 2,151 municipalities (equivalent to 40% of the total number of Brazilian health regions and 38.60% of the total number of Brazilian municipalities).

The data were obtained through interviews—guided by a semi-structured script—conducted between December 2016 and February 2017 as well as documental analysis of management tools and price schedules in contracts tendered between public managers and private providers.

The study subjects, selected via intentional sampling, were four managers and/or members of the municipal management team from different population strata of the health region studied, two managers of private hospitals in the region, one representative of the council of municipal health secretaries (Conselho de SecretáriosMunicipais de Saúde – COSEMS), one representative of state administrative center at the health region , and one representative of the inter-municipal health consortium, for a total of nine interviewees.

The coded identification system proposed by Goldim[16] was used when referring to the interviewees in the results section. The interviewees were coded with a letter followed by a number. The letter G (G1, G2, G3, ..., G7) was used for the public managers and the letter P (P1, P2) for the providers, in accordance with the order of the interviews.

The interviews were transcribed in full by the investigators and subjected to discourse analysis, in accordance with the ideographic (individual) and nomothetic (general) techniques proposed by Martins and Bicudo[17]. Ideographic or individual analysis refers to the ability to understand the language of each interviewed subject. This analysis occurred via the systematic reading of each interview, highlighting the units of meaning in the excerpts, which, after being interpreted, formed units of meaning[17].

Nomothetic analysis, in turn, corresponds to the process of passing from the individual to the general, which occurred through the grouping of the units of meaning of the subjects chosen based on their relevance to the phenomenon, and the verification of convergences, divergences, and idiosyncrasies of these units in relation to other outstanding ones, which helped to elucidate them at the end of this process[17].

This study is based on theoretical concepts of clientelistic practices[18-20], which aid in the analysis of the behaviours and attitudes of social subjects in Brazil. It is also based on "neoinstitutionalist"[21,22] concepts, whereby previous policies and their trajectory influence the results of public policies, producing institutional constraints that shape the behaviour of the social and political actors involved in the process, as well as aiding theunderstandof power dynamics and inequalities existing in social arrangements.

Regarding ethical issues, the study was conducted in accordance with Resolution no. 466/2012[23] of the National Health Council and was submitted to and approved by the institutional Research Ethics Committee of 29 August 2016.

Results and Discussion

The study subjects were asked questions regarding their age, training, and previous experience in the field. The mean age of the interviewees was 46 years, ranging from 30 to 68 years. All had higher education, and 66% had a *latosensu* specialization. Of particular note, the private providers had, on average, 8 more years of previous experience in health services management than the overall group and 10 more years than the group of municipal managers.

The analyses of the interviews enabled the construction of two general analysis categories: the first involved the factors related to the contracting of services, such as dependence, benefits, and interests made possible by the contracts; the second category involved factors and mechanisms related to regional healthcare management and governance, with regard to the behaviour of the actors and the distribution of power in the public-private relationship.

Dependence between managers of small municipalities and private providers: Benefits and interests

The results indicate that the public-private relationship in this health region involves a substantial dependence of the public sector on the complementary private sector and that this relationship is made possible, established, and maintained through contracts. As mentioned earlier, SMs do not have the installed capacity to perform medium-complexity procedures[11,12]; therefore, they must directly and/or collectively purchase services from private providers, even if the provider is located in another municipality or is under state management.

Brazilian law allows the complementary participation of the private sector in public health services through administrative contracts, agreements, and management contracts, whenever there is a proven need for such cooperation and it is impossible for the public network to expand its own services[24]. This also allows states and municipalities to complement the services stipulated in the SUS services table with their own resources, as long as this does not adversely affect user access to services[25].

However, the analysis of the existing contracts in the health region revealed that the values of the contracts between the public manager and the private provider are not based on the SUS price schedule but rather on the market price. Even the contracts established with providers through the regional health consortium do not obey the price defined by the schedule.

Several studies have discussed the implications for the healthcare system of the lack of adjustments to the SUS price schedule[8,11-13], which, in the neoinstitutional perspective[21,22], acts as positive feedback for the fulfilment of the contract between municipalities and service providers.

The managers' statements pointed to the practice on the part of providers of making available in the contract only the procedures they believe to be most profitable such that the managers do not reach an agreement with regard to their needs: [...] *I agree on availability, we work with what is available, and what is available to the public* (G1).

According to Matos and Pompeu[26], in situations of monopsony (a market in which there is only one buyer) or even in an oligopsony (a market in which there are few buyers), it is the buyer who imposes the rules to the sellers. However, in the healthcare system of the health region studied, the opposite is observed: it is the seller who sets the rules.

