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Outsourcing in Western Australian hospitals: Management considerations

Geraldine M. Martin
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**OUTSOURCING IN WESTERN AUSTRALIAN HOSPITALS
:MANAGEMENT CONSIDERATIONS**

by

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B App Sc (N Ed), Cert STN (Aust), MRCNA.**

**A Thesis Submitted in Partial Fulfillment of the Requirements
of the Award of**

**Master of Business
in the Faculty of Business, Edith Cowan University.**

Date of Submission: June 1996

USE OF THESIS

The Use of Thesis statement is not included in this version of the thesis.

ABSTRACT

This thesis examines Health Care Managers' considerations with and experiences of outsourcing services in Western Australian hospitals. Support services such as cleaning and maintenance are some of the areas which have been targeted for outsourcing (contracting out) by the state government. These services have traditionally been delivered by permanently employed staff either on a full or part-time basis, usually with active union involvement. Core services such as nursing and medical care which involve direct patient care delivery are not included in the outsourcing debate.

Firstly, this thesis reviews the literature on outsourcing and its application to the health care industry. Performance indicators and benchmarking are also explored within the context of contracted out services in a variety of settings. The implicit economic, social and legal implications are discussed.

This study involved Health Care Managers in Western Australian hospitals and was conducted between June 1995 and May 1996. Their experiences with outsourcing of services together with the hospitals and the communities they served were key considerations in the final analysis. The research findings support the views of more recent studies which emphasize the importance of the context within which outsourcing is implemented, such as rural versus metropolitan hospitals. Hospital size, location, accessibility to contractors, human resource issues and funding arrangements such as those which affect teaching and non-teaching facilities were identified as major determinants affecting the degree to which outsourcing had been embraced. Finally, the implications of this research for future studies are discussed.

DECLARATION

“I certify that this thesis does not incorporate, without acknowledgement, any material previously submitted for a degree or diploma in any institution of higher education and that, to the best of my knowledge and belief, it does not contain any material previously published or written by another person except where due reference is made in the text.”

Signature

Date June 1996

Geraldine Martin

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I dedicate this project to my parents Daphne and Lewis Andrew Farmer.

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CHAPTER 1: INTRODUCTION

Background to the problem

Outsourcing (contracting out) has been described as a

"straightforward process: it simply means that government agencies can provide services to the public by employing private firms, non-profit organisations, or even other governments"

(Rehfuss, 1989:5).

It is the major impetus behind the Western Australian government's decision to introduce competition into the delivery of public sector services by subjecting the delivery of public services to the discipline of the open market. Outsourcing has also been described as the key to creating new industries (Ruthven, 1994). This crucial aspect of the privatisation drive by many Western democracies still evokes considerable controversy over its merits and mode of implementation (Richardson, 1989). At both State and Federal level, competition principles are being implemented by either legislative or other measures (Atkins, 1996).

State-owned organisations have been described as "inefficient", being protected from market competition, funded by Treasury, benefiting from legislated monopolies, which are run by people supposedly motivated by public interest who actually

develop practices to suit their own needs, and generally perform poorly (Mackintosh, 1993:136). In this case, consumers have no choice of alternatives.

It has especially been linked to the radical right governments of Thatcher in Great Britain and Reagan in the United States, however, traditionally liberal democracies such as Sweden have also embraced components of privatising reforms in health, housing, childcare and other social welfare services (Samson, 1994).

Outsourcing has gained momentum and generally it is employed where specialised expertise is needed and hard to fill jobs exist (Lumsdon, 1992; Krpan, 1993; Taylor, 1993), with information technology and local government services being particular targets (Carlson and McNurlin, 1992; Birmingham, 1993; Krpan, 1993; Margolis, 1993, Rosenberg, 1993). It has been estimated that 80 percent of United States cities and counties use private companies to produce and deliver a wide range of public utility-type services (Gayle and Goodrich, 1990:3). Other major motivating factors to outsource relate to cost reduction and more flexibility with the workforce (Mark, 1994; Minoli, 1995).

Samson describes privatisation as “a truly international phenomenon” (1994:79). The division between opponents and proponents of privatisation is based upon and continually fuelled by a complex web of political, philosophical, economic and social motivations and differences.

As the public demands a larger range of better quality and more precisely focused services, the Health Department of Western Australia (HDWA) faces the challenge of continuing to provide a quality service at reduced costs. The state government's intention has been interpreted as a way to "dramatically change the funding and the current structure of health care delivery" (Milos, 1994:7).

Within this framework, some "in-house" services will be exposed to competitive provision from elsewhere in the health sector and/or from private providers, and outsourcing of services to private parties under an agreed service contract. This has obvious implications in all areas of service delivery in hospital and community settings alike. Hence health care agencies, particularly in the public sector, face an increasingly difficult operating environment.

The state government push to introduce market place pressure upon the public service sector has major implications for all areas. An examination of the impact of these reforms upon the Western Australian health industry and the issues facing Health Care Managers throughout the state is warranted.

Significance of the study

Research into this issue is essential to determine the current status and impact that outsourcing of services in health care is having. Management considerations of the actual and perceived impact of these reforms will provide useful data for the Health Department of Western Australia and individual health care facilities.

The recommendations made by the 1993 Independent Commission to review public sector finances have generally been embraced by the state government. There is a scant amount of information concerning the impact these reforms are having upon Western Australia health care facilities, particularly in the various areas of the state. On the surface, Health Care Managers regardless of the type of community they serve are being directed to pursue these reforms wherever possible. Long term benefits and problems have been extrapolated from short term results.

Purpose of the study

The purpose of this study is to provide data concerning the status of outsourcing (contracting out) practices within Western Australian hospitals. Individual management considerations and experiences are also examined.

Research questions

This study is directed by the following research questions using questionnaire and interview techniques:

How do health care managers decide which services will be outsourced? Are there services which managers do not wish to see outsourced?

What performance indicators will be necessary to ensure quality outcomes for the consumers of the service?

What do managers perceive as the major issues facing them when dealing with contractors and implementing an outsourcing strategy?

What has been the experience of managers who have dealt with contractors?

Are there differences between groups such as rural and metropolitan HCMs?

Definition of terms:

- **HEALTH CARE MANAGER (HCM)** denotes any of the following positions within Western Australian health care facilities:
 - **General Manager (GM)**
 - **Administrator**
 - **Director of Nursing (DON)**
 - **Health Service Manager (HSM)**(combined role of DON and Administrator)
 - **Administrative Assistant**
 - **Nurse Manager (NM)**

• PRIVATISATION

It is recognised throughout the literature that there are multiple definitions of privatisation. For the purpose of this study, the researcher has defined privatisation as **the process of transferring (“selling off”) state-owned service delivery systems to independent ownership thus “reducing the roles of government, while increasing those of the private sector, in activities or asset ownership” (Gayle & Goodrich, 1990).**

•OUTSOURCING (CONTRACTING OUT)

There are multiple definitions for this term as well. It is generally accepted that outsourcing is the process of moving away from the traditional in-house service provision model to one of allowing groups or individuals external to the organisation to provide the same service at a presumably reduced cost (King, 1994). The public

service still owns the service and control is maintained by “customising specifications and monitoring performance” (Domberger & Hall, 1995).

Structure of the thesis

This introductory chapter provides a background into the research and questions directing this study. Chapter 2 presents a comprehensive review of the literature on outsourcing in both Australian and international contexts with specific focus on the health industry.

Chapter 3 describes the methodology with details of the research design, setting, sample and methods used in the conduct of the research. How the research instrument was developed and implemented, and the handling of the data are also described. Ethical considerations and approval are stated.

Chapter 4 details the results of the data analysis in response to the information obtained from the questionnaire and the interviews. Sample characteristics are also described. Results are discussed as they relate to the literature on outsourcing of health care services and management considerations. Chapter 5 concludes the thesis with the inclusion of unexpected findings and recommendations for future research.

CHAPTER 2: LITERATURE REVIEW

“For nearly twenty years...health has been the most difficult public policy problem facing Australian governments...Demand is...boundless; vested interests proliferate; problems of inefficiency and unaccountability afflict supply; irrational considerations of ideology make rational policy discussion almost unattainable.”

(Nahan & Rutherford, 1993:169)

Outsourcing: General overview

Outsourcing is the new term for an old concept, that is contracting out work. The application of this concept to the public sector, however, is still in its infancy. The major objective of the Western Australian government's introduction of outsourcing is to expose public sector services to competition in the open market. It has also been described as “part of the reengineering of the corporation” (Minoli,1995:9) and is one of the major underpinning facets of privatisation. At both State and Federal level, competition principles are being implemented by either legislative or other measures (Atkins, 1996).

Internationally, government services provision has been revolutionised by major microeconomic reform. The most obvious aspect of these reforms is a move away from services supplied by in-house personnel to that of external contractors through

the process of competitive tendering and contracting out also known as CTC (King, 1994). The term CTC has been used to represent a variety of synonyms such as "outsourcing, market testing, vertical disintegration, unbundling, franchising and contracting out" (Rimmer, 1994:79). By using a competitive process, CTC, it is claimed, will allow a government or another organisation to decide who would be the most appropriate provider of that service (Rimmer, 1994).

Particularly in the western world and at all levels of government, a wide range of services traditionally provided by in-house personnel have been contracted out. Certain human resource functions such as recruitment and selection of staff have been targeted together with cleaning, maintenance, gardening, catering, engineering, staff development, garbage and recycling waste collection, information technology, child care and other social welfare functions.

Outsourcing in the Health Sector: The UK National Health

Service experience

The British National Health Service (NHS) has been described as rigid, over-centralised, completely lacking in "incentive for innovation and improvement in efficiency" (Enthoven, 1990:1261). Again in Britain, local government and health services were legislated to be delivered under "compulsive competitive tendering"

(CCT). These services have been required to award contracts to the lowest bidder, be it in-house or external contractors.

The NHS was exposed to wide sweeping microeconomic reforms under the Thatcher government. These reforms, whilst creating freer market structures, were nevertheless limited by political constraints. "Market rules" restricting contestability were imposed by politicians seeking to minimise the consequences in marginal constituencies (Maynard, 1991). Health reforms introduced by Thatcher are now being blamed for the NHS' current "critical" condition with nine London hospitals having been set to close due to a lack of cash.

The major emphasis was on the *efficiency* of the service at the expense of the *effectiveness* or quality of the service. This has cost the NHS dearly and supports the view of some researchers that poor quality and a failure to measure effectiveness results in greater costs that does the delivery and maintenance of high quality service (Deming, 1986; Griffin, 1993). In health care, poor quality service may result patients/clients having to be readmitted to hospital and subsequently cost more per patient as well as increase the discomfort and inconvenience experienced by the patient/client.

The essential flaw in some of the NHS reform initiatives is the apparent lack of regard for differences between patients such as their age and social situation. The

impact of clinical pathology such as heart disease, diabetes or similar conditions on the demand for NHS services appear to have not been considered. These differences impact on the cost of hospitalised patients who may have been admitted for treatment for a totally unrelated incident such as a fractured neck of femur. Existing pathology also requires treatment which naturally affects length of hospital stay and raise costs (Howes, 1994:36).

It is claimed that in the UK business sector Thatcher's reforms are now "bearing fruit" (Flynn, 1994:48). There was no mention, however, of the plight of the NHS under these reforms. Under these reforms, hospitals are competing for patients and purchasers are competing for beds. Since April 1993, it is claimed that tension between NHS regulatory bodies and competitive behaviour "which is in the spirit of the reforms... (leading to)...a public debate in the UK concerning the emergence of a 'two-tier' NHS" (Fenn, Rickman & McGuire, 1994: 126).

There is still, however, uncertainty about health outcomes and how best to finance these throughout Western health care systems (Fenn et al., 1994). "Mismatches" between rigid regulatory requirements and local financial considerations are still apparent (Ellwood, 1996:25). A 1994 survey of the NHS found that while the level of consistency in costing for contracting had improved since a 1991 survey, large variations still existed in the application of the NHS Costing for Contracting Guidance (Ellwood, 1996).

Obvious divisions exist between proponents and opponents of the reforms based on a complex web of political, philosophical, economic and social perceptual differences as to what responsibility government has in delivering public services. There still remains, however, a considerable amount of controversy over the merits and the way in which outsourcing has been introduced (Evatt Research Centre, 1990). It has been estimated that approximately 80% of cities and counties in the United States use private companies to produce a wide range of services (Gayle & Goodrich, 1990:3)

Contestability: Health Department of Western Australia

In 1993, the Western Australian government announced its intention to introduce business-like (competitive) processes into the public service arena. The then Minister of Health, Peter Foss, was quoted as saying that "contestability" had been embraced by the HDWA as a means of introducing

"competition into government sector services which have previously held a monopoly position or which has operated in a regulated or tied market...(and services)... are provided competitively in terms of quality, timing and price"

(HDWA, 1993:1)

Whilst there have been several changes of Ministers of Health since 1993, the current government remains steadfast in pursuing the reforms. Outsourcing is not a new concept in the health industry, but its use has been generally restricted to specialist services such as those skills required in capital works projects, computer services, security or waste removal (Domberger & Hall, 1995). The major areas being targeted are the “support” services in hospitals, such as cleaning, catering, maintenance and engineering.

The New South Wales government implemented similar reforms several years prior to the Western Australian government. They created a new combined role for a number of staff in the cleaning, catering and orderly departments. A Patient Care Assistant (PCA) was created whereby these staff under the direction of a senior registered nurse would carry out tasks such as unit cleaning, meal transportation and delivery, patient transport and messenger services. A similar system was implemented at Royal Perth Hospital in 1994 which attracted fierce union opposition. Nevertheless, the system continues based on its success and staff acceptance.

“Core” versus “support” services

In 1993, the HDWA indicated that “core” functions which represent activities directly affecting patient care, such as medical services or clinical nursing, will less

likely be affected than those "support" services which are supposed to indirectly affect patient care. Those services which are not essential to the core business of an organisation are much more likely to be put out to tender, especially where there is "a substantial commitment of scarce resources to non-essential services" (Domberger, Hensher and Wedde, 1993:403).

Support services within the health care context are hotel services, staff development, research, management, engineering, information systems and allied health. Hotel services included cleaning, catering, laundry, orderly and patient transportation, maintenance, security, transport and courier services and ground maintenance (Domberger & Hall, 1995:100).

There is growing interest in the health care arena with the increase of contracting out for social (human) services (Bernstein, 1991). These services involve very specific and personal services delivered to individuals. Issues related to the recipient's physical well-being, quality of life and even choices about living and dying are involved.

Outsourcing companies claim that the alternative to outsourcing is the creation of "in-house capabilities which are typically less productive, more expensive and often require a disproportionate amount of management time" (Thomas, 1995:26). Peripheral or support services are typically those outsourced which cannot be

described as directly part of the “true business function” of a company. Many of these peripheral services outlined by Thomas (1995:26) are those very same services targeted by the government for outsourcing.

Before any steps are taken to outsource, the following issues need to be seriously considered by management:

1. Determine who are the customers/consumers of the service
2. Determine what demands these consumers will have on the service
3. What steps will be necessary to measure these consumers' levels of satisfaction with the service
4. Determine if new methodologies for service delivery are appropriate
5. Define the level of performance required (standards/legislation)
6. Determine what are appropriate financial resources (human/material) to provide the service
7. Determine how the tendering process/ service contracts will be managed
8. Decide how contractors' performance will be monitored against policy and predetermined indicators (Jones, 1992:10).

Privatisation: Power in private?

Samson (1994) cites numerous examples of contracting out in Great Britain and the United States. His article presents an adaptation of Lukes' (1974) theory of power and examines what he terms as the "three faces" of privatisation. The first face of privatisation is based upon a "naive pluralistic model of society" closely coinciding with what Lukes refers to as "the one-dimensional theory of power" (Samson, 1994:80). Samson (1994:87) purports that this view results in

1. privatisation recreating many of the problems it was originally adopted to address or replaces these problems with different dilemmas,
2. a false assumption that the model of liberal capitalism provides an adequate foundation upon which privatisation rests, and
3. some groups benefiting whilst others are harmed.

The second face of privatisation relates to decisions made which result in "corruption, homelessness and social inequality, which may be products of contracting out and sell-offs" (79). Cuts in public sector expenditure such as social welfare programmes have resulted. As Samson argues, this decreasing or ending of the state providing certain services had wide reaching sociological implications, particularly for women.

Samson cites Brush (1987) whose research demonstrated that with the cessation of some social services the responsibility to continue to provide these services often

falls to women at home who often have to leave paid employment to that of unpaid home-based employment. Of particular note, community care services for the elderly, mentally or terminally ill often fell into this category. The general “community” assumption that women will naturally take up unpaid caring or nurturing roles remains prevalent. Combining this with the low levels of funding available for this group, we then find these people being herded into a social corral of inequality, self-provision and powerlessness.

The third face of privatisation Samson describes as the “The Hegemonic Project” relating to dominance, super-power and authority inherent in these reforms. Samson (1994:94) argues that this face has been advocated particularly by the Thatcher and Reagan governments with the aim of “manipulating public attitudes” based on the “narrow definition of privatisation which conveniently excluded privatising processes which were harmful to some social groups”.

Private hospitals are generally recognised for their ability to hold down health expenditure (Agenda for Reform, 1993; HDWA, 1993; Gray, 1995). Indeed for their own survival, it has always been necessary to be able to respond rapidly to changes internally and externally. Expensive, redundant services are rapidly eradicated and replaced with more appropriate services. Within public health systems, the wheels of change often move much more slowly and the levels of

bureaucracy appear far more complex and intricate than those existing in the private sector (Gray, 1995).

Gray (1995:19) cites the findings of Enthoven, an American health analyst who examined the NHS in Britain in 1985. Enthoven found that a range of structural problems hindered the efficiency of the NHS. He classified these problems into five groups, these being gridlock, inefficiency, overcentralization, poor information systems, and unresponsiveness.

The *gridlock* category refers to government cash limits with senior medical staff on long term contracts with a high degree of autonomy. Conversely managers had a low level of control. General practitioners were seen as independent contractors with substantial autonomy.

Inefficiency refers to incentives which actually discouraged efficiency. Hospitals demonstrating that they could increase throughput and reduce waiting times were having more people referred to them. The workload increased substantially without any extra resources being allocated.

Overcentralization refers to the pay and conditions of most staff being set by national agreements thus reducing flexible responses to changing market conditions.

Poor information systems demonstrated clearly that there was little or inadequate information or data collection systems dealing with casemix, caseloads, costs, and outcomes so that it was impossible to evaluate and compare performance.

Finally, unresponsiveness refers to the fact that the system was insensitive to needs of the consumers. Long queues, short consultation times, inadequate information and cancellation of services at short notice were commonplace.

Advantages of outsourcing

One key to competitive advantage is by keeping staff updated in their specialist areas and enabling them to be innovative (Kanter, 1984). Despite the adoption of outsourcing as a strategy for managing specialist skills and service of health care units, it is suggested, however, that it is still in its "infancy" (Mark, 1994:37).

Regardless of this, Mark (1994) presents a list of advantages, these being:

- reductions in direct costs
- flexibility in coping with periods of change
- freeing management to focus on its key organisational tasks
- access to a critical mass of expertise not available "in house" (p37).

Furthermore, Minoli (1995) suggests that in the area of information technology where outsourcing is a major force, other advantages are

- minimizing the user's investment and reducing financial risk
- protecting against technological obsolescence
- reducing the user's responsibility for designing, deploying, and validating complex and evolving IS functions and networks
- reducing the user's responsibility for ongoing management of a complex and evolving network and IS infrastructure, and for understanding and applying new (and perhaps initially risky) technologies
- decreasing staff numbers, ending up with less people, who are higher-level technical specialists, planners, and contract managers; in addition to reducing the responsibility of managing a large staff, this usually also reduces the expense
- achieving one-stop shopping (Minoli, 1995:2-3).

