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ORIGINAL RESEARCH

Outsourcing and benchmarking in a rural public hospital: does economic theory provide the complete answer?

SH Young

Bowater School of Management and Marketing, Deakin University, Geelong, Victoria, Australia

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ABSTRACT

Introduction: The ideology and pronouncements of the Australian Government in introducing 'competitive neutrality' to the public sector has improved efficiency and resource usage. In the health sector, the Human Services Department directed that non-clinical and clinical areas be market tested through benchmarking services against the private sector, with the possibility of outsourcing. These services included car parking, computing, laundry, engineering, cleaning, catering, medical imaging (radiology), pathology, pharmacy, allied health and general practice. Managers, when they choose between outsourcing, and internal servicing and production, would thus ideally base their decision on economic principles. Williamson's transaction cost theory studies the governance mechanisms that can be used to achieve economic efficiency and proposes that the optimal organisation structure is that which minimises transaction costs or the costs of exchange. Williamson proposes that four variables will affect such costs, namely: (i) frequency of exchange; (ii) asset specificity; (iii) environmental uncertainty; and (iv) threat of opportunism. This paper provides evidence from a rural public hospital and examines whether Williamson's transaction cost theory is applicable.

Method: Case study research operates within the interpretivism paradigm and is used in this research to uncover why the outsourcing decision was made. Such research aims to study real-life experiences by examining the way people think and act and, in contrast to positivism, allows the interviewer to participate to better understand the details and features of the experiences. In the present research, individual interviews were conducted with managers of the hospital and owners and staff of the vendor organisations using semi- and unstructured questions to ascertain the extent of, and processes used in, outsourcing specific functional areas, and areas that were not outsourced.

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Results: Pathology, radiology, dental technician services and lawn mowing were outsourced while food services was retained internally. The outsourcing of radiology was due to the hospital being unable (or unwilling) to finance new equipment and the problematical relationship between the existing radiologists, and hospital management and staff. Outsourcing resulted in increased staff morale, upgraded capital equipment and improved services. The outsourcing of pathology and dental technical services aimed to increase labour flexibility, thereby decreasing costs. Additional drivers in pathology were the changing nature of the funding arrangements rendering it profitable for the private sector to move into the provision of pathology and the increasing power of the medical scientists' union. The outsourcing of lawn mowing was simply to reduce costs. Food services was not outsourced because there was a lack of evidence that costs could be reduced. In addition, the existing relationships with food services staff were regarded as important because they had previously made immense changes to work practices, reduced staff numbers and decreased costs.

Conclusion: Transaction costs are important when analysing how managers make the outsourcing decision, but the evidence from this case is that not all transaction costs are included in the decision, and that such costs are more complex than can be included in the type of analysis often undertaken by decision-makers. Taking into account Williamson's variables, the research shows that the outsourcing of services did not comply solely with the levels of transaction frequency or the requirement of asset specificity. In addition, opportunistic behaviour was evident on the part of all parties and was used in some cases as a reason for outsourcing, and in others to sway the decision to the manager's predisposed choice. A variety of arrangements were used to reduce environmental uncertainty, such as the transfer of staff to the contractor and the use of long-term contracts. Indeed the case shows that relationships between the hospital, its staff and the vendor are an important consideration that may not always be factored into an analysis that relies solely on transaction costs.

Key words: competitive neutrality, contracting-out, health sector, national competition policy, outsourcing, public hospital, rural health, transaction cost theory

Introduction

The growth in public sector outsourcing in Australia is directly related to the policy of 'competitive neutrality' whereby government businesses are exposed to the same costs and obligations as if they were in private ownership[1]. This policy is designed to introduce competition into the sector and, in doing so, improve internal efficiency and customer responsiveness[1]. Economic principles underlie the Victorian Government's assessment of services to be contracted out, which is made on the assumption that:

...the expected benefits to economic efficiency and better resource allocation will outweigh the expected costs of implementation, [with] the focus being on the wider public benefit, not [only] on the benefits to the entity concerned[1].

Economic theories have also framed much empirical research into the movement towards market principles in the public sector[2-6]. In addition, the cost savings of contracting out have been extensively reported[7]. The concern of the government has been to lower costs, and to ensure that public sector instrumentalities become smaller, more efficient and more productive.

