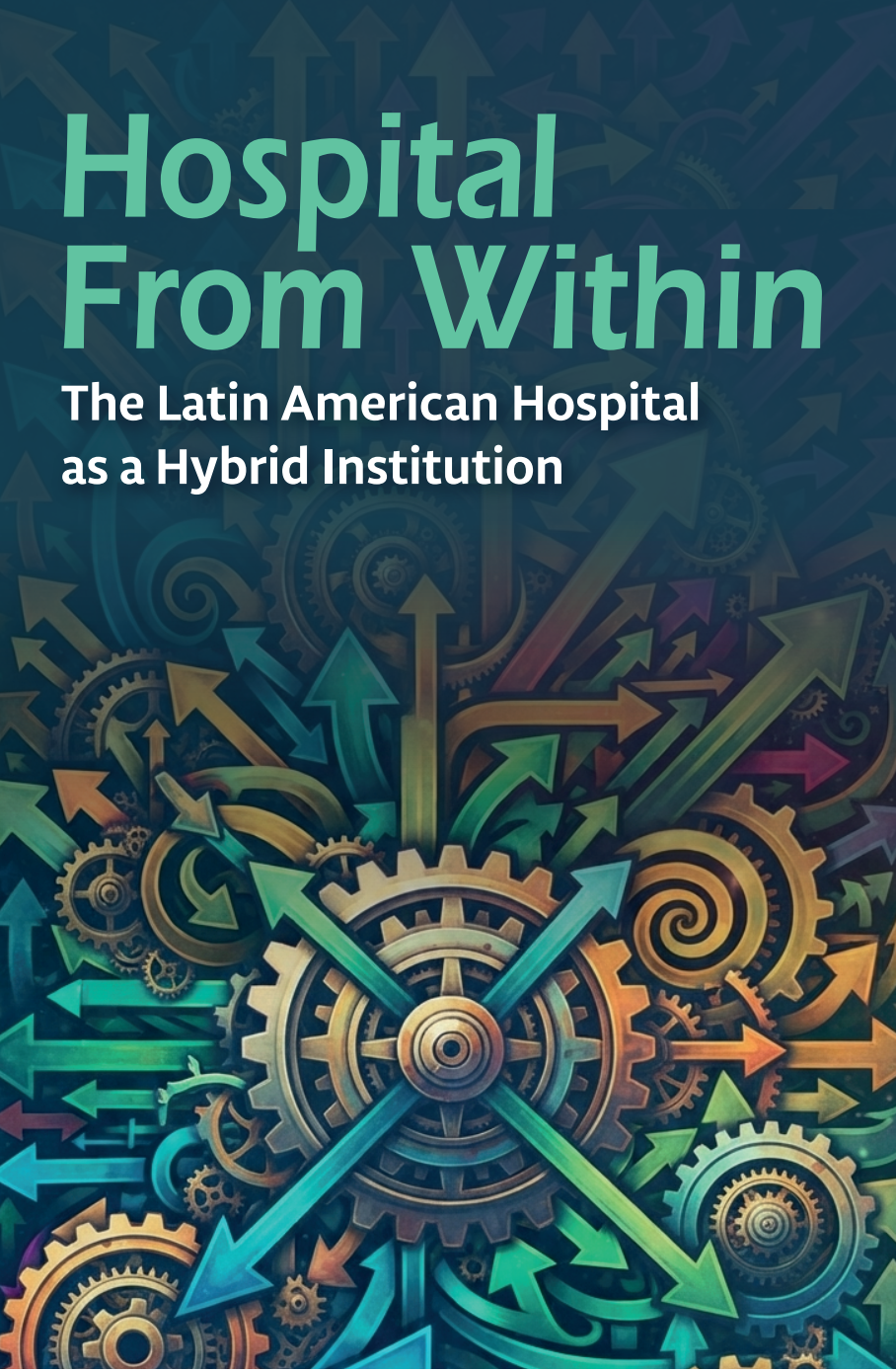
Hospital From Within

The Latin American Hospital as a Hybrid Institution



DIEGO HERRERA - DAVID GAUS

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CIESPAL | EDICIONES CIESPAL

ANDEAN HEALTH & DEVELOPMENT

2026

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First Edition

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https://ediciones.ciespal.org/

ISBN : 978-9978-55-212-4

Ciespal Edition, 2026

Contenido

How to Read This Book

This book is written for any reader curious to understand how a hospital works from the inside, not only for specialists in management or health. To keep the reading fluid, we have placed a few aids throughout the text.

The cream-colored boxes. gather scenes from hospital life. They are short stories—composed from real situations—that open each theme. You may read them as small vignettes: they illustrate, in flesh and blood, the problem the chapter goes on to analyze.

The blue boxes. Further background information about the subject provide.

The footnotes explain who each cited author is and what the less familiar acronyms, institutions, or technical terms mean. You need not read them to follow the thread; they are there should you wish to go deeper.

Introduction

The Hospital as an Institution: Between Administration, Power, and Social Organization

For more than a century, the hospital has occupied a central place in the organization of modern health systems. From the late nineteenth century onward, when scientific medicine began to consolidate itself as a professional practice and as an institutional field, the hospital was progressively transformed into the privileged setting for diagnosis, treatment, and medical research.

Yet, despite its centrality in the provision of health services, the hospital remains an institution that is difficult to understand from an organizational standpoint. The literature on hospital administration has historically tended to approach the hospital as a technical problem of management, focusing its attention on the optimization of resources, administrative efficiency, or the implementation of managerial tools. Although these approaches have contributed to the development of important techniques for managing health institutions, they have frequently overlooked a fundamental dimension: the hospital is not merely an administrative organization, but also a complex social institution.

Indeed, hospitals constitute institutional spaces where multiple forms of authority and distinct systems of organizational rationality converge. Within them interact the bureaucratic structures of the state, highly specialized

professions, political dynamics tied to the governance of the health system, and economic relationships that connect the hospital institution to the broader markets of the health sector. It is this convergence of organizational logics that turns the hospital into a hybrid institution, one whose understanding demands an analytical framework that reaches beyond conventional managerial models.

Yet this complexity is frequently obscured by the terms in which hospitals are discussed in public debate, where attention tends to concentrate on waiting lists, shortages of medicines, overcrowded emergency departments, budget deficits, or allegations of administrative inefficiency. However real these problems may be, they are habitually presented as isolated operational failures rather than as the surface manifestations of deeper institutional dynamics.

A delayed surgery may thus be interpreted as a problem of scheduling, a shortage of supplies as the consequence of deficient procurement, and a conflict between physicians and administrators as a mere failure of communication. Each of these readings contains a measure of truth; yet each, taken in isolation, risks obscuring the broader institutional environment within which such events acquire their meaning.

The difficulty of understanding hospitals lies precisely in recognizing that their organizational problems rarely originate in a single cause; rather, they are produced by the interaction among multiple systems of authority, competing organizational objectives, and institutional constraints that frequently remain invisible to those who experience their consequences most directly.

The sociology literature on complex organizations has noted that institutions such as hospitals are characterized by the coexistence of multiple systems of authority. On the one hand, hospitals form part of the institutional apparatus of the state, which entails the presence of bureaucratic structures oriented toward regulating the use of public resources and guaranteeing the provision of health services to the population. On the other hand, they depend on the

specialized knowledge of health professionals[1], whose professional autonomy1introduces particular forms of authority within the hospital organization.

To these dimensions are added the political dynamics that run through health systems and the economic relationships that link the hospital to external actors such as pharmaceutical suppliers, medical technology firms, and other participants in the health market. The result is an institution in which decision-making depends not solely on formal hierarchical structures, but also on processes of negotiation among different actors who hold distinct power resources and institutional perspectives.

Understanding this institutional complexity is particularly important in the context of Latin American health systems. In the region, hospitals operate within institutional environments characterized by administrative fragmentation, territorial inequalities in the distribution of health resources, and structural limitations in the financing of health systems. These conditions amplify the organizational tensions inherent to the hospital and pose specific challenges for hospital administration.

The Latin American context proves especially revealing in this regard, for many of the tensions that exist in more attenuated forms within highly resourced health systems appear here with heightened visibility. Administrative fragmentation, unequal territorial development, recurrent fiscal pressures, and persistent social inequalities together expose the institutional contradictions of hospital governance with unusual clarity.

For this reason, Latin American hospitals should not be understood as mere regional variations of organizational models developed elsewhere; they constitute, rather, a privileged setting for examining fundamental questions concerning authority, coordination, legitimacy, and organizational adaptation in the provision of health care.

1 The physician's capacity to decide the clinical course of action according to expert judgment, without taking direct orders from administration. It is a source of quality, but also of tension with management.

The Tripartite Architecture of Latin American Health Systems

Before examining the particular configurations of the hospital, it is worth situating the architecture that organizes nearly all of the region's health systems. Unlike the single-payer models that prevail in much of Europe, Latin American systems are usually articulated into three overlapping subsectors. The first is the **public subsector,** financed through general taxation and administered by the ministry of health, which provides services to the population without contributory coverage; its most fully realized expression is Brazil's Unified Health System (SUS2), universal in vocation. The second is the **social security subsector,** financed through mandatory payroll contributions and governed by its own institutes apart from the ministry: the IESS in Ecuador, the IMSS and the ISSSTE in Mexico, and the network of obras sociales in Argentina. The third is the **private subsector,** sustained by voluntary insurance and direct out-of-pocket payment, ranging from the individual clinic to the large insurer-hospital groups. The consequence of this division is a structural fragmentation: a single country sustains in parallel three logics of financing, three covered populations, and three administrative hierarchies that rarely coordinate with one another. This tripartition—and not the dichotomy between public and private—is the institutional framework within which the eight hospital configurations proposed in the following chapter must be read.

The consequences of this tripartite arrangement extend well beyond the mechanisms of financing, for it also shapes professional careers, organizational cultures, the patterns through which patients move among institutions, and even the expectations that citizens come to hold regarding the health system itself.

Physicians commonly move between sectors within the course of a single week, carrying the practices and assumptions of one institutional environment into another, while patients likewise traverse several systems at once, obtaining a consultation in one sector, diagnostic tests in a second, and specialized treatment in a third. What appears in administrative terms as fragmentation is thus experienced by individuals as a continuous labor of institutional navigation.

Hospitals therefore do not function as isolated organizations, but operate within complex ecosystems of interdependent institutions whose boundaries are, in practice, considerably more porous than formal regulation would suggest.

Over the past several decades, numerous Latin American countries have attempted to modernize hospital management through reforms inspired by managerial models developed in other institutional contexts. These reforms have promoted the adoption of strategic planning tools, performance evaluation systems, and quality control mechanisms aimed at improving the efficiency of health institutions. The results of these initiatives, however, have been uneven. In many cases, administrative reforms have produced formal changes in the organizational structure of hospitals without significantly transforming everyday institutional practices (Bossert & Mitchell, 2011; Vargas et al., 2016).

One reason for this pattern is that the reforms have been designed from a purely technical logic, without considering that the hospital is also a political and professional arena in which managing change demands negotiation, not merely implementation.

This observation points to a broader limitation in contemporary debates on hospital reform, within which administrative innovation is often presented as a matter of identifying the correct organizational technique—whether better indicators, improved planning instruments, stronger incentives, or more sophisticated systems of management.

Yet institutions rarely change merely because new procedures are introduced, since organizational actors interpret, negotiate, adapt, and at times resist reforms in accordance with established professional cultures, prevailing power relations, and entrenched institutional expectations. The implementation of a reform is therefore never a purely technical undertaking, but is always, and inescapably, a social and political process as well.

This book proposes a different approach. Rather than conceiving of the hospital solely as an administrative organization, it analyzes it as a complex social institution whose governance depends on the interaction among multiple systems of authority. From this perspective, understanding hospital administration requires integrating tools drawn from different fields of knowledge, including the sociology of organizations, the political economy of health, and institutional studies.

The book's central argument holds that many of the contemporary problems of hospital administration—organizational inefficiency, conflicts between professionals and administrators, difficulties in implementing institutional reforms, or the emergence of informal practices in hospital management—cannot be explained solely as management failures. Rather, they reflect structural tensions that emerge from the interaction among the distinct organizational logics that coexist within the hospital.

Chapter One constructs a typology of the institutional configurations observed in the region. Six of them are defined by the institutional matrix that predominates in each: the state bureaucratic hospital, the professional-academic hospital, the social security hospital, the charitable or philanthropic autonomous hospital, the public-utility hospital with dedicated financing, and the private-commercial hospital; to these are added two configurations in which political power predominates: the politicized hospital and the hospital captured by economic interests. Chapter Two examines the models of leadership and their tensions with professional autonomy. Chapter Three analyzes the political economy of hospital spending. Chapters Four and Five study organizational culture and informal practices as forms of institutional adaptation. Chapter Six diagnoses the contemporary crisis of the hospital model, and Chapter Seven explores its possible transformations.

Although each chapter addresses a distinct dimension of hospital life, all are bound by a common concern: to

understand how institutions shape the possibilities and the limits of hospital administration. The argument advanced throughout the book is cumulative, for concepts introduced in one chapter recur in subsequent discussions, disclosing on each occasion a different facet of the same institutional reality.

