

NON-CORE BUSINESS SERVICES IN THE POLISH HEALTHCARE SYSTEM – THE MANAGEMENT PARADIGM

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Abstract

The healthcare system management paradigm is to a large extent based on external resources. Hospital managers commissioning non-core business areas related to patient hotel did not analyse the costs of such activities. Such an approach then results not only in the absence of the benefits that outsourcing would bring but also the impossibility of insourcing.

Keywords: *budget, outsourcing, services, public procurement, hospital*

1. INTRODUCTION

After the Second World War (1945 - 1989), the Polish healthcare system operated based on the so-called Siemaszka model, i.e. universal healthcare. It was constructed on four pillars. They guaranteed, among other things, full access to healthcare for the whole population, financing it directly from the state budget and based on the central planning, exclusive state healthcare, a full and completely free range of health services and the absence of the private sector. The adoption of this model assumptions implied the state monopolised all the decision areas related to health protection. These included: financing methods, the amount of the funds transferred, health institutions deployment plan and structure, decisions on the medical equipment purchase and their distribution, staffing and planning the number of the trained medical personnel and educational methods applied. The amount of financial streams allocated was determined by the number of public healthcare facilities that were the key providers of medical services and the number of residents. As budgetary establishments, they were forced to make full use of the appropriations yet deprived of the possibility to decide on their allocation (Lewandowski & Walkowiak, p. 21). Then, the determined health service financing plan was increased annually by the amount representing the percentage of the financial resources use in the previous year. Such an approach led to the irrational decisions manifested by the uncontrolled purchases, low efficiency and quality of medical services provided and limited access to highly specialised services. Some hospitals and clinics posed a certain alternative as they were financed by the sectors that created and financed them, for example, the chemical, mining and steel or shipbuilding sectors, etc.

The reforms carried out in 1999 and 2003 which stemmed from the fact of Poland's accession to European Union were of significant importance for this sector functioning. The implementation of the provisions of the European Parliament and the Council into the Polish legal system has adapted the Polish legislation to the *Acquis Communautaire*. The National Development Plan (2004), adopted at the same time in 2004, not only assumed the improvement of public health by linking health promotion, prevention and education but also allowed the perception of health expenditure as a long-term investment and one of the many factors of the economic development.

The adopted Plan constituted the basis for the initiatory activities leading to the debt relief of public healthcare institutions (hospitals). At the same time, the market element was introduced by means of the possibility of creating non-public healthcare institutions for the healthcare system. The further decentralisation conducted to the creation of the health maintenance organisations (1997) the area of activity of which was related to the administrative division of the country. However, in 2003, the healthcare system was again centralised. The National Health Fund (NHF) has been appointed and become a beneficiary of the health maintenance organisations and both the main decision-maker as well as fund manager.

2. MATERIALS AND METHODS

2.1. Materials

For the needs of the study, both the information from the Supreme Audit Office from the period of 2004-2008 regarding prices of hotel services ordered by healthcare entities and own research with the employment of surveys carried out in 2018 covering the years 2009-2017 were used. These studies included the query of bidding documents for the provision of outsourcing services that have been made available by randomly selected units. In total, 57 organisational units (hospitals) were analysed, including: 23 units with the number of beds up to 150 and 9 units with the number of beds from 151 to 300, founded by the local self-government units. The founding body of other studied entities was a representative of the central government, i.e. the voivod, and they have the following structure: 10 units with a number of beds from 301 to 500 and 15 units with a total of 500 beds. The spatial coverage of the research enclosed the central, western and northern part of Poland. The research also includes both the reports of the President of the Public Procurement Office on the functioning of the public procurement system in 2009-2016 and own research on the supply side of the public procurement market in 2009-2017.

2.2. Methods

The generally applied quantitative as well as financial analysis methods were used for the analysis of the materials made accessible by the surveyed organisations and own research.

The analysed documents using the adopted methods allowed to formulate the thesis about a **limited range of outsourcing benefits as a management paradigm in the Polish healthcare sector (hospitals)**. In order to confirm it, the three entities were distinguished from the group of the studied organisations and they were further analysed in terms of the cause-and-effect relationship of the outsourcing influence on the hotel services costs (catering, laundry services and cleaning). The common denominator for the surveyed entities were the years of the contracts' conclusion.

