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Outsourcing in Healthcare Systems

In the supply chain management of healthcare organisations, outsourcing decisions have specific distinctiveness, namely, in the reasons and constraints of the decision, in the selection criteria of the activities left to third-party operators, in the type of possible agreements, and even in the impact of the outsourcing decision on the organisation. After the success of outsourcing within the manufacturing industry, the healthcare sector is considered one of top three sectors (along with the finance and legal industries) with a significant potential for growth in the application of outsourcing.

Outsourcing decisions frequently result in organisational change, even in low-volatility sectors such as healthcare. In an entrepreneurship environment, healthcare organisations adopt outsourcing solutions for the same reasons as in other sectors: Looking for efficiency, quality, and profitability gains. However, in healthcare units, outsourcing is part of volume flexible strategies to adapt capacity (namely in bigger organisations such as academic medical centres) trying to respond to demand fluctuations, care that is increasingly complex, and to the linkage between clinical performance and number of medical acts. In fact, in some European countries that are more politically reluctant to privatisations (e.g., the United Kingdom, Sweden, Spain, and Portugal), outsourcing of clinical services was a response to waiting lists.

Through contracting agreements with public and private providers (including public-private partnerships, PPPs), healthcare systems looked for access, quality, equity, and efficiency advantages. However, although there is evidence in primary care outsourcing agreements for access improvement (in provision, coverage, and use) gains, there is not clear evidence of equity, quality, and efficiency improvements. Evidence regarding efficiency gains has revealed some inconsistency.

Although the extension of outsourcing decisions from nonclinical to clinical activities occurred in the healthcare sector later than in other sectors, the phenomenon took a global scale with many reported cases, from medical transcription to the latest trend of medical tourism with people travelling abroad for healthcare services seizing the best relaxing environment for recovering.

Drivers for Outsourcing

After a broad study of outsourcing cases in several healthcare systems, the most pointed drivers for outsourcing in healthcare units were:

- Cost reduction;
- Risk mitigation;
- Adapting to quick changes without jeopardising internal resources; and
- Redefinition of value streams.

At first glance it seems attractive, the possibility of externalising noncore activities but critical to process-oriented organisations, the leverage of nuclear capacities and the possibility for critical mass to build up and achieve economies of scale. However not all outsourcing solutions bring all desired benefits. There is an array of different outsourcing solutions in healthcare that vary outsourcing decisions in healthcare units depending on:

- The kind of activity (modular versus integral; more or less contractible);
- The type of contract (classical versus relational);
- The contract duration;
- The specification level of performance requirements (process and outcomes indicators); and
- The payment mechanisms.

In our study, we've identified a clear distinction between outsourced clinical services with less proximity to the patient and the outsourcing of nonclinical actions, mainly support activities and business processes.

Risks and Importance of Performance Monitoring

Both in clinical and non-clinical areas, the main risks of outsourcing are: (1) losing control of suppliers (discontinuity of service quality levels, accountability issues, loss of competences, and information confidentiality problems); and (2) excessive supplier dependency and consequent loss of flexibility.

It is, however, important to stress the importance of performance monitoring to avoid quality problems such as infection risks, patient dissatisfaction, and hidden costs of support activities such as cleaning and meal services. Other nonclinical activities outsourced and identified as the main drivers of cost reduction are procurement and purchasing to group purchasing organisations (GPOs) with evidence of cost reduction

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advantages (10 – 15 percent in acquisition cost, 40 percent in transaction-related costs), but with some associated risks of oligopoly development and function duplications due to strategic misalignment.

The most reported risks of outsourcing clinical activities refer to integration difficulties in activities such as radiology and other laboratory functions. On the benefits side, the gains in expertise, capacity, and resource release need to be addressed in a balanced evaluation along with associated risks.

Also, contextual differences are crucial to understanding the advantages and risks of outsourcing in each healthcare system framework. Based on the source of funding, three main models can be identified: The Beveridge model, with predominantly public funding based on taxation (in the United Kingdom, Spain, Portugal, Greece, Italy, Sweden, Denmark, Canada, Australia, and New Zealand); the Bismarck model, with private-public providers and premium funding (Germany, France, Austria, Switzerland, Belgium, Holland, and Japan); and the private insurance model, as shown in the United States with predominantly private providers coexisting with Medicare and Medicaid social care. From all reviewed literature, we focused on Germany, United Kingdom, Australia, New Zealand, the United States and Greece, not only because of the higher number of articles founded regarding outsourcing practices, but also to illustrate the three different healthcare systems. Underlining the main differences in the principal healthcare system models, four different outsourcing trends are visible, as follows.