The objective is not to propose a universal model of hospital management, but rather to develop an interpretive framework capable of explaining why hospitals so frequently behave in ways that conventional administrative theories struggle to anticipate.

More than offering a technical manual of hospital administration, this work seeks to contribute to a broader understanding of the hospital as a social institution. Analyzing the hospital from this perspective makes it possible to recognize the organizational complexity of these institutions and to situate the problems of hospital management within the institutional, political, and economic contexts in which they unfold.

The tensions this book examines are not defects correctable through better managerial tools: they are constitutive features of an institution that operates at the crossroads of the state, the medical profession, politics, and the market. To recognize that condition does not solve the problem of hospital administration, but it is the indispensable first step toward no longer mistaking it for something simpler than it is.

Hospital Administration as an Institutional Problem

Vignette. Administering uncertainty

It is 4:00 p.m. One hour remains before the outpatient clinic closes.

A newly graduated family physician was hired under an apparently efficient arrangement: three days in the outpatient clinic, two days

in emergency triage. Each scheduled appointment lasts fifteen minutes. In addition, she must review the previous day's pending results.

The screen shows seven pending cases.

There is a recurring patient with repeatedly normal test results, in whom she suspects a somatization disorder. There is an asthmatic girl whose attack today appears mild but cannot be ruled out without evaluation. There is a man with acute lower-back pain and warning signs that might require immediate imaging studies or hospital admission. Four appointments remain unattended. Three patients wait in the hallway with an impatience they no longer bother to conceal.

The physician is exhausted. The clock advances.

The system demands productivity.

The clinic demands prudence. KJB

Editorial Reflection

At first glance the situation appears to be an individual dilemma, in which a physician must decide how to allocate the final hour of her working day; yet it is not, in any fundamental sense, a personal one, for another physician placed within the same organizational environment would confront remarkably similar constraints.

The tension arises because two legitimate yet competing rationalities converge upon a single institutional space: one that evaluates performance through measurable outputs, efficiency indicators, and patient throughput, and another grounded in clinical uncertainty, professional judgment, and ethical responsibility toward the individual patient.

Neither logic is, in itself, mistaken; the difficulty arises precisely because both lay claim to authority over one and the same decision.

The Industrial Model and the Promise of Efficiency

The classical managerial tradition begins from a shared assumption: efficiency emerges from standardization. Taylor[2] formulated it for the workshop (1911/1998), Fayol[3] for the firm (1916/1949), Drucker[4] for management by objectives (1954). All three agree that time can be fragmented, the process can be repeated, and variability must be eliminated.

These models were conceived for environments in which the product is homogeneous, the process is repeatable, variability is undesirable, and time can be fragmented without altering the essence of what is produced.

In a factory that machines screws, fifteen minutes produce screws.

In a hospital, fifteen minutes produce uncertainty.

This distinction amounts to more than a rhetorical contrast, for it brings into view a fundamental difference between industrial production and clinical work: whereas industrial systems seek to eliminate variability because variability threatens efficiency, clinical practice must instead confront variability as an intrinsic feature of human biology and human experience.

Patients do not present with identical conditions, predictable trajectories, or standardized responses to treatment; the attempt to impose industrial models

2 Frederick W. Taylor (1856-1915), American engineer and father of "scientific management": he argued that any task can be broken down into measurable, timed steps to maximize efficiency. His model, conceived for the factory, is the one this chapter discusses as it migrates into the hospital.

3 Henri Fayol (1841-1925), French engineer who formulated the classical principles of administration (planning, organizing, commanding, coordinating, controlling) that still structure business management.

4 Peter Drucker (1909-2005), Austrian-American theorist regarded as the founder of modern management; he popularized "management by objectives," that is, governing by setting measurable goals.

of predictability upon clinical environments therefore generates recurring tensions between administrative expectation and professional reality.

In the real hospital environment, especially in contexts of high demand and limited resources, this technical autonomy does not always translate into effective coordination. Professional autonomy can fragment clinical and administrative decisions if it is not integrated within an organizational framework that recognizes and responds to clinical uncertainty and patient vulnerability. The professional bureaucracy[5]—in theory focused on stability—does not guarantee systemic quality when the pressure for efficiency and quantitative metrics imposes practices that distort the freedom of clinical judgment, turning it into the mere execution of numerical targets.

Mintzberg[6] stresses that attempts at remote control (management from the top) that obsessively reorganize, exhaustively measure, and promote heroic leadership are detrimental to health care, because they disregard the real operating conditions on the front line.

Despite this warning, many contemporary health organizations have adopted management practices that replicate precisely what Mintzberg denounces: productivity metrics, vertical hierarchical controls, and leadership that privileges indicators over clinical values. This reveals a paradox: the selective acceptance of Mintzberg (what is useful for justifying efficiency) while ignoring his central warning (about the need to respect the logic of clinical practice). Thus Mintzberg is often cited to legitimize practices that he himself would consider mystical or counterproductive in health care.

5 A type of organization, described by Mintzberg, in which the work is controlled by highly qualified professionals (such as physicians) rather than by the administrative hierarchy; the hospital is its classic example.

6 Henry Mintzberg (b. 1939), Canadian management theorist. He is sharply critical of running health organizations "from the top" through indicators and constant reorganizations, and argues for management grounded in real practice.

Mintzberg's model proposes a descriptive reading of management: managers not as isolated heroes but as distributed participants in the system. This resonates with contemporary insistences that management must be "grounded in operations."

Nevertheless, the Mintzbergian view falls short when it comes to integrating the moral dimension of the clinical act, which cannot be understood merely as operational coordination. In a hospital, the ethical dimension—deciding between risk and benefit, distributive justice, human suffering—cannot be reduced to "mutual adjustments" among professional roles. Clinical ethics demands deliberation, shared responsibility, and the explicit recognition of human vulnerability, not merely autonomous professional performance.

Understanding this complexity requires integrating diverse perspectives. The sociology of the professions—Freidson[7](2001), Strauss et al. (1985)—shows that hospitals cannot be administered as ordinary bureaucracies because clinical knowledge redistributes authority toward professionals. Organizational institutionalism—Scott et al. (2000)—adds that the norms of the health field shape the internal structure of the hospital beyond any administrative directive. Political economy—Baumol[8] (2012), Travassos and Castro (2008)—reveals that spending pressures and territorial inequalities condition what is administratively possible. And organizational ethnography—Bosk[9] (2003)—demonstrates that informal norms regulate as much as, or more than, written procedures. Each approach illuminates one dimension; none, on its own, exhausts it. The following chapters develop them in their specific contexts.

7 Eliot Freidson (1923-2005), American sociologist of the professions. He held that medicine constitutes a "third logic" distinct from market and state: the physician's authority comes from knowledge, not from rank.

8 William Baumol (1922-2017), American economist. He described the "cost disease": in sectors that depend on direct human labor, such as health care, costs rise without productivity being able to keep pace with industry.

9 Charles Bosk (1948-2020), American sociologist; his ethnography of surgical services showed how unwritten rules govern medical practice as much as formal protocols do.

The physician in the exam room faces neither a problem of competence nor of dedication: she faces the collision between an organizational logic designed to manufacture screws and a clinical practice that cannot standardize uncertainty. To name that collision as an institutional problem—and not as an individual failing—is the first analytical gesture of this book.

The chapters that follow trace the consequences of this observation, examining how distinct institutional configurations emerge, how authority is distributed within hospitals, how financial constraints shape clinical possibilities, how organizational cultures take form, and how hospitals respond to the contemporary pressures that increasingly challenge their traditional role within health systems.

The aim is not to identify a single formula for successful hospital administration, for hospitals are too diverse, too deeply embedded in their particular histories, and too institutionally complex to admit such solutions; it is, rather, to develop a richer understanding of the organizational realities within which hospital administration must necessarily take place.

Hospitals are commonly described as organizations that deliver health services; this book proceeds from a different premise, holding that hospitals are institutions through which societies organize their response to human vulnerability. Their complexity, in the end, reflects the complexity of that task.

Chapter 1

An Empirical Typology of the Latin American Hospital

Observed Institutional Configurations

No Latin American hospital belongs exclusively to one of the configurations described here. A hospital in a Brazilian state may be bureaucratic in its procurement processes, professional-academic in its clinical organization, politicized in the appointment of its director, and captured in its relationship with certain pharmaceutical suppliers. The typology does not classify hospitals; it classifies logics that coexist within each hospital with varying degrees of intensity. They should therefore be read as ideal types[10] in the Weberian sense: analytical reference points that real institutions approximate to differing degrees and often combine. The dichotomy between "public" and "private" hospitals, still dominant in much of the administrative literature, proves particularly inadequate for the region, where some of the most important institutions occupy precisely the intermediate space between the two poles. For this reason, the following pages distinguish eight configurations, grouped into two families: six defined by the institutional matrix that predominates in each—state bureaucracy, professional authority, the contributory logic of social security, the charitable inheritance, the earmarked levy, and the market— and two in which the decisive force is political power, giving rise to the politicized hospital and the hospital captured by economic interests.

10 Pure conceptual models, in Max Weber's sense: no real hospital matches one exactly, but they serve as reference points for comparing and understanding concrete cases.

Hospital Configurations
Predominant Institutional or Professional Influence
1. State Bureaucracy
2. Professional Academic
3. Social Security
4. Charity or Philanthropic
5. Public Utility with Dedicated Financing
6. Private Commercial
Politically or Economically Driven
7. The Politicized Hospital
8. The Captured Hospital (by economic interests)

One of the most widespread models in Latin America is the **state bureaucratic hospital,** characteristic of health systems organized around the centralized administrative structures of the state. In this type of institution, hospital functioning depends to a large degree on formal regulations, detailed administrative procedures, and complex hierarchical structures. In this sense, the hospital operates as an extension of the public bureaucracy.

In Brazil, numerous hospitals directly linked to the Unified Health System (Sistema Único de Saúde, SUS) reflect this type of organizational configuration. Research on Brazilian hospital management has documented how the administrative structure of these hospitals is strongly conditioned by regulatory norms, multiple levels of institutional oversight, and complex bureaucratic procedures that structure administrative decision-making (Paim et al., 2011; Machado, Baptista & Lima, 2017).

Empirical studies of Brazilian public hospitals show that this administrative structure produces a series of recurring organizational features. Among them are extensive administrative procedures for the procurement of medical supplies, hierarchical decision-making processes that span different levels of public administration, and an institutional fragmentation derived from the coexistence of multiple levels of government in the management of the health

system. Taken together, these features have been described in the literature as forms of health bureaucratization in which compliance with administrative procedures becomes an institutional objective as significant as the very provision of health services (Giovanella et al., 2012).

The organizational consequences of this institutional model are widely known. The predominance of bureaucratic structures tends to generate slowness in decision-making processes, difficulties in implementing innovations in hospital management, and a limited capacity for organizational adaptation in the face of health crises. Although this model may help to ensure a certain degree of administrative control over the use of public resources, it also introduces rigidities that hamper the institutional response to the dynamic challenges of contemporary clinical practice.

A second institutional model observable in the region corresponds to the **professional-academic hospital,** particularly common in institutions linked to universities or medical training centers. In this type of hospital, the dominant organizational logic is not administrative bureaucracy but the professional authority of physicians and the academic structure of the clinical specialties.

In countries such as Argentina and Brazil, university hospitals have been described as professional organizations in which clinical knowledge and scientific authority play a central role in institutional organization. The organizational structure of these institutions is articulated around specialized medical departments, consolidated academic hierarchies, and significant professional autonomy for physicians in clinical decision-making (Freidson, 2001; Spinelli, 2017).

Research on Latin American university hospitals shows that this institutional model produces particular organizational configurations. In them, medical departments tend to exert considerable influence over hospital decisions, while administrative structures play a relatively limited role in regulating clinical work. As a result, institutional coordination depends to a large extent on informal agreements among

professionals and on academic authority within the medical specialties.

This institutional model presents evident advantages, especially in terms of clinical quality, scientific innovation, and the development of medical research. It also introduces, however, significant organizational tensions. The professional autonomy that characterizes these institutions can hinder administrative coordination, generate conflicts between physicians and hospital managers, and limit the institution's capacity to implement organizational reforms aimed at improving the efficiency of the hospital system.

A third model, largely invisible to the conventional dichotomy between public and private, is the **social security hospital:** the network of institutions that the contributory subsector operates for salaried workers and their families. These are the hospitals of the IMSS[11] and the ISSSTE in Mexico, the IESS in Ecuador, EsSalud in Peru, and the obras sociales in Argentina. Although they belong to the public sphere in a broad sense, they do not depend on general taxation but on mandatory contributions levied on wages, and they answer to their own governing bodies rather than to the ministry of health. In practice, they constitute a kind of parallel state within the health system, with their own financing, hospitals, and administrative hierarchy.