Regarding the form of the contracts executed, the municipalities studied can be classified into two groups with regard to the relationship that they have established with the private provider, especially in the hospital setting*: (1) SMs with an exclusive contract*, which includes municipalities that do not have hospital services in their municipal territory and establish a contract with only one hospital provider for access to the medium-complexity procedures available; and *(2) SMs with non-exclusive contracts*, which consists of municipalities that generally have a public hospital in their service network and have smaller contracts with several providers.

This categorization is justified because the two groups have distinct types of public-private relationships. Municipalities with exclusive contracts execute the services with a single provider. For this reason, they have benefits and privileges related to guaranteeing full assistance to their residents. These advantages include the ease of admitting and transferring patients in urgent and emergency situations, and the possibility—even when within a care network—of giving preference to the patients of these municipalities.

According to the interviewees' statements, the SMs with exclusive contracts always stay compliant with the provider. Additionally, in the political dimension, the contract is perceived to be an important factor for the evaluation of municipal management, both for the users and for members of the executive and the legislative branches of government.

The exclusivity practices mentioned may be associated with the clientelistic practices among public managers, private providers, and users. In the view of some managers, these practices may be related to funding, political pressure, and/or election campaign support in the contracting municipalities. Paim and Teixeira[27] argued that Brazil is currently rampant with patrimonialism and clientelism and colonized by private interests. Santos and Rodrigues[20] reported that clientelistic practices in SMs favour the private control of both public goods and voter access to services, due to the relationship with political-electoral interests.

In relation to the SMs with non-exclusive contracts, the results show that they shoulder the cost of approximately 75% of their own services (municipal hospitals) with funds from unencumbered sources and still need to complement the price charged by private providers for medium-complexity procedures.

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This reveals the interdependence between public managers and providers. Additionally, the municipal managers in the health region analysed do not see possibilities for change in the short term, and by contracting, they strengthen the private provider.

Inappropriate attitudes and practices were observed in the interviews, regardless of the municipal contract category. Of note among them were the following: charging for evaluation of patients transferred by the public system; performing high-cost exams as a prerequisite for patient admission; use of SUS beds with payment of procedures by the municipality and/or family; and medical care with successive follow-up visits in some specialties.

Solla and Chioro[28] observed that private healthcare establishments that are not subject to regulation may exhibit distortions, such as choosing which illnesses to service and making excessive requests for complementary consultations and examinations that are often unnecessary. Arretche[29] argues that local governments should take over the management of public policies and put into practice rules for decision-making processes and mechanisms of control and punishment, in order to provide incentives to change management behaviour.

The manager's statement, [...] *health is priceless but it has a cost* (G5), confers a certain naturalness to contracting and complementary payments by municipalities to providers for hospital procedures. In this respect, the managers appear to be in agreement with this situation.

According to the neoinstitutional current, the actions of social actors derive not only from their individual interests and ambitions but also from the influence of institutions on individual and collective behaviour, as a result of the historical convergence of policies associated with them. In this context, the preferences of each social actor are exogenous; that is, stimulated by the institutional organization[21,30]. This means that the institutions provide the background for the practices of the social actors, which are added to their own interests.

Arretche[29] agrees that whether local and national governments engage in responsible practices depends on the incentives that they are subjected to, and, to a large extent, they result from policy designs, rules, and social norms that encourage the behaviour of the actors.

A full understanding of the contract established is of utmost importance to the manager; however, the political and institutional dimension seems to involve training and recruiting public managers who, intentionally or not, are apathetic and individualistic and perceive themselves as weak and constrained. The justification for the permanence of this relationship is the manager's weak position. In this context, maintaining contracts with private providers is convenient for the municipal manager.

It can be seen that the relationships of benefits and interests pertaining to the public-private relationship in the health region strengthen established practices, enabled by the institutional realm in which political actors are inserted but no less influenced by their objectives. We therefore have an arena of conflicts, formed by power asymmetries between managers and providers, in which individual interests prevail over collective interests.

Management mechanisms: The behaviour of social actors and power in the public-private relationship in small municipalities

The results indicate that the managers practice incipient, reduced, and informal planning with respect to medium-complexity programming. The interviewees' statements show that the managers do not perceive the operationalization of planning in a bottom-up manner – as described in Decree no. 7508/2011[31] – and that they develop municipal management and planning instruments because of bureaucratic and legislative requirements.

So, this interfederative issue [planning], *it only occurs when obligations are imposed. When tasking the municipality with achieving a certain result, it is interfederative, from top-down* [...], *that bottom-up planning in the decree, never existed, never existed. Bottom-up* [planning] *does not exist* (G1).

In a scoping review of the decentralization of healthcare management to municipalities, Pinafo et al.[32] identified that medium-complexity agreements involve complex processes, in which the rules and definitions are not clear and are poorly defined in planning and monitoring instruments.