In the case of the health sector, the Human Services Department directed that non-clinical and clinical areas be market tested through benchmarking services against the private sector, with the possibility of outsourcing being implemented. These services included car parking, computing, laundry, engineering, cleaning, catering, medical

imaging, pathology, pharmacy, allied health and general practice.

This paper evaluates the application of economic theory to the outsourcing decision in an individual rural hospital. In doing so, it first discusses Williamson's transaction cost theory[8] and considers its application to the 'make or buy' decision. The paper then discusses the outsourcing events that occurred at the hospital and finally, analyses these events in light of Williamson's transaction cost theory.

Transaction cost theory

Transaction cost theory studies the governance mechanisms that can be used to achieve economic efficiency and proposes that the optimum organisational structure is that which minimises transaction costs or the costs of exchange[9]. The theory proposes that each exchange produces coordination costs of monitoring, controlling and managing the transaction. Williamson argues that such costs are to be distinguished from production costs, and a decision-maker can make a choice to use a firm structure, thereby producing the good or service internally, or the market place, by comparing transaction and production costs[9]. Researchers suggest that the firm is the optimal structure when it can accomplish exchanges at a cost lower than any other form [8,10,11].

Thus, cost is the primary determinant of the decision whether to outsource or to use internal production. However, because these costs are difficult to assess, Williamson uses four variables to provide further evaluative mechanisms, namely: (i) frequency of exchange; (ii) asset specificity; (iii) uncertainty; and (iv) threat of opportunism (Table 1). These variables shift the weighting between in-house production and use of the market[12] (p.26).

Table 1: Theoretical constructs of transaction cost theory

Costs Transaction costs Production costs
Transaction Type Frequency – decreases production costs Asset specificity – increases production costs
Uncertainty – increases coordination costs
Threat of Opportunism Small number of vendors – increases coordination costs Contracts – decreases coordination costs

From: Hodge BJ, Anthony WP, Gales LM. *Organization theory: a strategic approach* (5th edn). Upper Saddle River, NJ: Prentice Hall, 1996.

The first variable Williamson[8] identifies as affecting transaction costs is frequency of exchange, which refers to buyer activity in the market or the number of times the transaction occurs between the buyer and seller. The second, asset specificity, refers to the idiosyncratic nature of the transaction due to site, physical asset or human asset specialisation. An example of physical asset specificity is special-purpose equipment used in production, whereas a

unique location is an example of site specificity. Human asset specificity refers to personal knowledge and specialised words and expressions[9]. Williamson suggests that a market provides the most efficient governing structure for all non-specific investments because suppliers producing standardised products or services for sale to multiple customers can achieve economies of scale[8].

Williamson suggests that environmental uncertainty, the third variable, will produce transaction costs because contingencies may be unable to be specified for all situations, thereby increasing the time and number of processes an organisation needs to put in place to monitor and control the situation[8]. In such cases, the costs of bargaining to coordinate actions, measure performance and acquire information all increase the transaction costs of market exchange.

The fourth variable identified by Williamson refers to the threat of opportunism or self-interest, which is simply attributed to human nature. In this regard, opportunistic behaviour by vendors is held to increase greatly the coordination costs of market-based transactions, because there is a need to increase bargaining to draft the contract and to ensure the contractual outcomes are monitored[8](p. 32). Hodge, Anthony and Gales assert that this opportunism is increased by the very nature of asset specificity, which locks the organisation into relationships with outside vendors and makes it difficult to alter internal processes[13]. Market characteristics, such as the number of competitors in the market, may also influence the specifications, the bargaining and the submission process. Small numbers of exchange partners or buyers and sellers, may increase the susceptibility to exploitation by outsourcing partners. This may also be a feature of internal production where, in effect, there is only one seller and one buyer. As such, the act of requiring external bids for the provision of services provides market control of internal processes through prices and competition[14](p.303).

The decision to outsource, then, can be made on economic grounds, and Lacity and Hirscheim argue that Williamson's transaction cost theory 'represents a widely-accepted view that organisational members make outsourcing decisions based on economic rationale'[12] (p.25). But can transaction cost theory be applied to a hospital in the rural sector? To explore and answer the question, this article examines the decisions made by managers involved in the outsourcing process at a rural public hospital.