The defining feature of this model is the tripartite logic of its governance, in which the state, employers, and workers share ownership of the institution. The Mexican IMSS, founded in 1943, is the largest social security institution in Latin America; its Ecuadorian counterpart, the Ecuadorian Social Security Institute (Instituto Ecuatoriano de Seguridad Social, IESS[12]), administers some of the country's largest hospitals, such as the Teodoro Maldonado Carbo in Guayaquil and the Carlos Andrade Marín in Quito. This origin

11 Mexican Social Security Institute, founded in 1943: the largest social security institution in Latin America, providing health coverage to formal-sector workers and their families.

12 Ecuadorian Social Security Institute: the body that administers social security for affiliated workers in Ecuador and operates some of the country's largest hospitals.

shapes the hospital in particular ways. Its financing tends to be more stable and more generous per patient than that of the tax-funded public hospital, which usually translates into greater technological density and salaried medical staff with better labor protections. Yet that same contributory logic ties the institution's fate to the formal labor market and to the solvency of the social security fund, making it vulnerable to demographic aging, to the informality of regional economies, and to the recurrent use of its reserves for purposes other than health. Its administrative tensions are not so much those of bureaucratic rigidity as those of an institution caught between the logic of the insurer and that of the provider, frequently governed by actors whose principal expertise is neither medicine nor management, but labor and pension politics.

A fourth configuration, with deep historical roots in the region, is the **charitable or philanthropic autonomous hospital.** Its origins lie in the charitable institutions of the nineteenth century—the charity boards, the lay confraternities, and the religious orders—that organized hospital care before the modern state assumed that responsibility. The paradigmatic case is the Charity Board of Guayaquil[13] (Junta de Beneficencia de Guayaquil), founded in 1888 under the reform law of 1887 that authorized municipalities to delegate to charity boards the administration of hospitals, asylums, and cemeteries; to this day it administers some of Ecuador's largest hospitals, such as the Luis Vernaza and the Roberto Gilbert children's hospital. Legally, such institutions are an anomaly that the public private dichotomy cannot absorb: the Board is defined in law as an entity of the public sector, autonomous and governed by private law, which sustains the hospitals in its charge with its own resources—historically the lottery and private donation—and with those the state allocates to it. The hospitals run by religious orders throughout the region share the same hybrid character.

13 Ecuadorian institution founded in 1888 that, to this day, autonomously administers several of the country's largest hospitals, historically sustained by the lottery and private donation.

What distinguishes this model at the organizational level is the combination of a not-for-profit social mission with an administrative autonomy jealously defended against the state. Governance usually rests with a self-renewing board of notables who serve without remuneration—a structure that endows the institution with a managerial continuity and an insulation from political cycles that the state bureaucratic hospital lacks. This autonomy has historically allowed it to cultivate a strong institutional identity, a culture of responsible administration, and standards of care that often surpass those of its tax-funded counterparts. Its weakness is the mirror image of its strength: dependence on revenue sources vulnerable to economic crisis and to the state's periodic attempts to absorb the institution or curtail its privileges, together with a model of governance whose legitimacy rests on tradition rather than representation, and which may prove opaque to external accountability. It is in this model that the moral grammar of charity manifests itself most explicitly; but, as argued in the editorial note at the close of this section, that grammar is not confined to it, and its persistence across the entire typology poses a singular obstacle to the modernization of the hospital.

A fifth model, closely related to the previous one but distinct in its financial architecture, is the **public utility hospital with dedicated financing.** The clearest example is SOLCA[14], the Society for the Fight Against Cancer of Ecuador (Sociedad de Lucha Contra el Cáncer del Ecuador), a private entity of public utility that operates the country's principal oncological hospitals, among them the Dr. Juan Tanca Marengo National Oncology Institute in Guayaquil. What differentiates this configuration is neither its private legal form nor its public mission—both of which it shares with the charitable hospital—but rather the mechanism that sustains it: an earmarked levy. SOLCA is financed in large part through a 0.5% contribution that the law imposes on credit operations throughout the financial system, established in the Organic Monetary and Financial Code, in addition to the budgetary

14 Society for the Fight Against Cancer of Ecuador: a private public-utility entity that operates the country's main oncology hospitals, financed largely by a levy on credit operations.

allocations the state owes it by law. The institution thus possesses its own fiscal stream, formally separate from the general budget and from the contingencies of out-of-pocket payment or private insurance.

This dedicated financing confers on the model a singular organizational profile. Its own revenue stream permits a degree of specialization, technological investment, and planning horizon that few other institutions in the region can match, which is why hospitals of this type tend to become national referral centers for highly complex pathologies. The arrangement also concentrates a specific kind of tension. The institution depends on a tax base—in SOLCA's case, the volume of credit operations— whose fluctuations bear no relation to health needs, and it is exposed to the chronic nonpayment of the debts that the ministry of health and the social security funds accumulate with it. Its autonomy, finally, raises recurring questions of accountability, for an institution that administers what is in substance a public levy operates outside the ordinary control mechanisms of the public sector.

The sixth configuration in this family is the **private-commercial hospital,** the institution of the private subsector financed through voluntary insurance or direct out-of-pocket payment. Although the conventional dichotomy treats it as the natural counterpoint to the public hospital, in organizational terms it is only one configuration among several, and a heterogeneous one at that: it ranges from the small individually owned clinic to the large hospital integrated into a regional corporate network or an insurance group. Its dominant logic is that of the market: the institution must generate a financial surplus, and its decisions are governed, in the last instance, by the relationship between revenue and costs. That logic introduces a tension of its own between the institution's financial objectives and the clinical autonomy of its professionals: when the surplus depends on the volume of billable procedures, administrative pressure can push toward the overprovision of profitable services and the avoidance of unprofitable patients, in direct tension with clinical judgment—the obverse of the productivity

pressure described in the vignette that opened this chapter, but rooted in the same subordination of clinical reasoning to a financial metric. In the region's fragmented systems, moreover, the boundaries of this model are porous: private hospitals routinely sell services to the public sector and to the social security funds, and a single business group may simultaneously own hospitals, insurers, and pharmacies—configurations that connect directly to the hospital captured by economic interests analyzed below.

To these six configurations, defined by the institutional matrix that predominates in each —state bureaucracy, professional authority, the contributory logic, the charitable inheritance, the dedicated levy, and the market— are added the two examined below, in which the decisive force is none of the foregoing but political power: the **politicized hospital** and the **hospital captured by economic interests.**

The Persistence of Charity: An Inherited Grammar That Obstructs the Modernization of the Hospital

The six configurations described differ in their financing and their governance, but they share a common inheritance that the typology alone does not reveal: the moral grammar of charity. Before being a right, health care was in the region a work of mercy. The hospital was born of the asylum and the religious order, of the charity board and the ladies' committee—institutions that dispensed care not as something owed to the citizen, but as something granted to the one who suffers. This origin is most visible in the charitable and public-utility hospitals, where it is openly claimed as heritage; but it is not confined to them. It seeps into the state hospital as a paternalistic welfarism that treats the patient as a beneficiary of public generosity rather than as the holder of a right; into the social security hospital as the rhetoric of a benefit graciously conferred upon the worker; and even into the private hospital, which invokes its charitable foundations and its acts of philanthropy as a reputational currency. Charity, in sum, is less the feature of one type than the substratum of them all (Herrera, 2022).

This inheritance is not a harmless sentiment. It operates as an obstacle to the modernization of the hospital, because it silently substitutes one set of categories for another. Where there ought to be a right, charity installs a favor; where there ought to be accountability, it installs gratitude; where there ought to be a citizen entitled to demand, it installs a beneficiary from whom thanks are expected. An institution conceived as an act of mercy need not justify its results, only its good intentions: the gesture of giving is taken to be its own vindication. Under this logic, scarcity is reinterpreted as the natural limit of generosity rather than as a failure of provision, and the precariousness of care becomes something to be endured with resignation rather than challenged as the breach of an obligation. The language of charity, like the official language analyzed elsewhere in this author's work, thus performs a disciplinary function: it teaches those who receive care to ask for less and to be grateful for the little that arrives.

The organizational consequences are concrete. The charitable matrix legitimizes a government of notables and benefactors over a government of accountable managers, and privileges the moral authority of the donor over the technical authority of the administrator and the institutional rights of the patient. It tolerates opacity, because a gift is not audited. It resists the professionalization of management, which it perceives as a cold intrusion of calculation into a domain that ought to be governed by vocation and sacrifice. And it sustains a culture in which the self-abnegation of health personnel is celebrated as a virtue precisely where it ought to be read as a symptom of an institution that has normalized its own scarcity—the same moral erosion16and the same normalization of precariousness that this chapter describes elsewhere. To modernize the hospital is therefore not a mere matter of importing managerial tools—the very gesture against which this chapter warns—but of completing an unfinished transition: the passage from charity to right, from benefactor to citizen, from the mercy that gives what it can to the institution that owes what is due.

The Politicized Hospital
Health Institutions and Power Dynamics

In addition to the bureaucratic and professional configurations previously described, numerous Latin American hospitals exhibit a third institutional form characterized by the significant influence of political dynamics on their everyday functioning. In this type of organization, which may be termed the politicized hospital, administrative decisions are not explained solely by technical criteria of health management or by the professional logic of medicine, but also by political relationships that run through the state apparatus. The distinction from the bureaucratic-state hospital is therefore not one of ownership—both are public institutions embedded in the state—but of the principle that governs their decisions. In the bureaucratic-state hospital, authority flows from impersonal administrative rules applied with relative uniformity, however slow or rigid; in the politicized hospital, those same formal rules are subordinated to a party-political logic of loyalties, appointments, and electoral cycles, so that what determines a decision is less the norm than the network of power behind it. The bureaucratic hospital tends to fail through rigidity; the politicized one, through discretion.

The literature on health governance in Latin America has noted that public hospitals, as state institutions that manage strategic resources and provide essential services to the population, frequently become spaces where relationships of political power are manifested. These dynamics can influence diverse aspects of the hospital's institutional life, from the appointment of administrative authorities to the allocation of budgetary resources or the definition of organizational priorities (Belmartino, 2005; Fleury, 2009).

In many Latin American health systems, hospital directors are appointed by political authorities or by governmental bodies linked to the health system. This appointment mechanism can generate a close relationship between hospital management and political cycles. In some cases,

changes of government or shifts in political alliances produce frequent turnover in hospital leadership, which introduces discontinuities in institutional management and hampers the consolidation of long-term administrative projects.

Research on hospital systems in Argentina and Brazil has documented how these dynamics can translate into a high turnover of hospital authorities, the periodic redefinition of institutional priorities, and the influence of political actors on strategic administrative decisions. These situations do not necessarily imply irregular practices or corruption, but they do show that hospital administration is inevitably embedded within broader political structures that condition its functioning (Spinelli, 2010; Arretche, 2004).

In some contexts, these relationships can take on more complex forms, particularly when hospitals become integrated into local or regional political networks. In such cases, the hospital can become an institutional resource used to consolidate political support, distribute symbolic benefits, or strengthen clientelist[15] networks. The literature on social policy in Latin America has noted that public institutions charged with providing essential services, such as hospitals and health centers, can play a significant role in these processes, especially in contexts where the presence of the state is articulated through social programs and public services (O'Donnell, 1993; Nunes, 2007).

The organizational consequences of this institutional configuration are varied. In some cases, political influence can facilitate the acquisition of additional resources or strengthen the bond between the hospital and the community. It can also, however, produce effects less favorable to hospital management, such as the administrative instability derived from frequent changes in institutional leadership or the prioritization of political objectives over strictly health-related criteria.

15 Relating to clientelism: the exchange of favors, jobs, or benefits for political support, which can turn a public institution into a resource serving a network of power.

These dynamics underscore that hospital administration cannot be understood solely as a technical problem of organizational management. On the contrary, the hospital must also be understood as a public institution embedded in specific political structures, where administrative decisions are influenced by relationships of power that transcend the strictly health-related sphere.

The Captured Hospital Economic Interests and Health Governance

A fourth institutional configuration observable in various Latin American hospital systems corresponds to the hospital captured by economic interests. In this type of institution, actors external to the hospital exert significant influence over administrative and clinical decisions, conditioning institutional functioning in accordance with specific economic interests.

The international literature on health governance has identified multiple mechanisms through which processes of institutional capture[16] can occur in the health sector. These mechanisms include the influence of medical-supply vendors, pharmaceutical companies, business networks linked to the provision of health services, and other actors who participate in health markets. In contexts where institutional regulatory systems are weak or where administrative oversight mechanisms are limited, these actors can acquire considerable weight in hospital decisions (Savedoff & Hussmann, 2006; Transparency International, 2020).

In Latin America, various studies of health-sector corruption and hospital governance have documented situations in which administrative decisions related to hospital purchasing, the contracting of services, or the acquisition of medical equipment are influenced by external interests. These situations can manifest in practices such as the

16 A situation in which external interests (suppliers, firms, political groups) come to steer the decisions of a public institution to their own benefit, rather than the general interest.

preferential selection of particular suppliers, intermediation in supply-procurement processes, or the introduction of economic incentives that affect clinical or administrative decisions.

It is important to emphasize that institutional capture does not always take overtly illegal forms. In many cases, the relationships between hospitals and economic actors develop within formal regulatory frameworks, but they generate conflicts of interest that can affect the institutional autonomy of the hospital and the health-related rationality of administrative decisions.