2.3. Outsourcing in the Polish healthcare system – causes and effects

As a result of the 1989 disintegration of the Council for Mutual Economic Assistance (COMECON) Poland found itself in an economic void. Due to the strong efforts to adopt the western model of economy and management, the processes aimed at implementing solutions functioning in Western countries began. It required the reconstruction/restructuring of the inefficient socialist economy and departure from the central planning. The health sector and its inherent entities constituted one of the first areas of interest in this respect. The reconstruction started with the processes aimed at increasing the efficiency in both the financial and quality dimension. The first restructuring was carried out already in 1991 (Act On Healthcare Institutions, 1991). At that time, *budgetary* healthcare facilities were transformed into public health care facilities. The funds were transferred by the European Union under the PHARE pre-accession programme. The second restructuring – in the form of a debt relief – took place in 1999 and was the result of the system and economic reforms. At that point, market elements were introduced into the healthcare system with the intended result of increasing the availability of medical services together with their quality and rationalising costs. It began with the changes introduced to the hospitals, i.e. liquidations of some hospitals, combining others as well as the connection of wards, e.g. internal medicine+cardiology. The released funds were spent on the increase of wages, purchase of medical equipment and apparatus, modernisation and repairs as well as the adaptation of buildings and rooms for medical services provided. Since 2001, the re-generation of debt has begun in the public entities in the healthcare sector (hospitals). This condition was influenced by the terms and conditions for signing contracts for the provision of medical services which were dependent on the health maintenance organisations' revenues. Operating in the industrialised regions and insuring young people, these organisations have been able to achieve higher revenues and contract medical services of not only a higher quality but also more specialised (IBRD, p. 5). The operation of the health maintenance organisations (1999-2003) closed with a debt of about PLN 500 million, while their legal successor, i.e. the National Health Fund, required a subsidy from the state budget in the amount of about PLN 1 billion (Ministerstwo Zdrowia 2004). The re-debt of public health entities, otherwise known as financial and organisational restructuring, began in 2005. The reasons were:

financial insolvency of public entities in the healthcare sector, shortage of funds for the regular payment of liabilities and their inappropriate structure. The introduction of organisational solutions comprised one of the conditions for receiving funds for debt restructuring (repayment).

The restructuring process which begun in 2005 forced the healthcare sector entities to actively participate in the process of rebuilding the organisation. The basis for receiving financial support was the preparation and submission by the indebted entity of a recovery programme aimed at excluding future debt generating options in line with the principle that it is necessary to depart from the quantitative growth formula in favour of a qualitative one. The resignation of the services rendered so far (Lovejoy 1997, p.3) required the change of the organisational structure of the entity, presentation of the employment reduction plan in administration, secondary and auxiliary medical personnel, technical services, etc. and restrictions of other costs related to the operation of the entity. The outsourcing activities undertaken in the organisational sphere were associated with the diversionary activities related to dismantling a specific area (Coyne & Wright 1986, p.2), in particular, those of a spin-off type which consists in dismantling some of the areas still related to the parent undertaking (Baroncelli & Manaresi 1997, p. 235).

Seeking the solutions at the organisation (hospital) level, the managers of these entities paid attention to the outsourcing management concept. Since this model works well in for-profit organisations, it should also be successful in non-profit entities, hence, the non-core business services have been commissioned to external contractors.

The entire outsourcing process in the Polish healthcare sector can be divided into three stages: the first stage included non-core business services, the second stage was associated with the technical maintenance of facilities and medical transport, and the third stage related to the core business and encompasses the provision of some services to external recipients related to patient hospitalisation, e.g. diagnostics. At present, in many hospitals, the medical entity remains responsible for the medical service required by the legislator, the lack of which may lead to the liquidation of the subject's activity. Such an approach to outsourcing is contrary to the paradigm of outsourcing, which was promoted by J.B. Quinn and F. Hilmer. They claimed that the activities and areas characterised by a high degree of strategic sensitivity should not be transferred into outsourcing.