Methods

This research is set within the interpretivism paradigm which, in contrast to positivism, is appropriate in situations where the researcher is attempting to study real-life experiences by participation in order to better understand and express its values, details and features[15] (p.119). It is the preferred paradigm when dealing with complex social phenomena involving reflective people who make choices in the real world, with the choices themselves being contingent upon the environment[15] (p.120). Hence, interpretation examines the way people think and act, and assumes that bias is removed by accurately describing the meanings and interpretations of participants. In contrast, positivism in its attempt at establishing causal relationships, treats the 'world as a collection of discrete, observable elements and events that interact in regular, determined ways'[16] (p.4). Researchers operating within the latter paradigm aim to define what these elements are and how they interact, and assume that the world is simple, where these components can be isolated and examined without interference from unobserved factors, thereby reducing the world to statistical values[15] (p.5).

Operating within the former paradigm, the questions explored in this research are those that relate to the reasons for outsourcing decisions and the situational contexts in which these decisions are made, with the interviewer acting as a neutral observer. Questioning is used to uncover deeper meanings and underlying reasons and interpretations from multiple sources. By exploring the contexts in which the decisions are made, the research reports on why things happen rather than just giving description[16] (p.120). The

questions, then, are based on why or how the decision is made, in contrast to assessing the relative importance of factors leading to the individual decision, as would be reflected in positivist research. Yin[17] (p.6) explains that why questions are explanatory and likely to lead to the use of case studies as the preferred research strategy. This is because such questions deal with operational links that must be traced over time, rather than with frequencies or incidence.

Data collection

Initially, an interview with the Chief Executive Officer of the health organisation was conducted, using semi- and unstructured questions to ascertain the extent of, and processes used, in outsourcing specific functional areas and areas that have not been outsourced. Further interviews with decision-makers and staff in both outsourced and non-outsourced areas were then conducted. One-on-one interviews were conducted because group processes may influence information obtained through the use of focus groups[18] (p.296). In this instance, the influence could result in interviewees being unwilling to be completely honest and forthright in stating their reasons for the outsourcing decision.

Data gained for these purposes involved interviews that were held over a 10 month period, which covered all levels of hospital management, as well as those outside the hospital with involvement in the hospital's outsourcing process. Those interviewed included proprietors and staff of the outsourced areas, and union officials. The hospital interviews also involved those administering the outsourcing process, such as the Chief Executive Officer and line and support management.

Interviewees were first phoned to explain the research, and a plain language statement and consent form were forwarded to them. All interviews were tape recorded and transcribed. The duration of the interviews lasted, on average, 1.5 hours and, initially, asked participants to tell the outsourcing story and then proceeded to semi-structured questions designed around the specific prior theory. In establishing this interview protocol, the 'telling of the story' question allows the interviewees free reign to interpret the events using their own frames of reference. Support for this method of constructing interview questions comes from Dick, who states that:

> *The starting point is a question that is almost content-free. This is your warranty that the answers come from the respondent and did not simply arise because your questions created a self-fulfilling prophecy[19] (p.9).*

The documentation was gathered to analyse the situational context of the health organisation's operation when the outsourcing decision was made. Annual reports, consultants' reports, and internal documentation provided this information. Consultants' reports were confidential and were provided at the option of the managers. Restrictions were also put on supplementary internal documentation and, therefore, supplied only at the prerogative of the managers. Triangulation was gained through having interviewees from multiple parts of the case study entity and private sector vendor, as well as external consultants, industry association members and union officials. Participant demographics showing both the gender and job position of those interviewed are outlined in the following table.

Table 2: Demographics of participants: sex according to origin

Gender	Case study	Industry association	Union
Male	10	1	2
Female	3	-	2
Total	11	1	4

Table 3: Demographics of participants: job position according to origin

Job position	Case study	Industry Association	Union
Chief executive officer	1	-	-
Senior manager	2	-	-
Middle manager	5	-	-
Union officer	-	-	4
Outsourcing vendor	2	-	-
Consultant	1	1	-
Total	11	1	4

Tape transcriptions were then forwarded to the interviewees for checking, before being filed in a locked cabinet in the office of the researcher for privacy purposes. This fulfilled the need for credibility checks and ensured that the information was reflective of the participants' meanings and that the interviewer did not introduce bias.

Results

The hospital is one of the major employers of labour in the region, with 543 effective full-time staff. In 1999, it treated approximately 13 000 acute inpatients, 73 000 outpatients and served approximately 250 000 meals. Turnover amounted to $45.2m., with total assets of $55.6m. The hospital currently contracts out pathology, radiology, lawn mowing, dental technician, security and some engineering and maintenance activities. It was only services that had been conducted internally and market tested in compliance with National Competition Policy (NCP) resulting in their transfer to external contract provision, that were the focus of this article. Hence, radiology, pathology, lawn mowing, dental technician and food services will be examined.