Throughout the USA and the United Kingdom contracting out is common in all levels of government, engineering, legal services, health services and in the prison and correctional services. Some of the primary reasons given as to why governments contract out are cost effectiveness, flexibility, and responsiveness and control (Rehfuss, 1989).

As with the British health care reforms, the Western Australian health industry has commenced to extend the use of contracts beyond the traditionally specialist fields in order to achieve value for money and obtain further efficiency gains from providers.

As Mackintosh (1993:143) states the British emphasis is on securing improvements

in costs through what they pay for their contracts. There is no real evidence to date to suggest that the Western Australian government has different intentions for the health industry.

Disadvantages of outsourcing

Some of the major problems found with contracts, however, have been because contracts have been too broadly or vaguely worded. Atkins (1994) purports that contract terms and conditions must be understandable now and in 10 years time.

An excellent example of this is that cited in research conducted by Prest and Prest (1992), where in some American mental health institutions, patients were receiving sub-standard care because their individual needs were not stated in the contract and those contracted to do the work were not contractually bound to provide specific care requirements. Recipients of the care are left to the mercy and benevolence of the care providers who interpret their responsibilities and duties from a broadly and loosely constructed contract.

Specifically, the disadvantages outlined in the literature are the failure of the contract and the inherent costs of replacement of contractor and loss of business, lower quality outcomes, loss of control of the service or function outsourced, poor safety records of contractors, legal "mine fields", and finally greater costs related to set up

procedures to accommodate contractors and contract specifications (Bernstein, 1991; Prest & Prest, 1992; Griffin, 1993; Paddon, 1993; Brown, 1994).

Minoli (1995) suggests that organisations are becoming more “federated”. They are concentrating what they are good at, leaving the less creative tasks to someone else. He cites British Telecom’s decision to outsource its catering requirements which yielded an estimated 20-25% saving. Another example presented is that of Ford Motor Company’s decision to contract out the building of its engines to Japan’s Mazda.

Figure 1 is a graphic representation of what Minoli (1995:3) describes as “the pros and cons of outsourcing”. He analysed the impact outsourcing of information systems and technology had on a number of corporations. The advantages and disadvantages can be applied, however, to a number of situations facing government agencies and departments.

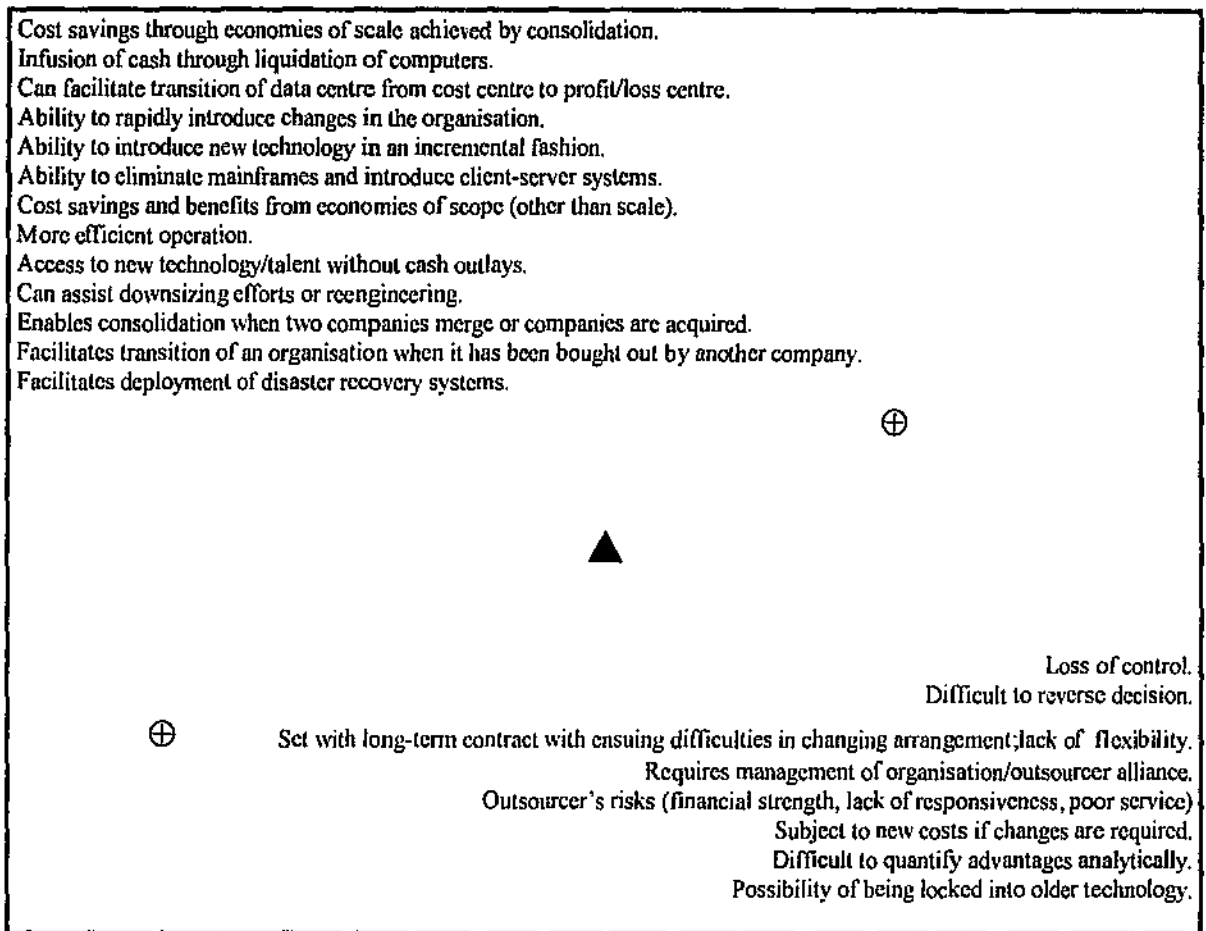


Figure 1: The pros and cons of outsourcing

(Minoli, 1995: 3)

Generally, some of the advantages and disadvantages from Figure 1 have direct application to the health care situation. The HDWA's claims that outsourcing of certain services will result in more efficient operation permeates much of the documentation coming from the department. Efficiency is seen as the driving force behind the government's initiatives in the area of outsourcing and privatisation. The disadvantages as highlighted in the literature and stated in Figure 1 outweigh the advantages as they apply to the health arena. Loss of control, inflexibility, new costs and legal considerations are some of the major concerns

Early efforts to outsource certain functions saw many managers outsourcing the entire function of a department. Minoli (1995) is of the opinion that this trend has swung around to managers now *selectively outsourcing* only certain functions, particularly in information systems. This swing to selectively outsourcing only certain parts of a function has resulted from managers' beliefs that in order to assume responsibility for a particular service, some degree of control over operations must be maintained.

Benchmarking

It is essential that a systematic form of benchmarking occurs before implementing outsourcing is considered worthwhile. Benchmarking is an important consideration within the framework of contestability and outsourcing (Julien, 1993). It is a process where organisations look at the processes and methods used by others and then determine which of these may be applicable to their individual unit's needs (Payne and Blackburn, 1993; Beaumont, 1994). Tomas (1993:79) uses the Xerox Corporation's definition which is "the search for industry best practices that lead to superior performance". Benchmarking has also been described as a management technique to encourage quality improvement (Liebfried & McNair, 1992; Patrick, 1992; Julien, 1993; Tomas, 1993; Weisendanger, 1993) by identifying specific

inefficiencies within individual departments or organisations which can then be remedied.

It requires that an organisation's talent be "developed and deployed against future needs" (Walker, 1992:239). Walker further suggests that it is management's responsibility to evaluate the quality of in-house talent relative to the talent to be found outside the organisation. There is a plethora of definitions, however, together with any number of steps to achieve the desired outcome (Cox et al, 1993). This is highlighted in Table 1.

<u>Type of benchmarking</u>	<u>Source of input comparison for benchmarking study</u>	<u>Source of outcome comparison for performance evaluation</u>
1. Internal	Within one organisation between work groups, divisions or locations	Within one organisation between work groups, divisions or locations
2. Competitive	Between organisations in the same industry competing in the same markets	}
3. Industry	Between non-competing organisations in the same industry	} }
4. Generic	Between organisations in different industries on similar operational processes	}Between }organisations in
5. Strategic	Between organisations which may or may not be competitors on areas of similar strategic importance	}the same industry }competing in
6. International	Comparison between organisations located in different countries	}same markets }

Table 1: Sources of input and outcome comparisons in different types of benchmarking as cited in Cox et al., (1993:3)

In practice, benchmarking combines two processes, those of extrinsic motivation and the sharing of knowledge (Mann et al, 1993:3). These authors suggest that employees will be motivated to improve their performance if they are provided with regular and open communication on how their company is performing against other comparable industries. There is a further suggestion that this information-sharing by management may stimulate and foster innovation and best practice.

The impact that benchmarking has for the contestability situation is that once best practices are identified, can contractors provide the service at this level without incurring further cost to do so? Tomas (1993) states that with the application of benchmarking, the health care industry can provide a service which ensures quality as well as reducing costs. Benchmarking, he states, can identify inefficiencies which can then be remedied. Camp (1989:12) states that the process can initiate a “search for industry best practices that lead to superior performance”.

It is essential, however, that organisations look at the processes and methods used by others and to then determine which of these may be applicable to their individual organisations’ needs (Payne & Blackbourn, 1993). The success or power of benchmarking lies in an organisation’s ability to learn from other organisations’ best practices and adapt them to their needs, not necessarily adopt them in total (Julien, 1993).

Benchmarking is, however, not without its limitations. Mann et al (1994:2) cite several studies which “challenged the notion that benchmarking is a guaranteed formula for success”. They cite an Ernst & Young study which surveyed 500 US companies to determine the success of the benchmarking programmes which had been introduced. They found that for those companies which were already performing well prior to the introduction of the programme, a variety of benefits and improvements were realised. Organisations which were considered to be performing at low or medium levels were not, however, able to demonstrate any significant benefits. This was attributed in part to a lack of understanding of the benchmarking process, loosely constructed infrastructure and poor resource allocations required to sustain the programme (Mann et al.,1993:2).

Performance Indicators

Jones (1992) argues that continuous comparison of performance with critical customer requirements against the best in the industry (direct competitors) or class (companies recognised for their superiority in performing certain functions) is conducted to determine what should be improved in the current service. Walker (1992) suggests that it is management's responsibility to evaluate the quality of in house talent relative to that to be found outside the organisation. Gayle & Goodrich (1990:5) claim that management do not always act in the best interests of either shareholders or taxpayers which can preclude “effective performance monitoring”.

The possibility that the quality of health care will fall is often the main reason given by the opponents of outsourcing. Musfeldt (1991) described quality health care as "consistently exceeding the expectations of the patient and family with the highest degree of technical expertise, efficiency and compassion".

It is essential to the success of any contractual arrangement that "performance specifications, observations, and written contractor reports should be part of every contract" (Rehfuss, 1989:221). In view of this, it is not surprising that the number of contract management firms is steadily increasing, particularly in the United States and Great Britain (Lutz, 1993). Contract and temporary workers have been described as the "invisible workforce" and the assessment of their performance in light of the organisation's core goals and quality assurance initiatives is paramount (Jacobs, 1994).

To analyse the quality of health care, MacDonald (1993) suggests that four perspectives be used, these being professional, consumer, staff and institutional. Table 2 outlines how quality can be measured by comparing actual outcomes to established outcome criteria (indicators) from the perspectives of the various people and groups involved in the health industry. Whilst the main emphasis in MacDonald's paper is on post-operative recovery data, it nevertheless has direct application to a wider range of patient services such as acute medical and obstetric settings.

PERSPECTIVE	OUTCOME CRITERIA (Effectiveness/quality indicators)
CONSUMER	Length of wait until surgical treatment Post surgical indicators <ul style="list-style-type: none"> • freedom from pain • staff response to needs • ability to resume normal daily activities
PROFESSIONAL	Morbidity data Mortality data Length of hospitalisation
STAFF	Time management Degree of on-the-job challenge Staff/skills mix
INSTITUTION	Measure costs Determine if research-based care was enforced

Table 2 : Indicators (outcome criteria) of quality health care from the perspectives of consumer, professional, staff and institution

From a professional standpoint, quality care is measured by the degree to which standards that are determined by professional bodies are met. MacDonald (1993) argues that many health professionals tend to exceed those requirements resulting in what she defines as “over-performance”. This would support the claim of Porter (1985) that over-performance results in more money being spent than is necessary to meet the needs of the population.

Unnecessary costs result from excessive or misdirected time spent on an activity, energy, personnel, equipment, or money. MacDonald (1993:16) suggests that health professionals ask themselves “Does this activity increase the quality of life of this client”? She suggests that if the answer is in the negative, then it is possible that the activity is superfluous and inappropriate. This is supported by King (1994:76) who

states that “it is erroneous to argue that a higher quality is always preferred if it involves a greater expense... (and that)...a decline in quality accompanied by a fall in price may be socially desirable”.

Paddon (1993) suggests that some departments, bent on surviving no matter what, will withhold vital information from contractors which may affect the whole process and in fact increase costs. Furthermore, various suggestions as to how contractors' individual performances are measured, monitored and evaluated is often left up to individual organisations to implement. A systematic and consistent process is required whereby all contracts come under the same set of guidelines, standards or legislation.

Australian Council on Healthcare Standards (ACHS)

Established in 1974, the ACHS was initially directed at surveying the standard of care delivered by acute care hospitals. Whilst this process has always been and remains voluntary, surveys now encompass a wider range of facilities such as nursing homes and ambulatory centres (Collopy and Balding, 1993:510). At the time of this research, there were twenty-one ACHS accredited public hospitals in Western Australia. This does not include those hospitals awaiting the results of their surveys.

Outcomes of care delivered are measured against pre-determined standards as set by the ACHS. It is management's responsibility to ensure that effective systems are in place to optimise customer satisfaction. "Customers" within this context can be patients, staff, community groups or executive members. Furthermore, management must ensure that the quality of care or service is the highest standard possible and that efficient work practices occur.

Various processes are involved which help to achieve these outcomes. Effective customer feedback mechanisms such as regular satisfaction surveys are often implemented. Risk management and staff development issues are vital considerations in ensuring the success of the programme. Above all, every "customer" should be treated with respect, dignity and courtesy (ACHS, 1994).

It is suggested, however, that the ACHS programme "primarily reflects the structure and processes of the facility and not the actual quality of patient care" and is more concerned with the *potential* a facility has to provide good care (Collopy and Balding, 1993:511). It is the providers of care who determine if this potential has been realised through formal quality assurance processes.

The private hospital cleaning industry is represented by the Australian Health Care Service Industry Association (AHCSIA). This association maintains that its members are obliged to comply with the association's code of practice as well as the

performance standards set to achieve and maintain ACHS accreditation status in the areas of “special and routine cleaning, use and care of equipment, waste disposal, infection control and the evaluation of cleaning effectiveness” (Domberger & Hall, 1995:105). When the NSW government announced its intention to outsource the cleaning services in state hospitals, the AHCSIA was able to claim that savings could be achieved without threatening the quality of the service (Domberger & Hall, 1995).

MANAGEMENT CONSIDERATIONS

Safety considerations

Following a major industrial accident in Texas, USA, Kochan et al (1992) were commissioned by the Occupational Health and Safety Administration (OHSA) to conduct a study on safety and health issues involving contract workers in the U.S. petrochemical industry.

Their data revealed that contract workers do experience a higher probability of injuries than direct hire workers. They relate these findings to the fact that contract workers are more likely to be employed to perform high-risk maintenance and renovation work; are less familiar with the workplace; may receive less safety training; the safety training they receive is less effective in reducing injuries received by direct hire workers. 38% of employees in the Kochan surveys found that these

people work in plants that do not have a formal procedure for considering safety in the selection of contractors.

The Western Australian Commissioner for Health issued an information circular in March 1996 concerning the management of contractor safety. Amendments to legislation, namely the Occupational Safety and Health Act 1984 (formerly Occupational Health, Safety and Welfare Act 1984), emphasised the responsibilities of all employers for the safety of contract workers. For those areas under the control of the employer, issues relating to the safety and well-being of contract workers cannot be contracted out. As is expected with in-house staff, policies and procedures governing work safety and personal protection must be maintained. "Guidance notes" have been prepared to assist health care managers in determining their responsibilities to contract workers and the provision of a safe working environment (HDWA, 1996).

Legal considerations

Jones (1992) proposes that a "partnership charter" rather than a legal contract be drawn up to signify mutual commitment and trust by both parties. Documentation concerning contracting behaviour, specifically specification development, "emphasise collaboration between purchasers and providers ...(and)...specifications should be shared, being constructed in collaboration with providers and their clinical staff... to establish common views" (Department of Health [UK] as in Mackintosh,

1993:142). Furthermore, the Department of Health [UK] document emphasises that the service required should not be specified in detail.

Effective and meaningful partnerships will never be formed, however, where management is unwilling to accept labor as a legitimate partner, where information and decision-making power is shared (Kochan et al, 1992:87). Kochan et al (1992: 84) found that contract workers who were more closely supervised by the employing organisation experienced fewer injuries compared to those supervised by the contractor.

Lawyers, however, are known to advise managers to avoid supervising contract workers to prevent being judged a "coemployer" (Kochan et al, 1992:87). An employing organisation may be judged a coemployer when it "supervises or controls the terms of employment for contract workers who are doing work similar to the work of direct hire employees" (Kochan et al, 1992:85). Under U.S. law these employers may become liable under Federal and State law for compensation and fringe benefit claims. Kochan et al discovered that generally employers were advised "to maintain sufficient separation between the two workforces to avoid these potential coemployment liabilities" occurring (1992:85).

Kermode et al(1994:14) argue that the Australian health care system is highly centralised and highly regulated. They argue further that within The Australian health care system, there are "micro-systems" which represent monopolies such as

medical services, public hospitals, and Medicare . There is a greater emphasis on "bottom line issues", that is, financial outcomes, being at the top of health administrators' agendas rather than a total approach to achieving quality outcomes at the best price possible. Kermode et al (1994) argue that nurses are health workers with the "best understanding of the quality of life issues for patients, and must be at the forefront of arguing for better measures for health" (p22). For this to eventuate, these authors argue that nurses need to be cognizant of the influencing forces which underpin their service delivery as well as developing a greater appreciation of the "complex public policy environment, in which market forces may be only one component" (Kermode et al; 1994:23)

While there are benefits of price competition in health care, it has been pointed out, however, that some organisations may deliberately choose to serve only "low cost" or "low risk" health consumers (Kermode et al; 1994:17). An environment is being created where various health groups are put into competition with each other. For groups of suppliers who compete with doctors, they are effectively regulated out of the market. Those health professionals without provider numbers under the Medicare system, such as independent midwives, are at a huge disadvantage in the market (Kermode et al; 1994: 18).

Financial considerations

"We talk about wanting value, working together, and rewarding the people who produce the highest quality; and the very next week we go out and contract on price. It is very schizophrenic " ***(Wrocklage, 1990:67).***

Reduction in direct costs is presented as one of the main advantages of outsourcing. It has been demonstrated, however, that this is counteracted by the costs incurred in "setting up the procedures, management and information systems which are necessary to make competitive tendering or contracting work "(Paddon, 1993:19).