Outsourcing in the Polish healthcare sector has been implemented on the basis of its two basic models, i.e. total and partial outsourcing. In the former, the external contractor asserts control over the entire process/area of activity separated from the organisational structure of the entity. In the latter, the control over the distinct part or the area is transferred to external contractors. A variation of total or partial outsourcing applied in the healthcare sector entities is contractual outsourcing. The type of contract concluded is important in this case. Based on the terms of cooperation in healthcare organisations, deterministic (closed) contracts which delineate the rights and obligations of the interested parties are strictly defined (Gruszecki 2002, p.63) and a contractor selected in the tender concludes a contract for the performance of the outsourced services. This choice is determined by the requirements in relation to the future contractor described in the Terms of Reference (PZP) (Public Procurement Law Act 2004). They concern, among others, the presentation of documents confirming the performance of the same or similar services of comparable value, employment status, certificates held, etc.

Contractual outsourcing, however, limits the relationship between the parties, focusing their attention mainly on fulfilling the conditions included in the contract (punctuality, quality). Still, another type of cooperation is impossible due to the opportunistic attitudes of outsourcing service providers that lead to the manipulation of information to achieve their own benefits (Shapiro 2005, p.45).

Outsourcing in the Polish healthcare sector has thus become a tool for disintegration of the organisation that, till then, has created one whole (Obłój 2002, p.45). The outsourcing system emerging as a result of numerous connections with external contractors demonstrates specific features of the network and the entity ordering its services is transformed into the center of contracts' management.

When deciding on outsourcing as a management concept, managers assumed: the reduction of the operating costs an employment, quality improvement, internal release and acquisition of the resources unavailable within the organisation, dealing with the areas that pose management problems, risk sharing and founding bodies' recommendations. The result of the actions taken was to increase the efficiency of hospitals' operations (March & Sutton 1997, p.8), which from that time on were realised from the hospital strategies point of view determined by the financial resources.

3. RESULTS

The research results (Figure 1) indicate that in 2004-2018 the most stable price could be noted for the outsourcing of food services (cat). The price increase took place only in 2005-2007 whereas in 2008-2014 the prices of the services provided remained at a similar level with a slight downward trend in 2015-2018.

Considering the outsourcing of cleaning and laundry services, the abrupt nature of prices for these services can be noticed. In 2004-2007 there was an increase in prices, and then in 2008-2012 the decline and then a further increase in 2013-2018. The rise of the outsourcing prices of maintenance/cleaning and laundry services resulted mainly from the macroeconomic policy, i.e. an increase in the minimum level of remuneration, since the cost of the increased wages was 'added' to the service price. This was also the case for catering services, but here it was partially offset by the fall in food prices.

The relatively constant outsourcing services price in individual years was also due to the contract conclusion period. Nevertheless, according to the Public Procurement Law (2004), the duration of such a contract may not exceed 48 months. Yet, contracts were most often concluded for a period of 12-36 months.

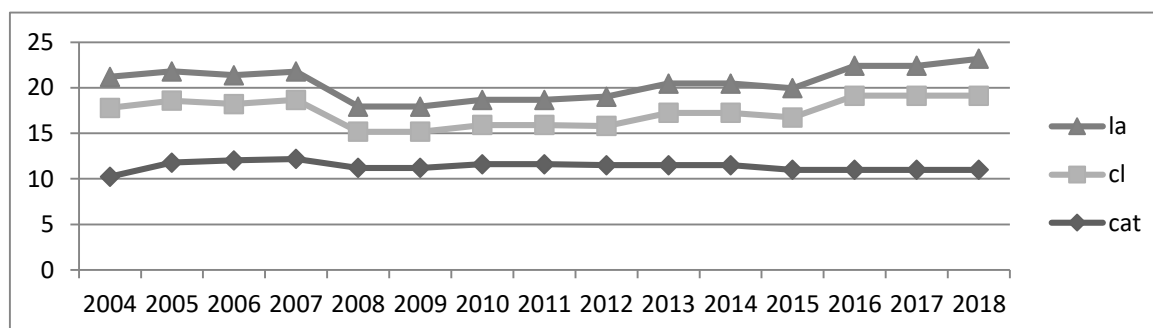


Figure 1. Average of hotel services outsourcing price in 2004-2018

Source: Information of the audit results, Supreme Audit Office, Warsaw 2009; calculations and own elaboration based on the studied units' accessible information; la – laundry service [kg], cl – cleaning service [m²]; cat – catering [per person].