Radiology

The Chief Executive Officer stated that the situation the radiology service was operating within throughout the early 1990s led to its outsourcing. First, as the equipment became obsolete, the cost of its replacement was prohibitive within the hospital's financial context. Second, the nature of the relationship between existing radiologists, management and the hospital staff produced conflicts of interest, management and financial problems, all of which led to poor staff morale.

Prior to the decision to outsource, the radiologists had not been supportive of the hospital, and had opened a private practice in competition. All persons interviewed saw this as unethical, especially when they pushed their own private practice at the expense of the public service. A staff member of the radiology department stated that the effect of this was that the radiologists, when working at the hospital, only performed tests on public inpatients, while all private outpatients were referred to the radiologists' private clinic. By transferring these patients to their private clinic they were able to by-pass the hospital's fee-setting principles, retaining the complete fee while charging a rate well above the scheduled fee.

Furthermore, a staff member of the radiology department reported that all requests to the hospital for equipment up-grades were ignored, with lack of funds always being cited as the reason. Because the radiologists were involved in such decisions, another potential conflict of interest became evident. The staff member believed that the hospital was not interested in upgrading the equipment and investing more in such an environment, with their overall aim being to introduce competition into the radiology area in order to

reduce the conflict. Additionally, the staff member referred to declining staff morale becoming apparent because of declining patient numbers. This soon reduced the hospital's private revenue, leading to insufficient funds for replacing out-dated equipment.

The 1993-1994 [hospital] Annual Report (to maintain anonymity and confidentiality the hospital is not named) summarised the rationale for the decision to outsource radiology in the following paragraph.

> *The need for this arose because of increased competition eroding the Department's workload, resulting in decreasing throughput with productivity losses, coupled with the need to re-equip the Department. All attempts to secure capital funding from the Department of Health and Community Services to re-equip have proved fruitless, resulting in the pursuit of privatisation. (p. 12)*

A long-term contract of 10 years, with another 10 year option, was negotiated with the private entity. The 1994-1995 [hospital] Annual Report specifically stated that '...the hospital looks forward to a *long* and mutually beneficial relationship with the private sector organisation [italics added]; p.7. The proprietor of the private radiology firm supported the need for a long-term contract when he stated that:

> *Building up a practice is a long-term job. Getting the right people employed is a long-term job. The hospital preferred a shorter contract but this was not entertained, as there is a need to establish the practice first and then make money.*

He believed that a profit would be made eventually, but if a 5 year contract was all that was offered, they would be 3 years into it and still making a loss.

In summary, a staff member stated that it was a smooth process because 'the private proprietors did the right thing; they were genuine people; they were well-liked by every-one; and it was a relief because the previous radiologists relationship with the staff and the hospital management was poor'.

The outsourcing of radiology was regarded as a success. The Chief Executive Officer stated that the privatisation process had turned a 'liability into a strength [when] it injected $3m. of equipment into the hospital department and resulted in the best radiology service outside the capital city'. To this it was added that staff numbers had increased and morale had improved. The Director of Medical Services and both practitioners and staff of the outsourced department supported these statements. There was also general agreement that, because the outsourcing arrangement brought in a new radiology practice, it injected a greater degree of professionalism and expertise into the service. Indeed, the proprietor of the service contended that usage had increased from 35 to close to 100cases per day. Furthermore, the injection of competition reduced costs and conflicts of interest between the parties.

> *The Director believed there were other benefits. The private company was paid on a fee-for-service basis which reduced his management problems, because it was the private company's problem to staff the service and to purchase the equipment. In addition, access to the private-patient market allowed the cost of the service to the hospital to be reduced. As the Director put it:*
>
> *The tender companies put in a price to perform the public work knowing that they can conduct their own private work from the hospital premises. If they didn't have access to the private market they would be likely to charge a lot more. They can break-even on public patients and then make money in private sector.*

This was confirmed by an interviewed with a union official who added, 'Radiology in the public sector has a guaranteed clientele, and is therefore a moneymaking area which the private sector wished to have. There is a guaranteed throughput and the potential profits are enormous'. Furthermore, the scheduled fee is charged to private patients which is beneficial for the whole community.