This criticism is further supported by the earlier work of Jones (1992:84) who claimed that costs are actually higher than first thought due to "management, monitoring and enforcement issues" and that "public accounting practices make it difficult to know the overhead costs of purchased services". This is further compounded by the confusion amongst health care managers as to the difference between efficiency, economy and effectiveness (Martin, 1994b). Sennett, Legorreta and Zatz (1993) defined *effectiveness* as achieving the desired outcome, whereas *efficiency* considers whether the outcome was achieved with an appropriate commitment of resources.

Research examining the impact outsourcing throughout Australia has highlighted the economic, social and cultural differences between metropolitan and rural

communities which naturally affect not only the outcomes of outsourcing but primarily whether outsourcing should even be considered (Rimmer, 1994). Rimmer (1994:84) suggests

“that in geographically isolated regions there could be insufficient competition for...contracts...contestability alone might not provide effective incentives to service providers to minimise costs”.

Despite an increase in Commonwealth expenditure in health (from 10.5% of 1972 Budget to 13.4% of 1992) evidence such as lengthy waiting lists for elective surgery indicates that demands for the service are still largely unmet (Nahan & Rutherford, 1993: 170). Health care represented 16.5% of the 1992 State Budget. All state governments operate within a constrained environment which is imposed by the federal government.

In accepting funding from the Commonwealth, state public hospitals must provide free treatment to Medicare patients. Additionally, the 1992 Federal Budget ensured that the continued survival of Medicare be assured by insisting that all state legislation embraced the principles of Medicare (Nahan & Rutherford, 1993: 170).

Cost-reduction strategy is characterised by tight fiscal/ management controls, minimisation of overheads, and the pursuit of economies of scale. An increase in productivity is determined by the unit cost of output per person. Strategies for

reducing costs include: reducing the number of employees, reducing wage levels, casual workers, subcontractors, automation, changing work rules, and job flexibility (Schuler and Jackson, 1987; Cascio, 1991).

Paddon warns those contemplating contracting out not to believe that it is the panacea of all the public service ills. It is important, he suggests, that we are not misled into thinking that contracting out and competitive tendering are the *only* solutions. Paddon's arguments are partly based on findings of OECD reports that "real" costs and the financial impact of outsourcing have been difficult to measure. He further suggests that apparent savings are being consumed by "the costs of setting up the procedures, management and information systems which are necessary to make competitive tendering or contracting work" (1993:19).

Other studies have shown that the savings of outsourcing were "short term" with not enough data to predict long term benefits (Zampetakis, 1993:35). This is also supported by outsourcing proponents who also see the need for further research to see if "cost savings persist over time" (Rimmer, 1994:84). Zampetakis (1993) cites information from an information technology benchmarking consultancy that outsourcing may cost twice as much as an internal data centre after 10 years on top of an initial 50% increase in costs.

Johnson and Winchell (1989) demonstrated that managers are spending too much time with contractors, paying high fees and continuing to do so even when the problem has been solved. Contractors in this study were also found to be having great difficulty in dealing with hospital departments about which they had limited operational knowledge.

The issues of control and accountability

“(Outsourcing is)...primarily a means of cutting costs, but it has also been criticised for its tendency to result in loss of control...contracts should be entered into with caution...it is important for organisations to leave room for flexibility, since a contract that meets a company’s current needs may not be adequate at a later time during the life of the contract”

Minoli, 1995:17.

Some researchers suggest that reduced control over the delivery process as well as the question of accountability remain one of the greatest concerns of health care administrators (Bernstein, 1991:3; Brown, 1994:21). In order to overcome the problem of accountability and reduced control, Brown (1994:21) recommends that "specifying required quality outcomes in the contract, and...monitoring performance during the contract period" occur. He also suggests that where outputs cannot or are

not accurately defined, difficulty in specifying or monitoring them may be experienced.

Purchaser/provider "split"

Central to the health reforms in Western Australia is the funding and allocation of resources under the Funder/Owner/Purchaser/Provider (FOPP) scheme. This "purchaser/provider split" separates health authorities as "purchasers" of services from "providers". Providers may be units, such as hospitals, still under the jurisdiction of the Health Department. This also encompasses the activities and funding of other health groups, especially community health groups and psychiatric services.

The theory behind FOPP is that purchasers act as patients' agents with providers concentrating on supplying services. The money is supposed to "follow patients, aligning resources with need and rewarding the efficient" (Mackintosh, 1993:139). The agenda of health care reformers is based upon separating purchasers and providers and creating a competitive market environment where consumers of the health care are supposed to be the main beneficiaries.

One of the main problems with purchaser/provider split is pointed out by Mackintosh (1993:146). Purchasers are meant to play the role of the client but they are the most

bureaucratic of systems and are not controlled by the people they represent and on whose behalf they buy services. Appointments to the purchaser group are made by the Health Department, some of which Mackintosh (1993:14) describes as "explicitly political". Despite their "public service" image, purchasers respond to their "paymaster's priorities" and costs may be cut "to the detriment of quality".

In her study of the community nursing experience, Mackintosh (1993) outlined that with hospital discharge rates rising, there was a tendency to develop throughput measures as performance indicators. She also maintains that these indicators could easily be included in contracts. Jones (1992:12) argues that "supervising contracting is impossible without numerous output indicators". He continues that a service must be defined and specified in detail before the competitive tendering process is begun. Specifications must be "auditable" and not subjective and open to interpretation.

With the emphasis on outputs or throughput, there are, however, increasing pressures on the quality of service delivered. Mackintosh argues that one way of resisting these pressures on the quality of service is "the involvement of front line staff" who are presented as having the knowledge to "design quality-based indicators and to implement them" (p151). Additionally, there must not be a "substantial level of provider control of quality...(but also)...at the provider level, the staff as well as the managers are involved" (p151).

Contract management

One of the major concerns, therefore, is the management of the various contracts involved with the different services within one health care facility. In an effort to contain cost, savings then have to be reinvested to ensure that the new process is duly administered. An increasing trend throughout the American health care system is the employment of contract management firms. It has been suggested that these firms can free up hospital administrators for other duties, provide supplies at lower costs, produce better quality and turn around troubled departments (Lutz, 1993).

Conversely what has been shown is that hospital administrators are spending too much time with contractors, paying high fees and continuing to do so even when the problem has been solved, and that contractors are having great difficulty in dealing with hospital departments about which they have little knowledge of how "things tick" (Bostrom, 1995). It is essential to the success of any contractual arrangement that "performance specifications, observations, and written contractor reports should be part of every contract" (Rehfuss, 1989:221). The number of contract management firms is steadily increasing, particularly in the United States and Great Britain (Lutz, 1993). It has yet to be demonstrated that Australian industries will be able offset these costs more effectively than their British or American counterparts. In order to overcome the problem of accountability and reduced control, Brown (1994:21) recommends that "specifying required quality outcomes in the contract,

and...monitoring performance during the contract period" occur. He also suggests that where outputs cannot or are not accurately defined, difficulty in specifying or monitoring them may be experienced.

Domberger et al (1993) claimed that in a study of a group of public and private sector organisations, the majority of contracts were still managed by one person. The most obvious difference between the contracts in operation in the two sectors was the average length of contracts. Private sector averaged one year for contracts, with the longest contract period being three years. The public sector, however, averaged four years with some contracts eleven and twelve years long.

It has also been argued that the appropriate length of contract is where the right balance "between offering contractors enough time to make a fair return and ensuring a competitive environment" is achieved (Domberger et al.,1993:408). Whilst shorter contracts allow greater flexibility in being able to be renegotiated more frequently, their disadvantage is that they are time consuming and disruptive, particularly for contractors who prepare the tenders. Conversely, contracts that are too long may reduce the benefits of performance being ensured with the threat of competition. Rehfuss (1989:229) suggests that contracting out should be avoided when

- (i) the contract is controversial (strong opposition or will divide the community)

- (ii) the contract cannot be terminated or resolved without embarrassment, or when a permanent commitment has to be made
- (iii) corruption is even vaguely suspected, and
- (iv) citizens' preferences and attitudes will directly impact on the operation of the contract.

**INDEPENDENT COMMISSION TO REVIEW PUBLIC SECTOR
FINANCES: AGENDA FOR REFORM 1993**

This commission was appointed by the Government of Western Australia to review the finances and operations of public sector agencies. The summary of its findings concerning the health industry was scathing. It stated that there was a lack of accountability, a lack of data, that patient care had “emotively overridden the logic of market analysis” (208), and that 90% of health costs are generated by medical staff and clinicians who are reluctant to expose the “medical domain to orthodox management practices” (208). Numerous examples of inefficiencies and poor financial and management practices were quoted throughout the report.

In the second volume of this report, the state’s health industry was one of the public sector departments to have its operational and financial situations examined. A number of recommendations were made to effect estimated savings in health care to the order of \$120 million. \$95 million of these savings were explicitly identified in the report.

As this thesis was being completed, the State Cabinet was examining detailed policies and a framework designed to facilitate implementation of competition principles. At both State and Federal level, competition principles are being implemented by either legislative or other measures (Atkins, 1996).

Recommendations

- The department's purchaser/provider model should be subjected to rigorous analysis, planning and ongoing evaluation.
- Head office costs and the associated regional administration framework should be analysed to ensure genuine cost reductions.
- The department's plans for new hospital beds should be rigorously and critically reviewed and changing treatment practices taken onto account.
- A genuine 38-hour week should be implemented for hospital workers.
- Changes should be introduced to nurses' schedules and work practices with benchmarking to industry best practices.
- Scheduling and work practices relating to domestic services should be reviewed and benchmarked to industry best practices.
- Productivity should be reviewed and more efficient work practices introduced for key administrators and medical staff.
- As a pilot study, selected public hospitals should be subjected to contract management, lease or privatisation.
- Privatised or contract out management of State Health Laboratories, Hospital Laundry and Linen Services, Food Services and Biomedical Engineering.
- Contract out other non-core support services in public hospitals.
- Take steps to encourage increased private health insurance such as priority for elective surgery in public hospitals for pensioners and Medicare card holders.
- Investigate public and private investment in day surgery facilities.
- Introduce accountability for teaching and research costs at tertiary hospitals.
- Arrange alternatives to tertiary hospital accommodation for nursing home and hostel patients.
- Close and/or restructure under utilised country hospitals.
- Raise management performance in public hospitals by establishing performance indicators, benchmarks and ongoing monitoring of results.
- Reorganise tertiary hospitals on a functional basis and establish best practices.
- Implement a user pays policy for appliances.
- Fully recover from the Commonwealth the costs for Veteran Affairs patients.
- Promote private sector involvement in outpatient services and accident and emergency services.
- Transfer State nursing home beds to the private sector.
- Resolve State/Commonwealth costly duplication of nursing home regulations.
- Assess community expectations for public health non-acute care programs to identify non-essential expenditure and inefficiency such as duplication of program delivery.

Conclusion

Some of the arguments for outsourcing specific services within the health care arena have been discussed; these being involved with cost reduction, flexibility, freeing up of management personnel to focus on priority tasks and access to specialised expertise. The proponents of outsourcing services generally present their arguments based on cost reduction and "bottom-line" considerations. The opponents, however, focus on the overall quality issues in patient care which the advocates of outsourcing are accused of "glossing over" (Samson, 1994).

Obtaining a balance between quality service and cost reduction strategy seems an extremely difficult task, which has yet to be convincingly demonstrated. Once managers have determined whether a quality service is more important than mere cost reduction exercises, then the health care agenda is less likely to be at risk of being driven by pure "economic rationalist" motives.

This literature review raised a number of questions about the suitability of outsourcing certain services in Western Australian hospitals. To date, the paucity of data concerning its application to the Western Australian health care environment juxtaposed with the government's confidence in the reforms prompted this research and provided a foundation for the development of the questionnaire and interview questions. From this, it is envisaged that the information gathered will provide a number of key stakeholders involved in outsourcing with a better understanding of

its advantages and disadvantages. It is anticipated that with this knowledge, the most appropriate decisions will be made according to individual need and context.

This chapter attempted to identify the various issues concerning outsourcing as they have occurred internationally, nationally or locally. This examination has demonstrated the differences between those who espouse the benefits of outsourcing and those who are diametrically opposed to any form of transfer of public sector services to the private sector despite the rationale. The experiences described in this literature review provide a reference point when examining the situation and considerations of various Western Australian HCMs so that similarities and differences may be isolated.

CHAPTER 3: METHODOLOGY

Introduction

The purpose of this chapter is to describe the methods, procedures and instruments used to conduct this research.

Research Design

A descriptive research design was used by “the researcher to describe meaningfully a set of data” (Gay & Diehl, 1992: 462). Questionnaire and follow up interviews of a sample of respondents were used. This design was deemed appropriate as

- 1) a paucity of knowledge and research into this problem exists
- 2) individuals, groups and processes are involved
- 3) the conceptual framework of this problem is lacking
- 4) practical application in addressing problems requires clarification
- 5) theoretical model development is required

(Burns & Grove, 1987; Polit & Hungler, 1991).

The descriptive research method is also appropriate here as it allows business and management problems to be fully examined through “the assessment of attitudes, opinions, demographic information, conditions, and procedures” (Gay & Diehl,

1992:235). Well conducted interviews are recognised as producing in-depth data not always possible with a questionnaire. Interviews allow a greater degree of flexibility and the interviewer is able to adapt with each situation and individual interviewee. Rapport and trust can also be established and participants may be more willing to provide richer and more meaningful data which they would not give on a questionnaire. Accurate and more honest responses are more likely to be provided during an interview. The researcher is also given the opportunity to clarify and explore questionnaire responses with participants (Gay & Diehl, 1992).

Target population and Sample

The target population was the General Managers/Health Service Managers of Western Australian hospitals who were sent a coded questionnaire and asked about the situation in respect to the outsourcing of health services within their facilities. These managers were chosen because they were the people directly or indirectly responsible for outsourcing services in their respective hospitals. In this role, they were also responsible for managing the emerging industrial and human resource issues.

The coding was necessary for the researcher to determine who would be willing to participate in the follow-up interviews as well as being able to gather information on possible differences between the metropolitan and rural settings.

ACHS accreditation status was determined. This information was necessary to ascertain if differences occurred between accredited and non-accredited hospitals and whether ACHS standards was seen as having any application in the outsourcing process. Similarly, private and public hospital (teaching and non-teaching) HCMs were invited to participate.

General objectives

To determine the extent to which Western Australian hospitals outsource their services.

To determine what services are outsourced and why.

To determine the outcomes of the outsourced service(s).

To determine the issues individual managers perceive as impacting on their health care agencies resulting from services being outsourced.

To determine if there were differences between groups, eg rural versus metropolitan hospitals.

Demographic information elicited was the postcode of the area, number of funded beds, number of FTE, ACHS status and years ACHS accreditation had been maintained if applicable. HCMs were also asked to specify their title eg Director of

Nursing, General Manager, Health Service Manager. Gender and ethnicity were not isolated.

Follow up semi-structured interviews with a sample of the group (country and metropolitan representatives) were conducted. The purpose of the interviews was to enhance the quality of data gathered via the questionnaires by allowing the researcher to clarify responses with the HCMs. It was also envisaged that the interview would allow the HCMs greater freedom to explore their concerns and experiences where the questionnaire did not permit.

Questions were constructed from the above research questions with questionnaire responses in mind. Managers were asked to what extent they outsource their services and why these services were chosen. If any performance indicators were used in evaluating the standard of the outsourced service, these were also explored. Specific experiences with contractors or the process of outsourcing were examined. Other information elicited through the interview process will provide the basis for further research in the area of quality assurance.

The information gathered provides a data base for hospitals currently examining the feasibility of either entering into or extending their current outsourcing practices. The ACHS will also benefit from this research as it will provide the council with a

further opportunity of meeting the needs of their customers, namely the health care facilities and the personnel they survey.

Ethical considerations

Following approval from the Committee for the Conduct of Ethical Research at Edith Cowan University, each General Manager or Health Service Manager (the title depends on the health service) were forwarded a questionnaire. Subjects were informed of the research by an accompanying letter assuring them of total confidentiality and their right to choose not to participate at any time. Consent was implied with the completion and return of the questionnaire.

To ensure and maintain confidentiality, the coding system used was only known to the researcher and all data was securely stored. Following the completion of the research, all data sheets, interview sheets and questionnaire forms will be destroyed. Records which are required to be preserved for a minimum of five (5) years will be stored on computer disk and be in the possession of the researcher.

Instrument

Data for this research were obtained with the employment of a questionnaire devised by the researcher. A detailed literature search failed to reveal the existence of an

appropriate research instrument specifically related to this area. The questionnaire was developed by the researcher based on the claims of both advantages and disadvantages of outsourcing made in the literature (Kanter, 1984; Bernstein, 1991; Mark, 1994; Minoli, 1995) (See Appendix).

A combination of open-ended questions and Likert scales was used. The categories used in the Likert scales related directly back to the literature dealing with both proposed advantages and disadvantages of outsourcing. The data gathered from the Likert scaled questions enabled the researcher to determine any statistical significance or differences between the various groups. Open-ended questions provided respondents with the opportunity to describe their experiences and feelings relating to outsourcing. The information gathered from these questions provided a basis for questions to be used during subsequent interviews with designated HCMs.

Questions 1 to 3 gathered demographic information, the HCM's position in the hospital, the type of hospital as well as ACHS accreditation status. Questions 4 to 6 determined what services, if any, had been outsourced, the rationale for the outsourcing decision and the outcomes. Question 5 asked HCMs to rate using a Likert scale (1 to 5, where 1= "not important" to 5= "very important") the specific factors behind the decision and the importance they as HCMs placed on each factor. These factors were taken directly from the literature concerning the advantages of outsourcing.

Questions 7 and 8 asked HCMs what services, if any, were likely to be outsourced in the future and the reasons behind the decision. The same Likert scale used in Question 5 was used in Question 8. Question 9 asked HCMs to select from a list of services those they thought should not be outsourced. They were also provided with a comments column beside each of the services. This list of services was constructed based on those services currently being targeted by the government reforms as well as other services considered “core” such as nursing.

In Question 10 the researcher constructed a list of disadvantages or problems associated with outsourcing as stated in the literature. The HCMs were then asked to select reasons and the importance of each from this list why they thought the services they had selected in the previous question should not be outsourced. This question was constructed using a Likert scale as in previous questions. Question 11 asked HCMs what advantages they saw in outsourcing and how important each advantages was to them. The Likert scale used in Questions 5 and 8 was repeated here.

Question 12, using the Likert scale from Question 10, asked HCMs to rate what they saw as disadvantages of outsourcing together with how important each of these disadvantages were. Question 13 asked HCMs how appropriate they thought the ACHS indicators would be in the assessment of contractors’ performance by indicating on a scale of 1 to 5, with 1 = not appropriate and 5 = totally appropriate. The HCMs were also asked to give reasons to substantiate their answer. Included in

this question was a statement “ I have no idea of how appropriate ACHS indicators would be in this case” which HCMs could tick. This was seen as particularly important to include given that not all surveyed hospitals are accredited with the ACHS .

The remaining questions (14 to 20) were open-ended asking respondents what they saw as some of the issues facing HCMs when dealing with contractors. They were also asked what had been some of their own experiences dealing with contractors. In this group of questions, HCMs were asked to identify services in which savings could and could not be made. The person responsible for managing the contracts in their hospitals was also determined together with what percentage of management time was being spent in managing contracts and contractors.

Instrument Reliability

A pilot study was conducted prior to this research commencing in order to establish the reliability of the questionnaire. Eight HCMs known to the researcher and representative of the same group in the main research completed the questionnaire. Three weeks later, this same group again completed the questionnaire. Test-retest reliability using Pearson’s product moment correlation co-efficient with values of $r = 0.981$ to 0.992 from amongst the groups was established.

