

Shared services arrangement in a decentralising healthcare environment – will it work?

Dinesh K. Arya^{1,2} MBBS, MD, DPM, MRCPsych, DM, FRANZCP, CHMS, DipHSM, MBS, FRACMA, FACHSE, ANZIM, MBHL, GAICD, Director, Conjoint Associate Professor (UNew)

¹Mental Health and Clinical Lead Innovation Support Unit, Hunter New England Local Health Network, District Head Quarters, John Hunter Hospital, Lookout Road, New Lambton, NSW 2305, Australia.
Email: dinesh.arya@hnehealth.nsw.gov.au

²Faculty of Health, University of Newcastle, PO Box 833, Newcastle, NSW 2300, Australia.

Introduction

To support implementation of National Health Reform and the National Health and Hospital Network Agreement,¹ changes are being made to the way hospitals and health services are funded and administered across Australia. In New South Wales (NSW), 18 Local Health Networks (soon to be called Local Health Districts) have been established. For each Local Health Network, a Governing Council (soon to be replaced by Health District Board) was also established. Early indication is that the incoming government is committed to strengthening local decision-making and accountability at network or district and hospital level.²

In November 2010, the then government in New South Wales (Labor) announced the establishment of a Clinical Support Division comprising three geographically based units – Northern, Southern and Western to help in the transition of previous 8 Area Health Services to 15 geographically-based Local Health Networks and 3 speciality networks.³ It was proposed that some clinical support functions, as well as some clinical services, may be delivered by the three Clinical Support Divisions. In April 2011, the new Minister of Health (Coalition Government) established a Transition Task Force and a Governance Review Team (both chaired by the Director General) with the intention to review and determine the appropriate location of health services-related functions, roles and responsibilities across the public health system in NSW. The indication from the new government is that it may not be in favour of establishing Clinical Support Divisions; however, the concept of shared services is still under consideration.

The perceived need for shared service arrangements

One of the key stated reason for ‘regionalisation’ (or development of the three Clinical Support Divisions in NSW) was to centralise some support (and possibly clinical) services to ensure that there was no net increase in health bureaucracy (as outlined in the National Health and Hospital Network Agreement).¹ In other words, it was proposed that increase in bureaucracy that may be needed to support an increase in number of health networks (or districts) would be balanced by a reduction in personnel in support services (health bureaucrats) by creating shared services for Local Health Networks or Districts (LHDs) in the form of three Clinical Support Clusters. Even if one makes an assumption that

this arrangement was not to assist staff in achieving higher productivity and outcomes than before as these arrangements were not necessarily introducing different funding, purchasing or contracting arrangements or endeavouring to introduce a free market and increase competition,⁴ the hope must have been that consolidation of support services and some clinical services would provide better economies of scale and allow reductions in staff providing these support and clinical services.

Another suggested reason for proposing to create an intermediary shared services arrangement was to assist the LHDs to focus on its core business, i.e. provision of clinical services. Of course, this argument became somewhat difficult to sustain with the proposition that Clinical Support Clusters may also provide some clinical services, despite the explicit intention to devolve accountability for the provision of clinical services to the 18 LHDs.

Moreover, it has to be acknowledged that the LHDs might differ in what each LHD might consider a ‘core’ service for which local accountability, decision making and direct function control is necessary. With the LHD Boards having been given accountability for performance of the LHD, a pre-determined shared service arrangement may therefore limit a LHDs ability to be accountable for performance. There also remains a concern that if shared service arrangements expand beyond the transaction-type services and begin to incorporate human resources, education and development, performance management, planning and other support functions required to support staff providing direct clinical care, it may begin to interfere with the LHD Boards’ ability to fulfil its responsibilities.

The phenomenon of shared or support services

Clearly, the attraction for shared or support services in public and private sectors alike, stems from the drive to be efficient. More often than not, development of shared services are a result of some need for downsizing,⁵ not because shared services are seen to be a more appropriate way of doing business, but because consolidation appears to be an opportunity to make efficiency gains. Outsourcing with the intention of having shared services is also not a new phenomenon in Australian public services.⁶ In NSW Health, shared service arrangements do exist for some transaction based services (procurement, warehousing and logistics), data centre operations and technical support services, linen and food

services. Health Support Services (HSS) was established in 2007, to provide common shared services across corporate, technology and disability services to NSW Health customers. It is also true that internationally, outsourcing arrangements, contracting out and creation of shared service entities for provision of some health services has also occurred in several health systems similar to Australia, including the United Kingdom and New Zealand. Both conservative liberal and labour governments appear to have embraced this idea. However, it is important to consider that numerous examples of outsourcing and developing shared service arrangements in the public sector that exist have been a way to downsize workforces and cut costs with the introduction of competition, implementation of free market in health or change in funding and purchasing arrangements. None of these considerations apply at this time. The prime driver for development of shared services is implementation of the reform agenda without increasing expenditure on non-clinical or support services.