The organizational consequences of this model can be significant. The influence of external economic interests can distort the institutional priorities of the hospital, generate cost overruns in the procurement of medical supplies, and weaken the capacity of hospital authorities to make decisions based exclusively on clinical or health-related criteria. In more extreme situations, these processes can contribute to the consolidation of corruption networks that affect the general functioning of the health system.

Understanding these dynamics is fundamental for analyzing the contemporary problems of hospital administration in Latin America. Far from constituting isolated organizations dedicated exclusively to the provision of health services, hospitals operate within complex institutional systems in which public and private interests, state bureaucratic structures, health professions, and economic actors interact. A clarification is in order before proceeding. Politicization and capture should not be read as two further boxes into which a given hospital falls cleanly, alongside the bureaucratic, professional, charitable, and market types. They are better understood as forces that can permeate any of those configurations in varying degrees: a state hospital may be politicized, a social-security hospital captured by its suppliers, a charitable hospital governed by the private interests of its patrons. Presented separately here for analytical clarity, in practice they rarely appear in a pure state. It is precisely this overlap—the simultaneous

presence of several logics within one institution—that the notion of the hybrid hospital, developed in the final chapter, is meant to capture.

Chapter 2

Synthesis of the Institutional Model of the Latin American Hospital

The Interaction of Bureaucracy, Profession, Politics, and Market

Vignette: The hospital that does not change

The hospital remained open. It was always open.

The lights never went out entirely, though in some corridors they flickered intermittently, as if the electricity, too, hesitated to hold on.

Outside, the line was no longer noisy. It had been noisy years earlier, when indignation still believed it could change something. Now it was a quieter line. More resigned. People arrived with thick folders, accumulated test results, expired prescriptions. They knew they would probably not find all the medications. They knew they might have to come back another day.

They knew it, and still they came.

In the hospital pharmacy, the list of out-of-stock medications filled nearly an entire page. The pharmacy aide explained in a neutral tone:

"We don't have it. Maybe next week."

There was no longer any anger in her voice. Nor any apology. Only a phrase repeated too many times.

In the doctors' lounge, the atmosphere differed from that of earlier years. There were no extended clinical discussions, no enthusiasm for new protocols. The talk was more of paperwork, of payment delays, of colleagues who had resigned or emigrated. Some were reviewing job postings abroad. Others were seeking additional shifts in the private sector to supplement their income.

One of the most senior physicians looked at the day's patient list. He knew the time allotted per consultation was insufficient. He knew diagnostic tests were missing. He knew the CT scanner had been out of service for weeks.

He had learned to adjust expectations.

"Let's handle what's urgent," he would say.

The rest remained pending.

Something always remained pending.

The nurses improvised solutions when supplies ran short. They reused permissible materials, rearranged shifts, shared resources across services. They did so with professionalism, but also with a kind of silent fatigue. It was not physical exhaustion alone; it was moral erosion.

In the administrative meetings the talk was of indicators, of ministerial targets, of quarterly reports. The figures had to be submitted on time, even when the context did not cooperate. The targets did not always speak to reality.

One day, a mother left the hospital in tears because there was no slot for a surgery that had been scheduled months earlier. The physician listened to her in silence. He promised no solutions. He only said:

"We will do what we can."

He knew that what was possible was no longer enough.

The press published a report on the hospital crisis. Staffing shortfalls, damaged equipment, and chronic supply shortages were mentioned. There were official statements assuring that structural solutions were being worked on. In the hospital corridors, the news was read with skepticism.

"Same as always," someone remarked.

The disenchantment was not strident. It was not constant protest. It was deeper: a shared sense that the system had ceased to surprise.

Editorial Reflection

The professionals had not ceased to be competent. Nor had they abandoned their ethics. But they had learned to work within narrow limits. To lower their aspirations. To protect themselves emotionally so as not to be frustrated each day.

The public adapted as well. Many began to save for private consultations. Others turned to family networks to obtain medications. Some stopped coming until illness became severe.

The hospital remained open. It functioned. It attended to patients.

But something intangible had eroded: the expectation of improvement.

And when the expectation of improvement disappears, the institution does not collapse immediately. It continues to operate. It produces statistics. It keeps to schedules. It issues reports. Inwardly, however, it accommodates itself to scarcity. The workers learn not to demand too much. The patients learn not to expect too much. The authorities learn to administer the crisis. There is no visible collapse. There is silent adaptation.

And that adaptation, more than material deprivation, is the true turning point.

Because when precariousness is normalized and resignation becomes culture, the crisis ceases to be perceived as transitory and begins to form part of the institutional identity.

That is where structural disenchantment begins.dcf

The Normalization of Scarcity and Professional Moral Erosion

The case narrated above does not describe merely a material crisis, but a deeper phenomenon: the progressive normalization of scarcity. When the lack of supplies, technological deterioration, or staffing shortages cease to be exceptional events and become a structural condition, the organization develops adaptive mechanisms that transform its internal culture.

The international literature has identified this phenomenon under categories such as “moral distress” and “moral injury” among health professionals. Moral erosion occurs when workers know the appropriate clinical course of action but institutional conditions prevent them from carrying it out (Epstein & Hamric, 2009; Morley et al., 2019). This repeated

dissonance between what ought to be done and what can effectively be done produces a progressive erosion of commitment.

This adjustment is expressed in the strict prioritization of the urgent, the systematic postponement of noncritical interventions, diagnostic simplification, and the reduction of consultation time: all of them behaviors of adaptation, not of incompetence.

These behaviors do not emerge from incompetence, but from adaptation to environments in which scarcity is structural. When such adaptation consolidates culturally, however, the institution runs the risk of internalizing diminished standards of quality.

The professional disenchantment described in press reports and regional studies should not be interpreted solely as individual fatigue. Various analyses in Latin America show that the combination of work overload, contractual precarization, and resource deficits affects both psychological well-being and the perception of professional efficacy (PAHO[17], 2022; The Lancet Regional Health–Americas, 2023).

In this context, moral erosion ceases to be an individual phenomenon and acquires an organizational dimension.

From the standpoint of organizational theory, institutions subjected to unstable environments tend to develop mechanisms of incremental adaptation. March and Olsen (1989) hold that public organizations frequently operate under a logic of "appropriateness" rather than "optimization": action proceeds according to what is feasible within given institutional limits.

In public hospitals with persistent deficits, this logic can lead to:

- Reactive management based on contingencies.

17 Pan American Health Organization: the regional public-health agency for the Americas, affiliated with the World Health Organization.

- Formal compliance with administrative targets without structural transformation.
- Adjustment of internal standards to the real capacities available.

The normalization of precariousness does not necessarily imply disorganization. On the contrary, it can produce a form of adaptive stability: the system learns to function with deficiencies. It does not collapse, but neither does it improve.

The Ecuadorian and regional press has repeatedly documented supply shortages, prolonged waiting lists, and the migration of professionals toward the private sector or abroad. These dynamics generate what some authors call "cycles of institutional vulnerability," in which the loss of human capital increases the pressure on those who remain, reinforcing collective erosion (World Bank, 2024).

In Latin America, the historical fragmentation of health systems and inequality in financing have consolidated environments in which hospital management operates under constant uncertainty (Inter-American Development Bank, 2023). This uncertainty favors pragmatic behaviors oriented toward maintaining minimal operability rather than toward attaining optimal standards.

Adaptation, consequently, is not synonymous with full resilience. It can become a mechanism for the conservation of the status quo.

Institutional Disenchantment and Organizational Legitimacy

The disenchantment described in the vignette has an external and an internal dimension. Externally, users experience frustration over delays, deficiencies, and perceived insufficient quality. Internally, professionals confront tensions between normative expectations and real possibilities.

From the standpoint of institutional legitimacy theory, public organizations depend not only on their technical performance but on the social trust they generate (Suchman, 1995). When the citizenry perceives sustained deterioration, normative legitimacy can weaken even if the institution continues to operate.

Recent studies in the region show that user satisfaction in public health systems is strongly influenced by the perception of treatment, the availability of supplies, and waiting times, beyond strictly measured clinical outcomes (OECD[18]& World Bank, 2023). The erosion of trust feeds narratives of structural inefficiency, amplified by the media.

At the same time, external distrust impacts professional identity. Sociological research indicates that when workers perceive a loss of social recognition, they may develop strategies of emotional distancing to preserve psychological stability (Hochschild, 1983; Morley et al., 2019).

This process does not imply an abandonment of ethics, but rather a defensive reconfiguration of commitment.

An Integrative Interpretive Framework: Normalized Precariousness as Organizational Culture

Articulating the preceding dimensions, an interpretive model with three interrelated levels can be proposed:

Structural Level

- Chronic underfinancing
- Fragmentation of the health system
- Deficit of human resources

Organizational Level

- Reactive management

18 Organisation for Economic Co-operation and Development: a grouping of mostly high-income economies whose averages are often used as a benchmark for international comparison.

- Decoupling between norm and practice
- Informal adjustment of standards

Cultural Level

- Normalization of scarcity
- Professional moral erosion
- Citizen disenchantment

The interaction of these levels produces a form of adaptive stability that is not equivalent to institutional improvement. The institution continues to operate, but under reduced expectations.

This framework avoids attributing the problem to isolated individuals and makes it possible to understand the phenomenon as a complex systemic configuration.

The Risk of Getting Used to It

The gravest problem of public hospitals in contexts of chronic precariousness is not solely the lack of resources. Nor is it, in isolation, administrative weakness or citizen dissatisfaction. The deepest risk is collective habituation.

When scarcity becomes everyday, it ceases to be perceived as an anomaly. When work overload is naturalized, it ceases to provoke. When delay is considered inevitable, it ceases to outrage. And when both professionals and users progressively lower their expectations, the institution does not collapse: it adapts.

That adaptation, however, has structural consequences.

The normalization of diminished standards produces a form of institutional stability that is equivalent to neither quality nor legitimacy. The hospital continues to function, but under a regime of reduced expectations. Professionals adjust their practice to what is possible, not to what is optimal. Patients learn not to expect more than the system can offer. The authorities manage the crisis as a permanent state, not as a transition.

In this scenario, moral erosion becomes organizational culture; resignation becomes a survival strategy; precariousness becomes institutional identity.

Disenchantment does not necessarily manifest in constant protests or immediate mass exodus. It is expressed in subtler ways: in the reduction of clinical enthusiasm, in the simplification of processes, in the contraction of the horizon of improvement. It is a cumulative phenomenon.

From the standpoint of organizational theory and institutional sociology, it can be argued that the erosion of legitimacy occurs not only when an institution fails visibly, but when it loses the capacity to project an expectation of transformation. Social trust is sustained as much by results as by the perception of future direction. When that direction dissolves, the institution enters a zone of adaptive inertia.

The hospital does not cease to exist, but it ceases to aspire

Understanding this phenomenon requires abandoning simplistic interpretations that hold individuals exclusively responsible or that reduce the analysis to financial indicators. Normalized precariousness is the result of the interaction among historical structures, political culture, institutional design, organizational incentives, and accumulated professional experiences.

For this reason, the challenge of contemporary hospital administration is not solely to restore supplies or stabilize budgets. It is to reconstruct institutional conditions in which excellence once again becomes a reasonable expectation and not a heroic exception.

As long as silent adaptation continues to be the principal survival strategy, the crisis will be not episodic but constitutive. An institution that learns to live permanently in crisis runs the risk of forgetting that its reason for being is not to administer scarcity, but to guarantee dignified, quality care.

That is the true turning point.

The institutional configurations described—the state bureaucratic hospital, the professional academic, the social security hospital, the charitable hospital, the public-utility hospital with dedicated financing, the private-commercial, the politicized, and the one captured by economic interests—should not be interpreted as isolated or mutually exclusive categories. On the contrary, the empirical evidence suggests that Latin American hospitals operate as hybrid institutions, in which distinct organizational logics coexist and interact simultaneously.

This characteristic distinguishes the hospital from many other public or private organizations. Whereas some institutions are dominated by a single, relatively coherent organizational logic, hospitals combine state bureaucratic structures, highly specialized professional hierarchies, political dynamics, and economic relationships with external actors. The result is a complex institutional organization whose everyday functioning depends on unstable equilibria among these different forces.

From this perspective, the hospital can be understood as an institutional field where four systems of authority converge. The first system of authority corresponds to the **state bureaucracy.** In public hospitals, the administrative norms of the state structure fundamental aspects of institutional organization, including budgetary allocation, personnel hiring, supply-procurement procedures, and general administrative oversight. These structures seek to guarantee control over the use of public resources and to ensure a certain degree of standardization in institutional management.

The second system of authority corresponds to the **professional field of medicine.** Hospitals depend on the specialized knowledge of health professionals to fulfill their principal function: the clinical care of patients. This dependence grants physicians and other health professionals a considerable degree of autonomy in clinical decision-making. As various studies in the sociology of

the professions have noted, this autonomy constitutes a structural feature of health organizations and limits the capacity of administrative authorities to control the clinical work process completely (Freidson, 2001; Strauss et al., 1985).