Statistical techniques

A number of statistical techniques were considered. Means, standard deviations and variance scores were obtained for the group as a whole as well as for individual sub-groups. The emphasis in this research is on individual management considerations and experiences with outsourcing of services in the health industry. Where appropriate, verbatim quotations have been provided in an attempt to illustrate the range of issues and concerns facing these HCMs. *T*-tests were conducted to determine if differences existed between rural and metropolitan HCMs' responses for all categories.

Limitations of the study

The cost of interviewing all health service managers in Western Australia would be prohibitive as well as the time required and the distance involved in travelling to the north-west area of the state. This limitation precludes involvement by remote area managers other than completing a questionnaire and/or participating in a telephone interview with the researcher. The direct, one-to one interview technique is noted for allowing the researcher to ask questions that cannot be answered adequately by the questionnaire, such as personal questions. It provides a certain degree of flexibility and allows the interviewer to pick up on points raised by the interviewee, thus adapting the situation to each subject (Gay & Diehl, 1992).

Conclusion

This chapter has outlined the research design of this study. Data collection, analysis and procedures have been outlined. Data analyses and quotations from the interviews conducted are discussed in the next chapter.

CHAPTER 4: RESULTS AND DATA ANALYSIS

Introduction

All Western Australian public hospitals were included in the research with ten randomly selected private hospitals being included. The total number of facilities surveyed was seventy (n=70). Thirty nine hospitals returned a completed questionnaire which indicates a 56% return rate.

Five HCMs contacted the researcher to state that they would be unable to participate for a variety of reasons, some of which were “because the issue is too hot... it’s too contentious an issue ... I don’t want this sort of information getting into the wrong hands... I don’t want anyone to know that I was responsible for giving you any information which may be used against me at a later date... what if the workers found out that I thought like that?”

Question 1: % Rural vs metropolitan respondents

Respondents were asked for the postcode of their area. This allowed the researcher to identify whether the hospital was from a rural or metropolitan area. This is confidential information used only by the researcher and is not indicated anywhere in this study. Rural hospital respondents (n=26, 66.6%) outnumbered their metropolitan counterparts (n=13, 33.4%) (Figure 2).

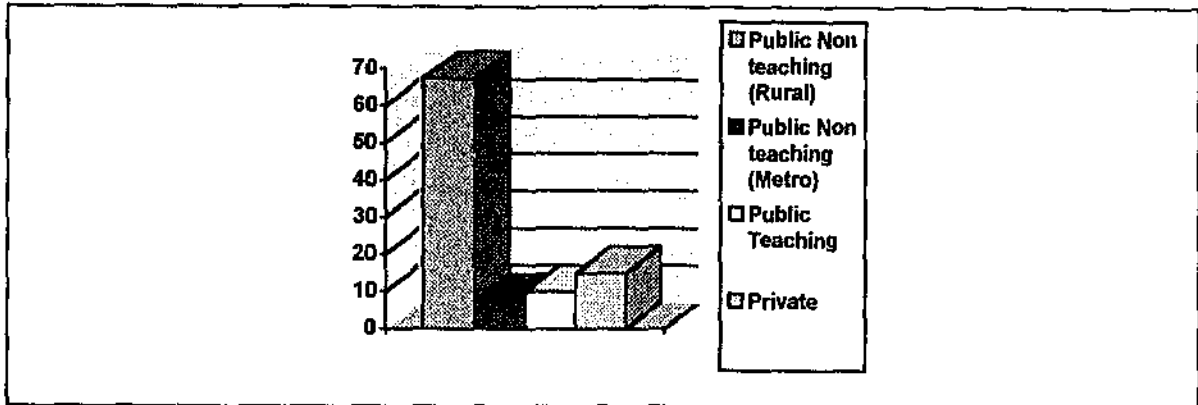


Figure 3: Percentage of respondents: Rural versus metropolitan and type of hospital (teaching versus non teaching, private versus public)

The majority of respondents were from rural health care settings with a bed status range of 8 to 100 (n=22, 56%)(Figure 4).

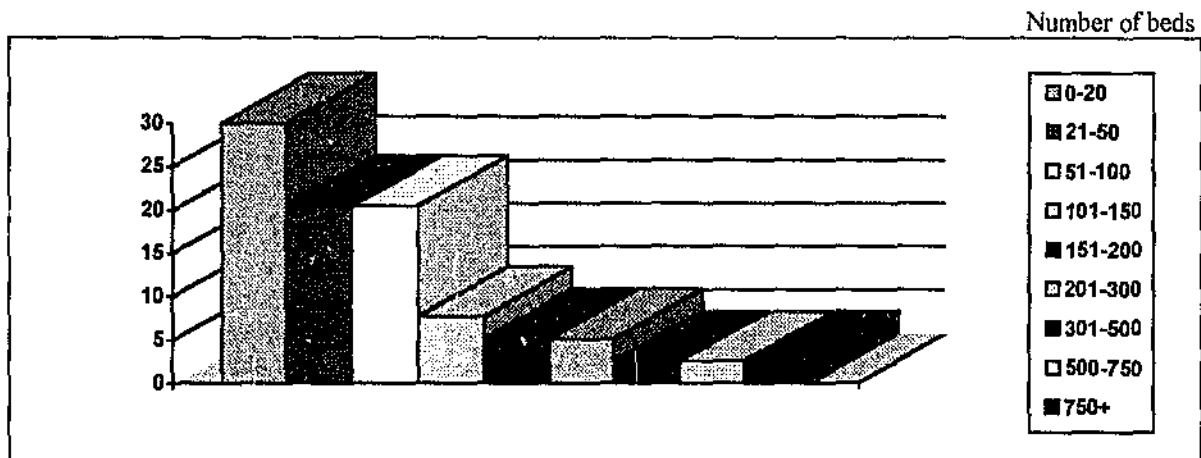


Figure 4: Percentage of respondents by number of beds

Question 3: ACHS accreditation status of hospital

41% of the group (n=16) had current ACHS accreditation. Those that were still awaiting results of a recent survey were not included in this calculation (n=3). Eight of the rural hospitals were accredited with the ACHS compared to seven of the

metropolitan group. Of the metropolitan group, three of the six private hospitals were ACHS accredited (Figure 5).

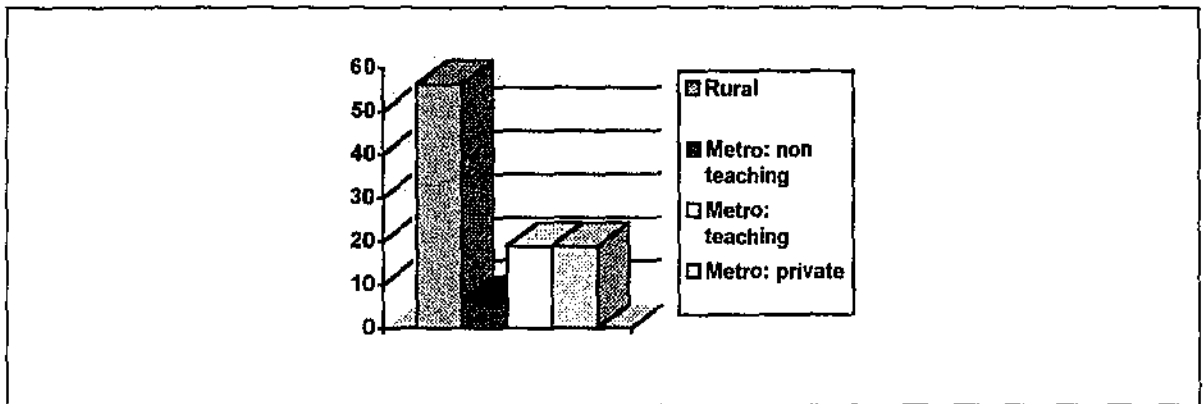


Figure 5: ACHS Accredited hospitals in survey

Question 4: Currently outsourced services

Table 3 indicates the range and frequency of services identified by respondents as being outsourced at the time of the survey. It should be noted that none of the respondents identified catering services. This may be due to the fact that whilst a number of hospitals were seriously considering outsourcing the catering sections of their hospital, final implementation was yet to take place.

←Service→

Hospital ↓	1	2	3	4	5	6	7	8	9	10	11	12	13
M(P)		✓				✓				✓		✓	
M(P)		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
M(P)						✓							
M(P)		✓				✓							✓
M(P)		✓	✓	✓	✓	✓						✓	✓
M(P)				✓	✓	✓				✓	✓	✓	
Rural				✓									
Rural		✓	✓	✓		✓							
Rural		✓	✓			✓			✓		✓	✓	
Rural						✓							
Rural						✓							
Rural				✓						✓	✓		
Rural						✓							
Rural			✓					✓					
Rural								✓					
Rural						✓							
Rural				✓						✓			
Rural						✓				✓			
Rural										✓			
P(N/T)					✓								
P(N/T)				✓	✓			✓		✓	✓		
P(N/T)						✓				✓			
P(T)			✓		✓	✓					✓	✓	✓
P(T)			✓	✓	✓	✓							
P(T)			✓	✓	✓				✓		✓		

Table 3: Services currently being outsourced by respondent hospitals.

Service number key

1= Catering

3= Maintenance

5= Security

7= Clerical

9= Cleaning

11=Radiology

13 = Staff Development

2= Engineering

4= Gardening

6= Allied Health

8= Laundry

10=Pathology

12 = Pharmacy

Hospital key

M(P) = Metropolitan private hospital

Rural = Any rural hospital including regional hospitals

P(N/T) = Metropolitan public non-teaching hospitals

P(T) = Metropolitan public teaching hospitals

Table 4 summarises the information from Table 3 and groups the information from the four hospital categories into frequency scores. The total outsourcing frequency for each service is also given. It must be noted that the Allied Health group represents a wide range of services such as Physiotherapy, Occupational Therapy, Psychology, Podiatry, Dietetics, and Speech Pathology. This score (n=16) does not indicate that where a hospital outsources one Allied Health service, it does not necessarily mean that it outsources all other Allied Health services or indeed provide that service in the first place. This was evident particularly with the smaller rural hospitals.

SERVICE	HOSPITAL CATEGORIES				TOTAL
	Metro Teaching	Metro Non-Teaching	Metro Private	Rural	
1. Catering	0	0	0	0	0
2. Engineering	0	0	4	2	6
3. Maintenance	3	0	2	3	8
4. Gardening/grounds	2	1	3	4	10
5. Security	3	2	3	0	8
6. Allied Health	2	1	6	7	16
7. Clerical	0	0	1	0	1
8. Laundry	0	1	1	2	4
9. Cleaning	1	0	1	1	3
10. Pathology	0	2	3	4	9
11. Radiology	2	1	2	3	8
12. Pharmacy	1	0	4	1	6
13. Staff Development	1	0	3	0	4

Table 4 : Frequencies of each outsourced service for each hospital category.

Only one hospital (private) outsourced its clerical services. At the time of survey, none of the teaching hospitals had outsourced its engineering, laundry or pathology services. The private hospitals, as a group, outsourced all services except catering. Fourteen hospitals did not outsource any service at time of survey. Of this group,

thirteen were rural hospitals with the remaining being a metropolitan teaching hospital. Seven HCMs of this group noted on the questionnaire that they had called for tenders to deliver catering and cleaning services, but were still awaiting submissions. Very clearly, “support” services were the main targets for outsourcing and the government’s reforms were slowly coming to fruition.

Question 5: Reasons for outsourcing

Table 5 indicates the overall ratings of importance for the group as well as ratings for rural and metropolitan HCMs. HCMs were asked to rate how important each of these reasons were in making the decision to outsource. A forced Likert scale with a scoring range of 1 to 5 where 1 = “not important” and 5 = “very important” was used. According to the mean scores of the overall group, the two main reasons for outsourcing were to reduce direct costs ($x = 4.31$) and to obtain expertise that was otherwise not available in-house ($x = 3.95$).

The rural HCMs rated their main reasons for outsourcing as cost reduction and secondly flexibility in coping with periods of change. The metropolitan HCMs rated expertise not in-house as their main reason for outsourcing with reduction in direct costs as their second choice.

Reasons for outsourcing	Overall ratings of importance 1= not important 5= very important			Rural HCMs' ratings of importance			Metropolitan HCMs' ratings of importance		
	Mean	SD	Variance	Mean	SD	Variance	Mean	SD	Variance
Reduction in direct costs	4.31	0.74	0.56	4.25	0.86	0.75	4.42	0.53	0.28
Flexibility with change	3.68	1.01	1.02	3.7	1.05	1.12	4.0	0.7	0.5
Enable staff innovation	2.73	0.96	0.92	2.72	0.78	0.61	2.75	1.5	2.25
Enable HCMs to focus on key issues	3.25	1.39	1.93	3.08	1.56	2.44	3.75	0.5	0.25
Expertise not in-house	3.95	1.29	1.67	3.53	1.5	2.26	4.5	0.70	0.5

Table 5 : HCMs ratings of importance of reasons behind outsourcing of current services. Mean scores, standard deviation and variance for total sample, rural and metropolitan HCMs.

An examination of the standard deviation (SD) and variance for the metropolitan group indicated that HCMs in this category were less divided than that of the rural group whose SD and variance scores indicated varying degrees of importance placed on cost reduction or expertise not to be found in-house.

A *t*-test was conducted to examine differences in the means of the rural and metropolitan groups concerning the importance of cost reduction. The result was $t = 0.38$ ($p > 0.05$, $df = 17$) which was not statistically significant. A *t*-test was conducted between the groups' means to examine differences in the area of expertise not being available in-house. A *t* value of 1.90 ($p > 0.05$, $df = 21$) did not indicate a statistically significant difference between group means.

Question 6 : Outcomes of outsourcing

HCMs were asked to identify the outcomes of the outsourced service(s). Table 6 outlines the data obtained and is divided into the four hospital categories as used in previous questions. Verbatim quotations have been used. Each bullet point indicates an individual response and the service(s) to which the comment applies.

Of the group which was currently outsourcing services (n=20), 17 HCMs expressed very positive comments about their experiences to date. Two HCMs made negative comments, one from a private hospital which had outsourced gardening services in the last twelve months and stated that she was not happy with the service. The other HCM from a rural hospital stated that there had been a drop in standards with the outsourcing of pathology and gardening.

The larger hospitals were able to make clear claims of savings such as “20% in economic benefits” and “estimated savings of \$52,000 pa” and their outsourcing ventures were on a much grander scale compared to smaller agencies. The smaller metropolitan hospitals with generally less experience of outsourcing made more general comments, but were relatively happy. Several HCMs stated that a drop in standards had been observed, but that the cost savings made the venture more attractive. All services which had been outsourced or were being targeted could be classified as “support” services which is in keeping with the government’s plan for reform in health care provision.

HOSPITAL CATEGORY	SERVICE (S) OUTSOURCED	→ OUTCOMES
1. Metropolitan Teaching	<ul style="list-style-type: none"> • Maintenance, security • Maintenance, IT, cleaning, couriers, security, waste removal, gardening, staff health clinic, chaplaincy • Gardening • Motor vehicle maintenance • Couriers 	<ul style="list-style-type: none"> → Very happy with service provided. → An average of 20% in economic benefits with a 90% level of effectiveness → Use of partnership approach has assisted in achieving quality outcomes → Fleet management scheme. Savings yet to be identified → Estimated savings of \$52,000 pa
2. Metropolitan Non-teaching	<ul style="list-style-type: none"> • Security, pathology • Pathology, radiology, security 	<ul style="list-style-type: none"> → Expertise not available here, happy with service. → Provision of cost effective service that may otherwise not be available
3. Metropolitan Private	<ul style="list-style-type: none"> • Pathology, radiology, security, laundry • Gardening • Gardening, pathology, pharmacy, security, allied health • Dietetics, management, engineering, pathology, pharmacy, podiatrist • Dietetics, occ therapy, pharmacy, physiotherapy, pathology, radiology, podiatry • Pathology, physiotherapy, pharmacy, radiology 	<ul style="list-style-type: none"> → Relatively happy with service → On the whole, not happy with the results. → We get tremendous service from all these people. → Regular contact and quality work → Happy. Work closely with all areas to ensure satisfaction. → Excellent
4. Rural	<ul style="list-style-type: none"> • Gardening, pathology • All allied health, maintenance, pathology, engineering, pharmacy. • Podiatry • Laundry, radiology • Pharmacy, occ therapy, radiology, engineering, maintenance, podiatry. • Gardening, pathology, radiology • Laundry • Gardening • Podiatry • Speech path, security, psychology, pathology, occ therapy, gardening, dietetics (share with another hosp) 	<ul style="list-style-type: none"> → A drop in standards → Adequate service for small country hospital → Satisfactory level of service provided → Improved standard/quality of linen. Detailed costing of linen used per clinical unit. → Cost savings in pharmacy, improved services in occ therapy, expertise not previously available with others. → Generally speaking, an overall improvement in each area → The final product is much improved - this came about because of change of contractor. → Cheaper, reduced but acceptable quality. → Public unhappy having to pay for a previously free service. Have accepted this now. → Increased availability of services and cost minimization

Table 6 : Outcomes of currently outsourced services in surveyed hospitals.

Question 7: Services to be outsourced in the future

Twenty seven HCMs stated that they would be outsourcing in the future which was a first time venture for some (n = 9) and an extension of an existing activity for the others (n = 18). Nine HCMs stated that they would not be outsourcing in the future with three stating that they were unsure.

This question also asked HCMs to specify which services would be outsourced in the future. Two of the HCMs from the public sector indicated that their hospitals would be managed privately in the near future therefore they were unable to respond. The main areas that were to be outsourced were most of the allied health functions, radiology, pathology, hotel services which includes catering, cleaning and orderly services, engineering, maintenance, and gardens/ grounds maintenance.

Question 8: Reasons for future outsourced services

Table 7 outlines the overall ratings of importance behind the reasons for outsourcing services in the future. Scores for the rural and metropolitan groups are also given.

According to the means, reduction in costs was the main reason for future outsourcing of services. For the metropolitan group, flexibility in coping with

periods of change and expertise not available in-house were the other main reasons for this group.

Reasons for outsourcing in the future	Overall ratings of importance 1= not important 5= very important			Rural HCMs' ratings of importance			Metropolitan HCMs' ratings of importance		
	Mean	SD	Variance	Mean	SD	Variance	Mean	SD	Variance
Reduction in direct costs	4.04	0.85	0.73	3.94	0.93	0.87	4.33	0.51	0.26
Flexibility with change	3.85	1.06	1.12	3.70	1.04	1.09	4.25	0.95	0.91
Enable staff innovation	2.95	1.39	1.94	2.88	1.40	1.98	3.33	1.52	2.33
Enable HCMs to focus on key issues	3.27	1.48	2.20	3.16	1.54	2.38	3.75	1.25	1.58
Expertise not in-house	3.13	1.71	2.93	2.88	1.74	3.04	4.00	1.41	2.00

Table 7 : HCMs ratings of importance of reasons behind outsourcing of services in the future. Mean scores, standard deviation and variance for total sample, rural and metropolitan HCMs.

A *t*-test was conducted to examine differences in the means of the rural and metropolitan groups concerning the importance of cost reduction. The result was $t = 1.00$ ($p > 0.05$, $df = 22$) which was not significantly different. A *t*-test was conducted to determine any differences between the group means concerning the availability of expertise in-house. The *t*-value obtained ($t = 0.392$, $p > 0.05$, $df = 17$) was also not statistically significant. Three HCMs indicated that they had no choice as it was government policy to outsource these services.

Question 9: Services which should not be outsourced

The majority of responses to this question stated that no clinical service should be outsourced. This included nursing ($n = 27$), and allied health services ($n = 7$).