However, the proprietor of the privatised service asserted that there were problems and costs associated with operating

the radiology service. First, the contractors had to ensure the staff were available to service the contract before putting in a tender. He believed that this scarcity of radiology and technical staff actually led hospitals to sell off their existing radiology departments. The hospital's human resource manager supported such a contention by stating that:

> *Inland hospitals struggle to find staff. Staff attraction and retention is better for larger multinational companies that can contract across the State. If professionals are scarce, that becomes a reason for outsourcing.*

Second, the fixed cost of equipment provided by the contractor added to the cost of staff, and meant that the service actually cost between $250 000 to $300 000 per radiologist employed. Even though in some rural contracts these costs were not covered, he stated, they were locked into the costs due to contractual obligations, and that only in some cases were they able to renegotiate the fee structure. In addition, because Government payments for radiology services had been reduced, there was a windfall for the hospital. The private organisation did not want to walk away from the contract because it could jeopardise gaining further contracts with the public sector. Another option, they believed, was to cut the service to the bare obligations of the contract, but a compromise was negotiated. The proprietor stated that 'if people are unreasonable the contract becomes unworkable'. Support for this proposition came from the Director when he stated that 'the key was tight specifications in the contract and a good relationship with the private company so that both sides were able to bend in difficult times'.

The location of the service did not change, thus maintaining the relationship with other hospital employees and allowing urgent hospital work to take priority over private outpatients. However, it was reported that the work became intense, with staff having to work during lunch and evening breaks in order to cope with the increasing number of patients and at the same time ensure the satisfaction of referring general practitioners. Waiting periods disappeared, and while overtime was paid, the viewpoint of the staff was:

> *It is now a private department and staff are responsible to the private firm, so if they don't bring in the dollars they would not be happy. We know we have to make a profit.*

The on-going contract-management costs were not included in the cost/benefit analysis, nor were the opportunity costs of staff time in preparing specifications. The Director of Finance stated that the contracts were initially written to reduce the administration costs of rolling-over contracts and it became a simple process then at the option of the private firm. No further cost/benefit analysis needed to be conducted, he added. However the hospital can give notice to not renew the contract. In fact, it no longer conducted cost/benefit analysis of the outsourced areas comparing internal to external provision because, the Director believed, the savings were so clear-cut that there was no need. After 2 years of comparisons, no realistic figures could be ascertained for internal servicing.

As to the future, the Finance Director stated that 'the decision could not be reversed because they could not consider equipping a radiology laboratory, for example, because of the cost of equipment. A CT scanner costs $1m. alone. And there are similar problems in pathology'.

Pathology

The Director of Medical Services stated that the outsourcing of pathology consisted of both cost and revenue imperatives. Governmental changes to the Medical Benefits Schedule (MBS) in 1991 had rendered this service profitable for the private sector. The fee for the service, payable by the Government as per MBS, was divided into a 'testing fee' and a 'patient episode fee', the latter fee of $15 per patient not being payable for services provided by the public sector. In addition, the market was growing as the population aged and technology changed, enabling new tests to be performed. This updated technology allowed for employees with lower skill levels to be employed, with the decision-making transferred from human to machine and providing for the payment of lower rates of pay.

Even so, the Hospital Scientists Union of Australia was seeking to increase Medical Scientists' rates of pay while resisting the introduction of flexible rostering. In this hospital, the staff were rostered from 8 am to 5 pm, with on-call and recall for pathology services after-hours being shared and paid for at time-and-a-half wage rates. The Director believed this produced inefficient salary costs and a lack of labour flexibility. The Director of Human Resources, when discussing the industrial environment surrounding pathology, stated that:

> *There was a push for team-based work structures in small departments. Simultaneously there were campaigns in the sector for reclassifications to higher levels, which priced the medical scientists out of the market. This push by the union for unsustainable income levels resulted in a statewide push for privatisation of pathology. Industrially they also had the ability to completely stop blood supplies and had strong bargaining power through their unity.*

In addition, the Director of Medical Services indicated that the impetus of an existing private hospital opening a laboratory in the area, thereby introducing competition into the provision of pathology services, produced fears of decreasing market share. The union official supported this, stating that:

> *The economic factors at this hospital were different. Even though cost shifting drove privatisation in Victoria, here the tenderer was not guaranteed an income as in other places. The winning tenderer would be unsure of retaining the volume of private billable work that had previously gone to the public hospital.*

This unpredictability is reflected in the reduction of pathology outpatient attendances by 53% between 1992/1993 and 1993/1994. And alongside this, variability in inpatient mix was occurring, leading to a decline in paying patients, which added another risk factor to the analysis. Private patients could elect to be admitted to hospital as public patients, thereby abrogating their responsibility for fee payment.