The third system of authority relates to the **political dynamics that run through public institutions.** In many Latin American contexts, hospitals operate within political systems in which decisions about institutional leadership, resource allocation, or organizational priorities may be influenced by political actors or by governmental cycles. These dynamics do not necessarily imply direct interference in clinical practice, but they can affect administrative stability and the continuity of institutional policies (Belmartino, 2005; Fleury, 2009).

Finally, the fourth system of authority is linked to the **economic relationships that connect the hospital to the health market.** Hospitals interact constantly with pharmaceutical suppliers, medical-equipment manufacturers, health-service companies, and other economic actors who participate in the health sector. These economic relationships are indispensable to hospital functioning, but they can also introduce incentives or pressures that influence certain administrative or clinical decisions.

The coexistence of these four systems of authority generates what may be termed the hybrid institutional structure of the Latin American hospital. Rather than operating under a single, coherent organizational logic, the hospital functions as a space in which distinct institutional rationalities compete and negotiate with one another.

This characteristic explains why many problems of hospital administration cannot be adequately understood through simplified managerial approaches. Reform proposals that focus exclusively on improving administrative efficiency or introducing new management tools tend to ignore the institutional complexity of the hospital. When these reforms are applied without considering the tensions among state bureaucracy, professional autonomy, political dynamics, and

economic relationships, their effects tend to be limited or temporary.

Understanding the hospital as a **hybrid institution** also makes it possible to explain the persistence of organizational phenomena that often baffle health-policy analysts. Among them are resistance to certain administrative reforms, the emergence of informal practices of organizational coordination, and the recurring difficulties in implementing management models inspired by business organizations.

From this perspective, hospital administration does not consist simply in applying management techniques or strategic-planning tools. Rather, hospital administration implies managing the institutional tensions that emerge from the interaction among the distinct logics that structure the hospital organization. The task of the hospital administrator resembles less the hierarchical direction of a firm and more the permanent mediation among distinct institutional actors who hold different power resources and organizational perspectives.

Understanding what type of hospital one is administering—bureaucratic, professional, social security, charitable, public-utility, private, politicized, or captured, or some combination of these—is the prior diagnosis that any institutional reform should undertake before proposing solutions.

Chapter 3

Hospital Governance in Latin America: Between Public Administration and Professional Autonomy

Vignette: What governance does not govern

A newly graduated physician has been posted for a year of rural service to a small town in the Ecuadorian Amazon, deep in the rainforest.

He has been at the cantonal hospital for a month when, one morning, an eight-year-old girl is brought into the emergency room.

She has traveled four hours by canoe to reach him.

He is alone, with a nurse as newly graduated as he is. There is no anesthesiologist. There is no surgeon. The girl is pale. Her vital signs are falling. He suspects an intra-abdominal hemorrhage. But what can he do without a laboratory, without an operating room, without blood? The ambulance is broken down. The nearest second-level hospital is four hours away by road.

The relatives who rowed without rest, seeing that nothing can be done for the girl, turn on him. Frustrated, unable to understand what is happening, they hurl their insults at the rural physician.

He understands their fury. He has nothing to offer against it.

In many Latin American countries, rural hospitals constitute the first and, at times, the only point of access to hospital services for extensive populations. These institutions operate in territories where the density of health resources is significantly lower than in urban centers. The most frequent

limitations include a shortage of medical specialists, limited diagnostic infrastructure, and logistical difficulties in supplying medications or hospital materials.

In these contexts, hospital administration confronts a structural problem: the need to guarantee continuity of care in an environment where the resources available do not always correspond to the health demands of the population. Hospital management then becomes a constant exercise in institutional prioritization.

One of the most recurrent difficulties is the retention of specialized medical professionals. Rural hospitals tend to experience a high turnover of health personnel owing to factors such as geographic isolation, limited opportunities for professional development, and salary differences relative to urban centers. Faced with this situation, hospital administrators must develop organizational strategies aimed at stabilizing institutional functioning, including cooperation agreements with higher complexity hospitals or teleconsultation mechanisms that compensate for the absence of certain specialties.

Another critical dimension of hospital administration in these territories is the relationship between the health institution and the local community. In rural settings, the hospital functions not only as a provider of medical services, but also as a social institution that articulates relationships among health professionals, local authorities, and community organizations. The institutional legitimacy of the hospital depends to a large extent on its capacity to respond to the health needs of the territory.

Institutional Analysis

This scene makes it possible to observe how hospital administration acquires specific characteristics when it unfolds outside the major urban centers. Unlike highly specialized hospitals, where management is oriented principally toward the optimization of complex clinical processes, in rural hospitals administration must

concentrate on guaranteeing institutional sustainability under conditions of limited resources.

From an organizational perspective, these hospitals function as adaptive institutions, in which administrative flexibility and the capacity for territorial coordination become fundamental resources for sustaining the provision of health services. Hospital administration in these contexts cannot be limited to applying standardized managerial models, but rather requires developing institutional solutions adjusted to the social and geographic characteristics of the territory.

This case illustrates how hospital governance depends as much on internal administrative capacities as on the hospital's insertion within territorial networks of health cooperation.

Hospital administration constitutes one of the most complex fields of contemporary public management. Unlike other state organizations, hospitals combine clinical, scientific, and administrative functions that depend on diverse and frequently autonomous institutional actors. This configuration generates particular challenges for institutional governance, especially in Latin American contexts characterized by fragmented health systems and heterogeneous state structures.

The concept of hospital governance has been used in the international literature to describe the mechanisms through which decisions are made within health institutions. Unlike the traditional concept of administration, which emphasizes hierarchical structure and administrative procedures, the notion of governance recognizes that hospital decisions emerge from the interaction among multiple institutional actors who hold distinct power resources (Saltman, Durán & Dubois, 2011).

The three tensions that structure hospital governance—the administrative pressure of the state, medical professional autonomy, and the political and economic dynamics of the environment— reproduce, at the level of institutional leadership, the four systems of authority described in the

previous chapter. What matters here is not to redefine them but to examine how leadership models respond to them in distinct ways.

These three tensions configure an institutional scenario in which hospital governance becomes a process of permanent negotiation among distinct centers of power. Hospital directors must balance the administrative demands of the state, the professional demands of the medical staff, and the external pressures arising from the political and economic environment.

Models of Hospital Leadership

In response to these institutional tensions, Latin American health systems have developed distinct models of hospital leadership. These models reflect different ways of balancing the bureaucratic, professional, and political logics that characterize the hospital.

Hospital Leadership Models
Administrative-Bureaucratic Model
Professional – Clinical Model
Managerial Model

One of the most widespread models is the **administrative-bureaucratic model,** in which hospital leadership is integrated within the hierarchical structures of the health system. In this model, hospital directors are usually appointed by governmental authorities and act as representatives of the state apparatus within the institution. Their principal function consists in ensuring compliance with administrative regulations and coordinating institutional functioning in accordance with the public policies of the health system.

A second model corresponds to the **professional-clinical model,** characteristic of university hospitals or institutions in which medical authority carries significant weight in the organizational structure. In this type of hospital, directors are usually physicians with an academic or clinical career,

and institutional decisions are made in close relation to the medical departments and the clinical specialties.

A third model, observed in some recent processes of health reform, is the **managerial model,** inspired by approaches from business management. This model seeks to introduce strategic-planning tools, performance evaluation, and results control into hospital administration. Although it has been promoted in various countries as part of public-sector reforms, its implementation has faced difficulties owing to the institutional particularities of the hospital.

The Limits of Managerial Reforms

Over the past several decades, many health systems have attempted to modernize hospital management through the introduction of managerial models inspired by the private sector. These reforms have promoted the adoption of tools such as performance indicators, management contracts, and institutional evaluation systems.

Numerous studies have noted, however, that the results of these reforms have been limited. One of the principal reasons is that hospitals do not function like traditional business organizations. The presence of highly autonomous professions, the complexity of clinical work, and dependence on public financing introduce institutional constraints that hinder the direct application of corporate management models (Mintzberg, 2012).

For this reason, some authors have proposed that improving hospital administration requires broader approaches that integrate institutional, professional, and political dimensions. From this perspective, hospital governance must be understood as a complex process of coordination among distinct institutional actors rather than as the mere application of managerial tools.

Hospital Governance and Institutional Complexity

If the hospital is, as has been argued, an institution in which bureaucratic, professional, political, and economic logics coexist, then the task of whoever leads it is not to eliminate those tensions—which would be impossible—but to construct institutional agreements stable enough for clinical care to be sustained in spite of them.

The task of the hospital administrator consists, to a large degree, in constructing institutional agreements that make it possible to articulate the different logics present in the hospital. This implies negotiating with health professionals, coordinating with health-system authorities, managing economic resources, and maintaining institutional legitimacy before the community.

In this sense, hospital governance can be understood as a form of institutional mediation, in which administrative authority rests not exclusively on formal hierarchies but also on the capacity to build consensus among actors with different interests and perspectives.

This approach makes it possible to understand why hospital administration constitutes one of the most complex fields of contemporary public management. Hospitals are not simply technical organizations dedicated to the provision of health services; they are social institutions in which scientific knowledge, state bureaucracy, political power, and economic dynamics converge.

Chapter 4

The Political Economy of the Hospital

Financing, the Health Market, and Institutional Inequality

Vignette. Clinical uncertainty and distributive justice in fragile systems

A twelve-year-old girl presents to the emergency department after six hours of abdominal pain, diarrhea, and low-grade fever following a return from the beach. She arrives walking. At first glance, the picture does not appear serious.

The general practitioner evaluates her initially and formulates a probable diagnosis of acute gastroenteritis. The proposed course of action—oral hydration and an analgesic—is clinically reasonable.

Clinical practice in emergency services, however, rarely follows linear trajectories.

The emergency physician reevaluates the patient and detects persistent pain in the right iliac fossa. In view of that diagnostic possibility, he decides to secure venous access and orders additional studies: complete blood count, C-reactive protein, electrolytes, stool ova-and-parasite test, procalcitonin, and a surgical consultation.

From the surgeon's perspective, the picture admits another interpretation. A significant percentage of cases of appendicitis can begin with diarrhea. He therefore orders an abdominal ultrasound.

The image, however, proves inconclusive.

Faced with that diagnostic uncertainty, a CT scan is ordered.

Meanwhile, the resident consults with infectious diseases. The history of a beach vacation introduces another etiological hypothesis: foodborne exposure. The possibility of anisakiasis or a parasitic infection associated with the consumption of raw fish is raised.

The workup expands.

Hours later, the total cost of the diagnostic process exceeds two thousand dollars.

From administration, then, an inevitable question arises:

"Was it necessary?"

From the clinic, another arises, equally legitimate:

"Was it prudent to omit it?"

This episode does not represent an irrational excess of resources. Rather, it illustrates a structural collision between two distinct rationalities: prospective clinical uncertainty and retrospective budgetary rationality.

The Illusion of Absolute Control over Spending

Hospital budgeting models seek predictability (Homauni et al., 2023). Hospitals, however, are systems of high operational variability (Olson et al., 2022). Biology offers no stability.

The budget presupposes regularity.

The clinic produces fluctuation.

Cutler[19](2020) demonstrated that technological innovation drives the growth of spending. The immediate availability of CT scans, biomarkers, and molecular tests broadens the

19 David Cutler (b. 1965), health economist at Harvard University, known for his studies on the weight of technological innovation in health spending.

diagnostic spectrum and reduces clinical uncertainty, but increases the unit cost per episode.

Absolute control of spending is epistemologically impossible in environments of acute diagnostic uncertainty.

Poor Hospitals and Distributive Justice: The Ecuadorian Case

In hospital systems with a structural constraint on resources, as occurs in numerous Ecuadorian public institutions, the same clinical course of action that in a high-income hospital is interpreted as diagnostic prudence acquires a different dimension: it becomes a redistributive decision.

Ecuador allocates between 8-9% of its GDP to health spending, but public per-capita spending continues to be significantly lower than the OECD average (World Health Organization, 2023; World Bank, 2023). Its budgetary absorption capacity is limited.

In hospitals with a rigid budget, each CT scan may entail a deferred surgery, an unreplenished supply, a patient displaced from their appointment, or an unfunded procedure. In health economics, this is termed opportunity cost[20] (Drummond et al., 2021): the resource consumed today is the resource that tomorrow will not be available for another patient.

Clinical uncertainty is universal. The capacity to absorb its cost is not. In robust systems, diagnostic variability is diluted across large budgets.

In fragile systems, each diagnostic expansion strains the operational equilibrium. Here a deeper dilemma emerges:

In contexts of relative abundance, the question is:

Was all of this necessary?

20 In economics, the value of what is given up by using a resource one way rather than another: what is spent on a patient today is what will not be available for another patient tomorrow.

In contexts of scarcity, the question is:

Whom are we displacing by doing it?

Individual clinical prudence is transformed into a **dilemma of collective distributive justice.** Scarcity does not eliminate medical uncertainty. It makes it more costly morally.

Epistemological Fragmentation and Institutional Responsibility

Morin[21](2008) warned that fragmented knowledge produces partial decisions about complex realities. The contemporary hospital, structured by specialties, reproduces this fragmentation.

Each specialist sees clinical risk.

No one sees, simultaneously, the aggregate financial risk.