The support services stated were management (n = 14), clerical (n= 12), hotel services (includes orderly, cleaning and catering services, n = 11) and staff development (n = 8). Five HCMs stated that no service should be outsourced, four of these being from rural hospitals with the remaining HCM from a metropolitan private hospital. This was the same HCM who was dissatisfied with the outsourced gardening service at his hospital.

Question 10: Reasons why services should not be outsourced

HCMs were then asked to give their reasons why the services they had outlined should not be outsourced. They were given a list of reasons and asked to rate how important each of the reasons was in them making that decision. A forced Likert scale with a scoring range of 1 to 5 where 1 = “not important” and 5 = “very important” was used. Table 8 outlines the mean, SD and variance scores for the overall group as well as the individual scores for rural and metropolitan categories.

Services which should not be outsourced	Overall ratings of Importance 1= not important 5= very important			Rural HCMs' ratings of Importance			Metropolitan HCMs' ratings of Importance		
	Mean	SD	Variance	Mean	SD	Variance	Mean	SD	Variance
Less control over quality	4.62	0.89	0.79	4.60	0.91	0.83	4.60	0.88	0.78
Lack of continuity of care	4.53	0.90	0.82	4.60	0.91	0.83	4.36	0.92	0.85
Safety concerns	4.25	1.10	1.22	4.20	1.19	1.41	4.36	0.92	0.85
Legal considerations	4.0	1.08	1.17	3.80	1.15	1.33	4.50	0.70	0.50
Financial considerations	3.70	1.27	1.61	3.60	1.37	1.88	4.00	0.92	0.85
Contractors require more supervision than inhouse staff	3.51	1.17	1.38	3.50	1.21	1.47	3.55	1.13	1.27
Contractors lack knowledge of the service	3.83	1.23	1.51	3.88	1.30	1.69	3.72	1.10	1.21
Setting up new systems too costly	3.51	1.25	1.57	3.66	1.23	1.53	3.11	1.26	1.61
Manager will have to spend too much time with contractor	3.44	1.15	1.34	3.50	1.14	1.30	3.30	1.25	1.56

Table 8: Importance of reasons why HCMs do not believe certain services should be outsourced. Mean scores, standard deviation and variance for total sample, rural and metropolitan HCMs.

The three main areas of concern were the first three reasons of the list, these being less control over quality, lack of continuity of care, and safety concerns. Table 9 summarises the *t* values obtained for each of these reasons.

REASON	<i>t</i> value	<i>df</i> (<i>p</i> = 0.05)
Loss of control over quality	0.19	35
Continuity of care	0.27	34
Safety concerns	0.14	36

Table 9: *t* values obtained for reasons not to outsource services in the future

None of these results was statistically significant. A further *t* test was conducted between the means of groups which had had outsourced services. "Safety concerns" was tested and the resulting *t* value was 0.37 ($p > 0.05$, $df = 24$). Whilst this was slightly higher than the overall score, it was still not statistically significant.

Question 11: Advantages of outsourcing

Based on the claims of Mark (1994) and Kanter (1984) concerning the advantages of outsourcing, HCMs were asked how important each of these advantages were to them in making a decision to outsource services. Five HCMs (4 from rural hospitals and 1 from a metropolitan non-teaching hospital) stated that they could not see any advantage whatsoever in outsourcing of health care services.

Rural HCMs did not have any part of their service outsourced at the time of survey. Of particular note, however, was that the metropolitan HCM in this group had already outsourced gardening, pathology, secretarial, and radiological services. The HCM was “generally not happy” with the outcomes of the outsourced services. A forced Likert scale with a scoring range of 1 to 5 where 1 = “not important” and 5 = “very important” was used. Table 10 outlines the mean, SD and variance scores for the overall group as well as the individual scores for rural and metropolitan categories.

Advantage of outsourcing	Overall ratings of importance 1= not important 5= very important			Rural HCMs' ratings of importance			Metropolitan HCMs' ratings of importance		
	Mean	SD	Variance	Mean	SD	Variance	Mean	SD	Variance
Reduction in direct costs	4.17	0.84	0.71	4.05	0.94	0.89	4.44	0.52	0.27
Flexibility with change	3.77	1.06	1.14	3.88	1.18	1.39	3.50	0.75	0.57
Enable staff innovation	3.35	1.19	1.41	3.47	1.17	1.38	3.00	1.26	1.60
Enable HCMs to focus on key issues	3.84	1.14	1.30	3.88	1.07	1.16	3.71	1.38	1.90
Expertise not in-house	3.76	1.43	2.04	3.73	1.36	1.87	3.60	1.61	2.62

Table 10: Advantages of outsourcing and importance of listed reasons to rural and metropolitan HCMs. Mean scores, standard deviation and variance for total sample, rural and metropolitan HCMs.

A *t*-test was conducted for the category "reduction in direct costs" between the mean scores of the rural and metropolitan hospitals. A *t* value of 1.18 ($p > 0.05$, $df = 27$) was not statistically significant.

Question 12: Disadvantages of outsourcing

HCMs were asked to choose from a list those aspects of outsourcing which they saw as disadvantages. This list was compiled from research conducted and quoted in the literature review of this study (Bernstein, 1991; Prest & Prest, 1992; Paddon, 1993; Minoli, 1995). A forced Likert scale with a scoring range of 1 to 5 where 1 = "not important" and 5 = "very important" was used. Table 11 outlines the mean, SD and variance scores for the overall group as well as the individual scores for rural and metropolitan categories.

Disadvantages of outsourcing	Overall ratings of importance 1= not important 5= very important			Rural HCMs' ratings of importance			Metropolitan HCMs' ratings of importance		
	Mean	SD	Variance	Mean	SD	Variance	Mean	SD	Variance
Less control over quality	4.47	0.73	0.54	4.54	0.72	0.51	4.33	0.78	0.60
Lack of continuity of care	4.19	0.85	0.73	4.29	0.85	0.73	4.00	0.85	0.72
Safety concerns	4.13	1.02	1.04	4.30	0.97	0.94	3.62	1.06	1.12
Legal considerations	3.94	1.06	1.12	4.00	1.11	1.23	3.75	1.03	1.07
Financial considerations	3.62	1.29	1.67	3.70	1.26	1.60	3.20	1.48	2.20
Contractors require more supervision than inhouse staff	3.61	1.22	1.51	3.73	1.28	1.65	3.25	1.03	1.07
Contractors lack knowledge of the service	4.06	1.02	1.05	4.13	1.09	1.20	3.90	0.89	0.76
Setting up new systems too costly	3.84	0.96	0.93	3.81	1.00	1.01	3.88	0.92	0.85
Manager will have to spend too much time with contractor	3.66	1.02	1.05	3.63	1.04	1.09	3.75	1.03	1.07

Table 11: Disadvantages of outsourcing according to HCMs and their level of importance.

Mean scores, standard deviation and variance for total sample, rural and metropolitan HCMs.

Quite clearly, the most important issue for the group overall as well as the individual rural and metropolitan categories was the issue of control over quality. The *t*-tests conducted on this issue supported the data by the low *t* value obtained ($t = 1.70$, $p > 0.05$, $df = 29$). The standard deviations also reinforced the observation that HCMs both rural and metropolitan shared very common concerns and consensus existed within each group. High mean scores were also achieved for all groups concerning lack of continuity of care and the contractor's lack of knowledge of the health service.

Question 13: ACHS indicators and contractors' performance

HCMs were asked to rate on a forced Likert scale the appropriateness of the ACHS indicators in measuring the performance of contractors. Table 12 demonstrates the differences found in responses with raw score being quoted. HCMs were also able to tick a box which stated "I have no idea how appropriate ACHS indicators would be in this case".

HOSPITAL CATEGORY				
	Metro Teaching	Metro Non-teaching	Private	Rural
ACHS Accreditation status				
Accredited	1, 2, 2	1	2, 4, 4	2, 3, 3, 4, 5, 5 "No idea" x 4
Not accredited	1	1, 5	4 "No idea" x 2	2, 3, 3, 4, 4, 4, 5, 5, 5, 5, 5 "No idea" x 3

Table 12: HCMs' views on appropriateness of ACHS indicators in measuring contractors' performance.

The results range from HCMs having no idea of the appropriateness of ACHS indicators in measuring the performance of contractors, ACHS being totally inappropriate to being totally appropriate, regardless of ACHS accreditation status. Because the majority of scores was received from the rural areas, a *t* test was conducted to determine any statistical significance between the accredited and not accredited groups. The resultant *t* value was 4.16 ($p > 0.05$, $df = 16$) which was statistically significant even at $p > 0.001$ level. A number of factors which could have attributed to this will now be discussed.

It may be that non-accredited hospitals have not had the opportunity to examine the ACHS indicators at any depth. This does not explain, however, the range of answers gathered from the accredited group, particularly the four HCMs who had no idea of the appropriateness of ACHS indicators. The standard deviation for this group was 1.21 with a variance of 1.46. One theory may be that these HCMs whilst having an excellent working knowledge of the ACHS process within their environment, may not have had the opportunity or education in the evaluating contractors' performance.

Eight HCMs stated that national standards and the application of benchmarking principles were the most appropriate way of evaluating contractors' performance and achieving consistency. ISO standards was mentioned by one HCM as being worthy of greater investigation. Another HCM from an accredited facility who rated ACHS

indicators as totally appropriate in measuring contractors' performance qualified her response with this comment:

"A national standard to benchmark the activity/ quality of various contracted services would be essential in ensuring some continuity of service delivery".

Other supporting comments for ACHS indicators were:

- ***"They are a national comparable measure."***
- ***"If covered in the contract then they are appropriate, but too many contractors do not consider themselves obliged to comply."***
- ***"I agree, but I'm not sure how closely standards would be able to be monitored effectively."***

HCMs from accredited facilities who did not see the ACHS indicators as appropriate gave the following reasons for their responses:

- ***"It would be critical to measure the performance of all contractors to ensure the "risk management" is minimised. The present ACHS indicators have far too many variables affecting them. Contractor performance would only be one of these."***
- ***"ACHS indicators principally relate to clinical services. The areas we are considering to contract out are non-clinical only."***

- *I don't think ACHS indicators apply appropriately to the areas for outsourcing.*

Question 14: Issues facing HCMs dealing with contractors

In Question 6, the majority of the group had expressed positive outcomes with their outsourced services. Responses to this question are divided into those HCMs with experience in dealing with contractors and outsourcing and those HCMs without experience. This has been done to draw a definition between actual and perceived issues and concerns.

Tables 13 and 14 have been constructed using the categories of quality, cost, industrial/HR issues, contract management/legal issues, safety, confidentiality and finally individualised service. These are the main issues emerging from the literature which is mainly from the United States and Great Britain. The researcher wished to ascertain if similar issues were being faced by Western Australian HCMs. Table 13 shows the responses of those HCMs with outsourcing experience whereas Table 14 is the responses made by HCMs who have had no experience with outsourcing but they perceive may be problems with contractors and outsourcing of services.

In all areas, those concerns of HCMs without experience in outsourcing had been the experience of those HCMs with outsourcing experience. The main areas were

quality of service, contract management, industrial conflict and individualised service.

ISSUE	FREQUENCY (n=20)	COMMENTS
Quality	8	<ul style="list-style-type: none"> Maintaining and monitoring quality. Compliance with organisational standards. Lower quality. Lack of control over quality. Unreliability and poor time management.
Cost	4	<ul style="list-style-type: none"> Low cost initially then higher cost later. Profit motive is paramount.
Industrial/HR issues	7	<ul style="list-style-type: none"> Dealing with unions. Cost of strikes. Union opposition. Redeployment of staff. Staff morale. Selling it to staff. Ability of industry to cope. Delineation of tasks. Communication between contracted staff and hospital staff.
Contract management /legal issues	13	<ul style="list-style-type: none"> Negligence. Larger hospitals have staff to do this, smaller hospitals don't. Lack of experience managing contracts. Time required to finalise contracts and monitor service. Poor tender specification. Inadequate contract documents covering all aspects of specified role. Accountability. Having to deal with too many people.
Safety	4	<ul style="list-style-type: none"> Unsafe practice. Cutting corners.
Confidentiality	3	<ul style="list-style-type: none"> Lack of control of what information they share about the hospital.
Individualised service	7	<ul style="list-style-type: none"> Lack of commitment. Lack of loyalty. Inflexibility and unable to change with hospital needs eg special dietary needs. Not aware of the full requirement of the service. Insufficient local knowledge of patients and community. Contractors not there when you want them. Lack of immediate response. Obtaining 24 hour service, 7 days/week.

Table 13: Issues facing HCMs *with outsourcing experience*

Only one HCM in the group without outsourcing experience cited “safety” as a concern. In the group with outsourcing experience “safety” had been a concern for 4 HCMs with contractors being accused of “unsafe practice... cutting corners”.

ISSUE	FREQUENCY (n=15)	COMMENTS
Quality	3	<ul style="list-style-type: none"> Quality of care. Control and maintaining of standards.
Cost	1	<ul style="list-style-type: none">
Industrial/HR issues	6	<ul style="list-style-type: none"> Grievance procedures. Line management. Performance management. Low morale of staff and community. Establish clear lines of communication. Staff redundancies. Lack of historical knowledge, sense of belonging and ownership. Creating “team approach” using contractors. Motivation / team spirit on the unit.
Contract management /legal issues	12	<ul style="list-style-type: none"> Increased work load. Contracts need to cover quality issues and performance indicators. Developing risk management strategies. Just getting the tender document right in the first place. Lack of knowledge and contract management skills. Supervision of contractors. “Fly by night” contractors from the metro with no local commitment.
Safety	1	<ul style="list-style-type: none"> Infection control.
Confidentiality	1	<ul style="list-style-type: none"> How much information will they need to have?
Individualised service	5	<ul style="list-style-type: none"> Insufficient local knowledge of patients and community. Lack of good contractors in rural areas. Lack of knowledge of hospital functions and needs. Round the clock service required. Inappropriate times when work is carried out.

Table 14: Perceived issues facing HCMs without outsourcing experience

Question 15: Individual experiences

HCMs were given the opportunity to describe their own experiences with the outsourcing process and contractors. Table 15 outlines HCMs' responses to Question 6 on the outcomes of the outsourced services for their hospitals together with their responses to Question 15.

The responses of those HCMs who have given contradictory information have been placed in *italics*. There may a number of reasons why these responses were given. It is possible that some HCMs gave responses they thought the researcher wanted to hear and following exposure to the following questions in the questionnaire, these HCMs may have been influenced by the list of possible advantages and disadvantages in the subsequent questions. This phenomenon was not noted in the pilot study period.

The researcher explored this phenomenon with a number of HCMs during the interviews. They supported the view of the researcher that in the early stages of the questionnaire, respondents may have been giving answers they thought they should be giving rather than what they really thought or had actually experienced. Another HCM suggested that respondents may have been reticent to provide information which may have been used against them at a later date despite reassurances from the researcher concerning confidentiality and anonymity.

Response to Question 6	Response to Question 15
Public not too happy paying for a previously free service, but have accepted it now.	Have had no particular problems apart from implementing Quality Activities
Vehicles are maintained under Fleet Management Scheme negating need for mechanics. Savings yet to be identified. Regular courier services were contracted providing estimated savings of \$52,000 pa	Ensuring the contractor achieves the standard of service specified. Maintaining a satisfactory standard.
<i>We get tremendous service from all these people</i>	<i>Sloppy work with certain contractors</i>
<i>Some cost savings, improved services and expertise available.</i>	<i>Poor quality work, high costs, failure to respond to items needing attention, sticking rigidly to the words in the contract, not abiding by contracts, cutting corners.</i>
An average 20% in economic benefits with a 90% level of effectiveness.	HR issues, dealing sensitively with in-house staff and redeployment.
Improved standard/quality of linen. Detailed costing of linen used per clinical unit.	No problems with current contracts.
With laundry services, final product and service much improved.	So far contractors have been very helpful and professional.
<i>Generally speaking an overall improvement in each area of outsourcing.</i>	<i>Resources not being returned as laid down in contract. Time frames not always being adhered to.</i>
Very satisfied with service provided.	Limited experience, however when I have it has been satisfactory.
<i>Relatively happy with service for pathology, radiology, security and laundry. With gardening, I am not happy with the results.</i>	<i>Contractors over commit their organisations using minimum staff to do maximum contracts, therefore may look good when they have 20 major contracts as a selling pitch. This states nothing of the quality of their work.</i>
<i>Regular contact and quality work.</i>	<i>Non-compliance and variance in quotes.</i>

Table 15: Comparison of HCMs' responses to outcomes of outsourced service versus their experience with contractors.

Question 16: Areas of savings and no savings

HCMs were asked for their opinions on where savings could be made and could not be made. Table 16 presents verbatim quotations from the HCMs. Very clearly, direct clinical care such as nursing was targeted as having no further savings to be made. Other support services, but still considered clinical, such as allied health were also mentioned as not having any further savings to be made.

The majority of the group targeted the non-core, non-clinical services such as grounds maintenance, catering, engineering, and cleaning as areas where savings could be made. There were, however, a number of HCMs who did not think that savings could be made in these areas. These HCMs were all working in rural areas.

There were a number of HCMs (n=8) who all mentioned the option of applying benchmarking principles in rural areas and not imposing what one HCM described as “metropolitan business nonsense” to the rural setting. This supports the claim of Rimmer (1994) that geographically isolated communities may not be able to benefit from outsourcing simply because they do not have the resources within the community to draw from and/or the community is so isolated that costs to provide the service by a contractor would be prohibitive for both contractor and health service.

SERVICE	SAVINGS Frequency	COMMENTS	NO SAVINGS Frequency	COMMENTS
Cleaning	12	• Would be only marginal	3	• Useless concept for country hospitals
Gardening	5			•
Laundry	2			•
Nursing	0		6	• Clinical areas should not be touched. Need to pursue a quality focus.
HR Management	2	• Mainly in areas of salaries, FTE, on costs for full time employees eg housing, vehicles, superannuation. More flexibility/service driven rosters.	6	• I can't see contractors putting up with what we do in the country.
Radiology	1	• Need to be able to charge private patients.		
Clerical	3		5	
Engineering/maintenance	6		4	• Profit goes to contractors
Catering	2	• But keep it in house.	5	• Ridiculous for country hospitals.
Medical equipment / servicing	1	• Tighter reins need on medical staff spending. Greater care needed when handling equipment.	1	• Cheaper products often breakdown. More costly in long run
Waste disposal	1	• Use of single items, packaging, greater recycling.		
Allied health		• Marginal	7	
Information systems	1	• Who can keep up?		

Table 16: HCMs recommendations for areas where savings can and cannot be made.

Question 17: Person responsible for contract management

The responses to this question are presented in Table 17.

HOSPITAL CATEGORY				
	Metro Teaching	Metro Non-teaching	Private	Rural
Respondent				✓✓✓✓✓✓
Contract Manager	✓	✓		✓
HSM/ General Manager		✓✓	✓✓✓✓	✓✓✓✓✓✓✓✓
Other (specified)	<ul style="list-style-type: none"> • Head of Dept • Manager Corp Services • Head of Dept with CTC Committee 	<ul style="list-style-type: none"> • Off site manager 	<ul style="list-style-type: none"> • Engineer • Unit manager 	<ul style="list-style-type: none"> • Business manager • Head of Dept • HRM & Finance manager

Table 17 : Position responsible for managing contracts at hospitals

There were eight different position titles given. The rural Health Service Manager (HSM) is a combined role of Director of Nursing and Administrator. For the smaller country hospitals, the HSM who was in most cases the respondent, would be handling the contracts. For the larger country hospitals, such as the regional centres, Heads of Departments or Business Managers would be handling contracting issues directly.

