ARTICLES

Submitted 06-02-2022. Approved 10-16-2023

Evaluated through a *double-anonymized peer review*. *Ad hoc* Associate Editor: Mario Aquino Alves

Reviewers: João Marcelo Crubellate, Universidade Estadual de Maringá, Departamento de Administração, Maringá, PR, Brasil. The second reviewer did not authorize disclosure of their identity and peer review report.

The Peer Review Report is available at this link.

Original version | DOI: http://dx.doi.org/10.1590/S0034-759020240105

ACTORS INFLUENCE IN THE DEFINITION OF INSTITUTIONAL LOGICS: AN EXAMINATION OF THE PRIVATE HEALTH PLANS' EXPENSES

A influência dos atores na definição de lógicas institucionais: Um exame dos gastos dos planos de saúde privados

Influencia de los actores en la definición de lógicas institucionales: Un examen de los gastos de los planes privados de salud

Lia Da Graça[*1,2] | lia.graca@unifesp.br | ORCID: 0000-0003-0254-0599
Arnaldo L. Ryngelblum[3] | arnaldoryn@gmail.com | ORCID: 0000-0003-3519-6333

[*]Corresponding author
[1]Universidade Federal de São Paulo, Programa de Doutorado em Ciências, São Paulo, SP, Brazil
[2]Escola de Guerra Naval, Laboratório de Simulações e Cenários, Rio de Janeiro, RJ, Brazil
[3]Universidade Paulista, Programa de Pós-Graduação em Administração, São Paulo, SP, Brazil

ABSTRACT

The definition of which expenses can be incurred in the private health field is an endeavor that involves a dispute between multiple logics. Private health operators in Brazil complain that medical expenses have increased during the last decade in Brazil, as do beneficiaries, who bear the fee readjustments that ensue. The study analyzed how the actors in the private health field influence the configuration of health care expenditures and the elements that interfere, identifying a model of institutional logic that best expresses these definitions in the field. The research is explanatory using archival data and interviews with executives of the organizations in the field. The results showed that the logics compete in the field with a discourse in which each actor understands that the others are responsible for the increase in expenses, and are against data disclosure and transparency to safeguard market competition. This case shows a coalition that is able to exercise its power to manipulate the readjustment of fees, because other actors will rather avoid confrontation in an alternative that does not solve the problem about the sector's expenses, even with the acknowledgment that it is becoming unsustainable.

Keywords: institutional logic, private health, health expenditures, power coalitions, data disclosure.

RESUMO

A definição de quais gastos podem ser incorridos no campo da saúde privada é uma empreitada que envolve uma competição entre múltiplas lógicas. As operadoras privadas de saúde no Brasil reclamam que as despesas médicas aumentaram durante a última década no Brasil os beneficiários também reclamam, pois arcam com os reajustes de valores decorrentes. O estudo analisou como os atores do campo privado da saúde influenciam a configuração dos gastos em saúde, quais elementos interferem nisso, e identificou um modelo de lógicas institucionais que melhor expresse essas definições no campo institucional. A pesquisa é explicativa por meio de pesquisa documental e entrevistas com executivos das organizações da área que permitiram a coleta de dados. Os resultados mostraram que as lógicas concorrem com um discurso no qual cada ator entende que os demais são responsáveis pelos aumentos das despesas e são contra a divulgação de dados e transparência para preservar a concorrência de mercado. O caso mostra uma coalizão que pode empregar o seu poder para manipular o reajuste das mensalidades, porque outros atores preferem evitar um confronto; essa alternativa não resolve o problema a respeito das despesas do setor, mesmo considerando que elas estão se tornando insustentáveis.

Palavras-Chave: *lógica institucional, saúde privada, despesas com saúde, coalizões de poder, divulgação de dados.*

RESUMEN

La definición de qué gastos se pueden considerar/incluir? en el campo de la salud privada es una tarea que implica una disputa entre múltiples lógicas. Las operadoras privados de salud en Brasil se quejan de que los gastos médicos han aumentado durante la última década en Brasil, al igual que los beneficiarios, quienes asumen los consiguientes reajustes de tarifas. El estudio analizó cómo los actores del campo privado de la salud influyen en la configuración del gasto en salud, qué elementos interfieren, identificando un modelo de lógica institucional que mejor expresa estas definiciones en el campo. La investigación es explicativa y utiliza datos documentales y entrevistas a ejecutivos de las organizaciones del rubro para la recolección de datos. Los resultados mostraron que las lógicas compiten con un discurso en el que cada actor entiende que los demás son responsables del aumento de los gastos y están en contra de la divulgación de datos y la transparencia para salvaguardar la competencia en el mercado. El caso muestra una coalición que es capaz de ejercer su poder para manipular el reajuste de las cuotas mensuales, porque otros actores prefieren evitar un enfrentamiento, en una alternativa que no resuelve el problema de los gastos del sector, incluso teniendo en cuenta que este se está volviendo insostenible.

Palabras Clave: *lógica institucional, salud privada, gastos en salud, coaliciones de poder, divulgación de datos.*

INTRODUCTION

Health spending growth has become a concern for families, businesses, and government. Instituto de Estudos de Saúde Suplementar (IESS), a non-profit organization sponsored by private health operators that carries out research for the industry, pointed out a nominal increase of 140% in medical assistance expenses between 2011 and 2019 (IESS, 2018; 2022a). In contrast, the Brazilian regulatory agency for the sector (Agência Nacional de Saúde Suplementar [ANS]), indicated a nominal increase of 154% during the same period, based on the information provided by operators (Associação Nacional de Hospitais Privados [ANAHP], 2022). With an alleged ever-narrowing profit margin to absorb the rising spending, participants in the private health sector disagree about the reasons for the increase as they vie for new ways to finance the sector (Martins, 2021).

The study analyzed how the different actors resolve the contradictions of multiple logics in the private health field and, thus, how this influences the configuration of health care expenditures, identifying a model of institutional logic that best expresses these definitions in the field. It is important to understand the factors that influence the actions and choices made by each field actor, how they impact the therapy adopted in each case, and, in consequence, the expenses that are the outcome of these choices. The practices and structures prescribed by the legitimated logic guide the medical procedures determining the expense increase and the fee adjustments at a specific moment. Other macro-level or distinct fields factors, such as inflation and exchange rates, may be influential. Assuming that logics consist of material practices and cultural elements, the field's actors will take them into consideration when competing over logic prevalence (Thornton & Ocasio, 2008).