Outsourcing in the German Healthcare Sector

The Bismarckian German healthcare sector suffered an evolution with demographic changes, the scarcity of resources for social security (mostly due to unemployment), and the decrease of physicians as main constraints for deep reforms in the hospital sector. One of the measures deployed was a new remuneration system based on diagnosis-related groups (DRGs), following the Australian system, starting in 2004 to be completely implemented in 2009. This new system, along with quality implications of integrated care (or integrated delivery systems), forced a second wave of outsourcing trying to achieve better cost-efficient outcomes than found in the first wave during the 1990s. Outsourcing in the United Kingdom, Australian, and New Zealand's Healthcare Systems In the United Kingdom, the National Health Service (NHS) system, created from Beveridge's 1942 report offered universal access and comprehensive coverage of services for all citizens but has undergone considerable changes throughout the past decades. These changes have often been portrayed as a move toward an internal market in the UK system. Under a conservative government and against the strong opposition of physicians and nursing personnel, provisions to reform the NHS (the National Health Services and Community Care Act) were intended to open the field to the private sector on a wider scale. Private hospitals were allowed to compete with regional and municipal hospitals for NHS patients, publicly owned hospitals could be acquired by private entities, and, most visibly, services were to be managed under prospective global budgets. The creation of trusts and an internal market at the beginning of the 1990s, and later in 1997 with the Blair government reforms led to the encouragement of private sector entrance and spreading of outsourcing practices that had begun in the 1980s. Likewise, Australia and New Zealand's healthcare systems, which are based on the same Beveridge concept, were driven by efficiency, flexibility, innovation, waiting-time reduction, and service range diversity gains to take measures such as the "national competition policy," which created outsourcing opportunities.

Outsourcing in the US Healthcare Sector

Funded through a complex mix of private and governmental insurance, the US healthcare system shows a great reliance on the mechanisms of the market, including contracting and competition that forces providers to do "more with less money". Outsourcing practices evidence is, however, much later identified in comparison to other sectors. Hazelwood et al. (2005) justify that fact because the ownership of most healthcare organisations is mostly not-for-profit (80 percent), government financed, and managed by committees, and not by an administration with a strategic plan and cost-driven decisionmaking processes. However, a growing outsourcing trend has emerged, driven by the JCAHO's quality markers (Joint Commission on Accreditation of Healthcare Organisations) and outlined by HIPAA (Health Insurance Portability and Accountability Act). In the late 1990's, around 75 percent of US hospitals had at least one outsourced function, not just in support services, as in early years, but also in the patient path of inbound to outbound functions. The growth trend is also stressed in studies using surveys of hospitals, long-term-care units, and clinics. Another growing trend is group purchasing organisations (GPOs), which service 97 percent of US hospitals that outsource procurement. The latest trend is medical outsourcing provided by partnerships such as one of the Parkway Hospitals in Singapore; the Johns Hopkins Hospital in Baltimore, Maryland; one of hospitals in Health Care City in Dubai; and the Mayo Clinic in Rochester, New York.

Outsourcing in the Greek Healthcare Sector

The Greek healthcare sector, also inspired by the Beveridge model, illustrates the importance of the public health sector as the main provider in an economically difficult environment. Despite the lack of empirical and published research on outsourcing in the healthcare sector, one study gives a full description of the Greek healthcare system constraints to outsourcing practices in public hospitals, leaving private healthcare providers outside the empirical setting, and focuses on the decision-making process, the extension of outsourcing, effects on public healthcare, and future trends; stresses the difficulty of decision making in public healthcare organisations; and explores the reasons of (dis)satisfaction with outsourcing decisions.

Conclusion

The existing literature is frugal in empirical research on performance models and measures in outsourcing cases. There is also a lack of published research on how healthcare organisations deal with outsourcing risks before and after the decision and in different contexts from organisational change processes, such as start-up organisations' outsourcing decisions. Lessons from other sectors' practices should be studied instead of thinking of outsourcing as a panacea to mitigate risks or simply reduce costs.

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