Five rural HCMs outlined problems with their level of contractual knowledge and the ability to cope with this additional duty, hence, their degree of uncertainty and negativity in the preceding questions when asked what issues faced them. Only one hospital specified that it had a contract manager to deal with all contract details.

Five of the respondents stated that a new position would have to be created to deal

with contractors and contract management. All these respondents stated throughout the questionnaire that additional costs would occur. This fact supports the claims of Bernstein, (1991); Prest & Prest, (1992); Griffin, (1993); Paddon, (1993); and Brown, (1994) that costs were often much higher than originally anticipated and were often too burdensome particularly for smaller facilities.

Given that it is claimed that contracts in the public sector are maintained anywhere up to three times longer than those in the private sector, contract management is an essential consideration for all health care units regardless of their size (Nahan and Rutherford, 1993). HCMs in this study indicated that they saw spending too much time with contractors as a major disadvantage of outsourcing. Given that they also stated that contractors lack of knowledge about the functioning of the hospital was a real problem, this time they need to spend with contractors may be unavoidable.

The majority of HCMs from the public hospitals had had limited experience with contractors and may be experiencing problems which were experienced by private HCMs in the earlier stages of their outsourcing ventures. Larger facilities such as teaching hospitals had appointed or were in the process of appointing a specific person to administer the contract management arrangements. Smaller hospitals, particularly those in the country, saw that contract management became an additional duty of their current position. Financial statements and annual reports were not available from all hospitals, therefore it was difficult to make any

judgement as to the cost savings made and whether one group was faring better than another. At time of survey, a number of the hospitals were about to embark on outsourcing or were in the first months of having outsourced a service, and they stated that they were unable to determine any potential long-term benefits or problems. This would support the claims of Zampetakis (1993) that projecting long term cost savings and benefits from data gathered over a short period of time is erroneous.

Question 18: % of management time in contract management

HCMs were asked to answer this question by marking along a continuum representing 100% which was divided into quarters each indicating 25% as follows:

0 _____ 25 _____ 50 _____ 75 _____ 100%.

Table 18 summarises the data. 67% of HCMs saw that managers spent up to 25% of their time dealing with contractors, 5% stated that the time spent was between 25 and 50%, 2.5% stated that the time spent was between 50 and 75%, with no one indicating greater than 75% was spent in managing contracts and contractors. 25.5%, however, stated that they did not know how much time would be spent on managing contracts as they had not commenced to contract out services.

The implications for HCMs relate to hidden costs associated with dealing with contractors. The time spent in contract management naturally impinges on time normally devoted to other duties. This in turn will affect subordinate staff who may have their workload increased as duties normally performed by the HCM will be delegated down to them. The creation of a position to handle contract management has inherent benefits, but must be weighed against the organisation's ability to support an additional middle management salary whilst trying to cut or contain costs.

% time managing contracts	% managers
0 -25%	67
25 - 50%	5
50-75%	2.5
75 -100%	0
Don't know	25.5

Table 18: Percentage of managers' time spent with contractors

Metropolitan HCMs : Public versus private

In this debate and particularly in the health industry arena, there have been numerous references to the notion that "private does it better". The private health industry is often quoted as achieving greater efficiency through the adoption of best practice principles (Agenda for Reform, 1993; HDWA, 1993; Gray, 1995). Scores and

responses on questionnaires from the private and public hospitals in the metropolitan area were analysed.

The responses and experiences of private hospitals in the metropolitan area compared to metropolitan public hospitals were different in that they had had more experience with outsourcing and were generally more satisfied with the service they received than were their public hospital counterparts. This may be due to the fact that unsatisfactory service and contracts had been terminated and the private HCMs now had greater experience in predicting and resolving conflicts or problems with contractors' work.

Much of what Gray (1995) cited about Alain Enthoven's analysis of the British NHS applies to the Western Australian system. Without any doubt, the Western Australian hospital system is in a *gridlock* with the existing strict government cash limits on health expenditure. Many senior medical staff often have continually extended contracts giving them a high degree of professional autonomy with little or no focus on the quality or the cost of the service they provide. In many of the departmental (non-teaching) hospitals, general practitioners are essentially independent contractors with high levels of autonomy.

Similar issues about *inefficiency* and *overcentralization* have existed in most Western Australian hospitals. As all hospital personnel adjust to the different

demands of changing clinical practice, such as the increase of same day surgery numbers, together with the changing labour relations such as workplace agreements and contracted services, much of what Enthoven observed in 1985 is slowly decreasing in prevalence in some Western Australian hospitals. There must be, however, a continued commitment by the funding authorities to provide the means for individual hospitals to effect reform and improve services.

Of the remaining categories described by Enthoven, *poor information systems*, warrants discussion as it applies to the Western Australian public health system. It is well recognised by those in the health industry that the lack of timely, correct information impedes effective decision making and ultimately affects health care delivery. Delays in obtaining information not only inconvenience the patient and hospital staff, but also indirectly raise costs. Storage of information, such as medical records, has always been problematic in terms of the sheer volume of information.

Legislative requirements necessitate the appropriate storage of information as well as the maintenance of patient confidentiality. The HDWA has recently embarked on implementing a new information system throughout the public health care system which is currently on trial in several hospitals in Perth. The HDWA has been criticised for its numerous attempts at implementing information systems which have resulted in "an expensive history of failures involving computer driven management

systems” (Agenda for Reform, 1993:xxxiii). These failures have been “bailed out” by the Western Australian taxpayer.

The private health industry would never have been able to support such a history. Indeed, it would have brought about its demise. Because the private health industry’s survival pivots on sound financial management and extensive research, it would never have embarked on some of the more questionable projects as did the HDWA.

The final category, *unresponsiveness*, is still very common in the public health system. There are still very long waiting times at outpatient and emergency departments. It is not uncommon for some patients to wait several hours only to find that the clinic is overbooked and that they will have to return at another time. There have been efforts to redirect these patients back to their local general practitioner, but these are being increasingly hampered by less doctors wishing to bulk-bill and patients being unable to fund the gap between scheduled fees and the doctor’s own fee schedule.

Private health insurance companies are constantly searching for ways to make private health cover more attractive so that they can not only attract more customers, but also retain their existing clientele. One of the major factors behind so many people “opting out” of private insurance is the expense of the premiums as well as

the fact that if one's condition is that serious, medical attention will be provided in a public hospital.

Policy change: Country Hospital Services Policy

During the course of this research and following the collection of questionnaires from respondents, the Health Department of Western Australia issued a policy statement governing CTC in country hospitals (HDWA,1996). This document had a major impact on this study and subsequent interviews with HCMs from the country areas. The policy formally recognised the need “to take account of the diverse situations involved in public service delivery” (p1).

Benchmarking was proposed as possibly the most appropriate means of achieving productivity in rural settings. The policy's objectives also recognised and reinforced the following presuppositions:

- Government remains accountable for service provision
- Examine the private sector market and replace services where better options are available
- Redirect productivity gains back into direct health care service delivery for country communities
- Risk assessment of outsourced non-core services, existing and proposed, to ensure a secure, reliable service delivery
- No export of jobs from country to metropolitan areas
- Encouragement of business opportunities for the local community and employee buyouts.

With benchmarking, it was recognised that smaller communities had limited opportunities and necessity to outsource services. This is supported by Rimmer (1994) as quoted in the literature review of this study (p 34). Responses from rural HCMs after the release of this document may be found in the following section which summarises the interviews with a sample of HCMs from both metropolitan and rural hospitals

This policy statement requires a detailed analysis as it addresses many of the issues and concerns rural HCMs noted in their questionnaire responses. The Operational Development Unit issued this policy in January 1996. Several rural HCMs stated that they were not aware of the document for several weeks later. It came to the notice of the researcher as follow-up interviews were being conducted at the end of February and early March, 1996 and therefore was not included in the original literature review. It is of sufficient importance to qualify for individual attention.

The policy presents rural HCMs with two “strategies for ensuring cost effectiveness”, these being firstly, CTC (Competitive Tendering and Contracting) and secondly, benchmarking (Appendix 2). With CTC, HCMs were referred to the HDWA Contracting Out Manual (October 1995) guidelines which were stated as

- identification of CTC opportunities
- activity definition, including Statement of Requirements
- identification of options for (continued) in house provision, in accordance with the Statement of Requirements
- cost current in house provision in accordance with Treasury Costing Guidelines

- issue an Expression of Interest
- evaluation of the external option, any management buyout option and the status quo
- management decision
- implementation

The policy document stated that the incentive for CTC implementation was “cost savings and quality improvement”. This claim was based on the argument that individual health care units would be able to redirect the savings they had made back into the community and thus improve community health services. This, it was claimed, would support the government’s policy of improving the health care services in rural areas.

The document outlined the HDWA requirements of rural General Managers and Chairpersons of boards of management to provide details of their CTC plans as “considerable tender evaluation needs to be in progress by early 1996”. In the cases where benchmarking had been adopted,

“that process needs to be activated with a similar sense of urgency. It is intended that significant results will be achieved by 30 June 1996 using this strategy” (1996: 3).

Country HCMs were directed to “make an objective assessment of the available options - CTC, benchmarking or a combination of both” (Appendix 2). CTC was stated appropriate for larger rural centres such as Albany, Bunbury, Geraldton, Kalgoorlie and Mandurah as these areas were considered to “have private sector

market potential for a range of non core services” (Appendix 2). Hospitals failing to institute either of the options “within a reasonable timeframe” (not specified) would face an inevitable “reduction in budget to compensate for productivity gains foregone” (Appendix 2). A copy of the Process for CTC and Benchmarking may be found in the Appendices section of this study.

Interviews with rural and metropolitan HCMs

Interviews were held with four metropolitan and four rural HCMs following the collection and collation of the questionnaires. A list of questions was compiled by the researcher, but these were only used as prompts (Appendix 3). The interviews were semi-structured which enabled the researcher a degree of flexibility if points required clarification or other issues were raised during the course of the interview or had been identified during the analysis of questionnaire responses. This section of the study presents the transcripts of the interviews. Following each question, a summary of the main issues and concerns raised by the HCMs is presented.

All the rural interviews were conducted by telephone and may have affected the quality of the answers gained from personal interviews. All the HCMs interviewed were very cooperative. Two of the four HCMs from the metropolitan area came from public teaching hospitals, with the other two coming from public non-teaching hospitals. The private HCM who had indicated on her questionnaire that she would

be willing to be interviewed was unable to participate due to an extended sick leave period.

Responses have been compiled to correspond with each question and then followed with the HCMs responses. The only means of identification used is the following key: Public teaching hospital: **T**; Public non-teaching hospital: **NT**; and Rural hospital : **R**.

One of the NT HCMs was interviewed on the same day he had officially announced to the staff that the positions in gardening, engineering, orderly, cleaning, linen and catering services were being put out to tender.

1. What has been your experience with outsourcing so far?

NT 1: *Pretty limited. We have had window cleaning and security contracted out for some time. We have progressed tender documents which offer separate contracts for gardens and grounds, orderly and domestic services, catering, and building facilities management (engineering).*

NT 2: *Pretty limited, but the laundry service we have contracted out works well. I am pleased with the way they operate - very customer focussed and extremely reliable.*

T 3: *It is really still in its infancy here. We are in the process of outsourcing our cleaning services with possibly catering and orderly services next on the list. I have found the Treasury Costing Guidelines very restrictive and I don't think it gives us much of an option other than to outsource.*

T 4: *Our experience with contracting out and workplace agreements began in February 1995. If you're going to have to put in lots of education of staff, forget it. It just costs too much. The move to outsource was based on a logical argument. People need to stick to the basics and see the 90/20 equation on paper. That means 90% effectiveness with 20%*

cost savings. Standards have dropped, let's be honest but the standard is still acceptable. We've saved money and we've been able to redirect it back into patient care.

R 1: *We've had no experience.*

R 2: *No experience to date, but we are contracting out laundry and gardening in the next few months.*

R 3: *We have contracted out lots of services as we have needed them. In the country hospital environment, it's feast or famine. Some of our more recent contracts have been with allied health people and the service is quite adequate for a small country hospital.*

R 4: *We outsource a number of services, some are fairly new contracts. We've managed cost savings in pharmacy, the service has improved in occupational therapy, and we now have expertise in other areas such as radiology that we didn't have before. I think it's working well so far.*

ANALYSIS

Experience with outsourcing was generally limited or HCMs had had no experience at all. Those HCMs with outsourcing experience described the level of service as "adequate", "acceptable", "working well", "very customer focussed" and "extremely reliable". Two HCMs described the Treasury Costing Guidelines as very restrictive and placing government hospitals at a disadvantage. Generally, outsourcing is in its infancy particularly in the public sector and data on long term effects are not yet available.

2. Has your opinion changed in any way towards outsourcing since you completed the questionnaire last year? If yes, what has caused this to happen?

NT 1: *I suppose the main problem for me to come to terms with is the HR or people issues here. It has placed a lot of stress on the people here including the management. A recent event was in the _____ department where the workers were offered an enterprise agreement and it looked like that they were going to accept it. Just before signing it, _____ decided that he wasn't interested any longer because he was losing out. He had been getting some sort of bonus related to higher duties which wasn't included under this new agreement. The other workers were furious because if they don't have unanimity the*

agreement doesn't go ahead. He has been completely ostracised by the group. Can't be too pleasant working there at the moment.

NT 2: *Not really, but the government sure seems definite in moving it along. I don't want to sound cynical, but I've been a HCM for nearly 15 years and I've seen ministers come and go with their restructuring and new ideas. I think, though, that this will probably progress much further than the other attempts. I think this government has more of a business mind than the previous government.*

T 3: *There is definitely evidence that it is growing in favour. Here at _____ hospital, the workers involved are predominantly women working part-time to supplement the family income. They come from a variety of ethnic backgrounds and they just can't understand why this is all happening. Some of them have been here for over 20 years. I still think the market is very immature and some of the HR policies of these companies are appalling. One of them pulls people in for 3 hour contracts at a moment's notice. How could anyone survive working like that? The health industry is unique, and there are still companies who don't recognise that and who make quotes without the slightest idea of the business.*

T 4: *Look it had to happen, so all those whingeing about it should put their energies into making it work for them. For too long, the philosophy of the union movement was ingrained here and we couldn't move without their permission. We couldn't get rid of anyone or clean out some of the "nests". On the other hand if a contract fails and I'm sure one big one will, and soon, then the politics will really fly and the unions will be saying "We told you so".*

R 1: *Definitely since the government has seen sense and issued the Country Hospital Services Policy. At least they are listening to the rural health community now and considering other options such as benchmarking. The whole contracting out push by the government for smaller country hospitals should never have happened. It was very disruptive to management/staff relations. The Country Hospital Services Policy has been a very positive step, addressing quite severe workplace unrest. The policy would have probably resulted from enormous pressure by the National Party who initiated a very articulate and effective political campaign against contracting out in country areas.*

R 2: *I must admit I'm relieved that someone is listening to us in the big smoke. With the release of the Country Hospitals Policy we can now at least look at some options other*

than outsourcing everything. I was really concerned about where I was going to find the people to do all this and the legal side of things has eased considerably for me.

R 3: *Not really, although we are breathing a little easier with the new policy about country hospitals. Why did they wait so long before they issued it and put us all through the hoops? It must have cost the taxpayer a fortune putting all the country managers through the training programs about contracting etc.*

R 4: *Not really because as a regional hospital we will still be expected to pursue outsourcing much like the guys in the metro areas. So far, I'm happy with what is happening. I only hope it continues.*

ANALYSIS

The HCM with the most experience of outsourcing was clearly intolerant of delays in getting outsourcing operating as well as union opposition. He described the situation at his hospital prior to contracting out as "terrible... full of union nests... could never get rid of anybody." Generally, the HCMs from the metropolitan hospitals had not changed their opinions since completing the questionnaire, but the impact that the outsourcing process had on human resources issues was becoming clearer. Not only had there been conflict between management and staff, staff members were fighting amongst themselves.

Most of the HCMs were concerned about the human resources issues and the impact that outsourcing was having on the groups least able to defend themselves, such as women from non-English speaking backgrounds. One HCM expressed concern over the way some of the longest serving cleaning staff had been treated by what she described as "being dumped".

The HCMs from the country hospitals had obviously changed their opinions of outsourcing given that the government had changed its approach to outsourcing services in the rural areas with the issue of its document “Process for CTC and benchmarking for rural managers” (Appendix). Regional hospitals in the country sector would still be subject to the outsourcing process and the views were generally positive.

3. Do you believe that performance indicators are an adequate means to ensure a quality service? Are the ACHS indicators appropriate or not?

NT 1: *Specifications should be included in the contract documents. There are pro-forma documents that we have been using. The Health Supply Services branch act as our agents. They print the tender documents and invite tenders from a panel of shortlisted providers. There are timeframes which must be adhered to. The ACHS indicators are far too general and open to interpretation. They are clinically focussed, so I won't rely on them with assessing contractors.*

NT 2: *I would like to think that the ACHS indicators are appropriate, but they're not because they're clinically focussed. I would like to see national standards or benchmarks so we could be on the same wave length.*

T 3: *For clinical areas, they would be fine, but they would have huge problems in the non-clinical areas. Contracts have to be quite specific and don't think ACHS could deal with that. May be we should be looking at other national standards such as ISO.*

T 4: *I have a problem with indicators. If they are imposed people think something is going to happen to them if they fail to reach a certain standard. I like to know what a contractor thinks is an acceptable number of complaints from customers per week. In my mind, I have the number “1”. If they can't answer me on that, then I'm not really interested in them.*

R 1: *I think the ACHS standards are totally appropriate because we need a national standard to benchmark the activity and the quality of the outsourced service and ensure we are getting some continuity of service delivery.*

R 2: *You asked me this in the questionnaire and I still have no idea if they would be appropriate. We definitely need to benchmark and I think this will pull a lot of country hospitals together and provide support for each other.*

R 3: *I'm not sure. We have to benchmark now according to government policy and I guess what works in another country hospital with its contracts will probably be fine for us too.*

R 4: *If the ACHS indicators cover all aspects of contracts, then okay. I'm not sure that they would and I still think that there are contractors who don't consider themselves obliged to comply. Some of them have a funny idea that government agencies have money to burn and will accept any standard dished up to them.*

ANALYSIS

Generally, HCMs did not believe that ACHS indicators would be appropriate in evaluating contractors' performance because the indicators were "clinically focussed". One HCM, who is also an ACHS surveyor, believed that they were entirely appropriate and could be readily adjusted to perform the task. She stated that the framework for the nationally recognised system of evaluation had already been established and should be considered in the context of a contractor's performance and compliance with standards.