Shared services might be developed as internal services or be contracted out to an external provider. To consider the advantages and pitfalls of shared service arrangements, it is important to differentiate between 'internal' shared services and 'outsourced' shared services, as considerations for these two types of shared services arrangements are quite different.

An internal shared service

The common argument for shared 'internal' services (i.e. within the span of accountability of the organisation) is that common management practices can be concentrated in a specialised unit able to deliver higher value at the lowest cost to the internal customers. Clearly, this provides an opportunity to achieve a higher level of expertise, consistency across different units within the organisation and also creates a point of accountability within the organisation. This can be an effective arrangement rather than having to diffuse responsibility across several units that often results in great variability in performance.

Such an 'internal' shared service allows accountability for that function to be managed internally and it is also possible to align outputs and outcomes of the organisational entity with the shared service unit as organisational outcomes are dependent upon the performance of this shared service unit.

An outsourced shared service

The reasons for outsourcing services to be provided by an 'external' shared service organisation are not dissimilar. However, the major difference is that accountability for the effectiveness of such a shared service now sits outside the organisation. Whereas the outputs and outcomes for the outsourcing organisation may be dependent upon the shared services provider, it does not have direct accountability over performance of the shared service provider. That is the reason why elaborate and extensive attempts are made to clearly specify types of services, how much they need and what can expect to be delivered. Outsourcing organisations are also often keen to ensure that they have the ability to evaluate the performance of the shared services.

At least in theory, inability to meet the needs and expectations of the outsourcing organisation would mean an inability for the shared service provider to remain viable. Hence, one can expect that it would be in the shared services' interest to be directed by the

outsourcing organisation. However, in the real world, outputs and outcomes of the shared service organisation are often different from the outcomes and outputs of the outsourcing organisation. For example, in the public health setting, the Health Board that has outsourced management of its information technology databases may wish to achieve good health outcomes by being able to use information contained in the databases differently; however, the essential output for the outsourced shared service is to maintain the database. Its performance is not dependent upon investing, prioritising or re-prioritising resources internally to customise the database to enable achievement of good health outcomes, as achieving good health outcomes is not an indicator of its performance.

Why Health Districts may resist outsourcing shared services?

One reason why LHDs need to be concerned about shared service arrangement or outsourcing of some services is because of difficulty the LHDs will have in prioritising, specifying and monitoring the quality of services provided externally. More importantly, at this time of change, when organisations are making all kinds of re-adjustments (including structural, financial and operations) to find the equilibrium price for delivery of services and equilibrium quantity to align with proposed activity based performance arrangements, LHDs would want and need as much control over redesign and reconfiguration of any and all services that may directly or indirectly affect its performance. By virtue of agreeing to outsource a service, LHDs might find that their ability to make locally informed decisions is compromised because of inability to redesign and reconfigure the support services to increase its performance or make efficiency, effectiveness or productivity gains. Clearly, the responsibility for clinical, and by extension economic and social outcomes will remain with the LHDs.

There is little debate about the fact that development of shared services has a considerable effect on the 'outsourcing' organisation. Reducing staff and slashing overheads invariably results in lowered morale and the workforce becomes less agile. This is because downsizing inevitably results in diminishing the need to improve, increase and expand the business and to eliminate those services that are not necessary. It is also true that shared services often attract the best and the brightest. This is understandable as shared services are expertise- and knowledge-based organisations. The most innovative employees tend to drift to shared services to take up the challenge of developing the new and the different and earn respect only available to experts and suppliers, rather than be subordinates. Although this does provide an opportunity for the outsourcing organisation to grow others internally, it is a net loss for the organisation to improve and innovate.

Even though there are numerous examples in manufacturing and also service organisations that have implemented shared services, the following points should be noted:

- Successful outsourcing of shared services is mostly limited to transactional areas, like payroll processing, data systems entry, and claims processing. This tends to work, but when shared service arrangements are extended to non-transactional areas, problems begin to arise.