Institutional studies have different views on how the logic promoted by an actor prevails over others when there are multiple competing logics present in a field (Thornton & Ocasio, 2008). The divergent actors' understandings point to a possible competition between multiple logics constituting an institutional field (Friedland & Alford, 1991), in which contradictions and conflicts can occur (Silva & Crubellate, 2016). Some studies speak of the dominance of one logic over others after a period of competition (Scott & Meyer, 1994). Studies have also remarked on the hybridization of logic, when after a period, the prevailing logic is the outcome of the combination of elements of the two previous logics (Pache & Santos, 2012). Other studies examine the coexistence of multiple logics, in which case, there is the possibility of alternation of prevailing logics or the combination of elements of a few logics (Waldorff et al., 2013; Greenwood et al., 2011).

This work analyzed the dispute between multiple institutional logics in the private health field in Brazil, seeking to answer how actors in the private health field influence the logic configuration that determines private health expenditures. In the literature review section, the paper examines how the logics models analyze change as a result of the influence of actors in the field. In the methodology section, it details the procedures to collect the information in the

field and to analyze it. The results section underlines the conflicts between the different logics supported by the field actors by examining the regular medical expenses and the inclusion of new technologies.

LITERATURE REVIEW

Institutional logics refer to the practices and beliefs present in modern society that prescribe how individuals and organizations engage in daily activities. While logics restrict action, they are also impacted by the actors' independent agency looking for alternatives (Holm, 1995). The presence of multiple logics in any context may involve contradictory prescriptions to the actors that elicit actions to transform the existing logics that provide individuals, groups, and organizations with cultural resources to transform identities, organizations, and society (Friedland & Alford,1991). Thus, in the long term, institutional complexity unfolds and reforms, creating different circumstances to which organizations must respond. Not only is this institutional complexity in a continuous flow, but organizations experience it in unique ways and to different degrees. Also, it is important to understand the relationship between institutional complexity and organizational responses (Greenwood et al., 2011).

This paper addresses a situation involving multiple logics that may conflict. Determining expenses by allocating resources in the private health field involves disputes and negotiations between the logics prioritized by the different actors (Friedland & Alford, 1991; Greenwood et al., 2011).

Several studies have examined how logic is enabled in a context. In the culinary field, the study by Rao, Monin, and Durand (2003) about the introduction of the nouvelle cuisine showed that it had replaced haute cuisine with the initiative of a few chefs that developed the elements that came to constitute the new logic, from culinary ingredients to the creation of new roles for chefs and other personnel. The study by Pache and Santos (2012) explores how four enterprises integrated competing social welfare and commercial logic and showed that these organizations selectively joined intact elements prescribed by each logic, resulting in a new one. This strategy allowed them to project legitimacy to external stakeholders without engaging in costly deception or negotiations. Lounsbury and Crumley (2007) explained intraorganizational processes initiated by fund managers that led to changes in the investment industry in the U.S. These managers began exploring new investment strategies that showed promising returns. Despite the resistance by the previous conservative investment logic that predominated in the industry, they introduced new analytic techniques that later resulted in the creation of a whole range of fund types, the professionalization of these former analysts, and, in consequence, the creation of a new investment logic.

Other studies approach the contradictions between logics through a nuanced coexistence perspective. Reay and Hinings (2009) present the case of an established field in which competing

logics of physicians and the Regional Health Authorities used specific mechanisms to manage the logics rivalry. In this study of the health sector in Canada, the persistence of two logics is highlighted: the state-public alongside the professional-medical logic. Collaboration was noted and verified when the actors maintained their identities, values, and independence. Through the associative work, the two logics have sustained temporary structures and systems to work reliably together. Emphasis was placed on the importance of collaboration between physicians and the government to resolve contradictions related to the coexistence and competition of the logics. Also, in another study in the health field, Goodrick and Reay (2011) described and analyzed competitive and cooperative relations between logics. They showed that actors did not follow an exclusive prescription but prioritized one logic at given moments. Some authors have interpreted that a field can adopt a certain logic adding elements from other logics (Borum & Westenholtz, 1995; Waldorff et al., 2013).

Ocasio and Radoynovska (2016) distinguish between organizational choices made in contexts of logic pluralism and complexity. Thus, multiple logics always affect contexts with no one dominating. In the case of pluralism, actors may face different logic prescriptions to follow. However, they understand it is possible to find a combination of elements of the different logics to shape a business model or strategy related to the coexistence perspective. In the case of complexity, on the other hand, it presupposes internal contestation, public questioning, and the introduction of new logics, all of which lead to a strategy adjustment and bears similarity with the cases of initiatives assumed by actors.

Greenwood et al. (2011) emphasize some actors organize in coalitions during these disputes and become more powerful than others within a field. Thus, organizational decisions are not simply a function of who participates. The relative degree of influence of a group within the organization or field is also important. Some groups become more powerful than others, and as a result, organizational responses to multiple institutional logics are likely to reflect the interests of the most influential group.

This paper has proposed to research the Brazilian private health field to examine how the logics prescribe the activities in the field and are, in turn, manipulated by the actors to define the medical procedures envisaged that best suit each one. The structure of expenses will be a consequence of this definition. The paper analyzed the field actors' understanding regarding the configuration of the practices that determine private health expenses.

RESEARCH METHODOLOGY

The objective of this research was to understand the participation of the actors in resolving the contradictions arising from multiple logics in the determination of medical procedures, the use of technologies and drugs in the treatment of diseases in the private health area, which dictate the current configuration of the private health care expenses.

Empirical context

The private health field consists of operators, which can be different kinds of companies, such as health plans, insurances, cooperatives, and philanthropies, which are intermediaries between beneficiaries and medical providers, authorizing consultations, exams, and so on; private and public providers, such as hospitals, clinics, laboratories, and drugs industry; the regulatory agency, ANS, which defines the sector's guidelines to operators and beneficiaries; professional associations and unions, among the main actors. Healthcare operators complain to ANS about the increase in healthcare expenses. The discussion intensified because, as IESS states, Brazil has one of the world's ten largest variations in medical costs (IESS, 2019). Abramge's (association of health plan operators, except insurance companies) superintendent confirms that expenses are growing in relation to the revenue: "The (companies' operational) result is far from a positive scenario" (Casemiro, 2023). However, interestingly, until 2021, there was no data available in the sector's databases related to the several therapies involving exams, medications, hospitalizations, consultations, and treatments. The data available is aggregate and, as such, does not allow a statistical study of the different medical expenses in the field. The expense aggregates make it difficult to identify the therapies' averages and outliers, which jeopardizes the analysis of the reasons for a noticeable dispersion. These data are essential, and their lack makes analysis, constant monitoring, or auditing impossible. ANS's healthcare data map is fed periodically by operators and is not audited (Lara, 2022). As of March 2022, the health expenses breakdown was comprised of hospitalizations (60%), medical appointments (9%), exams (12%), treatments (13%), and other outpatient services (7%) (IESS, 2022b).