The Director of Finance stated that the inability to access private revenue, the high labour costs and inefficient work practices resulted in a service ripe for contracting out. The 1994-1995 [hospital] Annual Report specifically stated that the major reasons behind this were concerns about the loss of revenue due to the establishment of a further pathology provider and the hospital being excluded from receiving the patient episode fee. The Director of Human Resources added that bargaining power was an important consideration at the political level in deciding which areas to outsource.

Six organisations tendered and each of the tenderers provided a discounted price compared with prevailing internal costs, to conduct the hospital's public patient tests in return for access to private outpatient work. The winning tenderer, which gained the contract for 5 years, was a private company that operates nationally as one of the three largest private providers of pathology services in Victoria, and has numerous sites in both public and private hospitals.

Tender specifications were particularly detailed due to the technical nature of pathology, and included such matters as the nature of the tests, the number of tests in each category, lead times between test performance and results and scope of tests. In the health sector some tests are very expensive to perform in low numbers, while others achieve economies of scale and may return a higher profit margin. Because the service had to meet Department of Health accreditation standards and was provided to private medical practitioners, the quality of service was maintained by market, as well as contractual, pressure. Hospital accreditation and quality assurance procedures also ensured that that the pathology service maintained quality and these accreditation requirements were written into the contract as specifications. However, other costs were ignored and not included in the cost/benefit analysis, in the same manner as radiology.

The ability of the private sector to perform the service at a lower cost than the public sector was due to a number of factors. First, 'loss leading' practices were common across the industry, whereby the prices tendered for public work were lower than the market price in order to gain access to

the private market. Second, the private sector wanted to move into the pathology industry to gain access to the patient-episode fee. Support for this proposition came from the Director who agreed that in this outsourcing occurrence, the pathology tender price was lower than the prevailing market price for public work. The union official also agreed, and added that 'it was no ordinary world at the time and there were offers that the private sector would do public patient testing for nothing'. The Director of Finance confirmed this when he stated that the private sector had a significant edge in costing the service compared with the public laboratory due to an ability to access the patient-episode fee.

Overall, the hospital saved approximately $200 000-$300 000 per annum from outsourcing its pathology services, an ongoing contribution to recurrent cost savings for the hospital. The Director of Finance stated that by making the service available to public patients at a lower cost than the hospital could offer, in effect the private laboratory passed on to the hospital a portion of the financial benefits it had obtained from the Government via the patient-episode fee. He elaborated by stating that because private laboratories work across hospitals in a particular region, they could gain access to greater economies of scale and so reduce the costs of the service. However, the disadvantage inherent in the whole privatisation process was that the profit is taken out of the hospital system and, specifically in this case, the money which had previously been used to fund medical equipment upgrades.

Dental technician services

The service was previously operated with a single staff member, but variable demand rendered internal provision uneconomic. The local private operator who won the bid on the basis of cost was able to viably operate because hospital patients supplemented the operator's private work. The Director of Finance argued that the service was not economic in terms of scale and to supplement revenue, private work would have been required. But, when competing for external work, they could not compete with private dentists in the general market place due to NCP's requirement of adding imputed taxes and accounting rates of return to the hospital's internal costs. Also, public perception was important, with the Board of Management concerned about perceptions in the local community of the public sector competing with private industry. Although the existing staff member was a bidder for the initial contract, it was awarded elsewhere. However, the contract has since been awarded to different providers a number of times, showing the competitive nature of the market. Two major dental laboratories in the town performed all the private dental work and, hence, with their significant volume of work, achieved economies of scale which reduced the cost compared to internal provision.

Lawn Mowing

Twenty years ago, four gardeners operated the hospital's lawn-mowing service but, with gradual attrition, staff numbers dwindled to two who were retrenched on the awarding of the contract to a local community provider, reportedly on the basis of cost. Despite all the interviewees claiming that cost was the deciding factor, on awarding the contract hospital management negotiated a reduced size and complexity of gardening service. However, it is unclear whether this was due to the need to reduce the service level or to the lack of expertise of the community provider in operating a complex service. Even though no detailed cost/benefit analysis was completed, the Director of Finance stated that he doubted the hospital could have run the service at the price tendered. The process consisted of receiving the tender price, making a comparison with internal costs and then negotiating the service level.