- To establish shared services, there is often a need to support it with considerable reorganisation and re-engineering effort within shared service entities, as well as within outsourcing organisations. Before making this investment it is useful to conduct a cost benefit analysis, especially endeavour to consider intangibles in terms of change, adjustment and realignment of people and functions required.
- It is true there are also some examples of stand-alone shared services in the United States (e.g. AlliedSignal); however, it must not be forgotten that most large corporations have chosen to create internal shared services with accountability within the organisation (e.g. Monsanto, Amoco, Rhone-Poulenc). There are very few examples of successful shared services external to span of accountability that have survived. More importantly, those that do operate, do so in a strong market environment (which is very different from the public services environment).

With regard to shared services arrangements, the Health Districts need to consider the following criticisms frequently made about service provision by shared services.

1. Line managers of outsourcing organisations are frequently unaware of what shared services entities provide. Such disengagement is a lost opportunity for redesign of functions to improve productivity, effectiveness or to generate efficiencies within the organisation.
2. Shared services are often unaware whether users are satisfied with those services and whether it is meeting their needs. Their preoccupation is to meet the agreed arrangements for supply.
3. Supply is maintained at the minimum agreed quantity and quality. Both outsourcing and supplier organisations have an agreed expectation that any enhancement will be costly for the supplier and will therefore be paid for by the outsourcing organisation.
4. The outsourcing organisation is often at the mercy of the shared service organisation to introduce enhancements. Often these do not occur according to the outsourcing organisation's timeframe or to their satisfaction as any enhancement is dependent upon the benefit the shared service organisation sees from implementing that improvement for its own business and survival.
5. It is difficult for the supplier of shared services to understand or appreciate attributes of supplied services that are important for the users.
6. It is also difficult for users to convey their needs, as it might interfere with supply arrangements. In this context the 'product' becomes more important than the 'people' for whom it was intended.
7. Enhancements to the outsourcing organisation are costly as these are costed at absolute cost, rather than at marginal costs – the difference often producing profit (or surplus) for the shared service.
8. For shared services arrangement to work for the outsourcing organisation, it is necessary for the entire organisation and workforce to be educated about what services are offered by the shared services organisation, what might be trade-off considerations for the organisation in terms of cost, productivity and satisfaction, how to escalate a change in specification (and what is possible), etc. This is a considerable cost for the organisation both in terms of investment in education as well as an ongoing opportunity cost for the entire organisation and its workforce for not having been able to understand implications fully.
9. Often the shared services supplier makes promises about 'educating' the outsourcing organisation about provision of services. Even when this occurs (which is often minimal) it is limited to 'management groups' rather than individual employees (the actual customers).
10. Often the outsourcing organisation is left at the mercy of shared services suppliers, as entrepreneurial spirit (and expertise) to implement improvements is within the shared services organisation. For each deserving improvement the outsourcing organisation is left with the challenge of then finding resources to buy yet another 'enhancement', irrespective of whether it really changes the outputs or outcomes (remember – not the same as that for shared services!).

Conclusions

It can be argued that in an open market, it is often not possible for an unresponsive shared service to survive for long. Losing customers cannot be healthy. However, this is not the case of public service monopoly support service. If the intention is to enable Health Districts to have fully functioning Boards and be held accountable for provision of healthcare, it is important that Health Boards consider accountability expectations, and then make decisions with regard to whether they wish to enter shared service arrangements.

The following final points may be useful to consider:

1. To achieve economies of scale, acquiring, purchasing and negotiating appropriate expertise to achieve specific functions is not unusual, novel or inefficient for small or large organisations. However, in entering any shared service arrangements the Health Boards may need to ensure that their ability to prioritise their resources appropriately and make informed decisions about how health resource will be invested, is not compromised.
2. Regionalisation experiment (i.e. creation of an independent 'regional' tier independent of the Health Boards, whether it is to do with purchasing, funding, planning or delivery of some healthcare) other than for transition-type services might present challenges and risks. It can result in diffusion of accountability, inefficiencies, delays and inability of Health Boards to plan and deliver services to its catchment population. The last two decades of market reforms within healthcare internationally suggest that these functions are always either centralised or decentralised, rather than being maintained at an intermediate tier. There are clear examples of such experiments from New Zealand, the UK and Scandinavian countries.
3. The move from decentralisation to centralisation (or vice versa) is often an attempt for the system to become more effective and efficient. There is a tendency to centralise if and when it is recognised that there are not enough economies of scale or the size of the Health District presents critical mass issues to enable efficiencies to be achieved. Similarly decentralisation occurs when the span of responsibility appears to be too large to manage the business of delivering healthcare.

Having said that, in recent years, move to centralisation of healthcare provision has been to increase the size of health service entities, rather than dissecting some aspect of system to regionalise part of the business.

Competing interests

The author declares that no conflicts of interest exist.

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