In contrast to the economy's price variation indexes, the alteration in medical and hospital costs (VCMH) includes the beneficiaries' use frequency and the price variation imposed by providers (IESS, 2019). The methodology used to calculate this index is based on a sample of 10% of all the expenses, including hospitalization expenses, consultations, treatments, examinations, and surgeries made by beneficiaries of individual plans (one kind of the plans marketed). The medical and hospital costs (VCMH) index is the only index made available to the public, calculated by IESS, Institute of Private Health Studies, which the ANS uses (in 2019, a new weighted formula was introduced that considers besides assistance expenses also the economy's inflation) to define the annual adjustment in the payments of individual plans, setting a reference to the field.

In 2012, ANS began collecting healthcare operators' expense statistics because of the record level of complaints from individual beneficiaries, which resulted in fee adjustments (Yazbek, 2014). ANS considers health assistance costs the sum of the expenses related to the direct provision of healthcare services informed by health operators. Operators inform the data, but the ANS does not conduct a due diligence to check them. The agency does not delve into the distribution of the different expense tickets, their averages, and outliers (ANS, 2021). While discussing the fee-for-service compensation model (payment for each procedure in a therapy) practiced in

the sector, IESS confirmed the problem with this remark about an alternative model: "One difficulty in implementing this (new) model (Capitation, "…a model of remuneration of doctors or other providers of health services, by establishing a fixed value per registered patient (per capita)" [ANS, 2019, p.28]) is the definition of the value per capita, due to the lack of statistical data." (IESS, 2017).

The figures provided by the IESS show the total number of procedures and the total health expenses, which do not identify which medical specialties, procedures, or medicines that use more resources. The ANS has a more detailed expense database (ANS, 2022; 2021), showing only the mean and total amounts of certain procedures. As reported, the control of expenses of health insurance companies and operators in the private health sector in Brazil is very recent.

Although physicians may autonomously prescribe treatments to their patients, the ANS is mandated to establish a list of procedures and treatments that operators must offer to their beneficiaries, irrespective of prescriptions that include procedures not listed. On the other hand, physicians face the speed of the introduction of new technologies (Gillum, 2013), and at times a professional has to stand by his technical knowledge to indicate a specific treatment not part of the mandatory list.

The importance of monitoring the sector's sustainability for the country's economy is highlighted since the private health field provides 3.6 million direct and indirect jobs, representing 8.1% of the labor force employed in Brazil and generating 9.2% of GDP (IESS, 2020).

Physicians have no consensus about how to proceed in each case treated. The costs vary according to the structure of the providers' medical-hospital services (hospitals, laboratories, clinics, and others). Therefore, it is possible to have different prescriptions and treatments and consequently distinct expense for the same diease. Evidence-based medicine (EBM) has tried to modify this conduct by introducing the concept of the best current evidence available, which promotes the standardization of therapies, with no success until now (Sackett & Rosenberg, 1995). Another relevant issue raised in a few studies is the fact that health operators focus their relations with providers on commercial and financial aspects, especially payments or expense deductions. Therefore, failing to negotiate quality procedures standards can, in the long run, result in smaller care costs (Gerschman, Ugá, Portela, & Lima, 2012).

Data sources

The methodology adopted in the research was of an explanatory qualitative nature because it is indicated for understanding the reasons that field actors offer to explain their choices of therapies and procedures and the resulting expenses (Yin, 2001).

Archival data helped build the scripts to interview executives representing the main actors in the field of private healthcare. The period analyzed was 2010-2020 (ANS, 2020a). The sources of data used in the archival research are presented in Table 1.

Table 1. Archival Research

Type of source	Name of source
Survey of articles in the press and media	Valor Econômico, Correio Braziliense, Exame Magazine
Academic articles on private health and health expenditure	Web of Science, Scielo and CAPES Periodic
Theses and dissertations	Web of Science, Scielo and CAPES Periodic
Online media of the main organizations of the field	Instituto de Estudos de Saúde Suplementar (IESS), Superintendência de Seguros Privados (SUSEP), Confederação Nacional das Seguradoras (CNSEG), Federação Nacional de Saúde Suplementar (Fenasaúde), Agência Nacional de Saúde Suplementar (ANS), Associação Médica Brasileira (AMB).
Press and Medical forums, workshops and sector seminars with specialists	Biderman (2017); Neiva (2018); Alves (2018)
Statistical data	Instituto Brasileiro de Geografia e Estatística (IBGE), Associação Brasileira de Planos de Saúde (ABRAMGE), Ministério da Saúde, Fundação de Proteção e Defesa do Consumidor (PROCON).
Legislation	Brazilian Constitution, Conselho Nacional de Justiça (CNJ), judicial decisions, lawsuits filed by associations.

Source: elaboration by the authors.

A semi-structured script was used in the field to explore how actors understand, participate, and influence the definition of treatments and technologies, determining the indications of exams and procedures that will generate private health expenses. It also explored whether the interviewees acknowledged the amounts implied by their choices and the current configuration of healthcare expenses.

The interviewees represent the main different actors that directly influence the expenditures in the Brazilian private health field, either generating the expenses or paying for the service, or the class association representing actors of the field. The different statements, the information from the sector's associations, and the media allow the triangulation of the researched logics (Creswell, 2010). The participants were the two main Brazilian hospitals: Sírio Libanês and Israelita Albert Einstein, whose interviewees were the president and vice president of innovation and technology, respectively; two medical-class entities: AMB and CREMESP, whose interviewees were the technical director and treasury director; a member of the board at Bradesco Saúde (insurance operator) and Laboratories Fleury, the superintendent of Fenasaúde; and finally two PROCON professionals, the public institution which defends the consumers (represented by a supervisor and a technical advisor). The interviews averaged one hour, with the shortest lasting 37 minutes (CREMESP) and the longest, an hour and forty-two minutes (Bradesco Saúde).

Data analysis

To analyze the dynamics between the actors in the private healthcare field, we coded the passages that detailed how practices, values, competencies, and resources were handled in the field, resulting in the expense picture described in the interviews, according to the definitions in table 2. These practices, values, competencies could be identified with a professional, a public/state, market, or consumer protection logic (associated with the family logic), based on Goodrick and Reay's (2011) characterization of society's logics.

We assumed that whenever there was a contradiction between logics, the prevailing logic determining how medical expenses are made can indicate how is the participation of each actor. Thus, a new medical procedure that gets practiced by physicians, although with resistance from health operators, shows that in the specific situation, the former were able to impose their logic. However, operators may succeed in limiting the procedure to certain conditions, in which case we can say that the prevailing logic in the example is made of the combination of conditions from two logics. There is also the possibility that two actors, privileging different logics, engage in a coalition in relation to a specific question, such as the introduction of new technology, when the physicians' professional logic will usually agree with beneficiaries' family logic.