Food Service

In 1997, outsourcing of food services was also considered, on the basis of financial gains and compliance with NCP.

A consulting group was contracted to investigate and benchmark the service against similar hospitals. The recommendation to outsource the food services department was rejected for a number of reasons (information from the

external consultant's report is not referenced to maintain anonymity and confidentiality). First, the staff were highly committed, a number having been employed for between 20 and 25 years. The Chief Executive Office believed these staff were very loyal, not highly paid and lacked transportable skills. Furthermore, they had cooperated with hospital management in the past to reduce costs and achieve savings by working with new technology and changing rosters and work practices. He stated:

> *A country hospital's decisions impact upon a lot of people and we have to bear in mind ramifications and consequences. To achieve results without retrenching staff is a good outcome. The hospital owes a debt of gratitude to them for making these changes, and so does not wish to privatise after the loyalty they have shown.*

The department manager, who added that characteristics of the rural area are important, supported this view. 'This is a local hospital employing local people and producing meals for local people.'

Second, the manager stated, 'It was not a good idea to outsource as jobs would be lost, including my own'. He added that most hospitals did not want to contract-out because they would lose management control. As such, their decision was not based so much on public interest as self-interest. Support came from a union official when he stated 'if the service is outsourced, the manager gets the sack so it is really about protecting their own jobs'.

Third, there were questions raised about the costing of the consultant's proposal by the functional manager and the Director, who both found inadequacies in the report in relation to staffing and meal costs. They further determined that outsourcing would not make savings. Because the functional manager's actions in introducing new technology and changing work practices had already been instrumental in saving costs, the Board accepted his recommendation.

Discussion

All the decisions were implemented in an environment of decreased funding, hospital amalgamations and the introduction of NCP. As such, political factors were important in setting the context in which each decision was made. The fiscal environment produced pressure on the hospital's ability to provide funding for capital replacement, while the characteristics of the rural labour market produced added pressure on the hospital's ability to obtain professional staff.

Specifically, the reasons for market testing the non-clinical services related to the desire to adhere to the ideology of the Government. The consequential outsourcing of dental technician services was due to a desire to increase workforce flexibility and focus on core competencies; outsourcing lawn mowing was to reduce costs. In rejecting the outsourcing of food services, personal objectives were important and other methods were used to reduce costs and increase workforce flexibility in the use of internal staff.

The outsourcing of the clinical services of radiology and pathology were conducted and continued in line with Government ideology, along with a desire to improve the management of industrial relations problems. The outsourcing of the former was due to the problematical relationship between management and staff and, hence, related to a desire to satisfy decision-makers' personal objectives.

Williamson's four variables will be used to frame the discussion[9].

Frequency of exchange and asset specificity

Williamson argues that firms should only engage in internal production when the transaction is specific and recurrent, while all standardised transactions should be provided by the market[8]. The contracting out of lawn mowing and the dental technician confirm to this. However, the outsourcing of

pathology and radiology transactions seem to conflict with this viewpoint. These transactions require human, location and investment specificity, and have high exchange frequency and thus it should be possible to provided these services internally at a cheaper cost.

However, with regard to radiology, the introduction of capital equipment by the contractors provided a financial benefit and allowed gains to be made in revenue through subsequent increases in patient numbers. Costs were also reduced through changes to working conditions, job losses and competition between a number of private firms in both the pathology and radiology decisions.

Food services had high exchange frequency and did not require human or physical asset specificity because labour was available locally. However, it was argued by the consultants that the specific nature of hospital food meant that external vendors could specialise and provide the food more cheaply. However, there was a lack of evidence that outsourcing would reduce costs further than the hospital had already achieved.

Human asset specificity was problematic due to the idiosyncratic nature of the rural labour market. The lack of expertise in a rural area often makes it impossible to use local contract labour. And in other cases, the contractor's location may be remote from the hospital so that using staff on an on-call basis is impractical. In contrast, the use of a national private company for radiology provision allowed the hospital to gain expert staff who were not available locally.

Opportunism

Additional factors, such as problems in managing staff due to their opportunistic behaviour, and the transfer of industrial relations problems to a third party, also impacted on the decision, although there was a lack of evidence that decision makers objectively costed such matters into the analysis.