4. What do you rate as the most important issue facing managers outsourcing services?

NT 1: *It's imperative that you have a contract manager. There is no way I would consider myself in this current job in any position to be able to handle contract. We will have to compliance test the process and I am expecting loads of complaints especially from people who are really opposed to contracting out and want to see it fail. As I mentioned, we are putting out four services to tender. I think that to achieve some economy of scale, the four of them need to be put together and perhaps look at appointing a Facilities Manager who would handle everything, ie contracts, HR issues etc.*

NT 2: *Loss of control, failure of the contract which could cost us more than we bargained for, inconvenience to staff and patients, medical staff jumping up and down when they don't get what they want, safety issues. We have to trust the contractor to look after his staff and not put them at risk which might put our staff at risk. I'm a little more worried about the safety issues than the financial risks!*

T 3: *Contract management is a big concern. We definitely need a contract manager, someone will soon be appointed, and he or she will need a lot of knowledge not only on legal matters, but also on QA and be able to bridge the gap between unions, workers and management. Safety is a big concern. Sure we have the OSH Act, but I'm not convinced about the safety records of some of these contractors. Government organisations cannot contract out duty of care. There will need to be a "rider" in all contracts which will protect us from shoddy or dangerous work practices. I still lack knowledge in contract management, even though I have been to numerous courses provided by the HDWA.*

T 4: *Contract management is a big issue here. I think it's a deficiency Australia-wide. The bigger the contract, the more lawyers involved and that's what pushes up costs. We still haven't got to the stage of defining outcomes other than cost savings. A contract "falls over" (fails) when there is inadequate supervision, low knowledge level of contracting staff, low staff levels, or the company tendered too low. Often with the big guys, the head office is often in Sydney or Melbourne and the local lads, like the state manager, are not authorised to make big decisions. It results in delays. We also need to include in our contract a negotiation clause where we have the right to veto where a contract is clearly failing to provide the service we need.*

R 1: *Managing contracts I guess and if it was to proceed here, selling it to the local community. Knowledge of contract management in the public sector is sadly lacking. Industrial relations implications are enormous. A real conflict arises out of staff being encouraged for a number of years to be multiskilled and they have achieved this. The next thing we do to them is say "No, we are getting in a contractor". The demarcation lines we got rid of will resurface and this will invariably impact on patient care.*

R 2: *Definitely a lack of knowledge on the contractor's part of just how a hospital like this functions and the impact outsourcing would have on the local community. The local people see this as their hospital and they are very protective and supportive of it. Our hospital is pretty old and I wonder how many contractors would like to work here. My staff*

are pretty amazing and work under lots of pressure and in less favourable conditions than some of our city workers do.

R 3: *The larger hospitals have inbuilt processes and other people to help run the contracting out. The rural hospitals have much less expertise to call on and I really don't have the time to supervise contractors more than I do my regular staff.*

R 4: *Contract management is a big issue for us here. The manager of the area concerned will be responsible for managing contracts affecting his area. There is a steep learning curve for us all. The government has assured us that there is funding available for education of the staff involved, but we are really miles from the metro area and actual physical support other than a telephone conference is really important to me.*

ANALYSIS

The major issues facing HCMs were contract management, what to do if a contract failed, their own knowledge of contract management, safety of contract workers, industrial conflict and for the country hospital HCMs, greater support from the HDWA head office was needed. The appointment of a contract manager was seen as crucial to the success of any outsourcing exercise.

5. Do you believe that there are separate issues facing country managers as opposed to metropolitan health managers?

NT 1: *Outsourcing in a smaller country hospital is just impossible. I've worked there and I can't see any contractor travelling miles just to clean a hospital floor. What sort of profit is in it for them?*

NT 2: *Yes, definitely. I've worked in a couple of country hospitals and I think it's a bloody nonsense to expect this to work in the smaller hospitals. I don't know who advised the government on this, but let's hope his contract isn't being renewed! Why didn't they just ask the country people in the first place?*

T 3: *Country hospitals are often the main employers in a community. I just can't see it working and who will they contract out to? They struggle as it is just getting core staff and keeping them.*

T 4: *They have different problems. Economies of scale for one thing. They have a huge responsibility to the community and provide employment. Their skill base is limited as well and they will have a huge problem with benchmarking as I think there are too many people in the field making decisions.*

The researcher did not ask this question of the rural HCMs as they had already been addressed in preceding questions.

ANALYSIS

All the metropolitan HCMs could not see how outsourcing would work in the rural sector. Those who had worked in country settings were particularly sensitive to the plight of rural managers with the retention of core staff, distance from the metropolitan area as well as a limited skill base from which to draw extra staff as needed. Clearly lack of consultation with the country people was raised as a major issue.

6. What do you see as some of the issues facing health care managers in the future?

NT 1: *Maintaining services within budgetary constraints. It's becoming more and more difficult. Facing complaints from customers as they become more empowered and aware of their rights. Getting medical staff to become more accountable and face their critics.*

NT 2: *The cost of technology, retention of good staff. I would like to have the authority to reward excellent service with appropriate remuneration. I can't as I would have all sorts of people on my back.*

T 3: *Clinical Directorates are radically changing the way in which we manage services. This is meant to address real integration of services, but for some it's an opportunity to set up mini-empires which is really destructive and leads to all sorts of inefficiencies. Health*

is so dynamic and complex. As a group, I think HCMs lack any real focus. I guess some of us have lost the plot and some of us I'm sorry to say have lost the patient.

T 4: *I think nursing will die off... they've specialised themselves into a corner. The dollar is driving medical accountability and there is a lack of government reality. Patient expectations will probably result in all sorts of law suits etc.*

R 1: *For those HCMs who are facing contracting out, ensuring quality of care is given within the contract management scenario will be paramount. Determining how you can still have an integrated workforce when there seems to be so many bosses particularly in day to day operations. Team work will be made more difficult to achieve.*

R 2: *Dealing with further funding cuts and trying to provide an acceptable service to the community. I hope this year's budget will be more promising especially to the rural areas.*

R 3: *The cost of technology worries me. People are expecting more and more that a new piece of machinery will be made available. Some of them have no idea how much it costs to purchase and then maintain the equipment, not to mention the labour costs to run it.*

R 4: *Government policies which are issued without much consultation with key stakeholders.*

ANALYSIS

The primary issues were costs, funding arrangements, technology and the effect these would have on maintaining current services. Achieving a team approach now that contract staff were being employed was seen as being more difficult to sustain and would probably adversely affect continuity of patient care and raise costs.

7. What are some of the issues concerning outsourcing which are facing YOU in the future?

NT 1: *As I mentioned before, funding and potential cuts to services are a worry.*

NT 2: *I think that what I said before applies here. We are going to have to outsource, there is no doubt. I am worried about contract failure and lack of contract management skills, not just for me, but for all management staff.*

T 3: *Cost cutting at the expense of the quality of the service. The people involved when a service is outsourced. I tire very easily with people who can only talk about profit margins. I am conscious of the personal and social issues as well which should be part of the equation.*

T 4 : *I'll be pretty upset if the government turns around and changes its mind. What a waste of energy and money if we go back to what we had. We need competition to keep this place running efficiently.*

R 1: *Establishing a program to really make benchmarking work is paramount so that apples are being compared with apples. You cannot merely compare one country hospital with another based on inpatient bed activity alone. Many rural hospitals are multipurpose with services being provided from Commonwealth, State and voluntary sources. There are enormous variations in activities. My staff currently care for 90 people over the age of seventy in their own homes. That means that we have been able to institute a program that has been highly cost effective by not having to hospitalise these people as well as achieve a high satisfaction rate with the patients and their families. I don't feel country people are given enough credibility for their ability to run country hospitals and really serve the community.*

R 2: *I just hope they think and plan a little more with the benchmarking project than they did with the whole outsourcing debacle. It should never have happened. On issues for me as a country HCM is the constant threat of closure. We are often faced with it and it seems like a threat from the government that they pull this out and wave it in our faces when they want us to jump. I think that now we have a coalition government in place, this may be less likely. I don't think Hendy Cowan will let any country hospitals be closed. It might be political suicide.*

R 3: *I'm not really worried about outsourcing now, but I hope benchmarking is a much more positive experience. Not all country hospitals are the same and I hope inpatient bed numbers is not the only thing they judge us on. Many of us do lots of other activities depending on the needs of the community we serve.*

R 4: *We are still facing the contracting out scenario, so I have lots of concerns about contractors not responding to items that need attention, higher costs, poor quality work or being inflexible about service needs because it's not stated in the contract. I fail to see how we can foster a team spirit here if we have lots of people here with numerous bosses.*

ANALYSIS

From a personal perspective, funding and potential cuts to existing services was still a crucial consideration for HCMs. The major concern for the rural group was the future benchmarking exercise. A great deal of energy and expense was recognised as having gone into the outsourcing process in the first place. The metropolitan HCMs were concerned about contract failure which one HCM described as “inevitable”. The rural managers wanted greater recognition for what they and their staff do in keeping country hospitals operating within budget and how they best meet the needs of the local community.

8. Is there anything you would have liked the government/department to have done which may have assisted you in dealing with outsourcing and/or contractors?

NT 1: *I have no problem with the concept that we need to show we are competitive. And I think we can do that. The decision to stop-start was a little unsettling and I didn't know at one stage what we should be doing. I believe that the Public Sector Management office has a hidden agenda and privatisation is still the big push. Treasury costing guidelines make it difficult though. Additional costs of about 20% are imposed on government agencies to provide “a level playing field” so that private agencies are not disadvantaged. Unfortunately we are disadvantaged and I can't see us being able to compete.*

NT 2: *Country people should have been consulted more extensively. I think it was a nonsense to expect the country folk to implement a program clearly doomed to failure. I would however have liked the process to move a little faster in the metro. May be they could have redirected all that wasted energy used in trying to sell this to the rural community back into the metro and we could have been much further along.*

T 3: *There should have been more push for internal reform. There was a lack of management skills as to know what to do. There should have been more resources put into reform and the target should have been much wider than just hotel services. We have to be careful not to get too excited about savings. Sure, the initial savings look great, but when*

you downsize to a critical level, then the savings level plateaus. Our savings haven't reduced our waiting lists.

T 4: *Time frames should have been in place right from the start. The steering group for CTC and Contestability should have had real world people. There should have been incentives to organisations who moved first and fastest. There should have been a series of trials to overcome industrial problems, to develop a strategy for failure and a strategy for practical education about contract management.*

R 1: *I would have established a working party with representative of all stakeholders. There should have been appropriate targets, not this state-wide, all encompassing drive to contract out services. They should have used pilot sites and they could have avoided a lot of pain. I think this recent experience has discredited the government enormously.*

R 2: *I would have consulted the people and the communities before making the decision to contract out. I think the government has lost a lot of face over this.*

R 3: *Fortunately now that I don't have to deal with them, I really don't care. I know that I have to concentrate on benchmarking and I think that a lot of energy should be poured into the education program for country people once we have been consulted. I guess to answer your question, I would have consulted the country people more. We do know what we are talking about and I'm sure we know our community's needs far better than a little metro bureaucrat.*

R 4: *I think the government made the mistake of putting us all in one pot, then deciding a strategy that would suit us all. Wrong! They should have consulted more widely than they did and had some of the key players do that such as country HSMs. They know how best to cut costs because they've had to do it year in and year out.*

ANALYSIS

More consultation particularly with country managers was clearly called for. Generally, the metropolitan HCMs did not have problems with being made to be more competitive, but they did have concerns with the way in which outsourcing was introduced to the industry and health staff. More of a focus on internal reform was highlighted as being far more appropriate than total contracting out. For some, the process had been too slow and Treasury Costing Guidelines were placing the

government agencies at a disadvantage. The rural managers were critical of the lack of consultation and consideration of issues specific to rural areas. Pilot sites were stated as having been considered. Some of the rural HCMs saw the government having been discredited by the way they had handled the outsourcing process and their apparent lack of understanding of those issue facing rural HCMs and communities.

Summary of interviews

In summary, the overall experience of these eight HCMs had been fairly limited with only one hospital being able to claim to have multiple contracts in place. The HCM of this teaching hospital claimed that he had been able to achieve a 20% cost saving with a 90% effectiveness level, meaning that 90% of the customers of the service were satisfied. He presented the researcher with a summary sheet which indicated that in April 1996, 25 contracts had been let, tenders for another 2 services were being evaluated, 5 services would be retained in house, tenders for another 2 services had been invited, and a staff buy out of a major department was currently being considered. He stated that standards had dropped but the outcomes were quite acceptable given that costs had been reduced by 20%.

This view is supported by King (1994) who stated that a reduction in the quality of the service accompanied by a fall in price “may be socially desirable”. It also supports the view of MacDonald (1993) who suggested that some health

professionals “over performed” which Porter (1985) claimed resulted in more money being spent than really necessary to provide for the needs of the population.

Regarding ACHS standards and their suitability, the majority of HCMs either did not know or did not think the standards were appropriate in evaluating contractors’ performance. One HCM who is an ACHS surveyor believes that the standards are entirely appropriate because as she put it in another discussion

“How many set of standards do you need? Given that the ACHS standards are nationally recognised, why don’t we look at adapting them to include contractors’ performance? Patient satisfaction surveys are a large component of ACHS and the accreditation process, so obviously if a contractor’s performance affects some part of the service and the patient’s care, then he should be part of the total evaluation process”.

A general concern over the issue of control over quality and accountability was evident both in the questionnaires and throughout the interviews. Much emphasis was placed on the quality of the contract and the specifications therein. This would add support to the claims of Brown (1994) who recommended that if specifications describing what quality outcomes were required and if performance was monitored, then the problems of accountability and reduced control would dissipate. This does not, however, explain who would be writing the specifications, defining the outcomes or monitoring the performance given that “supervising contracting is

impossible without numerous output indicators” (Jones, 1992:12). The larger hospitals had catered for and often had the funding available to appoint someone to deal with managing contracts, others did not. When asked, metropolitan HCMs had no hesitation in stating that someone would be appointed to manage contracts and contractors.

One of the major concerns was, therefore, that of contract management and adhering to Treasury Costing Guidelines. If smaller rural hospitals had been forced to pursue contracting out then the HCMs indicated that they would have been expected to manage the contracts as well as perform their other duties.

Treasury guidelines were described by one HCM as “a bloody nightmare” and she stated that the government’s intention to present a level playing field so that private industry would not be disadvantaged, clearly disadvantaged many of the public hospitals. To effect this “level playing field”, public hospitals were faced with an additional surcharge of about 20% on the contract they produced which as one HCM described “leaves us high and dry. We just can’t compete with that. I’m sure the government would be very surprised if we could!”

With the release of the Country Hospital Services Policy, the rural HCMs expressed relief that they were no longer expected to contract out services. They were unable to explain why the government continued to pursue such an unpopular decision for

so long. Several of them alluded to the political pressure and opposition to outsourcing applied by several members of the National Party, including Hendy Cowan, leader of the National Party in Western Australia, as well as the opposition of other local members.

For the other HCMs who were implementing an outsourcing program, the consensus was that they were generally satisfied with what was happening in their hospitals. Costs reduction and obtaining expertise that would not be normally available had been achieved. This supports the claims of Mark (1994) and Minoli (1995) as to some of the advantages of outsourcing. The metropolitan HCMs were, however, unanimous in criticising the government's attempts to implement a similar program in smaller country hospitals.

Benchmarking, which a number of rural HCMs mentioned in the questionnaire as the most appropriate strategy, was the way country hospitals were now being encouraged by the HDWA to pursue to increase efficiencies. Given the data from the rural HCMs, it would be a serious mistake for the HDWA to categorise all country hospitals based on their inpatient bed activity alone. The functions and services that rural hospitals provide are as diverse as the communities in which they dwell. As one HCM put it, "apples must be compared with apples". This would be supported by Julien (1993) who maintained that the real power of benchmarking lies

in an organisation's ability to learn from the best in its field and adapt the successes to its situation, not necessarily adopt them in total.

The major concerns facing these managers in the future related to budgetary constraints, maintaining a quality service, customer expectations and the rising cost of technology. For those facing a future of more and more services being outsourced, the issue of possible contract failure and additional costs incurred if this did occur was raised. Making medical staff more aware of their responsibilities in the area of accountability was a concern for several of the HCMs particularly in view of the Freedom of Information Act and the rights of consumers to access their medical records. For the rural HCMs, the issue of implementing a benchmarking program was uppermost in their minds. None of the rural HCMs knew what the government had planned in this area. The government policy states that this should be in place by June 1996. It was cause for concern for three of the rural HCMs that no one was sure what was happening and how the benchmarking program was going to be implemented.

When asked what they would have done differently if they had been in positions to do so, the unanimous answer was consultation with key stake holders, particularly in the rural areas. Mackintosh's claims (1993) that involvement of "front line staff" in formulating performance indicators is essential to ensuring a quality service was supported by the HCMs. As one HCM stated, involving "real people" in the

decision making process added credibility to any program. All the metropolitan HCMs agreed that the HDWA's decision to outsource services in the smaller country hospitals was doomed to fail. Generally, all agreed that one can always do better, but as one HCM asked

“How much more do they want past an excellent service? We are a lean, multiskilled group of people, accredited with the ACHS, and we meet the needs of our community both efficiently and effectively? What else is left?”

Summary of results

The questionnaire component of this research highlighted the concerns of HCMs in dealing with contractors, particularly in the areas of quality assurance, monitoring of contractors' performance and overall contract management. This was reinforced throughout the interviews.

There were clear differences between the rural and metropolitan HCMs and the issues they faced. The metropolitan HCMs did not have the same degree of difficulty with contract management although it was still a concern that it was carried out appropriately and by someone who was very qualified in the legal field. The responsibility appeared to fall into the laps of the rural HCMs who were expected to assume this additional responsibility without additional resources to implement it.

The HCMs cited a number of advantages of outsourcing as outlined by the literature (Mark, 1994; Minoli, 1995). When it came to them describing how outsourcing would benefit their hospitals, the rural HCMs were unable to state any advantages of outsourcing as it related to their situation. The metropolitan HCMs were also unable to see any advantages for rural hospitals given the rural facilities' isolation from the city area with the obvious access to a wider range of services available than is available in the country. This clearly supports the claims of Rimmer (1994) that geographical and specific community demands are diverse and complex and cannot be addressed with a unilateral, uniform approach.

CHAPTER 5:

CONCLUSIONS, RECOMMENDATIONS FOR FUTURE RESEARCH

Introduction

This chapter attempts to take findings from the questionnaires and interviews of HCMs to determine the current status of outsourcing in Western Australian hospitals and what are or have been the experiences and concerns of Western Australian HCMs.

Conclusion

This study examined a number of questions relating to outsourcing of services in Western Australian hospitals and the experiences and issues facing HCMs. From the data gathered, it appears that some HCMs see outsourcing as a viable effective option in health care delivery, despite the apparent lack of any systematic performance indicator system for contractors to determine long-term viability or effectiveness.

The response rate was comparable with other research, but drawing major conclusions from the data needs to be treated with caution. The HCMs who did not

want to participate because of the fear of retribution despite this researcher's assurance of total confidentiality may have had a wealth of outsourcing experience. In not being able to directly interview the rural managers, the quality of answers may have been affected, although the experience of this researcher is that the rural HCMs interviewed were very willing to participate in the research and answer the questions openly and honestly.

Outsourcing is still in its infancy in many of the public hospitals surveyed and therefore it would be foolhardy to make long term predictions on data collected over a short period of time. It is of concern, therefore, that proponents of outsourcing are willing to do so regardless of the fact that the market has been described by one their senior colleagues as "too immature" to cope.

In conclusion, each of the research questions is stated and addressed individually. This facilitates a greater understanding of the key issues arising from this research and provides direction for future study.

How do health care managers decide which services will be outsourced? Are there services which managers do not wish to see outsourced?

How HCMs decided which services were to be outsourced was not generally a decision they made. For government agencies, the final decision is made at ministerial and departmental level. The HDWA has issued a number of directives

and operational instructions concerning outsourcing throughout the state. Cost reduction and access to expertise not available in-house were major factors behind their reasons to outsource services which adds support to the research of Mark (1994) and Domberger (1994).

HCMs clearly defined the services that should not be outsourced, but the responses differed between the various categories of hospitals. All HCMs agreed that core services should never be part of the outsourcing equation. The majority also stated that much of allied health services should also remain in-house on a permanent, part-time basis. For rural hospitals, access to a variety of tradespeople and health professionals was limited or non-existent.