Table 2. Some characteristics of Logics Found in the Private Health Care Field

Logic in the Field	Description of practices, competencies, values	Features of the logic in the private health field in Brazil
Professional	Professionals have the technical knowledge to carry out their practice, alone or in partnership, allowing for professional control over the content of the work. Accreditation and education programs are controlled by the profession.	Medical professionals mainly privilege the treatment of diseases. Physicians and other professionals defend quality assistance but also look for financial returns. Other actors, such as providers and operators, may also pursue some of this logic's features.
Market	Actors use to privilege competitive practices and seek economic-financial results for business owners or corporate shareholders.	Health plan operators act in the field of private health to protect their economic interests, interacting intensely and pressing service providers, distributors of medical and pharmaceutical products, government, ANS, and beneficiaries. This group also includes health plan insurers. At the same time, they work to keep their legitimacy as valuable health intermediaries. Other actors, such as providers and professionals, may also pursue this logic.
Public/State	The government mainly assumes direct responsibility for the sector's sustainability, regulating and supervising the groups of society, aiming at the proper functioning of the various actors within the field.	This logic balances good medical care, citizens attended by their contractual rights, and companies in sustainable conditions. Other actors, such as providers and operators, may also pursue this logic.
Consumer-Protection (Family logic)	Consumer protection organizations mainly pursue correcting imperfections that cause harm to the consumer-beneficiaries.	The beneficiaries aim at unrestricted service and reasonable costs. To have access to the latest innovative procedures. Other actors, such as professionals and operators, may also pursue this logic.

Source: Based on Goodrick & Reay (2011), Vilarinho (2010).

RESULTS AND ANALYSIS

The evolution of revenues (monthly fees paid by health plan beneficiaries) shows that private health operators have experienced growth in the decade 2012-2021. The operator companies' revenues (only beneficiaries fees) displayed a 42% growth (considering the IPCA inflation index [IBGE, 2022]). On the expense side, the increase during the same period was 44% (ANS, 2022b). Health operators' operating profit has been positive in the last decade, although suffering a decline from 2014-19 due to the economic crisis that caused a reduction in the number of beneficiaries (ANS, 2021). From the beginning of 2018 until the first trimester of 2020, when the COVID-19 pandemic was confirmed, the operating profit grew 178% (ANS, 2022c).

IESS, on the other hand, points to an increase of 16.9% in the VCMH index during the single year of 2018 (IESS, 2019) and complaints about the growing expenses, given the reduction in the number of beneficiaries (IESS, 2020). Nevertheless, according to the data provided by ANS the total number of beneficiaries increased between 2020-22 from 47.4 to 50.1 million (Brasil, 2022). Other factors surveyed in the archival research, such as extraordinary expenses with judicializations, frauds, waste, and other inefficiencies (Conselho Nacional de Justiça, 2019), might also have affected the final economic-financial results of the operators.

Data breakdown by health assistance items - exams, treatments, surgeries, medical appointments, and hospitalizations (IESS, 2020) started being released only in 2020. However, it is still not statistically analyzed according to the different medical therapies (e.g., heart attack), which could indicate average and outlier expenses. The study could discern from the interviewees' declarations their understanding of how expenses are incurred, the inclusion of new procedures, the disclosure of expenses, and the sector's compensation model, the main topics that explain expense allocation.

Actors' influence in the expenses incurred

The contrasting points of view between the actors were expected. Nevertheless, it was likely that they would know and be able to depict the distribution of the expense items in a treatment, and that was not the case. In overview, physicians prescribe what they consider appropriate given the diagnoses. This way, actor 3 (CREMESP, a non-profit federal agency that supervises medical professional ethics) understands that "what impacts most on costs are the procedures and hospitalizations, which perform surgeries and complementary exams (…) but these are regular expenses, as long as there is proper management. These expenses are mandatory. There is no escape from it." Healthcare operators complain that physicians write prescriptions regardless of the costs implicated. According to actor 1 (Fenasaúde, a federation that represents 15 groups of private health care plans and insurance operators):

> Physicians use their insider information and their monthly income target to ask for more procedures and exams, especially if there is a third agent paying for these exams. This induces demand and there is a target income. The encouragement is also set up so that (there is an) incentive for people to be hospitalized more than necessary (…). Actor 1

However, more reasons for expense growth were mentioned in other declarations. Actor 4 (Bradesco Saúde, a healthcare insurance company) explains the complexity of medical inflation. According to him, there is another aspect weighing in the combination of cost factors. People are living longer. In another perspective, actor 7 (AMB, a non-profit association whose mission is to defend the professional dignity of physicians and quality healthcare of the population) mentioned concerns about the sustainability of the sector. He also mentioned that CREMESP is aware of the "prosthesis mafia" (unrequired transplants) and that cases must be reported to the respective regional medical councils, which adds the issue of bribery to the expenses. Actor 8 (Einstein high-technology private Hospital) revealed his concern with patients, but not with its expenses: "we work and act independently in this context, with no expense limits to set up values in the medical practice, according to the best protocols of our hospital". Actor 2 (Sírio-Libanês Hospital) says the sum of expenses depends on which link of the chain you look at. "The problem today in the system, there are some (operators and suppliers) that are doing very well, there are others that are doing very badly (economically)." The governmental consumer defense agency expressed a formal point of view. PROCON (actors 5 and 6) declared that costs are inherent to the business and should not be a concern for the government or beneficiaries and instead the operators must bear the risks. Idec (2022), a non-profit independent consumer association, has repeatedly questioned ANS about its fees readjustment methodology.

In terms of expenses, each statement by a field actor points the responsibility for the high expenses to other actors and their actions. The physicians' professional logic conflicts directly with that of healthcare operators, who blame mostly the first for excessive expenses, highlighting the operators' inclination for a market logic and its practices. Physicians see surgical procedures with hospitalization as the main expense tickets, apart from wastage and bribery that takes place in the field, which can be either a provider, supplier, or procurement problem. Hospitals' logic also conflicts with that of operators because of their reduced concern regarding expenses, prioritizing best practices. Consumer defense organizations favor beneficiaries, implying a family logic, which requests more transparency and standardization of readjustments that, consequently, forces a more objective control on expenses.

There was a general demonstration of the awareness on the part of the respondents that the expense situation is not sustainable (given the increasing number of new technologies, scope of procedures contained in the role, and aging of the population, etc.). Most of the actors contributed with suggestions on how to reduce expenses: renegotiation of expenses involving hospitals, operators, and suppliers, tax review proposals, analysis of the supply chain and role of health brokers in the final cost of drugs and equipment, and the creation of prevention policies. An emerging discussion was the impact of rollover spending due to the cumulative scope of

procedures, whereby new treatments are approved by health committees, but old ones are not extinguished. Additionally, different levels of assistance were addressed: primary, secondary, and tertiary. They focus on patient care according to the complexity required for each action.