There is no bad faith. There is fragmented organizational architecture. The solution lies neither in restricting tests blindly nor in imposing linear austerity. Nor in ignoring budgetary limits. The hospital is not a factory of costs. It is a complex adaptive system[22]. In complex systems, absolute control is an illusion.

Latin American public hospitals operate in contexts characterized by budgetary limitations, territorial inequalities, and fragmented financing systems. Unlike some European systems, where hospital provision is articulated through relatively homogeneous schemes of public financing, many Latin American countries present institutional configurations in which multiple financing mechanisms coexist: state budgets, social insurance, private payments, and specific public-policy programs. This

21 Edgar Morin (b. 1921), French thinker; his "complex thought" warns that dividing knowledge into watertight compartments leads to poor decisions about realities that are in fact interconnected.

22 A system made up of many elements that interact and adjust to one another, so that its overall behavior cannot be fully controlled or predicted from a single point.

diversity of financing sources introduces administrative complexities that affect hospital management (Giovanella et al., 2012).

In this context, hospital administration is closely linked to macroeconomic decisions and to the distribution of resources within the health system. Budgetary constraints can affect the availability of medical supplies, the hiring of health personnel, or the capacity to invest in hospital infrastructure. These limitations are not simply technical problems of financial management; they reflect political decisions about the allocation of public resources and the priorities of the health system.

The literature on the political economy of health has noted that hospitals occupy a particular position within health systems. On the one hand, they constitute fundamental institutions for the provision of complex medical services. On the other, they represent centers of significant expenditure within national health budgets. This combination of clinical centrality and economic weight turns the hospital into a key actor within disputes over health financing and the organization of the health system (Savedoff, 2007).

In addition to budgetary constraints, the political economy of the hospital is also influenced by the growing presence of health markets that interact with hospital institutions. Hospitals depend on a broad network of external suppliers that includes drug manufacturers, medical-equipment companies, health-technology firms, and specialized diagnostic or treatment services. These economic relationships are indispensable to hospital functioning, but they can also introduce incentives that affect administrative and clinical decisions.

One of the most influential sectors within this economic web is the pharmaceutical industry. Various studies have documented how the relationships among hospitals, medical professionals, and pharmaceutical companies can influence patterns of drug prescription, the adoption of new therapeutic technologies, or institutional decisions about the procurement of medical supplies (Light, 2010).

These interactions should not necessarily be interpreted as irregular practices, but they do reflect the existence of complex economic relationships that run through the hospital organization.

Another central element of the political economy of the hospital is territorial inequality in the distribution of health resources. In many Latin American countries, hospitals located in large urban centers have greater financial resources, more advanced technological equipment, and access to specialized personnel. By contrast, hospitals situated in rural or peripheral regions face significant limitations that affect their operational capacity. These inequalities reflect broader patterns of economic development and the territorial distribution of resources within national health systems (Travassos & Castro, 2008).

The interaction among public financing, health markets, and territorial inequalities configures a complex institutional environment for hospital administration. Hospital directors must make administrative decisions within this context of economic constraints and external pressures, which implies balancing clinical, budgetary, and political criteria.

From this perspective, hospital administration cannot be understood solely as a matter of organizational efficiency. Hospital management is deeply conditioned by the political economy of the health system, which determines the resources available, the relationships with economic actors, and the structural inequalities that run through the health system.

The question left by the case of the twelve-year-old girl has no technical answer. To know whether the CT scan was necessary would require knowing how many patients were awaiting that same resource on that same day, with what urgency, with what probability of benefit. That information is never available at the moment of the clinical decision. What can be designed are the institutional frameworks that make that opportunity cost visible before it is incurred. That is the true problem of the political economy of the hospital.

Chapter 5

Hospital Organizational Culture

Informal Norms, Professional Hierarchies, and Institutional Practices

Vignette: The organizational culture of non-change

The hospital was not collapsed. Nor was it empty. It simply functioned at half capacity.

At seven in the morning, the line already edged along the sidewalk. Women with children in their arms, older adults leaning on canes, men with worn folders full of old test results. The door remained closed while, inside, the lights were on.

When the entrance finally opened, the flow advanced without haste. At the window, a clerk alternated between attending to patients and the screen of her mobile phone. The procedure progressed with a constant, almost institutionalized slowness. A poorly printed ticket forced the process to restart. A missing signature sent the patient back to the beginning. Small errors, repeated systematically, became structure.

In the clinical area, one consulting room remained closed even though the schedule indicated care was being provided. "He's in a meeting" was the usual explanation. In another service, the search for a medical record delayed the consultation. No one seemed alarmed.

That same day an adverse event occurred: a procedure was performed on the wrong patient. The protocol existed. Wristband identification was mandatory. Yet when the organizational culture conveys that the consequences are improbable, risk loses visibility.

The incident generated a reaction only after the viralization of a video that revealed indifference in care. Investigations and disciplinary measures were announced. The problem, however, was neither the video nor the isolated error. It was the silent conviction that the system neither rewards effort consistently nor sanctions negligence with predictability.

The hospital was not collapsing; it was slowly eroding.

Organizational Culture and Institutional Performance

The scene described should not be interpreted as an individual deviation. From an academic perspective, it constitutes a manifestation of structural dynamics that articulate organizational culture, institutional incentives, and the sociopolitical environment.

The literature on hospital administration notes that organizational performance depends as much on resources as on the coherence between formal norms and informal practices (Mannion & Davies, 2018; Braithwaite et al., 2017). When rules exist but their application is inconsistent, what Bromley and Powell (2012) describe as institutional decoupling[23] emerges: a gap between what is normatively prescribed and what is effectively practiced.

In Latin American public hospitals, this phenomenon is expressed in technically adequate protocols that coexist with tolerated informal practices. This is not necessarily a matter of technical ignorance, but of a selective internalization of the norms.

Schein[24](2010) defines organizational culture as the set of shared basic assumptions that a group develops as it

23 The gap between what an organization says it does (its formal rules and protocols) and what it actually does in everyday practice.

24 Edgar Schein (1928-2023), American organizational psychologist; he defined an organization's culture as the set of shared, often invisible assumptions that guide how its members act.

confronts problems of adaptation and integration. In public hospitals, these assumptions include perceptions about authority, responsibility, and disciplinary consequences.

When supervision is perceived as sporadic and accountability as weak, a culture of minimal compliance can consolidate, in which the operational standard is to avoid sanctions rather than to attain clinical excellence (Mannion, Konteh, & Davies, 2010; Kuhlmann et al., 2019).

This pattern is usually associated with normative instability, frequent turnover of leadership, prolonged disciplinary processes, and a weak link between performance and institutional recognition.

The behavior observed can therefore be interpreted as contextual rationality. From the standpoint of institutional sociology, North[25] (1990) holds that institutions structure incentives through formal and informal rules. When formal rules lack consistent application, informal norms acquire primacy.

In this context, actors develop strategies oriented toward minimizing individual risks rather than maximizing collective results (Grindle, 2012): exploiting loopholes, negotiating exceptions, acting at the margins of the system as an adaptive rationality in the face of the unpredictability of merit and sanction.

The point is not to justify the behavior, but to understand its structural insertion.

Hospital systems require clear mechanisms of horizontal and vertical accountability (Saltman et al., 2011). When institutional correction depends on media pressure rather than on internal indicators, management becomes reactive.

Hospitals with high-performance cultures are characterized by coherence between norm and consequence, constant

25 Douglass North (1920-2015), American economist and Nobel laureate; he showed that "institutions"—the formal and informal rules of a society—shape incentives and, with them, people's behavior.

feedback, and stable leadership (West et al., 2015; Leggat & Balding, 2013). In the absence of these conditions, the organization tends toward structural mediocrity.

Nevertheless, factors such as labor precarization and professional erosion also influence institutional culture (Kuhlmann & Bourgeault, 2018).

The problem is not exclusive to Ecuador. Hospital reforms in Colombia, Peru, and Bolivia show similar patterns of formal autonomy with weakness in effective supervision (Bossert & Mitchell, 2011; Vargas et al., 2016; Rodríguez et al., 2020).

Studies in Peru evidence the persistence of informal networks in hospital management (Alfaro & Rivas, 2019), while in Bolivia tensions are described between centralized regulation and local capacity for control (Gutiérrez & García, 2018).

These findings suggest regional structural configurations linked to the historical trajectories of the state.

Hospital organizational culture is imbricated in the national political culture (Peters, 2010). When institutional trust is low, compliance with norms tends to become instrumental (Brinks et al., 2020).

In such contexts, professional ethics can fluctuate between genuine commitment and pragmatic adaptation.

Hospitals function as complex adaptive systems (Plsek & Greenhalgh, 2001). To intervene solely on one component—such as disciplinary control—without considering cultural and historical interdependencies can generate unforeseen effects.

From this perspective, hospital administration involves not only designing efficient organizational structures, but also understanding the cultural dynamics that shape the everyday functioning of the institution. Hospital administrators must navigate between formal and informal norms, negotiate with consolidated professional hierarchies,

and build coordination mechanisms that make it possible to integrate the distinct professional cultures present within the hospital.

Chapter 6

Corruption, Informality, and Institutional Practices in the Hospital

Vignette: Between institutional fragility and the moral economy of the organization

The hospital administration committee meets in extraordinary session.

The agenda is brief and delicate: to interview a surgeon reported by a patient's relative for alleged improper charges.

The surgeon enters with confidence.

Before any questions are put to him, he takes the floor.

He recalls that much of the hospital's surgical prestige is owed to his work. He enumerates complex surgeries, successful interventions, awards received. Then, in a more subtle tone, he notes that hospital authorities are not appointed in a vacuum: he alludes to political ties, to external influences, to networks of power.

Then he shifts the focus:

"Why am I being taken as a scapegoat?"

"Are there not improper charges at the cashier's window and in the pharmacy?" "Are appointments not sold for twenty dollars to older adults who cannot get one?"

"Are there not colleagues who block the schedule, operate in private clinics, and then return to the hospital?"

"Are complicated patients from private practice not admitted here?"

An uncomfortable silence fills the room.

The individual complaint is transformed into a systemic X-ray.

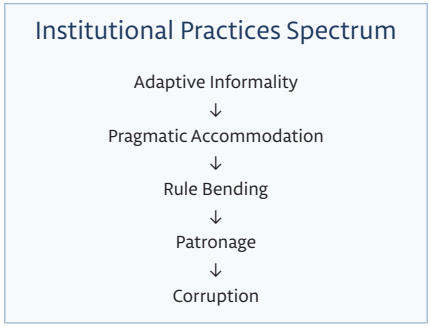
Editorial Caption

This vignette does not seek to normalize questionable practices. Rather, it illustrates how institutional actors navigate environments characterized by scarcity, uncertainty, and weak organizational capacity.

Corruption as a Systemic Phenomenon

The international literature defines corruption in health as the misuse of entrusted power for private benefit (Transparency International, 2019). In hospital environments, however, corruption takes on forms more complex than explicit bribery.

This chapter holds that hospital corruption is rarely an isolated phenomenon, rather part of a spectrum of institutional practices (figure). It is the result of progressive institutional capture, the fragmentation of responsibilities, and weak governance. Combating it demands more than individual sanctions: it requires a structural redesign of incentives, operational transparency, and active ethical leadership.



Not all informal practices are corrupt; but some forms of informality can create the conditions that facilitate corruption. The distinction matters, for it separates the everyday adaptations through which understaffed

institutions remain functional from the practices that erode their integrity.

It can manifest as:

- Informal charges
- Manipulation of waiting lists
- Strategic referral toward private practice
- Deliberate blocking of the schedule
- Selective use of public resources
- Political capture of appointments

Forms of Corruption in Hospital Settings

Type	Example	Main Consequence
Administrative	Procurement manipulation	Resource diversion
Political	Patronage appointments	Reduced capacity
Financial	Fraudulent billing	Fiscal loss
Clinical	Informal payments	Inequitable access
Organizational	Selective rule enforcement	Erosion of trust

Savedoff and Hussmann (2006) warned that health systems are particularly vulnerable to corruption owing to three structural factors: the asymmetry of information between professionals and patients, the professional discretion in clinical decision-making, the difficulty of exhaustively supervising the use of health resources.

In the vignette, the surgeon does not explicitly deny the charge. He displaces the accusation onto the institutional culture. That reaction reveals a deeper phenomenon: the moral normalization of deviance.

Hannah Arendt[26] (1963) described how bureaucratic systems can trivialize grave acts under the appearance of routine. In hospitals with institutional weakness, small irregularities can be transformed into accepted practice.

The justifications that circulate in these environments are always the same: “it’s always been done this way,” “it’s a

26 Hannah Arendt (1906-1975), German political philosopher. Her notion of the “banality of evil” describes how bureaucratic structures can render grave acts routine, and therefore invisible.

salary supplement," "the system forces you to," "everyone does it." Each is a microdeviation rationalized as a necessary exception.

Hospital corruption rarely begins with great embezzlements. It begins with microdeviations justified as necessary exceptions.