Some of the services targeted and already outsourced were mentioned as unsuitable for outsourcing, such as cleaning and catering. This response was more common amongst rural and other non-teaching hospital HCMs. It was generally not an issue in the larger teaching hospitals. The human resource issues, such as the people directly affected in these groups, was mentioned by the HCMs throughout the study. Women, particularly those from non-English speaking backgrounds, working in low paid, part-time employment were especially affected. There was little recognition for the service these people had given to the hospital over a number of years. The sense of community and team work is seriously being challenged with the increase of contract workers.

What performance indicators will be necessary to ensure quality outcomes for the consumers of the service?

In addressing the question of performance indicators and keeping in mind the findings of Mann et al (1994), ACHS accreditation status may be of value in determining which hospitals should benchmark their service provision. It must be kept in mind, however, that the ACHS standards and outcomes are *clinically* focussed and may be too broad in their terminology to be of any real benefit when it comes to specifications in contracts. Regardless of this, however, a nationally accepted framework does exist. Greater involvement by the ACHS in developing standards to evaluate contractors' performance may be of great benefit not only to ACHS accredited facilities.

The Ernst & Young study cited by Mann et al (1994) is of importance in this current research. What more can a hospital do that has demonstrated that it is running efficiently and achieves high quality health outcomes on a consistent basis? Benchmarking was found in the Ernst & Young study to actually improve companies' performance and benefits where the company was already performing well. It offered little benefit to the organisations which were performing poorly. This needs to be kept in mind by those planning the benchmarking exercise for the rural hospitals. One consideration should be rural hospitals which are accredited

with ACHS are part of a pilot benchmarking programme. This would ensure equity and consistency with the use of uniform standards.

What do managers perceive as the major issues facing them when dealing with contractors and implementing an outsourcing strategy?

The threat of loss of control over the quality of services and the additional potential workload associated with contract management was a major concern to all HCMs. Clearly, the overall concern was for the delivery of a safe, high quality, cost effective service and if outsourcing was a management tool that would effect this, then it will be pursued.

The HCMs from the smaller rural hospitals were unable to see any benefits of outsourcing, nor could they see how their communities would be able to support what one of them described as “a silly city-slicker’s idea”. The major issues that HCMs perceive as facing them in the future with outsourced services relates to their ability to ensure a quality service at reduced cost as well as ensure that contracts are managed appropriately and efficiently. Failure of contracts and the costs associated with this is a major concern for all HCMs.

What has been the experience of managers who have dealt with contractors?

The overall experience of HCMs with contractors was generally positive, however, a number of HCMs from a variety of clinical settings clearly contradicted themselves throughout the questionnaire. When asked about the outcomes of the services they had outsourced, such quotes as “quality work...cost savings, improved services, expertise available...tremendous service...overall improvement in each area of outsourcing...” were counteracted by other comments when they were asked about their experience with contractors. “Sloppy work with some...poor quality work, high costs, failure to respond to items needing attention, cutting corners...time frames not being adhered to...over commitment by contractors...non-compliance and variance in quotes” were some of the responses received to a question asking HCMs to describe their experiences with contractors. Those HCMs interviewed provided data which were consistent with the responses they had given on their questionnaires.

The HCMs from private hospitals outsourced a greater number and range of services and have done so over a longer period of time than their public sector colleagues. They indicated that they were generally satisfied with the quality of the service although one of them did indicate that some contractors’ work was “sloppy”. The claim of Kanter (1984), that a major advantage of outsourcing was that it allowed staff to be more innovative, was not considered a major factor for any of the HCMs surveyed.

Are there differences between groups such as rural and metropolitan HCMs?

In the rural context, as described by the HCMs, the majority of rural hospital health care workers were women who are often “propping up” the family income and providing for the day to day needs while the family waits for payments for the wool or crops comes in. Their employment provides a stable and constant source of income as well as providing the hospital with a workforce aware of the local issues affecting the community. Without that steady source of income, many of these people may be forced to seek out financial assistance from the government which has its own social and personal stigma attached.

It is accepted standard practice in a number of rural hospitals that staff often carry out duties which their metropolitan colleagues do not. Multiskilling in its fullest sense is commonplace. It was observed by the researcher that teamwork and collegial support was paramount in rural settings and underpinned the quality of care delivery.

As a purely speculative exercise, had rural HCMs been forced by government to pursue outsourcing in their areas, a situation similar to that described by Samson (1994) may have resulted. It was purported that privatisation recreates many of the problems it was initially meant to eradicate, replaces problems with other dilemmas, and some groups may have benefited at the cost of others.

The HDWA implemented numerous educational programs concerning contracting out targeting rural HCMs. The claim that it would never work in the rural areas by both metropolitan and rural HCMs and that it took the HDWA over two years to issue a policy that effectively released rural hospitals from the obligation to contract out adds fuel to the claims that the HDWA has an “expensive history of failures”. Perhaps the words of several rural HCMs sums up the feelings about the push for outsourcing in country areas: “it should never have happened”. Rimmer’s (1994) claims that the geographical isolation of many rural communities naturally affects any competitive initiatives is strongly supported in this study.

Clearly greater consultation and sensitivity to issues facing rural managers was warranted. Insufficient consideration of the complexities involved in health care in the rural communities has discredited the government. Much greater care should be taken with the proposed benchmarking exercise. It is essential that key stakeholders be consulted and pilot sites be established and evaluated before any major moves are made to implement the programme. Recognition of the supporting structures within individual hospitals should have also been considered.

Larger hospitals are generally more able to absorb the cost associated with contract management and may already have access to personnel who have the necessary skills to carry out these duties. Smaller departmental hospitals often do not have the same

access and may be disadvantaged. Commitment by the government in addressing these inequalities must be given in terms of appropriate financial support.

In summary, outsourcing of certain services in the Western Australian health care industry has been problematic. Hospital size, location, accessibility to contractors, human resource issues and funding arrangements such as those which affect teaching and non-teaching facilities were identified as major determinants affecting the success of outsourcing.

The outcome and experience for metropolitan hospitals, particularly for the larger units, may be different given that they have greater access to the resources necessary for a successful outsourcing exercise. The major opposition and subsequent failure of this initiative in the rural sector resulted from a lack of appropriate consultation and an insensitivity to the complexities involved in rural health care delivery. A major concern for all HCMs is contract management and the potential failure of contracts, increased cost factors and disruption to patient care.

Recommendations for future research

As outsourcing in Western Australian hospitals has been described in its infancy, an important issue is to determine the impact over time. Claims of cost savings with improved quality need to be carefully monitored. How quality outcomes are to be

measured in any health care facility, if national standards are not be used, requires definition.

The experiences of core services with contracted out support services would be a natural progression on from this research. An equally important research topic would be the experiences of patients who have received care from outsourced services to determine their level of satisfaction with the service. This would be more meaningful to examine the service over time if those patients/clients who are currently receiving long term care under the public hospital system have their care transferred to the private sector.

Given that the rural hospitals must pursue benchmarking, how the HDWA plans to implement and evaluate this exercise warrants further research. Progress of this project must be carefully monitored and tested against predetermined outcomes within tight timeframes. The status of benchmarking in the rural sector should be evaluated at three to six monthly intervals over the next two years. This would allow remedial action to be taken as required. Program management would be a vital way in ensuring the success of the implementation of benchmarking. Finally, how the HDWA gathers and analyses information about its complex health care system warrants serious attention given the criticism from all levels of the community and the disastrous outcomes of some of its initiatives and decisions.

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APPENDICES

APPENDIX 1:**QUESTIONNAIRE ON OUTSOURCING: MANAGEMENT CONSIDERATIONS
IN WESTERN AUSTRALIAN HOSPITALS**

1. Your hospital's postcode
2. Your position in the organisation (a) Health Service General Manager
 (b) Director of Nursing Services
 (c) Other(please specify)
-

Your hospital: teaching public
 non-teaching private

Number of beds _____

Total FTE _____

3. Is your hospital accredited by the Australian Council of Healthcare Standards (ACHS)?
 Yes No

If yes, how long has your health care facility been accredited ?

- less than 1 year
 1-3 years
 4-8 years
 8 years or more

4. If your facility is currently outsourcing (contracting out) any of its services, could you please indicate (✓) which services are being outsourced and how long (approx) they have been outsourced?

SERVICE	IS OUTSOURCED	NOT OUTSOURCED	LENGTH OF TIME	SERVICE	IS OUTSOURCED	NOT OUTSOURCED	LENGTH OF TIME
Clerical				Pathology			
Dietetics				Pharmacy			
Engineering				Physiotherapy			
Gardening				Podiatrist			
Hotel services				Psychology			
Maintenance				Radiology			
Management				Security			
Nursing				Social work			
Occupational therapy				Speech pathology			
				Staff Development			

Other (please specify)

SERVICE: _____ LENGTH OF TIME _____
 SERVICE: _____ LENGTH OF TIME _____

We do not outsource any service (Go to Q 7)

5. Why did you outsource these areas? Please indicate from the following list of reasons which applies to your hospital and how important each factor has been in the final decision.

	NOT IMPORTANT				VERY IMPORTANT
• reduction in direct costs	1	2	3	4	5
• flexibility in coping with periods of change	1	2	3	4	5
• enabling staff to be innovative	1	2	3	4	5
• freeing management to focus on key issues	1	2	3	4	5
• access to expertise not available "in house"	1	2	3	4	5

6. What have been the outcomes?

7. Is your facility **planning** to outsource certain services **in the future**?

Yes

No



Please specify which services:

COMMENTS

<input type="checkbox"/> Clerical
<input type="checkbox"/> Dietetics
<input type="checkbox"/> Engineering
<input type="checkbox"/> Gardening
<input type="checkbox"/> Hotel services
<input type="checkbox"/> Maintenance
<input type="checkbox"/> Management
<input type="checkbox"/> Nursing
<input type="checkbox"/> Occupational therapy
<input type="checkbox"/> Pathology
<input type="checkbox"/> Pharmacy
<input type="checkbox"/> Physiotherapy
<input type="checkbox"/> Podiatrist
<input type="checkbox"/> Psychology
<input type="checkbox"/> Radiology
<input type="checkbox"/> Security
<input type="checkbox"/> Social work
<input type="checkbox"/> Speech pathology
<input type="checkbox"/> Staff Development

Other (please specify)

8. If you answered "YES" to this question, how **important** have the following factors been in making the final decision?

	NOT IMPORTANT			VERY IMPORTANT	
• reduction in direct costs	1	2	3	4	5
• flexibility in coping with periods of change	1	2	3	4	5
• enabling staff to be innovative	1	2	3	4	5
• freeing management to focus on key issues	1	2	3	4	5
• access to expertise not available "in house"	1	2	3	4	5

9. Are there certain services which you believe **should not** be outsourced?

Yes

No



Please specify which services:

COMMENTS

<input type="checkbox"/> Clerical	
<input type="checkbox"/> Dietetics	
<input type="checkbox"/> Engineering	
<input type="checkbox"/> Gardening	
<input type="checkbox"/> Hotel services	
<input type="checkbox"/> Maintenance	
<input type="checkbox"/> Management	
<input type="checkbox"/> Nursing	
<input type="checkbox"/> Occupational therapy	
<input type="checkbox"/> Pathology	
<input type="checkbox"/> Pharmacy	
<input type="checkbox"/> Physiotherapy	
<input type="checkbox"/> Podiatrist	
<input type="checkbox"/> Psychology	
<input type="checkbox"/> Radiology	
<input type="checkbox"/> Security	
<input type="checkbox"/> Social work	
<input type="checkbox"/> Speech pathology	
<input type="checkbox"/> Staff Development	

Other (please specify)

10. Please circle your reasons for your answer and how important this is to you:

	NOT IMPORTANT				VERY IMPORTANT
• less control over the quality of service	1	2	3	4	5
• lack of continuity of care	1	2	3	4	5
• safety concerns	1	2	3	4	5
• legal considerations	1	2	3	4	5
• financial considerations	1	2	3	4	5
• contractors require more supervision than inhouse staff	1	2	3	4	5
• contractors do not have intimate knowledge of hospital functioning	1	2	3	4	5
• setting up procedures to ensure quality care occurs will be too costly	1	2	3	4	5
• managers will have to spend too much time with contractors	1	2	3	4	5
<hr/>					
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11. Please **circle** any of the following which you see as an **advantage** of outsourcing and rate how **important** it is to you:

	NOT IMPORTANT				VERY IMPORTANT
	1	2	3	4	5
• reduction in direct costs	1	2	3	4	5
• flexibility in coping with periods of change	1	2	3	4	5
• enabling staff to be innovative	1	2	3	4	5
• freeing management to focus on key issues	1	2	3	4	5
• access to expertise not available "in house"	1	2	3	4	5

12. Please **circle** any of the following which you see as a **disadvantage** of outsourcing and how **important** this is to you:

	NOT IMPORTANT				VERY IMPORTANT
	1	2	3	4	5
• less control over the quality of the service	1	2	3	4	5
• lack of continuity of care	1	2	3	4	5
• safety concerns	1	2	3	4	5
• legal considerations	1	2	3	4	5
• financial considerations	1	2	3	4	5
• contractors require more supervision than inhouse staff	1	2	3	4	5
• contractors do not have intimate knowledge of hospital functioning	1	2	3	4	5
• setting up procedures to ensure quality care occurs will be too costly	1	2	3	4	5
• managers will have to spend too much time with contractors	1	2	3	4	5

13. How appropriate do you think ACHS indicators are in measuring the performance of contractors?

NOT APPROPRIATE

1

2

3

4

TOTALLY APPROPRIATE

5

Why?

14. What do you believe are some of the issues facing health care managers when dealing with contractors?

15. What are some the specific issues you have encountered when dealing with contractors?

16. Do you believe that there are only **some** areas where savings can be made?

Yes

No

Please state which areas of **savings**:

Please state which areas of which there are **no savings**:

17. Who is responsible for managing the contracts operating at your hospital?

18. What percentage of management time is spent managing contracts and contractors?

0 _____ 25 _____ 50 _____ 75 _____ 100%

19. The researcher may be interested in conducting interviews. This would be on the basis of total confidentiality and you would not be identified in any way. Would you be willing to be interviewed by the researcher?

Yes

No

15. Please comment on any other issues relating to contracting out.

**THANK YOU FOR YOUR TIME AND COOPERATION.
PLEASE RETURN THE QUESTIONNAIRE TO ME IN THE ENVELOPE
PROVIDED.**

Geraldine Martin
October 1995

APPENDIX 2

PROCESS FOR CTC AND BENCHMARKING FOR RURAL MANAGERS

PROCESS

Identification of CTC opportunities:

This should include at least a review of all non clinical services provided by the hospital.

Activity Definition:

Identify service definition, quality requirements, volume measurement and development of statement of requests, in output terms.

Identification of Options:

Preliminary market appraisal

Management buy out

Contracting out

Maintaining in house provision against a benchmark cost (*commissioner of Health to be consulted including details of proposed cost savings*).

Issue an Expression of Interest or Request for Proposals Document

Where possible a request for proposals should be issued. However, in complex circumstances where final requirements are difficult to establish, an expression of interest may be more appropriate.

If FOI approach to be pursued, Commissioner of Health to be consulted.

Benchmarking

Detailed analysis of in house service provision needs to occur taking into account current actual cost

anticipated cost savings via internal efficiency and timeframe for achieving the savings

measurement of current activity against benchmark quality standards.

Evaluation

Comparison of prices against internal current and proposed costs and cash flow effect of different implementation timetable of different options. The analysis should include long term benefits such as new or expanded service provision that can be funded from savings.

Management Decision

Consideration of evaluation and impact of options (*Commissioner of Health to be consulted as to proposed final outcome*).

Implementation

to have commenced by 30 June 1996.

RURAL BENCHMARKING EXERCISE

Background

A Steering Group is overseeing the establishment of industry benchmarks for WA rural hospitals.

The concentration is on "non-core" services, but will also cover general management/administration, and clinical functions under groupings such as Medical, Nursing and Allied health.

Definition of Benchmarking

The Steering Group has adopted the following general definition:

"Benchmarking is deciding what is important; understanding how you now do it and how well you do it; learning from other how they do it; and applying what you have learnt in a way that leads to your doing it better than before. Then you do it again" (Ann Evans "Benchmarking").

Types of Benchmarking

Internal : Comparison of similar operations or functions within an organisation.

External: *Competitive:* Benchmarking in the same markets against organisations that produce competing products or services. ***Industry:*** Benchmarking externally against others in the same industry who are not direct competitors. ***"Best -in-class"*** : Benchmarking externally but not necessarily in the same industry.

How will the Benchmarking exercise operate

The intention is to compare public hospital costs on a "like to like" basis. In the first instance WA country hospitals of similar size, service profile, geography etc will be compared. Interstate comparisons will be obtained if possible together with relevant private hospital sector benchmarks (if any). The outcome will be the establishment of a "benchmark" cost for specific services (eg cleaning, catering, engineering etc) for application to hospital of similar makeup.

Current status of project

Research and analysis of benchmarking already undertaken within the health system completed.

Preliminary performance measures selected for services to be examined.

Draft input document ready for testing.

Training program endorsed.

Forward program

Hospital supply data to input document

Survey teams analyse and validate data

Analysis of survey reports

Establishment of benchmarks

Negotiate implementation plans

Summary

The Benchmarking Exercise is progressing according to the February-August 1996 timeframe.

APPENDIX 3

INTERVIEW QUESTIONS HEALTH CARE MANAGERS

Hospital type	TEACHING	NON-TEACHING
	PRIVATE	PUBLIC
	RURAL	METRO

What has been your experience of outsourcing so far?

Has your opinion changed in any way towards outsourcing since you completed the questionnaire last year? If yes, what has caused this to occur?

Do you believe that performance indicators are an adequate means to ensure a quality service? Are the ACHS indicators appropriate or not? Why?

What do you rate as the most important issue facing managers outsourcing services?

Do you believe that there are separate issues facing country managers as opposed to metropolitan health managers?

What do you see as some of the issues facing health care managers in the future?

What are some of the issues concerning outsourcing which are facing YOU in the future?

Is there anything you would have liked the government/department to have done which may have assisted you in dealing with outsourcing and/or contractors?

APPENDIX 4 INTERVIEW CONSENT FORM

Telephone: [REDACTED]

INTERVIEW CONSENT FORM

**STUDY TITLE: OUTSOURCING IN WESTERN AUSTRALIAN HOSPITAL:
MANAGEMENT CONSIDERATIONS.**

The purpose of my study is to determine

- the extent to which Western Australian hospitals outsource their services
- what services are outsourced and why
- the performance indicators being used to ensure an appropriate level of service delivery
- whether there are differences between hospitals from different areas in the state.

The knowledge gained from this study will be of major significance to all those involved in the provision of health care in this state.

The study will involve a large sample of Western Australian hospitals. Information will be gathered by questionnaire as well as through a follow up interview of a sample of those who have completed the questionnaire. If you agree to participate in the study, you will be interviewed at a place and a time suitable to you.

At any time you may decline to participate or continue to participate in the study. No names will appear on any of the documentation involved and the coding system used is only known to the researcher. Extracts of information gathered through questionnaire and/or interview may be used in the final report, however you will not be identified in any way. **Anonymity and confidentiality will be strictly observed at all times.** Participation is entirely voluntary and you may withdraw at any time without penalty. There are no risks associated with your participation.

The Committee for the Conduct of Ethical Research at Edith Cowan University has given its approval for this study.

PARTICIPANT STATEMENT

I _____, have read the above information on the study

(BLOCK LETTERS PLEASE)

relating to outsourcing in WA hospitals. I understand the nature and extent of the study and that I have the opportunity to ask questions. I know where to direct any questions that I may have. I agree to be interviewed by the researcher. I understand that my participation in this study is voluntary and that I may withdraw at any time.

SIGNED _____ CONTACT TEL: _____

SIGNED _____ (RESEARCHER) DATE ____ / ____ /199__