The dispute is set between distinct market logics defended by operators and medical providers, a professional medical logic prioritized by doctors and other medical professionals, a public logic on the part of ANS, and a family logic on the part of consumers. They each appear to influence the decisions about the procedures applied and adopted, but the power of each actor must be considered, and the apparent lack of involvement of others to explain why specific expenses are being made (for example, CREMESP suggests that hospitals and laboratories are responsible for cost hikes; operators complain about physicians).

Actors' influence in the inclusion of new medical procedures

The incorporation of new health technologies is also a source of expenses, which is regulated by ANS through the update cycles of the List of Procedures and Events in Health. The mandatory information requirements to update the List are the presentation of a Technical Scientific Assessment or Systematic Review with the description of the scientific evidence about the effectiveness, accuracy, safety of proposed health technology, and the study of Economic Evaluation in Health and Budget Impact Analysis (ANS, 2020b).

Actor 1 (Fenasaúde) made it clear that power largely influences ANS on adopting new technical procedures: it is only "the pressure of the most powerful group" that counts. Actor 2 (Sírio-Libanês): "the operator decides the importance of the procedure". Actor 3 (CREMESP): "the physician has the last word about it". Actor 4 (Bradesco): "this discussion is open and is not a peaceful one and the government should not interfere in the relations between the operator and the patient; either we have a free market or not". Actor 5 (PROCON) defends the consumer "who always loses the battle to the system or to the operator". Actor 6 (PROCON) says the "logic of the decisions are political, not technical". Actor 8 (Einstein): "I have my own medical criteria and logic, which I follow. I just cannot be unethical". Actor 7 (AMB) highlighted a very common and influential practice of drug manufacturers that consists of inviting professionals to visit the company's medicine production facilities, even abroad. The AMB's technology director considers this practice worse than industry-funded medical symposia because, here at least, technical issues are discussed. Apart from these topics, in a rare agreement, all actors interviewed complained about their small participation in the decisions at the Co-Saúde, the ANS's Health Regulation Pemanent Committee, a body that gathers the main field actors to discuss the procedures list and other issues related to the field, responsible for the inclusion of procedures that occurs every two years (in August 2022, the Chamber of Deputies established that ANS's list of medical procedures should not be mandatory, thereby implying that new procedures could be considered for coverage by health operators).

The inclusion of new procedures also involves finger-pointing, in which case specific actors or groups are seen as the ones with power (in the previous declarations, for example, Fenasaúde

blames doctors; Procon sees the beneficiaries as the weakest part of all) to decide about the inclusion into the mandatory list of procedures and, thus, influence expenditures (ANS, 2020b). The fact that the regulatory agencies (ANS and ANVISA for medicines and drugs), health operators, doctors, and the pharmaceutical industry are mentioned indicates their influence over procedures, proposing that elements of every privileged logic can be found in the justification of new procedures.

Expense disclosure

Interviewees confirmed that the regulatory agency receives aggregate information from operators on therapy costs. The items that constitute hospitalization expenses are not provided because ANS has only a mandate to regulate healthcare operators but not the field's providers, which makes it difficult to distinguish which are the big tickets and what justifies them. The sector's low economic transparency is a reason for complaints on the part of several actors. Actor 1 (Fenasaúde): "ANS does not have a technical cost-effectiveness threshold, it is very dependent on subjective evaluations and pressure from interest groups when it should be more technical and more transparent".

Actors have listed several different causes for the poor expense data reports: problems of transparency and disclosure (actors 1 Fenasaúde, 3 Cremesp, and 4 Bradesco Saúde), lack of data disclosure (actor 6 PROCON), lack of data audit (actor 5 PROCON). Actor 2 (Sírio-Libanês) and actor 8 (Einstein) indicated that they maintain independent databases on treatment costs for corporate governance purposes. Actor 8 recalled why ANS does not hold expense data because it is not possible for the operators to have all the data on treatment expenses since the provider (the hospital) does not deliver all its data and the hospital only has the data relative to the patient's admittance and procedures. In the words of Actor 8: "You get a lot of information, but not everything. The only one that has control is who performs the clinical procedure on the patient. Only Einstein (hospital) has this (control) in Brazil". The same actor admitted that the health sector exaggerates the usage of technology: "Much of it is true in (terms of) overuse (in the sector), fraud exists. The complaints are real".

Other important impressions on costs were provided by actor 1 (Fenasaúde): "He (the physician) feels that he is not burdening the beneficiary (when he recommends an expensive treatment), the concern is to get the earnings he wants". This statement reinforces that physicians work with a high level of autonomy to recommend treatments, pushing for the inclusion of new treatments. About the public information on expenses, actor 1 explained: "The operator has to send data and publish balance sheets every three months, and (…) on the other hand, hospitals, clinics, and laboratories are oblivious to this movement. This is a very important topic".

The declarations suggest that operators and providers are aware of the problem generated by the lack of disclosure but focus on the management of their individual businesses, irrespective of the growing difficulties it brings to the market with the fee readjustments and the consumers'

diminishing capacity to absorb them. This stance suggests that they have the power to avoid any disclosure.

The current compensation fee-for-service model

Actor 1 (Fenasaúde) clarified that the fee-for-service (payment for each service rendered) compensation model enhances waste and induces demand increase: "in the pure fee-for-service model, the risk is all on the operator's side because the other side is free to generate procedures and shares nothing. To reverse this, the contract would have to be according to the number of people treated". Actor 2 (Sírio-Libanês) agrees that it is necessary to create a payment model that takes these variables into account. Actor 3 (CREMESP) is the only one to consider the compensation model appropriate, with an important caveat, as it is believed necessary to revise the medical procedures classification. Actor 4 (Bradesco) believes the operator cannot interfere in the medical decision but can negotiate goals for the number of patients attended in some measure of productivity to be negotiated between the parties. Actors 5 and 6 (PROCON) understand that physicians, in general, are underpaid and suggest that this might be one of the causes of excessive exam requests. They also explain that the current compensation model leads operators to solve all problems by increasing the plans' fees. Actor 7 (AMB) recognizes the concern about the sector's sustainability. This actor mentions the importance of reviewing the adopted fee-for-service system instead of just addressing the compensation management, which is concerned with the operator-provider communication and exchange at the service provider's corporate governance level while the system's compensation model can influence the productivity and costs of the entire private health chain. Actor 8 (Einstein) considers it important to replace the fee-for-service system and advocates the beneficiaries' co-participation due to a cost-conscious use on their part, suggesting the adoption of the fee-for-value system (ANS defines fee-for-value as "a remuneration model that seeks to encourage the quality and efficiency of the services provided, through payment based on results and performance ("The P4P, payment for performance, is characterized by an adjusted remuneration of service providers' performance, … which must be associated with another specific model. In this way, P4P adjusts the amount of funds to be paid to the health care provider based on its performance through an existing method…" [ANS, 2019, p.24]), as opposed to payment for the number of services" [ANS, 2019, p.24]), which is the one adopted by the hospital.