The study of corruption in the health sector has traditionally been approached from legal or administrative perspectives that define it as a deviation from the behavior expected within public institutions. From this perspective, corruption is understood as the misuse of public resources or institutional authority to obtain private benefits. Although this definition is useful for identifying illegal conduct, its analytical scope is limited when one attempts to understand how certain irregular practices develop and persist within complex organizations such as hospitals.

Hospitals constitute institutions in which multiple systems of authority—bureaucratic, professional, political, and economic—converge, and in which the everyday management of scarce resources demands rapid and, at times, improvised decisions. In this context, the line separating formal administrative practices from informal solutions can become blurred. The literature on health governance has noted that health systems present conditions particularly conducive to the emergence of informal practices owing to the combination of three structural factors:

- the asymmetry of information between professionals and patients
- professional discretion in clinical decision-making
- the difficulty of exhaustively supervising the use of health resources (Savedoff & Hussmann, 2006).

Key Argument

Individuals do not enter institutional vacuums. They enter systems of inherited practices, expectations, and adaptive routines. Actors often inherit practices before they inherit formal responsibilities; understanding corruption therefore requires understanding institutions.

In Latin America, these factors are frequently amplified by broader institutional weaknesses that affect public administration. Incomplete regulatory systems, limitations in oversight mechanisms, and inequalities in the distribution of health resources can create environments in which informal practices emerge as pragmatic strategies for solving operational problems. In these contexts, certain practices that from a normative perspective might be considered irregular may be perceived by institutional actors as necessary mechanisms for guaranteeing the everyday functioning of the hospital.

Many practices commonly interpreted as corruption emerge within institutional environments already shaped by scarcity, fragmented governance, and entrenched organizational cultures—the very conditions examined, respectively, in the chapters on normalized scarcity, governance, political economy, and organizational culture.

This phenomenon has been analyzed by some authors through the concept of institutional moral economy[27], which makes it possible to examine how organizations develop implicit norms that orient the behavior of their members in situations where formal rules prove insufficient for solving practical problems. In the hospital, these norms can manifest in diverse forms, such as informal arrangements for managing supply shortages, personal networks that facilitate access to resources, or flexible administrative practices that seek to accelerate bureaucratic processes (Thompson, 1971; Fassin, 2009).

27 A concept from the historian E. P. Thompson: the set of shared norms and expectations about what is fair, which a community applies even when they appear in no law or regulation.

Concept Box — Moral Economy of the Hospital

The moral economy of the hospital refers to the set of shared beliefs regarding what constitutes a fair, legitimate, or acceptable allocation of resources under conditions of scarcity. It shapes:

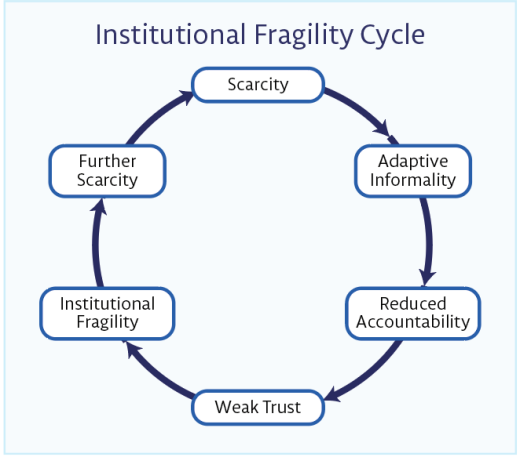
- informal cooperation
- prioritization decisions
- reciprocal obligations
- perceptions of legitimacy

It is important to emphasize that the existence of these practices does not necessarily imply a generalized acceptance of corruption within hospital institutions. Rather, it reflects the complexity of organizational environments in which health professionals must balance ethical obligations, institutional constraints, and urgent care demands. In many cases, hospital actors may experience tensions between their professional commitment to patient care and the structural limitations of the health system.

Editorial Clarification — Structural Explanations and Individual Responsibility

Structural explanations do not eliminate individual responsibility. Rather, they help explain why certain practices persist despite repeated reform efforts.

Nevertheless, when these informal practices consolidate and reproduce over time, they can generate problematic institutional effects. The normalization of informal arrangements can weaken the formal mechanisms of hospital governance, introduce inequalities in access to health services, and erode public trust in health institutions. In more extreme situations of institutional fragility (table), these dynamics can facilitate the emergence of more structured corruption networks that involve multiple actors within and outside the hospital.



The analysis of these dynamics requires a perspective that reaches beyond the identification of individual conduct. Hospital corruption must be understood as an institutional phenomenon that emerges within specific configurations of power, resources, and organizational norms. Understanding these configurations makes it possible to analyze why certain practices appear in certain contexts and why purely normative or punitive efforts tend to have limited effects when they are not accompanied by broader institutional transformations.

In this sense, the study of hospital corruption and informality is closely tied to the governance of the health system. Strengthening administrative transparency, improving oversight systems, and guaranteeing adequate working conditions for health professionals are important elements for reducing the incentives that favor irregular practices. These measures, however, must be accompanied by a deeper understanding of the organizational dynamics that shape the everyday functioning of the hospital.

What the surgeon before the committee demonstrated without intending to is that hospital corruption is not combated by pointing to the individual who deviates:

it is combated by redesigning the conditions that make deviance a rational strategy. As long as the system neither rewards effort nor sanctions negligence with predictability, the scene before the committee will be repeated with different actors and the same uncomfortable silence at the end.

Corruption cannot be understood solely as the product of individual misconduct, nor can it be reduced to a problem of institutional design. It emerges at the intersection of incentives, organizational cultures, governance arrangements, and moral expectations.

Sustainable reform therefore requires more than surveillance and sanctions; it requires institutions capable of generating legitimacy, accountability, and trust. Corruption, in the end, is not only a problem of persons: it is also, and inescapably, a problem of institutions.

Chapter 7

The Contemporary Crisis and Future of the Hospital

Demographic Transformations, Technological Pressure, and Institutional Sustainability

Vignette: Hospital, risk, and moral displacement in fragile contexts

The emergency-room door swung open violently.

It was not a deliberately dramatic gesture, but the immediate reaction to a critical clinical situation. In a matter of seconds the atmosphere changed: a sixteen-year-old adolescent was brought in on a stretcher, pale, sweating, with a rigid abdomen and unmistakable signs of hemorrhagic shock. The gunshot wound was recent. His blood pressure was dropping progressively while his heart rate rose in a physiological attempt at compensation. His oxygen saturation was beginning to deteriorate.

In this type of scenario, surgical time ceases to be an organizational variable and becomes a clinical frontier.

The presumptive diagnosis was clinically clear: penetrating abdominal trauma with hemodynamic instability. The therapeutic indication was equally so: urgent exploratory laparotomy.

From a strictly clinical standpoint, the sequence of decisions seemed evident. In the corridor, however, another word began to circulate.

"Code silver."

The suspicion of external risk—the possible presence of armed actors, reprisals, or confrontation—generated immediate tension within the team. The surgeon stated that he could not undertake the procedure under that context of uncertain safety. Minutes later, the operating room ceased to be available.

Formally, the justification was technical. From the intensive care unit, a patient with chronic renal failure and class IV functional heart failure was admitted for a catheter change. Apparently, the decision responded to clinical criteria.

Yet the episode reveals something deeper than a simple operational reorganization. The adolescent remained unstable.

The adolescent remained unstable.

Throughout much of the twentieth century, the hospital consolidated itself as the central institution of modern health systems. The expansion of scientific medicine, the development of new diagnostic and therapeutic technologies, and the professionalization of the medical specialties transformed the hospital into the principal setting for complex medical care. In the first decades of the twenty-first century, however, numerous analysts have begun to note that this institution faces a series of structural tensions that call its traditional organizational model into question.

One of the most relevant transformations is associated with global demographic change. The increase in life expectancy and the aging of the population have profoundly modified the epidemiological profile of contemporary societies. The infectious diseases that dominated much of the history of medicine have been progressively replaced by chronic noncommunicable diseases, such as cardiovascular disease, diabetes, cancer, and neurodegenerative disorders. These pathologies require prolonged medical care, continuous follow-up, and coordination among different levels of the health system, which poses significant challenges for a hospital model originally designed for acute interventions and relatively brief clinical episodes (World Health Organization, 2018).

To this epidemiological change is added the impact of technological innovation in medicine. The development of new diagnostic technologies, advanced pharmacological treatments, sophisticated medical devices, and highly specialized surgical techniques has extraordinarily

broadened the therapeutic capacities of hospitals. These innovations, however, have also considerably increased the costs of the health system. High-complexity medical-imaging equipment, biotechnological therapies, and minimally invasive surgical interventions require significant financial investments that strain hospital budgets.

The literature on health economics has noted that the health sector presents a structural tendency toward the growth of spending, a phenomenon known as cost disease[28]. Unlike other economic sectors, where productivity can increase through automation or economies of scale, many processes of medical care continue to depend on the direct interaction between health professionals and patients. This limits the capacity to reduce costs through traditional mechanisms of productive efficiency and contributes to the sustained increase of health spending (Baumol, 2012).

Another relevant factor in the contemporary crisis of the hospital is the institutional fragmentation of health systems. In numerous countries, especially in Latin America, hospitals form part of health systems in which multiple subsystems of financing and service provision coexist. The public sector, social insurance, private insurers, and independent providers operate within the same institutional space, which generates problems of coordination among different levels of care.

This fragmentation hinders the continuity of medical care and can produce duplication of services, inequalities in access to specialized treatments, and the overburdening of certain hospitals that function as referral centers for large populations. Hospital administration must operate within this complex institutional environment, where interinstitutional coordination becomes a permanent challenge (Giovanella et al., 2012).

The contemporary crisis of the hospital is also manifested in the labor sphere. Health professionals face increasingly

28 The structural tendency of health spending to grow because medical care depends on human time and cannot be automated like a factory.

demanding working conditions owing to the rise in care demand, the technological complexity of medical procedures, and the administrative pressure associated with quality-control and performance-evaluation systems. Various studies have documented high levels of professional burnout[29] among physicians and nurses, a phenomenon that affects both the well-being of health personnel and the quality of medical care (Shanafelt et al., 2015).

These structural challenges have led many health systems to rethink the role of the hospital within the overall organization of health care. Rather than constituting the exclusive center of the system, some contemporary models seek to integrate the hospital within broader networks of care that include outpatient services, primary-care centers, and community health programs. This approach, known as integrated care networks, attempts to improve coordination among different levels of the health system and to reduce pressure on hospitals through strategies of prevention and the early treatment of disease (Mendes, 2011).

The implementation of these models, however, faces significant challenges, especially in institutional contexts where health systems present administrative fragmentation, territorial inequalities, and financing limitations. In many Latin American countries, hospitals continue to function as the principal point of access to complex medical services, which reinforces their centrality within the health system despite the structural limitations they face.

The contemporary crisis of the hospital is not a transitory episode: it is the manifestation of a structural mismatch between an institutional model designed for the twentieth century and health needs proper to the twenty-first. The hospital is not failing; it is being overwhelmed by transformations that no isolated managerial reform can resolve.

29 Professional exhaustion: a state of physical and emotional depletion caused by chronic work stress, especially common among health personnel.

If the contemporary crisis describes the pressures that strain the hospital from within and without, the question that follows is necessarily prospective: what institutional forms will the hospital assume as it responds to them. The transformations now under discussion suggest not the disappearance of the hospital but its reinvention.

The Future of the Hospital

The discussion about the future of the hospital has occupied a growing place in the international literature on health systems. From the late twentieth century onward, various authors have noted that the traditional hospital model—centered on the care of acute episodes within highly specialized institutions—faces structural pressures that could profoundly modify its institutional organization. These pressures come from multiple sources: technological transformations, demographic changes, new forms of organizing care, and debates about the financial sustainability of health systems.

One of the most influential factors in these transformations is the development of digital technologies applied to medicine. The expansion of clinical information systems, telemedicine, the remote monitoring of patients, and the analysis of large volumes of medical data is modifying the way in which diagnostic and treatment processes are organized. These technologies allow certain clinical activities that previously required hospitalization to be carried out in outpatient settings or even in the patient's home.

The development of these tools has given rise to the idea of the hospital without walls, a concept that describes models of care in which the hospital institution is integrated with networks of community care, home-based services, and digital platforms for clinical follow-up. Rather than concentrating all medical activities within a hospital building, these models seek to distribute health care across distinct institutional spaces connected to one another through information systems (Topol, 2019).

The adoption of these technological innovations, however, does not eliminate the need for hospitals. Complex surgical interventions, intensive treatments, and numerous forms of specialized care will continue to require advanced hospital infrastructure. Rather than disappearing, the hospital appears to be undergoing a process of institutional redefinition, in which its functions are progressively concentrated on highly complex clinical activities while other forms of care shift toward more decentralized levels of the health system.

Another relevant trend is the growing importance of primary care and community medicine within the organization of health systems. Numerous studies have demonstrated that health systems with a strong primary-care base achieve better outcomes in population health and use hospital resources more efficiently. In this context, some models of health reform seek to reduce the centrality of the hospital within the system and to strengthen territorial networks of care capable of preventing disease and managing chronic conditions before they require hospitalization (Starfield, Shi & Macinko, 2005).