A good measure for the outsourcing prices may be the number of incoming offers per ad. On the one hand, it presents the drop in the number of incoming offers in 2006-2008 resulting from the 12 and 24 month-long contracts, and thus the lack of announcements of searching for an outsourcing contractor in those years. On the other hand, the observed drop in the number of offers submitted was the result of a decrease in the interest of external contractors in the provision of services to hospitals, especially since 2016. The main reason was, among others, the failure to meet the payment deadline by these organisations. Such an approach to outsourcing services contractors led to the situation when – against their economic interest – they became the hospital lenders (Figure 2).

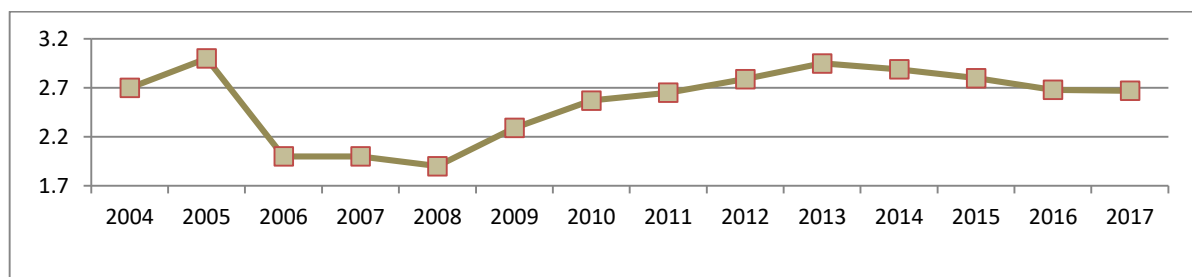


Figure 2. Average number of offers submitted in response to the outsourcing ad in 2004-2016

Source: The Polish Public Procurement Office, Report of the President of the Polish Public Procurement Office on the functioning of the public procurement system [2004-20016]

The hospitals indebtedness stems from the insufficient financial resources in the healthcare system and the lack of correlation between the actual cost of medical services provided in hospitals and their valuation by the National Health Fund as their payer comprises the main causative factor here.

Case studies

Processes under the slogan of restructuring which started in 2004-2005, based on outsourcing and aimed at reducing costs and increasing efficiency turned out to be a highly risky and often unsuccessful undertakings. This is indicated by the analysis of the non-core business services costs in the three selected medical entities (hospitals) - Table 1. These are the organisations founded and supervised by the territorial self-government unit and with the largest number of entities in the Polish healthcare system. The same year of the contract was adopted as the basis for selection of these units whereas the cost of providing the service in its own scope and the price offered by the external contractors comprised the reference base.

Year	Hospital 'A'	Hospital 'B'	Hospital 'C'
2005	+15.2	+17.3	+12.4
2006	+2.1	+3.3	+1.6
2007	+1,2	+0.9	+1.2
2009	-8.4	-0.3	-1.5
2011	-0.9	-0.6	-0.7
2014	-4.5	-2.6	-3.2

Table 1. Catering cost (per person) as a result of contracts concluded
(cost of providing services in-house=100)

Source: Own elaboration based on the documentation provided by the analysed hospitals, Feb. 2018

The separation of catering services from the hospital structure was the easiest task, so despite the unfavorable relation of own costs to the prices offered by external suppliers, the examined hospitals signed contracts for their provision. These actions were imposed on the hospitals since the failure to submit a restructuring plan by the end of 2005 resulted in the lack of financial means for their debt relief. Concluded in 2005-2007, contracts for catering services in all the surveyed hospitals indicate an increase in costs compared to those they would incur by providing the same services on their own.

The lack of a comparative analysis of own costs and market prices poses a big disadvantage on the part of contracting these services. The contracts concluded in 2005 indicate a 15.2% increase in

hospital A, 17.3% in hospital B and 12.4% in hospital C as compared to the costs of providing them on their own. An analogous situation can be noticed in 2006-2007. Only the short time the contracts were concluded for, and thus the expectation of a fall in prices, can be considered positive. Since 2009, it can be seen that the prices of catering services offered by external contractors were lower than the costs that the hospital would incur by providing these services on its own. The largest decrease was recorded in 2014. It amounted to 4.5%, 2.6% and 3.2% for A, B and C, respectively. It can therefore be concluded that the outsourcing of catering services turned out to be a beneficial project, which was in line with the expectations of the managers of the surveyed organisations.