The managers stated that the limited use of instruments for planning makes it difficult to implement the regulation or forecast the healthcare needs of the population and to define the mechanisms for access to medium-complexity services. The inter-municipal healthcare consortium does not present mechanisms for regulation and/or planning based on the real needs of the

municipalities either. The State, in turn, which is the entity with formal responsibility for medium-complexity services - since the municipalities surveyed are responsible for the management of primary care - is also insufficiently regulated.

Viewed based on the government concept of controlling/managing, regulation is characterized as a decision-making instrument for the implementation of local management and planning models. According to Fleury and Ouverney[33], the low capacity of the state apparatus is directly related to the inability of the public services to create efficient regulatory structures, and such structures are strongly influenced by the power of private organizations, thus preventing the coordination of the system by the government.

In the neoinstitutional context[21,30], the public-private relationship in the health region studied is reinforced by the incipient management mechanisms related to planning, regulation of access to services, and mechanisms for evaluating and auditing contracts, thus providing fertile ground for the inequities that occur in the public-private relationship in this context.

The providers believe that municipal healthcare managers are not adequately prepared for their job position and do not seek to know, be a part of, or understand the process of healthcare policies. Therefore, the municipal healthcare managers accept the determinations of the private providers, reproducing within their management the attitudes and postures of their peers: [...] *actually, I feel that there is a lack of knowledge by* [public] *managers, and perhaps little interest* (P1).

In this regard, Santos and Giovanella[34] indicated difficulties with regard to the consolidation of regional governments, for example: weak management policies, constraints in the provision of services, private sector interference, conflicts and disputes between municipalities and collective action, and the strategic but ineffective role of the State as an inducer of regional policies.

In describing the challenges and obstacles faced by management in the SUS, Fleury and Ouverney[33] reported that the alternatives "increasingly point to the need to strengthen the actors and to horizontalize power relations"; that is, municipal public managers need to be more skilled to be able to discuss, debate, and question the relationships with the private sector and with federal entities.

The behaviour of municipal managers influences their ability to govern and is related to other factors observed in the regional context, such as the large turnover of professionals in this role, the lack of technical training, low pay, political party nominations, the responsibility within a complex healthcare system, excessive demands, political crossings, and the low level of autonomy regarding decisions and management[13,35,36]. These factors hamper the continuity of public health policies[36] and change the direction and viability of municipal policies[13].

Silva[35] contributed to this discussion by arguing that the ability to govern is related to the manager's autonomy and that in many municipalities, this autonomy is tied to the mayor, mainly through the use of political criteria for selecting managers. Due to political nominations, health secretaries do not have decision-making power over resources (few manage the municipal health fund) and/or the direction of municipal policies.

In the interviewees' statements, it is possible to understand that this weakness in management is perceived by other political actors of the municipal legislative and executive branches, who interfere in the relationships, taking advantage of the power they possess to use the health department to further their interests and those of the people who elected them, which results in clientelistic practices.

Pase et al.[18] showed that political actors use clientelistic practices in a blatant process in which votes are exchanged for citizens' requests within an institutional process that allows and naturalizes these practices. Stokes et al.[19] believe that clientelism is a relationship of asymmetric exchange that involves the delivery of benefits, which returns in the form of votes or political support that has already occurred or could still occur.

The political interference discussed above deconstructs the healthcare networks and weakens governance and management processes. In the municipality, this practice strengthens the private sector and weakens the healthcare managers in their responsibility to the municipal system.

Menicucci[37] stated that the trajectory of health policies in the practices of the public-private relationship enables the construction of interested actors who mobilize and define the political decision-making arena. Conflicts and interests arise in this arena.

According to Matus[38], conflicts arise from the inequality of results involving the relationships and can develop in the cognitive, emotional, and interest-related dimensions. This last dimension is characterized by the benefits that one can ob-

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tain due to the losses that others assume. For the author, the game of interests occurs and is resolved by the relative value possessed by each player in the conflict arena.

The results of this study indicate that, individually, a manager of an SM will have little power and relative value in an arena of conflicts compared to a provider. Given these factors, in the search for regional results, managers do not mobilize and/or do not expose themselves in relation to service providers. The managers themselves mention the weakness of governance in the administration committee, because:

When we hold our meetings there is a type of talk [a behaviour], *a certain pressure to act* [to have attitude], *but when it is necessary* [for the manager] *to sit at the table for negotiation, there is cowardice. Leave it as it is! So that is why there are no intermediations. Because they do not exist!* [...] *Now, what needs to happen is that, whoever makes the allegation has to continue alleging the same thing at the negotiating table* [...] *So, when they talk, it's one thing, and but when the time comes to confront the situation, everything changes* (G5).