The outsourcing of radiology was pursued due to conflicts of interest between managers of the department and their staff, criticism of hospital equipment by the radiologists and incompatible personalities, attitudes and values between the hospital staff and the radiologists. Self-interest was also evident in food services where workers accepted change more readily once outsourcing had been used elsewhere at the hospital, or when outsourcing was threatened. In this regard, employees were willing to become multiskilled and change work practices to retain their jobs.

The power of the line and departmental managers was also an important consideration, because managers of the food services department displayed hierarchical authority and an ability to alter the Board of Management's perceptions through lobbying. Decision criteria and information was used selectively by these managers to sway the decision towards in-house production.

Manipulating figures and discrediting consultants' reports were examples of opportunistic tactics used to sway opinions by hospital management. In doing so, self-interest may also have played a part, because once the function is outsourced it is likely that the line manager concerned will lose their position. It was interesting that consultants' reports were accepted readily in some areas and opposed in others.

Another political motive was evident in the use of outsourcing of pathology to reduce the power of the medical scientists' union which, it was contended, would also reduce management problems. Loss-leading practices by the private sector was also used to break into the pathology market.

Multiple tenderers placed bids for the pathology and dental technician service which Williamson claims will reduce opportunistic behaviour on the part of vendors, decrease risk and ultimately lead to reduced costs.

In general, outsourcing reduced management problems in recruitment, rostering and general management of staff.

Environmental uncertainty

Environmental uncertainty was apparent in pathology with increasing competition and the decline in fee-paying patients. In radiology it was apparent in the decreasing Government fees payable to the service provider while the contract locked in the fee charged. In both services the acquisition of skilled staff was also problematic.

The use of long-term contracts to reduce environmental uncertainty was evident in this case. Hospital managers' indication that all incumbents were likely to regain the contracts provided for continuity of relationships, provision of much-needed capital equipment and stability of employment for staff most of whom had simply transferred from hospital employment to the private provider. In addition, because no further cost/benefit analysis were conducted since awarding of the initial contracts, it is improbable that the services would be transferred back to the hospital. Specifically, in the case of radiology, the cost of capital equipment provided by the contractor made it improbable that the service vendor would be changed.

Conclusion

Williamson claims that the nature of a transaction's frequency and asset specificity will determine the optimal governance structure that will reduce costs. In this case, high frequency of exchange was apparent in pathology, radiology and food services, but it was only the former two functions which were outsourced. In addition, although asset specificity was a requirement of pathology and radiology it was outsourced, in contrast to Williamson's prescriptions, suggesting that decisions made relied on additional factors.

Political imperatives, which could be classified as opportunism, were also important when making the decision between outsourcing and internal servicing. And examples of opportunistic behaviour were numerous in radiology, pathology and food services.

Environmental uncertainty was another factor considered by decision makers, and the hospital used a variety of arrangements to decrease such uncertainty. These included the transfer of staff from employment within the firm to the contractor in radiology and pathology, and the establishment of long-term contract terms, and thus relationships, between the hospital and contractor.

Within the context of adhering to Government ideology, in non-clinical areas the decision to outsource was based on economic reasons, such as the desire to reduce costs and increase efficiency, to increase workforce flexibility and focus on core competencies. In contrast, political reasons were often the impetus in the clinical areas, and focused on the desire to improve management problems, even though financial benefits were claimed to be the result. However it is questionable whether opportunism and environmental uncertainty were actually costed, or even if it was possible to cost them, in an objective manner, even though they were discussed as impacting on the decision. Furthermore, not all transaction costs were included in the cost/benefit analysis.

Although Williamson[8] argued that the primary criteria when choosing outsourcing is to reduce costs, Ghosal and Moran[20] argue that each firm adapts to market signals in its own individual way and that these individual actions result in different governance structures for essentially the same type of transaction. Outsourcing can be evaluated using transaction costs as its basis with each of the four variables impacting on each decision. However, the evidence from this case demonstrates that decision makers do not choose between outsourcing and internal production on the basis of transaction frequency and asset specificity alone. Opportunism and self-interest impacted on the decisions made. However, even though Williamson includes opportunism, or self-interest, of principles and vendors as a variable in this theory, the ability to cost this into the analysis is difficult[8]. Managers often give prominence to the view that reducing costs is the primary reason for outsourcing however, on the basis of the case, it is clear that such costs are more complex than often displayed in a financial cost/benefit analysis and typically include those

arising from the nature of the relationships between the hospital, vendor and staff.

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