The fee-for-service compensation model has been institutionalized for many years, and criticisms of it have only begun lately. A market logic supported mainly by healthcare operators seems to guide this behavior, which is explained by the perception that revenues might be growing slower than expenses. But, as the testimonies show, other actors also seem to favor another compensation formula. No actor, however, seems confident about a system and parameters to adopt.

DISCUSSION

The study proposed to analyze how the actors in the health field influence the configuration of healthcare expenditures, identifying a model of institutional logic that best expresses these definitions in the field.

There are a few main opposing discourses in the field. The first, expressing a market logic, lays the responsibility on physicians for the increasing health expenses due to excessive exams, treatments, and other procedures indications. This discourse has been supported mainly by health operators. At the same time, medical providers, due to the fee-for-service model, are also criticized by operator companies for exaggerated expenses due to, for example, prolonged hospitalizations, product usage abuse, and high charges. This latter combines aspects of the medical professional logic and economic gains from a market logic and is seen as different from the operators' market logic, who resist the increase in expenses for the sake of economic performance. This understanding on the part of the operators implies that a coalition of physicians and medical providers have the power to impose procedures, medicines, hospitalization, and more, which determines the expenses in the sector.

Another discourse was underlined by the medical associations, which express a professional logic, as they see medical procedures as the regular practice that must care, in the first place, for good medical outcomes. An example is the criticism the AMB receives for favoring the introduction of what other actors see as unnecessary procedures (not yet sufficiently tested or having equivalents already in the procedures list) so that new technologies in medical treatments may be introduced.

A family logic, expressed by consumer protection organizations, resists increases in fee payments and favors the inclusion of the newest medical procedures. A public logic is expressed by normalized measures of two regulatory agencies, which are at times repressed by political influence and marketing activities on the part of companies (Friedland & Alford, 1991; Lok, 2010).

The complexity related to the expense issue has to do with the fact that different actors dispute the definition of which procedures should be undertaken. However each one sees its logic as the correct one and tries to shun other actors' logics as responsible for unsustainable expenses. Physicians see it as their capacity to decide what treatment to adopt. Individuals and consumer organizations argue for the best and more modern treatments, while operators stick to what is economically reasonable. In contrast, the regulatory agency has to balance the needs of consumers and companies' sustainability.

The multiple logics described are manipulated by the actors to have their way in terms of the procedures approved and, consequently, the expenses incurred in the field, with the added discourse about data disclosure and transparency. Here, the unwillingness of hospitals and health operators to open up their databases is clear, under the argument that market competition must be safeguarded. For the sake of the free market preservation, according to these actors, one competitor should not have access to the details of its competitors' or suppliers' cost structures. This leads to a conflict between different market logics (medical professionals,

operators, insurance companies, hospitals), whereby the actors in the field claim the others are responsible for the increase in private health costs. In terms of the transparency issue, the power coalition composed of providers and operators avoids disclosing their data, which consequently results in successive adjustments of fees due to the lack of a clear picture of the sector's expenses. This is due to the regulations that operators and insurance must follow that tend to increase their costs, but also because these organizations understand that the expense charts, waste, and frauds produced by the system are out of their reach, and should be absorbed by beneficiaries.

Thus, the power of certain actors in the field apparently determines the competition result between the logics (Greenwood, Suddaby, & Hinings, 2002; Scott & Meyer, 1994). As was shown, despite the concerns about the sector's sustainability, beneficiary fees keep being readjusted by ANS, with only a limited capacity on their part to discuss their determination based on an index produced by an entity that is associated with the healthcare operators. This circumstance points out that other powerful actors, such as medical professionals and providers appear to be either unwilling or incapable to take a firmer stance participating in expense determination, seemingly nonsensitive to the growing future problems the sector may have to face..

The case of the private health field shows that field actors cooperate in several issues related to the sector, defending the logic of coalitions, for instance, about the introduction of innovations, but fail to cooperate properly to allow the accurate estimation of medical expenses (Reay & Hinings, 2009). Health operators have been redirecting the health plan sales to a category whereby there are not constrained by readjustment percentages from ANS. Providers and suppliers, however, do not dispute the figures with the health operators and ANS, which yields the way for fee adjustments based on the figures calculated by the institute associated with the operators. Neither providers and suppliers nor operators and regulatory agency promote a new logic into the field (although new compensation models are proposed) (Lounsbury & Crumley, 2007; Ocasio & Radoynovska, 2016). This case brings an example where a coalition of actors has the power to manipulate an aspect of the market, namely the adjustment of fees, because other actors would rather avoid confrontation in an alternative that does not solve the problem of the sector's expenses, given the acknowledgment that it is becoming unsustainable.

As the main issues approached in the study showed, the logic adopted in each one differed mainly because a different coalition of actors imposed with their power the way it should work (Greenwood et al., 2011). For instance, in the issue of expense disclosure, hospitals and operators maintained their option not to open up the details of their accounts, except for the aggregate figures sent to ANS. This is possible since private companies do not have to submit private data in a capitalistic market. This case exhibits, thus, features of logic collaboration at times and competition in others (Goodrick & Reay, 2011; Reay & Hinings, 2009). During these periods, the prevailing logic orienting the actions combined elements of different logics (Borum & Westenholtz, 1995; Waldorff et al., 2013; Ocasio & Radoynovska, 2016).

CONCLUSION

This work asked about the field's actors' influence in determining the logic configuration that guides private health expenses in Brazil, given that fees have become a concern for families and companies that provide benefits for their employees and also for health operators who claim that expenses are growing more than revenues.

The literature review indicated different theoretical models to analyze the situation. The multiple logic perspective specifically suggests that actors may wish to dispute the practices and beliefs of prevailing logic and successfully introduce a new perspective to a field. Another kind of analysis is the coexistence between different logics, where they can collaborate to resolve their contradictions.

The interviews and archival data indicated that multiple logics coexist in the Brazilian private health field. In relation to the expense question, there seems to be an uncomfortable coexistence between the field actors as they have to collaborate. However, this is not the case when it comes to the issue of expenses, since in this case, the specification of the expenditures is not provided so that a fair analysis of the field's performance can be made and fee readjustments can be calculated based on verifiable data.