The managers point out that the "cowardice" mentioned above is implicated in the indifference of managers towards regional problems. In the conflict with the provider, the losses are greater than the gains; therefore, the managers neutralize themselves, stay on "the fence", or align themselves with the provider. Some interviewees indicate that managers neutralize themselves in situations of conflict, since they opt to remain in their *comfort zone* (E1). This attitude may be determined by conditions beyond the contract, such as clientelistic practices, access-related interests, etc.

Considering that the concept of governance can, in this context, be understood as rules or processes that affect how powers are exercised, in which individuals and groups articulate their interests, mediate their differences, and exercise their legal rights and obligations[39], the weakness of regional governance in the medium-complexity network is observed, which reinforces isolated and individualistic municipal attitudes.

This weakness is intensified by the fact that, in the health region surveyed, the administration committee is not strong enough to mediate the relationship of interests and powers with the providers. Thus, assuming opposition to the provider will only be feasible for municipal managers when there are strong governance mechanisms so that the administration committee collectively elaborates strategies for consensual changes.

Regarding funding-related issues, it was observed that financial investment will not be sufficient for the health region if the ability to manage public health services is not improved. Thus, other entities may finance and/or fund the services but cannot manage them: *It will not work* [...] *it's no use, the State can make the biggest financial investment in history, but it will not work* (G7).

Regarding the participation of mayors in the management and governance of health actions, including those of medium complexity, Campos[40] states that the leader of the municipal executive must—in addition to supplying financial resources—make a political commitment to strengthen regionalization. However, the participation of mayors in healthcare administration committees is not always effective.

The municipal health department heads acknowledge that mayors, for the most part, do not want to discuss the sector, perhaps because of its complexity or due to ideological issues, since some managers do not envisage universal health care as something that is achievable in municipal services. Thus, mayorstend to reinforce contracts with private institutions and understand that the responsibility of the public sector should be restricted to primary care, directing other levels of care to the private sector.

Viana et al.[41] stated that the economic recession and the ideological alignment of several countries with the neoliberal discourse will result, among other things, in the deterioration of the fiscal capacity of the State, the retreat of social policies, and the strengthening of private markets.

Regarding this issue, municipal health department heads also share the idea of minimizing public health services, recognizing that the private sector innovates in a shorter timespan and provides better physical facilities, lower costs, and greater management capacity. For these managers, public services are highly bureaucratic and have an excessive number of workers, as seen in the statements: *Currently, there are 46 employees in the municipal health department—if it were private, I would manage with 15 employees* [...] (G5).

The governance and regionalization weaknesses discussed herein help elucidate the dynamics of power and inequalities in the social arrangements and act as a constraint on healthcare policies, reinforcing the practices of service providers and imposing a certain rigidity on institutions[21].

Some of the problems highlighted in this study were also identified by Viana et al.[41] when

analysing social protection policies, including in the healthcare sector, in Latin America and the Caribbean. The authors argued that, despite the different arrangements observed, the hybrid nature of the policies (public with participation of private services in supply and management) shows the difficulty of forming coalitions strong enough to break from the arrangements rooted in these institutions. This is mainly due to the influence of the neoliberal agenda, which stimulates the privatization of health services and appropriates the values of universality and equity of public health conceptions.

Final considerations

This study investigated aspects of the management and governance of MC healthcare in SMs of a Brazilian health region. Problems and characteristics similar to those observed in the health region studied may also occur in other small municipalities and/or health regions of the country, given that these represent 40% of the Brazilian regions.

The results indicate that the public-private relationship in SM regions is permeated by outbreaks of tension, stimulated by benefits and interests and shaped by asymmetrical power relations, which are made possible by practices adhered to by managers and providers and permitted and naturalized in the institutional spaces.

Also observed were characteristics that go beyond the legal and administrative areas, entering into the field of moral and ethical behaviour. The logic of production and capital is undoubtedly the most predominant, but the managers' apathy with respect to the absence of alternatives, or the maintenance of the relationship, is also a reason why this process is being maintained.

The region's governance, the regionalization process, and the mechanisms of accountability and social scrutiny should be more evident in the negotiating arenas where contracts are agreed upon, for the reflection, discussion, and resolution of issues pertinent to the relationship between the public entity and the private sector, thus strengthening the construction of the health "region", especially in the inter-managerial commissions.

The provision of contracts executed in blocks and/or networks of care in a manner agreed upon among managers, covering the entire region, is indicated as a possibility to confront the problems revealed in the present study. This measure should be headed by the state's Health Department, which is formally responsible for managing medium-complexity procedures in the region studied. Additionally, strengthening regional governance, regulatory management action, and social mobilization are possible and perhaps necessary strategies in this confrontation and can serve as guiding issues for other studies in this field.

Collaborations

JFM Silva and BG Carvalho participated equally in all stages of the study. CM Domingos revised the text, provided suggestions, and wrote some sections of the final version.

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