Year	Hospital 'A'	Hospital 'B'	Hospital 'C'
2004	+0.2	+0.3	+0.4
2005	+1.1	+1.3	+0.6
2008	+1.2	+0.9	+1.2
2009	+5.6	+4.3	+4.5
2012	+5.9	+5.1	+5.1
2015	+8.5	+7.6	+8.4
2015	+8.5	+7.6	+8.4

Table 2. Laundry service cost (kg) as a result of contracts concluded
(cost of providing services in-house=100)

Source: Own elaboration based on the documentation provided by the analysed hospitals, Feb. 2018

Laundry services in the surveyed units comprised the second most often outsourced area (Table 2.). After a slight increase in prices in 2004-2008 comparable with own costs, from 2009 the price of these services began to increase. The highest rise was recorded in 2015. It covered 8.5% in hospital A, 7.6% in hospital B and 8.4% in hospital C in relation to the cost of providing these services on their own. The increase in prices resulted, among others, from a reduced number of contractors interested in providing such services.¹ One of the reasons was the tightening of the sanitary requirements for laundries providing services to hospitals, while the second was an increase in the minimum level of remuneration (from 2015). The effects of these activities were included in the prices of the services provided.

Year	Hospital 'A'	Hospital 'B'	Hospital 'C'
2006	+0.1	+0.4	+0.4
2008	+0.6	+0.5	+0.6
2009	+0.4	+0.4	+0.3
2011	+0.9	+1.1	+1.5
2013	+0.9	+1.2	+1.1
2016	+3.9	+3.8	+3.5

Table 3. Cleaning service cost (m²) as a result of contracts concluded
(cost of providing services in-house=100)

Source: Own elaboration based on the documentation provided by the analysed hospitals, Feb. 2018

¹ Own research on the supply side of the public procurement market carried out in the years 2004 - 2016

The costs of cleaning services in the analysed period and surveyed medical entities showed a small but growing trend (Table 3). The highest increase was recorded in 2016. The reason, similarly as in the case of laundry services, was an increase in wages translating into an increase in the prices of services provided.

The increase in the cost of services provided in the surveyed units also results from the impossibility of insourcing these services what is used by external contractors dictating the prices of their services and the conditions of their provision. This thesis is confirmed by the number of bids submitted for the announcement of the tender for the provision of services in those years when tenders were announced. In the case of *catering* services hospital A received 2 offers in 2005-2007, hospital B and C – three offers, in the following years it was respectively 3 offers, 4 and 5 offers. The offer for the provision of laundry services in all hospitals in 2004-2008 received a response of 2 or 3 offers, while from 2009 it was only 1 offer. Cleaning services were the most popular in this respect which resulted from the fact that the contractors most often employed unskilled workers receiving the minimum wage while performing this type of services – 4 offers in hospital A, 4 and 5 offers in hospital B and C respectively.

4. DISCUSSION

The outsourcing adopted by the organisational units within the realm of the budget sphere raises doubts due to the lack of results in terms of reducing the costs of the areas/activities of the organisation inherent in their structure. Though it was built as an organisational management model, outsourcing failed to bring the expected results in the case of public sector organisations (hospitals) despite the use of the potential and capabilities of the specialised external entities.

The question then remains open in this case whether outsourcing leading to the complete elimination of the selected areas is the best solution in organisations financed from public funds, as in the case of the public hospitals. One should also consider insourcing and whether it is possible to rebuild liquidated areas of activity owing to their costs. This question is of particular importance due to the dual nature of the National Health Fund as a beneficiary of public funds. On the one hand, it remains the author of medical procedures and their prices, while on the other, it is the payer of the planned actions. Therefore, the binding is of feedback nature which can be depicted in the form of an algorithm:



This dependence has a pejorative impact on the financial management of hospitals. In many cases, it fails to take into account the real costs of medical services, which, in addition to the sensu stricto benefits, also include sensu largo (hotel) benefits.

5. CONCLUSIONS

The results of the empirical research presented in the study are a confirmation of the thesis that the adopted outsourcing in non-profit entities as a management paradigm does not always lead to the goal of reducing the operating costs of the entity, and hence its financial efficiency. When considering a public entity strategy, managers should consider:

- the risk resulting from the market condition in the form of the lack of competition,
- the insourcing possibility (return to the status quo),
- insufficient financial resources in the healthcare sector,
- other management concepts, e.g. building a shared services center with clusters as the prototype.

Summing up, it can be stated that what works as a management model in for-profit entities may not necessary work in non-profit entities.

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