The research also contributes to listing the main factors that impact the care expenses increase. The subjects raised by the actors provided the basis for future research analysis. In addition, the impact of increasing expenses generates conflict and dissatisfaction from healthcare beneficiaries to the largest providers in the field. The issues presented suggest which factors should be studied and approached, among them, those frequently identified as critical by most actors in the field, according to the interviews: the free-for-service model, the cost inherent to new technologies, requests of unnecessary exams, population aging, fraud, products abuse, unawareness of ANS detailed database on treatments per medical specialty.

The work showed that the examination of transparency, governance analysis, and compensation model indicate directions to solve the problem of increasing health expenditures and can reduce friction between actors, contributing to the harmonization of the field. The study is limited by the interview sample and, thus, to further its scope, interviewing other representatives of the main actors could add to the understanding of how expenses are defined, such as the private health regulatory agency, individual physicians, other hospitals, consumer agencies, and others.

REFERENCES

Agência Nacional de Saúde Suplementar (2018). *Caderno de informação da saúde suplementar: beneficiários, operadoras e planos*. ANS. https://www.gov.br/ans/pt-br/arquivos/acesso-a-informacao/perfil-do-setor/dados-e-indicadores-do-setor/informacoes-gerais/total-cad-info-set-2018.pdf

Agência Nacional de Saúde Suplementar (2019). Guia para implementação de modelos de remuneração baseados em valor. https://www.gov.br/ans/pt-br/arquivos/assuntos/gestao-em-saude/projeto-modelos-de-remuneracao-baseados-em-valor/guia_modelos_remuneracao_baseados_valor.pdf

Agência Nacional de Saúde Suplementar (2020a). *Dados consolidados da saúde suplementar***.** Rio de Janeiro.

Agência Nacional de Saúde Suplementar (2020b). *Fluxo das etapas de atualização do rol*. ANS. https://www.ans.gov.br/participacao-da-sociedade/atualizacao-do-rol-de-procedimentos/fluxo-das-etapas-de-atualizacao-do-rol

Agência Nacional de Saúde Suplementar. (2021). *Painel contábil da saúde suplementar*. ANS. https://app.powerbi.com/view?r=eyJrIjoiNjRiYTM0MjUtYjFhMy00NTI3LWE4ZGQtMDg4YzdlMzYwZjViIiwidCI6IjlkYmE0ODBjLTRmYTctNDJmNC1iYmEzLTBmYjEzNzVmYmU1ZiJ9

Agência Nacional de Saúde Suplementar (2022a). *Painel de dados do TISS*. https://app.powerbi.com/view?r=eyJrIjoiOTVmNTU0ZDktNjVlYi00NzZjLWIxMzItMTFhMTgyMzI1ODVkIiwidCI6IjlkYmE0ODBjLTRmYTctNDJmNC1iYmEzLTBmYjEzNzVmYmU1ZiJ9

Agência Nacional de Saúde Suplementar (2022b). *Dados gerais*. https://www.gov.br/ans/pt-br/acesso-a-informacao/perfil-do-setor/dados-gerais

Agência Nacional de Saúde Suplementar (2022c). *Dados consolidados por conta de resultado*. https://app.powerbi.com/view?r=eyJrIjoiNjViNzQ2NmQtYWFiNy00MzQ0LWJjODUtOGI3OWNlY2ZjNDgwIiwidCI6IjlkYmE0ODBjLTRmYTctNDJmNC1iYmEzLTBmYjEzNzVmYmU1ZiJ9

Alves, S. L. (2018, Jan 26). II Workshop de análise do impacto regulatório: O controle dos reajustes. In S. L. Alves [Conference session]. *CNSeg*, Rio de Janeiro, Rio de Janeiro, Brazil

Associação Nacional de Hospitais Privados. (2022). Taxa de sinistralidade, receita de contraprestações e despesa assistencial das operadoras do Brasil. https://www.anahp.com.br/dados-do-setor/

Biderman, I. (2017, Mar 27). Falta de transparência permeia questões da saúde, diz secretário de SP. IV Fórum de Saúde do Brasil: Transparência e Prevenção. *Folha de S. Paulo*. https://www1.folha.uol.com.br/seminariosfolha/2017/03/1870083-transparencia-permeia-os-problemas-da-saude-publica-diz-secretario-de-sp.shtml

Borum, F., & Westenholz, A. (1995) The incorporation of multiple institutional models: Organizations field multiplicity and the role of actors. In W. R. Scott & S. Christensen (Eds.). *The institutional construction of organizations* (pp. 113-131). Thousand Oaks. Sage.

Casemiro, L. (2023, Sep 1). Planos de saúde encerram 1º semestre com lucro de R$ 1,45 bi, apesar de perdas na operação. Extra. https://extra.globo.com/economia/noticia/2023/09/planos-de-saude-encerram-1o-semestre-com-lucro-de-r-145-bi-apesar-de-perdas-na-operacao.ghtml

Conselho Nacional de Justiça. (2019). Demandas judiciais relativas à saúde crescem 130% em dez anos. https://www.cnj.jus.br/demandas-judiciais-relativas-a-saude-crescem-130-em-dez-anos/

Creswell, J. W. (2010). *Projeto de pesquisa métodos qualitativo, quantitativo e misto***.** Porto Alegre, Rio Grande do Sul. Brasil. Artmed.

Friedland, R. & Alford, R. R. (1991) Bringing society back in: symbols, practices, and institutional contradictions. In J. DiMaggio & W.W. Powell (Eds.). *The new institutionalism in organizational analysis*. (Chap. 10, pp. 232-267). London: University of Chicago Press.

Gerschman, S., Ugá, M. A. D., Portela, M., & Lima, S. M. L. (2012). O papel necessário da Agência Nacional de Saúde Suplementar na regulação das relações entre operadoras de planos de saúde e prestadores de serviços. *Physis Revista de Saúde Coletiva*, *22*(2), 463-476. https://doi.org/10.1590/S0103-73312012000200004

Gillum, R. F. (2013). From papyrus to the electronic tablet: A brief history of the clinical medical record with lessons for the digital age. *The American Journal of Medicine*, *126*(10), 853–857. https://doi.org/10.1016/j.amjmed.2013.03.024

Goodrick, E., & Reay, T. (2011). Constellations of institutional logics: Changes in the professional work of pharmacists. *Work and Occupations*, *38*(3), 372-416. https://doi.org/10.1177/0730888411406824

Greenwood, R., Suddaby, R., & Hinings, C. R. (2002). Theorizing change: The role of professional associations in the transformation of institutionalized fields. *Academy of Management Journal*, *45*(1), 58-80. https://journals.aom.org/doi/abs/10.5465/3069285