These transformations pose important questions for hospital administration. If the hospital ceases to be the sole center of the health system, its institutional governance will have to adapt to new forms of coordination with other levels of care. Hospital directors will have to manage not only a complex internal organization, but also to participate in broader institutional networks that integrate community services, primary-care centers, and public health programs.

The reorganization of the hospital is also influenced by debates about the financial sustainability of health systems. The increase in health spending in numerous countries has led governments and international organizations to seek strategies that make it possible to control costs without compromising the quality of medical care. These strategies include changes in hospital financing mechanisms, incentives to reduce unnecessary hospitalizations, and clinical-management programs aimed at improving institutional efficiency.

The introduction of cost-control reforms, however, can generate tensions with the clinical objectives of the hospital. Health professionals tend to perceive these reforms as attempts to limit medical autonomy or to subordinate clinical decisions to economic criteria. The hospital governance of the future will have to find ways of balancing these concerns, recognizing both the need for financial sustainability and the centrality of clinical judgment in medical practice.

Finally, the future of the hospital is also linked to cultural transformations within medicine. Contemporary patients participate ever more actively in decisions about their own care, and health institutions face greater demands for transparency, quality, and social responsibility. These expectations are redefining the relationship between hospitals and communities, compelling health institutions to develop new forms of communication and citizen participation.

In this scenario, the hospital of the future will not be simply a technologically advanced version of the twentieth-century hospital. Rather, it is taking shape as an institution embedded in complex networks of health care, where coordination among distinct actors—health professionals, administrators, public authorities, and patients—will be increasingly important for guaranteeing the quality and sustainability of the health system.

The hospital of the twenty-first century will not disappear, but it will have to relinquish being the exclusive axis of the health system. Its future value will reside less in its capacity to concentrate all medical resources under one roof and more in its ability to coordinate, from a position of high complexity, the networks of care that surround it. That shift—from center to node—is the true challenge of contemporary hospital governance.

Chapter 8

The Hospital as a Hybrid Institution

Toward a Critical Theory of Hospital Administration

The preceding chapters have constructed, through the typology, the analysis of governance, political economy, and organizational ethnography, an image of the hospital radically different from the one assumed by management manuals: not an optimizable machine, but a field in which four systems of authority—bureaucracy, the medical profession, politics, and the market—permanently negotiate their preeminence. What remains is to draw out the consequences of that image for those who administer it. The notion of the hybrid hospital was already introduced at the close of Chapter III, where it served to name the coexistence of several institutional logics within a single organization. What that chapter stated in passing, this one develops in full: here the hybrid condition is no longer a closing observation but the organizing idea, examined for what it implies for the daily work of those who manage the institution.

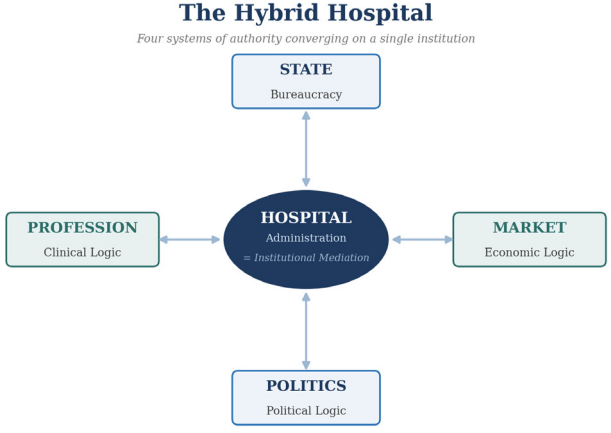
The notion of the hybrid hospital was introduced in Chapter III as an interpretive hypothesis. The preceding chapters have progressively demonstrated its empirical implications through analyses of governance, political economy, organizational culture, institutional fragility, and contemporary transformation.

Throughout the preceding chapters it has been shown that the hospital does not constitute merely an administrative organization oriented toward the provision of medical

services. Rather, it is a complex social institution in which multiple systems of authority and different organizational rationalities converge. These rationalities originate in distinct institutional fields: the state bureaucracy, the medical profession, the political dynamics of the health system, the markets of the health sector, and the informal organizational practices that emerge in the everyday management of the hospital.

The result of this convergence is a hybrid institution, characterized by the coexistence of formal administrative structures and informal processes of coordination that configure the real functioning of the hospital organization. Understanding hospital administration requires recognizing this hybrid condition and analyzing how the distinct institutional logics that run through the hospital interact (figure 1).

Figure 1. The hybrid hospital: hospital administration as the institutional mediation of four converging systems of authority.



The Four Systems of Authority

State Bureaucracy and Institutional Regulation

In numerous countries, especially in health systems with a strong public-sector presence, hospitals form part of the institutional apparatus of the state. In these contexts, the hospital organization is regulated by administrative frameworks that seek to guarantee transparency in the use of public resources, equity in access to health services, and compliance with normative standards defined by national health authorities.

These bureaucratic structures fulfill important functions in the governance of the health system, but they also introduce operational limitations into hospital functioning. Complex administrative procedures, prolonged contracting processes, and rigid hierarchical structures can hinder the institution's capacity to respond to urgent clinical needs. Hospital administration must then operate within a regulatory environment that simultaneously protects the public interest and limits organizational flexibility.

The Medical Profession as a System of Authority

Unlike many traditional bureaucratic organizations, the hospital depends profoundly on the specialized knowledge of highly trained health professionals. Medical practice is grounded in professional autonomy and in the exercise of clinical judgment, which introduces a particular form of authority within the hospital organization.

Physicians do not act simply as employees within an administrative hierarchical structure; their authority derives from their command of scientific knowledge and from their direct responsibility in clinical decision-making. This professional autonomy can generate tensions with the administrative objectives of organizational efficiency or cost control, especially when clinical decisions imply the intensive use of hospital resources.

Hospital administration must constantly navigate these tensions, recognizing the centrality of medical knowledge without losing the capacity to coordinate the institutional functioning of the hospital.

The Hospital as a Political Institution

Hospitals are also embedded in broader political contexts that influence their institutional governance. Decisions about hospital financing, the allocation of health resources, or the appointment of hospital authorities usually depend on political processes that transcend the hospital organization.

In many health systems, public hospitals operate within structures in which governmental authorities exert direct influence over institutional leadership. This relationship can produce administrative instability when political changes translate into frequent turnover in hospital leadership or into abrupt redefinitions of institutional priorities.

The political dimension of the hospital, however, can also facilitate access to resources and strengthen the relationship between the hospital institution and the communities it serves. Hospital administration must develop capacities to operate within these complex political environments, balancing institutional demands and social expectations.

Health Markets and Economic Relationships

The hospital forms part of economic networks that connect health institutions to actors in the health sector market. Pharmaceutical companies, medical-technology manufacturers, insurers, and hospital supply vendors interact constantly with hospital institutions.

These economic relationships can influence administrative decisions related to the acquisition of medical equipment, the selection of pharmacological treatments, or the adoption of diagnostic technologies. When institutional regulatory mechanisms are weak, these interactions can generate conflicts of interest or distortions in health priorities.

Hospital administration must manage these economic relationships while maintaining the institutional autonomy of the hospital and prioritizing clinical and health-related objectives over commercial interests.

Informal Practices and the Institutional Moral Economy

Finally, the everyday functioning of the hospital reveals the existence of informal practices that complement the formal structures of institutional governance. These practices emerge when established administrative procedures fail to respond quickly enough to clinical needs or when the structural limitations of the health system compel hospital actors to seek alternative solutions.

Moral Economy and Informality

Informal practices emerge when institutional demands exceed formal organizational capacity. These practices:

- facilitate coordination
- preserve continuity of care
- create governance challenges
- may become institutionalized

Health professionals and administrators develop networks of informal cooperation that facilitate access to medical resources, accelerate administrative processes, or coordinate patient transfers among institutions. These practices can be interpreted as expressions of an institutional moral economy, in which hospital actors justify certain informal actions as necessary for guaranteeing the continuity of medical care.

Although these practices can contribute to the operational functioning of the hospital, they also pose important challenges for institutional governance, especially when they become permanently institutionalized.

Administering Institutional Tensions

The contemporary hospital must therefore be understood as an organization in which multiple systems of authority interact simultaneously. Hospital administration consists, to a large degree, in managing the tensions that emerge from this interaction.

Hospital administrators must balance the demands of state regulation with medical professional autonomy, respond to political pressures without compromising institutional stability, manage complex economic relationships, and, at the same time, maintain mechanisms of organizational coordination that make it possible to sustain the everyday functioning of the hospital.

From this perspective, hospital administration cannot be reduced to the application of managerial techniques. It is an institutional practice that requires understanding the social, political, and economic dynamics that shape the functioning of health systems.

> **Key Argument**
>
> Hospital administration is not the application of management techniques. It is the institutional mediation of competing systems of authority.

Recognizing the hospital as a hybrid institution makes it possible to move beyond simplified interpretations of hospital management and opens the possibility of developing approaches to health governance more sensitive to the organizational complexity of these institutions.

Ultimately, understanding this complexity constitutes a fundamental step toward designing models of hospital administration capable of responding to the contemporary challenges of health systems.

Toward a Critical Theory of Hospital Administration

The analysis pursued in these pages converges on a single proposition: that hospital administration is best understood not as a branch of general management but as a distinctive institutional practice, one defined by the continuous mediation of authorities that answer to different logics and cannot be subordinated to any one of them. A critical theory of hospital administration begins precisely where managerial reductionism ends—at the recognition that the hospital is governed, simultaneously, by the state, the profession, politics, and the market, and that no technique can dissolve that plurality.

Such a theory does not abandon the tools of management; it relocates them. Indicators, planning instruments, and incentive systems retain their usefulness, but only within an interpretive horizon that grasps why hospitals so often resist them. The task of the administrator, on this view, is less to optimize a process than to hold an institution together under conditions of permanent tension.

The hybrid hospital is not an exception within contemporary health systems. It is their dominant organizational form. Understanding hospital administration therefore requires moving beyond managerial reductionism and toward an institutional analysis capable of recognizing the coexistence of multiple sources of authority. The future of hospital governance depends less on technical sophistication than on the capacity to mediate these tensions without losing sight of the ethical purpose of health care.

Conclusion

From Center to Node, from Scarcity to Dignity

If a single thread runs through these chapters, it is that the hospital cannot be governed as though it were one thing. The factory metaphor that opened this book—fifteen minutes that produce screws, fifteen minutes that produce uncertainty—was not an ornament but a diagnosis. Every difficulty examined here, from the rigidity of the bureaucratic hospital to the discretion of the politicized one, from the moral grammar of charity to the silent normalization of scarcity, arises from the same source: the attempt to subordinate an institution governed by four competing logics to a single rationality that none of them, on its own, can supply.

To call the hospital a hybrid institution is therefore not to describe a defect awaiting correction, but to name its constitutive condition. The state bureaucracy seeks control; the medical profession claims autonomy; political power pursues loyalty; the market demands surplus. These are not malfunctions to be engineered away by the next managerial reform; they are the permanent tensions within which clinical care is, against the odds, sustained. The administrator who understands this ceases to look for the technique that will finally make the hospital behave like a firm, and takes up instead the slower, less visible work of mediation—building agreements stable enough to let medicine be practiced amid forces that will never be fully reconciled.

This recognition carries particular weight in Latin America, and in Ecuador especially. The Ecuadorian case illustrates

dynamics observable throughout Latin America. Here the typology is not an abstraction but a daily geography: the social-security hospital of the IESS, the charitable autonomy of the Junta de Beneficencia de Guayaquil, the earmarked levy that sustains SOLCA, the rural cantonal hospital where a newly graduated physician faces, alone, a decision for which no protocol prepared him. In systems marked by fragmentation, territorial inequality, and chronic underfinancing, the tensions described in these pages are not softened but amplified, and the moral cost of every clinical decision is correspondingly higher. Here prudence is never only a clinical virtue; it is always, also, a question of distributive justice.

The gravest risk, as argued throughout, is not collapse but habituation: the quiet conversion of scarcity into culture, of resignation into identity, of moral erosion into the ordinary weather of institutional life. An institution that learns to administer its own precariousness without protest has not resolved its crisis; it has forgotten that it is in one. To resist that forgetting—to keep excellence a reasonable expectation rather than a heroic exception—is the deepest task of hospital governance, and it is one that no indicator, however well designed, can discharge in its place.

The hospital of the coming decades will not be the technological perfection of the twentieth-century model but its institutional reinvention: less a center that concentrates every resource under one roof than a node that coordinates the networks of care surrounding it. That displacement—from center to node—will demand of its administrators a competence the management manuals do not teach: the capacity to hold together, without dissolving, the bureaucratic, the professional, the political, and the economic, while keeping faith with the single purpose that justifies the whole enterprise.

For in the end the hospital is neither a machine for producing efficiency, nor a budget to be balanced, nor a network of interests to be managed. It is the institution a society builds to honor an obligation it owes to those who suffer. Its reason

for being is not to administer scarcity but to guarantee dignified care; and the measure of its administration is not how smoothly it processes the possible, but how faithfully it refuses to mistake the possible for the just. That refusal—quiet, daily, and unrewarded—is where the true work of hospital administration begins.

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