Greenwood, R., Raynard, M., Kodeih, F., Micelotta, E. R., & Lounsbury, M. (2011). Institutional complexity and organizational responses. *Academy of Management Annals*, *5*(1), 317-371. https://doi.org/10.5465/19416520.2011.590299

Holm, P. (1995). The dynamics of institutionalization: Transformation processes in Norwegian fisheries. *Administrative Science Quarterly*, 398-422. https://doi.org/10.2307/2393791

Instituto Brasileiro de Defesa do Consumidor (2022). Não ao reajuste abusivo de planos de saúde! Linha do tempo. https://idec.org.br/reajuste-de-planos-de-saude/linha-do-tempo

Instituto Brasileiro de Geografia e Estatística (2022). Inflação. https://www.ibge.gov.br/explica/inflacao.php

Instituto de Estudos de Saúde Suplementar (2017). Modelos de remuneração: o problema não é falta de alternativas. https://www.iess.org.br/publicacao/blog/modelos-de-remuneracao-o-problema-nao-e-falta-de-alternativas-0

Instituto de Estudos de Saúde Suplementar (2018). Análise Especial do Mapa Assistencial da Saúde Suplementar no Brasil entre 2011 e 2017. https://www.iess.org.br/sites/default/files/2021-04/ES19-ANÁLISE%20DO%20MAPA%20ASSISTENCIAL%20DA%20SAÚDE%20SUPLEMENTAR%20NO%20BRASIL%20ENTRE%202011%20E%202017.pdf

Instituto de Estudos de Saúde Suplementar (2019). Brasil tem uma das 10 maiores VCMH do mundo. https://www.iess.org.br/publicacao/blog/brasil-tem-uma-das-maiores-variacoes-de-custo-medico-hospitalar-no-mundo

Instituto de Estudos de Saúde Suplementar (2020). Despesas das operadoras sobem mesmo com queda de beneficiários. https://www.iess.org.br/publicacao/blog/despesas-das-operadoras-sobem-mesmo-com-queda-de-beneficiarios

Instituto de Estudos de Saúde Suplementar (2022a). Análise Especial do Mapa Assistencial da Saúde Suplementar no Brasil entre 2016 e 2021. https://www.iess.org.br/taxonomy/term/1731

Instituto de Estudos de Saúde Suplementar (2022b). VCMH/IESS Variação de Custos Médico-Hospitalares. Retrieved Nov. 13, 23, from https://www.iess.org.br/vcmhiess

Lara, N. (2022). *Análise Especial do Mapa da Saúde Suplementar no Brasil entre 2016 e 2021*. IESS, Instituto de Estudos da Saúde Suplementar. https://www.iess.org.br/sites/default/files/2022-09/analise-mapa-assistencial-2016-a-2021%20-%20v3.pdf

Lok, J. (2010) Institutional Logics as Identity Projects. *Academy of Management Journal*, [S. l.], 53, 1350-1385.

Neiva, L. (2018, April 23). Aproximação entre setores público e privado deve aprimorar gestão da saúde. V Fórum de Saúde do Brasil. *Folha de São Paulo*. https://www1.folha.uol.com.br/seminariosfolha/2018/04/aproximacao-entre-setores-publico-e-privado-deve-aprimorar-gestao-da-saude.shtml

Lounsbury, M. & Crumley, E.T. (2007) New Practice Creation: An Institutional Perspective on Innovation. *Organization Studies*, 28(7), 993–1012. [https://doi.org/10.1177/0170840607078111]

Martins, P. R. (2021, sep 24). Pandemia impulsiona startups de saúde e acelera digitalização do setor. Folha de S. Paulo. https://www1.folha.uol.com.br/seminariosfolha/2021/09/pandemia-impulsiona-startups-de-saude-e-acelera-digitalizacao-do-setor.shtml

Ocasio, W., & Radoynovska, N. (2016) Strategy and commitments to institutional logics: organizational heterogeneity in business models and governance. *Strategic Organization*, *14*(4), 287-309. https://doi.org/10.1177/1476127015625040

Pache, A.V., & Santos, F. (2012). Inside the hybrid organization: selective coupling as a response to competing institutional logics. *Academy of Management Journal*, *56*(4), 972-1001. http://dx.doi.org/10.5465/amj.2011.0405

Rao, H.; Monin N.P., Durand, R. (2003) Institutional change in Toque Ville: Nouvelle cuisine as an identity movement in French gastronomy. *American Journal of Sociology*, *108*(4), 795-843. https://doi.org/10.1086/367917

Reay, T.; & Hinings, C. R. (2009) Managing the rivalry of competing institutional logics. *Organization Studies*. *30*(6), 629-65. https://doi.org/10.1177/0170840609104803

Sackett, D. L. (1995). The need for evidence-based medicine. *J Roy Soc Med*, *88*, 620-624.

Scott, W. R. & Meyer, J.W. (1994) *Institutional environments and organizations: structural complexity and individualism*. Sage.

Silva, F. R. & Crubellate, J. M. (2016). Complexidade institucional: um estudo bibliométrico na publicação recente em teoria institucional. *Revista Eletrônica de Ciência Administrativa*, *15*(2), 116-132. https://doi.org/10.21529/RECADM.2016009

Thornton, P. & Ocasio, W. (2008). Institutional logics. In: R. Greenwood, C. Oliver, K. Sahlin & R. Suddaby (Eds.). *The Sage handbook of organizational institutionalism* (pp. 99-129). Sage.

Vilarinho, P. F. (2010). A percepção da captura política da saúde suplementar no Brasil. *Cadernos Ebape*, *8*(4), 694-709. https://doi.org/10.1590/S1679-39512010000400009

Waldorff, S., Reay, T., & Goodrick, E.A. (2013). Tale of two countries: how different constellations of logics impact action. In M. Lounsbury, E. Boxenbaum (Eds.). *Institutional logics in action*, *39*, 99-129. Emerald Group Publishing.

Yazbek, P. (2014). Como reclamar do seu plano de saúde ou seguro da forma certa. *Exame.com*. https://exame.abril.com.br/seu-dinheiro/como-reclamar-do-seu-plano-de-saude-ou-seguro-da-forma-certa/

Yin, R. K. (2001). *Estudo de caso: Planejamento e métodos*. Porto Alegre: Bookman.

CONFLICTS OF INTEREST

The authors have no conflicts of interest to declare.

AUTHORS' CONTRIBUTION

Lia Da Graça: Conceptualization, data curation, formal analysis, Investigation; Methodology; Validation; Writing – original draft; Writing – proofreading and editing.
Arnaldo Ryngelblum: Conceptualization, Investigation; Methodology; Supervision; Validation; Writing – original draft; Writing – proofreading and editing.